To the Graduate Council:

I am submitting herewith a thesis written by Lucile A. Mathews entitled "Child Victims of Sexual Abuse: A Comparison of Treatment Methods." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Social Work.

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CHILD VICTIMS OF SEXUAL ABUSE: A COMPARISON OF TREATMENT METHODS

A Thesis

Presented for the

Master of Science in Social Work

Degree

The University of Tennessee, Knoxville

Lucile A. Mathews

June 1980

3041875

ACKNOWLEDGEMENTS

The original idea for this paper and the methodology used to explore the subject have changed many times during the past months. Without the guidance of Dr. George W. Ayers, I would have been unable to adjust to these changes in order to complete this paper. His ability to lead and to give appropriate directions has been invaluable.

In addition, I am grateful to the other members of my thesis committee, Dr. W. David Harrison and Professor Denzel Johnston. Their interest and timely suggestions have been most helpful.

Finally, I am grateful to Ms. Janet Rosenzweig, the director of the Project Against Sexual Abuse of Appalachian Children in Knoxville, Tennessee. The material, which she generously made available to me, and her enthusiastic support were particularly beneficial.

ABSTRACT

This paper explores the treatment methods used in counseling child victims of sexual abuse. It will examine the effectiveness of treatment methods along three dimensions. These dimensions are: (1) the rate at which the families of the victims were able to remain intact, (2) the rate of recidivism of sexual abuse of the victims by the perpetrators, and (3) the degree to which self-destructive behavior of the victims was controlled or reduced.

The methodology used to explore these areas is two-fold. First, previous publications were researched to determine the need for treatment by child sexual abuse victims and the types of treatment methods presently being used by therapists. Second, a survey concerning treatment methods and statistical data demonstrating the effectiveness of the methods was sent to 19 sexual abuse treatment centers in the United States.

A review of previous research revealed that the majority of clinicians and researchers believe that child sex abuse victims are in need of treatment. Those children who are victims of sexual abuse by family members or close family acquaintances, especially surrogate parents, tend to be in need of long-term therapy, frequently psychotherapy or casework therapy. Those children, who are victims of sexual abuse by a stranger, usually can be treated with crisis intervention therapy. Further review revealed that most clinicians treat the victim as part of the family instead of a separate and distinct client or patient.

With the exception of Henry Giarretto's Child Sexual Abuse Treat-

ment Program, there is a dearth of statistical data concerning the effectiveness of the treatment methods used by therapists. This lack of statistical data was evident also in the examination of the treatment centers which responded to this author's request for program information. This lack of statistical data resulted in a very limited comparison of the treatment methods.

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INTRODUCTION

Problem Areas in Literature

Sexual abuse of children is generally considered by the lay community to be an act which rarely occurs. When it does occur, it is most often described as an act of physical violence by a psychotic stranger to a child he happened to entice with candy or some trinket. Professionals in law, social work, psychology and medicine are not greatly aware of a different interpretation of the problem. The subject is so abhorrent to most people in both the lay and professional communities, they usually dismiss indications of sexual abuse as childhood imaginations or some other convenient explanation. The underlying reason for this attitude and thinking is the general lack of information concerning sexual abuse of children. In addition, there is a specific lack of information concerning treatment methods for child victims. An illustration of this lack is found in the Comprehensive Textbook of Psychiatry-II. There was only one article on incest in both volumes of the text, and sexual abuse was not mentioned in the index. In the article on incest the treatment of the problem was discussed in approximately 500 words.[1] This sample of the scarcity of literature on treatment methods for child victims of sexual abuse is typical of the literature in general.

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[1]D. James Henderson, "Incest," Comprehensive Textbook of Psychiatry-II, ed., Alfred M. Freedman and Others (2nd ed.; Baltimore: Williams and Wilkins Co., 1975), II, 1538.

Another problem in the area of sexual abuse of children which will be addressed in this paper is the relative scarcity of treatment centers for children, who are victims of sexual abuse, and their families. This phenomenon naturally follows the lack of information in the literature as well as lack of training in most graduate schools in the areas of mental health, law and medicine.[2]

Another contributing factor to the paucity of treatment centers and methods especially for the child victim is that incest is usually kept secret either by the victim or the non-offending parent. For this reason, therapy is usually centered around the adult who was victimized as a child; thus, most treatment models are designed for the adult.[3] Only in the last few years have therapists begun to write about treatment models for child victims as the subject is gradually becoming more recognized. As a result, most of the literature on this subject is in journal form. The time required to write and publish a book has had an effect on the scarcity of literature in book form.

Purpose

During the process of reading the literature on the subject of treatment methods for childhood victims of sexual abuse, it was discovered that the description of these few methods rarely included a formal evaluation procedure. The purpose of this paper is to determine

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[2]Susan Forward and Craig Buck, Betrayal of Innocence (Los Angeles: J.P. Tarcher, 1978), pp. 177-178.

[3]Ibid., pp. 20-22.

the number and examine the types of treatment methods presently used with child victims of sexual abuse. These methods will be analyzed and compared with each other. The final procedure will be to draw a conclusion concerning the most successful method.

An important issue which will be addressed in this paper is that of the legal aspect of treating a sexual abuse victim and his or her family. In the case of sexual abuse by a stranger or someone who is not a close relative, the legal issue is not as complicated as it is when the act is incestuous. However, the prosecutor, defense attorney and judge are often guilty of victimizing the victim, intentionally or not. For example, in an attempt to avoid prosecution of cases in which the likelihood of conviction is less than very strong, the district attorney general often demands the child to be explicit and open in their discussion of the sexual abuse incident(s). This attitude by the prosecutor eliminates many cases from being tried because the child cannot meet these demands. In addition, the child often feels additional guilt about the entire series of events surrounding the actual act of sexual abuse. Therefore, one of the issues to be examined as a part of the treatment method for victims of sexual abuse is the extent to which the legal issue is addressed.

Definition of Sexual Abuse

There are various definitions of sexual abuse of children. Even though the focus of this paper is on sexual abuse in general, there must be parameters set and a specific definition of the term. According to Kempe and Kempe,

> Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles.[4]

Inherent in this definition of sexual abuse is that incest is one part of it. The literature treats incest much more thoroughly than it does sexual abuse. For the purpose of this paper, the definition of incest is overt physical contact of a sexual nature between members of the same family. Consanguineous and non-consanguineous family members are included as well as those by common law marriage. In addition, anyone who has lived with the family in a position of authority long enough for the child to look on that person as a surrogate parent is also included. Most researchers include oral-genital contact, genital and/or anal intercourse and fondling of the genitals as overt sexual abuse. Some other researchers further include explicit verbal requests for sexual contact or exhibition of the genitals in a sexual manner which causes discomfort to the child as overt sexual abuse.[5] Both of these descriptions of sexual abuse are included in this author's definition of overt physical contact. This definition is not meant to imply that covert sexual abuse is not important or of potential danger to the child. In fact, Rosenfeld states that sexual misuse of children which can be

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[4]Ruth S. Kempe and C. Henry Kempe, Child Abuse (Cambridge: Harvard University Press, 1978), p. 45.

[5]Karin C. Meiselman, Incest (San Francisco: Jossey-Bass, 1979), pp. 59-60.

disturbing to the child include such non-contact activities as continued sleeping with a child, especially of the opposite sex, bathing or bathing with an older child, allowing an older child to watch the adult dress or urinate or defecate, or to allow the child to watch sexual activities. Rosenfeld considers these activities to be seductive and potentially emotionally harmful.[6] In addition, a study by Laury shows that covert sexual stimulation by parents can lead to subsequent sexual problems. Sharing a mother's bed by a male child is an example Laury gave of covert sexual stimulation.[7] However, it is not the intention of this paper to extend the definition or exploration of sexual abuse to this degree.

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[6]Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," Psychiatric Opinion, 13(2):8 (April, 1976).

[7]Gabriel V. Laury, "Effect of Faulty Sleeping Arrangements on Children's Sexuality," Medical Aspects of Human Sexuality, 10(12):17 (December, 1976).

CHAPTER I

AWARENESS OF EFFECTS OF SEXUAL ABUSE ON CHILDREN AND THE NEED FOR TREATMENT

The Effects of Sexual Abuse

Research on incest began in America in 1937 with a study by Bender and Blau; soon to follow were researchers, Sloane and Karpinski, in 1942. However, it was 1950 before the subject appeared in professional journals with any regularity.[1] According to Summit and Kryso, prior to 1960 the literature in psychiatric journals portrayed incest as a rare incident which happened only between a retarded girl and her sociopathic, ignorant father. Even though there has been some progress made in the research of this phenomenon, there is a need for more research of victims who give evidence of harm and a continued search for those victims who do not exhibit evidence of harm. It is the opinion of these two authors that until reliable data is gathered about the many facets of incest, treatment methods and other types of intervention will continue to be haphazard and uncertain.[2] Weitzel agrees that too frequently an ill-conceived intervention or a so-called treatment plan can be more damaging than the incestuous relationship. The total disruption of a family can

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[1]Karen C. Meiselman, Incest (San Francisco: Jossey-Bass, 1979), pp. 27-28.

[2]Roland Summit and JoAnn Kryso, "Sexual Abuse of Children: A Clinical Spectrum," American Journal of Orthopsychiatry, 48(2):249 (April 1978).

heep guilt on the victim who is already feeling guilty.[3]

According to Meiselman, Cormier and his associates conducted a study concerning father-daughter incest in 1962. They were among the first authors to suggest that incest was more prevalent and covered a wider range of socio-economic strata than previously thought.[4] Since 1962 the evidence is growing to support the premise that incest is relatively widespread. However, there remains a deficiency in the literature concerning the etiology, types of participants and short-term and long-term effects of sexual abuse on the victims. According to Rosenfeld, we don't know what effect the age of the victim, relationship, duration and frequency of sexual activity and similar variables have on the victim. Because of this lack of knowledge, therapists must be very cautious to carefully assess each individual as a part of therapy.[5] Since Rosenfeld wrote the article stating this warning, there have been two significant contributions made to the literature. These books, Betrayal of Innocence by Susan Forward and Craig Buck, and Incest by Karin Meiselman, reveal some of the long-term effects of sexual abuse on the victims. Before conclusive statements can be made concerning these long-term effects, other studies must be conducted. Schultz agrees that the need for treatment of these victims lacks documentation in agency reports or social work literature.

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[3]W.D. Weitzel and Others, "Clinical Management of Father-Daughter Incest," American Journal of the Diseases of Children, 132:129 (February, 1978).

[4]Meiselman, op. cit., p. 68.

[5]Alvin A. Rosenfeld and Others, "Incest and Sexual Abuse of Children," Journal of American Academy of Child Psychiatry, 16(2):338-339 (Spring, 1977).

Most textbooks in the field do not even mention sexual abuse treatment needs or standards.[6] Rosenfeld adds that even though sexual abuse has been recognized legally, it continues to be neglected by many clinicians.[7]

Prevalence of Sexual Abuse

The reader might ask legitimately if sexual abuse of children occurs with great enough frequency to warrant increased efforts to deal with it appropriately. In a 1968 study by Gil concerning the incidence of child abuse, it was reported that there were 550 reported cases of sexual misuse of children in California during that year. This estimate was based on information received by the Central Registry of Child Abuse in California.[8] More recent studies indicate this number is a gross underestimate of the actual number of incidents. Dr. J.J. Peters states that sexual assault happens with greater frequency than thought in the past. Too often the report of sexual abuse has been attributed to the child's fantasy of an Oedipal nature since the reported perpetrator was usually the girl's father. Dr. Peters' experience at the Philadelphia Sex Offender and Rape Victim Center at Philadelphia General Hospital allows him to report the following statistics. During the years

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[6]L.G. Schultz, "The Child Sex Victim: Social, Psychological and Legal Perspectives," Child Welfare, 52:148 (March, 1973).

[7]Alvin A. Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," Psychiatric Opinion, 13(2):10 (April, 1976).

[8]D.G. Gil, "Incidence of Child Abuse and Demographic Characteristics of Persons Involved," The Battered Child, ed., R.E. Helfer and C.H. Kempe (Chicago: University of Chicago Press, 1968), pp. 21-23.

