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CHILD SEXUAL ABUSE:
A COMPREHENSIVE FAMILY BASED APPROACH TO TREATMENT

Alan Carr
Department of Psychology,
University College Dublin

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Correspondence address: Dr Alan Carr, Director of the Clinical Psychology Training Programme, Dept of Psychology, Science Building, University College Dublin, Belfield, Dublin 4, Ireland.

email: alan.carr@.ucd.ie

Phone: +353-1-7062390

FAX: +353-1-7062846

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ABSTRACT

Narrow definitions of CSA which focus on repeated penetrative abuse yield prevalence rates of 2% and 4% for males and females respectively. Most abusers are male. About two thirds of all victims develop psychological symptoms and for a fifth these problems remain into adulthood. Children who have been sexually abused show a range of conduct and emotional problems coupled with oversexualized behaviour. Traumatic sexualization, stigmatization, betrayal and powerlessness are four distinct yet related dynamics that account for the wide variety of symptoms shown by children who have been sexually abused. The degree to which children develop the four traumagenic dynamics and associated behaviour problems following sexual abuse is determined by stresses associated with the abuse itself and the balance of risk and protective factors within the child's family and social network. Case management requires the separation of the child and the abuser to prevent further abuse. A family therapy based multisystemic programme of therapeutic intervention should help the child process the trauma of the abuse and develop protective relationships with non-abusing parents and assertiveness skills to prevent further abuse. For the abuser therapy focuses on letting go of denial and developing an abuse free lifestyle.
INTRODUCTION
The use of a child for sexual gratification is referred to as child sexual abuse (CSA). CSA may vary in intrusiveness (from viewing through fondling to penetration) and frequency (from a single episode to chronic abuse). A distinction is made between intrafamilial sexual abuse such as father-daughter incest and extrafamilial sexual abuse. In this paper we will be largely concerned with intrafamilial abuse. A systemic model for conceptualizing these types of problems and a family-based systemic approach to therapy with these cases will be given.

In studies of CSA prevalence rates vary from 2-30% in males and 4-60% in females (Smith & Bentovim, 1994). The female/male ratio for victims of CSA varies from 2.5:1 to 5:1. Under 20% of abuser are women. CSA occurs with children of all ages but there is a peak for girls at 6-7 years and at the onset of adolescence. Estimate of the proportion of cases where CSA is intrafamilial range from about 30% to 75%. Girls are more commonly abused intrafamilially and boys are more commonly abused extrafamilially.

SYSTEMIC MODEL OF CHILD SEXUAL ABUSE
Single factor theories of sexual abuse which focus on attributes of the victim, the abuser or the social context within which the abuse occurs have been largely superceded by systemic models which conceptualize abuse as an interactional cycle of behaviour and beliefs which involves the victim, the perpetrator and other members of the child's social system. (Bentovim et al, 1988; Finklehor, 1984; Furniss, 1991; Trepper & Barrett, 1989). Within this cycle, children with particular characteristics which render them vulnerable to abuse are abused by perpetrators who are motivated for specific reasons to abuse the child and who have overcome internal and external inhibitions which would prevent the abuse occurring.

Behaviour patterns and beliefs
The cycle starts with the abuser reflecting on the possibility of sexually abusing a child. The abuser may engage in such reflection both because of the specific trigger situation in which he finds himself and because of a general predisposition to be motivated to abuse children. Typically this motivation involves experiencing CSA as emotionally congruent, being aroused by children, and having access to adult partners blocked, for example by a spouse's unavailability through illness or depression (Finklehor, 1984). The perpetrator then creates a situation in which external factors that may prevent abuse are removed or minimized. This is facilitated, if the child has little parental supervision or support from a non-abusing parent and if the perpetrator and child are in a socially isolated situation. Once in a situation where there are few external inhibitors for CSA, the perpetrator overcomes personal inhibitions. He may minimize the impact of internal inhibitors such as guilt or fear of being caught through constructing a belief system in which the abuse is justified, its negative impact on the child is denied and the possibility of being detected is denied. Alcohol or drugs may also be used to reduce the inhibitory power of fear and guilt. The perpetrator may then coerce the child into sexual
abuse by promising rewards for compliance and threatening punishment for non-compliance with the sexually abusive acts. In response to the perpetrator's coercion, the child's resistance is overcome. The cycle may repeat the next time the perpetrator finds himself in a trigger situation. Once a pattern of abuse becomes entrenched it may continue because children fear that their own safety or the integrity of the family will be threatened if they disclose the abuse. They may also fear reprisals from others and feel intense guilt associated with a belief that they were responsible for the abuse.

