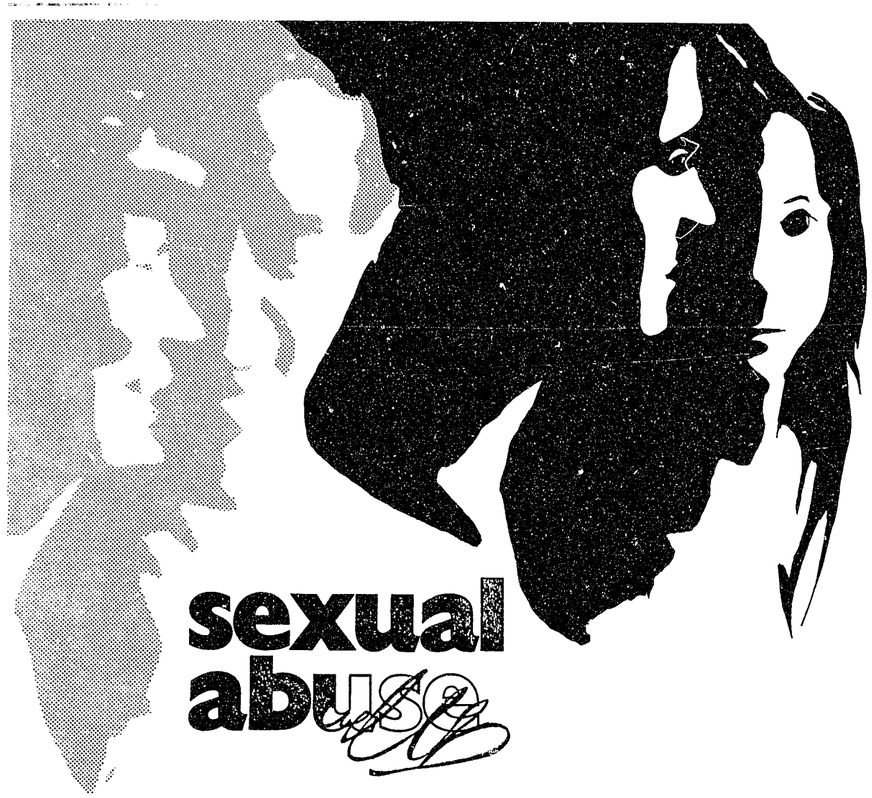

THERAPEUTIC & SYSTEMS CONSIDERATIONS FOR THE CHILD AND FAMILY

Edited by Claudia A. Carroll, L.S.W.II, Psy. D.
and Bruce Gottlieb, L.S.W.II

Colorado State Department of Social Services
Division of Family & Children Services
1575 Sherman Street
Denver, Colorado 80203

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THERAPEUTIC & SYSTEMS CONSIDERATIONS FOR THE CHILD AND FAMILY

sexual abuse

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PREFACE

In July, 1982 the Colorado State Department of Social Services sponsored a two day conference on child sexual abuse. The conference planners, Claudia Carroll and Bruce Gottlieb, brought together an experienced and diverse group of Colorado practitioners who presented workshops on both treatment and systems issues of child sexual abuse. The conference was attended by 250 people representing social work, psychiatry, psychology, law, education, medicine and the concerned public. This book is based on the conference. The purposes of the conference and this book are to identify major issues and trends and to stimulate the exchange of perspectives and practice among those who are concerned about preventing and treating child sexual abuse.

In Colorado, as in other states, awareness of and concern for the sexually abused child and his family has grown quickly in the last few years. The Colorado State Legislature is dealing with nearly a dozen child sexual abuse bills this session. Schools are developing prevention education programs for children. Community agencies such as law enforcement, court services, social services, mental health and health care are developing cooperative policies and mechanisms to enhance effectiveness of identification and intervention. Practitioners are confronting personal feelings about child sexual abuse and learning more about how to intervene in ways which minimize trauma for the victim, establish evidence necessary for court action, and treat the victim and family.

The phenomenon of child sexual abuse is not new in Colorado or anywhere else. However, the extent to which it is now recognized and treated as a major social problem is new; the social phenomenon is now a social problem. This is a critical phase in which there is the opportunity to make major progress, to develop knowledge, skills and program directions and to lay foundations for the period of slower, incremental change that likely will follow.

Colorado, through the seminal work of the Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect and the American Humane Association, helped create awareness of and directions for the field of child abuse and neglect twenty years ago. Since then many Coloradans have made substantial contributions to this field. This conference and book and the concern and interest of all those who participated reflect continued commitment to maltreated children and their families.

Jane Berdie, MSW
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sexual abuse

Systems Issues

THE TREND OF CHILDHOOD SEXUAL ABUSE IN COLORADO REFLECTED IN THE CENTRAL REGISTRY

By Joann F. Davies, M.S.W.

The presentation of statistical data in a dynamic and exciting fashion is not a skill I possess. Because I find the data extremely interesting and important to all of us as we look at the dimension of the problem of childhood sexual abuse, I will be giving this information toward the end of this presentation.

As I reviewed the history of child abuse reporting in Colorado, I found that I would like to put my emphasis on that history so that we may look at childhood sexual abuse within the framework of the problem of all childhood maltreatment.

The identification of this phenomena has a history of 101 years in Colorado. In 1881, at the height of silver mining in the state, the Colorado Humane Society was organized "to protect children and dumb animals." Colorado had only been a state for five years. This was a time in our economic history when the mining of minerals brought the on-rush of people into the state for quick riches. That there should also be a concern for the child is to the credit of this group of pioneers.

Related to the Colorado Humane Society's beginnings was the earlier history, some five years previous, of the city of New York's near-failure to protect a child. In 1876, a nine-year old, Mary Ellen Wilson, was found by a church worker brutally mistreated by her guardians. There was no law under which the church people could protect this child except under the provisions provided by the Society for the Prevention of Cruelty of Animals.

I do not know if the founders of the Colorado Humane Society read the *New York World Telegram* where this story possibly appeared, but in any event, the Colorado founders also decided that children and "dumb animals" needed protection.

Membership in the Society was easy to achieve. One mailed $2.00 to Society headquarters in Denver and received a badge which they could wear ascertaining that they were indeed protectors of children and animals. It is not hard for me to imagine, as a devotee of "Little House on the Prairie" that many of the members resembled Charles and Carol Ingalls and their kindly neighbors.

Twenty years after the formation of the Humane Society, in 1901, the State Legislature enacted a law officially recognizing the organization which was then called the State Bureau of Child and Animal Protection. An appropriation was made and volunteers had police powers to "prevent wrongs to children and animals."

Six years later in 1907, the juvenile court system was established in Colorado. This was toward the end of the Edwardian era, a time in which children were viewed as miniature adults. However, legislative members of Colorado's House and Senate perceived children as needing other than adult courts to protect them.

Following the passage of Social Security Act in 1935, Divisions of Child Welfare were established in all 63 Colorado Counties. Historically, this was the height of the Depression, with severe drought covering this section of the country. Although child welfare divisions were established, their protective service functions were limited in terms of use of the court. Filing of dependency and neglect petitions were limited to juvenile court workers and the Bueau of Child and Animal Protection.

This situation continued for the next 14 years when, in 1950, a concerned group of citizens in the Denver area spearheaded a drive to demand trained staff in child welfare divisions. The League of Women Voters was one of the leading proponents in this effort, and within the State Public Welfare Department, Marie C. Smith, Director of the Division of Child Welfare, was the professional staff member who exerted a powerful influence on legislators. She and her advisory committee advocated for child protection effectively. This was a time in the nation in which complacency, family togetherness, "woman's place is in the home," and the quiet, postwar Eisenhower years prevailed.

The actions of this advisory committee and these persons were effective with the Legislature. In 1951 that body failed to fund the Bureau of Child and Animal Protection, and the State Department of Public Welfare, the present State Department of Social Services, instructed county child welfare divisions to move ahead in providing protection to children. The first steps were to invite local law enforcement persons to refer cases to the divisions and to advise these law enforcement people of the name of a foster family where children might be taken for protection.

Another five years passed, and in 1956, by State Public Welfare Board policy, protective services was designated a basic child welfare service to be provided in all counties.

Protective measures for children now moved ahead with more speed, and the gaps grow shorter in the strides taken. In July 1962 Dr. C. Henry Kempe's article on the Battered Child Syndrome was published in the *Journal of the American Medical Association*. The following year, then-Senator Richard Lamm, now Colorado's governor, acted as chief sponsor of the initial Colorado Child Abuse Reporting Law. This was the first state in the nation to pass such a measure.

The statute was pretty restrictive. All physicians and institutions "were required to report any child under 12 who had or has a physical injury." Six years later, in 1969, the number of the professions mandated to report abuse was increased and children up to 18 were to be reported.

A State Central Registry to track these reports was established. Sexual molestation was included for the first time in the definition of abuse. Minor changes were made in the law the next few years and in 1975 the entire Article 10 of the Children's Code, the Child Abuse Reporting Act, was repealed and reenacted.

The stimuli for this action came from several sources. First, in 1974, then-President Richard Nixon signed the National Child Abuse and Neglect Act which established a National Center for Child Abuse and Neglect, and provided funding for states and other organizations to research issues in child abuse and neglect. On the local scene, a four-year old Denver child died early in 1974 of injuries caused by abuse. His case was picked up by an investigative reporter for *The Denver Post*, and child abuse became an issue on the front pages for many months to follow. As a result of this death and the investigative reporting, lay and professional people concerned with child protection met in late 1974 and organized a grassroots organization which exists today, the Metropolitan Child Protection Council.

By the time the 1975 Legislature convened, lay and professional persons joined the ranks of those eager to testify to the kind of statute which they wanted as a tool by which children could be protected. Since the passage of the Child Abuse Reporting Act of 1975, several additions have been made, including sexual exploitation and prostitution in the definition of child abuse. The basic statute, as reenacted in 1975, remains the Act which continues today as the basis for reporting, investigation, and offering of services to abusive and neglectful families.

The Central Registry of Child Protection was established in 1969 to collect statistical and demographic data on children and their families who have an abuse or neglect problem; provide a tracking system to identify children who are re-injured; and serve as a diagnostic tool for persons who are assessing and treating the child.

To highlight the tremendous recognition of child maltreatment, including sexual abuse, I quote two statistics from the Registry. In 1971, 176 reports were made statewide. In 1981, 6,611 reports were filed. The sharpest increases began in 1975 following reenactment of the present Child Abuse Reporting Act and *The Denver Post* investigative reporting on child abuse and neglect.

In this conference we will be addressing issues concerning sexual abuse within the family, namely, incest, and the data I present will concern only this form of sexual maltreatment. I will not be addressing sexual abuse against children by third-party perpetrators.

During the five-year period 1977 through 1981, the Registry received confirmed reports of almost 2500 victims of incest. This is 11% of the children identified as otherwise abused or neglected over that five-year period.

Of these 2500 children, 85% were girls. The following data concern ages of children at the time of the report, not necessarily at the time the incest first began: Ages birth to 5 years, 11%; ages 6 thru 10, 25.5%; ages 11 thru 12, 12.6%; ages 13 through 15, 27.3%; 16 through 18, 21.6%.

The perpetrators of this abuse were predominantly male. Seventy-five per cent of the perpetrators were parents to the child. The balance were other relatives or persons living in the household.

Of the 2500 children, 62% were the only child in the family reported as the victim. Another 25% of the children were second victims in their family, and another 9% were one of three victims of incest. There were another hundred children who were the fourth, fifth or sixth victims in the family.

The identification of children who are sexually abused appears to come largely from three groups: Schools, medical personnel and law-enforcement. These professions reported 41% of all confirmed reports for the last five years. I think it is most commendable that schools, with their concern about the parent/school relationship, are so willing to report in the effort to protect children.

Sexual offenses against children are more likely to result in court action than are other forms of abuse. For example, 32% of the children of non-sexual abuse were known to the courts; whereas 49% of the incest victims were involved in a Dependency and Neglect Petition. Of the children for whom a D&N petition was filed, 8% of non-sexually abused children had their petition sustained, but 15% of the sexually abused children were found to be dependent and neglected.

In the criminal courts, conviction of non-sexual abusers was 1%; for sexual offenders the conviction was 5% of those against whom charges were made. For this latter group, another 36% received deferred prosecution.

Child sexual abuse identification, reporting and treatment is probably in its infancy as we look at the response to this kind of abuse against the background of other physical maltreatment of children.

The human barriers which cause people to hesitate, to shy away from, to avoid recognition of harm to a child; the age-old, deeply rooted belief that a man's house is his castle; the still-present, if unconscious belief, that children are the property of their parents — all of these barriers come into play as doctors, teachers, mental health staff, neighbors, social workers, and police persons make the decision to act on what they see or have reason to believe is harmful to a child.

The identification of sexual abuse carries with it the additional burden of taboo. Professionals who assess and treat child victims and their families must deal with societal as well as personal feelings about this behavior.

As the Director of the Colorado Central Registry for the past ten years, I believe it is helpful to me and to you to have access to statistical data on the state of child abuse reporting in Colorado. More important is the reality that,

despite the short span of time in which we have been asked to respond to this phenomena, a mere thirteen years, here in this state, we have been able to assemble today such a galaxy of professionals from such a variety of disciplines, all of them practicing in this state.

A Central Registry may identify those children and families in need of services. However, it is the practitioner in the field who delivers services and ultimately protects the child.

A LARGE COUNTY SEXUAL ABUSE PROGRAM: ADULT DIVERSION PROGRAM IN EL PASO COUNTY

By Anne B. Topper, ACSW; LSW II

BACKGROUND

The Adult Diversion Program for Incest Offenders that has been developed in El Paso County in Colorado Springs was born primarily out of a feeling of desperation. The El Paso County Department of Social Services was being inundated with referrals of sexual assault and incest cases and was confounded by a lack of uniformity in how these cases were dealt with both in-house and in the community, especially in the legal system. We found it was impossible to deal with some of the cases facing criminal prosecution because attorneys for the defendants would not allow contact with any social work staff, feeling that such contact was a tacit admission of culpability. Treatment options for incest offenders and their families were severely limited. The situation was further complicated by the fact that while there was recognition that the reporting of incest was becoming a more frequent occurrance, financing for additional staff or resources in the community was non-existant, especially since impending fiscal cutbacks for both Social Services and Mental Health staff were looming large even then.

Even before learning of Dr. H. Giarretto's work in California and Peter Coleman's in Washington, it was decided that the County ought to try to develop a plan for diversion (later provided for in the Colorado Children's Code) that would fit the peculiar and particular needs of the community. Colorado Springs is a fast-growing community with a very transient population, including a large military contingent. The mean age of the population is relatively low. Furthermore, the city is politically quite conservative and was somewhat "soft on punishment" for sex offenders. In addition to these community factors, there was some concern felt by Social Services staff members who found that working with incest families was very difficult. We knew that trained people in the community with knowledge about the dynamics of incest were very scarce. In fact, many therapists in the community felt that working with these families was neither very gratifying nor productive. Of course, we had found as had others, that unless there is some legal mandate to provide impetus for treatment, incestuous families are very reluctant to remain in treatment for a length of time sufficient to ameliorate many of the family dysfunctions — and that denial can make a remarkable comeback as a family defense without a documented legal admission from the perpetrator.

Countering these conditions was the fact that a growing body of knowledge was beginning to appear about treatment of incest offenders and their families, and hope for effective intervention sprang eternal. Encouragement from Dr. C. Henry Kempe and the National Center for Prevention of Child Abuse and Neglect in Denver, who felt as we did, that remediation in these families was possible, and support from Joann Davies, Director of the Central Registry on Child Abuse and Neglect at the Colorado State Department of Social Services to go ahead and try to develop our own program, helped us feel our idea was a sound one. For three years, I button-holed everyone I could think of who could be instrumental in supporting even the idea of diversion. By the time we felt we were ready to approach Bob Russel, the El Paso County District Attorney with our plan, we were well prepared; he was willing to risk diversion and other significant community members were primed and ready to participate.

PRE-PROGRAM DEVELOPMENT:

An Ad Hoc Committee was appointed and included representatives from the District Attorney's Office, law enforcement personnel including employees of the police department who had the specific assignment to investigate sexual assault cases, a representative from the mental health center, a member of the defense bar who had represented sex offenders in many cases (and who had served as a Guardian Ad Litem in many other cases), another attorney who had served in the Public Defender's Office, as well as representatives from the County Department of Social Services. The Committee met weekly for several months to hammer out a diversion contract that would not abridge the constitutional rights of the alleged offender, would meet the legal requirements placed upon the different agencies, would minimize additional agency costs, and emphasize treatment and rehabilitation. Of primary importance was the all important admission of culpability.

The Committee also developed a list of exclusions — those circumstances which would render the individual ineligible for Diversion. The District Attorney's major reasons for excluding an individual from the Diversion Program are these:

1. Persons charged with sexual assault crimes on victims not related to the suspect by blood or marriage, or on victims with whom the suspect has resided for twelve months or less.

2. Persons who use physical violence, overt threats or intimidation which imply or state threats of bodily harm to the victim during or subsequent to the sexual assault crime.

3. Persons who have been previously convicted of any sexual assault crime, or who are currently charged with any sexual assault crime, or who have been granted deferred sentencing or deferred prosecution on any sexual assault crime.

4. Persons who have committed sexual assault crimes over an extended period of time on multiple victims to whom the suspect is related by blood, marriage or adoption, or multiple victims with whom the suspect has resided for more than twelve months, or a combination of such victims.

5. Persons previously accepted into and/or discharged from the Incest Diversion Program.

An attempt was made to communicate with the therapeutic community to describe exactly what was being contemplated and to ask for their support. Further, it was explained that referrals of incest offenders and their families might be made to them if they were interested in working with such cases.

Two exclusions that were deemed necessary by the Department of Social Services were:

1. Persons who do not desire to participate in the Incest Diversion Program.

2. Persons who are insane, as defined in 16-8-101-Colorado Revised Statutes, 1973 as amended, or who are certifiable under 27-10-105, or 27-10-106, C.R.S., 1973 as amended.

All of the above were strongly supported by the Committee and by the administrations of the various agencies. These were the official exclusions. However, DSS staff has found that the individual who states that she/he is willing to "go along" with signing the contract even though continuing to vehemently deny culpability, is such a poor prospect for treatment that we are not willing to accept these persons in the diversion program.

A copy of the Adult Diversion Agreement now used in El Paso County may be found in Appendix B.

SOCIAL SERVICE PROCEDURES:

The vehicle used by the county for treatment planning and review of the above-mentioned cases is the Child Protection Team. The county has constituted a special team to staff and review incest cases. This team (modeled after the regular Child Abuse Team that reviews child abuse cases other than sexual assault) meets once a week and follows the cases in the Diversion Program with great regularity. The first team meeting is called an Initial Consideration. At this time, the team considers whether or not there is a probability that the alleged offender might meet the conditions for the Program. If it appears that the individual would indeed be eligible, psychological evaluations are arranged. When the psychological testing results are obtained, the worker assigned the case is given a date for another team meeting when an estimate of the offender's treatability is discussed, reviewing the psychological evaluation and social history information to make this determination.

At this Child Protection Team Meeting, a decision will be made as to whether or not a client meets the conditions of the program.

A. If the client is determined not eligible, the caseworker will proceed by filing a Dependency and Neglect Petition and provide the usual protective services to the family. The Protective Services coordinating clerk will then send a copy of the staffing notes to the designated individual at the District Attorney's Office.

B. If the client appears eligible:

1. The Unit coordinating clerk will send a copy of the staffing minutes to the District Attorney's Office indicating that there are no apparent relevant exclusions applicable on this case.

2. The date of the next meeting, four weeks after the initial staffing, will be provided to the caseworker who is designated as case manager.

3. The worker presents a Diversion Contract to the client and has him/her sign the first line, only.

4. Client then decides to request entry to the Program, or not, knowing that entry to the program constitutes an admission of responsibility of his/her actions.

5. The worker and client will arrange for a psychological evaluation for the client.

6. The worker will file a Dependency and Neglect Petition.

7. The caseworker (knowing already what date the Child Protection Team will meet) will request the psychological evaluator and/or any other involved therapists to attend the next Child Protection Team Meeting.

THE CHILD PROTECTION TEAM MEETING:

A. Input from the District Attorney's Office on prior offenses should be available at this time.

B. A review of the psychological evaluation, the staffing minutes and any other pertinent information that the caseworker, or other professional (i.e. evaluator, therapist, school personnel) may have, will be conducted.

C. A discussion and decision on whether to offer the contract is made.

D. If the decision is to offer the contract:

1. The treatment plan will be finalized in written form so the client will have a copy;

2. A review date will then be set;

3. Worker will present the treatment plan to the client;

4. If the client still agrees, he/she signs all the clauses in the contract. (One week is allowed for the caseworker to accomplish this.)

5. Original contract is returned to the Protective Services clerk.

E. If the decision is to not offer the contract, the Diversion process stops, but the regular Protective Services procedures will continue.

Additional reviews are scheduled at varying intervals to determine how successfully the treatment objectives are being carried out. If it appears that the individual who signed the contract is out of compliance, conditions of lack of compliance are reviewed and the individual or client is given the perogative of attending one team meeting to explain why he/she has not been able to comply with the contract. In general, only those circumstances which are totally beyond the client's control are allowed as reasonable excuses for lack of compliance. Such circumstances might be the inability to schedule appointments with the therapist as verified by the therapist, a serious illness of the client, etc. If, after such a meeting, the client still remains out of compliance with the terms of the treatment program, and with the Diversion contract, his diversion from prosecution is terminated and the case is referred to the District Attorney for immediate prosecution. In the few cases where this has occurred, prosecution has been prompt with the offender being found guilty, resulting in either incarceration or committment.

