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A Study of the Effects of Child Sexual Abuse, Treatment, and Interventions

Catherine P. Coyle

A STUDY OF THE EFFECTS OF CHILD SEXUAL ABUSE, TREATMENT, AND INTERVENTIONS

by

Catherine P. Coyle

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ABSTRACT

The last two decades have seen the topic of child sexual abuse emerge from an issue that was considered rare, or at least uncommon, to one currently viewed as a leading concern of mental health professionals. Public reaction to incest and sexual abuse has changed from one of disbelief to one of active concern. Public awareness and education about the issue of child sexual abuse has developed into a critical area of concern.

Sexual abuse of children is now recognized as a serious mental health problem, both because it is so widespread, and because of increasing evidence of its traumatic effects. In the very recent past, mental health clinicians were rarely, if ever, exposed to the topic of sexual abuse in class content, supervision, professional conferences, or literature, although therapists now report that rather than seeing a solitary sexual abuse survivor, their client load consists of two-thirds of clients reporting experiences of childhood sexual abuse.

The methodology employed in this research project was qualitative. A survey was used to gather information from mental health professionals in a mid-west metropolitan area. One hundred thirty-four surveys were returned from a total of 270 distributed to therapists who were associated with hospitals and agencies that specialized in treating children who had been abused sexually.

The intent of the study was to discover whether mental health professionals in the St. Louis metropolitan area agreed about the definition of sexual abuse, the various effects of sexual abuse on children who had experienced this trauma and

what kind of treatment modalities were indicated. Questions in the survey focused on the effects of the experience of sexual abuse on children, as well as on the corresponding implications for treatment.

The purpose of the study was to gain practical information about a sensitive, but critical area of treatment for therapists and others concerned with the welfare of children.

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CHAPTER 1

INTRODUCTION

Child sexual abuse has long been a sordid part of history, tolerated along with other abusive practices by many cultures (Schyetky & Green, 1988). The concept of "Patria Potesa" in ancient Roman law gave a father complete power over his children, including the right to commit infanticide or to sell his children into slavery (Haugaard & Reppuccio, 1988).

The recognition that children are abused sexually is a disturbing reality which has only been acknowledged as an important social problem by both professionals and society at large in the last few decades (Sgroi, 1989). The emergence of an interest in child sexual abuse as an issue of public concern is due to the joining of the advocacy of the women's movement with the children's protection movement. Although the children's protection movement and the women's movement have placed the problem of sexual abuse into a different theoretical perspective and have suggested different remedies for it, their interest in championing the issue may account for victim's new willingness to report what was previously an unmentionable experience (Finkelhor, 1984). The children's protection movement placed sexual abuse in the context of other forms of child abuse and neglect, while the women's movement identified sexual abuse with the issue of rape (Brownmiller, 1975).

According to Hauggard, and Reppucci (1988), the first well-known reports came from Kinsley et al's 1959 study of female sexual behavior. The rate of reported incidents of molestation of both boys and girls has risen from year to year since that study was completed. It is believed that the increase in the rate of reporting has lead

to an increase in public awareness. Heightened awareness then creates a climate that favors reporting, so that while reports of physical abuse of children increased by 16% nationwide from 1983 to 1984, during the same period reports of sexual abuse increased by 59% (Garcia, 1986). In the state of Minnesota, reports in the year 1986 of male and female sexual abuse were up 77% from 1984, and up 133% from 1982 (Hunter, 1990). In the general population it is believed that between 15% and 45% of women and between 3% and 9% of men have been sexually abused as children (Finkelhor, 1980). In Minnesota, one of every twenty-five male high school students and one of every fourteen male college students reports that he is a victim of sexual abuse. A review of several national studies puts the prevalence of sexual abuse in males at between 2.5% and 16% (Hunter, 1990). MacFarlane, K., Waterman, J., Conerly, S., Damon, L., Durfee, M., & Long, S. (1986), relate the increase in reporting of experiences of child sexual abuse to greater public awareness and acceptance. They note that when a community opens a child abuse hotline and begins advertising treatment services, or gives media exposure to the issue, reports increase dramatically (MacFarlane, Waterman, et al, 1986).

Further awareness of the issue of child sexual abuse came from the sexual assault field, which in the 1970's led to the opening of rape crisis centers, often on college campuses. As these rape crisis centers opened to respond to a growing awareness of stranger rape, they were increasingly receiving calls from incest victims who reported having been raped, not by strangers, but by men they knew, and by

family members, including fathers, brothers, uncles, grandfathers, cousins, and others in custodial roles (Courtois, 1988).

The late 1970's through the early 1990's has seen considerable work and effort in the development of child sexual abuse as a multidisciplinary subspecialty of psychological treatment (Conte, 1990). The treatment issues of child sexual abuse have now become a leading concern of mental health professionals and a new topic of mental health research (Cole & Putnam, 1992).

Effective treatment of the sexually abused child requires an understanding of the significant impact issues for the victim. Treatment goals need to be a reflection of the impact issues (Porter, Blick & Sgroi, 1989).

Empirical studies on child sexual abuse indicates probable short-term effects, including fear, anxiety, depression, anger, hostility, inappropriate sexual curiosity, public masturbation, changes in eating habits and sleep patterns. Research also suggests a connection between sexual abuse, running away, and delinquency (Reich & Gutierres, 1979).

Long term effects of childhood sexual abuse include chronic depression, self-destructive behaviors, feelings of isolation, poor self-esteem, a tendency toward revictimization, substance abuse, and difficulty in trusting others (Brown & Finkelhor, 1986). Adult survivors of child sexual abuse also may report experiencing sexual dysfunction, avoidance of sexual activity, or sexual maladjustment (Courtois, 1988, Maltz & Holman 1987). Other reactions that researchers have identified with the aftermath of child sexual abuse are dissociative phenomena such as

depersonalization, amnesia, loss of sense of time, as well as trauma intrusion phenomena such as flashbacks and somatization (Courtois, 1988).

Cole and Putnam (1992) reviewed current research on the long term effects of incest. They identified a number of disorders in which the incidence of childhood sexual abuse, particularly incest, significantly exceeded the chance rate of occurrence. The conditions identified by Cole and Putnam (1992) include borderline personality disorder, multiple personality disorder, somatoform disorders such as pseudoseizures, pelvic pain, and gastrointestinal disturbances, eating disorders and substance abuse in women.

Many studies have found survivors to have higher levels of anxiety, depression, self-destructive and suicidal tendencies, as well as difficulties with intimate relationships according to Ratican (1992). Allers, Benack and Allers (1992) observed three characteristics of unresolved childhood sexual abuse in adult survivors over 65 years of age. These characteristics are, specifically, chronic depression, elder abuse, and the misdiagnosis of residual abuse trauma as dementia or mental illness.

This study is concerned with the impact issues of child sexual abuse and the accompanying implications for treatment. It is not unusual for therapists educated even fifteen years ago to report that the topic of child sexual abuse was never discussed or even mentioned in classes, in supervision, in conferences, or in literature (Markowitz, 1992).

While mental health providers are key to identifying and treating victims, they are not trained properly according to Mary Arnesworth, a Houston, Texas trauma

specialist (Vanderbilt, 1992). Victims of child sexual abuse are too often misdiagnosed and hospitalized for everything from manic depression to schizophrenia (Vanderbilt, 1992). Researchers who have worked with adults over the age of 65 who were sexually abused during childhood have observed these clients continuing to battle the residual effects of the abuse. These residual effects commonly appear in the form of chronic depression and revictimization in the form of elder abuse, but may be misdiagnosed as dementia or mental illness (Allers, Benjack & Allers, 1992).

Misdiagnosis occurs because the therapist, psychiatrist or doctor does not know what to look for, does not consider childhood sexual abuse a possibility, or does not believe the patient's account of what has occurred (Vanderbilt, 1992). These therapists, psychiatrists, and doctors are responding to a century old lead of Freud and his followers. On April 21, 1986, Sigmund Freud presented a paper entitled "The Aetiology of Hysteria" to the Society for Psychiatry and Neurology in Vienna, Switzerland. In this paper Freud claimed that sexual experiences in childhood must be recognized as being the traumas which lead to a hysterical reaction to events at puberty and to the development of hysterical symptoms (Freud, 1896/1984). His findings were based on the accounts of 18 of his patients, men and women who told him about their childhood abuse, often by their fathers. Freud (1986) concluded that infantile sexual experiences were the fundamental preconditions for hysteria.

Freud's paper was rejected by his colleagues, and within a year Freud had privately repudiated what he termed the seduction theory (Herman, 1992). There has been much speculation regarding Freud's repudiation of his theory. Herman (1992) states that Freud's correspondence made clear that he was increasingly troubled by the radical social implications of his hypothesis. Miller (1991) contends that Freud's repudiation of the truth was a result of Freud's not being able to bring himself to confront the truth about his own childhood. Freud suspected his own father of abusing several of his own siblings.

The seduction theory stated that child sexual abuse is the cause of most - or even all - mental illness, the drive theory held that child sexual abuse almost never happens, that a person's memories are false, and that mental illness and neuroses come from a child's conflicted desire for sex and murder (Vanderbilt, 1992). Ever since Freud, the Oedipal theory has been used to refute claims of child sexual abuse. The legacy of Freud has been to denounce the reality of incestuous abuse, and where discounting is impossible to blame the child for being the one who wanted sexual contact in the first place (Russell, 1986). Miller (1991) argues that Freud suppressed the truth to spare himself and his friends. Miller contends that Freud locked the doors of awareness of child sexual abuse and hid away the key. Courtois (1988) writes that many of her patients who are survivors of childhood sexual abuse report that when they had been previously medically examined they were treated for their symptoms, but for the most part the symptoms were never attributed to abuse,

even when the evidence was obvious. Instead, symptoms were frequently described as psychosomatic or without basis, or another diagnosis was given.

To accept the idea of Freud's deception means accepting that nearly a century of child rearing, analytical training, law enforcement, and judicial and medical attitudes are based on a lie, and the men and women who should be able to identify abuse and help prevent and punish it have never learned the basics (Vanderbilt, 1992).

Admitting that sexual abuse exists has been an ongoing struggle for many years. It is a bitter struggle that requires adults to face issues that are difficult and unpleasant. These issues include sexuality, deviant behavior, the abuse and terrorizing of children, and the violation of social norms. It necessitates the recognition that members of our families, communities, and social institutions, such as schools and churches, use children sexually. (Conte, 1990) Human beings have psychological defenses that operate within to protect them from acknowledging what is painful or anxiety-provoking, and professionals in the field for child sexual abuse are included in this group. Conte (1990) states that professionals often held beliefs that tended to minimize their anxieties and discomforts about sexual abuse rather than dealing with actual reflections of the problem. Conte (1990) illustrates several examples of how mental health professionals defended themselves against the reality of child sexual abuse. The first commonly held erroneous idea was that all children who had been sexually abused would present with recognized core symptoms such as behavioral regression, somatic complaints, and fearfulness. A sure sign of sexual

abuse was the child who presented with sexual knowledge, sex play, or sexual talk that was considered not developmentally appropriate. According to Conte's (1990) research, it appears that not all abused children will exhibit these behaviors and that some non-abused children will exhibit them.

Other erroneous ideas that have inhibited the professional development of the field of child sexual abuse treatment are listed by Conte (1990). The first is that sexual abuse or incest is the sexual expression of non-sexual needs such as depression, poor self-esteem and difficulties in relationships with women. According to Conte (1990), neither of these ideas were supported by research. Rather research indicates that 49% of incestuous fathers and stepfathers abused children outside of their own families at the same time they were abusing their own children. Accepting the perpetrator's view that his motivation is not actually sexual may make it easier for the professional to interact with a sexual offender; however, the acceptance of this belief may minimize or distort the nature of the behavior experienced by the victim (Conte, 1991).

Finally, the idea that prevention harms children has hindered the professional development of the field of sexual abuse treatment (Reppucci & Haugaard, 1989). A growing body of research has failed to identify any unanticipated consequences of prevention training. Generally, research on prevention training has found positive results. Binder and McNeil (1987) found no significant increases in behavior problems recorded by parents' ratings. Miltenberg and Thiesse-Duffy (1988) found no new behavioral problems, nightmares, or other lasting emotional reactions.

Research by Patton, 1991, indicates it is the defense mechanism of the therapist who is attempting to calm his or her own anxiety about dealing with sexual matters that perpetuate the existence of these obstacles to professional growth and development. While professionals have made significant gains in recognizing that many children are sexually abused and new research findings continuously challenge long-held beliefs, there is still work to be done (Patton, 1991).

Mental health professionals may always battle with the psychological defenses inherent in human beings against the belief that children are abused sexually (Everstine & Everstine, 1989). However, clinicians are beginning to accept the grim reality of the sexual abuse of children and an ever-increasing number of professionals are willing to work in the field of child sexual abuse. The last three years have witnessed the births of three new journals devoted to the subject of interpersonal violence that include research on childhood sexual abuse. Now, in the 1990's, social science journals almost always include articles on the topic of childhood sexual abuse. A multidisciplinary professional society, The American Professional Society on the Abuse of Children has as part of its focus childhood sexual abuse. Most professional meetings as well as regional and state conferences devote attention to the subject (Conte, 1990). Much is now written on what should be included in the attention of professionals in this field.

Statement of the Problem

The last twenty years have been crucial in the development of child sexual abuse treatment as an important area of psychological treatment. The treatment

issues of child sexual abuse have become critical concerns of therapists treating children in hospitals, clinics and private practice. This study is concerned with identifying the most frequently observed effects of child sexual abuse and the implications for treatment.

Purpose of the Study

Ten years ago, it would have been possible to describe "the state of the art" in child sexual abuse intervention in a few paragraphs or less (Sgroi, 1989). In the last two decades the problem of child sexual abuse has become a leading concern of mental health professionals and a new topic of mental health research (Cole & Putnam, 1992). Researchers and practitioners in the field of child sexual abuse have identified numerous impact issues that require inclusion in treatment plans. The purpose of this study will be to describe what mental health practitioners today are including in treatment plans for the clients they work with. The study will focus on what therapists believe about the effects of sexual abuse and the necessary components and modalites of treatment for clients who are victims of childhood sexual abuse.

Child sexual abuse has traditionally been defined as the exploitation of a child for the sexual gratification of an adult, while incest is more narrowly defined as the sexual exploitation of a child by a family member (Schyetky and Green, 1988). Lew (1988) combines the terms and expands the traditional definition of incest as sexual activity between blood relatives to include sexual activity between a child and any individual in a position of authority, trust, power, and protection who uses this

position to victimize a child. This paper will use the terms child sexual abuse to refer to any act of exploitation of a child for the sexual gratification of an adult or older child. Adult is broadly defined as an individual in a position of authority, trust, power, and protection who uses this position to victimize a child. Gil (1993) includes children as perpetrators when differences in age, size and status contain the dynamics of threat, force or coercion. Sexual abuse occurs from a powerful individual to a less powerful one. This concept is also contained in the definition of adult used here.

Clinicians and researchers in the field of child sexual abuse have treated and reported on the treatment of many victims over the past twenty-one years since the phenomenon was officially labeled. A review of the literature indicates that many professionals have observed similar impact issues of the experience of sexual abuse for victims. Researchers have further identified treatment goals to address the impact of the abuse, and to promote healing.