**Predisposing historical contextual and constitutional factors**

A range of historical, contextual and constitutional factors associated with the perpetrator, the child and the wider family context may predispose families to the occurrence of child sexual abuse.

**Perpetrator factors.** A range of factors underpin perpetrators' motivation to abuse including being aroused by children, and having access to adult partners blocked, or having limited skills for making and maintaining non-coercive sexual relationships. Historically personal experience of being abused may render the perpetrator vulnerable to experiencing CSA as emotionally congruent.

**Victim factors.** The child may be predisposed to being unable to resist abuse because of lack of strength, lack of assertiveness skills, fears about the consequences of not engaging in abuse or the presence of a physical or intellectual disability. Following the abusive acts, children's resistance to further abuse may be weakened because they may believe that they were partly responsible for the abuse and because they fear the consequences of disclosure.

**Family factors.** Bentovim et al (1988) provide an important account of disorganized and overorganized patterns of family functioning which are commonly observed in cases of father-daughter incest. In disorganized families, CSA occurs because the chaotic way the family functions entails few external inhibitors for the father's or older sibling's abuse of the children. The father typically abuses a number of children and this is partially acknowledged within the family but kept secret from the public. The father bullies the family into accepting his right to abuse the children, so the abuse serves to regulate conflict within the family.

Overorganized families function in an apparently ideal fashion with an idealized marriage and apparently adequate child care. The father, typically abuses a single child and this is kept secret and remains unacknowledged within the family. Sexual dissatisfaction within the marital relationship, conflict-avoidance within the marriage, and a non-supportive relationship between the abused child and the mother characterize these families. Physical illness or psychological problems such as depression may contribute to the mother's involvement in an unsatisfying relationship with her partner and an unsupportive relationship with her daughter. The father and daughter may take on parental roles with respect to the ill mother or the father may take on the role of the bully to whom both his partner and daughter are subordinate. In other instances sexual dissatisfaction within the marriage may be associated with the father viewing himself as subordinate to his partner. In these cases, the father and daughter may both adopt child-like roles with respect to the mother.

In both overorganized and underorganized families a central risk factor is the absence of a supportive and protective relationship between the non-abusing parent and the child.
Effects of CSA

Sexual abuse has profound short and long-term effects on psychological functioning (Berliner & Elliott, 1996; Kendall-Tackett, Williams & Finklehor, 1993; Wolfe & Birt, 1995). About two thirds of sexually abused children develop psychological symptoms. Behaviour problems shown by children who have experienced sexual abuse typically include sexualized behaviour, excessive conduct and emotional problems, school based attainment problems and relationship difficulties. In the eighteen month period following the cessation of abuse in about two thirds of cases behaviour problems abate. Up to a quarter of cases develop more severe problems. About a fifth of cases show clinically significant long-term problems which persist into adulthood.

One of the most useful models for conceptualizing the intrapsychic processes that underpin the behaviour problems or symptoms that arise from sexual abuse is Browne and Finklehor's (1986) traumagenic dynamics formulation. Within this formulation, traumatic sexualization, stigmatization, betrayal and powerlessness are identified as four distinct yet related dynamics that account for the wide variety of symptoms shown by children who have been sexually abused.

With traumatic sexualization, the perpetrator transmits misconceptions about normal sexual behaviour and morality to the child. These may lead the child in later life to either engage in oversexualized behaviour or to avoid sex.

With stigmatization, the perpetrator blames and denigrates the child and coerces the child into maintaining secrecy. Following disclosure, other members of the family or the network may blame the child for participating in the abuse. The child develops negative beliefs about the self including the ideas of self-blame and self-denigration. These beliefs lead to self-destructive behaviours such as avoidance of relationships, drug abuse, self-harm and suicide. The child may also internalize the abuser's demand for secrecy and dissociate whole areas of experience from consciousness. These dissociated memories may occasionally intrude into consciousness later in life as flashbacks.