In the agency's campaign to inform the therapeutic community about the program and to specify to them what the expectations of the client referred to Diversion are, considerable emphasis was placed on the fact that the client must agree to:

1. Make payment for any expenses incurred while in therapy (these expenses are those incurred by the client himself/herself, not necessarily incurred by the victim or by the spouse).

2. Make a commitment to attend therapy sessions as prescribed.

3. Make a good faith effort for change.

Only those individuals against whom it is possible for the District Attorney to file charges are found eligible for the Diversion Program. In the event an individual chooses not to comply with the recommended course of treatment, it is necessary to have some recourse to bring him before the court. If the case were not fileable, then the Diversion Program could be viewed as a paper tiger since there would be no serious legal consequences available for failure to comply with the recommended treatment plan.

It has been necessary in the past three years to occasionally launch another effort with the community to keep them informed of the Adult Diversion Program, addressing with them what the benefits are as well as what the drawbacks may be. The District Attorney has always been fully cooperative with the program. It has been conceded by both this Department and others that he did indeed take some risk in taking a public stance that it was "not only not necessary to throw every one of these guys into the slammer," but that both the offender, his/her family, and society, has been better served by an extensive rehabilitative program for these individuals. The program has steadily grown and it is our expectation that it will continue to do so, particularly with the development of an in-house family therapy program.

I have often been asked why we opted for deferred prosecution instead of deferred sentencing which is more commonly used. This option was selected at the direction of the District Attorney's Office to reduce the burden upon the District Attorney's Office and the court. It was felt that the same ends could be achieved by deferred prosecution enabling the entire case to remain with the Department of Social Services which could then focus upon the family as a whole — the preferred treatment milieu, rather than to have the offender's case referred to Adult Probation and the child's case remain with DSS.

Adjunctive to the Diversion procedure, which is directed exclusively to the offender, is the parallel action which is instituted by the Department in Juvenile Court. In each case, a Petition in Dependency and Neglect on behalf of the child or children is initiated and adjudicated (there are a few exceptions when an Informal Adjustment is requested). In this way, the treatment team has legal sanction to intervene with all appropriate members of the family and therefore can institute or recommend a treatment plan to include all family members as necessary. Since incest by definition is a family-based dysfunction, treatment must also be family oriented.

To date, the Program has been very effective and has been viewed by the community as a whole, and particularly by the agencies involved, as being helpful in developing treatment resource. Importantly, a successful conclusion for the cases for which Diversion had been initiated has clearly been achieved. There have been no known instances of recidivism in those families in the Diversion Program. We have had some cases in which a family has had to leave the jurisdiction of the District Court for good reason and the recommended treatment program has been carried out in the new locale through the means of the Interstate Compact. The District Attorney's Office has agreed to extradite an offender if terms

of the treatment program are not adherred to, that Diverion be revoked, and that the offender be returned to the local jurisdiction to face prosecution. It has not been necessary to invoke this action in the three and a half years that the program has been in effect.

THE DRAWBACKS OF THE PROGRAM:

The entire process of the initial consideration staffing through the Child Protective Team Meeting and the reviews and follow-up reviews to monitor progress is lengthy and time-consuming. The legal burden is indeed a heavy one. The necessity of parallel action in Juvenile Court to involve members of the incestuous family, in addition to Diversion, further compounds the expenditure of a great deal of time on legal issues. Because all members of the therapeutic community do not share the philosophy of the Department regarding the harmfulness of incest, not only to the victim, but to the family as a whole, there have been occasional strident differences of opinion as to what constitutes adequate treatment. The issue of control — that is, who is to say when enough treatment has been provided and what constitutes reasonable functioning of the family — is one that is, at times, hotly debated. The Department's stance is that since it is generally held liable for the safety of the child and is, in fact, mandated by the Children's Code to provide protection for abused children that have come to its attention and to prevent further abuse, it should have the controlling or determinant decision in these cases, pursuant to the approval of the court. Generally, most cases do follow the pattern designed by the team and the case manager.

STRENGTHS OF THE PROGRAM:

One of the biggest plus factors evolving from the Divesion Program is growth of additional community resources for incest treatment, not only within the Department of Social Services, but in the mental health system and private therapeutic community as well. An Offenders' Group for men has been developed which is conducted by the Mental Health Center. Preliminary reports indicate excellent treatment results and achievement. This group was a bit slow to start, but now has a waiting list. Additionally, groups for victims of various ages are conducted in the Mental Health Center, and these groups focus not only on therapeutic issues around the incest incident, but also on general self-esteem/socialization/relationship issues that are so necessary for the victims of sexual assault. Other treatment modalities for individuals, for mothers and daughters, as well as for the family as a whole, are used as indicated. An additional resource that will become available soon is a Family Therapy Team developed by Social Services. Alcohol treatment is frequently prescribed. Again, it should be stressed that the available resources in the community have been expanded, broadened and re-directed, taking what has previously been available in the community and enhancing the cooperative efforts without substantive and additional special funding earmarked only for incest treatment. While this was born out of necessity rather than by choice, it has, we think, proved to be a trimmed-down and effective use of existing resources.

Increased community awareness, improved community education, greater community inter-agency cooperation have been realized as a result of the program. This has generated increased reporting. Of considerable benefit to both Social Service and the law enforcement agencies is the growing recognition that incest is not a problem to be dealt with only by "the cops" or "the welfare," but is, in fact, a community concern requiring community attention.

Under this system, the victim is very seldom required to provide testimony before the court about the incest incident, which can be a disastrous experience for a child who may have already undergone destructive emotional trauma. Generally, treatment can be implemented very quickly in these cases because the need to protect the alleged perpetrator from an admission is abrogated by his involvement in the Diversion Program. The lack of recidivism in cases involved in the Diversion Program also attests to its effectiveness. The fact that so many community agencies were consulted and were involved in the development of the Diversion Program, has promulgated education about the problem of incest throughout the community and has lessened the reluctance to report such cases to Social Services or to law enforcement. As a result, we have had a number of individuals from various agencies contact the Department to know how they could also become involved in the education of the community about incest, as well as in remediation of the circumstances once it occurs. And, of course, as I have stated before, the fact that the program has been developed without allocation of additional financial resources has been the strongest point in selling the program not only to Social Services, but also to other agencies in the community.

Perhaps of all programs that have been generated by the Department in the past ten years or so, this has been the one that has been most widely accepted in the community and one against which there have been fewer complaints than others. We have, as an agency, been quite pleased with the results and although we have not had a lot of testimonials from the "graduates" of the program, the lack of recidivism is testimonial sufficient in and of itself.

A MEDIUM SIZE COUNTY SEXUAL ABUSE PROGRAM: BOULDER COUNTY

By Heidi Mountain, M.S.W.

The development of the Boulder County Sexual Abuse Team began in November, 1976 when the Boulder Child Abuse Team reviewed the way sexual abuse cases were being handled within the county system. Careful examination of that intervention process revealed a number of destructive events which appeared to occur in the majority of incest cases:

1. The victim was exposed to numerous interview situations and was asked to repeat the details of the sexual experiences again and again, often to insensitive listeners. In short, the victim was harrassed and acutally pressured to recant her story.

2. The alleged perpetrator usually denied the allegations and, under the advisement of counsel, refused to discuss his problem with involved professionals. Chances for initiating therapeutic intervention were negated.

3. When a case did go to court, the agony of testimony took its toll on the entire family as witnesses were usually unprepared and confused by the trial process. In the majority of cases, the defendent was acquitted, as a criminal case of incest is so difficult to prove. Failure to prosecute not only resulted in significant loss of time and money for the justice system, but also gave the perpetrator a feeling of "vindication" with no rehabilitation.

4. Victims were often placed in long-term foster care, which nurtured feelings of abandonment from their primary family. The family often blamed them for "telling." This set up a "we-they" situation. The victim's nightmare was intensified.

5. Community agencies were usually disorganized in their approach and often spent the most time fighting among themselves. The net result was inconsistent communication with the family and an ineffective and confusing treatment plan.

6. A number of family members seemed to exhibit more emotional instability after the intervention process than before. There were frequent suicide attempts, increased drug and alcohol abuse and repeated incidents of delinquent behavior patterns.

In summary, careful incest case analysis revealed that intervention methodology was largely responsible for intensifying family trauma. A decision was made to make incest cases a priority and two child protection workers from the Department of Social Services were asked to develop an effective sexual abuse program and coordinate community skills around this project. The task began with three basic steps:

1. Careful review of all available literature related to incest.

2. Personal and written contact with existing sexual abuse programs throughout the country who appeared "successful" in particular areas of program operation.

3. Establishment of a "Boulder community effort approach" to combat the county-wide incest problem.

Heavy emphasis was placed on this last step. Numerous meetings were set up with various agency heads to discuss the sexual abuse problem, share information and enlist their ideas and support. The key question promoted among the community professionals was "How can **we** create an effective system for dealing with our incest problem?" Critical attention was given to members of the civil and criminal justice systems because of their crucial role in all cases. Concerns, ideas and case decisions were routinely shared and explored. Soon, basic program policy was developed.

Within approximately seven months, the skeletal framework for the program had been created and numerous community agencies were involved in the process. Community education and participation had significantly sharpened case identification skills, resulting in a marked increase in the referral rate. The Sexual Abuse Team suffered from severe staff shortages. In late 1978 additional funding was sought through a grant application from the Law Enforcement Administrative Assistance Association. The funding was awarded in April of 1979 and provided for additional 3 and 3/4 staff, enabling the following program expansions:

1. Implementation of a specialized training effort to enhance social worker-law enforcement team skills and coordination.

2. Creation of an in-house treatment program to minimize referrals to outside facilities where coordination and consistency could not be easily controlled. The dyad treatment modality and Parent's United Groups became an important part of the program.

3. Inclusion of a community outreach component to specialize in community education, training and coordination.

4. Development of a research project to a) gather significant data relating to the sexual abuse problem in Boulder County and b) assess the accomplishment of incorporated program objectives.

Following the completion of a very careful hiring process, the Sexual Abuse Team personnel list included a project director, four direct service workers (divided into two male-female teams), clerk-steno-researcher, clerk-steno volunteer, evaluation consultant (funded by the Department of Social Services), and one social work

field-placement student. All personnel were involved in a month long training program which concentated on interview techniques, treatment issues, public speaking skills, community resources and related professional contacts, and personal reactions to incest.

By July of that year the program was ready to go into full operation. Program philosophy was firmly developed and was based on the following four major premises:

1. Incestuous behavior is one symptom of a dysfunctional family. It is a maladaptive mechanism adopted to maintain a balanced family system. Through treatment this mechanism can be replaced with healthier and more productive behavioral patterns, improved self concepts, and positive role relationships of all family members.

2. The most optimal approach to treating a dysfunctional incestuous family system involves preservation of the primary family, whenever possible.

3. The Civil and Criminal Court systems can be highly effective in helping the family when involved therapeutically versus punitively.

4. Because a number of agencies are involved in responding to the incestuous family, coordinated intervention is imperative. An effective program relies heavily on a community based system. Primary parties involved in coordination efforts are:

Department of Social Services
Law Enforcement
District Attorney
Judicial Systems — Civil and Criminal Courts
Attorneys — Prosecuting and Guardian Ad Litems
Mental Health Centers and Private Therapists
Education Systems
Health and Hospital Systems

PROGRAM STRENGTHS:

In the initial project year, the incest referral rate increased approximately 60%. This rise appears to be a direct result of the concentrated community and outreach effort. The increase in the number of sexual abuse cases permitted the Team to provide in-depth intervention to over 100 families, as opposed to 32 the year before, thereby significantly increasing the number of individuals who received rehabilitative services.

An important program accomplishment was the 78% acknowledgement rate the Team maintained in perpetrator interviews throughout the year. As previously mentioned, emphasis was placed on the investigative process, conducted by the social worker-law enforcement team. Initial interviews were carefully planned and followed a specific outlined procedure designed to diminish threat and encourage openness and cooperation. All investigations were completed in one day and all family members were interviewed separately to avoid collaboration. Mid-interview discussions gave the interviewers a chance to assess the situation, consult with the District Attorney if necessary, and strategize the remainder of the interview. All these program procedures seemed to positively effect the Team's ability to gather factual information and begin a trusting treatment relationship.

The treatment component was influenced positively by the high perpetrator confession rate. This permitted all family members to confront the incest problem and work on a variety of related dysfunctional issues, individually and together. Various negative behavior patterns, closely associated with incest, were diminished significantly. The majority of families treated became productive community members. Key to the treatment process was the development of self-help groups: Parents' United (see Appendix C) and Sons and Daughters United. Not only did the groups serve as a support system which functioned to monitor the treatment process, but they also strongly encouraged social responsibility and growth. Group members took on various tasks, including public speaking and writing newspaper articles, to help combat the county incest problem. The recidivism rate for all involved families remained at zero.

The Team's coordination with the Justice System, encompassing Law Enforcement, District Attorney's Office, Probation Department and the Civil and Criminal Court Systems, clearly resulted in faster, more efficient handling of sexual abuse cases. On each case the Team provided written interview transcripts and attended appropriate District Attorney staffings to permit a first hand account of the investigation process and therapeutic assessments. Written reports and verbal consultations benefited all levels of complex decision making. Also, the project kept 100% of its "treatable" perpetrators from being incarcerated. This factor, along with the great reduction in court costs, resulted in a sizeable saving of time and money.

Other agencies also benefited from the program. Length of foster care placement was cut drastically, as the program philosophy concentrated on reuniting families as soon as possible. The Mental Health Center and other therapeutic facilities were relieved of many treatment hours with incestuous families. Schools, medical centers and child care institutions learned to appropriately identify and refer families for help. Through numerous presentations and newspaper articles, the lay community, too, broadened its awareness and understanding of the sexual abuse problem.

PROGRAM WEAKNESSES:

One area where the program manifested weakness was its neglect of its relationship within the Boulder Social Services Department. So much emphasis was placed on the development of outside community relationships, that support and understanding from within Social Services was simply taken for granted. Compounding this neglect was the fact that special programs, such as the Sexual Abuse Team, receive special recognition, special funding, and special favors — all of which can

create jealousy, anger and resentment from the older programs who are not sharing in the limelight. The Boulder Project was no exception and had to deal with a great deal of conflict and hostility because of its early "isolationist" attitude, particularly with other Child Protection Staff.

In retrospect, another problem was a lack of awareness for the need of professional and agency follow-up in certain areas. Just because initial support and understanding has been developed does not mean that that relationship is "written in stone" and can then be taken for granted. As in any healthy on-going relationship it demands nurturing with follow-up contacts, discussions, etc., redefining its existence and involvement. When breakdowns in the Boulder community system did occur, such as misunderstandings, sudden lack of support, etc., they almost always could be traced back to lack of any or significant contact. The lesson here is that mechanisms to insure appropriate regular communication must be built into each community relationship system.

The Boulder Sexual Abuse Program was unique in that it encompassed a total effort to combat a county sexual abuse problem. It took primary responsibility for the investigative, treatment, community and research components of the project. This "gestalt" approach permitted a high degree of consistency, organization and coordination within the program. Most importantly, however, was the community based philosophy upon which the program was built. This community system was where it really derived its strength, support, and expertise.

A RURAL COUNTY COMMUNITY-BASED SEXUAL ABUSE PROGRAM: THE MOFFAT COUNTY INCEST TREATMENT PROGRAM

By Lisa B. Kilrow, B.A.

The decision to set up a treatment program for sexual abuse began with Colorado Senate Bill 26 and the funds made available through that bill. A focus of Senate Bill 26 was to prevent children from being lost in the social services system, with an emphasis on planning new programs to prevent unnecessary foster placement and other types of out-of-home placements of children. In an attempt to evaluate what type of program might best address such issues, the Moffat County Department of Social Services began to review their child welfare cases. Without doubt, cases involving incest stood out as those requiring maximum intervention and foster care placements, while at the same time being the least successful.

This conclusion was made by observing the "typical" incest case. In the majority of cases the child was removed from the home indefinitely. If the victim was younger than thirteen, then foster care usually lasted as long as legally possible, an average of two years. If the victim was a teenager, then likely they remained in foster care until emancipation. Further trauma was perpetrated on the child by the fact that lengthy placement often involved multiple changes in foster homes. For example, one case involved a girl who was thirteen when placed in foster care and who by age sixteen had lived in twelve different foster homes!

Detrimental effects of leaving a child in foster care unnecessarily are many. It often increases the child's sense of responsibility for the sexual abuse and subsequent break-up of the family. There is an implication that she (the victim) is the one being "punished." Long term placement can increase the child's sense of differentness. Additionally, in our experience, families who were not reunited after an extended period of time tended to stop, or resist, working in treatment, thus necessitating longer placements of the child.

Although the child was removed from the home based on the allegations of sexual abuse, admissions by the perpetrator were almost non-existent in the average case. Such cases were difficult to adjudicate in both civil and criminal courts. In both courts the legal process was exceedingly stressful for the victim, involving her testifying and being cross-examined about the specific details of the sexual abuse. In essence, the victim was placed on trial rather than the perpetrator. If the perpetrator maintained his innocence, thus denying his responsibility, treatment was severely limited. This also placed the victim at risk for future molestation and scapegoating, because the failure of the legal system to find the perpetrator guilty vindicated him, leaving the child again unprotected.

Despite agency interventions the families were not getting better. Although the helping professions had good intentions, it wasn't working. Often these families would have repeated involvement with department of social services because of recidivism. Often the victim, acting out the unresolved emotional and psychological conflicts of the family, would become involved in delinquency, promiscuity, drugs or other behaviors which warranted further community intervention. The system was continually responding to the symptoms of the pathology in the sexually abusive family rather than addressing the core problem of longstanding maladaptive patterns of functioning of the family.

The decision was made by the Moffat County Department of Social Services to implement a program to address such problems. The first step was to launch a community organized program. Because of the numerous agencies that are involved in an incest case, it was clear from the start that if this program were to succeed it needed to be community based with each agency holding responsibility for program effectiveness. Toward this end there were several meetings held between agencies.

These meetings were both formal and informal at the agency and individual level. Program needs were addressed as well as negotiation of agency roles. The process occurred over a six month period of time. Agencies involved included the police department, sheriff department, probation, district court, district attorney, public defender, private attorneys, mental health, detoxification center, department of social services, hospitals, private physicians and schools. What resulted was a highly coordinated systematic approach. This was a much smoother, more effective process whereby professionals focused their efforts on the family's needs rather than having to deal with problems in network machinery, territoriality, and so on.

A second fundamental step was education. It was clear that what knowledge we did have was not effective in successfully treating incestuous families. Training focused on four basic areas: 1) dealing with personal reactions to incest and one's own issues with sexuality; 2) understanding the dynamics and etiology of incest; 3) how to interview families so that an admittal could be obtained; and 4) specific training around treatment issues. Training was in part provided by funds available through Senate Bill 26. In addition, with the focus on community organization, the agencies began to train each other by sharing their specific skills with other professionals. For example, mental health put on a workshop on suicide. The sheriff's department presented a workshop on body language and investigation skills. The district attorney's office provided legal information. This sharing of information occurred both in formal presentations and in "shop-talk" one to one discussions. A secondary though not less important benefit was that out of these discussions a much closer, trusting and satisfying working relationship developed between agencies that had not previously existed.

A second aspect of education was aimed at helping the lay community understand and support the new program. Moffat County is a relatively small rural community (population 13,129). This education was done in the form of newspaper articles, radio interviews, posters and presentations to community groups such as Lions Club, Jaycees, sororities, etc. Due to the problems the program would later encounter regarding confidentiality, this education proved essential. In addition, it was hoped that the incestuous family members would be more likely to seek help if they knew a specific program was available which was validated by community support for treatment rather than incarceration.

The final step in the program was the treatment itself. This was begun by forming two therapy groups — the "parents group" and the "victims group." These groups were later to become part of the national sexual abuse treatment groups known as Parents United and Brothers and Sisters United. Bringing the parents together into a group was a dynamic step in treatment. The parents were able to see that they were not alone, and that there were others who could understand what their family was struggling with. For many it was the first time they felt they were taking a stand and thus a step in treatment. Many were forced to confront their previous defense of denial. The first meeting of the parents group gained more ground than several individual therapy sessions had. There are things that one perpetrator could relate to another that even the best, most well-intentioned therapist could not bring out.

The victims group was equally productive. The first group consisted of girls ranging in age from four years to eighteen. Typically, the first reaction was one of shock when they found out that they were not the only girl to have been sexually molested. There was relief as well as anger, but the strongest feeling was comfort in that they were not alone. An extension of the groups was an on-call system whereby both parents and victims were available at all hours to sit and talk with families going through the investigative phase. This availability lessened the trauma for the new families as well as provided them with a therapeutic, helpful introduction to the program.

PROGRAM STRENGTHS:

The program has now been in effect for two years and continues to treat families successfully. There are several strengths to this community oriented program. In a time of cut-backs and employment freezes, this program is efficient and cost effective. The cost of not having to maintain a perpetrator in prison (often the alternative when no treatment program is available) is in itself an enormous savings. In addition, the cost of long-term foster care is avoided and almost all children are returned to the home by one year, with the largest percentage returned within six months.

This program has proven to be effective in preventing worker burn-out. The work involved in providing treatment is often intensive and draining. However, the feeling of "spinning one's wheels" is less prevalent when one has a defined role and approach and when one is not isolated professionally. Frustrations with coordinating community services are lessened to a great degree when the structure is already present for a smoothly functioning system.