1973 through 1974, 210 of the 300 children brought to the hospital following sexual abuse were interviewed by a social worker. Thirty-two percent of these 210 children reported they considered not telling anyone about the assault. The reasons given for this hesitation were fear of their parent's reaction and/or retaliation by the offender. One victim, who had been assaulted by her uncle, said she considered not telling anyone because she did not want to get into trouble; she expressed concern that everyone would be angry with her also.[9]

Kempe and Kempe state that between 1967 and 1972 the number of sexual abuse victims examined at the Denver General Hospital increased ten times. In 1972 there were 5,000 sexual abuse cases reported for the entire country according to statistics of the Children's Division of the American Humane Society. Kempe and Kempe think that the actual figure must be ten times higher in reality. Their reasons are that there is no central mandatory reporting place and there is a general lack of reporting to police, state welfare agencies, hospitals, etc., because of the fear of retaliation, guilt, shame and unwillingness to break up the family on the part of the victim. Kempe and Kempe further state that incest incidents are more prevalent now than a decade or more ago because of an increase in the divorce rates and remarriages. Thus, people who are not related by blood are living

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[9]J.J. Peters, "Children Who Are Victims of Sexual Assault and the Psychology of Offenders," American Journal of Psychotherapy, 30(3):398 (July, 1976).

together. The taboo against incest between non-consanguineous family members is not as strong as it is for consanguineous family members.[10]

To further substantiate the prevalent thinking that sexual abuse is under reported, Gagnon conducted a study among 12,000 female college students. Of these students, 26% reported that they had been victims of sexual abuse prior to age 13. Only 6% of these respondents had reported the incidents to the authorities.[11]

Even though it is statistically uncertain the exact number of sexual abuse cases occurring in this country each year, there is growing consensus of opinion among experts in the fields of mental health and child welfare that the actual number of cases is grossly under reported.

Differences Between Sexual Abuse and Incest

As mentioned previously, there are variances in the types of sexual contact which collectively are known as sexual abuse. For the purpose of this paper, sexual abuse is distinguished from incest in that sexual abuse refers to sexual contact between a child and someone not related in some manner to that child. A review of the literature reveals that in 80% of the cases involving sexual

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[10]Ruth S. Kempe and C. Henry Kempe, Child Abuse (Cambridge: Harvard University Press, 1978), pp. 44-47.

[11]J. Gagnon, "Female Child Victims of Sex Offenses," Social Problems, 13:181 (Fall, 1965).

misuse of children, the perpetrator was known to the child and his/her family. In addition, the perpetrator is often considered an authority figure by the child.[12] Another study involving 44 child victims brought to Boston City Hospital following an incident of sexual abuse indicated that 78% of the incidents happened in the child's home. This confirms that the perpetrator was known to the family. It is further stated that since the home is normally considered safe territory by a child and there was literally no safe place in this home, the child's sense of trust for safety and responsible actions by the adult male in the home was impaired.[13]

In addition to the information that the majority of the perpetrators are not only known to the child, but are in a position of authority in the family, there is evidence in the literature which substantiates the information that there is a general lack of physical force used by these perpetrators. Peters found that 54% of the victims reported no violence or physical force.[14] Rosenfeld states that his clinical work with children at Beth Israel Hospital in Boston has revealed not only a lack of sexual abuse being the presenting problem for therapy, but a rarity for coitus to have occurred with pre-adolescent victims of sexual abuse.

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[12]Peters, op. cit., p. 399.

[13]Ann W. Burgess and Others, "Child Sexual Assault by a Family Member: Discussion Following Disclosure," Victimology 2(2):237-239 (Summer, 1977).

[14]Peters, op. cit., p. 402.

In addition, the adult was rarely orgasmic with these young victims. With the adolescent patients, Rosenfeld found that if the relationship was heterosexual, coitus often occurred with the adult being orgasmic. However, rape was a rare occurrence even with the older victims.[15]

Prevalence and Effects of Various Types of Incest

Incest includes physical contact of a sexual nature between consanguineous or non-consanguineous family members. Weitzel reports that even though sexual contact between siblings is considered to be the most prevalent type of incest, father-daughter incest is reported most frequently.[16] This is further substantiated by Meiselman in her psychotherapy sample of incest victims; she found approximately 65% to be father or step-father and daughter pairing and approximately 19% of the brother-sister category. Meiselman surmises that brother-sister incest possibly is less prevalent than other professionals in the field think Meiselman states that there is less opportunity for an older brother to initiate sexual contact with his young sister because the chance of there being an older brother-younger sister combination in a family is not as likely as there is to be a father-daughter combination. Meiselman's sample revealed no older sister-younger brother

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[15]Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," op. cit., p. 11.

[16]Weitzel and Others, op. cit., p. 128

incest combination.[17] Forward, however, states that sibling incest is by far the most widespread type of incest even though it is usually the least damaging.

Forward's experience with approximately 300 incest victims reflects that when the sibling aggressor is much older and coerces the victim to cooperate, the effects can be very damaging. In addition, the more violent the coercion, the greater the negative effects. Betrayal of trust is more keenly felt when the sibling aggressor has a position of authority, which usually accompanies age. Forward found that when the brother is much older and violently abuses his sister, he usually suffers psychological damage also.[18] Meiselman's sample included three adult men who had been the aggressor in sibling incest; two out of these three men had been involved sexually with other family members also. The one pure form experienced serious marital and sexual adjustment difficulties. Meiselman states this degree of disturbance in the male aggressor in sibling incest is rare. Meiselman concludes that brother-sister incest appears to be generally less disturbing than most other types because of the absence of the dependency role factor and the lessening of the taboo. Fewer cases are seen in research because researchers often obtain their samples from the judicial system or counseling agencies.

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[17]Meiselman, op. cit., pp. 75-78.

[18]Forward, op. cit., p. 85.

[19]Meiselman, op. cit., pp. 295-297.

Father-Daughter Incest

As previously stated, father-daughter incest represents approximately 65-80% of all types of incest. Meiselman found the fathers to be of average intelligence, rarely psychotic, and a typical member of the community in general. Unemployment did not play a particularly substantial part in the total picture. One factor did stand out; that is the use of alcohol at the time of the incest incident(s). The father was not necessarily an alcoholic; however, alcohol did seem to be used, probably to lessen the inhibitions for incest. The age at which the father initiated incest with his daughter seemed to indicate the general psychological health of his family of origin. Generally speaking, if the father waited until his daughter was pubescent, his family of origin was relatively healthy.[20]

Forward's experience reflects an incidence rate of 75% of father-daughter incest. Her description of the father is consistent with that of Meiselman. Forward states that most of these fathers are responsible in matters other than sexual impulse control with their daughters. The relationship between the father and mother is almost always poor. The father is often morally opposed to adultery; therefore, he turns to his daughter for tenderness and affection. This father does not necessarily lack morals and is often confused and disgusted at his own actions. He simply never

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[20]Ibid, p. 75.

learned to fully inhibit his incestuous desires as most of us have.[21] It is not unusual for the father to be sexually involved with more than one daughter; as the first daughter reaches middle adolescence and becomes somewhat independent, he turns his attention to the younger, less defensive daughter. By this time the father has built up strong defense mechanisms for his incestuous behavior which allows him to initiate the second affair with more ease.[22]

Grandfather-Granddaughter Incest

Less prevalent forms of incest include grandfather-granddaughter relationships. Approximately 8% of the subjects in Meiselman's psychotherapy sample reported this type. The grandfathers were not described as senile or typical of the dirty old man image. These men were gentle and non-threatening. The granddaughter was cooperative at the time of the incest, but developed serious guilt feelings later. An unexpected finding by Meiselman was that the granddaughters were the most intelligent and more representative of middle-class standards than the victims of other forms of incest. No conclusion can be logically drawn here because of the small sample, however.[23]

Grandfather-granddaughter incest represents 10% of Forward's sample. Forward has found that if the grandfather is young, the

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[21]Forward, op. cit., pp. 31, 55-56.

[22]Meiselman, op. cit., p. 329.

[23]Ibid, pp. 288-291.

dynamics are much like those of father-daughter incest. If he's older, incest might be his way of showing that he is not "over the hill." He lacks confidence in his ability to perform with a strange woman, but has no fears with his granddaughter. He is rarely forceful with his granddaughter; however, she feels much guilt after a time period of cooperation.[24]

Uncle-Niece Incest

Uncle-niece incest is rarely found represented in research samples. Meiselman surmises that because the uncle is not in the nuclear family in most cases and the dependency roles are not disturbed, the effect is not severe enough for the victim to seek psychotherapy. She concludes that if the uncle is violent or if he is a surrogate father, the damage on the victim can be severe.[25]

Father-Son Incest

Father-son incest is rare; however, of all the possible homosexual incest pairings, it is the most common. The father is not usually a psychopath; he almost always initiates the relationship. The son usually cooperates out of curiosity; the relationship is short-lived because the son cooperates only a few times. The father usually experiences great guilt. The sons have a wide range

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[24]Forward, op. cit., pp. 101-104.

[25]Meiselman, op. cit., pp. 285-288.

of outcomes represented in various studies. However, the samples in these studies are too small for conclusions to be drawn.[26]

Forward has found that father-son incest results more from a psychological breakdown in the father than a family dysfunction. Even though the father is suffering from personal conflicts, this fact is not as readily apparent as it is in the mother in mother-daughter incest. The effect on the son is severe. The son hates his role model; thus, he hates himself.[27]

Mother-Daughter Incest

Mother-daughter incest cases are extremely rare. The mother is often severely disturbed, and this is easily apparent. She is often infantile and emotionally needy; she has difficulty with the process of self-object differentiation. This mother is similar to other incest offenders in that the sexual act is an expression of a need for tenderness, affection and physical closeness.[28] Meiselman had only one victim of mother-daughter incest in her sample; in this case, the mother was emotionally disturbed as was the daughter as an adult.

Mother-Son Incest

According to Meiselman, mother-son incest is regarded as the

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[26]Ibid, p. 313.

[27]Forward, op. cit., p. 133.

[28]Ibid, pp. 118-119.

least common and the most abhorrent. Meiselman had only two cases of this type of incest in her sample. In one case, intercourse took place; the result was severe emotional disturbance for the victim. In the other case, sexual intercourse did not occur; there resulted mild disturbance for the victim.[29] Forward found the relationship between the participants of mother-son incest to be tender and loving. The mother must seduce the son overtly or covertly for intercourse to occur. The mother is usually a very needy and dependent person with a psychologically or physically absent husband. Her need to re-create a lost loving relationship with the son substituting for the father is stronger than the pure sexual need. Intercourse is very rare; in fact, this incest is usually of a covert nature.[30]

Brother-Sister Incest

In addition to the previously mentioned opinion of Forward that father-daughter incest is reported most frequently and that sibling incest is very prevalent also, Weeks states that brother-sister incest appears to happen with greater frequency than other types of pairings in the middle and upper socioeconomic levels. Father-daughter appears to happen with greater frequency in the low

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[29]Meiselman, op. cit., pp. 298-308.

[30]Forward, op. cit., pp. 73-74.

socioeconomic levels.[31] Incest, in general, seems to transcend social strata, however.[32]

Victim Typology

The sex of the incest victim is overwhelmingly female with Forward reporting the percentage to be 90% female.[33] This female is usually the oldest female child in the family; in the majority of the cases, she is pre-adolescence or adolescence. Even though this child usually is not a victim of physical force at the time of sexual contact, she is often physically abused at other times. The recent median age for an incest female victim is nine to ten years old.[34] Forward gives the median age of her clients, who were victims of incest, as seven or eight. She states she knows other therapists whose clients' ages range between 11 and 13. Forward has not discovered any evidence to suggest that either the age of the victim or the duration of the incest substantially affected the degree of emotional damage.[35]

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[31]Ruth B. Weeks, "The Sexually Exploited Child," Southern Medical Journal, 69(7):849 (July, 1976).

[32]Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," op. cit., p. 11.

[33]Forward, op. cit., p. 20.

[34]Kempe, op. cit., p. 51.