The purpose of this study is to question a group of mental health professionals treating victims of child sexual abuse to determine whether they agree with the researchers and each other about the impact of the experience of sexual abuse on the children they treat, and if there is agreement concerning goals for treatment. It is the hypothesis of this researcher that agreement with the experts in the field exists.

CHAPTER 2

REVIEW OF THE LITERATURE

That children are abused sexually is a disturbing concept which has only been acknowledged as an important social problem by both professionals and society at large in the last few decades (Sgroi, 1982). Child sexual abuse has emerged as a major social problem in the consciousness of the public only since the late 1970's (Finkelhor, 1984). Sexual abuse of children is now recognized as a serious mental health problem, both because it is so widespread and because of increasing evidence of the long term traumatic effects (Herman, Russell & Trocki, 1986). Social workers who went through family therapy training 15 years ago were never exposed to the topic of sexual abuse in classes, supervision, professional conferences or literature, yet it is not uncommon for therapist to report that in the last decade their private practices have gone from including a solitary sexual abuse survivor to now having two-thirds of their cases involve clients reporting childhood sexual abuse (Markowitz 1992).

Previously, little attention was paid to the problem although prohibitions have existed against the sexual abuse of children especially in the form of incest since ancient times (Haugaard & Reppuccio, 1988). Until the dramatic emergence of child sexual abuse as a social issue in the 1970's this problem was considered relatively uncommon by professionals. The issue was addressed by moralists from time to time, who felt that children were being sexually abused as a result of the liberalization of sexual values. However, since they used the issue of child sexual molestation to

campaign against other social reforms such as the introduction of sex education, the end of censorship, and the humane treatment of offenders, their concern about child sexual abuse was in general minimized by professionals (Finkelhor, 1984). Another reason for the lack of attention to the problem of child sexual abuse may be attributed to the concept of "patria potesta". Patria potesta under ancient Roman law gave a father complete power over his children including the right to commit infanticide and to sell his children into slavery (Haugaard & Reppuccio, 1988). Freud's labeling incest reports from adult patients as fantasy, further led to the misconception that child sexual abuse was a rare phenomena (Everstine & Everstine 1989). Finkelhor (1984), identifies the gender politics of sexual abuse as an issue that often hampered effective public action. Sexual abuse is a problem which incriminates a particular sex - men. This is an uncomfortable fact for many men to deal with. When those men occupy powerful policy-making positions, it makes it easier to look the other way (Finkelhor, 1984).

Child Sexual Abuse in History

Child sexual abuse has long been a sordid part of history, tolerated along with other abusive practices by many cultures. Schyetky and Green (1988), summarize the incidence of incest in mythology and the Bible. In Greek mythology, Zeus was conceived out of the incestuous union of Cromum and his sister Rhea. Zeus, himself was insatiable in his sexual appetites and married his own sister Hera. Zeus's progeny was enormous and included in the many attachments he made were numerous married women, his granddaughter Thalia, his aunt Leto, his sister

Demeter, and many unknown young girls. Persephone was conceived as a result of Zeus's relationship with Eruopa, daughter of the King of Sidon, and he went on to rape her as well.

Incestuous themes are also found in Norse mythology. Volsung, father of Signy and Sigmund is killed by his son-in-law, who also imprisons Sigmund. Signy disguises herself, goes to Sigmund in prison and becomes impregnated by him. The son she gives birth to avenges his grandfather by killing Signy's husband and subsequently releases Sigmund.

In Indian mythology Brahma, considered to be the first of the gods, faced a similar problem to the one which perplexed Adam in the Bible. Brahma created, out of his own flesh, a female partner, with whom he fell in love. Brahma and his wife/daughter went on to create the human race (Schetky & Green 1988). A popular Indian god Ganesha had the head of an elephant. One explanation for the elephant head was that Ganesha was found in bed with his mother by his father when he returned home after a long trip. the angry father did not recognize his son and cut off his head. After learning the truth, the father was filled with remorse, and declared he would replace his son's head with the first one he saw, which happened to be that of an elephant.

Among Egyptian deities, brother-sister incest was quite common. Not, the goddess of the sky married her twin brother, Geb and the result of their union was five children. These children also intermarried, with Osiris taking his sister Isis as his bride and Nephytys marrying her brother Set. The Pharaohs followed the example

of the gods with the most notorious of incestuous unions being the marriage of Cleopatra and her brother.

Suggestions of an incest taboo existed as early as ancient Greece, and many mythological tales ended in violence, a condition that Schetky and Green (1988) compare to the common sequela of incest today. In Sophocles' play Oedipus unknowingly killed his father and married his mother with whom he had several children. On learning the truth, Oedipus was so horrified that he blinded himself. Jocasta, his mother/wife hangs herself, their two sons killed each other, and their daughters were buried alive.

In the Bible, the children of Adam and Eve had no alternative to incest if they were to perpetuate the species, and Noah's family faced a similarly perplexing dilemma as sole survivors of a world wide flood. Lot's wife became unavailable to him when she was turned to a pillar of salt, and although his daughter's motives were to perpetuate his line, their joining with him was incestuous. Lot's faculties were impaired by alcohol a condition that in biblical and mythological incest was to render the male amnestic, and to present him as blameless.

The sexual abuse of children as we conceptualize it today is not mentioned in the Bible, although prohibitions against incest are found in the Book of Leviticus:

> *The man who lies with his father's wife has uncovered his father's nakedness; both of them shall be put to death, their blood is upon them (Leviticus, 20:11). If a man lies with his daughter-in-law both of them*

shall be put the death; they have committed incest, their blood is upon them (Leviticus, 20:12).

Incidents of incest in the Bible often seems to have involved primarily siblings and as such involved less abuse of power than father-daughter incest. Often the female was an active participant who emerged from the experience with increased power or prestige, perhaps as a result of the birth of a child.

In history as well as in the Bible, children were considered along with women as the property of men. As such they were regarded as expendable and treated with little empathy. It was not until the sixteen century that childhood emerged as a distinct phase of development (Postman, 1982). The invention of the printing press heralded the spread of information and literacy. The teachings of the Jesuits about the innocence of children helped to promote the idea that children should be protected from the secrets of the world (Postman, 1982).

The Emergence of the Issue of Child Sexual Abuse

The emergence of child sexual abuse as a social issue in the public spotlight is in large part due to the promotion of the issue of sexual abuse by a coalition of groups. Finkelhor (1984) identifies these groups as the women's movement and the children's protection movement. These groups were actively promoting other social policy concerns and already had the attention of the public and the policy makers when they attacked the issue of child sexual abuse. The merger of these two groups focused public attention on the issue of child sexual abuse as never before.

Although the child protection movement and the women's movement have placed the problem of sexual abuse into a different theoretical perspective and have suggested different remedies for it, their interest in championing the issue may account for people's new willingness to report what was previously an unmentionable experience (Finkelhor 1984). The child protection movement placed sexual abuse in the context of other forms of child abuse and neglect, while the women's movement identified sexual abuse with the issue of rape (Brownmiller, 1975).

Definition of Sexual Abuse

Haugaard and Reppucci (1988), examined the various definitions used by researchers, the legal system, and professional care givers in the general area of child maltreatment and the specific area of child sexual abuse. Hauggard and Reppucci (1988) concluded that there exists a "Myth of shared meaning", p. 29. After reviewing the variety of terms used by professionals, Hauggard and Reppucci urged that a clear definition of terms is critical since a consensual definition did not exist. Lacking a consensual definition and shared understanding of how child sexual abuse is defined, professionals should at least have a clear understanding of their differences and definitions in order to facilitate and coordinate their efforts (Hauggard & Reppucci 1988). For clinical purposes, child sexual abuse can be defined as any sexual activity, overt or covert, between a child and an adult, or older child, where the younger child's participation is obtained through seduction or coercion (Ratican, 1992).

Sgroi, Blick and Porter (1989) expand the definition of child sexual abuse as a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance.

Schetky and Green (1988), define child sexual abuse as the exploitation of a child for the sexual gratification of an adult. Incest is a narrower form of child sexual abuse referring to sexual exploitation of a child by a family member. Lew (1988), clarifies the terms sexual abuse and incest. He expands the traditional definition of incest which is sexual activity between blood relatives to include any individual in a position of authority, trust, power, and protection who uses this position to victimize a child. This definition seems to be shared by many therapists who work with issues of sexual abuse and defines incest as a violation of a position of trust and differs from other forms of sexual abuse in that the perpetrator is assumed to stand in a protective parental role to the victim (Lew, 1988). A parental relationship assumes that the child involved should be able to turn to the adult for care, comfort and understanding. An incestuous relationship is a violation of that trust by an adult who is guilty of sexualizing the relationship. It is not less of a traumatic experience if the adult is not a family member. Children trust adults until their experience teaches them not to. This defines sexual exploitation by an older caretaker as incest because

it destroys the natural trust of a child. The perpetrator according to Lew, (1988) can be a relative by blood or marriage, a parent, step-parent, older sibling, neighbor, family friend, teacher, member of the clergy, therapist, physician, baby-sitter or camp counselor who violates the trust inherent in the relationship. Incestuous offenses, according to Groth, (1989) are not confined to sexual activity between a biological father and daughter, but encompass any sexual relationship in which the adult occupies a parental authority role in relation to the child.

This is not to minimize the trauma caused by a sexual attack by a stranger, but the element of trust is not as dramatically violated. Sexual abuse by an adult known to the child violates the concept that home is a safe place. Children are taught from earliest childhood that family and friends are to be trusted. They are also warned about the dangers of trusting strangers. The message for children is clear and reinforced that home and family are equated with safety, but strangers and straying from the family mean danger (Lew, 1988).

When a child is sexually attacked by a stranger, it is consistent with what the child has been prepared to expect. The child who has been sexually attacked by a stranger will turn to the safety of his or her family for support, understanding and nurturing. This enables the child to feel the protection necessary to begin healing in safety. The family offers comfort, encouragement and protection until the child can again be safely guided back into the world (Lew, 1988). When the perpetrator of sexual abuse has been a caretaker, who then can the child turn to for safety? Who will comfort, understand, and protect?

Incest frequently takes place in a familial climate of pervasive terror, in which ordinary caretaking relationships have been profoundly disrupted (Herman, 1992). Where incest occurs in a relationship of caretaking, it creates confusion and conflicts about appropriate sexual development, family roles and issues of trust (Maltz & Holman, 1987). Incest takes place in an atmosphere of altered, often profoundly disrupted relationships, the child faces a formidable developmental task (Herman, 1992).

The sexually abused child is faced with formidable tasks of adaptation. S/he must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is unpredictable, and power in a situation of helplessness. Without the ability to care for or protect herself, she must compensate for the failure of the adult caretakers in her life with the only means at her disposal, an immature system of psychological defenses (Herman, 1992).

The closer the emotional tie between the victim and the perpetrator, the more certain is the loss of trust (Lew, 1988). The victim of incestuous abuse not only has to deal with the results of the physical act, but also with the devastation of his or her ability to trust. If she cannot trust those relationships closest to her, how can it be safe to trust anyone? The destruction of the ability to trust is a key issue for incest victims, and the rebuilding of this ability becomes an important developmental task for survivors (Lew, 1988; Maltz & Holman, 1987).

Extent of the Problem

As recently as ten years ago, child sexual abuse was regarded as a rather uncommon problem. The first well-known reports came from Kinsey and others' 1959 study of female sexual behavior (Hauggard & Reppucci, 1988). Since the 1960's there has been a surge of interest in child sexual abuse. This caused reports to begin to mushroom at a rapid rate. Between 1983 and 1984 reports of child sexual abuse rose by 59% (Everstine & Everstine, 1989). In the general population it is believed that between 15% and 45% of women and between 3% and 9% of men have been sexually abused as children (Finkelhor, 1980).

A landmark study by Mills College professor Diana Russell (1977) reported that 38% of the 930 women in San Francisco who were interviewed reported having been sexually abused. Psychiatrist Judith Herman (1981), in an attempt to determine the reliability of subject's memories of childhood sexual abuse, found that 74% of those memories could be independently confirmed and another nine percent could be indirectly supported. In looking at the increases in reported cases of child abuse over the last 5 to 8 years, one might conclude that there is a current epidemic of child molestation that is getting worse and worse (MacFarlane & Waterman et al, 1986).

Believing that one in three girls and one in seven boys are sexually molested as children means accepting that more children are sexually abused than wear braces, take piano lessons, go to summer camp, or play in Little League (Markowitz, 1992). MacFarlane and Waterman relate this increase in reporting to greater public

awareness and acceptance of the existence of child sexual abuse, and note that when a community opens a child abuse hotline, begins advertising treatment services, or gives media exposure to the issue, reports increase dramatically (MacFarlane & Waterman et al, 1986).

Many therapists accept the fact that sexual abuse is a more common problem than previously imagined, and routinely ask all their clients, male and female, if they are aware of any past or present sexual abuse in the family. These questions about sexual abuse are being asked in the context of taking a family history to normalize the process and to reduce anxiety and embarrassment (Markowitz, 1992).

Perpetrators

After reviewing the literature on the subject of child sexual abuse, Finkelhor (1984) concludes that men constitute about 95% of the perpetrators in cases of abuse of girls, and 80% in the cases of abuse of boys. Finkelhor separates the problem of sexual abuse from physical abuse when he states that virtually all data collected show that sexual abuse is committed primarily by men. In nonclinical surveys of adults reporting retrospectively on childhood sexual experiences, the male perpetrators vastly outnumbered the women (Finkelhor, 1984).

Finkelhor defines sexual abuse as a problem of male socialization, and outlines four differences between men and women which may explain why women are less likely to abuse children sexually. These women learn earlier and much more completely to distinguish between sexual and nonsexual forms of affection; men grow up seeing heterosexual success as much more important to their gender identities

than women do; men are socialized to be able to focus their sexual interest around sexual acts isolated from the context of a relationship, and, finally, men are socialized to see as their appropriate sexual partners persons who are younger and smaller than themselves, while women are socialized to see as their appropriate sexual partners persons older and larger.

The Revised Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (American Psychiatric Association, 1987) describes a diagnostic class of sexual disorders that include paraphilias or sexual deviations. These disorders are characterized by repetitive sexual acts that involve nonconsenting partners or preference for use of a nonhuman object for sexual arousal. There is no effective typology in the description of child abuse offenders (Schetky & Green 1988). Individuals who commit child sexual abuse cannot be distinguished from those who do not - at least in regard to any major demographic characteristics (Groth, 1989). Offenders do not differ significantly from the rest of the population in regard to level of education, occupation, race, religion, intelligence or mental status. Offenders can be found within all socioeconomic classes. Offenders obviously differ from non-offenders in that, when faced with stressors they cannot cope with, seek relief by engaging in sexual activity with children (Groth, 1989).

Psychoanalytic theory views paraphilia, or perversion, as an expression of unresolved problems in childhood development (Becker & Kaplan 1988). Freud first theorized that the choice of an immature sexual object is a result of a fixation at an infantile level or an unresolved oedipus complex. He later hypothesized that

perversion may be a regression to perverse sexuality, an early state of sensual gratification. Social learning theory emphasizes the importance of conditioning experiences rather than intrapsychic processes (Becker & Kaplan, 1988). These researchers attribute much of human sexual behavior to learning and experience.