A third strength is that this program is humanistic rather than punitive in its approach. The philosophy of the program is that incest is a symptom of an emotionally dysfunctional family. The goals of the program are to treat the problems the family has rather than to punish the individual who has acted out those problems. Incarceration or hospitalization is only recommended if a perpetrator is unwilling or unable (i.e. is a serious character disorder, is psychotic, or is dangerous) to participate in the program.

The resiliancy of Parents United and the victim's group stand out as another very important strength of the program. During the two years the program has been in existence, three therapists have left. Although such losses created some change and redefinition of treatment, the program itself continued to function in a highly effective manner with the parents themselves providing the foundation.

In discussing strengths it is important to give credit to the foster parents who voluntarily participated in a six week training program designed to assist foster families with victims of incest in placement. The training addressed basic education about incest. This included understanding and putting into perspective one's personal reactions to sexual abuse, and understanding the manner in which incest victims tend to act out their emotional problems and conflicts. These parents were instrumental in lessening the trauma of foster placement, in providing a safe environment in which the victim felt free to express her feelings, and finally in helping the child make the transition back to his/her own home.

PROGRAM WEAKNESSES:

Over time, the weaknesses of the program became apparent as well as its many strengths. Identifying such problems was instrumental in streamlining the program and should be helpful in avoiding such problems in future programs. With this thought in mind, the following issues are presented.

The importance of the legal system as a treatment modality has become very clear. Our program found out that if the perpetrators do not admit legally to felony charges they do not benefit from the program. It is extremely important to have legal clout. The perpetrator knows that the program is an alternative to incarceration. At times this is a strong motivator when perpetrators are struggling with internalizing control over their impulses, and treatment seems too painful or slow to them. Although the stress of court involvement is high for the family, the benefits far outweigh the disadvantages in long term treatment.

A second problem encountered by the program was the lack of built in rewards or incentives needed to support the family in treatment over an extended period of time. The family's perception of having to be involved in group and other therapies weekly for an indefinite period of time "no matter what" often created frustration and resistance. What sometimes resulted was "client burn-out" or major resistance, with the families having little sense of focus in treatment.

A third weakness identified by workers was the perpetuation of the "victim syndrome." All families entered the program with the knowledge that the program was victim oriented in treatment in that it focused on the victims' needs. The purpose of this stance was therapeutic in conveying that the incestuous behavior was the adult's responsibility. What needed to be emphasized in addition to this focus was that the victim was responsible for the choices she had now, that it was maladaptive and a distortion for her to not take responsibility for her current actions.

Confidentiality for families in treatment continues to be an issue due to the small size of the county. Every family in the program has had to confront the problem of an important person in their life discovering their participation in the incest treatment program. This is a particularly sensitive area when it is in relation to employment or child custody issues. Favorable community education continues to be of primary importance in addressing this problem.

The role of alcoholism is much more involved than was initially seen by the staff. Clients who were not being treated for their alcoholism did not benefit from treatment. Until the perpetrator unequivocably stopped his/her drinking there was no assurance that further sexual abuse would not occur, as the alcoholic episodes prevented one from taking complete responsibility for one's behavior. Additionally, when an alcohol problem was not addressed at their initial involvement in the sexual abuse program, it often became the arena of resistance for the individual, halting all progress in other areas. An alcohol evaluation prior to involvement in the sexual abuse program and an alcohol treatment order, as needed, in the probation order are often helpful adjuncts to the initial treatment plan.

Another problem encountered during the program was the professionals' own reaction to clients' response to treatment. In retrospect, it appeared common for families to become quite resistant to treatment following the initial disclosure of the incest. During this period of family denial the professionals involved would begin to question whether or not the family was indeed appropriate for treatment. Such questioning created unnecessary stress for all involved and could have led to the termination of a family for the wrong reasons. These periods of denial need to be seen as a normal progression in treatment.

Although there were several professionals outside of the program involved in the beginning stages of the program, a regular consultant was not used. In retrospect and considering the fact that treating incestuous families was a relatively new experience for all the staff, a consultant would have been an asset to the program. Having an experienced person in this area would have been helpful in providing treatment supervision, a potentially different viewpoint, and in identifying or clarifying problems in the treatment.

Setting up regular "community meetings" was strongly recommended at the beginning of the program formation. Such meetings were to be regularly scheduled times when representatives from all agencies involved in the program would meet and discuss what was working and what was not. This was not a problem initially because of the program's newness and uniqueness. However, as the newness wore off and individuals became more and more involved in their own work, communication began to lag. Problems began to develop, thus straining working relationships. Had a regular meeting been scheduled strains might have been avoided.

It is difficult, if not impossible, to condense two years of work into this paper. The hope is that the information provided is helpful in assisting new programs in their beginnings. The families benefitted significantly making change with courage and commitment that was truly inspiring.

A TEAM WORK APPROACH IN THE INTERVENTION OF INCEST CASES: INTERVIEWING THE PERPETRATOR

By Georgia M. Garland, MSW, and Gerald L. Utesch

This paper details the procedures developed over a period of several years by a county caseworker and a detective in the Police Department, City of Aurora, Colorado. Having witnessed the distress of children and families at the time of agency interventions, we felt that family stress could be ameliorated by using a structural interviewing process while at the same time obtaining the necessary information about the sexual abuse.

The objectives were:

1. To obtain a confession.

2. To transfer responsibility for the relationship from the child to the parent/perpetrator.

3. To generate ownership of the problem by the entire family.

4. To prepare the family for immediate therapeutic intervention.

5. To elicit interagency cooperation and stimulate the formulation of common goals which contribute to the protection of the child and the preservation of the family.

Underlying values and assumptions which relate to the above objectives are that parents have a strong desire to parent effectively and appropriately even though their efforts may be distorted and detrimental to growth. The second assumption is that the guilt experienced by the perpetrator is appropriate, and can be utilized to change behavior. The third assumption is that the problem is not limited to the victim and perpetrator but affects every member of the family as well as the family as a whole.

The overall design of intervention includes structured interviews with the referring party, the victim, siblings or other involved relatives, and lastly the mother. The purpose of these interviews, over a period of six to eight hours, is to establish the facts, provide support to the victim, gather information about the father, and assess the family relationships and other resources available to the family, such as financial and emotional supports. The crucial interview and data gathered is that gained by interviewing the mother. It must establish the degree of support and protection available to the victim. It should explore her commitment to the perpetrator and the marriage. It should aid her in establishing a base from which she is able to accept the facts, and ultimately support both her husband and the child. She will benefit from assurance that help and support are readily available to her as well as the family. All of these objectives cannot be met during the initial interview when the mother is having difficulty accepting the facts; however the stage is set for accomplishing these ends when the wrap up following session occurs later.

This format presupposes the participation of a female caseworker and a male police officer. The setting of the police department is more conducive to a structured interview.

STRUCTURED INTERVIEW WITH PERPETRATOR

A. The first contact is usually by telephone. The police officer always makes the call.

   1. Make excuse for perpetrator to come to headquarters (i.e. child in custody as runaway or child caught shoplifting). If too many hints are given, father may run or commit suicide.

   2. Explain wife is already here, but too busy to talk.

B. When father arrives, take to isolated interview room.

   1. Present are police investigator, social worker, and suspect, perhaps also the wife.

   2. Advisement of rights (Miranda Warning)

      a. Call it sexual assault, not rape or incest. Could also call it child abuse.

      b. After he signs rights form and waives, get it off his mind by moving on.

C. Be friendly — shake hands, introduce self.

   1. Explain our role and responsibilty.

D. Father is told that we believe that he is sexually involved with victim.

   1. Watch reaction.

   2. Listen for denial (disregard and continue).

   3. Begin to try to establish rapport with him.

   4. Get away from subject by finding out what is important to him.

      a. job
      b. family
      c. church
      d. sports
      e. house and yard
      f. citizenship
      g. clubs
      h. hobbies

      Take plenty of time to talk. Be a good listener. Listen for things that are most important. Note resources.

      Any comments should be of praise for his involvement or how hard he works. Continue to give positive reinforcement. Be understanding and empathetic.

E. Remove the wife from the interview by suggesting she reassure the children, call a friend, etc.

F. Gradually move conversation into his family background.

   1. How treated by mother.

   2. Father

   3. School

   4. Dating relationships

   5. Relationship with parents at this time.

G. Move to how he met wife.

   1. What attracted him to her.

   2. How met (look for anything to laugh about in relationship)

      a. Look for parallels in his parents relationship and his relationship with wife.

   3. Go back into relationship with parents.

   4. Go back to relationship with his wife after marriage.

      a. Expectations

      b. How many children — what sex.

      c. What are expectations of and for children, how does he individualize children (reflect back to him his own perceptions; begin to form guilt feeling that will later be basis for direct confrontation and also sets up guilt issues to be dealt with in therapy).

   5. Discuss his relationship with wife.

      a. How she treats him (mothering).

      b. How she relates to him emotionally.

      c. How he feels about her compared to other women.

      d. Other wives of friends.

      e. If you could just fantasize, would you choose your wife?

      f. Does she meet your needs, sensitive to your job feelings?

      g. Does she accept him as a good father (begin to examine and look for role reversal between wife and daughter)?

   (At this point the caseworker leaves.)

H. Move to detailed sexual relationship with wife.

   a. Infidelity (his - hers) why?

   b. Her sexual attitudes.

   c. Her performance (details, how often, any perversion). Interrogator can then change position of chairs and move in close, unobtrusively.

   d. Is she satisfied — is she sick — does it hurt her?

   e. Is he happy and satisfied (physically — emotionally)? May need to use illustrations from one's own life (either factual or fabricated).

   f. Reassurance, Sympathy, and Understanding. i.e. She must make you feel terrible! What do you plan to do about it? I'd like to help you with the problem.

I. Transition to sexual assault of daughter.

   1. Statement that daughter has said she was sexually molested by him (no details) say, "I believe it."

   2. He will deny.

      a. Stop denials by suggesting she is provocative, more sensitive to your needs, listens to you, how she acts, flirts.

      b. Go along with denials. Alternatives — say you believe he turned to her because wife not taking care of him. Must be wife's fault. Suggest maybe only touched breast and she misinterpreted it.

3. Begin to give minor details of what she alleges. Reassure — "I can handle it." "I understand." Sympathy. "I think you really wanted it to stop, but didn't know how." "Tell me about it." "I can help you deal with your wife and children." "I can help with job," etc.

4. Actively speculate on how it happened.

   a. Upset in natural father/daughter relationship.

   b. Sexual curiosity.

5. As he begins to break, move in closer.

   a. Put arm around shoulder.

   b. Hold hand.

6. Confession — let him talk it out.

   Sympathy/Reassure

   a. Slowly ask specific questions to establish time , date, details.

   b. Ask why if he can tell.

   c. After whole story, get written confession.

7. Give alternatives of legal side:

   a. charges

   b. dependency action

   c. foster care

   d. divorce

   e. separation

   f. job

   g. mental health

8. Stress Social Services is here to help family.

9. Offer to help tell the wife. Many times a difficult task if she does not already know and is invested in denial.

10. Do not make promises that cannot be kept. Do offer to facilitate matters with the district attorney, etc.

11. Remain supportive.

12. Have the perpetrator make a **written** statement.

13. Reassure him that although the responsibility for the relationship is his, successful resolution will require his full participation. His daughter needs to experience him as a loving, appropriate father and his presence is necessary to the family.

14. Congratulate him for taking this responsible, but painful step.

15. Assure him of your availability.

J. Assess father for suicide potential.

   a. Contract with him, if necessary, for non-destructive behavior.

The caseworker is then brought back in and a discussion ensues about the process, both civil and criminal, and what the perpetrator and family might expect from the legal and Social Services systems. The family is reassembled and the discussion reiterated, questions answered and assurances given. The family is given the names of several therapists, their preferences explored and an appointment made with a therapist **before** they leave the police station.

This process enables the father and family to confront an oppressive secret, mobilize and choose a new direction and perhaps most importantly, to maintain hope for the future. A confession permits immediate expectations, and the strengthening of the marital/parental system. Furthermore, the family can be preserved for the child — ending the unhappy practice of long term foster care which often results in permanent banishment. Lastly, the child is not placed in the position of testifying against her father and carrying the additional burden of guilt should he be incarcerated.

In conclusion it should be noted that the instances where this technique was successful were in father-daughter incest cases. There was a positive emotional investment in family life on the part of the father and substantial guilt was in evidence. Problems were neurotic or psychotic in nature rather than characterological. The composition of the investigative team, male police officer and female caseworker was such that successful disposition of these cases occurred wherein the male police officer seemed able to establish rapport with the perpetrator (despite the threat of his authority) which then made possible the perpetrator's confession. The female caseworker was able to move the family immediately into treatment upon the perpetrator's confession.

SEXUALLY ABUSED CHILDREN AND THE CRIMINAL COURTS

By Priscilla Conrad, B.A.

Prior to 1982, very few cases of sexual abuse against children proceeded any further in the criminal justice system than a police report. This was due, in large measure, to the threat the system held for those who were charged with the responsibility of protecting children. Prosecutors, too, felt reluctant to subject a child to cross-examination even at the preliminary stage, much less in a trial setting.

While the system lumbered through an occasional reported case, a concentrated effort among professionals in the field of child abuse and family violence was being made to educate communities to the dynamics of such abuse, while at the same time pioneering new methods of treatment for perpetrators. This educational effort was manifested by a dramatic increase of cases entering the system. The cause of these increases will not be addressed here, but rather the effect they have had on a cumbersome and tradition-bound system.

Police, prosecutors and judges began to feel the pressure of increased reports. How were these children to be dealt with? What could be done to better prepare children for court testimony?

Clearly, new techniques were needed to aid a child witness to relate the events surrounding a crime. This task fell, in many areas, to the Victim Services Unit of the District Attorney's office. In Denver, as Director of such a program, this writer began to seek ways of coping with the system's expectations regarding child witnesses. These expectations were challenging indeed. For instance, a child witness must understand the nature of an oath to tell the truth, and to articulate the difference between a lie and the truth. In the State of Colorado, a child age ten or over is considered presumptively competent, while a child under age ten is considered presumptively incompetent. A child, as with any adult witness, must be able to observe, recall and relate the circumstances of the crime.

Where to begin? Police officers, the first to feel the pressure of increased reports, began experimenting with anatomical dolls as a tool for interviewing child victims. They found the dolls to be an effective method in securing information.

These same dolls have become an even greater aid to victim service advocates in preparing a child witness for testimony. Home visits are now made to interview the child in familiar surroundings and establish a feeling of trust with the advocate who will be with the child during any court appearance. A picture of the courtroom is drawn and the child is placed by name in the court setting. Much emphasis is given to court personnel who are responsible for the safety of witnesses and where they are stationed in the courtroom. Questions the child will be asked are reduced to terms the child can understand. The child uses the dolls, initially, to show the advocate what happened. This removes some of the embarrassment the child feels about the event. In most cases, the dolls aid the child to eventually verbalize the circumstances of the crime during this home visit.

The most important step a victim advocate takes during this visit is to find the level of the child's understanding concerning right and wrong. This information is given to the District Attorney so that terminology the child can understand will be used in establishing competency. These techniques have been successful in many instances, but there is still much to be done.

As an advocacy system designed to insure the rights of an accused person, the criminal justice system is ill-suited to provide protection or redress for child victims of sexual abuse. In the opinion of most observers, a child can be as traumatized by the system as by the crime.

If sexual abuse cases must remain in the felony courts, further efforts must be made to assist child witnesses. Anatomical dolls should be allowed as demonstrative evidence and prosecutors must have the courage to use them. They must also fight to keep the dolls from being boxed away as part of a court's evidence. Photographs of the exhibits, taken from various angles, can be substituted in the appellate record in place of the dolls. Prosecutors must also begin to look at video equipment as a tool for taking testimony from a child, thus removing the distractions and fears of a courtroom setting.

Perhaps the proper resolution for some cases, such as incest filings, would be their removal from the burden of the felony court to the less restrictive area of the Juvenile Court. This portion of the District Court system is already involved in dependency and neglect petitions in relation to physical and sexual abuse against children.

However, such an action would require changing the statutory laws governing these cases. It would be a long and arduous effort but it would be my hope that those providing services to children would begin the task.

sexual abuse

Treatment Issues

CURRENT FINDINGS AND CRITICAL RESEARCH ISSUES OF THE 80'S

By Claudia Carroll, LSWII, Psy. D.

This presentation will highlight some of the research being done in the field of childhood sexual abuse. I will primarily be discussing research on the long-term effects of sexual abuse on the victim. One study about perpetrators will also be included. Reported effects of sexual abuse on children vary widely from transient stress reactions to severe neurotic and character problems to latent psychoses. Clearly, many factors contribute to the variable effects of sexual abuse on the victim with the psychological effects variably dependent, I believe, on four factors:

1. The child's development status before the sexual abuse and at the time of the abuse.
2. The nature of the abuse.
3. The victim's perception of the meaning of the sexual interaction.
4. The context in which the sexual abuse occurs — the 'abusive matrix'.

Let me state here that I have yet to see a case of sexual abuse perpetrated on a child or adult victim where there were not psychological sequelae associated with the sexual abuse and the pathogenic environment in which it occurred. Obviously I see a biased population as they are in treatment. Some people say a little incest isn't bad, but the incest taboo in our society is exceedingly important, as it insures the safety of the home to the child. The child may have received love and nurturing through the sexual relationship, yet at a heavy price. The sexual taboo allows parents and children to be closer as each knows that there are boundaries and the certainty of these boundaries is known by all, so that their caring and love of the other is safe. For the victim of sexual abuse, caring and love is not safe, and indeed affection and sexuality can merge. From time to time people present information that incest does not cause severe damage. I believe this argument denies the pathological environment in which the child is raised. Excerpts from the article "Children Not Severely Damaged by Incest With a Parent" written by Yorukoglu and Kemph[1], describes two children as having apparently healthy ego functioning who were allegedly relatively unaffected by the incest. (Such small N's are a big problem which is repeatedly reflected in the literature.) Although the authors describe two children in their article, I will only highlight one, as I believe he represents the questionable findings regarding both children.

Tim was 13½ and had been sexually abused by his mother for two years. When placed in foster care, he stole, broke windows, ran away, participated in mutual masturbation with boys in bed, exhibited himself to younger boys and had homosexual tendencies. He was described as manipulative and smooth. He felt responsible for the incest. On psychological testing, he revealed depression and self-destructive tendencies. For example, on the Incomplete Sentence Blank, he said, "Sometimes I feel that I might kill myself" and was admitted to the University of Michigan's Psychiatric Hospital. The conclusion that the authors had drawn — that the child was not damaged by the incest because he had functioned, at least superficially, adequately prior to the disclosure is clearly debatable. They stated, "During the two year period of incestuous relationships,Tim had no adjustment problems or any scholastic difficulties." In other words he wasn't known to social services, mental health, or the court, and was doing alright in school. I believe what often happens is that we forget how exquisitely adaptive the child may be both in meeting the parents needs and in other spheres of functioning, and, indeed, in looking at this boy's history he did have many problems. He felt responsible for the incest, and ultimately exhibited severe acting out behaviors.

Those who argue that sexual abuse of the child may be useful to the child's development deny the pathological environment in which the child is raised and the profoundly narcissistic use of the child by both parents. In other words, the sexual abuse per se is symptomatic of a vast array of pathological problems in the family. It is this pathogenic environment in which the incest occurs which is unequivocally damaging to the child. Thus, I would suggest the child victim's pathology is mainly related to the predominantly narcissistic stance of the parents, and consider incest as just one more link in the long chain of exploitations these children are subjected to. One of the misconceptions in the field of sexual abuse is focusing on the sexual act itself rather than the emotional environment in which it occurs. This 'abusive matrix', the atmosphere of non-empathic and emotionally abusive parenting is, I feel, the important factor in later personality development. The lack of empathic, good-enough parenting, is the schism in the parent-child relationship which is so closely associated with all forms of child abuse.

RESEARCH FINDINGS AND IMPRESSIONS:

Dr. Estela Beale, Mr. Bruce Gottlieb and I had an opportunity to study nine cases of homosexual sexual abuse in which children were sexually abused by a parent or step-parent of the same sex. The children's ages were two to fourteen years. In none of these situations was the sexual abuse an isolated event. What was remarkable to us in evaluating the children were their defects in ego functioning characterized by poor impulse control, low anxiety and frustration tolerance, severe speech defects, spotty cognitive development in spite of average or better-than-average intellectual ability, marked motor retardation, or more frequently, dramatic hyperactivity, short attention span, and a pronounced inability to sublimate aggressive and sexual drives. The single trait found in all of these cases was a definite limitation in regulatory systems, with a high reliance on external controls. According to our observations, the clearly most deficient area, mainly the development of the self and

the establishment of object relations, is highlighted. Every child in this study revealed profound pathology in both of these areas. These children had an inability to experience any definitive sense of self, to maintain a clear self representation, as well as to project a clear self image.

In the failure-to-thrive work of Ms. Christy Cutler and Dr. Clare Haynes, they found 40% of the mothers of failure-to-thrive babies in their study population and 4% of the controls had been sexually abused in some form as children themselves. I believe this preliminary relationship of failure-to-thrive and sexual abuse speaks to the common thread of the problem being one of disturbances in attachment, bonding and deprivation in one's formative years. Such problems can take many forms: physical abuse, neglect, emotional abuse, sexual abuse and so on. Despite the unhappiness of their own childhood, the parent may be compelled to repeat the scenario of their own early lives. We see this striking similarity of the repetition in the high number of parents of children now being seen in the sexual abuse program at the C. Henry Kempe National Center, whose parents were also sexually abused. Not only were they sexually abused but the form and type of abuse is strikingly parallel to that which the parent experienced. In other words, if the mother was sexually abused by a relative, then the chances are her child will be sexually abused by a relative at approximately the same age as she had been, and experience a similar form of sexual abuse.