The dynamics of betrayal begin when the trust the child has in the perpetrator is violated and the expectation that other adults will be protective is not met. These violations of trust and expectations of protection lead the child to believe that others are not trustworthy. This loss of a sense of trust in others may give rise to a variety of relationship problems, to delinquency and to intense feelings of sadness and anger.

The dynamics of powerlessness have their roots in the child's experience of being unable to prevent the abuse because of the perpetrator's use of physical force and psychological coercion. This may be compounded by the refusal of other members of the network to believe the child or take effective professional action. The child, as a result of this experience of being powerless, may develop beliefs about generalized personal ineffectiveness and develop an image of the self as a victim. These beliefs may lead to depression, anxiety and a variety of somatic presentations. The experience of powerlessness may also lead to the internalization of a victim-persecutor internal working model for relationships, which sows the seeds for the child later becoming a perpetrator when placed in a position where an opportunity to exert power over a vulnerable person arises. Factors
associated with child protection processes including a lack of support at disclosure, multiple investigative interviews, multiplacement experiences, extended legal proceedings and proceeding which are not child centered or child-friendly all contribute to the powerlessness dynamic.

**Protective factors**

A number of factors have a positive influence on the outcome for children who experience CSA (Browne & Finklehor, 1986; Kendall-Tackett, Meyer-Williams & Finklehor, 1993; Spaccarelli, 1994, Furniss, 1991). Better adjustment occurs where the CSA is less severe and chronic and where it occurred as a single form of abuse rather than in conjunction with physical abuse or neglect. Whether the abuse was perpetrated by a family member or by someone outside the family affects outcome because it has a bearing on the degree to which trust was violated. The less trust was violated the better the child's adjustment following abuse. At a personal level, specific characteristics and skills of abused children are protective factors. Important protective factors include assertiveness skills, physical strength, and functional coping strategies like seeking social support and using socially supportive relationships as opportunities for catharsis. For intrafamilial sexual abuse, a strong supportive relationship with the non-abusing parent is a critical factor for insuring adjustment following abuse. Support for the victim from members of the extended family is also a protective factor.

**FAMILY BASED TREATMENT FOR CSA**

In families where CSA has occurred effective therapy programmes are premised on a broad based assessment. Following the work of Trepper and Barrett (1989), Giaretto's (1882), and the Great Ormond Street Group (Bentovim et al, 1988; Furniss, 1991) it is now best practice to offer family based treatment following thorough assessment. Family based programmes typically include intensive group work and dyadic work with family subsystems also. Thus, alongside regular whole family meetings, group therapy may be offered to the abused girls from a number of different families together. In parallel with this, the abusing fathers from a number of families may complete a group work programme together. Concurrently the mothers from these families may attend a group work programme together and so also may the siblings. Concurrent mother-daughter sessions and couple sessions are also held in this multisystemic approach.

**Contracting for assessment**

A contract for assessment with the possibility of subsequent family-based treatment may be offered to families in which father-daughter incest has occurred. Contracting for assessment in cases of CSA may take a number of meetings. Initially it may be useful to meet with the involved statutory professionals including the referring agent. These statutory professionals may be from probation departments, child protection agencies or specialist mental health agencies. The aim of this meeting is to establish that a referral is being made from a statutory agency to a treatment agency, and the
respective roles that these two agencies will adopt if the family agree to an assessment contract. Ideally the statutory agency will agree to monitor the compliance of the family with protective living arrangements for the victim. This may include the father living out of the house or the child being in care. The statutory worker may also take the role of keeping the appropriate courts or legal authorities informed of the any non-compliance with assessment and treatment. The family treatment service ideally, should agree to confine their input to assessment and subsequently treatment, if that is appropriate and decline to take on any statutory responsibilities. Once the roles of the statutory referring agent and the family therapy service are clear, then a three way meeting involving the statutory service, the family therapy service and the family may be held.

The outcome of this three way contracting meeting should be that the statutory referring agent is viewed as enlisting the aid of the family treatment agency to help the family reduce the risk of further CSA, and to assess whether family reunification is a viable long-term therapeutic goal. The perpetrator may acknowledge his ambivalence but agree to attend therapy because he wants to remain connected to the family and (in some jurisdictions) avoid legal sanctions. In cases where the child is in care, the foster parents or child-care workers should be invited to this contracting meeting and be asked to agree to facilitate regular and frequent supervised access between the parents and the child. Finally, agreement should be made to reconvene after a family assessment has been conducted to give feedback on whether or not the family therapy service judge the family to be suitable for family treatment.