[35]Forward, op. cit., p. 20.

centers in the United States reflects the following statistics concerning the ages and/or sex of sexual abuse victims. The Family Resource Center in Albuquerque, New Mexico reports that from January, 1976 to March, 1978, 60 victims were treated of which 93% were female and 7% were male. The median age of the victims was not given. The Family Sexual Abuse Project in Edina, Minnesota reports that during October, 1978 to March, 1979 the age and sex of the typical victim is teenage and female, respectively. The Child Abuse Unit for Studies, Education, and Services in Chicago, Illinois reflects the following statistics. Of the victims, 88.9% are female and 11.1% are male. Of both sexes, 25.8% were below age six with 35.1% being between the ages of six and 11 and 39.1% being between the ages of 12 to 17. The Project Against Sexual Abuse of Appalachian Children in Knoxville, Tennessee reports that from October, 1978 to March, 1979 the child clients ranging in age from four to 17 are female 65% of the time and male 35% of the time. However, of all the child victims, a full 99% are female with only 1% being male.[36]

There are several possible reasons that male victims are seldom reported. The most obvious and simplist possible reason is that males are not frequent victims of incest compared to females. Swift suggests that the more a particular behavior deviates from the norm, the less likely a participant is to report it. The literature suggests that sexual abuse of males is considered more taboo and deviant

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[36]Berkley Planning Associates, Evaluation of the Clinical Demonstration of the Treatment of Child Abuse and Neglect, (Berkley: Berkley Planning Associates, 1979), pp. 52-53, 73, 106, 127.

than sexual abuse of females.[37] Forward adds another possible reason when she states that a male is less likely to report incest because he cannot legitimately claim to have been violated if intercourse takes place.[38]

Is There a Need for Treatment?

According to Kempe and Kempe, sexual abuse of a child robs that child of control over his own body and the right to choose his own sexual partner on an equal basis.[39] Researchers disagree with each other concerning the effect of sexual abuse in general and incest in particular have on a child. In addition, the difference between short-term and long-term effects is a source of disagreement. Even though both sides of the issue of effects of sexual abuse will be presented, it will be apparent that those researchers who believe there are serious negative effects of sexual abuse on the victims greatly outnumber those who discount or minimize the negative effects. This is true not only for this paper, but for all of the professional literature.

Bender and Grugett's report is based on their study of children who had an atypical sexual experience; they conclude that incest does

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[37]Carolyn Swift, "Sexual Victimization of Children: An Urban Mental Health Center Survey," Victimology, 2(2):323 (Summer, 1977).

[38]Forward, op. cit., pp. 76-77.

[39]Kempe, op. cit., p. 43.

not have to be damaging to the child.[40] Forward points out that the Guyon Society, which is very loosely based on the writings of Rene Guyon and Freud, advocates sex for young children with the slogan, "Sex by eight or else it is too late."[41] Yorukoglu and John Kemph studied two children, one male and one female, who had had long-term incestuous experience with opposite sexed parents. Neither of the children manifested any serious overt emotional disturbance. The authors point out that both the victims had received good mothering prior to the incest and that this might account for their ego-strengths.[42]

Some authors suggest that there is a difference between sexual abuse by a stranger and incest, or at least sexual abuse, by someone well known by the child. For example, in Sagarin's study of the effects of incest, he states that the effects of incest as well as the etiology and frequency may be found to be dependent on the variable of whether the relationship between the perpetrator and the victim is consanguine or affinal.[43]

This author's personal view is supported by that of Meiselman.

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[40]Lauretta Bender and Alvin E. Grugett, Jr., "A Follow-Up Report of Children Who Had Atypical Sexual Experience," American Journal of Orthopsychiatry, 22:836 (October, 1952).

[41]Forward, op. cit., p. 16.

[42]Atalay Yorukoglu and John P. Kemph, "Children Not Severely Damaged by Incest with a Parent," Journal of the American Academy of Child Psychiatry, 5:123 (1966).

[43]Edward Sagarin, "Incest: Problems of Definition and Frequency," Journal of Sex Research, 13(2):133 (May, 1977).

Meiselman states that incest is usually emotionally damaging to the victim because of the role reversal with the mother and the disturbed family structure which is conducive to the occurrence of incest.[44] This author believes it is probable that the two factors are likely to produce abnormalities in the development of the child(ren) even if incest does not occur. Not only is it impossible to isolate incest from the rest of the family pathology, it is necessary to view incest as a part of an even larger disturbed system and not as just an isolated sexual incident. Incest, alone, does not always create negative psychiatric conditions; however, it tends to predispose people to have certain tendencies for future sexual problems and difficult general relationships with people. Weiner states that studies of families in which incest had occurred for a long period of time reflected that the incestuous relationship seemed to be a cohesive factor. When the incest was terminated, family disruption and disintegration usually occurred.[45]

The focus of this paper is on the practical aspect of treating the sexually abused child victim. Therefore, it is academic and unnecessary to belabor the issue of which came first, the incest or the family dysfunction. The point is that the majority of professionals in the mental health field conclude that there is usually emotional damage to the child victim of the incestuous family. In

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[44]Meiselman, op. cit., pp. 55-58.

[45]Irving B. Weiner, "A Clinical Perspective on Incest," American Journal of Diseases of Children, 132:123-124 (February, 1978).

order to accurately assess the different treatment methods for child victims of sexual abuse, it is important to distinguish between the short-term effects and long-term effects.

The short and long-term effects of sexual abuse are partially contingent upon the reaction of the family, police, physicians and others to the incident(s). Adult reactions range from disgust to hysteria. If the child is not supported in her or his attempt to cope with the sexual incident, this can lead to sexual deviations and other maladaptive behaviors.[46] Children seldom react with highly visible emotional response. This could be because the incident is not usually brutal; or it could be an inability to express feelings freely. This non-verbalization is too often interpreted as absence of caring.[47] The immediate reactions to incest are feelings of guilt, a tremendous need to receive love from the abuser, stress because of the secrecy surrounding the incidents, feelings of fear and shame.[48] In addition, the victim feels used, betrayed and worthless except as a sex object. After incest continues for several months, the victim realizes she has power over her abuser and she is both loved and hated for this power. Often, after a girl seeks public help, she is regarded by friends and relatives as dangerously attractive. Thus, she is often considered "fair

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[46]Weeks, op. cit., p. 850.

[47]Peters, op. cit., p. 402.

[48]Forward, op. cit., pp. 21-23.

game" for other male relatives.[49] Even though it is rare for adolescent and most latency age female victims to develop severe psychotic breaks,[50] projective psychological tests reveal patterns of self-images of worthlessness, guilt, defenselessness and feelings of being threatened from all sides.[51] Other specific symptoms portrayed relatively quickly by some incest victims are eating and sleeping difficulties, negative feelings toward men, increased fear of being on the streets and loss of interest in school.[52]

Mental health professionals often treat people whose presenting problem is for some other emotional dysfunction; it is rare for an adult patient or client to seek therapy specifically for incest which happened during childhood. Usually, the fact that incest is in the background is revealed after therapy has progressed substantially. Heims and Kaufman conducted a study in which they concluded that adolescent girls who had been sexually abused by their fathers or step-fathers tended to develop character disorders.[53] Through her experience as a therapist with adults, who were child victims of

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[49]Summit, op. cit., pp. 243-244.

[50]Marshall D. Schechter and Leo Roberge, "Sexual Exploitation," Child Abuse and Neglect: The Family and the Community, ed., R.E. Helfer and H.C. Kempe. (Cambridge: Ballinger Publishing Co., 1976), pp. 149-154.

[51]Kempe and Kempe, op. cit., p. 54.

[52]Peters, op. cit., pp. 399-400.

[53]Lora W. Heims and Irving Kaufman, "Variations on a Theme of Incest," American Journal of Orthopsychiatry, 33:311-312 (March, 1963).

incest, Forward concludes that if the child is allowed to live with the guilt and responsibility she feels about the sexual abuse, he or she attempts to punish himself or herself for this "sin." Because of a feeling of worthlessness, the victim believes he/she does not deserve any benefits; thus, he/she creates situations in which there can be punishment through self-destructive behavior. Since trust in others is extremely difficult for these adults, they tend to marry people who will punish them and thus reinforce their feeling of worthlessness.[54] Summit and Kryso agree that female incest victims tend to marry men who will physically and emotionally abuse them; the adult female has a further tendency to set her family children up for incestuous experiences. These authors found that 90% of the women, who were in a shelter for physically abusing families, were childhood victims of incest.[55] Meiselman has done extensive research concerning long-term effects of incest. She reports that all of the adult women in her psychotherapy sample, who reported childhood incestuous incidents, felt the incidents were detrimental to their present life. The only woman who minimized the effect of incest also reported a very supportive mother who allowed complete expression of feelings. The sample showed that the majority of the women had engaged in a series of personally and sexually unsuccessful relationships with men. The minority of the women tried to avoid problems with men by isolating themselves from men. Sixty-two percent of the women experienced some

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[54]Forward, op. cit., p. 22.

[55]Summit, op. cit., pp. 247-248.

type of sexual problem; these sexual problems ranged from frigidity to promiscuity and being sexually responsive only if pain is inflicted. Meiselman states that even though there are many women who have problems in the area of frigidity and who never had an incestuous experience, when incest has occurred it has a significant effect on the woman's particular kind of anxiety and fear surrounding the sexual situation. Only a small minority of the women in the sample had strong enough homosexual feelings to cause them to engage in a lesbian relationship.

Women, who were victims of sibling incest, had great difficulty relating to their sons in such a way as to suggest displacement of feelings for their offender brothers to these sons. In addition, these sisters report sexual maladaptive behaviors. The sisters were substantially more likely to be promiscuous than were women who were victims of father-daughter incest. Meiselman concludes that incest is often carried to the next generation. Women who set their daughters up for incest generally do so because they are masochistic and passive. As a result, they do not function adequately in their marital heterosexual experiences.[56]

In summary, the short-term and long-term effects of incest are potentially devastating to the victim; however, there are so many variables at work, it is virtually impossible to accurately predict a linear cause and effect. As Rosenfeld put it, to view sexual misuse of children as a continuum showing the extent of physical contact and

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[56]Meiselman, op. cit., pp. 57-60, 183-185.

to some degree the nature of the contact does not necessarily mean that behavior found at one end of the continuum is more damaging than on the other. There is simply no conclusive evidence to support such a simplistic view.[57]

The Legal Aspect of Sexual Abuse

The legal issues involved with sexual abuse are complex because of the rights of the accused and the psychological needs of the victim being at odds with each other. As if this issue were not difficult enough, incest confuses the legal issue even more. Because the legal aspects of these offenses are so pertinent to the overall method of dealing with the child victim of sexual abuse, including incest, it is necessary to examine the legal influences.

Carla Dowben is an attorney with the Department of Obstetrics and Gynecology, which oversees eight family planning and prenatal clinics in Dallas; she reports that the number of reported incest cases is about 10-20 times as great as those in which the offender actually serves a prison sentence. She is in favor of strong legal sanctions in order to insure initiation and continuation of psychological treatment of the participants of sexual abuse.[58] There are variations in state laws concerning what legally constitutes incest and the degree to which a child victim's testimony can

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[57]Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," op. cit., p. 12.

[58]Carla Dowben, "Legal Tolerance of Incest," To be published by the National Center on Child Abuse and Neglect, D.H.E.W., Washington, D.C., pp. 1-2.

be accepted without corroborating evidence. As Slovenko reports, all 50 states have laws which prohibit incest; however, many states do not consider sexual intimacy between affinal family members incestuous. Other state laws include step and adoptive family members and have extended the consanguinal family members to include uncles, aunts, grandparents and cousins. The legal penalties for incest are just as varied with sentences ranging from 1 to 20 years depending on the degree of relationship between the participants. Even if incest between affinal participants is not prohibited, there is a law against contributing to the delinquency of a minor or child molestation.[59]

One of the most destructive legal issues to the victim is the view that judges in some states take concerning the need for a corroborating witness to testify in addition to the child. Another requirement in some states is that the prosecutor must show proof that the perpetrator used undue influence or force on the child victim. A particular deterrent to successful prosecution of an offender against an adolescent girl is that even one consented sexual act by the girl, in addition to the incest, can negate the incestuous offense. A very few states have begun to relax these requirements. In 1972, the South Dakota Supreme Court ruled that incest as a crime needed no corroboration and since the girl in question, age 11, was too young to give informed consent, she was a victim and not an accomplice.[60] This type of thinking by people in the legal pro-

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[59]Ralph Slovenko, "Incest," SIECUS Report, (May, 1979), pp. 4-5.