Turning to another study, Tsai et al[2] of the University of Washington reports a retrospective study of adult women victims which looks at the differential adjustment of adult women sexually molested as children. They took three groups: A group consisting of 30 women seeking therapy for problems associated with childhood molestation, a second group consisting of 30 women molested as children, but who had never sought treatment and considered themselves to be well-adjusted, and thirdly, a control group of 30 women who had not been molested. Two self report questionnaires and an MMPI were given to all.

This study must be interpreted cautiously as there was no prior objective screening as to which of the two groups of women victims were, in fact, functioning better. The study is valuable though, I believe in identifying some of the common findings and significant differences of those victims seeking treatment versus those not seeking treatment of that study population.

Among the common findings were:

1. The sexual abuse for both groups started between ages 6.3 years to 7.4 years.

2. Most waited a year to disclose the molestation and 53% of those seeking treatment had waited at least 11 years to tell anyone.

3. The molestation had most frequently been by a relative in both victim groups.

Significant differences in the two groups were seen in a number of ways.

1. Those victims seeking treatment were older when last molested (median age 12 years) than victims not seeking treatment.

2. The molestation had gone on longer for victims seeking treatment (mean 4.7 years) than victims not seeking treatment.

3. Victims seeking treatment were sexually abused more frequently than victims not seeking treatment.

The type of sexual act was different for the two groups. Women seeking treatment reported that intercourse was attempted more frequently than women victims not seeking treatment. The feelings recalled at the time of the molestation were also different. The treatment group had more negative feelings toward the molester, more painful responses during the molestation, felt more upset after the incident, and more pressure to not tell anyone. They also had more guilt about the sexual activity, and felt that it had had more of an impact on their lives than the non-therapy group. Those in the group seeking treatment were significantly less satisfied with their current sexual relationships and their relationships with men than were members of either the non-therapy group or the control group. On the MMPI findings the most frequently elevated scale configurations of the treatment group would suggest a history of poor family relationships, an attitude of distrust toward the world, difficulty in becoming emotionally involved with others, sexuality seen as a hostile act through which anger is released, a tendency to confuse sexuality with aggression, and finally, low self concept.

The authors noted two major findings of this study. First, as suspected, women seeking treatment for problems associated with childhood molestation were significantly less well-adjusted than either women who had been molested but were not seeking treatment, or women who had not been molested. Secondly, adult adjustment differences may be explained by the varying reports of the molestation. Specifically, women seeking treatment reported a later age of last being molested, that is, being twelve or older. This may be explained by the fact that the older child may feel responsibility or guilt over failing to prevent it. They may be more aware of social norms, and this comes concommitantly at a time in adolescence when there is increased sexuality. Another possible explanation for the different adjustments may be the stronger negative feelings associated with the molestation. Remember, the women seeking treatment felt more pressure to participate, more guilt, greater dislike of the molester, and stronger feelings of being upset. All of these feelings may be associated with later psychosexual problems. Finally, women victims seeking treatment had been molested more frequently, and the molestation had gone on for a longer period of time than for those victims not seeking treatment.

It is interesting to note that the victims not seeking treatment were asked what they believed contributed to their adjustment. Two factors were suggested more frequently than all others. They had received support from friends and family members that they had not been at fault, had no reason to feel guilty, and they were still a worthwhile person. Also, they felt they now had sympathetic and understanding sexual partners who helped them discontinue generalizing to all men feelings attached to the molestation.

Again, one must be cautious around the interpretations of this study and its limitations. It is possible that the women in the treatment group are less well-adjusted than those not seeking treatment for reasons completely unrelated to the molestation. Secondly, self-report and retrospective data may be influenced by conscious distortion and/or memory deficits.

The conclusion, though, is interesting in that women molested as children may differ substantially in terms of later adult adjustment and such differences may be mediated by the emotional responses evolved in others at the time of the incidents. The healthier people came from less pathogenic environments.

Now I would like to turn to another study. This one was done by Meisselman[3] in 1980 which reports the findings of sixteen female victims of incest in treatment compared to sixteen non-incest females in treatment. They were matched on age, education, ethnic group and both groups were referred by their therapists. The MMPI was given to both groups. The incest victims reported more problems in sexual areas than the controls. This is not surprising. Actually I think all of these research findings are not particularly remarkable other than they are beginning to validate the subjective impressions of clinicians which heretofore have been untested. Research is beginning to clarify some of our clinical impressions in the area of sexual abuse. Meisselman's conclusion was that while incest was not specifically linked to any diagnostic category, it is associated with various kinds of later sexual problems.

Male incest perpetrators were compared with non-incest child molesters by Panton[4], 1979. The MMPI configurations of the adult male incest perpetrators were compared to the non-incest child molesters. He found there was a marked similarity between the mean profiles of the two groups. Both the male incest perpetrators and the non-incest child molesters showed feelings of self-alienation, despondency, rigidity, inhibition, and feelings of not being able to function adequately in heterosexual relationships. Interestingly, the incest perpetrators were more socially introverted than the child molesters. This was the only scale that was higher on their MMPI. I believe this fits with the incest perpetrator usually having such an extraordinary poor self image and poor self esteem that they have difficulty going out of the family for sexual contact, instead choosing a child within the home.

CRITICAL RESEARCH ISSUES OF THE '80'S

Where do we go from here? What are the critical research issues of the 80's? A hefty question. One must necessarily ask what needs to be done now and which questions are important to pursue? One of the areas I would suggest is looking in more depth at victims — why some survive fairly well, why others do not; what are the variables which contribute to adjustment or maladjustment in adulthood following sexual abuse as a child. Why are some people more stress resistant than others? Biological factors are clearly important. Some babies are sturdier than others and there may have been helpful people around at critical points. How do we look at this question more objectively?

Another area of interest is what is the overall relationship between child sexual abuse and physical abuse and neglect? Are these separate, or is there a common denominator such as I have suggested in the concept of the schism in the parent-child relationship?

Thirdly, what are the fundamental behavioral and personality factors that differentiate extrafamilial from intrafamilial offenders?

Fourthly — Are their particular psychological residuals which result from the various forms of abuse.

Related to this is another question. What type of treatments are useful in sexual abuse? And with which patients?

Finally, what can research tell us about "therapeutic interventions" so that we do not further perpetrate abuse on the child. At times the way in which we intervene can be unnecessarily damaging to the child and perpetrator.

The challenges of understanding childhood sexual abuse are complex. Many questions face us as we move ahead in this quickly changing field. We must answer these and other questions if we are to become more effective in treating this difficult problem.

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MEDICAL EVALUATION OF SEXUAL ABUSE*

By Barton D. Schmitt, M.D.

Incest refers to any sexual activity between persons too closely related to marry. Adopted and step children are included in most legal codes. Incest can be divided into 3 types: molestation, sexual intercourse, and family-related rape. Child molestation includes fondling the genitals of the child or asking the child to fondle or masturbate the adult's genitals. Non-touching offenses such as genital viewing and deliberate exposure to sexual acts or pornography also fall into this category. Without detection and intervention, molestation almost always progresses to full sexual intercourse. Sexual intercourse includes vaginal, oral, or rectal penetration (or attempted penetration) on a non-assaultive basis. Less than 10% of incest is the assaultive, forced intercourse type (family-related rape). The level of physical examination and laboratory investigation depends on the type of incest.

CLINICAL HISTORY

Sexual abuse victims may present to the physician in several ways. The child may disclose the incestuous relationship to her mother and be brought to a physician at that time. If the mother does not believe the child, the child may later tell a girlfriend, friend's mother, or school counselor and be brought in. Some adolescents will disclose their secret to a physician in a private interview. At other times the physician must elicit the history of incest based on his suspicions. His suspicion should be aroused when a pre-pubertal child is brought in with vaginal bleeding or other unexplained genital symptoms (e.g. vaginitis). A pregnent adolescent who has not dated and offers no information regarding the baby's father, should be suspected as being an incest victim. The main cause of any veneral disease in the pre-pubertal child is sexual transmission from adults. Other suspicious behaviors or findings are compulsive masturbation, precocious sexual behaviors, adolescent prostitutism, running away, a rectal or vaginal foreign body, proctitis (inflamation of the rectum) or recurrent urinary tract infection.

Incest cases require careful history-taking because less than half of the victims have any physical or laboratory findings. A detailed explicit account of sexual experiences by a pre-pubertal child should be considered hard evidence in these cases. Interviewing should proceed gently and at the child's pace. Pictures or anatomically correct dolls can be used to clarify body parts and the child's vocabulary should be elicited and used. Content of the interview should be focused on "what" and "where" questions, rather than "why" or "when" questions. If a social worker has performed an indepth interview, the physician can review this material and repeat only the parts relating to sexual activities. Corroboration of the history is helpful in court.

PHYSICAL EXAMINATION

Most female victims perfer a female physician to examine them, but the sensitivity and gentleness of the physician are of greater importance. A body surface exam should be carried out for any signs of non-genital trauma, especially bite marks or grab marks of the face and neck. An abdominal exam should assess the possibility of pregnancy. The mouth should be examined for signs of acute trauma such as redness, abrasions or purpura (purplish discoloration). The rectum should be examined for signs of trauma or laxity. The external genital should be visually examined (with the girl in a frog-leg position) for signs of trauma, laxity, or vaginal discharge. Most acute gential injuries occur between 4 and 8 o'clock (see Figure 1). The labia minora and posterior forchette are damaged first, followed by tears of the posterior hymenal ring. A speculum examination of the vagina is rarely needed except in the presence of non-menstrual vaginal bleeding or major trauma of the external genitals.

Acute trauma to the gentials, rectum or mouth usually heals completely in 4 to 7 days. Laxity of the anal sphincters is usually temporary and changes to spasm within a few hours after penetration. However, dilatation of the hymenal ring causes a permanent change to this structure. In pre-pubertal girls, a hymenal ring of 5 mm or greater to inspection is abnormal. With repeated penetration, the opening will often be greater than 10 mm. Following the onset of puberty, hymenal laxity must usually be assessed by palpation. A review of the medical findings in 6 case studies on pediatric sexual abuse victims (both family-related and not) is displayed in Table 1.

LABORATORY DATA

The amount of laboratory evidence sought depends on the history. (1) Molestation victims usually receive a wet preparation from the genital area or urine analysis for sperm. (2) Sexual intercourse victims receive tests for sperm if less than 96 hours have passed since the last sexual contact. (Also tests for acid phosphatase if less than 24 hours have passed.) In the vagina, sperm are motile for 6 hours and non-motile for 72 to 96 hours. Acid phosphatase persists for 24 hours. Sperm and semen can also be recovered from the mouth and rectum when these sites are involved. Rimsza found evidence for semen in 30% of the patients in which it was looked for (5% overall). While the presence of semen substantiates the victim's history, the absence of semen does not contradict the history of vaginal intercourse. Cultures for gonorrhea are taken from the throat, vagina and anal canal in all victims. Less than 5% of the victims have positive cultures for gonorrhea. Occasionally tests are found to be positive at sites initially denied by the child because of embarrassment (especially the throat). Tests for syphilis are not routinely indicated.

In addition to the preceding tests, a forensic examination collects specimens that help to determine the identify of the perpetrator. These specimens include pubic hair, scalp hair, fingernail scrapings, blood samples and sperm type. The specimens are usually transferred to the police laboratory in sealed, signed and dated envelopes. While this extensive evidence is mainly collected in cases of third party sexual abuse, it is also indicated in family-related rape cases. A gynecologist or emergency physician may be consulted to provide this examination. See Table 2 for a list of specimens to collect in a rape evaluation.

DIAGNOSIS

The diagnosis of child molestation and most sexual intercourse rests on the graphic history offered by the victim. False accusations are rare except for psychotic patients or sexually active patients who are angry at their father/stepfathers. Laboratory findings are usually absent because of the long delay before the victim feels safe in confiding in someone. If sexual intercourse has occurred within the previous 96 hours, laboratory evidence for acid phosphatase or sperm help to confirm the diagnosis. The finding of a dilated hymenal ring is supportive of the patient's history of vaginal penetration and may precipitate an admission of guilt by the alleged perpetrator. Obviously, such laxity could also be self-induced or caused by a foreign body or a finger. Also, the hymenal ring will be normal in attempted (unsuccessful) intercourse or in simulated intercourse between the girl's thighs. In family-related rape cases, the victim is usually brought to an emergency room immediately. The diagnosis is then confirmed by evidence of recent genital and non-genital trauma as well as positive laboratory findings. Overall, a normal physical and laboratory examination is compatible with most types of sexual abuse and never disproves it.

TABLE 1
Review of Pediatric Literature on Medical Findings In Sexual Abuse

Author and Site	No. of Patients	Mean Age	Male Victims %	Family-related Offender	Genital Trauma	Nongenital Trauma	Evidence of Penetration	Normal exam	Semen= (N)	GC= (N)	Syphilis= (N)
Rimsza, Phoenix, AZ 1982	311	9.2	14%	42%	16%	16%	32%	23%	5%	6%	0
Orr, Irvine, CA 1979	100	9.2	14%	37%	13%	15%	9.3%	65%	2.4%	4.71%	?
DeJong, Thomas Jefferson, Phil. 1982	416	girls 10 boys 7	17%	23%	11%	7%	?	76%	?	3%	?
Tilelli, Mpls, MN 1980	130	11.3	13%	23%	33%	combined	?	66%	?	2%	?
Scherzer, Baltimore City H. 1980	73	all < 14 y.o.	16%	20%	17%	?	?	83%	4%	3%	?
Ellerstein, Buffalo, N.Y. 1980	16 boys	9.7	11%	13%	50%	18%	?	50%	6%	0	0
	154 girls	10.2		25%	35%	combined	?	65%	?	?	?
Barton Schmitt, M.D. Denver, CO July, 1982											

*Adapted from "Child Abuse" in Green, M. and Haggerty, R.T. (eds), **Ambulatory Pediatrics** III, W.B. Saunders, Philadelphia, 1982

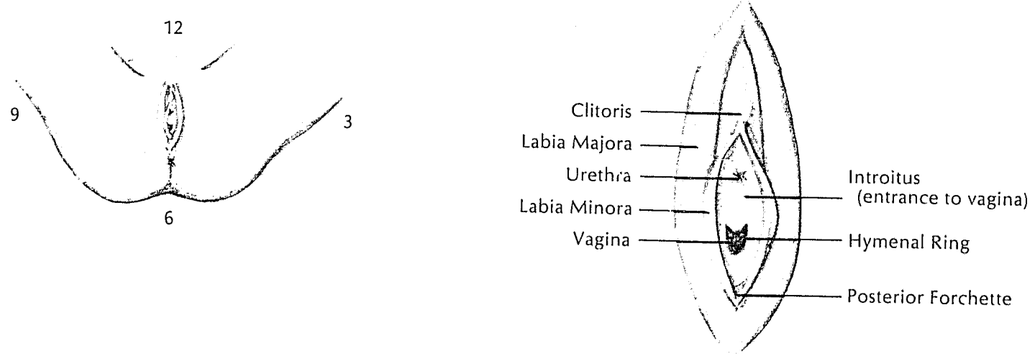
TABLE 2

RAPE EVALUATION: SPECIMENS TO COLLECT

1. Soiled clothing (for blood or semen)
2. Plucked scalp hair*
3. Plucked pubic hair*
4. Foreign hair
5. Vaginal secretions (wet-mount) for motile sperm and Trichomonas
6. Vaginal secretions (air-dried) for sperm, sperm typing and acid phosphatase - (the same with suspicious secretions from any site)
7. GC cultures (X3)
8. Blood of victim for syphillis serology and blood type
9. Saliva of victim for typing
10. Foreign blood (for typing)
11. Fingernail scrapings (for typing)
12. Toxicology - blood or urine specimens, if patient was drugged.

*Defer, if no foreign hair is detected.

Fig. 1
Normal Anatomy:
External Genital Area of Prepubertal Female



Note: Vulva = Labia Minora and Introitus

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PSYCHIATRIC EMERGENCIES IN MEDICAL PRACTICE: THE COVERT PRESENTATION OF SEXUAL ABUSE*

By Michael P. Weissberg, M.D.

THE PROBLEM

Unfortunately, psychiatric emergencies occur in medical practice with a great degree of regularity. Often, however, if the physician is not alert to them they may go undetected until too late. The medical practioner very often has the opportunity for early detection, emergency treatment, and referral of psychiatric emergencies. This offers an excellent chance for the prevention of morbidity and mortality, since the medical practitioner may be able to intervene early in the course of an impending emergency before a dangerous situation becomes inevitable. For instance, in one study of 60 successful suicides over 80% of these individuals had seen their doctors within six months before they killed themselves, and over 50% of this same group of patients had seen their doctors within one month or less of their deaths. Over two-thirds of these patients had histories of previous suicides or threats, yet these histories were known to only two-fifths of the physicians responsible for their care. There was substantial evidence of depressive illness in three-quarters of these patients, yet the diagnosis was rarely made and therefore the depression was not treated.

Medical practitioners may also inadvertently "promote" dangerous behavior in their patients. In another study of 32 patients who had commited suicide with an overdose of medication, 29 (91%) had seen a physician within six months of their deaths. Of these 29, 16 (55%) had obtained the means to kill themselves in a *single* prescription from their physicians within a week or less before their suicides. Patients may go from emergency rooms to clinics collecting medicines as a means for suicide. A 35 year old, divorced woman came to a medical emergency room complaining of insomnia of three weeks' duration. She was given 60 capsules of Dalmane 30 mg. and a follow-up appointment to the medical clinic. When her chart was reviewed, she was called back the next day. She admitted to collecting medicines for a suicide attempt and was grateful to be offered psychiatric consultation. She was relieved to have been "found out."

Even though all patients are not as open to intervention as this woman, medical practitioners must be alert to the possibility of a psychiatric emergency in their patients. Psychiatric emergencies may be defined as *any* alteration of feeling, thinking, or behavior that, if left unattended, may lead to harm either to the patient or to someone in the patient's environment. The emergency may be identified by the patient, his family or friends, or only by the physician. In all cases, psychiatric emergencies occur when there is a failure of the patient's normal coping mechanisms in response to stress. The stress may be external (loss of job, health, a loved one), internal (a psychological conflict), or a pathophysiological process (intoxication). Often a number of factors are present. For example, a divorce may reactivate unresolved grief about the earlier death of a parent, which may lead to suicidal behavior in a patient whose coping mechanisms have already been weakened by excessive use of alcohol. Patients may present their difficulties either directly or indirectly, but it is the physician's responsibility to suspect the presence of an emergency in *any* patient who appears to be under stress.

These patients may complain of physical symptoms that may be labeled as "crock" complaints, which makes it even more difficult for the physician to find out what is truly wrong. Child abusers and spouse abusers may seek medical attention with somatic complaints as their "ticket of admission" to the health delivery system. Victims of such abuse may also come to their physicians or go to an emergency room with unexplained trauma or other somatic complaints in an effort to covertly seek help.

It is up to the physician to take these complaints seriously and not act on the temptation to dismiss them as "just in your head." Only then will the patient begin talking about what really is wrong. The following case demonstrates the importance of accepting the patient's somatic "ticket of admission," as well as gathering information from as many sources as possible in a potential emergency. A 54 year old man, who had a chicken bone removed from his esophagus three months before, came to his physician complaining of a lump in his throat, even though two previous esophagograms were normal. The patient said he was depressed but denied any suicidal ideation. Only when the wife was interviewed alone did the physician find out that the patient had told her of his plan to shoot himself. Therefore, in all emergency situations it is important to get information from as many sources as possible. Major errors occur when this is not done. For instance, family or friends will often tell about a recently purchased gun, violent threats, or other obviously important information.

Some common situations that may involve a psychiatric emergency are: 1) suicidal thoughts or actions, which may occur in any affective disorder (neurotic depression, psychotic depression, manic-depressive illness) as well as in other diagnostic categories (schizophrenia, personality disorders, substance abuse); 2) domestic violence leading to spouse abuse and child abuse (including incest); 3) alcohol or drug intoxication; 4) poor impulse control due to a personality disorder; 5) exacerbation of psychotic thinking, particularly command hallucinations to harm oneself or another, during a schizophrenic illness; and 6) personality changes leading to anxiety and depression due to an organic brain syndrome. The more specific signs and symptoms of all of these conditions are covered elsewhere in the book.

*From: **Understanding Human Behavior in Health and Illness,** Simons, Richard C. and Pardes, Herbert (eds), Baltimore, Williams and Wilkins, Chapter 70, 1981. Reprinted with permission.

Initially, when faced with a possible psychiatric emergency, the medical practitioner needs to answer two questions: 1) Is the patient's altered feeling, thinking, or behavior secondary to an organic brain syndrome and physical illness?, and 2) How dangerous is the situation at hand?

COMMON ERRORS IN EVALUATING DANGEROUSNESS

Why is the potential for dangerous behavior so often overlooked in patients? There are many reasons for this. Sometimes it can be due to a lack of knowledge or training. For instance, if a physician does not know what to look for, ask about, or do, then important clues to dangerousness may be overlooked. Also, the issues of suicide, homicide, child abuse, spouse abuse, and incest usually are anxiety provoking for the physician, and therefore, their presence may be denied, as has been indicated in earlier chapters on these subjects.