Groth (1989) divides sexual offenders of children into two basic types, fixated or regressed, with regard to their primary sexual orientation and level of sociosexual development. He labels fixated those males who at the onset of their sexual maturation develop a primary or exclusive attraction to children. Although these men may engage in sexual activities with peers and may marry, children remain the preferred object of their sexual interests. When these men engage in sexual relationships with agemates, it may be the result of social pressure, or it may be a means of access to children (Groth, 1989). Other offenders are labeled regressed by Groth (1989). These men exhibit a conventional sociosexual development entering into adult relationships until these relationships become conflictual, at which time they turn to an interest in a child. Fixated child molesters are drawn to children sexually in that they identify with the child and appear to want to remain children themselves, while regressed offenders are drawn to children sexually in an attempt to replace their adult relationships which have become conflictual (Groth, 1989). Psychologically the fixated offender becomes like the child; they tend to adapt their behavior and interests to the level of the child, whereas the regressed offender experiences the child as a pseudoadult. They tend to relate to the child as if the child were their peer or agemate.

The difference in differentiating whether an incest offender is a fixated or regressed offender has important implications with regard to the meaning of the offense, the risk the offender represents to the community, the treatment of choice, and the prognosis for recovery or rehabilitation (Groth, 1989). In cases of incest involving a fixated offender, the dynamics of the individual offender are of paramount importance and the family dynamics, relatively speaking, are nonessential or extraneous. The fixated offender's attraction to children is a product of his development and a characteristic of his psychological makeup (Groth, 1989). Family dynamics play a far more integral role in cases of incest involving regressed offenders. The interrelationships among the family members of the nuclear family, the structure of the family network, the dynamics of the participants, the environmental context and the situational events affecting the family all have more relevance according to Groth (1989). Groth (1989) estimates that ninety percent of incest offenders are regressed offenders whose sexual involvement with their own children has occurred in the context of a deteriorating marital relationship. According to Groth, most incest appears to be the result of family dysfunction, and is rarely found in stable, harmonious, well-functioning families.

There are no definitive personality characteristics of sexual abuse offenders; however, there are some traits that offenders appear to share. One of the basic components in the psychology of the incest offender is his deep-seated, core feeling of helplessness, vulnerability, and dependency. Offenders more often describe themselves as helpless victims of external forces and events rather than as persons

in control. Perpetrators often report feeling isolated and separate and lacking a sense of intimate attachment, belonging, or relatedness to others. Often there is an intellectual defect which limits the individual's ability to cope with life demands in a mature and adaptive way. Psychologically, offenders are often immature persons in regard to human relationships. They lack the ability to appreciate the needs and feeling of others, and fail to understand the impact of their actions on others. Offenders are often self-centered and hypersensitive persons who are overly responsive to criticism and quick to project blame for their own difficulties on others. Offenders, according to Groth (1989), often misunderstand and misinterpret the actions of others which leads to troubled interpersonal relationships.

What creates a sexual predisposition toward children on the part of an adult is not completely understood. It is not known what exact biological, sociological, or psychological components, what developmental events, at what points, and in what combinations and intensities are critical in the formation of such a sexual orientation (Groth, 1989). One developmental crisis that may have long range effects is sexual victimization. More so than non-offenders, sexual offenders appear to have a higher incidence of having been sexually victimized when they were children. A conservative estimate according to Groth (1989) is one out of every three perpetrators was a victim of child molestation.

Adult-child sexual behavior serves partially to gratify some need of the offenders. Whether to defend against anxiety or to express an unresolved conflict, the incestuous offender becomes dependent on sexual activity to meet some

emotional need. Although it is a sexual offense, incest and other forms of sexual abuse are not motivated primarily by sexual desire. It is the use of a sexual relationship to express a variety of unsolved problems or unmet needs in the psychology of the offender that have less to do with sensual pleasure and more to do with issues surrounding competency, adequacy, worth, recognition, validation, status, affiliation, and identity. It is the sexual misuse of power (Groth, 1989).

The Four Preconditions Model of Sexual Abuse

Finkelhor (1984) identified four preconditions that exist in the abused child's environment. Finkelhor advises adding the exploration of sociological factors to the theories of sexual abuse.

Finkelhor sees sexual abuse as a widespread social problem that has sociological dimensions that need to be included in the theories that are studied. He proposes a model that incorporates both psychological and sociological explanations of childhood sexual abuse. Finkelhor (1984) calls it the Four Preconditions Model of Sexual Abuse. Finkelhor reviewed many factors that have been proposed as contributing to sexual abuse, especially those relating to victims and families as well as those relating to offenders. Finkelhor (1984) suggests that all factors relating to sexual abuse could be grouped as contributing to one of four preconditions that led to sexual abuse. The conditions that Finkelhor identified are:

1. A potential offender needs to have some motivation to abuse a child sexually.

2. The potential offender has to overcome internal inhibitions against acting on that motivation.
3. The potential offender had to overcome external impediments to committing sexual abuse.
4. The potential offender or some other factor had to undermine or overcome a child's possible resistance to the sexual abuse.

Finkelhor (1984) suggests three factors that may explain why an adult or adolescent becomes motivated for or interested in having sexual contact with a child. These are first, emotional congruence, relating sexually to the child satisfies some important emotional need of the individual; second, sexual arousal, the child becomes a source of sexual gratification for that person; and third, blockage, alternative sources of sexual gratification are not available or are less satisfying to the individual.

Finkelhor states that not all of the components are required for sexual abuse to occur, but in many cases elements are present from each of the three in identifying motivation for sexual abuse. Finkelhor presumes that most members of society have inhibitions against acting on a motivation to sexually abuse. He sees disinhibition which he defines as overcoming internal inhibitors as a requirement for sexual abuse. He states that no matter what motivation exists to sexually abuse a child, if a potential offender is inhibited by social taboos from acting, then abuse will not occur. Finkelhor separates individual factors for disinhibition from social and cultural. He lists individual factors such as use of alcohol or drugs, psychosis,

impulse disorder, senility and the failure of incest inhabitation mechanism in the family dynamics of the individual. External factors identified by Finkelhor are the social toleration of sexual interest in children, weak criminal sanctions against offenders, the ideology of patriarchal prerogatives for fathers, social toleration for deviance committed while intoxicated, child pornography, and finally the inability of males to identify empathetically with the needs of children.

The third precondition identified by Finkelhor concerns inhibitors in the environment external to the offender or the child. Listed as the most crucial external factor is the supervision a child receives from others in her environment. As Finkelhor points out, although mothers have been indicted as perpetrators, research findings related to the importance of mothers in protecting children appears regularly. Research findings show growing evidence that when mothers are physically or psychologically absent, children are more vulnerable to abuse. The protection mothers provide to their children includes supervision but is not limited to physical presence; it also encompasses knowing on what is going on for a child, knowing when a child is troubled, and being someone the child can readily turn to for help. Judith Herman (1981) reported that the difference between families in which father and daughter have what can be described as a seductive relationship and families where that relationship becomes actual incest is that in the incestuous families the mother is either physically or psychologically incapacitated. The mothers in the families where a seductive relationship existed were able, it seems, to act as a deterrent to sexual abuse. Other individuals such as neighbors, siblings, relatives,

friends and teachers who interact closely with a child and are familiar with her environment also inhibit abuse.

Another form that external inhibition may take is the absence of opportunity. For instance, when a potential abuser and a child are left alone in the absence of any other supervision, it may help to overcome the external inhibitions that often exist against sexual abuse.

Overcoming the resistance of the child is the fourth precondition for sexual abuse. The notion of a capacity to resist or avoid being abused involves many subtle aspects related to children's behavior and personality. Abusers undoubtedly sense that some children will not make good targets. Finkelhor (1984) identifies both individual and cultural factors which exist that can lead to overcoming a child's resistance to being sexually abused. Many things may overcome the ability of children to avoid or resist becoming victims of abuse. According to Finkelhor (1984) usually one or more of these things are present in every abuse situation. A major risk factor is anything that makes a child feel emotionally insecure, needy, or unsupported. A needy child will be more vulnerable to the offers of attention, affection, or bribes. A child who feels unsupported will be afraid to tell. Emotionally abused, disabled, or disadvantaged children, as well as those who have a poor relationship to their parents are at risk. Also, socially isolated children who have few friends, or children who receive no physical affection from a father and children whose mothers are distant or punitive are at risk of being unable to avoid sexual abuse.

If a child's relationship with an abuser is based on trust, the abuser may use that trust to coerce or threaten the child into complying. Finally the child's capacity to avoid or resist abuse may be irrelevant if the abuser uses force to involve the child in sexual activity.

The Four Conditions Model - Family Systems Model

Finkelhor does not offer his model in place of other model; rather he sees other models such as the Family Systems Model encompassed by the dynamics of the Four Conditions model. Finkelhor reformulates the family systems model and offers the following example of how family dynamics can be encompassed within the Four Preconditions model in the following way:

Precondition I: A man becomes sexually interested in his daughter after the deterioration of his relationship with his wife (blockage). He may perceive that the daughter has favorable qualities similar to those of his wife, she may give him uncritical admiration and he may be able to easily manipulate her to fulfill his sexual and emotional needs (emotional congruence). Perhaps the man was himself sexually abused; he at least has had sexual fantasies about his daughter and may have masturbated to these fantasies (sexual arousal).

Precondition II: The man's internal inhibitions against perpetrating sexual abuse are overridden by substance abuse or a personal crisis in his career. The man rationalizes that he loves his daughter, that no great harm will be done, or that incest is preferable to an affair.

Precondition III: The mother is unavailable to provide external inhibitions for some reason. Perhaps the man has instigated rivalry between mother and child or mother is alienated. Usually the daughter does not feel close enough to confide in her mother.

Precondition IV: The daughter's resistance to her father's advances is undermined because of her basic trust in her father or because of her need for his attention and affection. The daughter may desire what she perceives as her favored status or position as the family anchor holding it all together.

Finkelhor believes that the Four Preconditions model places responsibility where it belongs, with the perpetrator. He explains that the family system's theory states that the mother is unsupportive and unprotective of her daughter. Finkelhor sees this as blaming the mother. His model views the problem of a mother's failure to protect or a child's failure to resist as contributing factors only. The burden of responsibility is placed with the offender who has already made conscious moves toward offending and already participating in antisocial behavior.

The Four Conditions model combines psychological and sociological explanations. Another advantage of the Four Conditions model according to Finkelhor (1984) is its ability to integrate both psychological and sociological factors. This allows for the flexibility required of a model that is able to integrate new developments in knowledge about sexual abuse. Past theories linked sexual abuse with abnormal psychology. But recent developments point to a more widespread problem, one that needs to be accounted for in sociological terms as well.

Finkelhor incorporates social factors as well as psychological factors in his Four Preconditions model and offers the following illustrations.

Precondition I: Certain social factors may motivate adult men to desire sexual interaction with children. Finkelhor includes the following characteristics: an erotic premium on youth, smallness and submissiveness in sexual partners along with a tendency of some males to eroticize all their affectionate relationships. The characteristics make the idea of sexual relations with children more emotionally congruent for potential offenders. Other factors that may contribute may be child pornography, and repressive social norms about masturbation and alternative sexual outlets.

Precondition II: Social factors which influence men to overcome their internal inhibitors are according to Finkelhor (1984): The social toleration of sexual interest in children, weak criminal sanctions levied against offenders, and the ideology of patriarchal prerogative for fathers which assumes he can demand what he wants from children, including having his sexual needs met. Another social factor with far reaching implications is an acceptance of deviant acts committed under the influence of drugs or alcohol. Again Finkelhor lists child pornography and males' inability to identify with the needs of children.

Precondition III: Finkelhor identifies several social factors which may account for the failure of external inhibitors to protect children from sexual abuse: Finkelhor concludes that a lack of available social supports for mothers results in their being overly dependent on husbands. Dependent, isolated women are often ineffective

protectors of children. A second social factor cited by Finkelhor is the disappearance of stable communities and neighborhoods which results in children having fewer familiar adults acting as care givers who supervise and monitor their activities, thus serving as additional protectors. Finally Finkelhor contends that in our society there exists an ideology of family sanctity which deters outsiders from interfering in family affairs. This ideology tends to protect abusing parents rather than abused children.

Precondition IV: The inability of children to resist or avoid the entrapment of sexual abusers may be undetermined by social factors as well. Pervasive societal anxiety about sex often prevents important information about sexual behavior from being given to children to could then be enlightened and alerted to what constitutes an abusive situation. Parents often fear that knowledge about sexual behavior will harm their children so important information is kept hidden.

Use of Finkelhor's Model in Treatment

The four conditions model demonstrates clearly that sexual abuse is a complex problem, and as such implies that working with abusive families and individuals require complex solutions. The model provides a framework for evaluation and intervention operating at four separate sites to end and prevent the re-occurrence of abuse. Finkelhor (1984) suggests that therapists can evaluate the implications presented by each of the four mechanisms in each abusive situation in order to develop strategies that can be implemented in reinforcing areas that are weak. Use of the model as a framework for assessment will enable clinicians to plan the most effective strategy in working with a family. Finkelhor (1984) maintains that the model

directs therapists to attend to a variety of vulnerable points, empowering them to design comprehensive strategies to address them all.

Finkelhor (1984) offers his four preconditions model as a way to organize current knowledge about sexual abuse which can make it more easily accessible to those involved in the work of sexual abuse treatment and prevention. Finkelhor (1984) acknowledges that the model presents the complexities of sexual abuse, an awareness of which should keep us from being seduced by simple explanations. On the other hand, Finkelhor argues that the model should prevent us from getting discouraged by that complexity. He contends that his model presents sexual abuse as a problem with causes and explanations, many of which are not yet fully understood. The model is, however, open-ended so new ideas and findings can be incorporated into the existing structure.

Male Victims

Feminists involved in the areas of rape crisis and child abuse and neglect broke the silence about sexual abuse (Hunter, 1990). This led the way to the formation of treatment and prevention programs for both victims and sexual offenders. These programs provided an environment in which relevant questions were asked about experiences of personal sexual victimization. Victims and offenders provided the evidence that boys were sexually abused, and to the recognition that young males were a sizable victim group (Porter, 1986). In a landmark article, Finkelhor (1980) estimated that approximately 9% of the male population of the country had been molested in childhood. Previous estimates varied

between 2.5% and 8.7%. In August, 1985 the San Francisco Chronicle published the results of a poll which estimated that the ratio of girls who were molested exceeded that of boys two to one. For many years it was believed that the prevalence of girls who were abused was closer to between 10 to 12 girls to one boy. If the higher estimate is accurate, males form a sizable part of the problem.

Though the core issues of sexual abuse effect both male and female victims similarly, differences in psychological impact and behavioral manifestations do exist. Porter (1986), identifies two issues which surface among male victims that differ markedly from those of female victims. Two issues which appear to effect males are a confusion of sexual identity, and feelings of powerlessness. Males who have suffered early traumatic sexualization often later demonstrate aggressive sexual behaviors.

The sexual abuse of boys by women certainly exists, however the majority of studies indicate that boys are most often sexually abused outside the home by men (Porter, 1986). Research reveals that molestation of boys is nearly always committed by a man. Reinhart (1987), reported that 96% of the perpetrators in his sample of 189 cases were male (p. 231). When the abuser is male, homophobic confusion and fear surround the victim. Given the general homophobic attitude of society and the lack of accurate information about the homosexual experience, this confusion about sexual identity is not surprising. Males who have reported being sexually abused report having to deal with the fear of homosexuality because another male had a sexual experience with them (Porter, 1986). These fears may result in distancing and

alienating the male victim from other males who might be supportive. The result is painful and destructive isolation.