Family treatment services should decline referrals where the victim is unprotected during family assessment and treatment, since to offer clinical services in the absence under such circumstances may maintain the abuse. Ideally, the father/perpetrator, not the child/victim should move out of the house, since this sends a clear message about the victim's innocence and need for protection and the perpetrators guilt and requirement for atonement.

Assessment
To illustrate the process of assessment and treatment, an example of a case of intrafamilial sexual abuse is presented in Figure 1. A three column formulation of the abusive process is given in Figure 2. A formulation of exceptions to this process is given in Figure 3. The first aim of family assessment is to construct three column formulations, like those presented in Figures 2 and 3, of the abusive process and exceptions to it. In constructing a problem formulation, the behaviour pattern containing the abusive act is set out in the right hand column of the formulation. The belief systems which subserve this are placed in the middle column and the predisposing risk factors are placed in the left hand column. In constructing an exception formulation, the behaviour pattern in which the abuse was expected to occur but did not, is placed in the right hand column of the formulation. The belief systems which subserve this exceptional non-abusive episode are placed in the middle column and the protective factors are placed in the left hand column. Constructing both problem formulations and formulations of exceptions to the problem is important, since it is the exceptions to the problem that
provide the basis for many aspects of effective treatment (Carr, In Press; Miller, Hubble, Duncan, 1996; White, 1995).

The second aim is to assess the family's capacity to benefit from family based treatment. A comprehensive schedule of assessment procedures is presented in Table 1. The schedule includes provision for assessment of all relevant family subsystems and their relationships with members of the wider professional network. Assessment may span a number of sessions and include sessions with various subsystems of the family and aspects of the wider social network. Initially assessment should focus on a reconstruction of the abusive incident and previous similar incidents, i.e. the problem maintaining behaviour pattern. Belief systems of parents and other family and network members that underpinned action in this cycle of abuse and secrecy may then be clarified. Of particular importance here is the process of denial of the abuse by the perpetrator. These belief systems in turn may be linked to predisposing risk factors which have been listed above in the systemic model of sexual abuse. In constructing a three column formulation of exceptions to the abuse, the victim's capacity to resist the perpetrator and the capacity of the mother to protect and support the child deserve particular attention.

The abuser's response to confrontation of his denial requires careful attention during assessment. The process of confronting the denial of the abusing parent may be conducted in different ways. Some professional confront the abuser themselves in individual interviews. Others, show the abuser a videotape or transcript of the child's account of the abuse. Other's favor family confrontation sessions in which the abused child supported by the whole family confront the abuser. Whatever method is used, the aim of this procedure is to determine the openness of the abuser to giving up denial and to do this without unduly distressing the abused child. Abusers engage in denial because giving it up may entail leaving the family home; prosecution; social stigmatization and personal admission of guilt. It is, important to empathize with the alleged abuser about his reasons for engaging in denial, and to preface this with the statistic that in less than 10% of cases do children make false allegations (Jones & McGraw, 1987).

Furniss (1991) has developed a hypothetical interviewing style that he uses in family interviews where one or both parents deny the abuse. He explores who within the family is best and worst at bottling-up secrets (such as birthday surprises). He asks each family member what they believe would happen if the abuse had occurred and the abuser admitted to it. Who would be responsible for the abuse. Who would be responsible for protection. What would be the consequences for those who failed to protect the child. What would be the consequences for each family member of lack of trust.

For eventual partial or complete family re-unification, the non-abusing parent must be able to confront the abusing parent; ask him to leave the house; and then later decide whether to work towards permanent separation or family re-unification whichever is the preferable option. To be able to follow this route there must be sufficient differentiation within the marriage, at the time of disclosure for the non-abusing parent to be able to confront the abuser. Observing how the mother manages
these challenges and draws on professional support and support from the extended family to do so is a critical part of the assessment process.