[60]Dowben, op. cit., pp. 2-6.

fession is rare. In addition to judicial barriers, there are emotional barriers set by family members in incest cases and the barrier of so few treatment centers. The judges, lawyers, police, etc., interviewed by Forward thought that unless the perpetrator has a history of violence, he should be ordered to receive treatment instead of sentenced to prison. However, there is a serious lack of treatment centers for perpetrators of sex crimes or their victims.[61]

Schultz has the opinion that in most sexual abuse cases, the act itself is not the most damaging component. The most damaging component is the family's reaction of horror, condemnation of the victim and desire for prosecution no matter what the consequences for the child victim. The legal system causes the victim to recreate the incident many times often in the presence of the defendant and with cross-examination by the defense attorney.[62] When the charge is incest, the emotional damage to the victim also includes increased guilt feelings about sending the father to jail, embarrassment to the family, decreased income, etc. Spencer recommends a change in the laws to reflect an understanding of the conflicts involved. In addition, legal clinics with lawyers and social workers knowledgeable about the trauma of sexual abuse should be made available.[63] Burgess reports on a program in Boston which uses

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[61]Forward, op. cit., p. 161.

[62]Schultz, op. cit., p. 151

[63]Joyce Spencer, "Father-Daughter Incest: A Clinical View from the Corrections Field," Child Welfare, 57(9):588-589 (November, 1978).

a victim consultant for sexual abuse cases. This consultant works with the child prior to the court hearing to aid in cognitive recall of the incident. The consultant continues to be available to the child and to the district attorney to facilitate uncovering the facts without serious emotional trauma to the child.[64] It is this author's opinion that a treatment center, which focuses on child sexual abuse victims, should have a legal advocate component built into the system. This component will facilitate the treatment process.

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[64]Ann Burgess and Anna Iaszlo, "When the Prosecutrix is a Child: The Victim Consultant in Cases of Sexual Assault," Victims and Society, ed., E.C. Viano (Washington: Visage Co., 1976), pp. 386-389.

CHAPTER II

METHODOLOGY

The methodology employed by this author to analyze and compare treatment methods used with child victims of sexual abuse is as follows. A list of 19 treatment centers in the United States was used from Jerome Kroth's book entitled Child Sexual Abuse. A letter was written to each center requesting information concerning their treatment methods for child victims of sexual abuse. A copy of this letter can be found in the Appendix. In addition, a report by the Berkley Planning Associates was made available to this author by the director of the Project Against Sexual Abuse of Appalachian Children in Knoxville, Tennessee. This report contains a program assessment of the project in Knoxville and three other treatment centers located in other parts of the United States.

The third source of data concerning this type of treatment method is from a review of the literature. A chart was designed to categorize the various components of treatment methods. The figure which demonstrates the use of this chart in the comparison of the two centers with statistical data, can be found on Page 63. According to Peter Kettner, there are certain components which should be included in a guideline for comparison of treatment methods. Even though Kettner wrote primarily about casework treatment methods, some of these components were considered important enough to use as

guidelines in comparing psychotherapy and casework treatment methods.[1] It is this author's opinion that involvement with the legal system is important to the overall success of the treatment of the child; it is for this reason that this component was included in the chart. Three elements by which success of treatment can be measured are the last features to be included in the chart. Advocates of a particular treatment method should specify the elements by which a method can be termed a success or failure. This author considers the three elements listed to be accurate indicators of success or failure.

For this purpose of this paper, a treatment method which can be included in this study must meet the following criteria. Part of its focus must be on the child victim of either sexual abuse in general or incest in particular. There must be a treatment plan designed to help the victim cope with his/her feelings and behavior and the reality of the situation. For example, simply the removal of the child from the incestuous home to a replacement home or to assist the mother and child in relocating is not considered treatment, for the purpose of this study. The exclusion of this service to the child is not meant to imply that it is not important; however, it is beyond the boundaries of this paper to include this type of treatment.

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[1]Peter M. Kettner, "A Framework for Comparing Practice Models," Social Service Review, 49:634-641 (December, 1975).

CHAPTER III

COMPARISON OF TREATMENT METHODS

There are many different versions of treatment modalities used in the counseling setting between a professionally trained therapist and the client or patient. For the purpose of this paper, a professionally trained therapist is defined as a psychiatrist, psychologist, psychiatric social worker or similarly educated counselor. The number of treatment methods available for use with child victims of sexual abuse is conceivably just as high as it is for all types of clients. The focus of this paper is to determine the number and types of treatment modalities presently being used with child victims of sexual abuse. The original plan included a comparison of those treatment modalities to determine the most effective method. However, because of a lack of statistical data, a thorough comparison of effectiveness is not possible. Therefore, this author will present a summary of suggestions for treatment proposed by various authors. Second, the results of this author's request for information concerning various treatment centers in this country will be given. Last, this author will present a discussion of the two treatment centers located in Santa Clara County, California and in Dallas, Texas which have released substantial statistical data and only one measure of effectiveness, respectively.

A Broadview of Treatment Selection and the Difficulties of Treatment Selection

The different treatment modalities used by clinicians for all types of clients/patients and discussed in Comprehensive Textbook of

Psychiatry - II include psychoanalysis, psychoanalytic psychotherapy (which is further delineated as insight therapy, relationship therapy, and supportive therapy), crises intervention, brief psychotherapy, behavior therapy, client-centered psychotherapy, primary therapy, transactional analysis, gestalt therapy, reality therapy, rational-emotive therapy, milieu therapy, organic therapy, humanistic treatment and family therapy. This array of therapies is not exhaustive; however, it does illustrate the large number of possible treatment modalities. According to the differences among traditional psychotherapy as a modality and the innovative forms which emphasize self-awareness, encounters, and other forms of self-realization have been obscured if not completely obliterated.[1] Most authors of the subject of sexual abuse have avoided making a choice of a single treatment modality which should be used with child victims of sexual abuse. In an article written for the benefit of doctors, not all of whom are psychiatrists, Herjanic and Wilbois state that there is not one specific prescription for the treatment of sexual abuse victims. Each victim and his/her family is unique in their dynamics and response to the abuse; therefore, the treatment method and whether counseling is even feasible or not has to be determined by the individual needs of the family.[2]

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[1]Hans H. Strupp and Grady Blackwood, "Recent Methods of Psychotherapy." Comprehensive Textbook of Psychiatry - II, ed., Alfred M. Freedman and Others (2nd ed.; Baltimore: Williams and Wilkins Co., 1975), II, 1909.

[2]Barbara Herjanic and R.P. Wilbois, "Sexual Abuse of Children: Detection and Management," Journal of American Medical Association, 239(4):333 (January 23, 1978).

The difficulty of choosing a successful treatment method to be used with victims of incest is further complicated by the fact that incest occurs as a result of many pre-determined factors. It is difficult to determine the degree of influence each contributing factor has on the incestuous situation. Most of these factors have been long-standing within the family. Both the complexity of the contributing factors and the length of their existence makes prevention and treatment of incest very complicated. Because different participants react to the incestuous situation and to counseling in different ways, the treatment must be geared individually to the specific response of the individual. Because incest means different things to different participants, the importance and the type of treatment must vary. This leads to difficulty in discussing treatment in a general way. Intensive psychotherapy or psychoanalysis is warranted sometimes. Other treatment approaches include frank discussion about sex in general and the normalcy of incestuous feelings including the acceptable, non-destructive ways these feelings can be expressed. Family therapy is often needed since there is usually a problem of role confusion among all of family members significant to the incestuous situation. If the offender has an acute psychiatric illness, successful treatment of this usually leads to a remission of symptoms of dysfunction, including incest. Henderson further states that once the incestuous behavior is reported and discussed, the likelihood of it reoccurring is slight.[3] This view of the possibility of recidivism

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[3]D. James Henderson, "Incest," Comprehensive Textbook of Psychiatry - II, ed., Alfred M. Freedman and Others (2nd ed.; Baltimore: Williams and Wilkins Co., 1975), II, 1538.

is not shared by Meiselman, who states that simply the disclosure of incest has not kept many fathers from resuming the abuse with the daughter in question or younger or more vulnerable daughters. In addition, even if incest itself does not reoccur after disclosure, the family circumstances and weaknesses which led up to the incest remain and need to be alleviated.[4]

A review of the literature has revealed many gaps in the area of effective treatment for child victims of sexual abuse. In the first place, there is not a great deal of literature on incest treatment at all. Secondly, that which does exist focuses primarily on the offender. According to Kroth, there are very few longitudinal studies which measure changes in the incest victims especially with regard to treatment effects.[5] Even though the previously-mentioned books by Forward and Meiselman were published after Kroth's book, their reports of the longitudinal effects of incest on the victim do not include a scientific study using a control group. Kroth further states that research has yet to determine a treatment method which has been proven to be the best one for victims of sexual abuse. The emphasis now is on developing a variety of approaches. Most of the agencies Kroth surveyed tended to specialize in the use of one treatment method; however, Giarretto's Child Sexual Abuse Treatment Program gives equal emphasis to individual family, couples and group counseling

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[4]Karin C. Meiselman, Incest (San Francisco: Jossey-Bass, Co., 1979) p. 340.

[5]Jerome A. Kroth, Child Sexual Abuse (Springfield:Thomas, 1979), p. 83.

using the humanistic approach at all levels of intervention. The method(s) chosen depends on the needs of the individuals involved in the incestuous situation. Kroth states this flexible approach is the most rational and practical since there is no one method proven to be the most effective.[6]

Kroth conducted a national survey of treatment agencies which are at least partially involved in counseling sexual abuse victims. He found only 9% of a total of 148 responding agencies that devote their entire program to treatment of sexual abuse. In addition, he found that 93% of the participating agencies provide social work counseling, 88% provide family counseling, 82% provide individual therapy, 63% provide couples counseling, 57% provide some form of abuse self-help groups and 51% provide group therapy. Kroth concludes that group treatment is underused although it is a good method to combat prevalent feelings of isolation.[7] Even though the literature reflects a general trend toward increased emphasis on counseling for all members of an incestuous family, there remain some examples of disregard for the victim. For example, Awad, who is a psychiatrist, describes his involvement with a family in which there had been father-son incest. He focused on short-term behavior oriented therapy for the parents; the doctor did not even mention a need for counseling for the victim.[8]

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[6]Ibid, p. 173.

[7]Ibid, pp. 167-171.

[8]George A. Awad, "Father-Son Incest," Journal of Nervous of Mental Disease, 162(2):138 (February, 1976).

This author found there is a marked lack of treatment exclusively for the child victim of incest. The exception is one treatment process which was found to focus entirely on the child. In James' work with seven teenage girls sentenced to juvenile correction centers for running away from home, and/or prostitution, she started a group treatment process. Because of geographic distance between the correction center and the girls' homes, the girls were the only ones in their families who received counseling. Even though there was some measure of success, James concluded that in her opinion and that of the girls, more success would probably have been realized if the family members had received counseling also.[9]

In cases of sexual assault, meaning rape, attempted rape or other overt sexual advances on a child by a stranger or someone barely known by the child, treatment centers tend to focus more on the child victim than they do in cases of incest. Berliner and Peters propose the use of crisis intervention with the child victim of a sexual confrontation with a stranger. A great deal of emphasis is put on helping the child readjust to the normalcy of participating in everyday activities.[10] The child should be encouraged to ventilate her feelings, but at her own rate and in her own way. Peters states

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[9]Kathleen J. James, "Incest: The Teenager's Perspective," Psychotherapy: Theory, Research and Practice, 14(2):154-155 (Summer, 1977).