Some physicians will not ask about dangerous behavior because they feel they are putting ideas into their patients' heads by asking about these matters. No doubt the approach has to be a tactful one, but most patients are relieved to find someone interested enough to ask about personal difficultues. Physicians cannot suggest suicide or homicide to someone who is not contemplating it already. In fact, it has been my experience that the real embarrassment in a full, frank discussion with a patient mostly comes from the doctor and not the patient. Patients will only be as comfortable and open as their doctor allows them to be. People will not talk about personal matters unless the doctor signals a willingness for them to do so. Similarly, physicians sometimes feel that asking questions about violence may be demeaning or insulting to the patient. This again is a rationalization and a way to avoid subjects that physicians find anxiety provoking.

Potential emergencies may also not be inquired about (or taken seriously) because of feelings that psychiatric problems are "made up" by the patient, and therefore they are not "real." For example, a 24 year old man was brought to the emergency room following an eight pill overdose of sleeping pills. The situation was not thought serious because of the number of pills taken and therefore the patient was viewed as "manipulating." The patient was sent home with his father only to be brought back the next day with a fatal self-inflicted gunshot wound through the heart. The patient may have been "manipulating" but also was seriously suicidal.

Often the physician is not specific enough while obtaining the history of violence. This, too, is a way of avoiding a difficult subject. For example, when asking about homicidal impulses one must find out if the patient has ever hurt anyone, how, with what, and whether the victim was hospitalized. The same is true for suicidal impulses. Physicians should inquire *directly* about suicide in any patient who appears to be depressed or under stress. The patient should be asked, for example, "Have things ever seemed so bad that you thought of taking your life?" If the answer is yes, the details about past attempts and current plans must be obtained. Getting the specifics will help the clinician reach a much more complete and realistic evaluation of how lethal the present situation really is.

It is important for the physician to be aware of his or her own prejudices which could interfere with the fullest evaluation of a patient's crisis. For example, most people are horrified by child abuse or incest but it must be inquired about if the situation warrants it. Awareness of, and attempting to control, one's own feelings and prejudices will help to widen the scope of inquiry and not limit what the patient is allowed to talk about.

Some people have the attitude that personal violence, particularly suicide and spouse abuse, should not concern the physician, that these behaviors are private matters. Although philosophical questions should concern every physician, these attitudes usually indicate that the doctor is very uncomfortable with the question of personal violence. In many cases where "Doesn't the patient have a right to die?" is heard, the patient is either disliked, or it is the doctor who feels hopeless and helpless.

THE WORK-UP

During a psychiatric emergency, everyone is anxious: the patient, the family, and the doctor. It is in just these situations that important details may be overlooked. It therefore is critical that the work-up be organized in such a way that nothing is forgotten. Remember that the questions of *lethality* and *organicity* should be answered as soon as possible.

I would recommend six basic steps in organizing the work-up: 1) Observe the outward behavior of the patient, including his mood and appearance. This can be deceiving. A calm patient may be highly dangerous, while an agitated patient may not be suicidal or homicidal at all. Some patients appear to relax after deciding to die or to kill someone else. 2) Take a history from the patient. Why is the patient here now? Particular inquiry should be made about the precipitating event, previous level of functioning, and past coping mechanisms in other stressful situations. 3) Obtain a history from friends or relatives, especially if the patient seems confused, withholding, or if the story just does not seem to hang together. Are the friends and relatives part of the problem? Or will they be reliable allies and help with the treatment? 4) Do a mental status examination. This will help in establishing whether the patient is suffering from a functional psychosis or is suffering from a pathophysiological process which is causing psychological symptoms (organic brain syndrome). 5) Do a physical examination. Special note should be made of signs of frequent fights, or signs attributable to past suicide attempts. Do not forget that psychiatric emergencies can occur within the context of physical disease. 6) Finally, evaluate your own emotional reaction to the patient. The physician's response to the patient can be an extremely important diagnostic tool. For example, in social situations it is normal to avoid disquieting people; in medicine this is

cause for further psychological investigation. If the examiner feels sad while talking to a patient, a depression should be looked for. If the examiner feels frightened, he should ask himself what is frightening about this patient and explore the situation further.

COMMON ERRORS IN TREATING DANGEROUS BEHAVIOR

Some doctors may take a moralistic or condemning attitude toward violent behavior once it is discovered. This will only serve to alienate the patient and increase the potential danger. Others may do just the opposite, and offer reassurances that "everything will be all right." Even though the doctor should always transmit hope to the patient, empty reassurances will make the patient feel even less understood and will create further problems.

Sometimes doctors react to a dangerous person by trying to "out macho" the patient, by trying to be overly "cool," challenging, or even humiliating. Patients who resort to violence are extremely sensitive to any slight. This approach is never helpful, and may be a very dangerous course of action because it may force the patient toward further action to assuage his already injured pride.

At times, in the excitement of the encounter, the doctor may forget to take necessary precautions. For instance, he may see an obviously excited or angry patient alone, in a small room where there is not enough distance between them, with no immediate help available, with the door closed. The clinician may threaten force with no backup to enforce the threat, or the patient may be carrying a weapon and has not been disarmed. These courses of action are obviously dangerous. Therefore, planning ahead is a must. Under no circumstances should the physician be a hero or be hesitant to ask for help, including from the police. If, unfortunately, the choice becomes either letting the patient escape or placing the doctor in danger, the patient must be let go.

Many physicians also are unclear about their legal and ethical responsibilities when faced with potential violence. All states have laws in the area of child abuse; most allow *all* physicians to hospitalize patients against their will if it seems that they are likely to be a danger to themselves or others. Although holding someone against their will can be very unpleasant, most suicidal and homicidal patients are seeking external controls and are usually relieved to have been "found out" and stopped in time.

EMERGENCY TREATMENT

The two primary principles of treatment in psychiatric emergencies are: 1) maintain the patient's self-esteem by warm, empathic, and interested listening; and 2) maintain the patient's life by proper diagnosis, evaluation, and treatment. This includes the use of physical or chemical restraints when necessary.

The therapeutic benefits of a thorough psychological evaluation should not be underestimated. Patients in crisis are often confused as to what really is wrong and can benefit from the objectivity of another person. During a successful psychological evaluation, a chaotic story may become intelligible to both the patient and the physician. The delineation of the precipitant and the conflict may in and of itself be highly beneficial. People in crisis suffer from markedly lowered self-esteem; they are ashamed, bewildered, and may feel guilty. A hopeful and kind listener can help many patients regain lost confidence in themselves and in their environment.

I have delineated six steps in the work-up of psychiatric emergencies. I will conclude this chapter by suggesting six areas which the physician should keep in mind as he or she is preparing the immediate treatment plan for a patient in crisis.

1) Do I really understand why the patient presented now and the circumstances of the present decompensation, or am I missing some important information? 2) Do I understand the seriousness of this patient's condition, or am I going along with the patient's or the family's denial of how bad things really are? 3) Has the crisis passed, or is the patient still overwhelmed by what initially caused the emergency? 4) Do I dare let the patient go home, or am I sending him back into a pathogenic environment where nothing has really been changed or resolved? 5) Do I need an immediate consultation with a psychiatrist? 6) If I am going to send the patient home, what kind of follow-up have I arranged? Will the patient follow the treatment plan? Or is it too dangerous for the patient to be alone?

Ultimately, the physician has to follow his or her own educated opinions and intuitive feelings about what would be useful in psychiatric emergencies. If the use of force and involuntary hospitalization is considered, it should be done without undue fear of legal retribution. It is my experience that successful malpractice suits will more likely result from neglecting a potentially lethal situation than from making an honest clinical mistake.

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THE MARITAL DYAD

By Bruce Gottlieb, M.S.W., LSWII

This paper is based on four and a half years of experience treating incestuous families at the C. Henry Kempe Center for the Prevention & Treatment of Child Abuse, in Denver, Colorado. The treatment has been with victims ages four to thirty-four years in groups as well as individual therapy. In conjunction with treatment of victims, I have treated male offenders and their spouses in individual therapy, marital therapy, and groups for marital dyads. The treatment has been for an average of eighteen months.

The material presented here is not conclusive. I do however, want to share my preliminary findings about the marital dyad as it relates to object relations theory. I believe the marital dyad re-enacts attempts by each parent to replay their rapproachment or early struggles of separation.

One of the most controversial questions asked is what role each parent plays or does not play in the incest. Is only the active aggressor responsible, or is there also collusion by the "innocent" parent?

Some therapists don't see any responsibility in the spouse who is not part of the actual molestation. Other therapists feel that the mothers are always involved with father's acting out with the daughter. Others may feel that the male aggressor is untreatable even after treatment, a high-risk for acting out again.

It would seem there has to be more involved in the incestuous act than such simplistic explanations. There is something special about the marital relationship in incestuous families. We need to look at both the conscious and unconscious motivations of the parents and what they may be re-enacting with each other as well as why they appear to have such a great need for this relationship since each often complain about deficits in the other.

To begin with, I have observed the following: in all the families, at least one of the parents was sexually abused as a child. In addition, they were either overstimulated visually or verbally, or raised in families that were extremely uninformed about sexual development. My assumption, then, is that the parents are confused and anxious about sexual matters.

The following characteristics appear consistently within these families:

MOTHERS

If the mother was sexually abused as a child, her child is at risk to be sexually abused at about the same age as she had been. If, for example, the abuse was by father and uncle and involved oral sex, then the daughter is likely to be orally sexually abused by father and/or uncle.

Certainly, this finding warrants further exploration as to the unconscious motivation of mother and her compulsion to repeat the initial trauma with her daughter.

There are two ramifications of this. 1) Is the sexual re-enactment an identification by mother with her own mother? With physical abuse we have seen the same techniques of abuse handed down from generation to generation. The sexual abuse pattern repeating itself, certainly has similar characteristics to suggest some identification with the same sex parent. 2) If the only love received as a child was eroticized and most other needs were neglected, we can assume that a great many conflicts will arise around her adult sexual relationships. As a child, this adult was basically ignored except when services were needed. Whenever she was approached in some "warm" fashion, it was so she could accomodate someone else's needs. She was used to meet the needs of others. Some of these feelings probably become re-activated around her sexual relationships today, thus she may feel the need to escape the conflictual feelings characteristic of her sexual relationship.

Another characteristic of mothers that is found with regularity is her extreme passivity and withdrawal from the family, with concomittant depression. Besides being sexually abused as children these women received little love or nurturance for their existence apart from being a need fulfilling object. Positive regard came only when she addressed the needs of others, primarily her parents. This did not have to be sexualized, although it frequently was. If, as a child, she took care of her parents psychological needs, then she received some minimal emotional supplies and attention. This was, unfortunately, her only chance to gain a positive sense of self. But, it was done at the expense of not only not getting her needs met, but her needs were rarely even acknowledged. The ramifications of this is that the wife's only positive sense of self comes from being able to care for somebody else — so she finds a needy man. From the start of this marital relationship, for the woman, it is therefore based in conflict.

The wives have been caretakers all their lives. When they grow up chronologically they are anxious to have their needs met. However, since their lives have been based in meeting other's needs, their needs today are not recognizable to them because they have been suppressed for so long. How can they give when they themselves are empty? However, giving has been the only source of meaning in their lives. The only behavior that brings satisfaction is also the behavior that stirs up the most

painful conflicts. Although the wives look like good caretakers, they are just as needy as their husbands. The wives need the husbands to be caretakers, but it doesn't work well for them. The men frequently provide satisfactory material support with roof, clothes and food. For example, John's wife Judy feels she has to perform sexually with him in order to be given a new dress or to have grocery money. She feels exploited, so through her withdrawal and depression she unconsciously offers her child sexually to get what she wants and needs, while simultaneously saving herself the feeling of being exploited again. This is also played out in a non-sexual way by having the daughter take on wifely tasks through a role reversal. The daughters frequently become primary caretakers of other siblings, do the housework and often prepare meals for the husband. The mother's pay-off in this relationship with the husband is to be taken care of financially, yet not having to take care of his needs, since in an unspoken way this becomes the daughter's responsibility. I believe this is the wife's desperate attempt to fulfill her earlier, unmet psychological needs.

The mothers diagnostically appear to be women with a variety of character disorders. They have rigid defenses, with denial seen as their primary defense. As she becomes more anxious, feeling exploited or trapped by the family situation, she moves to outside resources for repressing her anxiety. These women tend to use diversions out of the home that will take what they have to offer, providing a positive sense of self by allowing her to give, yet, this outside situation doesn't engulf her as her family does. Such sources of self-esteem are usually jobs, church or some similarly time restricted situations. The other common reaction to stress is withdrawal via depression. These women feel overwhelmed and have no idea what is overwhelming them. They have denied their feelings so long that they are not consciously recognizable. Depression, denial and withdrawal become their means of survival.

HUSBANDS

The husbands are often low-functioning, borderline personalities. They have very poor defenses and are extremely needy. Unlike their wives who are at least given the opportunity to give, these men are either ignored and/or belittled by their wives and significant others regardless of their attempts to please.

The raminifaction of this is that they suffer from very low self-esteem and have urgent longings for a relationship. He is a man wanting to be taken care of, and he looks for a person who needs to give.

The wife is viewed by the husband like an object of a narcissistic child. Only his needs are important and any separation by the object creates extreme anxiety.

These men were almost always severely physically and emotionally abused and frequently sexually abused as children. Coupled with the abuses and the humiliation they were subjected to, these men were expected to be strong and impervious. It is very difficult to be "macho" with no solid sense of self. For example, Bob always wears at least one, usually two, articles of clothing with his name on it. This appears to be helpful to Bob in confirming his identity. Sexually, one sees this fluid self identity and low self-esteem in their difficulty with adult women. Little girls are less of a psychological threat sexually and become easier mates when these men become threatened, either when the wife withdraws, or when faced with an adult relationship.

One often sees the sexual acting out taking on a more primitive function. The men use their adult sexuality as a way to replace their childhood deficits in the mother/infant relationship. Sex becomes a merging and an attempt to recreate symbiotic feelings. Sex to the man, whether with the wife or with the child, is also used as a tool for making contact and establishing a masculine identity. The sexual contact also appears to be used as an affirmation of his existence.

THE DYAD

The parents needs match up in this fashion: The woman wants to feel needed without being truly involved in the relationship. The man wants to be given to. The woman has a fear of being engulfed. The man wants total attention from his spouse. The woman is passive aggressive. The man wishes to feel in control and strong. The woman avoids sex and the man uses sex as an affirmation of both himself and his strength. Both use the child to get their needs met that are not being met in the marital relationship.

CASE EXAMPLE

PHASE 1 — The meeting of Bob and Judy. Judy's History: Judy was sexually abused by both her father and uncle, who had intercourse with her and performed cunnilinctos. Her mother was basically unavailable to her and died unexpectedly when Judy was 9 years old, never mourning her mother's death. Judy was expected to take care of everyone in the family when she was still a child herself. Bob's History: His father was never interested in him except to physically abuse him. His relationship with his mother was similar. Bob recalls that one day when he was about ten, he had a flat tire on his bike en route to church. He was about five minutes late to church having had to push his bike the rest of the way. The pastor, whom Bob greatly admired, would not tolerate lateness from an altar boy. Bob was taken downstairs and received a severe spanking on his naked buttocks from the priest. "I looked up to him and it was also important to my father that I be an altar boy, but I never returned to church again." What this vignette offers is Bob's desperate attempt at pleasing and others lack of empathy for him, and his rage at abandonment. What the priest reenacts in humiliating Bob and his lack of empathic caring is identical to what Bob had continually experienced with his father. Bob's withdrawing from church marks his last attempt at pleasing others due to his disappointment that once again supplies were unavailable to him. From that point on, relationships for Bob would exist around his needs or there would be no

relationship. He had never had, before Judy, any significant relationship, either with friends in high school, other girlfriends, or with family members.

Judy is in need of a man who will build and support her fragile self-esteem. He has to be very lonely, and Bob is. Bob is in need of someone who looks motherly with the need to take care of him, and Judy does. Each finally has his or her idealized object. Or do they?

PHASE 2 — Engulfment and withdrawal. Bob pushes Judy on a daily basis, both sexually and emotionally, since he is in need of affirmation. Three months after they are married while on a camping trip, Judy forgets her birth control pills. Daughter No. 1 is on the way. Judy complains that Bob was sexually overactive for her. She also felt he wasn't allowing her any space psychologically. Judy cannot say no, nor can she back off from Bob, both because she psychologically needed him while also feeling the need for distance in the relationship. Pregnancy thus provided a multitude of shields for her to protect herself from Bob. Child No. 2, two years later, is described as another accident by Judy, yet, in the same sentence she states, "But, she was a welcomed child." Judy is currently pregnant with their 4th child.

PHASE 3 — Withdrawal and Abandonment. Bob wants more of Judy. Judy not only cannot give to Bob, but her "shields," the children, have now overwhelmed her with their growing needs. She feels her only salvation is total withdrawal from husband and family. This produces low self-esteem for Judy, so she turns to the church. "If I could only be accepted by anyone, God, then I could feel OK about myself." Bob feels abandoned.

PHASE 4 — Denial and Subsequent Use of External Control. Bob is furious. He is not being given to emotionally. His house is a mess. He has turned to the children, but they do not fill his void either. Bob puts in for a transfer that takes him to Korea for one year. This keeps Bob from facing his anger and disappointment at Judy. An interesting side note is that upon arrival in Korea, Bob becomes an alcoholic. "Always with a bottle in my hand." He was not a drinker prior to his leaving nor after his return. The bottle for Bob becomes a transitional object while away from Judy. For Judy, Bob's going to Korea removed one of her energy drains.

PHASE 5 — The Sexual Abuse. The basic functioning in the family is the same upon Bob's return home. Judy says, "I never had any sense of the children as people with needs. I don't have energy to relate to them." Bob comes home, placing a multitude of demands on Judy psychologically and sexually. Judy pulls away to the church again. Every night that Judy plans to go to church Bob takes her out to dinner. He does everything in his power to keep her at home with him and the children. When Bob was asked if he ever thought how it might have been different if Judy were home and whether that would have kept him from acting out with the children, he replied, "Of course, I was afraid of what would happen if she left, so I tried to keep her at home." His lack of internal control is obvious. He is angry at his object for not being more available. His poor sense of self-esteem is acted out with his children, as well as his need for affirmation. When asked what the sexual contact with his daughters meant to Bob, he replied, "It made me feel better. I thought they enjoyed it." This further displays Bob's inability to see other people as separate individuals with needs of their own. All the while, Judy says she was so preoccupied with herself, that she had no idea that the children were responding any differently.

In treatment, Bob and Judy usually sat on the couch, not particularly close, yet close enough to hold hands. Yet, the hand-holding was not of a warm, supportive, caring style — rather it was like two people holding onto the edge of a cliff for dear life, both frightened and child-like.

Through treatment it was suggested to Bob and Judy that they place their children in foster care due to the residuals of problems each of the children carried. Both became worried. Bob was frightened that Judy would be angry at him, and consequently, he would lose her love. Judy was worried about being considered a bad parent. In terms of their early object deprivation, what these fears seem to replay for each of them is the following:

For Bob, he was afraid that since he had been a "bad boy," he would be totally rejected as he had been as a child.

For Judy, her fear of not being the omnipotent caretaker would result in severe rejection.

Bob and Judy ultimately decided the professionals were right, and that the children were in need of foster placement and intensified help. It is important to note here that the parents were told once the children were placed in foster care, Bob would be able to move back home again since he was living out of the home at that time, at our request. Returning home was of urgent importance to Bob, so although they made a good decision for the children by allowing them to go into placement their motivation to do this wasn't without their primary need for each other being involved in the decision.

During the session of deciding to voluntarily place the children in foster care, Bob had his arm supportively around Judy's shoulder, and there was none of the usual tension in his face. He was also sitting upright, and looked less engulfing to Judy. When, during the session they were asked if they might not also be feeling a sense of relief by placing the children, they each responded positively. Judy felt like finally she could have time to herself, later possibly renewing her energy for her marriage. She spoke of one day being the supportive parent she would like to be. Bob felt that now he and Judy would be able to get close — what he has yearned for. His treatment goal was to "become one again." In the following session, Judy makes the following slip. She was talking about the children being placed in foster care, and states, "The only **drawback** to this is that now Bob will be home with me." What Judy consciously meant to say was that the only advantage to this was that now Bob would be home with her. Bob wants to become one again, and Judy wants separateness that Bob still cannot allow.

Judy's fourth pregnancy, again another "accident," is characterized by morning sickness and her wish for "space," but she cannot say so directly. She still cannot say no to Bob's daily sexual demands. In the following session Bob becomes highly anxious, and frantic in his request to be allowed to go back home on a regular basis, even though the children have yet to be placed. His primary reason for this is that now he has a roommate, and he and Judy have no private time to have a sexual relationship. Judy's whole conversation centers around feeling sick and not being interested in sex. She cannot state that directly to Bob, and Bob still cannot hear her.

What does the incest play out for a woman like Judy? One of the key issues is her attempt at building her self-esteem as a good caretaker. If she believes her daughters were sexually abused and takes action against her husband, then she has now become the sacrificing, good caretaker of her daughter. If she doesn't believe her daughter and becomes supportive of her husband, then again she becomes the good caretaker — this time in the marital dyad.

SUMMARY

What has been described in the above example involves adults who have not yet developmentally separated adequately as children. In essence they have not adequately mastered the rapprochment stage of development. Each is in need of giving and being given to. However, each of their needs are so overwhelming, that they are unaware of the needs of the other person with whom they relate. Relationships based only on their own narcissistic needs due to poorly developed object relations and incomplete object constancy, will be unsatisfactory to both parties, and set the stage for sexual abuse to occur.

Sexually abusive couples are frequently in conflict about who gives to whom and when, so that they are constantly battling each other for meager supplies neither can give freely. They are also unaware of what supplies they need. Nor do they know how to negotiate getting one's needs met. They only know they feel a compelling void they have always felt and they begin to search elsewhere to get their needs met — the women outside the family, the men within the family.