**Contracting for treatment**

When contracting for treatment, following assessment, the referring statutory professional, the family therapist or therapy team and the family should attend the contracting meeting. A three column formation of any exceptions to the abusive patterns and a three column formulation of the family process in which the abusive incident was embedded, constructed with the family during the assessment process, should be outlined. In light of this a statement should be made about the capacity of the family to benefit from family based treatment. The checklist set out in Table 2 offers a framework for assessing a family's capacity to engage in treatment. Where the perpetrator accepts responsibility for the abuse, where both parents are committed to meeting their child's needs; where they are committed to improving their own psychological well-being; and where they have the ability to change by reducing denial and increasing protectiveness, the prognosis is good. Where less than three of these conditions are met, it is unlikely that even the most skilful professional team would be able to offer a viable treatment package. In such instances family re-unification is not a valid treatment goal.

If the family therapy service can offer treatment to the family because it meets the criteria for treatment suitability, then specific goals, a clear specification of the number of treatment sessions and the times and places at which these sessions will occur should all be specified in a contract. Such contracts should be written and formally signed by the parents, the family therapist and the statutory referrer. The treatment contract should be designed to help family members meet these specific goals and progress should be reviewed periodically. Treatment goals for sexually abused children may include:

- Developing assertive self-protective skills
- Developing a protective relationship with the non-abusing parent or carer
- Learning to control conduct and sexualized behaviour problems
- Processing intense emotions associated with the abuse and related coercion
- Developing a positive view of the self
- Being open to negotiating a relationship with the abuser that has appropriate boundaries.

These goals rest on the assumption that for sexually abused children to avoid re-abuse, they need to be able to deal assertively with potential abusers and to develop a trusting and confiding relationship with a non-abusing parent. They also need to deal with the behavioural and emotional sequelae of abuse. For managing the behavioural difficulties associated with sexual abuse they need to develop self-control skills to them prevent acting out sexual and aggressive impulses. For managing the emotional difficulties associated with abuse they need to repeatedly remember, in a supportive therapeutic context, their memories of the abuse which are being suppressed, dissociated or otherwise avoided. This re-exposure is essential for emotional processing of traumatic memories. Sexually abused children also need opportunities to reflect on their strengths, their positive qualities and their
positive relationships so that they can develop a positive and non-victimized self-image. Finally, in cases of incest particularly, children require opportunities within which to consider the possibility of forgiving the abuser and developing a relationship with the abusive parent within which they are protected from the risks of further abuse.

Typical goals for non-abusing parents or carers in CSA cases are:

• Learning how to offer the abused child a protective and supportive relationship
• Working through the mixed feelings arising from the abuse.

These goals rest on the assumption that for non-abusive parents to prevent further sexual abuse, they need to foster trust in their relationship with their abused child. In cases of incest, it is vital that the non-abusing parent be given an opportunity to deal with their mixed feelings and divided loyalties concerning their abusive partner and their abused child.

Typical treatment goals for perpetrators of CSA include:

• Giving up denial and accepting full responsibility for the abuse
• Developing a lifestyle that does not involve sexual abuse
• Demonstrating remorse and offering a full statement of responsibility and apology to the abused child and other family members.

These goals rest on the assumption that for the risk of abuse to be diminished the abuser must be given the opportunity to 'own' and take full responsibility for their abusive behaviour and its consequences. An outcome of this is a stated commitment not to re-abuse and to develop a pattern of living that minimizes opportunities for re-abuse.

These child-focused and parent-focused goals may all be achieved within the context of a multisystemic intervention programme which includes regular family therapy sessions and concurrent group therapy for individual family members, with mother-daughter sessions and couple sessions scheduled as required.

**Family treatment interventions**

Ideally the abuser must live outside the family for the duration of the therapy, until the family develops protective patterns of interaction to prevent re-abuse. This may require at least a year of work. In many cases of father-daughter sexual abuse, family re-unification may not be possible and therapy may aim to negotiate a protective home environment in which it is safe for the father to have periodic supervised access to the children. To conduct family therapy in situations where the abuser is still strongly locked into denial and the non-abusing parent has not yet taken a protective stance towards the abused child compounds the abused child's distress and should not be done.