When a male victim is sexually abused by a female, sexual confusion may also exist. If the male victim experienced fear of, or a lack of response to the sexual experience, it may also suggest to the victim that his sexuality is in question. A further damaging effect of female abuse on the male victim stems from society's perception of male sexuality. Female abuse of male victims is often minimized, and while not condoned, it may be seen as a beneficial experience for the male who is introduced to his manhood early.

In the past, the experience of young male victims has been neglected and young male victims have been encouraged to minimize their experience because of the differential sex-role expectations of males and females in our society.

Society has tended to view sexual victims as female and sexual aggressors as males. Furthermore, society expects and rewards self-reliant, stoical, and aggressive behavior from males. Males who have been abused are likely to experience the abuse as evidence of failure of their masculinity, because they were unable to protect themselves. A misconception of operating in the past was that sexual abuse was less harmful to boys. This may have been based on the equally erroneous misconception that boys are tougher and less easily damaged than girls. Clinical evidence shows that sexual abuse is equally as damaging to males as it is to females (Porter, 1986).

Whether the sexual abuse of the male victim was perpetrated by a male or a female, significant effects are the result. If the abuser was a male the victim suffers from fears of homosexuality; if the abuser was a female the male victim's experience may be minimized, or if he felt fear or displeasure, again the male victim may face homophobic fears. This points to the need to validate the male victim's experience and to educate to societal homophobia. This educational component seems crucial to male victims' treatment and recovery.

Male victims who are sexually abused, like female victims, feel a loss of control or power. Male victims are more likely than females to turn their fear and rage at that loss of power outward into aggressive and antisocial behavior. Males seem to act out the same offenses perpetrated against them personally (Porter, 1986). Knopp (1982), in a description of sex-offender treatment programs for adolescents, reports that up to 100% of some groups have revealed that they experienced some type of early sexual victimization.

Male survivors as well as female survivors share a common tendency to use alcohol or other drugs to suppress feelings. Residential treatment programs for substance abuse are finding that as many as 90% of the women and 60% of the men in treatment were sexually abused as children (Swink & Leveille, 1986). Other types of self-destructive behaviors demonstrated by male victims range from self-mutilation to suicide; compulsive sexual activity coupled with intense feelings of self-loathing and shame; eating disorders; and difficulties maintaining intimate relationships (Porter, 1986).

While the potential for young male victims to later act out sexually aggressive behavior exists, it is not inevitable. Young male victims are not destined to become sex offenders. Early therapeutic intervention with male sexual victims will lessen the possibility of their reacting aggressively as it provides alternative ways of responding to sexual abuse (Porter, 1986).

Long Term Effects of Childhood Sexual Abuse

Sexual abuse is a destructive and infectious crime for which society pays emotionally, financially and spiritually. It affects more of the population than cancer, heart disease, or AIDS (Vanderbilt, 1992). Victims of childhood sexual abuse have lost many important elements of their childhoods. They may have lost their parents or their families. They have lost their innocence, their memories, their ability to trust, and at least the opportunity to grow up and develop in the ways and in the time given to children who were not abused (Vanderbilt, 1992). According to Lew (1988), incest survivors have lived lives governed by secrecy and the lies they've been told by their abuser. Their experience and memories have been denied. They have been told that what happened did not happen. Their reality has been denied. They were told that the terrible things were good things and that they were to blame for their abuse.

In the last two decades the problem of child sexual abuse has become a leading concern of mental health professionals and a new topic of mental health research (Cole & Putnam, 1992). The late 1970's through the early 1990's has seen considerable work and effort in the development of child sexual abuse as a

multidisciplinary subspecialty (Conti, 1990). The first phase of professional development in responding to child sexual abuse was characterized by efforts to recognize that the problem was in fact a problem at all.

Acknowledging that the phenomenon of child sexual abuse exists has been an ongoing struggle for many years. A struggle that requires adults to face issues that are difficult and unpleasant. These issues include sexuality, deviant behavior, the abuse and terror of children, and the violation of social norms. It necessitates the recognition that members of our families, communities, and social institutions, such as schools and churches, use children sexually (Conte 1990). Human beings have psychological defenses that operate within to protect them from acknowledging what is painful or anxiety-provoking. At an extreme level these defenses are seen in the minimization, rationalization, distortion, and denial of the perpetrator. Those who love and care for the victims of sexual abuse are also subject to their own defense mechanisms as they struggle to understand what young victims are trying to tell them. Victims of sexual abuse employ their own defense mechanisms which sometimes hides the actual abuse from them for many years. When children have been sexually abused within the family (intrafamily), often parents react with denial and hostility and by rejecting the child (Sgroi, 1989). Parents of children who have been sexually abused by someone outside the family may also deny the significance of the abuse in an effort to deal with their own pain, embarrassment, and guilt. These parents wish to forget, because they also feel traumatized and guilty to some degree for their children's problem (Sgroi, 1989). Conte (1990) describes how

defenses prohibit victims and their families from seeking treatment which could help them to understand that sexual abuse is real and that victims' reactions are a natural response to the abuse. Conte (1990) asserts that intervention by professionals is going to be an important component in the professional development of sexual abuse treatment well into the next century.

Conte (1990) continues his development of the effects of defense mechanisms and how these affect the professional development of the field. Professionals often held beliefs that tended to minimize their anxieties and discomforts about sexual abuse rather than dealing with actual reflections of the problem. Conte (1990) cites several examples of erroneous ideas held by professionals about the issue of sexual abuse. The first common erroneous idea was the belief that a child who had experienced sexual abuse would present with recognized core symptoms, such as behavioral regression, somatic complaints, and fearfulness. These behaviors are currently recognized as indicators of childhood stress and may be caused by other traumatic events such as parental death, divorce, or school difficulties. It was common until just a few years ago to read in professional reports and in the literature that a child was or was not abused because she or he did or did not present with the "core symptoms". Conte sites the result of a study he conducted in Seattle (Conte & Schuerman, 1987) where 21% of the children were without any of the symptoms. Conte (1990) concludes that there is a real need for further study of developmental stages, ethnic and class groups, and normal sexual development in children.

A second erroneous idea affecting the professional development of sexual abuse treatment surrounds beliefs about sexual offenders. Conte (1990) lists two assumptions that he believes are not supported by research. The first is that incest offenders do not act out sexually outside the family. Conte sites Abel, Becker, Cunningham, Rathner, Mittleman and Rouleau (1988) whose research indicated that 49% of the incestuous fathers and stepfathers in their study abused children outside of their own families at the same time they were abusing their own children. The second assumption is the belief that incest is the sexual expression of non-sexual needs such as depression, poor self-esteem, difficulties in relationships with adult women. This misconception has led generations of professionals to direct attention toward non-sexual problems. Accepting the perpetrator's view that his motivation is not actually sexual may make it easier for the professional to interact with a sexual offender; however, the acceptance of this belief may minimize or distort the nature of the behavior experienced by the victim. Victims report that the experience of even "less sexual" behaviors such as fondling or kissing, as painful, intrusive, and frightening. It is the defense mechanism of the therapist who is attempting to calm his or her own anxiety about dealing with sexual matters that enable this condition to exist.

The idea that sexual abuse prevention programs harm children has been suggested by Reppucci and Haugaard (1989). Conte (1990) disagrees with this view (which he suggests is another erroneous belief brought on by the need to avoid the anxiety that comes from dealing with sexual material), and instead points to a

growing body of research that has failed to identify any unanticipated consequences. Conte (1990) holds that, generally, research on prevention programs have had positive results (Binder & McNiel, 1987; Miltenberg & Theisse-Duffy, 1988; Swan Press & Briggs, 1987). Conte (1990) concedes that there is no research available currently that indicates that children are actually able to use the content of prevention programs to prevent being abused; however, he states that there is also no research indicating that prevention efforts are ineffective.

Treatment Issues

Effective treatment of the sexually abused child requires an understanding of the significant impact issues for the victim. Treatment goals need to be a reflection of the impact issues (Porter, Blick & Sgroi, 1989). Any consideration of treatment interventions with children must consider developmental factors. Given the fact that abuse can occur at any age, it is important to consider the various perspectives regarding the role of age at onset of abuse. A child's age is thought to be a significant factor in determining how traumatic an assault has been and how successful will be the child's recovery (Burgess & Holmstrom, 1984 and Everstine & Everstine, 1989). Research indicates that the younger the child, the more vulnerable he or she is to trauma, and the more likely to be overwhelmed by the experience (Everstine and Everstine, 1989). Friedrick (1990) outlines several developmental processes pointing out links between what theory and research data report, and what he considers relevant implications for developing treatment plans for children who have been abused.

Cognitive Development

An important developmental factor that can influence a child's response to stress is the child's cognitive appraisal of the event. Cognitive appraisal is defined as the idiosyncratic, personal meaning of the event to the individual child. Friedrick suggests that the trauma experienced by children who have been sexually abused is similar to the trauma of children who have lost a parent to death or divorce. Similarities among the experience of a child who loses a parent to death or divorce and sexual abuse are that both are experienced by the child as a stressful event over which the child has no control. Both experiences are unwanted, but the child is helpless to change the situation. From the perspective of coping with stress, the child's view of a predictable world is altered by the loss of a parent. The world may now seem unpredictable and the child may fear that such events could occur again. Frederick (1990) further suggests that other out-of-control experiences such as sexual abuse might also leave the child with a pervasive sense that the world is unpredictable and out of the child's control.

At Midwest Children's Resource Center, a specialty child abuse service of Children's Hospital, Inc. of St. Paul, Minnesota, 65% of the referrals for suspected sexual abuse are children ages 5 and under. Approximately 50% of referrals seen for suspected abuse at the Mayo Clinic of Psychology are also 5 and under (Hewitt & Frederick, 1991).

Young children, those defined as preoperational or concrete operational have several options regarding their cognitive reactions to out-of-control experiences.

These are to either blame themselves or to blame others. Research concluded that when seeking a cognitive explanation for a parent's death, many children blamed themselves while other children blamed the surviving parent (Arthur & Kemme, 1964). Finkelhor (1990) proposes that a similar reaction can be observed in sexually abused children so that some children will react by blaming themselves and others blaming their mothers.

Researchers conclude that there is much individual variability with respect to the way in which children respond to trauma at any given age. Researchers cannot agree, however, at which age(s) children are most vulnerable to being negatively influenced by stressful experiences. Maccoby (1993) presented a compelling argument that if the unfamiliarity of situations increase their stress value, then young children experience greater stress because so much is unfamiliar to them. Young children have only a small repertoire of coping skills to help protect them from becoming disorganized. As a result, an extended abuse experience may cause a young child to generalize that all adults are abusive. Maccoby (1983) stated that children cannot be upset by events if they do not understand the harmful implications of these events. In this respect they are buffered by their cognitive age. Maccoby (1983) reported, however, that when an arousing event led to a negative outcome, the younger the child the greater the likelihood of extensive behavioral disorganization. The ability of the infant and toddler to achieve a true awareness of erotic stimulation is severely limited by cognitive immaturity which mires her thinking

in the preoperational mode. Therefore, infantile sexual experiences remain primitive and unassimilated by adult standards (Schyetky, 1988).

Kegan (1982) observed that preschool children are prone to form faulty perceptions of the reasons for the loss of a parent, often assuming responsibility and as a result feeling intense guilt. Wallerstein and Kelly (1980) found that children's responses to parental loss were clearly related to their developmental level. Predominant themes among preschoolers were fear, macabre fantasy, bewilderment, replaceability, guilt, and emotional need.

Kurdek (1981) reports that school age children, too, experience a profound personal loss when one parent leaves. Wallerstein and Kelly (1980) identified common reactions in school age children of pervasive sadness, disorganized behavior, feelings of deprivation, and yearning for the departed parent, inhibition of aggression toward the father and anger at the mother, and loyalty conflicts. Wallerstein and Kelly (1980) found in adolescents a fully conscious and intense anger, a shaken sense of identity, somatic symptoms, and a tendency to align with one parent. Kurdek (1981) suggested that adolescents' reactions were different from younger children because of the adolescent's cognitive maturity and ability to turn outside the home for comfort and advice. Therefore adolescents may be less traumatized than younger children because of greater understanding, yet adolescence is a period of renewed egocentricity which may explain, according to Frederick (1990), why being stigmatized by a traumatic event may be more salient in this developmental period. Brown and Finkelhor (1986) found no clear relationship

between age at onset of sexual abuse and the degree of behavioral disturbance. They stated that the age of onset may be less important than the stages of development through which the abuse persists. Maccoby (1983) concluded that it is unlikely that there is any linear increase or decrease with age in vulnerability to stress. Wallerstein and Kelly (1980) concurred that although children of different ages tend to react to different aspects of parental loss and tended to have different styles of coping, vulnerability is not different among age groups. Friedrick (1990) suggests that children who have experienced sexual abuse may follow similar patterns across age groups.

Cognitive development comes into play regarding the accuracy of the child's report of abusive events. It is difficult to perform laboratory research that is relative to real life and remain sensitive and ethical (Frederick, 1990). Research regarding children's recall of events indicates with some certainty that children tend to minimize and underreport the extent of their abuse experience. The reason may be that younger children have less sophisticated language ability while older children possess a more keenly developed sense of shame and embarrassment. Research on memory and suggestibility in children concludes that whereas young children are generally more vulnerable to misleading suggestions than older children and adults, they do not appear to be more suggestible when it comes to recalling the most salient and memorable aspects of an event, such as who, what and where (Garbarino et al, 1989).

Social Development

Social development refers to the child's development of his/her expanding interpersonal world and the development of attachment to parents, care givers and peers. Children who are reared in chaotic or stressful homes may be less well equipped to negotiate successfully the critical developmental tasks that need to be accomplished. They may experience difficulty with arousal modulation, self-control and relationship formation. For example, physically abused children have been shown to have developed an anxious-avoidant attachment relationship with a caregiver as a means of protecting themselves against future incidents of maltreatment (Cicchetti, 1987). This adaptive behavior of developing insecure attachment relationships with primary caregivers results in impaired social relationships and has been associated with diminished cognitive development which may impact or diminish future learning ability (Friedrick, 1990). Friedrick (1991) learned through his research related to psychotherapy with sexually abused children that these children who have formed insecure attachments also have difficulties developing an autonomous sense of self. They have an impaired sense of self, and of their capabilities, goals, activities and feelings. Abused toddlers use proportionately fewer internal-state words, attempt more strenuously to master feelings, and experience themselves in more negative ways. Revictimization often occurs as a result of abuse, especially with children who organize their behavior around the expression of anger and hostility, and assume a role of victimizer or with children who organize their behavior around their sense of their unworthiness and

poor self-image in the role of victim (Friedrick, 1991). Feelings of loss and learned helplessness, repressed anger and hostility and an impaired ability to trust, as well as difficulties with social skills have been identified by Porter, Blick & Sgroi (1982) as crucial impact areas following child sexual abuse. Children who view themselves negatively have difficulty interacting with peers. The peer group serves as an important socialization arena, but children with impaired attachment relationships and little ability to trust miss out on this positive socializing influence, or else may even be involved in a peer group that confirms their negative self-image (Friedrick, 1991).