[10]Lucy Berliner, "Child Sexual Abuse: What Happens Next?" Victimology, 2(2):327-330 (Summer, 1977); J.J. Peters, "Children Who are Victims of Sexual Assault and the Psychology of Offenders," American Journal of Psychotherapy, 30(3):419 (July, 1976).

that the parents should be helped to react to the situation just as they would if the child had sustained only a broken leg. Over-reaction or under-reaction by the parents can cause emotional difficulties for the child which can be more damaging than the actual sexual incident. Peters is very explicit about the likely reactions of the child and the needed responses by the parents.[11] Berliner states that in cases of incest, crisis intervention is the initial method of choice to be followed by long-term therapy; however, she does not specify or imply the type of long-term therapy.[12] This difference in appropriate treatment modalities is further discussed by Burgess, who states that crisis intervention can be the treatment of choice in situations in which the perpetrator was neither a family member nor violent. Cases in which the perpetrator was a family member but not a parent or parent figure are more complex and should be treated by having the entire nuclear family involved; short-term therapy is usually appropriate. When the father or surrogate father was the perpetrator, the treatment must focus on several facets within the family's dynamics. The child's psychosexual developmental level must be determined and treatment should be geared to foster this development. Roles and responsibilities of all the family members must be examined and corrected. Burgess believes that the types of treatment must also be geared to variables of the situation such as duration of the incest, relationship between the victim and the perpetrator and

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[11]Peters, op. cit., pp. 419-420.

[12]Berliner, op. cit., p. 328.

the amount of violence used by the offender. Burgess specifies that when there are multiple child rape victims, each one should be encouraged to individually express her feelings for the other victims at the time of the incident and at the time of the treatment. Being co-victims can be a burden to the relationship and should be addressed. Burgess further delineates the different types of rape victims ranging from physical handicaps to social handicaps.[13]

In an article written for psychiatric nurses who counsel with child victims of rape, Burgess suggests two treatment modalities. In the behavioral model the focus is on the desensitization of the child to whatever is her negative behavior resulting from the rape experience. Phobic reactions which are reported or observed are the target of change. Another suggested treatment model for the rape victim is called the psychological model in which the child is encouraged to set priority items to discuss with the nurse.[14] As discussed in the previous chapter, incest tends to be more emotionally damaging to the victim than sexual assault by a stranger or little-known perpetrator. Logic suggests that the intensity of actual treatment and related literature should focus on the victim in cases of incest. However, the opposite is true. The discussion of specific objectives and procedures of counseling child rape victims is more

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[13]Ann Burgess and Others, Sexual Assault of Children and Adolescents (Lexington: D.C. Heath and Co., 1978), pp. 67-74, 139-140.

[14]Ann Burgess and Others, "Counseling the Child Rape Victim," Issues in Comprehensive Pediatric Nursing, 1(4):51 (December, 1976).

explicit than for incest victims. Treatment for the incest victim tends to be discussed in the literature along with treatment for the entire family; this reflects the manner in which the victim is counseled.

A significant gap in the literature concerning treatment of incest is the lack of research in this area. One of the few studies is by Kennedy and Cormier in which they describe the mechanics of treatment but fail to indicate the theory base or particular treatment modality used. Their study involved 30 fathers who had had incestuous relationships with their daughters; there were 36 daughters involved in the study. The mechanics of the treatment included the following: (1) Immediate treatment following disclosure of the incestuous relationships, (2) The mother, father, daughter triad always being included with other family members involved as deemed necessary, (3) Initial level of intervention on an individual basis being followed by dyad treatment of mother-daughter and husband-wife, and (4) An immediate plan suggested to the family and to the Court. By following this procedure, Kennedy and Cormier state the majority of their subjects were able to maintain an intact family which was able to function better. When separation did occur, it was usually after careful planning with the father's continuing to give emotional and financial support; only two fathers left the family without future involvement. The authors did not state what they meant by "functioning at a better level."[15]

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[15]M. Kennedy and B.M. Cormier, "Father-Daughter Incest: Treatment of the Family," Laval Medical, 40:947-949 (November, 1969).

Most authors failed to systematically research or discuss the subject of treatment for the incest victim. In general, the literature contains suggestions such as the clinicians should be aware of the way in which the secret of ongoing sexual activity was revealed because this will have an impact on the type of reaction by the victim.[16] Sholevar contends that family therapy is the only feasible treatment model for incestuous families. He bases his belief on the approach of family therapy that adaptive or maladaptive behavior by family members is a response to forces generated by other family members.[17] Weiner states that since some incest victims are severely psychologically damaged but others are not found to have any pronounced adverse effects, clinicians should avoid stereotype notions of what treatment method will be most effective or even if all victims should be involved in treatment.[18] Still other authors propose family therapy in conjunction with individual therapy.[19] Group therapy is a treatment method which is gaining attention and acclaim with the victims as well as other significant family members.[20]

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[16]Burgess, Sexual Assault of Children and Adolescents, p. 90.

[17]G.P. Sholevar, "A Family Therapist Looks into the Problem of Incest," Bulletin of American Academic Psychiatry-Law, 3(1):29 (April, 1976.

[18]Irving B. Weiner, "A Clinical Perspective on Incest," American Journal of Diseases of Children, 132:123 (February, 1978).

[19]Frank S. Pittman, III, "Incest," Current Psychiatric Therapies, 17:131 (Annual Publication, 1977).

[20]H.C. Kempe and R.S. Kempe, Child Abuse, (Cambridge: Harvard University Press, 1978), pp. 53, 56.

Rosenfeld states that he uses the same treatment modality with child victims of sexual abuse as he does with those of physical abuse; this method involves psychotherapy for all the family members. Rosenfeld admits some success and some failures with this method and has yet to determine if this method is the most effective or not.[21] Spencer states that the emphasis should not be on the specific approach to be used as on a good understanding of the dynamics of the incestuous family. In addition to stressing the importance of protection and reassurance for the child, Spencer suggests the clinical relationship should be built on trust, support and an opportunity for the child to ventilate and deal with his/her true feelings. Spencer states that even though family therapy holds promise for some families, to use it with certain families puts the child in increased danger of having the incest repeated.[22] Unfortunately, Spencer neglected to explain the reason she thinks recidivism is likely. In a general discussion of direct social work with a child, Bond states that the extent and type of this direct service should be geared to the age of the child, the nature of the problem and the parents' capacity to allow and/or participate in the child's treatment. Kempe and Kempe sum up the matter of effective treatment by stating that the true test of successful therapy is determined by the child's ma-

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[21]A.A. Rosenfeld and Others, "The Sexual Misuse of Children: A Brief Survey," Psychiatric Opinion, 13(2):11 (April, 1976).

[22]Joyce Spencer, "Father-Daughter Incest: A Clinical View from the Corrections Field," Child Welfare, 57(9):583-589 (November, 1978).

turation into adulthood without emotional impairment.[23] This requires longitudinal studies of the child from the time of disclosure and treatment to adulthood. Even though this author agrees with Kempe and Kempe that this is the true test, it is beyond the scope of this paper to attempt such an evaluation.

A Review of Treatment Suggestions

There are several authors who have written on the subject of counseling the child victim of sexual abuse but whose works do not include a measure of success rate. Even though these works are not of primary importance in this evaluation of treatment methods, no paper on the treatment of child incest victims would be complete without a discussion of these authors and their suggestions. These various approaches to treatment will be compared on the basis of theory base(s), level of intervention and the amount of interaction with the legal system. These three categories, which are part of the criteria used to assess the treatment centers, were chosen because of their importance for a well-rounded approach to treatment. The first authors to be discussed are Brant and Tisza, who are child psychiatrists at Beth Israel Hospital in Boston. Even though their theory base was not explicitly stated, because of their educational background, it is assumed to be some type of psychotherapy or psychoanalysis. These authors recommend a team approach to work with the family. Special attention is paid to the family roles and dynamics. The child's psychosexual developmental stage determines the focus

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[23] Child Welfare League of America: Standards for Child Protective Services (New York: Child Welfare League of America, Inc., 1973), p. 40; Kempe and Kempe, op. cit., p. 54.

of his/her treatment. Treatment to family members beyond the mother, father, daugher triad is not mentioend. There is substantial interaction between the therapist and the legal system. The court is used as a powerful control device; in addition, the therapist prepares the family for court proceedings.[24]

Susan Forward, who specializes in child and adult victims of sexual abuse, uses psychotherapy with emphasis on psychodrama. The level of intervention is individually geared to each case. Forward uses individual therapy with the victim and offender; she also treats the family as a unit. Forward prefers to work with the victim in a group with other victims. Forward believes close cooperation with the legal system is needed.[25]

The next approach to be examined is that of David Walters. Walters does not specifically state his theory base but does differentiate between short-term and long-term therapy based on the needs and desires of the clients. Walters focuses on the family, but prefers to begin therapy with the child first. He advocates using two therapists; one therapist counsels the child while the other therapist deals with the adults. There is close consultation between the two therapists. Walters advocates having smooth relations with the legal system; however, he prefers that charges not be brought because

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[24]R.S. Brant and V.B. Tisza, "The Sexually Misused Child," American Journal of Orthopsychiatry, 47(1):89-90 (January, 1977).

[25]Susan Forward and Craig Buck, Betrayal of Innocence, (Los Angeles: J.P. Tarcher, 1978), pp. 163-176.

the court experience is too detrimental to the child's emotions.[26]

Charles Gentry, who is the Director of Child and Family Services of Knox County, Tennessee, has had extensive experience counseling with victims of sexual abuse. In his article Mr. Gentry does not specify his theory base. Emphasis is on encouraging the victim to ventilate his/her feelings and to improve the self-concept. In addition, the need of the child for an appropriate role model to aid the process of change is important to Gentry's treatment method. The level of intervention includes the individual and the family; if the type of sexual abuse is incest, siblings of the victim should be included also. The specific order in which treatment should occur, i.e., individual first, in conjunction with family unit, etc., was not specified; there seems to be an emphasis on the need for family therapy if the family dysfunctions are to be treated successfully. There should be cooperation between the therapeutic and legal systems so that unnecessary splitting of families will not occur.[27]

Burgess has written extensively on the subject of rape and counseling the victim from the viewpoint of a psychiatric nurse. Burgess suggests using either crisis intervention, short-term therapy or family therapy depending on the needs of the people involved. The variables which impact on the needs of the individuals have been

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[26]David R. Walters, Physical and Sexual Abuse of Children: Causes and Treatment (Bloomington: Indiana University Press, 1975), pp. 148-164.

[27]Charles Gentry, "Incestuous Abuse of Children: The Need for an Objective View," Child Welfare, 57(6):359-360, 363 (June, 1978).

previously discussed. Burgess further suggests treating the individual victim or the family unit, but does not specifically state the order of treatment. Play therapy is used quite a bit with young victims of either rape or incest. Burgess proposes extensive involvement with the legal system; her approach is to provide support for the victim through education of the court process. The importance of being an effective witness is stressed as well as giving emotional support as it is needed.[28]

The last author to be assessed in terms of treatment recommendations is Paula Slager-Journe, who has written about her experiences as a therapist involved with victims of sexual abuse. The theory base used is primarily family therapy using psychoanalytic psychotherapy with emphasis on support therapy. In addition, behavior modification can be used to treat certain symptoms exhibited by the child. The level of intervention is both individual and family unit depending on the diagnosis. If the family members have isolated themselves from outsiders, Slager-Journe proposes that the best sequence to use is individual therapy first, followed by conjoint family therapy, family therapy and later group therapy. The importance of intervention with the legal system was not addressed in the article.[29]

In summary, since only one author, Forward, was explicit in

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[28]Burgess and Others, Sexual Assault of Children and Adolescents, pp. 181-230; Burgess and Others, "Counseling the Child Rape Victim," pp. 47-51.

[29]Paula Salger-Journé, "Counseling Sexually Abused Children," The Personnel and Guidance Journal, 57:103-107 (October, 1978).

stating the theory base, it is difficult to make an accurate statement concerning the one used most frequently. Burgess uses crisis intervention in sexual assault cases in which the victim did not know the offender and was not brutalized. The other authors seem to have a theory base which is primarily psychotherapy. All of the authors use individual and family therapy. They focus on family therapy, possibly to the degree of slighting the child victim; the exception to this is Walters, who proposes the use of two therapists, one especially for the child. The other possible exception to neglect of the child's need for therapy is that used by Forward, who admittedly prefers victim group therapy. It was not clear whether Forward uses this method with child victims or victims who have reached adulthood. Most of the authors are flexible in their use of treatment models and the level of intervention. As previously mentioned in this chapter, to be rigid in these two areas is a mistake in light of the lack of data demonstrating the most effective approach. In addition, this author believes that because of the great number of variables affecting the incestuous family, the single most effective treatment method will be difficult to determine. Slager-Journé does not consider group therapy appropriate for use with children whose major problem is incest. This method is thought to be appropriate for the parents of an incest victim because the parents are often withdrawn and isolated.[30] Unfortunately, Slager-Journé gives no clear explanation of the reason to avoid group therapy with this type of child victim.