Neither parent has the ability to give to the other. The children are constantly used as shields. The children also receive very little from either parent and both parents attempt to use the children to satisfy deficits in their object relationships which have existed since their childhood. The parents are desperate for need gratification and consequently turn to the children.

The rapproachment child is in need of a balance of support and space. There is a need to develop a sense of self with increased confidence in one's abilities to negotiate life. If the child is constantly pushed aside and never allowed to re-fuel from the parents, serious psychological problems develop. A pseudo sense of self and independence coupled with an underlying dependency need for safety and caring is ever present. Conversely, if the child is never allowed to venture out on his/her own, stifling the child's independence based on the parent's needs, then the child will be constantly struggling to be free.

Whether pushed away or engulfed, both children need a combination of space and refueling. However, even in normal development conflicts are present in both positions for the child. What happens for the fixated child is the lack of appreciation by the parent to allow the child to come and go as needed because of the child's needs, rather, the child is forced to remain in a position based on the parent's needs.

Negotiating a reciprocal relationship based on compromise and mutuality is the basic element lost for these parents. Others exist only as need fulfilling objects, not as people in their own right.

The problem, primarily with the men, is that without the object present, they feel abandoned. The attempts by both parents to get their early object needs met, along with poor object constancy is typical of abusing families in general. These families act out in a sexualized fashion, primarily because of the inappropraite sexual overtures these parents were subjected to in their own childhoods.

It is essential to realize that it is not only the inappropriate sexual overtures nor only the deprivation experienced in these parents' past, but rather a complex interweaving of the deficits in both their object development and their sexual development that culminates in incest.

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INTERVIEWING THE SEXUALLY ABUSED CHILD FROM A DEVELOPMENTAL PERSPECTIVE

By Lupe-Rebeka Samaniego, Ph.D.

Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles.[1]

Sexual abuse can take several forms (incest, pedophilia, as well as sexual exploration and molestation). In interviewing a sexually abused child it will be significant to assess the form that the abuse has taken. Intervention techniques also need to take into consideration whether a single episode of abuse has occurred or whether the child was involved in incestuous acts of a chronic nature. For example, incestuous relationships between fathers and daughters may begin as early as 3 years of age and continue throughout life. Sexual exploitation occurs most frequently however, during the latency or adolescent period. Frequently, the sexually abused child is faced with serious deficits in adaptation throughout their ongoing development. The psychological damage that the abuse leaves may not be fully experienced, however, until the child reaches adult maturity.

INTERVENTION

The following provides a brief guideline to aid the interviewer who works with the abused child. It is important to stress that familiarity with normal developmental lines and their various dimensions are crucial. The interviewer must also work within a solid conceptual framework in order to understand and to integrate material. Interviewing the sexually abused child requires that the interviewer become sensitive to the complexities of child development. The manner in which the child organizes his/her world needs to be considered. The different areas of functioning that emerge in the sexually abused child's behavior may seem puzzling to the interviewer who may not be aware of all the dimension's inherent within normal development.

The initial interview with the child will set the pace for future therapeutic interventions. Depending on how it is conducted, the interview may be experienced by the child as therapeutic, and thus helpful, or it may represent to the child another form of abuse. Interviewers who become interrogators (seeking minute sexual details) may leave the child feeling like a victim of another assault.

— Guidelines —

1. An interviewer is not only asked to assess the nature of the sexual abuse that precipitated the visit — one needs to assess the child's overall functioning as well. One may have to ask oneself the following questions: What kind of personality structure has the child achieved? How much damage has been done? How does the child's current personality organization compare with age-appropriate behavior? In other words, the five year old child who sits calmly and blandly, answering all questions, is **not** acting age-appropriately. The child may indeed be facilitating your interview process, but one needs to wonder about the pseudo-mature aspects of the child's behavior.

2. An interviewer needs to quickly assess the mode of communication in which the child will be best understood. Once this is understood and utilized most children present with a unique access to their world. For example, the use of play therapy techniques such as a doll house, may be quite appropriate for a 7 year old child who feels comfortable with the use of symbolic play. Another 7 year old child may become quite inhibited with such play. It would then be best to determine in what mode this child will be communicating. (For example, verbal activities, drawings such as 'Family' and 'Draw A Person' may be utilized.)

3. It is important to stress to all children of all ages that the current relationship that they have with the perpetrator is destructive. One needs to communicate an awareness of the tremendous distress and worry that it is causing them. It is also important to relate that you will be helping them establish a more meaningful relationship (if at all possible).

4. Answer the child's questions directly, including questions regarding the illegality of the acts as well as the possibility of the perpetrator's incarceration. Your reality-oriented responses will be experienced by the child as empathic. If you are uncertain about the disposition of the case, or the disposition of the child, it is important to say so. You may also remind the child of the availability of those significant individuals interested in the child's well being.

5. When the child asks no questions, the interviewer needs to give the child whatever information you have available. Many children do not ask questions simply because they are frightened and/or do not know what to ask. The child may be experiencing tremendous ambivalence about the interview and the interviewer. In general, children feel relieved when they are freed from the burden of the abuse that may have been haunting them for years. Help the child clarify what confusions you sense.

Other significant data includes the organization and depth of the material presented by the child. Greenspan[2] delineated important categories which may help an interviewer assess the age-appropriate or developmental stage of children in general. The sexually abused child may demonstrate departures from this range. Greenspan's categories can be quite helpful in interviewing the sexually abused child. They include the following:

a. Assess the physical integrity of the child. Assess the overall physical well-being in terms of height, gait, general health, etc.

b. Notice the emotional tone of the child during assessment. How variable are the emotions? Example: does the child show a wide range of affects in a 3 minute period?

c. How does the child relate to you as a human being during the interview? Example: is their style withdrawn, confused, pseudo-mature, plastic?

d. What are the specific affects and anxieties that become elaborated during the interview? For example: Are they worried about themselves, their parents, or is their massive denial about the circumstances involved?

e. How does the abused child use the environment of the interview room or playroom? How are the themes played out? Is there fear of body damage, abandonment, losing love, losing sense of self?

f. What are the themes that develop in talk or play? How organized are they? What is the sequence?

g. A last but not least important issue relates to your own subjective emotions regarding the child. What does the child evoke in you? What are your general feeings during the interview? Did you experience any specific fantasies? These subjective feelings may be utilized to better understand their world.

DEVELOPMENTAL TASKS

As children grow and mature they need to master certain developmental tasks that are essential for organizing development. When a child experiences a trauma, such as in sexual abuse, their emotional development may be hampered. Normal development may, at best, be interrupted; at worst, the child may experience long lasting psychological damage. The child's development may also remain psychologically arrested. The child's way of perceiving him/herself and others may be distorted and pose serious difficulties in adequately relating to others. For the purpose of this paper, some of the developmental tasks that children experience in three different age-groups are outlined. The groups are divided into three sub-groups: the toddler, the school-aged child, and the adolescent. An outline follows delineating how an abused child may potentially experience the onset of the abuse during each developmental stage.

I. Toddler Stage:

A. If development has proceeded normally a child in the toddler stage should have mastered the following general tasks[2, 4, 5]:

1. adjusted physiologically to extrauterine life

2. begun to differentiate self from mothering person (develops sense of autonomy and physical independence)

3. developed basic trust in their environment

The child who enters the toddler stage is faced with mastering those tasks necessary for growth and maturity. The child is in the midst of increasing his feeling of self-worth. The child begins to shift from a passive position to a more active one where he begins to feel in control of his environment. The following developmental tasks aid this process:

4. Development of Language

a. provides toddler with greater sense of control over environment since he can now name objects

b. ability to express fantasies via symbolic play

5. Internalizing Process

a. image of mother and parenting figures become part of the self image; Child begins to follow rules and demands of parents, the 'pre-cursors' of super-ego

b. self-esteem begins to be established in part from the positive feelings of parents toward the child

6. Curiosity is at its peak — curiosity and admiration about own body and body parts are integrated into feeling of self-worth.

7. Feelings of possessiveness of the parent of the opposite sex and rivalry with parent of the same sex begin to be expressed and resolved.

B. Sexual Trauma during Toddler Stage:
Onset of sexual trauma during this stage may result in the following symptoms or behaviors:

1. Phobias — they may represent the fear of being overwhelmed by unacceptable wishes and impulses. Night terrors may develop. Phobic mechanisms may take the form of fearing bodily injury.

2. Excessive preoccupation about their own and other's bodies

3. Heightened sexuality and aggressivity in play and in relationships.

4. Language may be reinstinctualized (as in certain cases of stuttering[1, 3])

5. Developmental regressions such as clinging behavior, excessive shyness and withdrawal, and a sense of helplessness

II. The School-Aged Child:

A. Developmental tasks[6]

1. To master and acquire new learning skills

2. To achieve a definite identity

3. To achieve greater physical prowess

4. To develop a "conscience"

5. To tolerate frustration and control aggression

B. Abuse

1. Threatens child's feelings of mastery

2. Exacerbates feelings of inferiority

3. Threatens developing coping mechanisms

4. May experience sudden onset of depression, insomnia, massive weight loss or gain, truancy

5. Sudden school failure and/or learning difficulties

III. Adolescence

A. Developmental tasks

1. To integrate emerging sexuality with their own sense of self

2. Oedipal feelings resurface along with unresolved fantasies and wishes

3. Active involvement in identify formation (may look toward role models for sexual identification and sexuality)

4. Continued integration of conscience and peer group standards

B. Abuse

1. Defenses such as rationalization, denial of affects and projection may be utilized to ward off emerging sexuality

2. Significant interruption of emerging awareness of acceptable interpersonal relationships

3. Vulnerability to parents' expectations

4. Premature emancipation from family ties

5. Hysterical symptomatology, promiscuity, prostitution, and disorderly conduct may follow

6. Lack of pleasure in future physical and sexual contact

In brief, interviewing children who have experienced sexual abuse demands effort, appreciation of developmental issues, and tasks inherent within each phase. A primary task involves comprehending the purposefulness of the child's behavior and an understanding of the child's internal world. If conducted with such appreciation, the interview will set the pace for positive future therapeutic intervention.

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INDIVIDUAL PSYCHOTHERAPY WITH THE RESISTIVE PERPETRATOR

By Dana L. Cogan, M.D.

Individual psychiatric treatment of incestuous offenders can often be a very difficult, frustrating, and intense experience, particularly with those individuals who lack motivation, and who are coming for treatment primarily to fulfill expectations of the courts. Quite often, the patient's ego-strength is marginal, he has been "put through the mill" legally and socially, and his involvement in treatment is viewed more as a punishment than as a tool which he can use to grow and mature. In this paper, I will attempt to address common resistances encountered in working with these patients, and will attempt to offer the reader suggestions and ideas of how to lower the resistances of perpetrators of incest so that their involvement in psychotherapy can be rewarding. The ideas I will be expressing are impressionistic, and so are based more on experiences that I have had in working with these men rather than on "hard," statistical research.

I would like to begin by emphasizing that resistance, a patient's opposition to the therapeutic process, is part and parcel of every psychotherapy geared toward assisting a patient in getting to know himself more thoroughly. It is my view that resistance is simply a method (sometimes conscious and sometimes unconscious) that patients have of maintaining their own internal psychological equilibrium. None of us enjoy the pain and anxiety we experience when looking inward if this means touching wounds which have not healed. We become frightened whenever our views of the world or our views of ourselves are significantly threatened. We seek protection from pain and in so doing construct defenses even as children to lessen that pain. Involvement in psychotherapy leads toward a gradual giving up of immature (childhood) and maladaptive defenses, and a redefining of the meaning of life and our place in it. Psychotherapy also means having to look at our previously inflicted wounds, those things we do not like about ourselves, and sometimes those things we do not like about other people. We are bound to encounter pain as a result, and so resist the therapeutic process, but from this we can attempt to understand both what makes the world the way it is and the part we play in it.

Some of us have more reasons to resist than others. In order to understand why those of us who are involved in incestuous relatonships need to resist so strongly, I would like to briefly familiarize (or refamiliarize) the reader the the types of wounds that incestuous fathers have encountered as children. I will be focusing on the psychological make-up of the fathers as it is with male offenders that I have had the most experience. I will present a brief case study, and will then generalize from there. While reading the story of J.B., I would ask the reader to think of the incestuous involvement of these men as a defense, a dressing over the wounds of childhood impregnated with a mild anesthetic.

CASE STUDY

J.B. was a large-framed, casually dressed, gray-haired, sullen, and unfriendly man of fifty years who stated that he had been ordered into treatment by a local juvenile court judge. He tersely explained that his two daughters had accused him of incest, and that all three of his children, including his son, had said that he had physically abused them. He had been forced out of his home by local authorities, his daughters had been placed in residential care, and he was not allowed contact with any of his children except under the supervision of a female social worker whom he viewed as "an asshole." His wife was not wanting to have much contact with him, although she would ask him to come to the home to make repairs or to keep the family car in operation.

J.B. had a very difficult time talking about his incestuous relationships with his two teenaged daughters. He was clearly ashamed of his actions and anticipated that I would be equally judgmental. When he did present facts regarding sexual involvement with them, he was very vague, minimizing both the frequency of the sexual contacts and the degree of intimidation and force used. (The court records indicated that the older daughter, O.B., had been forced to have sexual intercourse and to orally stimulate her father over a period of four years, on one occasion allegedly at gunpoint. The younger daughter, Y.B., had been forced to have both intercourse and oral sex with her father for two years. Both girls felt that their mother knew of these activities.)

When I asked J.B. to tell me of his early experiences in life, he described rather significant emotional deprivation within his relationship with both parents. He described his father as having been a very busy attorney who was "ambitious and always somewhere else." His father's absence generated within him a feeling that "there was something lacking." When they were together, both were puzzled as to how to relate to the other. "Who wants to be a buddy anyway? It's artificial. A grown man just has different interests from boys. I am not even sure it is desirable. A kid has to grow up and use his own mentality." Additionally, J.B.'s father was a strict disciplinarian who was at times physically abusive.

Mother was described with disdain. He viewed her as a foolish, disorganized, and domineering woman with whom he could not entrust his feelings. Much of this was apparent when he described his first memory. He stated that at the age of two, his mother gave him a bottle of sour milk at nap-time. Even though he was barely able to speak at that age, he was somehow able to convince her that the milk was sour, commenting that "she was amazed that I was right." In another early memory, he reported that on one occasion he was able to shed the leash and harness she forced him to wear, and ran to a local butcher shop to ask for a weiner. "When I did that, my mother caught me and took me home and vented her displeasure." My impression was that J.B. did not develop a sense that he could take good things in from his mother, instead viewing her as inadequate, controlling, confining, unempathic, and demeaning.

J.B. did not have many friends when he was a child, although he did have a few. He spent many hours reading. His favorite book was about a serf during the time of King Arthur who was "not recognized as royalty." He also spent long hours traipsing around the woods near his home. He found looking at bugs more interesting than involving himself with people. He became fascinated with "mechanical things," and so also spent a good deal of time taking these objects apart and putting them back together again.

During his adolescence, he pursued an interest in the Boy Scouts well beyond the age that most teenagers do. Indeed, it was not until after high school that he gave this up.

With regard to his interest in members of the opposite sex, he stated that a few times he enjoyed cuddling with girls on the bus during band trips, yet in general did not feel that he had much in common and "usually had better things to do."

J.B. graduated from high school in the top third of his class, having excelled on national tests and having come in first in his school in physics. Following his graduation, he attended a state university for two years. He felt that this had been a mistake as he had gone more out of his father's expectation. He stopped at the end of the second year as he was not able to sustain his interests in academic subjects and as he was considered a financial burden by his parents.

Within a couple of years of his dropping out of college, he met his wife, stating that he was attracted to her as she was very tall and female. He described her as a shy, indecisive, yet intelligent woman who was very ambivalent about having a family or a career.

J.B. dated W.B. for two years, and then established a common-law marriage with her which lasted until shortly before the time that W.B. discovered that she was pregnant. Following the separation, J.B. stayed away from the family for a period of two years. He eventually returned to Denver, although he did not have much contact with W.B. or his children for two more years, explaining that W.B. was very unhappy about his absence and that he wished to avoid an "hysterical scene."

Eventually, W.B. became pregnant by someone else, and was unable to work. J.B. was contacted by the Department of Social Services for child support. He assisted his wife in finding an apartment and provided her monies to live on, although he did not have significant face-to-face contact with her for another five to six years. During the time that he was in Denver, he spent almost all of his time working, which was characteristic of him.

J.B. and W.B. finally married because of "outstanding moral compulsions," certain tax benefits, the ease of buying a home, and "Why not?". During the first year of formal marriage J.B. worked ten hours per day, six days per week.

It was during the last four years of their being together that J.B. was sexually involved with one or both of his daughters. He drank excessively, was arrested twice for Driving Under the Influence, and ultimately had his license revoked for twelve months. He estimated that he consumed approximately a fifth of alcohol on any given day, which had also resulted in a deterioration in his physical appearance, in his physical health, and in his ability to get various home projects done.

Others described him as having been very threatening, domineering, forceful, physically abusive toward the children, sarcastic, irritable, strict, and overly intrusive.

J.B. was not able to fully explain his behavior during that four year period of time except to say that his wife was cold sexually and that his excessive use of alcohol had changed him somehow. He was very quick to complain about the mistreatment he had received by the courts and others, referring to the police who had intervened as "storm troopers." He admitted that he felt guilty about having had sexual contact with his daughters, yet at the same time adamantly denied that he had threatened them or physically abused them. It was his general perception that others were over-reacting by insisting that he become involved in individual and couples therapy, and by removing him and his two daughters from the family home, emphasizing that he was sure that no further sexual contact would take place. (A good portion of his protest appeared to be related to concerns he had about W.B.'s being alone and the possible ramifications of this, given his general view of her, i.e., that she was inadequate, needy, and unable to make logical, independent decisions.) He believed that abstinence from alcohol (which had been accomplished) was the key to his refraining from such activities in the future, yet at the same time did feel that it was important for him to understand the underlying reasons for his actions.

He, thus, entered treatment on a very ambivalent note.

The early history presented by J.B. is not at all uncommon when one speaks with fathers who have incestuous relationships with their daughters. Typically, these men have experienced a great deal of emotional deprivation as children. Their fathers are described as having been harsh authoritarians who were both hated and feared, and admired and respected. Often the fathers were physically abusive, and more importantly, they were emotionally neglectful. Their sons were not presented with an adequate role model, such that later on in life these sons have tended to have difficulties in their identities as men.

Mothers of these men oftentimes were also emotionally unempathic and unavailable, which further intensified both a strong hunger for closeness and feelings of anger and resentment that basic emotional needs had not been met. Simultaneously, the lack of early need-meeting tended to make these men either very dependent (over fifty percent are supported by other family members or social agencies, twenty to fifty percent are alcoholic) or

"super independent" (not allowing themselves to become emotionally dependent on others even when this might be appropriate). When their needs were met as children, the need-meeting was based on the needs of the adults, such that gratification of these needs was provided in a rather haphazard and inconsistent fashion.

Some of the mothers were also very domineering, if not sadistic and cruel. These traits, coupled with similar traits in the father, generates a domination-submission conflict within the child, who later on identifies with the parents' domineering stance to the point that they become tyrannical. Submission within the minds of these men means feeling very vulnerable to the whims, cruelty, and irrational thinking of others. In order to disallow the experiencing of this vulnerability, these fathers rigidly and forcefully exert control over other people. They have a very difficult time relaxing around others, particularly when they are feeling criticized, inadequate, helpless, or saddened, which is most of the time.

Feeling states in general are viewed by these men as dangerous. Their relationships with others tend to be superficial and distant, including the relationships that they develop with their wives and children. Allowing themselves to become close to others generates a great deal of anxiety, which they control by controlling the relationships. It is my view that this anxiety stems from feelings and memories of their childhood experiences attempting to push into consciousness. As a means of coping with this anxiety these men become like their parents rather than remember how they felt as children. They become very insensitive to the feelings and needs of others, become emotionally distant, and dominate rather than submit to the experiencing of the feelings they carry around inside of themselves all of the time. This defensive operation does not work well, however, as oftentimes the rage from within is so overwhelming that they lose control of themselves. Once an abusive sitaution has taken place, they typically feel remorseful, and an already low self-esteem is lowered further. As this occurs over time, they become even more fearful of intimacy, and a number of these men become frankly paranoid, projecting their own rage onto others.

Given their fears of intimacy and the need to maintain significant distance from others emotionally, the hunger (for closeness, nurturance, tenderness, compassion from others, and intimacy, itself) intensifies. Viewing adults as unreliable, not understanding, hurtful, disappointing, and generally unsafe, they turn to their daughters in an effort to receive the sustenance that they did not have as children. This, too, is very frightening for them, and most often it is necessary for these fathers to anesthetize themselves with alcohol in order to achieve the closeness and intimacy they seek. In my view, they choose sexual intimacy not only because of their poorly formed identities as males, but also because there is not much need to talk. The gratification they receive tends to be immediate and confined within a relatively brief period of time. The sexual act itself is usually very self-centered, with little attempt on the part of the fathers to please their daughters physically. Incestuous involvement, therefore, may be a deviant form of masturbation.

It is my contention that for the fathers sexual relationships with their daughters are in large part a defense, a protection against feeling the pain, frustration, anger, disappointment, humiliation, degradation, and neediness that they experienced as children. As with other maladaptive defenses, this defense does not work effectively. The rage and vengeance they felt toward their parents as children is vented on their daughters. The problematic feelings remain inside without resolution, and their feelings about themselves are further made worse. They have not developed relationships within which they are able to have their needs met, and, instead, feel further alienated from others. Once the sexual activities have been discovered, these men experience additional humiliation, yet also some relief.