Sexual Development

Finkelhor and Browne (1985) discussed the concept of traumatic sexualization. This concept refers to a process in which a child's sexuality, which includes both sexual feelings and sexual attitudes, is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. According to Finkelhor (1984), the degree of sexualization will vary with the abuse experience and the child's level of development. It appears that for the age range of 3 to 12 years, sexual behavior, most notably sexual preoccupation and masturbation, is significantly more evident in sexually abused children than in either normal or psychiatric outpatients (Friedrick et al, 1989). Friedrick concludes that the earlier than average introduction to sexual activity appeared to stimulate these children to behave in a sexual way.

That all child victims of sexual abuse need some level of therapeutic intervention regardless of the perpetrator is generally agreed upon by professionals

in the field (Sgroi, 1982). Timely treatment can prevent the emergence of destructive and dysfunctional behavior patterns and redirect others in a less destructive way. Who participates in treatment and the modality of treatment chosen will depend on each unique set of circumstances presented by a particular case. The ideal combination of treatment modalities for sexually abused children - both those who were abused by a family member as well as those who were abused by someone outside the family, would provide the opportunity for group, dyad and family therapy. Resistance to family therapy exists for victims because participation in treatment requires parents of victims to assume responsibility and be accountable for their actions. Parents often react to the disclosure of intrafamily child sexual abuse with denial and hostility, and by rejecting the child. The child is then identified as "the problem". When a father has sexually abused his child, it is not uncommon for the non-offending spouse to initially be supportive of the child only to reverse that position and protect the father instead (James and Nasjlete, 1981). Some women cannot accept that their husbands would lie to them about something so important, or they strongly need to believe husbands who promise the behavior will stop. These women need to believe these men because often they feel that their own lives will be destroyed if they do not protect the men.

Parents of children abused by someone outside the family are equally likely to resist therapeutic intervention because of guilt and embarrassment at their inability to protect their child. Often these parents will deny the significance of the impact of sexual abuse on their child. Often these parents, in an effort to relieve their own

trauma and guilt, erroneously believe that treatment makes things worse by bringing up the issue again and again when they just want the child to forget. To acknowledge that treatment is beneficial for the child is too painful for the parent. (Sgroi et al, 1982)

Impact Issues and Treatment Implications

Child sexual abuse is an etiological factor in some of the most severe mental disorders, including dissociative disorder, anxiety disorders, eating disorders, sexual disorders, affective disorders, personality disorders, and substance abuse (Brickman, 1984; Gelinas, 1983).

In constructing a developmental framework for conceptualizing the effects of child sexual abuse, Cole and Putnam (1992) focused on father-daughter incest as a particularly disturbing form of child sexual abuse because it occurs within the domain of the child's main source of support and socialization. Father-daughter incest is far more common than previously realized (Finkelhor, 1980; Herman, 1981), with an estimated incidence of 1 in 70 females (Finkelhor, Hotaling, Lewis, and Smith, 1990). Cole and Putnam (1992) focused on incest and its specific psychopathogenic influences on the development of self. They argue that certain psychopathological outcomes in adulthood have a high probability of association with a history of incest and that self-development is a central organizing construct for understanding such outcomes.

Cole and Putnam (1992) reviewed current research on the long term effects of incest, and identified a number of disorders in which the incidence of childhood

sexual abuse, particularly incest, significantly exceeds the chance rate. These conditions are borderline personality disorder, multiple personality disorder, somatoform disorders (particularly pseudoseizures, pelvic pain, and gastrointestinal disturbances, eating disorders, and substance abuse disorders in women).

Cole and Putman (1992) identified two themes shared by these different disorders that suggest disruptions in self-development: a) deviations in the intrapsychic process of defining, regulating, and integrating aspects of self, and b) deviations in the related ability to experience a sense of trust and confidence in relationships. These disruptions in self-development, according to Cole and Putnam (1992), are manifest as identity confusion, dissociation of aspects of self such as sense of separate selves, loss of memories about self, disturbances of body image, poorly modulated affect and impulse control, self-critical and self-destructive tendencies, insecurity in relationships, particularly distrust, suspiciousness, lack of intimacy and isolation. Cole and Putnam (1992) found a correlation of these disorders with a history of incestuous sexual abuse. Vander Kolk (1987) reported that children are particularly vulnerable to the long-term effects of psychological trauma, especially when the perpetrator of the trauma is at the same time the adult on whom a child relies for love and protection.

Incest interferes with the typical self and social development, and the psychiatric disorders most closely associated with a childhood history of incest reflect these impairments in self and social functioning (Cole and Putnam, 1992). Research in developmental psychology, according to Cole and Putnam (1992), reveals that self

and social development are important, continuing themes throughout infancy, childhood, adolescence and adulthood, and that each developmental transition is associated with revision and change in one's self-definition and integration, in the self-regulation of behavior and affect, and in the scope and quality of one's social relationships. The incest experience according to Cole and Putnam (1992) interferes with these necessary developmental transitions in a manner that increases the risk of serious psychopathology.

Terr (1991) cites childhood psychic trauma such as sexual abuse as a crucial etiological factor in the development of a number of serious disorders both in childhood and adulthood. According to Terr (1991) childhood psychic trauma leads to a number of mental changes that eventually account for some adult character problems, certain kinds of psychotic thinking, considerable violence, much dissociation, extremes of passivity, self-mutilation episodes, and a variety of anxiety disturbances.

Empirical evidence does not yet support a correlation between childhood sexual abuse and post traumatic stress disorder according to Cole and Putnam (1992), because the few studies that have linked the two have been conducted with child samples. However, Vander Kolk's (1987) studies of the effects of trauma stated that the human response to overwhelming and uncontrollable life events is remarkably consistent and correlate with the core features of the post traumatic syndrome. Gil (1991) concludes that many of the psychological consequences of child sexual abuse can be considered post traumatic re-enactment of unresolved

traumas. Eth and Pynoos (1985) concluded that the typical early response of sexually abused children involved deleterious effects on cognition. These included effects on memory, school performance and learning, as well as affect, interpersonal relations, impulse control and behavior. Terr (1990) pointed out that while adults who are shocked or severely stressed tend to talk, dream, or otherwise visualize it. Children tended to repeat the trauma in action. Terr (1990) further stated that although the traumatic events were external, they were incorporated quickly into the mind, especially when the victim felt helpless to stop the traumatic event, which is usually the case in childhood sexual abuse.

Trauma can be resolved in either positive or negative ways (Gil 1991). Positive resolution results in the survivor being able to process the trauma in a realistic way, experiencing the accompanying pain, anger and loss. Survivors of trauma who achieve this type of resolution break patterns of helplessness, gain control over their lives and no longer allow the trauma to dominate their mental lives (Gil, 1991). Those who experience negative trauma resolution continue to live in the emotional environment of the traumatic event, and according to Kardiner (1941) experience some consistent human responses to the event. These are: persistence of a startle response and irritability, proclivity to explosive outbursts of anger, fixation on trauma, constriction of general level of personality functioning and an atypical dream life. According to Gil (1991), most typical of the negative effects of unresolved trauma are feelings of re-living the trauma through intrusive thoughts or dreams, and of numbing. These responses, which are psychologically and physiologically based, are

consistent with the diagnostic category post-traumatic stress disorder which was incorporated into the DSM-III-R in 1980.

Dissociation is a response strongly related to trauma. Janet (1889) first reported that dissociated states often followed childhood sexual or physical abuse. Dissociation is a process of separating, segregating, and isolating chunks of information, perceptions, memories, motivations, and affects. It serves as a defense against severe stress because the individual can protect herself against the original trauma. However, it allows for a predisposition to react to subsequent stress or stimuli as if they were an original recurrence of the trauma.

The extent to which child sexual abuse victims experience the same reactions is not known; however, many studies have reported serious deleterious long range effects. These intrude the basic components of a child's self. They include emotional effects such as overwhelming guilt, anger, depression, anxiety, loss of innocence, and loss of feeling of normalcy, and is often manifest in recurring frightening memories and dreams, increased stress and tension and somatic complaints. Effects on interpersonal behavior result in the child victim experiencing isolation and difficulty relating to and trusting others as well as confusing with regard to sexual acting out and feeling damaged. In boys, behavioral effects have resulted in the development of aggressive behavior, higher levels of suicidal thoughts and self mutilation (Haugaard and Reppucci, 1988).

There is repeated suggestion in the literature that women who are victims of childhood sexual abuse become victims later in life. Investigators have found

incidences of childhood sexual victimization in the histories of rape victims and victims of spousal abuse (Miller et al, 1978). Women sexually abused as children appeared to be more susceptible to later sexual violence, perhaps because these women reported more depression, more psychiatric symptoms, more helplessness, and lower self-esteem, all of which would impact their perception of themselves as victims.

According to Herman (1992), people who have endured horrible events suffer psychological difficulties. There exists a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse. Because traumatic syndromes have basic features in common, Herman (1992) believes that the recovery process also follows a common pathway, and states that there are fundamental stages of recovery. Herman (1992) cites the following fundamental stages: establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community. Other clinicians and researchers conceptualize the healing process in a variety of ways.

Porter, Blick and Sgroi (1982) examined child sexual abuse impact issues and the treatment implications of each. They identified ten impact and treatment issues for victims of child sexual abuse. They are as follows:

1. "Damaged goods" syndrome
2. Guilt
3. Fear

4. Depression
5. Low self-esteem and poor social skills
6. Repressed anger and hostility
7. Impaired ability to trust
8. Blurred role boundaries and role confusion
9. Pseudomaturity coupled with failure to accomplish developmental tasks
10. Self-mastery and control

Sgroi (1982) reported that the first five impact issues were likely to affect all children who had been sexually abused, regardless of the identity of the perpetrator. The other impact issues (6-10) were more likely to affect intrafamily child sexual abuse victims. In cases where the perpetrator is a known and valued person to the child, many of the responses and treatment issues listed for intrafamily victims may also occur.

Damaged Goods Syndrome

The "damaged goods" syndrome is a fusion and confusion of reactions, physical, mental and social. There may have been actual physical injury or fear of physical damage. When physical damage or pain has indeed occurred, the child has a concrete reason to believe that she was damaged. In many cases there is no actual physical damage, but when a child experiences pain it may lead her to presume an injury has occurred. Even if the pain was transient, the presumption of injury leading to permanent damage may remain if definite steps are not taken to correct this misperception. Another way the child victim is labeled as damaged

goods identified by Burgess and Holmstrom (1979) can be in the response of the family and the community to learning that a child has been sexually abused. Society places profound emphasis on an individual's introduction to sexual behavior with others. A sexually experienced child is an uncomfortable and troubling paradox and a reminder of the ambivalence, conflicts, guilt and fear surrounding many members of society regarding human sexuality (Sgroi et al, 1982). A sexually victimized child, inappropriately viewed as neither a child nor an adult, but rather as a piece of "damaged goods" is particularly vulnerable. If they are perceived as so altered and damaged that normal constraints and restrictions about sexual behavior do not hold, these children may be victimized again and again (Sgroi et al, 1982).

Sgroi et al (1982) recommend treatment of the "damaged goods" syndrome begin in a concrete fashion with a comprehensive physical examination of the child victim, performed by a physician knowledgeable about child sexual abuse and aware of the psychosocial issues. If the child sustained physical damage, it should be identified and treated medically as soon as possible. More often no physical damage is present and the equally important process of empowering this information emphatically to the child and the family should be done immediately.

Objections to a physical examination of asymptomatic sexually abused children were often made on the grounds that examination would "further traumatize the child". However, Sgroi et al (1982) argues, it is far more preferable to confront the child's and parent's fears directly and enable the physicians to provide a reality basis for the affirmation that the child is alright. Sgroi et al (1982) believes that the

ability to state authoritatively that there is no physical damage or that the physical damage has been treated is a therapeutic stepping stone in the process of convincing the child, the family, and significant others that the victim has not been irreparably damaged. Parents, teachers, siblings, and others should be made aware of the importance of behaving toward the victim as a child of appropriate age and experience -- not as an adult or a piece of "damaged goods" (Sgroi et al, 1982).

Guilt

Not all sexually abused children feel guilty about their behavior before disclosing the activity; however, intensive feelings of guilt are almost a universal victim response (Sgroi et al, 1982; Gagliano, 1987; Courtois, 1988:, Donovan & McIntyre, 1990). Sexually abused children usually experience guilt on three levels. First: responsibility for the sexual behavior; society tends to blame sexual abuse victims of any age (Burgess and Holmstrom, 1974). Amazingly, the perpetrator's assertion that a seductive child is responsible for the sexual behavior is often given credence by judges, attorneys, police officers, physicians, social workers, and the like. Second: responsibility for disclosure. Children may be the deliberate disclosing agent or someone else may disclose the sexual activity, but the child in many cases will feel that she has betrayed the perpetrator and violated their relationship because the sexual relationship could only exist as long as it remained a secret. Often the perpetrator will blame the victim and intensify this response (Burgess and Holmstrom 1975). A third way children assume responsibility is to accept responsibility or blame for the disruption which often accompanies disclosure, especially in cases of

intrafamily sexual abuse. Often the victim's family and significant others perceive the child as responsible for the disruption in the family (Sgroi et al, 1982).

Therapists can and should consistently convey to the child, family members, and the perpetrator that a child can never be held responsible for initiating sexual activity with an adult or older person. Therefore, the child also cannot be held responsible for the disruption following disclosure. The therapist must convey the message to all that the child had a right to expect protection, not abuse, from the perpetrator. And when disclosing, the child had the right to expect protection from the other adults in her life. Blame needs to be placed with the perpetrator who alone is responsible for the sexual activity and all of the negative consequences which may result.

Fear

Fear of the consequences of sexual activity, fear of the consequences of disclosure, fear of continued episodes of sexual abuse, as well as fear of reprisals from the perpetrator may be expressed on a conscious or unconscious level. Often they are manifested by sleep disturbance or nightmares (Sgroi et al, 1982; Finkelhor, 1986; Courtois 1988).

Therapist needs to assist child victims to identify and express their fears and to talk about their feelings. Fears should be addressed directly and approached concretely. The child's home should be made to feel as safe as possible. In the absence of a parental ally, some other significant other can be used to establish safe relationships.

Depression

Nearly all child victims will exhibit some symptoms or signs of depression after disclosure of sexual abuse (Finkelhor, 1986; Courtois, 1988; Sgroi et al, 1982). Children who are continually being sexually abused may also appear depressed. They may appear sad, subdued, or withdrawn, or complain of fatigue or physical symptoms. Some children react with self-mutilation or suicide attempts.

Therapist should be alert for signs of depression and suicidal thoughts or feelings. Opportunities for expression of all feelings should be provided and encouraged. Child victims need to be believed and supported, and reminded of this often. Severely disturbed victims may require hospitalization for their safety (Sgroi et al, 1982).

Low Self-Esteem and Poor Social Skills

The fears, guilt and blame often felt by sexually abused children tends to undermine the child victim's self-esteem. The labels of "victim" and "damaged goods" compounds feelings of self-worth and undermines a child's self-confidence (Sgroi et al, 1982; Cortois, 1988).