Family therapy sessions are a forum in which the reality of sexual abuse is shared by all family members, and the three column formulation is offered as a map which highlights the abuse maintaining roles of all family members within this and the belief-systems which allow these roles to persist. However, family sessions are also a form within which the three column formulation of those exceptional circumstances within which abuse was expected to occur and did not may be explored further with a view to building on the family strengths inherent in these exceptions.
Each time a family session occurs and the reality of the abuse is acknowledged by all family members, the processes of denial, secrecy and coercion that accompanied the abuse are further weakened. Family sessions provide a forum where siblings can contribute to supporting a family ethos that undermines the secrecy of abuse. Where siblings have been abused or have been in danger of abuse, this may emerge in whole family meetings.

The development of a more protective relationship between the non-abusing parent and the abused child may be identified as a particular focus for work to prevent the recurrence of the abuse. This work may require the child to express her anger and disappointment to the non-abusing parent and the non-abusing parent to express regret and guilt. Mothers, in cases of father-daughter incest face many obstacles in reaching a position where they can wholeheartedly support their abused daughters. Many mothers view supporting their daughters as synonymous with leaving their husbands. When the abused child and the non-abusing parent have expressed their views about the past and their roles in the abuse maintaining system, the focus moves to ways in which the abused child and the non-abusing parent may spend time together to develop a supportive relationship. Often this will involve closing the emotional gap that has developed during the period of the abuse.

A difficulty with this type of work is that while the non-abusing parent is trying to develop this supportive relationship with the abused child, the abused child will typically be showing a range of conduct, emotional and sexualized behaviour problems. Behavioural family work on these using contingency contracts and reward systems for appropriate behaviour will be required. This work, will help non-abusing parents draw a clear generational boundary between themselves and the abused child. The struggle around these issues of behavioural control may span a considerable period of time, since a lack of appropriate generational boundaries is an integral aspect of child sexual abuse. Non-abusing parents may use the forum of group therapy to seek support during these difficult struggles. Abused children may use individual or group therapy as a forum for developing self-control skills also.

Once the relationship between the abused child and the non-abusing parent has become protective and a firm integenerational boundary has been drawn and once the abusing parent’s denial has begun to decrease markedly as a result of group therapy for abusers, a series of sessions in which the abused child and the protective parent meet with the abuser may be convened. In these sessions the abused child supported by the protective parent confronts the abuser with their experience of the abuse and forcefully expresses the anger and distress associated with abuse, the coercion and the secrecy and requests that the abuser give up denial. It is important that in these sessions that the full impact of the abuse on the child be made clear to the abuser. When the abuser says that he wishes to give up denial and apologizes and makes a commitment that he will not re-abuse the child again, the more family members that are a witness to this the better. It may be appropriate to involve all siblings and members of the extended family in this apology session. However, it is important that the abused child feel no pressure to forgive the abuser. Abused children may say that they hope they will be able to forgive the abuser when he has consistently shown over a period of years that he can be true to his word. Apology sessions work best if the abuser is helped in
individual sessions to construct a written apology which is read out during the apology session. There is a danger if the apology is not written, that under pressure in the apology session the abuser will lapse into justifications for the abuse and denial of responsibility.

At this stage, a series of sessions for the mother and father may be held. These sessions may be used to help the couple work through the feelings that they have for each other arising from the abuse. Abusers may use these sessions to express guilt and remorse. Non-abusing parents may use the sessions to express anger and disappointment. There may then be a shift in focus to the present and to planning either the gradual reintroduction of the abuser into family life or separation. In either situation the therapist coaches the couple in problem-solving and communication skills since problems in conflict management is a central difficulty for many families in which abuse occurs. Overorganized families tend to avoid conflict, and often abuse is part of a conflict avoidance behaviour pattern. Under-organized families tend to use acting-out sexually or aggressively as a way of regulating conflict.

The overall strategy for communication and problem-solving skills training is to explain the skills and point out how necessary they are for jointly handling stressful child-care tasks. Then couples are invited to demonstrate their current level of skill development by taking a non-emotive issue and communicating or problem-solving around it. The therapist then gives feedback, first indicating the couples competencies and then pinpointing areas where improvements are required. Once the couple show competence in managing non-emotive issues, they are invited to progress to discussing emotive issues. The therapist interrupts them when they break the rules of good problem-solving or communication and coaches them back on track. Homework assignment which involve practicing these skills are also given.