By the time that one of these fathers presents for treatment, he usually has managed to bolster his defenses and attempts to once more use his characterologic defenses to cope with the stress of developing an intimate relationship with the therapist. He appears to be untrusting, hostile, threatening, and as repulsive a character as he can make himself look. Inside he feels frightened, ashamed, inadequate, insecure, and narcissistically injured. He attempts to seek simple solutions for his difficulties and simple explanations for his behavior. He make promises that he will "behave," and that he will never again be "bad." He will resist treatment because he imagines that the therapist will see him as he sees himself, and because he is afraid to find out what is wrong with him. Later on in treatment, he will resist in order to avoid experiencing feelings from his past which he has had to deny.

In order for treatment to be effective, the individual therapist must provide the patient with a relationship within which he can tolerate the experiencing of feelings from the past. The therapist must take a non-judgmental, supportive, empathic, sensitive, and initially non-confronting stance if a therapeutic alliance is to develop. This can be a very difficult position to take for many therapists as most of us have a tendency to feel protective of the victims, angry at perpetrators, and repulsed by images of a father's forcing his penis into the mouth, anus, or vagina of a helpless little girl. It is of crucial importance for therapists treating these men to develop an ability to maintain emotional distance from their own feelings of revulsion, anger, and so on, if the therapist is to be able to maintain his or her own objectivity. This can be a very difficult feat, yet one which must be accomplished if the therapist is to remain available to the patient as a helping person.

The therapist's assumption and maintenance of this position is the first step required to counteract the patient's resistance. This position must be assumed from the first minute of the first session and must be maintained until the last minute of the last session. It is within the first

session that the therapeutic stage is set. Complaints that the patient has about the way he has been treated by others up to this point in time must be listened to empathically, and the therapist must not defend the actions of others. To do so would generate an immediate negative transference which might never be worked through. Attempts should be made to identify the feelings that the patient is expressing unless they are totally obvious. The therapist should ask the patient how he feels about being involved in treatment, and an effort should be made to let the patient know that as far as you as an individual are concerned his involvement in treatment is voluntary. If reports are to be written for court purposes, this must be discussed at the time of the initial interview, with an explanation on the part of the therapist that the reports will be written honestly, in generalities, and in a way such that the patient will not be humiliated. It should be explained that the writing of such reports does make the treatment not totally confidential, although it is my practice to allow patients to review these reports with me before they are submitted to others. I let the patient know that the content of the report will reflect my thinking regarding his progress in treatment, yet I will listen to him if he should find the way that I have expressed my thoughts to be offensive.

Also during the first session, I find it very helpful to educate the patient about psychotherapy as a process. I explain that the primary purposes of treatment are to allow the patient to get to know himself better, to heal old wounds, to give him greater satisfaction in life, and to give him a greater variety of alternative ways of dealing with his feelings and conflicts. I emphasize that I will not be judging him, but am simply there to help him understand himself. I let him know that the outcome of treatment is dependent upon his ability to develop a relationship with me which he can use to face difficult feelings, and that it will be important for us to talk about our relationship as the treatment unfolds. I let him know that it is important to work between sessions, and that the benefit he receives from treatment will to a large degree depend on the effort he puts into it. I tell him he has the responsibility for beginning each session (so that we are sure to talk about those things important to him), and that he may choose anything to talk about that he feels is important.

Throughout the balance of the treatment, it is important to maintain a positive transference with the patient, and to avoid the development of a negative transference. Whenever negative feelings toward the therapist are in evidence, it is important to deal with these quickly. Should negative reactions appear with some frequency, it is important for the therapist to examine whether or not he or she has been too withholding, too depriving, too confrontive, too empathic (which may feel like smothering), or off-target with the use of interpretations. It is also important for the therapist to search for evidences of counter-transference, particularly when frustration within the therapeutic process has reached maximal levels. If none of the above seems to apply, then most likely the patient is using negative views of the therapist in order to avoid a positive relationship involving intimacy. This should then be interpreted in a non-judgmental fashion.

The position of the therapist in relation to the patient needs to be an active one, but should not involve the therapist doing more than his half of the work. It is important to allow the patient to become realistically dependent upon the therapist, yet the therapist should refrain from rescue attempts and other such situations that the patient may generate. For example, it is important to let the patient know that he or she is available for therapeutic purposes, but not to save the patient from going to jail. In my view, such attempts at rescue are demeaning and infantilizing, and show disrespect for the patient's adult self. The sharing of personal experiences on the part of the therapist is generally not a good idea. The focus of the treatment should be on the patient or on the relationship between the patient and the therapist at all times. When the focus is shifted such that the therapist's life experiences are highlighted, almost inevitably this will detract from the effectiveness of the treatment as a whole.

A common resistance which I have encountered early on in therapy is that of the patient's pounding his chest in remorse and declaring himself a dishonorable and disgusting member of society. I explain to the patient that it is important for him to develop an ability to suspend judgment for periods of time in order to develop an understanding of the effects of his childhood on his behavior. At times I will make a premature interpretation, for example, stating that his incestuous involvement with his daughter has been used as a defense against painful feelings from the past. Another common resistance encountered early on is the patient's attempt to berate the system (the courts, the departments of social services, etc.) ad nauseum. Oftentimes, the patient is attempting to avoid looking inward by keeping his focus outside of himself. When encountered with this resistance, I frequently will make a somewhat premature interpretation, namely that the patient is carrying on in this manner in order to avoid painful feelings inside.

In these situations, I act as an alter-ego for the patient, at the same time emphasizing that it is important for him to develop an ability to stand back from himself and examine his feelings and actions non-judgmentally. As the patient begins to develop this ability, I praise him for doing so, encouraging his sorting things out and simultaneously bolstering his self-esteem. I demonstrate my congratulations to him by shaking his hand at the end of a particularly productive session or by patting him on the back as he leaves. (Care must be given, particularly when the therapist is female, to ensure that these gestures are not sexually stimulating or overly gratifying.) Thus, the therapist cannot fully maintain a position of neutrality in relation to the patient as one might do with patients suffering from other disorders.

At times, as is true of most therapies, the patient will reach a point at which he feels stuck. The patient may come in not knowing what to talk about, may ramble on and on about seemingly superficial issues, may beg for guidance, or may speak of the feeling that the items from the past that we discussed the session before are of little importance. At these times, I will suggest to the patient that we take a look at a what is going on within him unconsciously. I explain that there are a variety of ways to get to unconscious material, including the interpretation of dreams, fantasies, slips, daydreams, and so on. It is not uncommon for the patient to then come in with a significant dream at the time of the next session which when interpreted spells out those feelings and memories which he has been needing to avoid. If he does not produce such a dream, I empathize with how important it must be to avoid whatever it is that he is needing to avoid, simultaneously pointing out that he is depriving himself of an opportunity to grow. If I have the sense that the resistance is a conscious resistance, I will speak with him about how he is feeling about me and his treatment, or ask if there is something that he is not telling me about.

Most of the above is concerned with unconscious resistance. When I run into a situation involving conscious resistance of treatment, I take a different approach. I advise the patient that some people are simply not able to use therapy effectively as they are unwilling to take the risks inherent in developing a therapeutic relationship. I let them know that it is equally possible that it may be a case of a "bad mix" of patient and therapist. I then suggest that we meet for an additional four sessions, and that we review the progress at the end of that time. If it does not appear that there has been any progress, I let the patient know that I will be writing a letter to the judge to advise him that treatment with me is to be terminated. Often this will be enough to motivate the patient to be less resistive.

Before ending this paper, I would like to say a few words about countertransference. Some therapists are simply not able to work with sexual offenders as they are not able to overcome the feelings that are generated when they hear about the details of incestuous activities. It is a very common experience for workers in this field, particularly those who do not actually treat patients, to feel repulsed, vulnerable, frightened, disgusted, and very angry. If the worker or therapist acts out these feelings with the patient, the results can be very destructive. Workers and therapists I have talked with have found that it is usually beneficial to discuss their feelings with colleagues, and sometimes have found it advantageous to examine their early experiences in life to see whether or not the patient's verbalizations are stirring up conflicts from their own childhoods. Sometimes a worker or therapist can resolve these conflicts independently without becoming involved in treatment themselves, and sometimes not.

My hope in presenting the above information has been that the reader will be able to use this information so as to develop a more empathic understanding of resistive perpetrators. Once a therapist is able to achieve a position of comfort in dealing with these men, therapy with incestuous fathers can be very rewarding.

FAMILY THERAPY WITH SEXUALLY ABUSIVE FAMILIES

By Patricia Mrazek, A.C.S.W., Ph.D.

Over the last decade family therapy has gained immense popularity and has been applied to every conceivable psychological problem. Along with that, however, have come many criticisms, particularly from more traditional psycho-therapists. Many of the criticisms, from my viewpoint, have been justified. For a long time the field of family therapy has lacked a unifying theoretical structure and has focused instead on the techniques for producing change. On the positive side "technique implies craftsmanship; attention to detail, concern with the product function, and investment in results."[1] On the negative side, it brings to mind images of "people manipulating other people . . . and specters of brain washing or control for the sake of personal power."[2] "The moral concern is absolutely justified, furthermore, technique alone does not insure effectiveness. If the therapist becomes wedded to technique, remaining a craftsman, his contact with patients will be objective, detached, and clean, but also superficial, manipulative for the sake of personal power, and ulimately not highly effective."[3]

All of this is not meant to imply that family therapists agree even on specific techniques that should be used. There are many "expert" family therapists who travel the world espousing their particular theory and techniques for change. "The field of family therapy is full of clinicians who change chairs a la Minuchin, give directions a la Haley, go primary process a la Whitaker, offer paradoxes in Italian, tie people with ropes a la Satir, add a pinch of ethics a la Nagy, encourage cathartic crying a la Paul, review a tape of the session with the family a la Alger, and sometimes manage to combine all of these methods in one session."[4] Perhaps if all of this were combined with a genuine sense of compassion for the troubled family the therapist might just so confuse the family members that there would be a flight into health at least temporarily. It would be a flight away from the therapist. But for most therapists this grab bag of techniques simply would not work.

Therefore, what we have is a relatively new field which is still struggling to organize its theoretical constructs, to unify its techniques and to discuss what should be implied to whom and when, and to access the short and long-term outcome of its application.

It is important to acknowledge these problems of the field generally before we consider family therapy with sexually abused children and their families, for the difficulties with theory, technique, and outcome will only be magnified by application of family therapy to sexual abuse, for the latter is also in an embryonic stage regarding interventions. There is a fair amount understood clinically and published in the professional literature about the psychodynamics of incest and of sexual abuse perpetrated by a third party. But treatment is an entirely different matter.

As yet there is no evidence that any one particular unit of treatment, such as individual, marital couple, or whole family, is specifically indicated in the treatment of child sexual abuse. Likewise, there is little reason to believe that any particular theoretical orientation, such as humanistic or psychodynamic psychology, is more helpful than another. The therapist is therefore left with his own clinical judgement as his guide. He will use his own theoretical framework to understand causation, and his decision as to who to treat will follow from that. If he sees the intrapsychic abnormality of the adult offender as the locus of the pathology, he is likely to offer individual treatment to that person. If he sees the family as a system whose interactions are faulty, he is more likely to treat the family as a unit. The danger with these approaches, particularly with the therapist using a single treatment method, is that all families will be expected to fit the same theory of causation and the same method of treatment. Such singular or specialized professional interests do not allow for rational evaluation of treatment effectiveness.[5]

The clinician who looks to the literature for help on the theory and technique of treatment with sexually abused children and their families will find remarkably little. There are about a dozen references on family therapy with incestuous families, but most of these do little more than advocate its use, either diagnostically or as a last stage of treatment. This cautiousness about the timing of the introduction of family work has never been thoroughly addressed, but the potential destructiveness in family interviews is often alluded to. Therefore, family therapy is reserved until after successful interventions have been made with individuals and various dyadic combinations. This is the model that the Santa Clara County Child Sexual Abuse Treatment Program has utilized.[6] While that program has reported remarkably high success rates, what is not yet known is the importance of any particular treatment modality in the overall effectiveness; for example, is family treatment a necessary component or could individual, dyadic, or group treatment in combination with the intervention by the court produce a similarly positive result?

Family therapy can be helpful to some sexually abusive families some of the time when utilized by some clinicians. This is my premise for the remainder of this paper. What I will be presenting are collections of ideas in work which I have done over the last five years, for before that I was not a family therapist; I was a family-oriented therapist. This may sound like semantics, but the premises underlying the two concepts are quite different. As I explain what I see as the difference, I would like the reader to assess his own placement on this continuum. A family-oriented therapist is concerned with parents and with their children. The individual psychopathology of the parents of the victimized child, and perhaps even the child's siblings will be assessed, and each family member's treatment needs will be considered. But every member may have a different evaluator/therapist and together those clinicians will at case conferences discuss how the family member may be affecting each other. This is done with great difficulty because it is hard to discuss family interactions from an individual psychodynamic perspective. Even if the family-oriented therapist sees the entire family as a unit, it is still the individual, or at most, a dyad which is the focus.

A family therapist, on the other hand, conceptualizes the family as a unit to be his patient or client. He thoroughly understands and keeps in mind the individual psychodynamics of each of the family members and significant others, such as third party offender, but his view of the family is always broader than this. He sees the family unit as a system, with a history, present, and future, ever-changing and effecting the individual. He may work with the whole family, or it may be impossible for a myriad of reasons for him to ever sit down with a particular whole family. He may work with subsystems, that is, the individual, various dyads, or a whole family minus one reluctant member. This is still family treatment for the repercussions of all subsystem work are considered for the effects that they will have on the whole family. For example, a mother and her children might be seen but the father who is absent from the home is also absent from the therapy. However, his presence is felt through the brief effect that his history and potential future have on the family. Not only is this understood, it can become a part of the treatment itself.

Becoming a family therapist is an evolution. I see individual psychodynamic theory as an essential base and family theory as an expansion in perspective — an add on rather than a replacement for. I say this because of a sense of caution. I myself am still in the relearning process. I am constantly having to recognize my mistakes in treatment and to clarify what might have been more useful to a particular family group. There is no replacement for training and the ongoing process of constructive self-criticism.

Let us now consider systems theory as it applies to sexually abused children and their families. In the systems model, the behavior of all family members is considered as well as their perceptions and memories which change over time as interactions occur. The locus of pathology is never an individual as an isolated entity but rather an individual in context. For example, an incestuous father is never considered to be an isolated problem, no matter what his diagnosis might be. How he has been influenced by his family and what will happen in the future is critical in understanding him. And time never stands still, so as the perceptions which the family members have of the father change, so do their feelings and behaviors toward him. His own perceptions, feelings, and behaviors are influenced and perhaps altered. Therefore, the feedback loops which interconnect the individual family members are crucial to the concept of systems functioning.

Now I would like to present an additional theoretical construct which has been helpful to me in understanding systems. This idea was formulated by Kinston and Bentovim[7] at the Hospital for Sick Children in London. Every family can be characterized as having surface action and depth structure.

A family's . . . surface action . . . is its characteristic pattern of communication, alliance, parental function, boundary integrity, atmosphere, affective status, and relationships with the outside world. (A family's surface action) serves to give psychosocial support to all family members and to provide nurturance and socialization for the children. Such "healthy" surface action depends on a depth structure in the family whose stressful events in the family of origin (that is, which affected the parents as children) and in the family of procreation (that is, affecting the parents as adults) have been accepted, integrated, resolved and worked through. This gives rise to a functional way of being for the family and to a web of common and inter-subjective meanings to these events which enables the family to respond creatively to normal life-crisis and to the developing needs of all members of the family . . . Without such working through and integration of stressful events, the family system appears to be required to develop the characteristic surface action which is repetitive and circular and which develops a compulsive, dominating urgent pattern of interactions which cannot be stopped on request for more than a brief period of time despite obviously destructive consequences. Such a dysfunctional action appears to be required as the way of either avoiding, denying, or deleting the meaning of all the similated stressful events, or repeating and generalizing them so that past stressful events are constantly being replayed in various forms. Alternatively there is an attempt to deal with stressful events by a massive attempt to overcome the event or deposit it on some other person as the "source of all bad things." Thus, the family develops a number of pathological meaning systems which underlie the surface action, and this handicaps the family's ability to respond creatively to new significant external stresses or the internal demands of the family life cycle.[8]

Obviously, an incestuous family is a dysfunctional family system. It is essential to our work with such a family that we truly appreciate the tremendous internal and often unconscious pressures leading to the dysfunction and continuing that chaotic existence despite all the negative consequences. Those of you with a psychodynamic orientation understand what power early unresolved stress can have on an individual. This is compounded and complicated within the family system.

An incestuous family is one where the surface action of the family does not meet the needs of family members for nurturance, care, and warmth in an appropriate way relative to the maturity of those individuals. Instead, a sexualization of what should be nurtured physical contact is substituted. This "solution" itself adds to the dysfunctional surface action, and the resulting possessiveness, secrecy, and guilt can pervade the family's life, and the "solution" becomes the problem in its own right . . . There are many different "routes" to this incestuous family surface action from the depth structure of the family whether resulting from events experienced by the parents as children in their family of origin, such as depriviation in incestuous relationships, or in the family of procreation, such as absence of a parent or marital breakdown.[9]

We must be careful not to simplify our process of understanding. Having experienced incest as a child does not explain why a parent then molests his or her own child or allows a spouse to do so, for not all sexually abused children grow up to repeat their experience. What is important to understand is why for that particular sexually abused child the stressful events went unresolved; what personal meaning has that child, now as an adult, attributed to the events? I think that too often we as clinicians gather the facts, the history, but we do not really take the time to help our clients convey the feelings and meanings of those events.

Whatever the original stressful event, incestuous families seem to share a belief that on the one hand close relationships and intimacy in adult relationships cannot be risked, and on the other that any separateness leads to disintegration and abandonment. Such pervasive and shared meaning seems to maintain the pathological surface action which contains incestuous behavior and perpetuates it over long periods.[10]

If we look at specific aspects of the family systems surface action, we can begin to pinpoint areas of dysfunction which become guidelines for planning particular interventions. These are only some of the problem areas for incestuous families, but they will provide an idea of how a family therapist might conceptualize or analyze the difficulties.

Subsystems within a family can be formed on the basis of generation, sex, or function. The boundaries and roles within an incestuous family have become confused in many ways. For example, generational boundaries are often crossed not only in regards to sex but also, for example, in terms of who has the decision making power. There is often also a rapid reversal of roles. For example, a mother may solicit sexual relations with her adolescent son and then soon after infantilize him by demanding that he seek permission for any food that he takes from the refrigerator.

The incestuous behavior in a family can be seen as a symptom which has helped the family avoid facing a painful reality. The incest can also serve as a defense against the family's fears of disintegration and abandonment by particular family members. Family myths are very common. A myth is a body of beliefs a family has about itself that may contain only a small element of truth. Myths are maintained as a way of helping a family maintain its behavior. For example, a very common myth in incestuous families is that the mother is weak and vulnerable and that she will be unable to tolerate the truth and may even die if she discovers the incest. In fact, the mother may be very strong but may be needing to deny the occurrence of incest not out of weakness but for much more complicated reasons.

The feedback circularity within a family allows it to maintain a homeostasis or equilibrium with which it is comfortable. Clinicians often view a family's homeostasis too simply. In fact, an involved process of interaction occur-

ring over a rather lengthy period of time may all contribute to the family's equilibrium. If time were frozen at any one particular point, a false idea of the family's system would be gained:

The R Family

Mr. and Mrs. R have not spoken to each other for a week, and neither can remember the last time they had intercourse. They have not made any attempts to resolve their differences, but Mr. R has found some consolation with his adolescent daughter, Terri, sharing late night meals in front of the television set and occasionally going on outings. Eventually, he approaches her sexually and she responds because of her concern for her father and the excitement of keeping a "secret" from Mrs. R. But Mr. R becomes very possessive and demands intercourse several times a day. Eventually, Terri complains to her mother who in turn chastises Mr. R. The marital fight that ensues has a quality of sexual excitement to it, and Mrs. R. seems more alive than she has been for months. Mr. R., however, finally breaks down in tears, asking his wife's forgiveness. He promises to leave Terri alone and to spend more time with his wife. This results in a dramatic withdrawal from Mrs. R. who cannot tolerate even the potential for closeness in the marriage. In the following days, she avoids her husband. The system is left open for further incest.

Now let us turn to the evaluation of incestuous families as a whole system. In 1979 Anderson and Shafer reported that sexually abusive families were analogous to character-disordered individuals. Before they initiated treatment, a thorough diagnostic study of the parents individually and of the family as a whole was made. The family diagnostic session included a structured task and an assessment of the family's position along a continuum described by Lewis et al in 1976.[12] Families were asked to work together to complete a simple assigned task such as planning a vacation together or determining a solution to a puzzle. They were then assessed on a continuum from chaos to authoritarian to egalitarian structure. "Success in treatment is optimally defined as not only cessation of the incest and development of new, non-abusive responses, but is demonstrated family interaction at a higher level of development.[13]

I am in agreement with Anderson and Shafer's idea that all incestuous families should be seen as a unit during the diagnostic phase. Seeing them together will yield valuable information about boundaries or lack of boundaries between subsystems, special alliances, communication patterns, myths, and family efforts to maintain or recreate the homeostatic patterns that existed prior to the incest. In my experience resistance to doing this comes from three fronts:

1. Juvenile court judges who forbid all contact between the victimized child and the parents, at least the "offending" parent;
2. The social service worker; and
3. The family itself.