Many children victimized by their own families have been isolated from outside relationships, which results in limited social skills. Limited social skills make any attempts to engage friends or agemates difficult, which further decreases self-esteem. As a result, child abuse victims feel unworthy and undeserving and it is not unusual for these children to see and describe themselves in derogatory terms (Sgroi, 1982).

Therapist aware of the high occurrence of low self-esteem among child sexual abuse victims can provide individual therapy and a safe environment for these children. Encouragement to identify and express negative feelings about themselves can open the way for these children to eventually enter a group of peers. Group therapy is viewed as the most effective treatment modality for this impact issue. Victims derive intense support from a positive group experience, and opportunities to enhance self-esteem abound (Schietky and Green, 1988, Sgroi, 1982).

Repressed Anger and Hostility

Most child sexual abuse victims experience anger at the perpetrators who abused and exploited them, as well as at parents or family members who failed to protect them (Finkelhor, 1986, Sgroi et al, 1982). Their anger may extend to extended family, friends, and community members, depending on how their disclosure of the abuse was accepted. In the large majority of cases, however, this anger is repressed rather than expressed. This repressed anger may be manifested by depression or withdrawal, sometimes physical symptomatology, sometimes by aggressive fantasies or behavior, and on occasion as psychotic symptomatology (Sgroi, 1982).

Therapist must be prepared to establish a safe environment in which to encourage child victims to get in touch with their anger in a healthy and non-destructive fashion. Group therapy can also provide opportunities for child victims to learn to express anger in a safe setting (Sgroi, 1982).

Inability to Trust

The degree of impairment in a sexually abused child's ability to trust will depend on many factors: the identity of the perpetrator, the type of relationship between the perpetrator and the child, the degree of pain or discomfort or conversely, pleasure, satisfaction or advantages experienced, the amount of disruption following disclosure, the response to disclosure by others, and so forth (Sgroi et al, 1982). The child victim's inability to trust is often a direct consequence of broken promises and has a concrete reality basis which can become a major therapeutic issue (Courtois, 1988; Sgroi et al, 1982).

Sgroi (1982) links inability to trust with the child victim's low self-esteem and past experiences of betrayal. Recovery is often slow as feelings of alienation and betrayal can only be overcome through experiencing more satisfying interpersonal relationships. A combination of individual and group therapy is likely to be more successful than individual therapy alone (Sgroi, 1982).

Blurred Role Boundaries

Victims of child sexual abuse frequently experience role confusion due to the inevitable blurring of the role boundaries between the perpetrator and the child. If the perpetrator is a parent or care taker, role confusion is greatly magnified and can be shared by other family members. Some mothers of sexually abused children begin viewing and treating the child as a peer and a rival, often further escalating the role confusion (Schyetky and Green, 1988, Sgroi, 1982).

The therapist's task in helping the child victim resolve role confusion may involve instruction and exploration of appropriate role modeling behavior. This will be facilitated if it is reinforced by at least one adult family member. Ideally, the perpetrator will explain to the child victim his or her responsibility for creating the confusion and overstepping the parent/child boundary. When the family cannot or will not participate, role-playing can be included in the treatment process (Sgroi, 1982).

Pseudomaturity and Failure to Complete Developmental Tasks

The extensive stimulation and disruption that usually accompanies sexual abuse interferes with the normal accomplishment of age-appropriate developmental tasks of childhood and adolescence. Role confusion often leads to the child's premature assumption of adult roles, which further widens the gap between them and their peers. Often being identified by their peers as victims increases the isolation, so victims are left with no appropriate social outlets.

Treating this impact issue requires that the sexual abuse be stopped and the child victim's caretakers acknowledge his or her right to behave as a child. Pseudomature victims must be allowed to give up psuedomature responsibilities and act like a child. Only then can unaccomplished developmental tasks be addressed. When the child's home situation does not permit the assumption of a child-like role, this impact issue may be impossible to treat (Sgroi, 1982).

Self-Mastery and Control

Child sexual abuse is a violation of the victim's body, privacy, and rights of self-mastery and control. It is a violation with subtle and long-lasting effects and unless the child victim receives treatment, prospects for avoiding the destructive consequences of failure to achieve self-mastery and control are extremely poor.

The therapist's task is to convey a new message to the child victim -- a message that acknowledges her rights to privacy and protection. Self-mastery and control imply accountability, behaving responsibly toward oneself and others, development of independence from one's family and background, and freedom to make one's own choices. Role-modeling, role-playing, peer-group support, and positive peer pressure are recommended treatment modalities (Sgroi, 1982). Effective decision making and good judgement are achieved when individuals are permitted opportunities to make choices and be responsible for their own actions without fear of reprisals (Sgroi, 1982, Schetky & Green, 1988).

Other researchers in the area of childhood sexual abuse have identified many traumatic effects of the experience for children. There is considerable variation in what these therapists include in their treatment plans. Mrazek (1981) recommends laying the groundwork for treatment by 1) providing a safe setting to facilitate the discussion of feelings regarding individual and family problems, including their sexual experiences; 2) providing positive male and female role models; 3) allowing children to relate to peers who have had similar sexual experiences and 4) enhancing the child's overall social skills. Steward et al (1986) also included 1) helping children

articulate thoughts and feelings and 2) enhancing social skills. They also added 3) encouraging the child's ability to ask for help; 4) providing an experience with a caring and comforting adult to deal with issues of abandonment and loss; 5) helping children develop a realistic sense of competence; 6) supporting mastery of normal milestones, and 7) confronting the egocentric assumption that the abuse is their fault. In a discussion of group therapy for adolescent girls, Blick and Porter (1982) recommended incorporating the following issues: 1) ventilation of anger; 2) socialization; 3) preparation for court; and 4) sex education. Gagliano (1987) focused treatment issues on the 1) discussion of incest; 2) the alleviation of guilt; 3) the discussion of parental roles; and added 4) sex education. Nelki and Watters (1989) addressed the issues of 1) anger and punishment, 2) fault and responsibility, 3) telling someone, and added 4) meeting strangers safely, 5) positive and negative feelings, 6) keeping family secrets, 7) issues of touching with people you know well, and 8) body image.

Developing a sense of safety, dealing with personal feelings about the self and the family, issues of trust, self esteem, sexuality and future victimization were dealt with by Friedrick (1991), Singer (1989), Alexander et al (1989), Donovan and McIntyre (1990) and Gil (1993).

Friedrick (1990) describes the controversy in the conceptualization and treatment of families in incestuous abuse. He relates that at 1988 Hilton Head Conference on Child Sexual Abuse, two noted clinicians and theoreticians in the area of sexual abuse, Lucy Berliner, M.S.W. and Noel Larson, Ph.D., engaged in a seven

hour debate regarding the place of family therapy and theory in understanding and treating incestuous abuse. "Those who saw family issues as primary in the etiology and treatment of incest were at odds with clinicians whose primary emphasis was protecting the victim from further abuse." (Friedrick, 1991, p. 167) According to Friedrick, a primary reason for the strong differences of opinion that exist between family therapists and victim advocates is the concept of circular causality that exists within the system for family systems theorists. This theory holds that every member of the family is viewed as an integral part of the system and actions of each member of the system, and actions of each member of the system affect every other member of the system. This may be construed as implying blame on the system rather than the perpetrator. A therapist who is primarily a victim advocate would argue that a perpetrator is solely guilty of the abuse and that the child and other family members are not contributing to the incest. A polarization of the sexual abuse treatment field between victim advocacy theorists has existed in the past; however, according to Friedrick there may be a "softening of the purely systematic viewpoint" for many family therapists who, according to Bograd (1986) assess the impact of wife abuse, stated, "Responding to wife abuse challenges family therapists to take unapologetically value-laden stands." p. 146. Similarly, family therapists treating victims of child sexual abuse have been expressing an appreciation for the place of individual psychopathology in families with serious psychological problems. It appears systems theory is developing an appreciation for the different levels of systems, including family and individual levels. Friedrick (1991) cites the following

examples of the differences in view, for example, some incestuous fathers are increasingly seen as having both criminal and compulsive components along with pre-existing emotional problems that they bring to the family system. In addition the child victim and non-offending mother are increasingly being viewed as reflecting roles that have been attributed to them in a dysfunctional family system. Giarretto (1982) pioneered an approach to treating families where sexual abuse had been identified, which combined couples, marital, family, and dyad therapy with self-help groups and community supports.

Because of the long term patterns of behaviors that often exist in sexually abusive families such as the tendency to isolate family members. Caution must always be used to ensure that the individual child victim rights to be protected is never subsumed to the family's desire for treatment. Friedrick (1990) suggested the following goals to ensure protection of the child victim:

1) an admission of guilt by the offender;

2) appropriate parental authority;

3) improved behavior in the victim and in her relationship with the protective parent;

4) completion of individual/group therapy for the adolescent perpetrator

5) an expanded social network for the victim.

Gelinas (1988) suggested the following four criteria to measure successful family treatment: 1) the definite termination of incestuous abuse; 2) a healthier family structure, with greater individual autonomy in family members, 3) enhanced communication, and 4) improved conflict-resolution skills. Friedrick (1990) suggested

adding the following criteria: significant improvement of the marital relationship with all parties acting more adequately, as well as a decrease in the child's level of parentification and an increase in her self-esteem and assertiveness.

Herman (1983) stated a slightly different criteria, stating that safety for the child victim is not established simply by improving the sexual or marital relationship of the parents. Herman's criteria would involve a correction of the mother-daughter relationship to include the ability of the mother to feel able to protect herself and her children, as well as the daughter's ability to believe that she can use her mother for protection. James and Nasjletti (1983) believe that family therapy is essential, if the relationship dynamics which allowed the abuse to occur in the first place are going to be changed. James and Nasjletti advocate an approach which involves several treatment modalities which include developing individual therapeutic relationships with the key family members, moving them to group therapy, followed by dyadic/conjoint sessions. James and Nasjletti (1983) caution that care is taken to ensure that the perpetrator and child victim not be brought together in a session until enough work has been done so that the child victim is emotionally strong enough to confront the perpetrator, and equally important in that the perpetrator is willing to accept and verbally express his or her full responsibility for the sexual abuse.

In summary, while theorist expresses a diversity of approaches, that victims of sexual abuse in general need some level of therapeutic intervention is strongly suggested by most. It seems that questions regarding who participates and what

modality of treatment will be chosen will depend on each unique set of circumstances presented by each particular case.

Knowing what component of therapeutic interventions are included in the treatment process of therapists will expand an understanding of the state of sexual abuse treatment today.

Therefore, there may be evidence to support the idea that therapists include some components of treatment more frequently than others.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to gather information about the opinion of mental health providers treating children who had been sexually abused. This study was concerned with identifying those impact issues that researchers and clinicians stated were critical areas of concern to be addressed in treatment. The study focused on the effects of sexual abuse on a child, and the resulting implications for treatment. This researcher wanted to determine what components of the impact issues identified by noted experts in the field of child sexual abuse were considered important enough to be included in the treatment plans and goals of mental health practitioners treating victims of child sexual abuse.

After reviewing the literature, a list was compiled of symptoms that were generally identified by researchers as effects of sexual abuse on children. Using this list of symptoms and the corresponding treatment implications, informal interviews were conducted with therapists working at a child abuse treatment agency which served many children referred for sexual abuse treatment. A survey was developed to obtain information about which of the impact areas therapists included in their individual or group practices with their clients who had experienced sexual abuse.

Subject Selection

Mental health practitioners in this study were those who are affiliated with an agency that specializes in the treatment of child abuse and child sexual abuse; therapists who advertised that child sexual abuse treatment was an area of

specialization; therapists who were referred by other professionals who were aware of their work with the victims of child sexual abuse; personnel affiliated with three children's hospitals; and several private agencies. A representative from each agency was contacted to request assistance from agency clinical staff. A list of clinicians was compiled from agencies contacted. A total of 270 surveys were sent to participants. Each participant was sent a cover letter explaining the purpose of the study, along with a copy of the survey. Participants were instructed to respond to each of 22 statements by placing a checkmark in the box below the statement indicating their response choice. Two statements required rank ordering choices from a list. Following the statements were responses providing the researcher with demographic data about the respondents. A self-addressed stamped envelope was provided for each participant. Instructions were provided to participants to indicate whether they wished to receive a copy of the results. All participants were given the option of remaining anonymous.

Description of the Sample

One hundred thirty-four surveys were returned which provided a return rate of 49% after the first mailing. No reminder or follow-up surveys were mailed out. Respondents consisted of 134 mental health practitioners, 36 males and 97 females with an average of 9.6 years in practice. The highest percent (58.2%) of those responding held masters degrees; 12.7% were doctoral students; and 11.9% held doctoral degrees. The remainder consisted of 8.2% with bachelor level degrees and 8.2% of Masters level students.

Respondents listed the following fields of education: 43.3% social work; 2.2% psychiatry; 32.1% psychology; 9.0% education; and 12.7% other. Those listing "other" were nurses, counselors, art therapists and music therapists. Table 3.1 illustrates the responses.

Table 3.1

Demographic Data	
Male	36
Female	97
Years in Practice	9.6
Percent of caseload of child clients for whom sexual abuse is an issue	50
Level of Education:	
Undergraduate	0
Bachelors	8.2%
Masters Student	8.2%
Masters	58.2%
Doctoral Student	12.7%
Doctoral	11.9%
Field of Education:	
Social Work	43.3%
Psychiatry	2.2%
Psychology	31.1%
Education	9.0%
Other	12.7%

Respondents were asked to list the methods they had used to acquire knowledge of sexual abuse treatment. The table below illustrates the responses.

Table 3.2

Method of Acquiring Knowledge of Sexual Abuse Treatment Issues

Method	Percentages
Formal Education	84.3%
Work with Clients	96.3%
Continuing Education	94.6%
Workshops	85.8%
Colleagues	87.3%
Books, Journals	95.5%
Personal Victimization	12.7%
Other	

Table 3.3 below illustrates the responses of the participants to the inquiry regarding the percent of caseload of child clients for whom sexual abuse is an issue. The table shows that 17 of the 134 respondents did not provide the information, and the largest number of respondents (17) checked that 50% of their caseloads were comprised of children who had been sexually abused.

Table 3.3

Percentage of Caseload Involving Sexual Abuse

Percentage	# of Respondents
0	17
1	1
2	3
3	1
5	9
6	1
10	6
12	1
15	1
20	9
25	8
30	8
35	1
40	4
50	17
55	1
58	1
60	2
75	5
80	8
85	4
90	3
95	1
98	1
99	4

The Survey

Clinicians and researchers working in the field of child sexual abuse have studied the effects of the experience on the children they have treated. A variety of effects on the individual child were identified, including feelings of anger, depression, guilt, shame, hostility and pseudomaturity. Further effects included low self-esteem, poor social skills, feeling like damaged goods, being unable to trust, identifying oneself as a victim, and failing to accomplish developmental tasks. Some other effects influenced the relationship between the child and others, such as the child identifying with the perpetrator, the child feeling ambivalence toward his or her mother, the child needing to keep secrets, having a negative image of their family, and having an unclear understanding of family roles and boundary issues.

Survey items were developed to reflect the opinions of the researchers regarding the effects of child sexual abuse. Thirteen statements were developed to correspond to the impact issues identified by those considered experts in the field.