In communication training, couples need to be trained in both listening to each other and in sending clear messages to each other. Listening skills include giving attention without interruption, summarizing key points made by their partner and checking that they have understood accurately. Skills required to send clear messages include discussing one problem at a time; being brief; deciding on specific key points; organizing them logically; saying them clearly; checking that they have been understood and allowing space for a reply. Couple are encouraged to make congruent "I statements rather than "you statements" or declarations. Couples are praised for avoiding negative mind reading, blaming, sulking, name-calling or interruptions.

Problem solving involves defining large, vague and complex difficulties as a series of smaller and clearer problems; brainstorming options for solving these smaller problems one at a time; exploring pros and cons of each option; agreeing on a joint action plan; implementing the plan; reviewing progress; revising the original plan if it was unsuccessful; and celebrating if it was successful.

Once couples have been coached in the basics of communication skills and problem solving skills, they are invited to use them to try to solve emotive problems associated with joint child care responsibilities such as who should feed and change the baby on specific occasions and how personal time away from the responsibility of child-care should be organized for each person. The
therapist should praise couples for using skills correctly and get them back on track of they fail to use problem solving and communications skills correctly. They should also be encouraged with emotive problems to declare that the problem (not their partner) makes them feel bad and to acknowledge their own share of the responsibility in causing the problem (rather than blaming their partner). They should be encouraged to anticipate obstacles when engaging in problem solving.

**Concurrent group therapy for abused children**

Group therapy may be conducted as a short term (12 session) programme with 5-8 group members in a closed group. For these groups to work well it is useful if they are fairly homogeneous, with participants being the same age and having suffered either intrafamilial or extrafamilial abuse. Ideally such groups are run jointly by a male and female therapist who offer the child an alternative model of parenting, to that offered by their own parents, marked by openness, clear communication and respect. Group work for abused children provides a forum in which they can recount and remember the traumatic abusive events and ventilate their intense mixed feelings about the abuse. These feelings include anger, sadness, anxiety, loyalty, sexual feelings and confusion. Often these intense feelings and related memories have been spit-off from awareness and have not been integrated into the children's views of themselves. Through recounting and remembering, this material may be processed and integrated into the view of the self. Gradually children may reach a situation where they explicitly recall the abuse and the feelings, both negative and positive associated with it. They must be helped to clarify that it was the abuser who was guilty and not them, although things that the abuser said may have made them feel guilty as may the pleasurable aspects of sexual arousal that they may have felt. They may be offered an opportunity to experience their anger towards the abuser, their fear of him, their sadness at the loss of the type of relationship they would have liked to have had, their anxiety that the family may split up for ever, and their continued loyalty to the abuser and guilt about disclosure which conflicts with their feelings of loyalty to the abuser. Anger at the non-protective parent may also be explored and sadness that the non-protective parent was unable to help.

A second function of the group is to learn to distinguish between needs for affection and care on the one hand and sexual needs on the other. Abused children may have difficulty making this distinction and may therefore signal to peers or carers that they require sexual gratification when they actually want emotional support. In this context information about normal sexual development, and the normal way people's sexual needs are met may be given. Normal heterosexual and homosexual development may be discussed. For children who have been abused by a same sex parent, beliefs that this will effect their sexual orientation need to be addressed. Where children or teenagers engage in sexual acting out behaviour, a behaviour modification programme in which the child is rewarded for appropriate rather than sexualized attempts to get emotional needs met may be used. This type of programme may be run in the group and at home, with the non-abusing parent monitoring the child and giving the rewards for appropriate behaviour. With teenage children a self-control and self reinforcement system may be used.
A third function of the group is to provide the children with peer based social support. In this context it is important that groups be narrowly age banded since during childhood and adolescence children find it easier to gain social support from peers of about the same age.

A fourth function of the group is to learn to identify situations in which abuse might occur and how to manage these assertively. Role-play and rehearsal or video-feedback are useful methods for learning assertiveness skills.

A fifth function of the group is to help abused children work out what they would like to achieve in their relationships with their parents. Usually this involves finding a way to speak to their parents, particularly about intense negative feelings, so that the abused children feel heard rather than silenced or coerced into secrecy. Children can use the group to rehearse what they want to say to the family in family sessions about their anger and disappointment, their sense of betrayal, their sense of being worthless and powerless, their wish to forgive and to trust but their difficulty in doing so.