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[30]Ibid, p. 108.

The final characteristic to be summarized is the degree of intervention in the legal system. Most of the authors felt there should be some involvement with the legal system. Walters prefers that the child not be involved in the court process because the resulting emotional damage can be more detrimental than the sexual assault. Slager-Journé did not mention whether she thought any active involvement in the legal system is important or not. It would appear that it is unimportant by the fact of it being omitted from discussion.

In conclusion, the general consensus of opinion among these authors seems to be a heavy investment in family therapy with emphasis on psychotherapy except in cases of sexual assault by a nonviolent perpetrator not previously known to the victim. Burgess believes that crisis intervention is the best method for the latter type of case.

Assessment of Eight Treatment Centers

In addition to the literature which describes various treatment methods, several treatment centers have been examined concerning the treatment models used at each center. The data used are from two main sources. The first is a response to the letters sent by this author to known treatment centers in this country. Of the 19 mailed, 4 were returned because the centers were no longer at the address used; 1 was not a treatment center, and 6 responded with various information. Information sent by 1 of these 6 centers is not applicable. Therefore, only five centers sent materials that this author is able to present. Four of the 6 centers sent no specific data con-

cerning the success rate of their programs. The Dallas County Child Welfare Treatment Project had only one criteria by which success was measured. Because of this statistical information, limited as it is, the Dallas Project will be compared with the project in Santa Clara County, California. The California project has been thoroughly described in the literature. In addition, this project's relatively extensive statistical data has been released. Because of this fact, no attempt was made by this author to correspond with the center in Santa Clara County.

In addition to the four centers which responded with usable data, this author obtained a report in which four sexual abuse counseling centers were described. However, there is no specific statistical data contained in this report to indicate the success rate of the methods used. Because of interesting differences in the approaches of these eight centers, they will be compared with each other using the following criteria: (1) theory base, (2) level of intervention, target group and average length of treatment, (3) roles assumed by the therapist and client and the type of relationship established, (4) procedure and process of the treatment, and (5) the level of intervention of the legal system.

Brooklyn Society for the Prevention of Cruelty to Children, Rape Services Unit

The treatment service unit is part of a government social services department. It is presently funded to provide protective services including therapy to child victims of rape in which the perpetrator was a household member or the rape occurred as a result of

neglect by the child's parents. The theory base is not specified; since the term social worker was used in the correspondence received by this author, the likely theory base is social casework. The counselor concentrates his/her efforts on helping the child effectively cope with the emotional trauma of the rape and the ensuing court hearing. Some attention is given to the mother to help her deal with her feelings about the perpetrator, usually her husband or boyfriend. No mention was made concerning counseling the offender. The counselor is very concerned with establishing a warm relationship with the child. No specific information was given concerning the procedure or the process of the treatment. The counselor is very involved with the child in the court process by making this experience less traumatic. However, the degree of intervention in the legal system was not addressed beyond this level.[31]

Joseph J. Peters Institute

This center was formerly the Center for Rape Concern; therefore, the clientele is composed of both rape, sexual assault by an unknown perpetrator or incest victims as well as the family and/or offenders. The theory base is crisis intervention and psychotherapy. It was not specified which treatment modality was used for a particular type of client. Individual and family therapy is made available to all types of clients with parent group therapy reserved for incest

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[31]Correspondence from Robert R. Walsh, Executive Director, The Brooklyn Society for the Prevention of Cruelty to Children, February 21, 1980.

cases. None of the other criteria was addressed in the information sent to this author.[32]

Washington Department of Social and Health Services, Pierce County Child Protective Services

The treatment service unit is a part of the government agency of social services. A specialized unit composed of trained counselors provides therapy for incestuous families. The name of the model is "Incest: Family Treatment Model." The theory base was not specified; however, as the name implies, the focus in on family therapy. The Center's philosophy includes an attempt to create and strengthen individual identity boundaries within each person in the family. Because of the emphasis on developing the client's self-awareness and the intended outcome of autonomy and individuation, this author categorizes the theory base as primarily humanistic. The target group is the triad of the incestuous family. The siblings of the victim receive only indirect services. The level of intervention includes individual, dyads, groups for the victim, offender and spouse, family therapy and presentations. Presentations include voluntary contact by the client(s) in the form of talking with a new referred incestuous family or making public presentations. The minimum length of treatment time is 50 weeks for the parent's group, the offender's group and the spouse group. There is no specific time for termination of the victims' groups. The individuation of roles taken by the client(s) and therapist is not addressed; the importance

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[32]Correspondence from Linda C. Meyer, Associate Director, Joseph J. Peters Institute, February 5, 1980.

of having a non-judgemental attitude and relationship with the clients was stressed. There are certain unique procedures used by this Center which warrant attention. First, each newly referred family is contacted by a family which has almost completed the program; the main purpose is to convince the offender to enter a guilty plea with the district attorney and to accept treatment. There are other specific characteristics which the offender must have to be a candidate for this program. One of these is that the offender must not have a conviction record of similar offenses; another important criteria is that the spouse, usually the mother, must be willing to fully cooperate with the therapy. If these and other criteria are met, the child is almost always removed from the home. Since this is an unusual procedure in light of the admission of guilt by the offender and the willingness of both parents to cooperate with the therapist, the reasons for removal of the child will be explained. The first reason is to preserve the criminal evidence by keeping the child away from those who would influence him/her to withdraw the accusation of incest. Another reason is to impress upon the family the seriousness of the matter and the need for a guilty plea and complete cooperation. In addition, the spouse is often angry with the child immediately after disclosure of the incident; the child needs to be protected from being made to feel more guilty than he/she already feels. The child is returned to the home as soon as it is deemed physically and emotionally safe for him/her to be with his/her family again. The interaction with the legal system is one of the main features of the Center. Even though the offender

must be tried by the court, in all cases to date, the victim has been spared the trauma of having to testify. The family is in therapy for 90 to 120 days. This, along with diagnostic evaluations and police investigations, helps the court in making an appropriate ruling.[33]

Community Counseling and Personal Growth Ministry

This Center is separate from, but works in close cooperation with, the governmental agency for child protective services. The theory base was not specified and was not described extensively enough for this author to categorize it. The focus is family therapy with the level of intervention being individual, dyad, triad, entire nuclear family, as well as group therapy for parents and for adolescent victims. The average length of treatment is 6 to 12 months. The procedure which was discussed was that of using male-female co-therapy in any intervention level except individual therapy. The goal is to keep the family intact while changing the dysfunctional family into one that is not destructive. There is some interaction with the legal system mainly in the form of making verbal and written reports to the court concerning clients before the court; the intent is to increase interaction with the legal system.[34]

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[33]Correspondence from Peter F. Coleman, Social Workers, State of Washington Department of Health and Social Services, February 6, 1980.

[34]Correspondence from Judy Bayens, Staff, Community Counseling and Personal Growth Ministry, Grand Rapids, Michigan, February 21, 1980.

Project Against Sexual Abuse of Appalachian Children (PASAAC)

This treatment center, located in Knoxville, Tennessee, is entirely devoted to treatment of those persons involved in sexual abuse. It works in close cooperation with the child protective services governmental agency. The theory base is described as a combination of casework, psychotherapy and sex therapy. The sequencing and timing of these modalities is contingent on the assessment and diagnosis of the family members. Crisis intervention is used as a part of the casework modality. The target group is all or any part of an incestuous family or one in which sexual assault by an unknown or non-relative perpetrator has occurred. The offenders, whether in a family unit or alone, are given treatment. The usual procedure is to begin with individual therapy and continue at this level until the personal crisis is over; then there is a move into either marital or group therapy to be continued by family therapy. The average length of treatment is 9 to 10 months, but this is not pre-determined. The role of the therapist is one of active and persistent outreach, especially with a reluctant client; usually there are two therapists involved with each family. The role of the client was not specified except that he/she participates in the decision to terminate therapy. The importance of developing a trusting and caring relationship with the client is stressed. The procedure includes: (1) intake, (2) investigation if assistance is requested by child protective services personnel, (3) diagnosis and treatment planning, which is a continuous process, (4) treatment, (5) reassessment, (6) termination, and (7) follow-up. Intervention with the legal system is viewed as an

important part of the treatment process; intervention includes, but goes beyond, the usual cooperation of testifying and making written reports to the court. Personal contact with judges and district attorneys has resulted in some agreement to consider the treatment center as an alternative to incarceration of the offender.[35]

Child Abuse Unit for Studies, Education and Services (CAUSES)

This Center, located in Chicago, Illinois, is concerned with treatment of the families involved in incest; it works closely with the government agency legally mandated to provide child protective services. The theory is described as supportive psychotherapy combined with casework in which outreach and the use of community support systems is a vital part. Crisis intervention is used with each family immediately following disclosure of the secret of incest. The target group is the incestuous family with primary targets being the victim and the offender. All of the family members who are significant to the incest are included in treatment. The level of intervention ranges from individual, dyad, triad, and group therapy for the victims and family group therapy. Each of three principals involved in the incestuous situation is assigned an individual therapist. Treatment lasts a minimum of six months with no maximum time given. The role played by the therapist is a very active one; a treatment contract is drawn up between the therapist and the family in which each person agrees to do certain things. The relationship between the clients

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[35]Berkley Planning Associates, Evaluation of the Clinical Demonstration of the Treatment of Child Abuse and Neglect, (Berkley: Berkley Planning Associates, 1979), pp. 95-126.

and the therapist is one that is fostered from the first contact between them. Each case receives crisis intervention initially; after the crisis has been resolved each member is given diagnostic psychological tests as well as an assessment of the way in which the family functions. The procedure is divided into the following stages: (1) intake, (2) investigation if assistance is requested by the investigative agency for child protective services, (3) diagnosis, (4) treatment, (5) reassessment which is done weekly and quarterly, (6) termination, and (7) follow-up. The legal intervention for this treatment center is non-existent. There is another treatment center in Chicago which is based in the Cook County Juvenile Court; this center serves clients who are involved in court proceedings. Thus, CAUSES personnel treat clients in an atmosphere that is non-punitive and non-coercive.[36]

Family Sexual Abuse Project

This treatment center, located in Minneapolis, Minnesota, does not appear to be involved closely with the government agency for child protective services. Its primary function is treatment of those incestuous families which meet certain eligibility requirements. The theory base was not explicitly stated. However, this author categorizes the theory base as psychoanalytic psychotherapy with emphasis on relationship therapy. This categorization is based on the treatment description of this center and the descriptive classification of psychoanalytic psychotherapy with the sub-category of relationship

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[36]Ibid, pp. 127-160.

therapy found in the Comprehensive Textbook of Psychiatry-II.[37] Specifically, there is emphasis on the incestuous family's current conflicts; interviewing and discussion are primary techniques of exploration. The therapist and the client are very involved in defining the problems and developing a plan for treatment. The Center employs a treatment team to treat the whole family as the client. A distinguishing feature of the treatment modality is the modified use of the 12 steps used in the Alcoholics Anonymous program. The entire incestuous family is the target group. Individual sessions are conducted as needed, but are not an automatic level of intervention. Group therapy for each classification of family members is emphasized. Families are involved with various treatment team members with each person having specific roles and responsibilities. The clients are actively involved in that they write periodic self-assessments in addition to having an optional grievance procedure available. The emphasis on establishing a warm relationship between the clients and team members was not specifically addressed. The procedure in this treatment is as follows: (1) intake, (2) orientation, (3) intensive treatment, (4) reunification, and (5) aftercare. The entire treatment process is designed to last 11 months. Intensive treatment lasts 16 weeks. Reunification lasts 8 weeks; and aftercare lasts 5 months. When a family is presented for intake, two criteria must be met for the family to be eligible for treatment. First, the father must be willing to leave the home and not return until the