Another area of concern for these experts was the development of treatment goals which included information on modalities of treatment methods such as individual, family, group, etc. Ten survey items were developed to ask for information about the effects of intervention, the approaches most often used, and the anticipated outcome of treatment.

Information from researchers was presented to clinicians during interviews to obtain feedback on the content of survey items.

The survey consisted of 24 questions, 22 of which were to be answered by choosing one response on a Likert scale. The responses ranged from strongly agree through agree, no opinion, and disagree to strongly disagree. The first question asked participants to respond to a definition of sexual abuse. Items 2, 3, 6, 7, 8, 10, 11, 12, 17, 18, 19, 20 and 21 asked about the effects of the experience of sexual abuse. Items 4, 5, 9, 13, 14, 15, 16, 22, 23 and 24 were concerned with those components of treatment which therapists considered important enough to include in their goals with clients. Items 3, 7, 12 and 17 were stated in inverted terms so that a negative response indicated agreement, while a positive response would indicate disagreement with the theories of noted experts in the field. Item 20 contained a list of sixteen symptoms identified by noted experts as those most frequently observed in the children they had treated. Participants were instructed to place a checkmark next to the five symptoms they saw most frequently in the children they treated. Item 22 consisted of nine statements concerned with the most important indicators of successful treatment of sexual abuse. These indicators were those identified as significant by noted experts in the field. Participants were instructed to place a checkmark before the five most important indicators of successful treatment.

The survey requested participants to complete demographic data indicating sex, age, years in practice, and percent of caseload of child clients for whom sexual abuse is an issue. Information was also requested about level of education, field of education, certification, licensure, or specialty. Finally, a checklist which requested participants to choose which of eight possible methods they had used to acquire

knowledge of sexual abuse treatment issues. Participants were requested to check all that applied to them.

Data Analysis

One survey was completed by this researcher with opinions believed to be consistent with those experts in the field of child sexual abuse whose works were cited in the literature review. This survey was designated the experts survey. The results of the other 134 surveys were tabulated and the responses were compared within the surveyed group and to the experts survey.

CHAPTER FOUR

RESULTS

One hundred thirty-four surveys were returned from a population of mental health practitioners who were affiliated with hospitals or agencies who were known by their reputations to treat children who had been sexually abused. The responses on the surveys were compared to one which was completed by the researcher with responses believed to be consistent with the opinions of those experts in the field of child sexual abuse whose works were read while surveying the literature on this topic. Because the field of child sexual abuse treatment is a relatively new one, there are a limited number of "experts". In this study, experts are being defined as those doing research and direct clinical work with children, who are writing and reporting the results of their work. Therefore, the impression of this researcher reading the literature would be that there seems to be consistency among the findings of those experts.

Respondents' responses were re-grouped so that strongly agree and agree were combined, and strongly disagree and disagree were combined. This change from a five point scale to a three point scale was an attempt to simplify and clarify the results. Therefore, the possible responses on the Likert scale were now agree, no opinion, or disagree.

The following is a description of the survey items indicating the re-grouping of the items and the reduction of the Likert scale items to three responses: agree, no opinion and disagree. Beneath each survey item are listed the respondents

agreeing, having no opinion or disagreeing. The items are grouped in the following manner: Item 1 defines child sexual abuse; Items 2, 3, 6, 7, 8, 10, 11, 12, 17, 18, 18, 20 and 21 address the effects of the experience of child sexual abuse; and Items 4, 5, 9, 13, 14, 15, 16, 22, 23 and 24 are concerned with those components of treatment which therapists considered important enough to be included in their treatment plans with clients. Items 3, 7, 12 and 17 were stated in inverted terms so that a negative response indicated agreement, while a positive response would indicate disagreement with the opinions of the experts in the field. Those items and responses will be grouped together.

Item 1 which defined sexual abuse follows with the percentage of agreement.

1. Child sexual abuse involves any sexual activity, overt or covert, between a child and an adult or older child, where the younger child's participation is obtained through seduction or coercion.

Agree	134	No opinion	0	Disagree0

One hundred respondents chose strongly agree and 34 chose agree. This indicates 100% agreement with the "experts" survey as well as 100% agreement within the group surveyed.

The following table illustrates the respondents' agreement with the definition of sexual abuse.

Table 4.1

Agreement with definition:

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Agree Strongly	1	100	74.6	74.6	74.6
Agree	2	34	25.4	25.4	100
	TOTAL	134	100	100	

Those items concerning the effects of child sexual abuse follow. The items are grouped from highest to lowest agreement with the "experts" survey.

19. Dissociation, a process of separating and isolating chunks of perception and memories is a response of some victims of child sexual abuse.

Agree 132 No opinion 2 Disagree0

10. After disclosure, it is not unusual for a child to feel guilty that he/she has betrayed the perpetrator.

Agree 129 No opinion 2 Disagree3

11. Children frequently express feelings of responsibility for their part in the sexual behavior.

Agree 129 No opinion 2 Disagree3

2. The extreme stimulation and disruption that usually accompanies sexual abuse interferes with the normal accomplishments of age-appropriate developmental tasks.

Agree 127 No opinion 3 Disagree4

There was generally high agreement between the surveyed population and the "experts" about the effects of child sexual abuse described in items 19, 10, 11 and 2. Agreement with the "experts" was high (98%) in identifying dissociation as a response of some child victims. Participants also appear to agree with the "experts" that after disclosure it is not unusual for a child to feel guilty about betraying a perpetrator.

Ninety-six percent of respondents agreed with the above statement and 96% also agreed that children frequently express feelings of responsibility for their part in the sexual behavior. In response to item #2, which addressed the stimulation and disruption that usually accompanies sexual abuse and identified it as an interruption that interferes with normal accomplishments of age-appropriate developmental tasks, 95% of respondents agreed with the "experts".

There was moderate agreement on items 6, 21 and 8.

6. Child victims of sexual abuse frequently repress the anger they experience.

Agree	125	No opinion	4	Disagree5

21. Many of the psychological consequences of child sexual abuse are consistent with the core features of post traumatic stress disorder.

Agree	122	No opinion	11	Disagree1

8. Victims of child sexual abuse frequently experience role confusion due to the blurring of the role boundaries between the perpetrator and the child.

Agree	117	No opinion	9	Disagree8

The items indicated several other effects of child sexual abuse. Item #6, which stated that child victims of sexual abuse frequently repress the anger they experience, drew an agreement of 93% with the experts. In response to item #21 "Many of the psychological consequences of child sexual abuse are consistent with the core features of post traumatic stress disorder", 91% of the respondents agreed with the "experts". Eighty-seven percent of those surveyed agreed with item #8, "Victims of child sexual abuse frequently experience role confusion due to the blurring of the role boundaries between the perpetrator and the child."

The following four items concerning other effects of sexual abuse were stated in inverted terms to determine if respondents were reading carefully. On the inverted items, disagree indicated agreement with the "experts" opinions regarding those effects of sexual abuse. There was generally high agreement with items 3, 7, and 12, but only moderate agreement with item 17.

7. Child victims of sexual abuse rarely present with symptoms of depression or withdrawal.

Agree	2	No opinion	2	Disagree130

3. Sexually abused children rarely experience sleep disturbance or nightmares.

Agree	3	No opinion	4	Disagree127

12. Sexually abused children rarely assume personal responsibility for the disruption which often accompanies disclosure of intra-family sexual abuse.

Agree	5	No opinion	4	Disagree125

17. The age of the child at the time of abuse is rarely a factor in the severity of the impact on the child.

Agree	7	No opinion	10	Disagree 117

That child victims of sexual abuse present with symptoms of depression or withdrawal elicited a response of 97% agreement between the respondents and the experts. Respondents also highly agreed (95%) that sleep disturbances and nightmares are seen in children who have been sexually abused. There was a 93% agreement between the surveyed group and the "experts" about item #12, that stated that sexually abused children assume personal responsibility for the disruption which often accompanies disclosure of intrafamily sexual abuse. There was 87% agreement between the groups in response to #17 which addressed the correlation between a child's age and the severity of the impact of sexual abuse.

Item 18, which follows, elicited the least agreement (46%), and the highest percent of no opinion (18%) and disagree (36%) scores.

18. A younger child is more vulnerable to damage from traumatic sexual abuse because young children have only a small repertoire of coping skills.

Agree 62 No opinion 24 Disagree48

The following items on the survey concerned participants' opinions regarding treatment issues. The items are listed from those with the highest percent of agreement to those with the lowest percent of agreement with the "experts".

23. When family therapy is indicated with an incestuous family, it is imperative to ensure that the child victim's rights are protected.

Agree 130 No opinion 4 Disagree0

4. In therapy, sexually abused children should be provided with many opportunities to express all of their feelings in a supportive environment.

Agree 129 No opinion 2 Disagree3

14. The ideal combination of treatment modalities for sexually abused children would provide the opportunity for a combination of individual, group and family therapy.

Agree 120 No opinion 7 Disagree7

There appears to be a strong consensus (97%) of opinion in response to item #23, which states that when the treatment modality indicated family therapy, it is imperative to ensure that the child victim's rights are protected. In response to item #4 which stated that, in therapy, sexually abused children should be provided with many opportunities to express all of their feelings in a supportive environment, 96% of the participants surveyed agreed. Item #14 stated, "The ideal combination of treatment modalities for sexually abused children would provide the opportunity for a combination of individual, group, and family therapy." Eighty-nine percent of participants agreed with the experts about the benefits of a combination of treatment modalities.

The following items also concern treatment issues.

5. A positive specialized group therapy experience is an effective treatment modality for sexually abused children who have low self-esteem and poor social skills.

Agree 117 No opinion 9 Disagree8

13. All child victims need some level of therapeutic intervention because early treatment can prevent the emergence of destructive and dysfunctional behavior.

Agree 110 No opinion 7 Disagree17

24. The goals of sexual abuse or incest therapy are long-term goals based on the enormity of the corrective emotional experiences needed by child victims.

Agree 92 No opinion 29 Disagree13

There was more variation in the responses of the participants to the next three statements.

9. Reframing the experience of sexual abuse as only one of many difficult experiences that can make up a child's life can be helpful in correcting the misperception of the child as "damaged goods".

Agree	81	No opinion	20	Disagree33

15. It is important for a therapist to include questions about sexual abuse in all initial interviews.

Agree	77	No opinion	14	Disagree43

16. Positive outcome for sexually abused children is often related to length of treatment.

Agree	32	No opinion	33	Disagree69

Sixty percent of the respondents agreed with the "experts" on item #9, reframing the experience of sexual abuse as only one of many difficult experiences that can make up a child's life, can be helpful in correlating the misperception of the child as "damaged goods".

In response to item #15, which stated that it is important for a therapist to include questions about sexual abuse in all initial interviews, 57% of the participants agreed.

Only 24% of participants agreed that positive outcome for sexually abused children is often related to length of treatment, 33% had no opinion and 69% disagreed.

In response to item #5, which stated that a positive specialized group therapy experience is an effective treatment modality for sexually abused children who have

low self-esteem and poor social skills, 87% of the mental health practitioners surveyed agreed with the "experts".

Item #13, which stated that all child victims need some level of therapeutic intervention because early treatment can prevent the emergence of destructive and dysfunctional behavior, elicited 82% agreement with the "experts".

Sixty-eight percent of those surveyed agreed with item #24 which said that the goals of sexual abuse or incest therapy are long term goals, based on the enormity of the corrective emotional experiences needed by child victims.

To determine how participants' responses compared to the standard or experts responses, surveys were scored by using the regrouped responses on the Likert scale items. Individual responses were then compared to the standard. Responses on the Likert scale items were scored at 22. Disagreement with the standard subtracted 2 points from the 22 possible points, and no opinion subtracted 1 point. For example: for subject #001 the subject had one "no opinion" (-1) and two disagrees (each -2) for a total of -5, which was subtracted from a total possible score of 22, for a score of 17 (22 - 5 = 17). The average score of participants responses was 16.43%.

The following table illustrates the survey score.

Table 4.2 - Comparison of Respondents' Scores with Experts' Scores

Value	Frequency	Percent	Valid Percent	Cumulative Percent
7	2	1.5	1.5	1.5
8	1	.7	.7	2.2
9	3	2.2	2.2	11.9
10	2	1.5	1.5	5.0
11	5	3.7	3.7	9.7
12	3	2.2	2.2	11.9
13	6	4.5	4.5	16.4
14	15	11.2	11.2	27.6
15	10	7.5	7.5	35.1
16	18	13.4	13.4	48.5
17	14	10.4	10.4	59.0
18	19	14.2	14.2	73.1
19	12	9.0	9.0	82.1
20	12	9.0	9.0	91.0
21	6	4.5	4.5	95.5
22	6	4.5	4.5	100.0

To determine consistency within the group surveyed, subgroups were chosen and the survey scores of the subgroups were compared. Two statistical tests were applied to determine what difference, if any, existed between the groups based on gender, personal victimization, level of education and field of education.

The Mann-Whitney U test is analogous to the parametric independent samples t test. It tests whether there is a significant difference between two independent samples. The Mann-Whitney U test is a more powerful test, a median test, therefore it is better as a nonparametric alternative to the t test. The null hypothesis for the Mann-Whitney U is that the two groups do not differ. There is no significant difference within the group, based upon the different sub groupings. The Mann-

Whitney U test, like the independent samples t test, can be used with two samples of unequal number.

Two items, gender and personal victimization, were tested to determine if the null hypothesis is true. The following table illustrates the result. The large score obtained (.5756) indicates that we cannot reject the null; therefore, no significant difference exists between groups based on gender or personal victimization.

Table 4.3 - Survey Score by Gender

Mann-Whitney U - Wilcoxon Rank Sum W Test

Mean Rank	Cases	
63.94	35	Gender = 1 Male
68.13	97	Gender = 2 Female
	133	TOTAL

			Corrected for Ties
U	W	Z	2-tailed P
1636.0	2302.0	.5598	.5756

The following table illustrates agreement within the group based upon personal victimization.

Table 4.4 - Survey Score by Personal Victimization

Mann-Whitney U - Wilcoxon Rank Sum W Test

Mean Rank	Cases		
66.43	117	METHG = 0	No
74.88	17	METHG = 1	Yes
	134	TOTAL	
			Corrected for Ties
U	W	Z	2-tailed P
869.0	1273.0	-.8432	.3991

Again, the observed significance level is large (.3991). Therefore, the null hypothesis cannot be rejected. This again indicates that there is consistency in the total group based on personal victimization. In other words, victims scored no higher than non-victims.

The Kruskal-Wallis One-Way Analysis of Variance was also applied to three categories: field of education, level of education and the scores of the group as a whole to determine if a difference existed between groups.

The following tables illustrate the results.