The judge's reaction may be in response to his own disdain and feelings of repugnance towards the parents; he may truly feel he is helping the child by forbidding all contact with the family. However, he is failing to appreciate the clinical usefulness of seeing firsthand how the family operates as a system. The social service worker, on the other hand, may feel that he or she does not have the diagnostic skills to make family assessment and does not consider referral of the entire family for this purpose.

The clinician, whether a social worker, a mental health worker, or a therapist in private practice, who evaluates the family initially as a unit will continue to have a unique relationship with the family from that time forward. He or she has given a special message to the family; that is, even though the adult perpetrator is held personally and legally responsible for his actions, the incest problem belongs to the whole family; only if they all work, individually and together, will they be able to alleviate the conditions which produced the incest in the first place. Even though the family may find this initial interview difficult to get to they may be pleasantly surprised that they can actually organize themselves to do something together. For those families who are already separated with either the child or perpetrator out of the home, this may be a very tense time. The clinician may have to be very active, forging the way. I have gone out to cars in the parking lot to retrieve reluctant fathers when no family member was able to do so. I have sat on the steps with adolescents helping them enter the room and have their first encounter with their parents following the disclosure of the incest. If the evaluator/therapist can convey a sense of calm and confidence, he may be able to reduce the inevitable tension that the family is feeling. He is in effect saying, "I am here to help you make things better without destroying any person or the family as a whole." The engagement process, however, begins long before that actual first interview. In my experience, the closer in time to the report that the family therapist has his first contact with the family, the greater the chances for recruiting the family for at least a diagnostic session. The crisis of disclosure may actually precipitate some openness in the family for the defenses are more vulnerable, and temporarily the homeostasis has been shaken. The earlier the family therapist enters the "chain of treaters" the better the chances for engagement. Hopefully, this first meeting will happen within the first week following disclosure of the incest. If a referral is made, for example, to a family therapist a month after disclosure and investigation, then it is much more difficult, perhaps even impossible, for the therapist to get "into" the family system which may have regained a prior rigidity.

When a family comes together for an interview they usually do not know what to expect. This request to come together may in itself produce a crisis. There may be attempts to exclude a family member from the appointment altogether, for example, the "problem" adolescent, the alcoholic father, or even the "baby" of the family who turns out to be six years old and incredibly vocal about the family's problems. Therefore, as a general principle I do not expect anyone in the family to bring in anyone else. I either contact each family directly

or arrange for the social service worker to provide "a personal escort."

It is often helpful to include even the youngest of children in at least the beginning of this evaluation session. Often the younger ones are the ones who disclose the most, for example, comments are made such as "mommy's gone a lot" or "sister cries sometimes at night, I hear her." If there is another adult in the waiting room, such as a social service worker or an extended family member, younger children can be asked to leave the room if parents and the victim-child are reluctant to discuss certain issues such as the sexual abuse in front of the child's siblings. But a word of caution is warranted. Sometimes such a request is merely another smokescreen by the family and a means of avoiding highly charge material. For example, a ten year old girl and her mother were reluctant to let a six year old sister in to a session during which sexual abuse by her adoptive father with the ten year old was discussed. I went along with this but finally recognized that it was red herring. When the younger daughter was included in these discussions, she quickly told about the father's sexual abuse of a young neighborhood girl. This was new information. The mother had known about it but had wanted the incident kept quiet, primarily because she had taken no steps to protect her own daughters even after knowing about the assault on the neighbor's child.

The decision about who should be seen in the evaluation, the number of sessions, and so on should clearly be a decision of the therapist, not a decision of the attorney's family or court. If necessary, the judge should be asked to order a family evaluation. If the therapist is skilled, the guardian ad litim and others need not be concerned about the child being scapegoated and chastised by other family members in the session(s). The therapist can refuse to allow this to happen. He can become active, intrusive, indignant, then challenge the family, reinterpret the child's behavior, or whatever is necessary to protect the child. He can even end the session. The child may have heard all of this from the family before and not ostensibly appear to be upset by it. Then the therapist's actions may be designed with a different intent. Instead of protecting a vulnerable child from the new attack, the therapist may be creating an atmosphere of alarm or a sense of vulnerability, in challenging the family which has lost all objectivity to quit taking such hostile exchanges in stride.

How does a family therapist begin? Usually it is with some general comments such as "I have found this approach of seeing families together useful . . . a family knows itself best, etc." Asking the family to tell you about "itself" often produces giggles from the younger children. But who speaks first and for whom and how others respond is as important as the content that is being shared.

The task for the clinician is a complicated one and is sometimes conceptualized as being that of a "psychoshaker." The equalibrium within the family must be disturbed enough either by the crisis, which has already occured, or by the therapist within the session so that the usual retreats are blocked; the family then has to move in a different direction. The therapist must be active, even intrusive, and determined to participate in the system so he can modify it. But to do this the therapist also must be liked and respected by the family. If he is not, they will not give him a chance.

Family therapy work can begin after the adult perpetrator has admitted responsibility for the sexual abuse. A combination of individual, dyadic, and family work can be useful; for example, family members may come to two appointments a week but with only one of these being a family session. If an incestuous father continues to deny the incest, and the victim is an adolescent or a very strong and precocious child, there may be some advantage to having some sessions in which the child confronts the parent. But many children are unable to do this and unless the other parent is an ally it may be best to wait until individual work with the father is more successful.

There is a wide variety of techniques which can be useful within the family sessions. (Mrazek and Bentovin, 1981) Creating boundaries between subsystems can help reinforce appropriate roles between parents and children. For example, the parental subsystem can be asked to work together to resolve a minor problem while the therapist works with the child subsystem to stay out of the negotiation. If the marital system is working on issues which are inappropriate for the children to be hearing, the children can be asked to leave the room. Likewise, the sibling subsystem may find it useful to discuss common feelings and experiences while parents are absent. Within the sessions the use of physical space (such as moving chairs) and the therapist's use of body gestures can help create boundaries where there were none before.

Additionally the exploration of family myths can help families understand the history of a belief system that is more fiction than fact. Redefining a situation can also be useful. For example, although a therapist can not acutally lie, one side of an ambivalence can be exaggerated. For example, the therapist might say, "Dad's a cuddler, isn't he? Does he ever give Mom a cuddle?" This redefines the incest in terms that the children are more comfortable with and it also puts the sexual behavior back in the marital subsystem where it should be. There is also the use of positive connotation. This technique can help a child feel less responsible and guilty. For example, the therapist might say, "This child has sacrificed herself to keep this family together. She has refused all attention from her peers and boyfriends and instead has devoted herself to her father so that her parent's marriage need not break up." The use of family trees or genograms can be used to not only elicit the historical facts about a family but also the meanings that have become attached to those facts. It can be useful to trace back through a family and determine where else there has been incest or prior deprivation. This can lead to a shared feeling within the family of vulnerability and misuse. A sibling who is no longer in the home but who has grown away

from the family and matured can be asked to come back to the sessions and act as a "co-therapist," relieving pressure from the family scapegoat within the session by revealing information as to how the family system has operated in the past. It is also important to find new roles for family members which are healthier than the ones that the clinician is asking them to give up. It may be necessary to be quite concrete in terms of defining these new roles and responsibilities. For example, it may be appropriate to say to a child, "Since you are no longer going to be so busy keeping Dad happy and keeping this family from blowing apart, you're going to have a lot of time on your hands. What we need to do now is to figure out ways that you cannot only be busy but happy doing things that are new to you." Another technique is the facilitation of more open discussion on issues that are very emotionally laden for these families such as sex, affection seeking, and discipline. For example, the clinician may help the family discuss their fears of abandonment. In one case this led to a thirteen year old girl discovering how she allowed herself to be a sexual victim of a third-party caretaker because she knew that her mother would then rally, bring her home, and take better care of her at least temporarily. Enactment can also be used to help family members interact with each other in the therapist's presence in a new way. For example, the therapist may place the chairs of the mother and father in a way that they face each other and then stand behind the mother while the parents are asked to discuss a particular issue. The therapist can help the mother by making minor suggestions to her as to what she can say to carry on the discussion. The children are asked to observe but to stay out of this action. The technique of focusing helps a therapist zero in on a particular theme or repetitive behavior that has been used to highlight more general issues. Changes are made through focusing on the more minor behavior, with the hope that the improvement will generalize. Therapists can also create intensity within a situation, that is, heightening the impact of a message. For example, he can show how frequently a dysfunctional transaction occurs. "There you go again. Did you see that? You are again acting like Molly is your wife, instead of your daughter." Additionally, the technique of conveying power can be useful. For example, the parents can be asked who has had an experience or situation that is similar to what the child is now going through. That parent is then asked to be the one identified as helping the child. For example, if a child is feeling frightened about being in foster care and it is the mother who has also experienced foster care she can be asked to talk to her child about what that situation is like.

If no progress is being made within the family sessions that may be a clue that it is necessary to go to the subsystem to free up some material which then can later be brought back into the larger unit. For example, a mother not only was having difficulty controlling her adolescent daughter's acting out but also appeared to be getting satisfaction from the girl's behavior. None of the efforts within the family session were getting anywhere so the mother was seen alone. It was already known that she had been a victim of incest perpetrated by her biological father. Within the individual session, however, she told for the first time in the six months of therapy that she had been repeatedly homosexually assaulted by her stepmother. One of her worst fears was that either she or her daughter would become lesbians. Therefore, her daughter's heterosexual acting out served to lessen this anxiety.

Finally, it is useful to help the family truly understand why the incest occurred and why the family system has operated as it has. But one caution: interpretation should only be used if it does not get in the way of therapy. Interpretation alone with no change in behavior does not produce satisfactory results.

Family therapy is certainly not a cure-all for incestuous families, and it may not even be appropriate to try in all cases. However, with some families it can be extremely valuable. For those where it is not therapeutic it may at least yield valuable information which the clinician may use in hearings for termination of parental rights.

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sexual abuse

Appendices

APPENDIX B

EL PASO COUNTY, COLORADO

ADULT DIVERSION AGREEMENT

Name _____ D.O.B. _____

Address _____ Phone _____

Employment _____ Address _____

SSN or Military ID# _____

I, _____ have been advised of my right to speedy prosecution and to have a speedy trial and hereby waive those rights for a period of two months until the date of _____ for consideration by the Adult Diversion Program. Upon acceptance into the program, I will give an unconditional waiver of those rights.

I, _____ admit responsibility for the situation which brought this matter before the Adult Diversion Program, and I understand that such admission will not be used against me in any criminal prosecution, including impeachment, but this will not extend to any new offenses admitted to.

I, _____ agree to give a release to the Adult Diversion Program for medical or psychosocial information from any physicians and counselors whose services are secured as a requirement of this program.

I, _____ agree to participate in any counseling or therapy that is recommended as a requirement of my Adult Diversion Program or any counseling or therapy approved by the Adult Diversion Program and I agree to pay any costs incurred by these requirements.

I, _____ understand that if I fail to cooperate or comply with any requirements or conditions placed upon me by the Adult Diversion Program that I may be removed from the Program and criminal prosecution may be instituted against me.

I, _____ understand that in any proceeding to remove me from the Adult Diversion Program, I will be informed of the recommendation for removal from the Program. I will be notified of the date on which the Child Protection Team will review the recommendation and I may be present to hear the reasons for removal from the Program and I may respond to the Child Protection Team on those reasons.

I, _____ understand that the duration of this Agreement is to be no more than 24 months and that upon successful completion of the Program, that the District Attorney agrees not to prosecute me upon the incident which brought me into the Adult Diversion Program.

I, _____ understand that the date of the signature of the District Attorney's Office will be the effective date of my acceptance into the Program.

I, _____ understand that I will inform the Adult Diversion Program of any change in address or employment.

I, _____ have read this Agreement and understand the statements and requirements it contains and agree to abide those statements and requirements.

_____ _____

Date El Paso County Department of Social Services

_____ _____

Date Participant

_____ _____

Date Deputy District Attorney

APPENDIX C

PARENTS UNITED

by Jeff Slaga, Boulder Department of Social Services

I. How can you start a Parents United Group?

- A. Call or write for specific information from: Parents United, Inc. P.O. Box 952, San Jose, California - phone (408) 280-5055.
- B. Bring incestuous families together on a weekly basis for treatment, then ask Parents United to incorporate your group.

II. What is Parents United?

- A. Self-help program to promote personal responsibility
- B. Support group to reduce isolation
- C. Therapy group with professional facilitators
- D. Anonymous group of incest perpetrators and/or spouses

III. What are the advantages of a Parents United Group?

- A. Provides a place for sharing the family secret
- B. Reduces social isolation
- C. Provides possibilities of support for professional staff in some matters:
  1. fund raising
  2. transportation for victim's group
  3. intake
  4. resource and reading material
- D. Provides peer confrontation which decreases denial quite effectively
- E. Provides a place for weekly contact between worker and client
- F. Mixed male/female groups
- G. Nationally incorporated non-profit status

IV. What are the disadvantages of a Parents United Group?

- A. Parents unite versus authority figures
- B. Increased denial due to collusion
- C. Increased stress for therapist/social workers:
  1. Increased enmeshment - clients feel everyone else's anxiety
  2. It's hard to deal with a number of borderline clients at one time and in one group.
  3. Need to meet at night so clients won't miss work
  4. Increased time demands on staff
     a. group planning meetings
     b. liason meeting with the Parents United officers
- D. Transition between business meetings and therapy time is difficult
  1. accentuates power structure
  2. increases control battles

BOULDER COUNTY CHILD SEXUAL ABUSE TREATMENT PROGRAM

Participation Agreement

You have been referred to the Boulder County Child Sexual Abuse Treatment Program. Prior to participating in the Program, it is important that you understand how the Program is operated, what you can expect, and what will be expected of you.

There are two parts of the Program in which you will be involved:

1. You will be required to attend a weekly group which is the Parents' United Group. This Group is designed to increase your understanding of the family problems which led to sexual abuse, and to help support you in making changes so that your family can become more healthy.

2. Family members may be required to participate in clinical therapy while they are involved in the Program. Therapy may include individual, family, marital counseling, or classes. These services may be provided by a therapist approved by this Program; through the Mental Health Center; or, in some cases, by a staff member of the Sexual Abuse Treatment Team.

As a participant in the Program, you will be expected to:

1. Attend all group and therapy sessions, be on time, and remain for the duration of the sessions. (Unexcused absences may result in termination from the Program.)

2. Participate in the sessions and be willing to discuss your own behavior and feelings.

3. Respect all confidentiality of the group members by:

   a) Not disclosing or discussing any personal information given by any member of the group outside the group.

   b) Protecting the identity of all members by not disclosing the identities of any group members.

4. Share experiences and encourage others, when needed.

5. Be willing to give others honest feedback about themselves and accept same from others.

6. Be sincere in seeking help to modify behaviors which contributed to the sexual abuse.

7. Commit yourself to the improvement of family relationships.

In turn, you may expect therapist and group leaders to be responsible for:

1. Work with each participant in a professional and ethical manner.

2. Help each participant understand the problem of child sexual abuse and find solutions that are individually meaningful and socially acceptable.

3. Confidentiality is contingent upon involvement with Civil Court and Probation.

This agreement will be in operation on a continuing basis until treatment is terminated. The Sexual Abuse Team may terminate your participation in the Program if the above expectations are not met.

I have read the above descriptions and expectations and agree to them as basic conditions of my participation in the Boulder County Child Sexual Abuse Treatment Program.

Participant	Date
Participant	Date
Sexual Abuse Team Worker	Date

GENERAL CRITERION FOR ADMISSION TO PROGRAM AND TO PARENTS' UNITED GROUP

1. Admission will be determined on an initial individual assessment with progress to be monitored 90 days after admission and then every six months.

2. Priority for admission will be given in the following descending order:

   a. Perpetrators who have admitted their guilt to their families, and who are subject to the Civil or Criminal jurisdiction of Boulder County.

   b. Separated families in which the child(ren) is under the age of 18.

   c. Intact families in which the perpetrator does not admit his guilt, but the spouse wishes treatment

GENERAL CRITERION FOR ADMISSION TO ADOLESCENT GROUP

1. To be determined by initial, individual assessment with periodic assessment 90 days after admission and then every six months.

2. All victims are eligible who are under the age of 18 and are residents of Boulder County. Priority will be given if space is an issue to:

   a. Intact families.

   b. Separated families in which there is perpetrator/victim contact.

   c. Children who are assessed in particular need of such a treatment group, but do not meet above criteria.

ADMISSION POLICY FOR REFERRALS TO THE GROUP

Any referral for the Parents' United Group or Adolescent Groups from other agencies or BCDSS teams other than the Sexual Abuse Team are to be called in to the Intake worker on the schedule for the Sexual Abuse Team that day. It will be that worker's responsibility to record all pertinent information and to bring it to the next staff meeting. The referrals will then be staffed by the Team as to group appropriateness and the current capacity of the groups to accept new membership outside the Sexual Abuse Treatment Program. When a referral is accepted from outside the Sexual Abuse Treatment Program, the intake worker who was originally contacted by the referring party will be assigned to be a liaison for the new participant.

DISMISSAL POLICY

Consideration for dismissal will be given to any of the following:

1. Failure to cooperate with treatment plan or failure to show progress.

2. Failure to comply with the **Participation Agreement.**

3. Chronic inability to utilize group treatment as demonstrated by any one of the following behaviors:

   a. Client monopolizes group. Does not use the group for input, but rather to gain attention.

   b. Client disrupts growth potential for other group members through monopolization of group.

   c. Other group members express/exhibit intimidation or fearfulness of particular client.

   d. Client is not able to integrate what is appropriate material for the group and what is not appropriate. This can be measured by the number of interventions needed by the group leader in order to set limits.

4. Reoccurrence of incest or repeat of the offense while in the Program.

5. Evidence of continued alcohol and/or drug abuse.

APPENDIX D

SEXUAL ABUSE BIBLIOGRAPHY

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APPENDIX E

CHILD SEXUAL ABUSE AND INCEST FILMS

"Child Molestation: When To Say No" 16mm, color 10 minutes
A film for children. Describes ways children can protect themselves from sexual abuse much more effectively than the "don't take candy from strangers" approach. +

"Child Sexual Abuse: The Untold Secret" 3/4" videocassette color
Gives excellent coverage of problems of incest for junior and senior high students. Especially appropriate for female victims. +

"Childhood Sexual Abuse - 4 Case Studies" 16mm color 60 minutes
Training film uses a case-history approach to facilitate discussion and analysis of techniques. Two reels, two stories on each. Therapist uses her sessions with real cases, quite effective and sensitive.*

"Double Jeopardy" 16mm, color 40 minutes
A good film which focuses on the insensitivity to the child sexual abuse victim during uncoordinated investigations by community agencies and the legal system. Suggests various improvements in coordination and professional sensitivity. + *

"Incest: The Victim Nobody Believes" 16mm, color 21 minutes
A group of women who were sexually abused as children describe their experiences. Heightens awareness of sexual child abuse and its impact on a victim's entire life. + *

"The Last Taboo" 16mm color or videocassette 28 minutes
Six case histories of childhood sexual abuse illustrate the trauma associated with such incidents and the need for counseling programs. *

"No More Secrets" 16 mm, color 13 minutes
Uses live-action and animated sequences to deal with three situations of abuse: an older brother who harasses his younger sister when she undresses, a man who molests his 10 year old nephew under the pretext of wrestling with him and another man who molests his daughter. The children in the film demonstrate ways to say no to adults who touch them in ways that make them uncomfortable, and the film urges children to confide in an adult who will believe them and protect them when they tell about an abusive incident. + *

"The Path of Incest" video cassette 23 minutes
An interview with two adult women victims. +

"Speak Up, Say No!" color filmstrip/ audiocassette 6 minutes
This filmstrip uses a cartoon character to show children that sexual abuse is not their fault and encourages them to report incidences. When and how to say no is discussed and a distinction is made between "OK" and "Not OK" touching. A teacher's guide is available. +

"A Time for Caring: The School's Response to Sexual Abuse"
16 mm
Helpful in preparing educators to handle students who come to them to report incest in their homes. +

"The Touching Problem" 16mm color 26 minutes
This overview of sexual abuse of children discusses the definition, nature, incidence, types and effects of the problem. Designed to help adults learn how to talk to children about this delicate subject, The Touching Problem increases viewers' awareness of the emotional trauma experienced sexual abuse prevention skills to young people. *

"Who Do You Tell?" 16 mm or videocassette 11 minutes
Combining animation with live footage of kids talking openly and honestly about their own experience, Who Do You Tell teaches young viewers, ages 7-12, about the variety of people who are part of everyone's support system. Designed to create a safe space for talking about their concerns, the film lets children see and feel for themselves that it's ok to tell someone. Leader's Guide with discussion questions. + *

These audio-visuals (+) are available through the Kempe National Center on Child Abuse and Neglect Resource Center, 1205 Oneida St., Denver, 80220, 321-3963. These (*) are available from the State Department of Social Services Library, 1575 Sherman St., Denver, 80203, 4th floor, 866-2253.

Kempe Center Film Loan Policies: Reserve films as far in advance as possible. No more than 3 films may be ordered for use over the same period of time. A rental fee of $12 will be charged for each 16mm film on loan.

State Social Services Film Loan Policies: Reservations for films should be made as far in advance as possible. Return the film no later than the day following the last showing. The patron must assume full responsibility for the cost of returning the film to the library at an insured rate. **Materials may be checked out only by Colorado state or county department of social services employees.** No rental fee.

This book may be ordered from The C. Henry Kempe National Center, 1205 Oneida, Denver, CO 80220, (303) 321-3963. $3.50

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