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[37]Strupp and Blackwood, op. cit., pp. 1911-1917.

reunification stage is determined. Second, a payment plan must be worked out. Sometimes several weeks pass before these two criteria can be met. The family receives no therapy during the interim unless a crisis arises. The only intervention with the legal system is the use of the system as a threat or actual court intervention for a family which is reluctant to be involved in treatment. The importance of further interaction with the legal system was not addressed.[38]

Family Resource Center (FRC)

This treatment center, located in Alburquerque, New Mexico, is primarily a treatment facility which is not heavily involved with the government child protective service agency. The primary theory base is casework, which is used with all families. Psychotherapy is used in addition to casework with some families. Crisis intervention is used initially to affect a significant level of change. Long-term psychotherapy and casework are seen as the most effective methods for indepth change. The target group is all child victims of sexual abuse, parents, perpetrator and occasionally the siblings of the victim. The primary focus in on the family unit. The level of intervention is determined by the treatment plan; the preferred method is to begin with the individual. As the individuals are ready, each moves to group therapy. There is group therapy for adults and one for children. The last level to be encountered is family therapy. The average length of treatment is six months for crisis intervention. Occasionally a family will accept longer-term therapy. The roles of

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[38]Berkley Planning Associates, op. cit., pp. 73-94.

the therapists include the use of a team approach with each case even though there is a primary therapist. The importance of establishing a trusting, caring relationship with the client was not specifically addressed. However, the implication drawn from the general description is that a positive relationship is very important. Everyone, including the client, participates in determining needs, assessing progress, and deciding on termination. A very thorough diagnosis and assessment is deemed paramount even in crisis intervention cases. The procedure is to set time-limited contracts with the clients; this includes options for negotiation. The intervention with the legal system is limited to discouraging criminal prosecution whenever possible and responding to requests by the court for written reports.[39]

A Comparison of Treatment Centers with Statistical Data

With the addition of three categories to evaluate the program, the same criteria used to analyze the eight previously described treatment centers will be used with the center Henry Giarretto began in Santa Clara County, California in 1971. The name of the project is Child Sexual Abuse Treatment Program. Giarretto states that the goal of the treatment program is

> to alleviate the emotional stresses of the experience and of punitive action by the community; enhance the processes of self-awareness and self-management; promote family unity and growth and a sense of responsibility to society. The purpose is not to extinguish or modify dysfunctional behavior by external devices. Rather, we try

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[39]Ibid, pp. 45-72.

> to help each client develop the habit of self-awareness (the foundation for self-esteem) and the ability to direct one's own behavior and lifestyle.[40]

Figure 1 demonstrates variables used to compare and evaluate the Child Sexual Abuse Treatment Program (CSATP) and the Dallas County Child Welfare project, both of which provide program evaluation data. The percentages of rate of recidivism and rate of families which remain intact are reported by these two centers but are invalidated by this author.

The treatment used at CSATP is the humanistic treatment method. The sequential phases of growth when this method is successfully used are: (1) self-assessment and confrontation, (2) self-identification, and (3) self-management.[41] A variety of techniques is used under the umbrella of humanistic treatment; these techniques include transactional analysis, Gestalt therapy, conjoint therapy, psychodrama, and family therapy. Special emphasis is drawn from the discipline, psychosynthesis, which stresses the self as the beginning point of growth determined by the will.

The target group is primarily composed of the family unit of incestuous families in which the father and daughter combination exists. The level of intervention involves individual therapy, dyad, conjoint, all of the children in therapy with the mother, triad, family therapy, to be followed by the self-help groups, Parents

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[40]Marshall D. Schechter and Leo Roberge, "Sexual Exploitation," Child Abuse and Neglect: The Family and the Community, ed., R.E. Helfer and J.E. Kempe. (Cambridge: Ballinger Publishing Co., 1976), p. 152.

[41]Ibid, p. 154.

Center	Theory Base	Level of intervention; target group; length of treatment	Roles and Relationship	Process and Procedure	Intervention with legal system	Rate of Recidivism	Rate of families remaining intact	Rate of victim self-destructive behavior
CSATP	Humanistic	Individual, dyad, conjoint, victim and siblings with non-offending parent, triad, family, self-help groups; Incestuous family unit; minimum of ten hours	Specific roles for clients and therapists; positive relationship is important	Well-defined process and progression of consecutive stages beginning with individual therapy	Great interaction with use of the legal system to the benefit of the entire family	0% with a minimum of 10 hours treatment	90% of children removed were returned within the first month of treatment; 95% were eventually returned	Substantially reduced; no figures available
DCCW	Humanistic	Individual, family, group; Incestuous family unit; length of treatment not given	Roles were not specified; positive relationship is important	Progression of consecutive stages not specified	Is considered important with actual intervention somewhat limited	5% with a minimum of 2 treatment hours	Not available	Not Available

Figure 1. Comparison of treatment methods used by the centers with statistical data.

United, Daughters United, and Sons United. These self-help groups originated at CSTAP have spread to a few other treatment centers. Giarretto follows a certain sequence in moving the family members from one level of intervention to another. First, the individuals receive separate counseling; when each individual is ready, the mother-daughter combination is involved together, followed by all children with the mother, husband-wife, father-daugher, the triad, then self-help groups. The minimum length of time is ten hours of treatment.

The roles of each family member and the therapist are well-defined and the tasks are specific. The therapist is involved not only in teaching techniques to enhance self-awareness but also provides support and/or referral services. These services include helping to find new housing, legal referrals and other necessities which could facilitate the clients' growth process. There is one counselor involved in therapy for the members of the triad. Relationship is an essential feature of therapy at CSATP. A non-judgemental, compassionate and caring attitude must characterize the therapist.

The client is very involved in setting goals; this is viewed as a feature of growth toward self-management. The objectives of each stage of development are carefully planned; mastery of each step is required before the next level can be attempted.

There is extremely close cooperation between the treatment center and the legal system. Giarretto states that a strong interaction with the legal system is essential to a successful treatment program;

this interaction facilitates the legal system's non-punitive intervention.[42]

CSATP has conducted its own program evaluation. Rate of recidivism of incest between the 600 father and daughters combinations, who received a minimum of 10 hours of treatment, has been zero. Of the same number of families, 90% of the children whose removal was necessary for safety reasons were returned within the first month of treatment and 95% were eventually returned. The self-destructive behavior normally exhibited by victims shortly after disclosure of the incest has been reduced in intensity and duration as treatment ends.[43]

The only other treatment center with published statistical data reflecting evaluation of the program this author was able to locate is the project in Dallas, Texas. This treatment program, which was begun by Dallas County Child Welfare (DCCW), is composed of treatment counselors from DCCW and the Texas Department of Mental Health and Mental Retardation. The project is very similar to Giarretto's CSATP, on which it was based. The similarities between the DCCW project and CSATP are in the following areas: humanistic theory base; target group of families in which child sexual abuse had occurred; level of intervention, including group, family, and individual treatment; awareness of the need to have influential intervention with the

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[42]Ibid, pp. 149-158; Burgess, Sexual Assault of Children and Adolescents, p. 232.

[43]Schechter and Roberge, op. cit., p. 157; Linda Robinson and Carol Duncan, "Incest: What is Dallas County Doing About It?" p. 7 (Mimeographed).

legal system; and the importance of establishing and maintaining a positive, caring relationship between the therapist and the client. The literature on the Dallas project did not specifically address the roles and responsibilities of the clients and therapist or the specific procedures and process through which a client moves through the various stages of treatment. Three perceived differences between DCCW project and CSATP are: (1) the lack of sequential levels of intervention through which the family must move at the Dallas project, (2) the physical separation of the Dallas project and a part of the legal system, and (3) the lack of extensive statistical data evaluating the Dallas project. This is not meant to be negative criticism of the Dallas project. In reference to the first difference, this author noticed that the Dallas clients do not enter individual therapy first to be followed by various dyads, mother and all the children, conjoint, family and finally group therapy, as is the case with CSATP clients. In reference to the second difference, there is a difference in logistics; however, the philosophy is the same. Project personnel of both centers are active and aggressive in the attempt to gain the confidence of the legal system in order to treat the incestuous families more equitably. The third difference reflects the difference in length of existence between the two centers. The Dallas project was not completely funded until March, 1978. Even though the statistical data of the Dallas project is limited, it shows that of the 60 incestuous families which participated in group therapy at least twice, there were only three cases of recidivism.[44]

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[44]Robinson and Duncan, op. cit., pp. 6-11.

Additional Research on CSATP

Because of the relatively extensive experience of the CSATP staff and the success of their own program evaluation, researchers have become interested in the program. Kroth studied 51 incestuous families involved in treatment at CSATP in an attempt to determine a measure of success for the treatment methods used. A cross-sectional study assessed the families at various times during the treatment process to determine progress or regression. The various members of these families were studied concerning 44 separate items. This author will report only a few findings in this paper. A significant statistic concerning the victims showed that after 14 months of treatment the degree of nervousness and psychosomatic symptoms (bed wetting, sleep disturbances, breathlessness) dropped from being present in 47% of the victims to 6%. In addition, signs of retarded personality development were almost completely eliminated.

Kroth states that the best measure of a center's success is the rate at which victims and families come to the center for treatment. At CSATP between 1974 and 1977 there was an average increase of 40% in the number of families beginning treatment. The reputation for success which CSATP enjoys has spread among professionals in the legal system, social service system, and among members of the general public.

Not all of the items studied by Kroth were found to be improved significantly. One of the negative findings about CSATP is that the percentage of parents who stated they would possibly keep any future molestation a secret went from 18% at the first part of treatment to

41% at the end of 14 months. Kroth suggests this is a warning for CSATP staff to effect a firmer follow-up program for program dropouts and for formally terminated clients. Another negative finding is that the unmolested siblings of the incest victim showed a higher degree of nervous symptoms than the victims did at termination. Kroth states this indicates that these siblings, who were probably not in treatment, should have been. The third negative finding shows that 36% of the incestuous families reported a problematic sexual dysfunction between the parents at the beginning of therapy; this dropped to only 24% at the end of therapy. Kroth concludes that because there should have been a more significant decrease, a more specific sex therapy program is warranted.

Kroth's overall analysis of CSATP is that even though the data, which demonstrates the success of CSATP, are only tenable, there are little, if any, data to support other approaches such as a psychiatirc-medical model, behavioral approach, etc. Giarretto's claim that 90% of families who received at least 10 treatment hours were reunited with almost no recidivism has not been matched elsewhere. Kroth concludes that the impact of the family therapy approach at CSATP for both the parents and the child victim is clear and favorable.[45]

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[45]Kroth, op. cit., pp. 84-193.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

An analysis of the eight treatment centers which lack statistical data reveals the following similarities. There is a heavy use of casework and psychotherapy with moderate use of crisis intervention. There is almost total focus on the family as the treatment unit. The levels of intervention include individual, family, dyad, triad and group therapy. Most of the centers used two or more therapists with each family.

There are several differences which are revealed through this analysis. The center located in Brooklyn stands alone in its approach to the victim as a treatment target. Because the main goal is to provide emotional support and assistance in coping with the rape incident and the following court process, the child is the primary target of treatment. There is no serious attempt to change the indepth manner in which the family functions. This limitation is very likely a result of a lack of funds. Other differences noticed concerning the level of intervention is that only PASAAC and FRC have a preferred order in which clients move from one level to another. As previously pointed out, this is an important feature in the successful Santa Clara County project.

Another striking difference is the requirement by FSAP that the father must move out of the home and a payment schedule must be set up as a pre-requisite for treatment. In the Pierce County, Washington project the child is almost always removed from the home and

the father (if he is the perpetrator) must enter a formal guilty plea. This author is reluctant to accept this as the best approach because of two reasons. The first reason is that many victims will not receive needed help because the father either refuses to move away from the home or refuses to enter a guilty plea. There is clear evidence of the difficulty in convicting child molesters as was pointed out in Chapter I. The second reason this author prefers not to remove the child from the home, except in cases of extreme emergency, is because this move adds guilt to the child, who already feels as if she were at fault. Removal is perceived by the child to be a form of punishment, which reinforces these feelings of guilt. One of the reasons given for removal of the child was to preserve the evidence; however, it was further stated that the court has yet to use a child victim so protected as a witness. It is good that the child does not have to testify; but it makes one wonder if the removal is really necessary.