Table 4.5 - Survey Score by Field of Education

Mean Rank	Cases		
68.84	58	EDFLD = 1	Social Work
50.50	3	EDFLD = 2	Psychiatry
67.51	43	EDFLD = 3	Psychology
56.04	12	EDFLD = 4	Education
70.06	17	EDFLD = 5	Other
	133	TOTAL	

			Corrected for Ties	
Cases	Chi-Square	Significance	Chi-Square	Significance
133	1.7678	.7784	**3.1585**	**.5317**

Table 4.6 - Survey Score by Level of Education

Kruskal-Wallis One-Way Analysis of Variance

Mean Rank	Cases		
62.59	11	EDLVL = 2	Bachelors Degree
62.59	11	EDLVL = 3	Masters Student
67.55	78	EDLVL = 4	Masters Degree
62.24	17	EDLVL = 5	Doctoral Student
75.44	16	EDLVL = 5	Doctoral Degree

			Corrected for Ties	
Cases	Chi-Square	Significance	Chi-Square	Significance
133	1.3308	.8561	**2.3776**	**.6667**

Table 4.7 - Scores of the Group as a Whole

N	Mean	Stan. Dev.	Lowest Score	Highest Score
134	15.35821	3.33675	7.00	22.00

In summary, there appears to be consistency within the group, based upon the tested parameters. This indicates that area practitioners seem to follow similar assumptions about sexual abuse treatment issues, regardless of education, field, gender or personal victimization. Stated in statistical terms, the applied tests failed to find a significant difference within the group, based upon the different sub-groupings.

This lack of difference in the St. Louis area group is important. It is the first step in showing consistency with the experts at large. Logically, one would hope to find consistency, since consistency would make agreement with the experts more likely.

Item #20 presented a list of sixteen symptoms identified by the experts as those seen in the children they treated for sexual abuse. Respondents were instructed to choose the five symptoms most frequently observed in their client populations.

20. From the list below, place a check mark next to the five symptoms you see most frequently in the children you treat for sexual abuse.

1. Damaged goods syndrome
2. Guilt
3. Repressed anger, hostility
4. Impaired ability to trust
5. Pseudomaturity
6. Identification with perpetrator
7. Ambivalence toward non-offending parent
8. Failure to accomplish developmental tasks
9. Low self-esteem
10. Poor social skills
11. Depression
12. Blurred role boundaries
13. Shame
14. Need to keep family secrets
15. Negative image of family
16. Identification of self as a victim.

All of the symptoms were checked by the participants. Those responses with the most frequent number of checks were as follows: guilt (122); low self-esteem (107); impaired ability to trust (85); repressed anger, hostility (76); shame (68); and depression (63). Items that a moderate number of respondents chose were the following: blurred role boundaries (38); pseudomaturity (32); poor social skills (29); failure to accomplish developmental tasks (28); and the need to keep family

Table 4.8 - Symptoms Most Frequently Observed

#2	Guilt	122
#9	Low self esteem	107
#4	Impaired ability to trust	85
#3	Repressed anger, hostility	76
#13	Shame	68
#11	Depression	63
#12	Blurred role boundaries	38
#5	Pseudomaturity	32
#10	Poor social skills	29
#8	Failure to accomplish developmental tasks	28
#14	Need to keep family secrets	27
#1	Damaged goods syndrome	17
#7	Ambivalence toward non-offending parent	13
#16	Identification of self as a victim	13
#6	Identification with perpetrator	10
#15	Negative image of family	7

secrets (27). Those items chosen the least number of times were damaged goods syndrome (17); ambivalence toward the mother (13); the identification of self as a victim (13); identification with the perpetrator (10); and negative image of family (7).

The final question on the survey asked respondents to choose five of nine statements which indicated for them the most important indicators of successful treatment of sexual abuse.

22. Place a check mark before the most important indicators of successful treatment of sexual abuse. Choose up to five statements.

1. The definite termination of incestuous abuse
2. A healthier family structure with greater autonomy for all members
3. Enhanced communication
4. Improved conflict resolution skills
5. Significant improvement in the marital relationship with all parties acting more adequately

6. A decrease in the child's level of parentification
7. An increase in self-esteem & assertiveness for both non-offending parent and child
8. The non-offending parent feeling able to protect him/herself and children
9. The child believing that he/she can use non-offending parent for protection

The following table illustrates the results of the participants' responses with the actual number of times each was chosen.

Table 4.9 - Indicators of Successful Treatment of Sexual Abuse

#1	The definite termination of incestuous abuse	113
#7	An increase in self-esteem and assertiveness for both non-offending parent and child	110
#8	The non-offending parent feeling able to protect him/herself and children	86
#9	The child believing that he/she can use non-offending parent for protection	83
#3	Enhanced communication	72
#2	A healthier family structure with greater autonomy for all members	54
#6	A decrease in the child's level of parentification	36
#4	Improved conflict resolution skills	33
#5	Significant improvement in the marital relationship with all parties acting more adequately	27

CHAPTER FIVE

DISCUSSION

Evaluation of Research Procedure

This research project was initiated in an effort to determine what the experts in the field of child sexual abuse were reporting about the phenomena. It was an attempt to answer questions such as those that follow: how pervasive was the problem; which individuals were likely to become perpetrators; who was likely to be a victim; and what dynamic existed in the family to allow or prevent sexual abuse from happening. Additional questions about the individual child existed as well, such as: what were the short and long term effects of sexual abuse; what impact did the experience of disclosure have on the child, and what implications did this have on the modalities of treatment chosen. Finally, was there consistency in the findings of those treating sexual abuse victims, an what skills and strategies were these experts saying would be successful in the treatment of child victims.

Experts in the field of child sexual abuse were considered those individuals treating child victims, conducting research and writing about the results, and those whose work was considered credible by others in the field.

Information for the survey questions was taken from readings in the literature that described current research in the area of child sexual abuse. Interviews were conducted with clinicians working in the field of child sexual abuse to obtain their opinions. The survey items were reviewed by these professionals for feedback on the content of the inquiries as well as the format.

A review of the literature revealed that experts in the field were identifying significant effects of sexual abuse in the children they were treating. Researchers were treating children displaying a range of emotions, such as anger, hostility, guilt, shame and depression. These children frequently were described as having low self-esteem, poor social skills, an impaired ability to trust, blurred role boundaries and an identification of themselves as victims. Additional symptoms observed by clinicians and researchers included a need on the part of the child to keep secrets, the child having a negative image of their family, an attitude of ambivalence on the part of the child toward their mother, and an identification with the perpetrator. Experts also diagnosed sleep disturbances and nightmares in child victims. An observation of some child sexual abuse victims led clinicians to conclude that some children were also delayed or prevented from accomplishing developmental tasks within the expected range of time.

Respondents to the survey items strongly agreed with the experts, and indicated seeing all of these symptoms to some varying degree. Guilt was overwhelmingly identified, followed strongly by low self esteem, impaired ability to trust, repressed anger, shame, and depression. All of the other dynamics were identified to a lesser degree, as indicated on table 4.8.

Since the information gathered was provided by voluntary participants who completed the survey and mailed it back, the data gathered should be accurate and valid. The findings indicate that the responses of a diverse sample of mental health practitioners from the St. Louis metropolitan area appear to be consistent. Area

practitioners seem to follow similar assumptions about the definitions of child sexual abuse, and the effects and implications for treatment of children, regardless of their level of education, field, gender, or personal victimization. No significant difference could be found within the group or between the respondents and the experts.

A limitation existed in this research effort, because there was no opportunity to validate the survey by having it completed by the actual experts in the field whose works were surveyed in the literature review. Therefore, it was not possible to ascertain, at this time, if there exists agreement between the experts (those researchers and practitioners cited in the Literature review) and the respondents to the survey. However, one survey was completed by the researcher with responses considered to be consistent with those of the experts.

In comparing the results of the "experts" survey to the 134 surveys returned, it would seem that there was high agreement with the experts' definition of sexual abuse. Respondents listed either agree (34) or strongly agree (100) that sexual abuse involved any sexual activity, either overt or covert, between a child and an adult or older child, where the younger child's participation is obtained through seduction or coercion.

The results of the survey items concerning the effects of childhood sexual abuse showed strong agreement among the surveyed population. All of the items except one elicited an 87.3% agreement rate as follows: dissociation (98.5%); interference with age appropriate developmental tasks (94.7%); guilt at betraying the perpetrator (96.2%); feelings of responsibility (96.2%); repressed anger (93.2%); post

traumatic stress (91.0%); role confusion (87.3%); depression and withdrawal (97.0%); sleep disturbance or nightmares (94.7%); responsibility for disrupting the family (93.2%); and the age of the child having an effect on the severity of the impact of the sexual abuse (87.3%). The item that elicited responses with the most variation was #18: A younger child is more vulnerable to the experience because young children have only a small repertoire of coping skills. Responses indicated 46.2% agreed and 17.9% had no comment, while 35.8% disagreed.

There was less consistency within the group about treatment issues, although agreement was still fairly high, with a range from 97.0% to 57.4% on all items except one (at 23.8%). The following items elicited a high to moderate rate of agreement: In family therapy the child's rights must be protected (97.0%); sexually abused children should be provided with opportunities to express their feelings (96.2%); ideal treatment would involve individual, group and family therapy (89.5%) group therapy can improve low self-esteem and poor social skills (87.3%); early treatment can prevent dysfunctional behavior (82%); goals of sexual abuse treatment are long term (68.6%); reframing the experience can influence the effect of damaged goods syndrome (60.4%); the importance of including questions about sexual abuse in all initial interviews (57.4%); and a positive outcome being related to length of treatment (23.8%).

Implications for Future Research

One implication about the high agreement of the surveyed population on the effects of the experience of childhood sexual abuse appears to be evidence that a

unified body of information is growing. When agreement exists about the effects of childhood sexual abuse, perhaps it will lead to higher agreement about the corresponding implications for treatment. No questions in the survey used in this research project addressed the issue of the hopefulness for recovery for sexually abused children. This is certainly an important question, as information about effective treatment modalities increases among those professionals devoted to the care and service of abused children.

Survey of Child Sexual Abuse Treatment Issues

The purpose of this survey is to gather information on the opinion of therapists regarding the treatment of children who have been sexually abused. Please take about 10-15 minutes to answer the survey.

Directions

Most items can be answered by placing a checkmark (✓) in the blank box. Please respond appropriately where information is requested for other questions.

1. Child sexual abuse involves any sexual activity, overt or covert, between a child and an adult or older child, where the younger child's participation is obtained through seduction or coercion.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

2. The extreme stimulation and disruption that usually accompanies sexual abuse interferes with the normal accomplishments of age-appropriate developmental tasks.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

3. Sexually abused children rarely experience sleep disturbance or nightmares.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

4. In therapy, sexually abused children should be provided with many opportunities to express all of their feelings in a supportive environment.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

5. A positive specialized group therapy experience is an effective treatment modality for sexually abused children who have low self-esteem and poor social skills.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

6. Child victims of sexual abuse frequently repress the anger they experience.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

7. Child victims of sexual abuse rarely present with symptoms of depression or withdrawal.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

8. Victims of child sexual abuse frequently experience role confusion due to the blurring of the role boundaries between the perpetrator and the child.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

Continued on next page

9. Reframing the experience of sexual abuse, as only one of many difficult experiences that can make up a child's life, can be helpful in correcting the misperception of the child as "damaged goods".

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

10. After disclosure it is not unusual for a child to feel guilty that he/she has betrayed the perpetrator.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

11. Children frequently express feelings of responsibility for their part in the sexual behavior.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

12. Sexually abused children rarely assume personal responsibility for the disruption which often accompanies disclosure of intrafamily sexual abuse.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

13. All child victims need some level of therapeutic intervention because early treatment can prevent the emergence of destructive and dysfunctional behavior.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

14. The ideal combination of treatment modalities for sexually abused children would provide the opportunity for a combination of individual, group and family therapy.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

15. It is important for a therapist to include questions about sexual abuse in all initial interviews.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

16. Positive outcome for sexually abused children is often related to length of treatment.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

17. The age of the child at the time of the abuse is rarely a factor in the severity of the impact on the child.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

18. A younger child is more vulnerable to damage from traumatic sexual abuse because young children have only a small repertoire of coping skills.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

Continued on next page

19. Dissociation, a process of separating and isolating chunks of perception and memories is a response of some victims of child sexual abuse.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

20. From the list below, place a checkmark (✓) next to the five symptoms you see most frequently in the children you treat for sexual abuse.

- ❑ damaged goods syndrome
- ❑ guilt
- ❑ repressed anger, hostility
- ❑ impaired ability to trust
- ❑ pseudomaturity
- ❑ identification with perpetrator
- ❑ ambivalence toward mother
- ❑ failure to accomplish developmental tasks
- ❑ low self esteem
- ❑ poor social skills
- ❑ depression
- ❑ blurred role boundaries
- ❑ shame
- ❑ need to keep family secrets
- ❑ negative image of family
- ❑ identification of self as a victim

21. Many of the psychological consequences of child sexual abuse are consistent with the core features of post traumatic stress disorder.

strongly agree ❑ agree ❑ no opinion ❑ disagree ❑ strongly disagree ❑

22. Place a checkmark (✓) before the most important indicators of successful treatment of sexual abuse. Choose up to five statements.

- ❑ the definite termination of incestuous abuse
- ❑ a healthier family structure with greater autonomy for all members
- ❑ enhanced communication
- ❑ improved conflict resolution skills
- ❑ significant improvement in the marital relationship with all parties acting more adequately
- ❑ a decrease in the child's level of parentification
- ❑ an increase in self-esteem and assertiveness for both non-offending parent and child
- ❑ the non-offending parent feeling able to protect herself and her children
- ❑ the child believing that she can use her non-offending parent for protection

Continued

23. When family therapy is indicated with an incestuous family, it is imperative to ensure that the child victim's rights are protected.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

24. The goals of sexual abuse or incest therapy are long-term goals, based on the enormity of the corrective emotional experiences needed by child victims.

strongly agree	agree	no opinion	disagree	strongly disagree
❑	❑	❑	❑	❑

Please complete the following demographic data:

____ Male ____ Female ____ Age ____ Years in practice

____ Percent of caseload of child clients for whom sexual abuse is an issue

Level of education:

Undergraduate____ Bachelors ____ Masters Student ____

Masters _____ Doctoral Student ____ Doctoral ____

Field of Education:

Social Work ____ Psychiatry ____ Psychology ____

Education ____ Other (Specify) _____

Certification or Licensure/Specialty: _____

What method have you used to acquire knowledge of sexual abuse treatment issues: (Check all that apply)

____ formal education
____ working with clients
____ continuing education
____ workshops
____ colleagues
____ books, journals
____ personal victimization
____ other (explain)

February 25, 1994

Dear Colleague,

I am currently completing the requirements for a Masters of Arts degree in Professional Psychology from Lindenwood College. The final requirement for this degree is a research project. As part of my project, I have designed a survey to inquire into the theories that guide the treatment of children who have been sexually abused. My interest in this topic stems from work over the past three years with abused and neglected children at Family Resource Center where I am employed as a Family Preservation Therapist.

Your name has been suggested as a professional who would be willing to participate in a project which is concerned with sexual abuse treatment issues. Your cooperation and participation are greatly appreciated, as without it, the project cannot be successfully completed. Returning the completed survey will serve as your informed consent and agreement to participate. Please complete the survey and return it to me by March 15, 1994 in the enclosed envelope. It should only take between ten to fifteen minutes of your time to complete.

Upon completion of the study, the results will be made available to interested individuals. If you wish to receive a copy of the results, please indicate this by completing the statement at the bottom, tearing it off, and returning it to me. If you prefer to keep your response confidential, return the request slip in a separate envelope.

Again, thank you for your cooperation and participation in this project.

Sincerely,

Catherine Coyle M.A.

Catherine Coyle, M.A.
Family Therapist

Please send a copy of the results to me:

Name _____

Address _____

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