The project in Knoxville has had the most success in intervention with the legal system to strengthen the position of the Center so that more incestuous families can be helped rather than punished. Full cooperation by the legal system can only strengthen the success rate of treatment. Therefore, all of the centers need to put more effort into this area of the total picture of help for the incestuous family. The child, who is the victim of sexual assault by a stranger, also needs greater understanding and protection by the legal system. Only through ongoing education of judges and attorneys can this happen.

A Comparison of Treatment Centers with Statistical Data

The same criteria used to analyze the eight previously described treatment centers were used to compare the two centers which demonstrated statistical data.

Because the Dallas project was based on CSATP, this author compared the two treatment centers in the process of describing the Dallas project. It is difficult to draw a conclusion based on the statistical data. The data of the Dallas project is simply too limited to be conclusive. The primary differences between the two centers are: (1) the lack of sequential steps of the level of intervention at the Dallas project, and (2) the lack of the use of self-help groups in Dallas. The self-help group is not to be confused with group therapy. Group therapy is a major part of the Dallas project and CSATP. A self-help group lacks a major role by a professional leader; rather the members are involved in mutual aid usually in the form of support, understanding and education.

A comparison of the eight previously analyzed treatment centers and CSATP is inconclusive also. However, the major similarities and differences will be summarized. In contrast to the Washington project and FSAP in Minnesota, neither DCCW or CSATP have any eligibility requirements for treatment. In fact, CSATP has demonstrated that these tactics are not necessary for a successful program. Another difference is that many of the eight treatment centers use a team of therapists or at least two therapists to work with a family; however, CSATP uses only one therapist for a family. Therefore, if it is more cost effective to use one therapist, this method has been proven

effective with the type of program at CSATP.

Even though all of the eight treatment centers attempted to improve the clients' self-concept, CSATP uses specific tasks and well-defined objectives for the clients and the therapists in the teaching of ways to increase self-awareness, self-identification and self-management. The other treatments lack this specificity. This author concludes that if the future statistical data of the various program evaluations are not as impressive as those at CSATP, this feature is one to consider implementing.

Another important difference noticed between the group of eight centers plus DCCW and CSATP is the emphasis CSATP places on the need to initially provide the clients with referral services or direct services to satisfy the need for housing, legal services, public assistance, etc. It is necessary for these types of issues to be resolved before the clients can be expected to concentrate on the actual therapy. This need was not specifically addressed in the literature concerning the other centers. If it is as under-emphasized in reality as it was in the literature, this is an issue which needs to be addressed by these centers.

The last major difference to be discussed is the lack of emphasis on an aggressive, but cooperative stance with the legal system. Even though the project in Washington has extremely close interaction with the legal system, it does not appear to try to change the legal system to benefit the victim. In addition to CSATP and DCCW, the only project which is taking an active, aggressive role in an attempt to change the procedure of incarcerating all perpetrators is the Knoxville project, PASAAC.

The two general similarities found with all of the treatment centers are: (1) the involvement of the client in some decision-making portion of the treatment procedure, and (2) the importance of establishing a warm, caring relationship between the therapist and the client(s). The degree to which the clients are involved in setting treatment procedures varies from center to center. It can be concluded that client involvement and rapport are important criteria for treatment.

The purpose of this paper was to compare the treatment modalities used with victims of sexual abuse and to determine the method which is most successful. Because statistical data of the various treatment centers is extremely limited, this author can only conclude that CSATP in California is the most successful center in terms of rates of recidivism of incest, families which remain intact after 10 hours of treatment and a reduction in the duration and intensity of self-destructive behavior exhibited by the victims. Hopefully, after the more recently begun centers have had more time to evaluate their programs, statistical data will be available for a more successful evaluation of the treatment models.

Some recommendations can be submitted from the comparisons of these treatment centers. Family therapy is not always the treatment of choice initially even though all of the centers use family therapy at one point during the procedure. Because family members differ in their ability to relate to each other and to the therapist, it is necessary to provide various levels of intervention for the family members.

Even though the staff at CSATP use many different treatment techniques, the treatment methods used by the centers are basically social casework, psychotherapy or humanistic. Chaneless suggests, and this author agrees, that some of the other treatment modalities need to be researched for appropriate use with victims of sexual abuse.[1] As previously stated in Chapter III, Burgess reports using behavior modification with victims of rape. Possibly this method could be used with incestuous families also.

There has been some research concerning the effectiveness of self-help groups. One study reported by Gartner and Riesmann reveals the success of a self-help group network among mental patients who were released from a mental hospital. Those former patients had a lower rate of re-entering the hospital than did the control group which did not have the benefit of self-help groups.[2] Thus, it is possible that one of the major reasons for the success of CSATP is the emphasis which is placed on participation in one of the three self help groups, Parents United, Sons United and Daughters United. Therefore, greater use of self-help groups by other treatment centers is warranted.

As this author has previously stated, a greater emphasis on active intervention with the legal system is needed. Treatment centers need to be able to use the power of the legal system to either recommend incarceration of violent sex abusers or those not amenable

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[1]Sol Chaneless, "Child Victims of Sexual Offenses," Federal Probation, 31:56 (June, 1968).

[2]Ian McNett, APA Monitor, 10(2):2 (December, 1979).

to treatment or to recommend that treatment be substituted for incarceration. Burgess has stated that one of the best ways to accomplish this intervention with the legal system is to have many face-to-face meetings with police, probation officers, judges, prosecutors and defense attorneys to convince them of the treatment center's credibility and the desire to combine practicality with compassion. Until the treatment center can establish this type of attitude, it is feasible to consider the persuasion of judges to order treatment in conjunction with the prison sentence.[3] Cooperation among the many facets of the legal system and social service system is essential in successful treatment of sexual abuse. The problem is simply too complex to expect one segment of the community system to be able to successfully master all of the different ramifications of helping the victim of sexual abuse and his or her family.

As pointed out in Chapter I, the laws regarding sexual abuse of children are not consistent among the 50 states. Giarretto calls for the need for a national position to be taken against this type of child abuse. In addition, there needs to be more effective and consistent laws and subsequent penalties. These laws and penalties should be well publicized.[4] Possibly this type of action would do for child sexual abuse what similar action has done for child physical abuse. That is to bring the subject out in the open so that the lay

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[3]Ann Burgess and Others, Sexual Assault of Children and Adolescents (Lexington: D.C. Heath and Co., 1978), pp. xxi, 239.

[4]Henry Giarretto, "The Treatment of Father-Daughter Incest: A Psychosocial Approach," Children Today, 5(4):35 (July-August, 1976).

community, as well as those professionals who have an interest in social welfare, will have the opportunity to learn more about this complex problem.

Special emphasis must be put on increased research into the treatment of sexual abuse of children with attention given to the incestuous families. This author found program evaluation of existing treatment centers to be seriously lacking except for CSATP. The treatment center in Knoxville (PASAAC) is approximately one year from having statistical data to evaluate the success of its treatment methods.[5] Hopefully, this is the case with other treatment centers.

Since the long-range effects of sexual abuse on the child are relatively unexplored, the treatment centers need to research this aspect of treatment. Special attention to the victims seems to be generally lacking among the treatment centers analyzed in this paper. It appears that it is not preferable to treat the victim separate from family therapy; however, this author is concerned that not enough attention is being paid to the special needs of the victim. Only through follow-up research with the victims after therapy and even into adulthood can we know if the present treatment methods are effective.

In addition to more research, there is a need to educate the public and professionals about the knowledge already available. For example, Burgess points out the need for more training for police, child protective service counselors, hospital personnel,

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[5]Interview with the Director of PASAAC, March 5, 1980.

teachers and other groups of people who will likely come in contact with child sexual abuse victims before the therapist is involved. If these people don't know how to best react to the child and the parents, they can cause substantial damage to the future therapy.[6] This author further concludes that education of the same groups of people to which Burgess referred is needed to train them in the area of high-risk factors so that early detection or possibly even prevention can be improved. These people should be apprised of the fact that incest happens with greater frequency than one would think and that it knows no limit in socioeconomic levels. As Meiselman points out, some of these high-risk factors are: alcoholic parents; parents whose sexual relationship is severely lacking in mutual satisfaction; parents who were child victims of sexual abuse; fathers who are domineering with passive wives who are emotionally or physically absent from the home; the jealous father; parents who are mentally ill or are of subnormal intelligence; and daughters who have assumed the role of wife and mother.[7]

Brant and Tisza report other high-risk factors which are important for public education as well as for those groups of people who are likely to come into contact with victims of sexual abuse. Research has shown that children who have been previously sexually or physically abused are likely targets of additional sexual abuse. Because of intense emotional needs, these children set themselves up for this

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[6]Burgess, op. cit., p. 144.

[7]Karin C. Meiselman, Incest (San Francisco: Jossey-Bass Co., 1978), pp. 333-334.

masochistic pleasure and attention. Therefore, foster care workers and parents need special education in recognizing the likelihood of the sexually or physically abused foster child being the victim of sexual abuse. Another high risk factor is the single parent home. In some cases, the need for closeness and affection is so strong in the single parent, the parent seeks this closeness from the child which can lead to inappropriate stimulation for the child.[8]

In addition to the need for these high-risk factors to be publicized, there is a great need for additional treatment centers for victims and families of sexual abuse. This author was able to find only 23 centers; 4 of these centers had either moved or closed and could not be contacted. Until funds and interest result in additional centers, there is a need to educate physicians who may have to fill the role of a therapist.[9] This education could be accomplished through attention to this subject in medical schools and medical journals.

In summary, this author concludes that the two major areas which warrant substantial attention is education of the lay community and professionals who are likely to be confronted with actual or potential victims of sexual abuse. The high-risk factors and present knowledge of existing treatment methods should be publicized through a national campaign against child sexual abuse. Additional research to evaluate

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[8]R.S. Brant and V.B. Tisza, The Sexually Misused Child," American Journal of Orthopsychiatry, 47(1):87 (January, 1977).

[9]Barbara Herjanic and R.P. Wilbois, "Sexual Abuse of Children: Detection and Management," Journal of American Medical Association, 239(4):333 (January 23, 1978).

the present treatment methods and to explore the use of other types of therapy has been shown to be an area which is severely lacking. For it is through progress in these two areas that the problem of treatment and prevention of sexual abuse of children can be diminished.

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APPENDIX

APPENDIX

7311 Stockton Drive
Knoxville, TN 37919
January 30, 1980

I am gathering data concerning the various treatment models used by professionals who provide therapy for child victims of sexual abuse. The data will be described and evaluated in my Master's Thesis for the School of Social Work at the University of Tennessee. This letter is a request for your assistance in providing me with information concerning: (1) the treatment model(s) used at your center, (2) the person(s) counseled, i.e., victim, perpetrator, etc., (3) the type of intervention, i.e., individual, family, group, etc., (4) attempt and/or success of attempted intervention in the legal system, (5) evaluation of the treatment methods concerning rate of recidivism, percentage of family units kept intact, etc.

In order for me to have adequate time to assess this data, I would like to have it sent to me by the latter part of February. Thank you for your assistance to me.

Yours truly,

Lucile A. Mathews

VITA

Lucile A. Mathews was born in Hawkinsville, Georgia on July 16, 1944. She attended elementary school in that town and was graduated from Hawkinsville High School in 1962. The following September she entered Wesleyan College in Macon, Georgia; in 1966 she received a Bachelor of Science degree in Physical Education. In the fall of 1967 she began teaching and continued in that profession until June 1970.

After moving to Knoxville, Tennessee in 1972, she began a career in social work at the Tennessee Department of Human Services. She entered the Graduate School of The University of Tennessee, Knoxville, in September 1978. She received the Master of Science in Social Work degree in June 1980. She will return to the Department of Human Services after being on educational leave.

She is married to W. Ed Mathews, Jr. and they have one son, William Edgar Mathews, III.