A final function of the group is to help abused children develop a view of the self as good, worthwhile and powerful rather than powerless.

**Concurrent group therapy for non-abusing carers**

Therapy for non-abusing carers ideally should be conducted in homogeneous groups. Group work should allow members to ventilate feelings of remorse and guilt and to receive support from other group members. Non-abusing carers may receive information on how to establish a protective relationship with their children and support each other during the difficult process of recovery within the group. The group is a forum in which non-abusing carers may brainstorm methods for effectively protecting their abused children in future. The group may be used as a forum for exploring how non-abusing wives may re-negotiate their relationships with their abusive husbands. A final function of group work for non-abusing carers is to provide a place for dealing with issues arising from non-abusing carers own experiences of intrafamilial sexual abuse, which is not uncommon. Their children's disclosure may reawaken memories and feelings associated with this abuse which may be processed within the group.

**Concurrent group therapy for abusers**

Therapy with abusers has two main goals. The primary goal is to let go of denial and own up to the sexual abuse. The second goal is to accept the addictive nature of sexual abuse and to develop a lifestyle that includes strategies for managing potential relapses.

A high level of persistent confrontation coupled with empathy and support is required to help abusers give up denial because of the many important functions fulfilled by this defense. Denial wards off a sense of guilt for having hurt the abused child and allows the abuser to preserve a view of the self as good. Denial removes the fear of prosecution, punishment and loss of family relationships. Denial may also allow abusers to avoid recognition their own abusive childhood experiences. Finally denial allows the abuser to continue to engage in a psychologically addictive process.
For abusers to construct a lifestyle that includes strategies for avoiding relapsing into abuse, the combined problem-solving resources of a group are particularly useful, both in generating ideas and options and in critically evaluating group members attempts to implement these experiments in new ways of living.

To achieve the goals of letting go of denial and developing a new lifestyle a number of therapeutic approaches are useful. In the early stages of the group treatment programme, members may begin by describing to the group, the sequence of events that commonly occur in their episodes of abuse. These cycles typically begin with a specific triggering event or build up of stresses that leads the abuser to feel tension. This in turn leads the abuser to engage in a sexual fantasy which often involves images of abusing the child. The fantasy leads on to active planning about how to arrange the next episode of abuse. Here sexual arousal may become more intense and be the precursor of the abusive actions. The abusive act may lead to a sense of relief for the abuser and may be followed by coercive threats or bribes to retain a veil of secrecy around the abuse. Putting the abusive cycle into words is an important first step in letting go of denial.

These patterns of interaction that surround abusive episodes may occur within the context of wider patterns of interaction that involve attempts to control the abuse. From time to time abusers may feel guilt because they recognize that the abuse is damaging their child and so they attempt to stop. Anxiety, irritability and restlessness may then be experienced particularly when trigger events occur and so the abuser relapses into the original pattern of abusive behaviour.

Abusers' behaviour in these cycles of interaction is often underpinned by dysfunctional internal working models of intimate or caregiving relationships which in turn may often have their basis in predisposing early life experiences of physical or sexual abuse. Making these links between the pattern of interaction in which the abuse is embedded, the beliefs, expectations and narratives concerning relationships and abusive early life experiences is an important part of therapy.

Typically abusers pepper their accounts of these abusive cycles with cognitive distortions that reflect their denial of their responsibility and culpability. They may deny that the abuse happened at all; minimize the number of times it happened; minimize the degree of coercion or violence involved; minimize the effects of the abuse by claiming it will probably do little harm in the long term and minimize the degree of their wrong doing by pointing to more severe cases of abuse. They may also attempt to reduce their guilt by maximizing or exaggerating their virtues. Thus they may point out ways in which they have been helpful or caring to the abused child or behave like a perfect group member showing pseudo remorse and supporting the therapist in his attempts to help other group members show remorse. Denial may also find expression in projecting blame. The abused child may be blamed for provoking the abuse. Abusers may also blame outside factors such for their abusive actions. For parents who sexually abuse their children these factors may include drug or alcohol use or the sexual difficulties that they have with their partners. This projection of blame involves defining the self as powerless to control their addictive abusive behaviour. The therapist's role is to encourage the group to confront all of these expressions of denial, while also inviting the group to support the group member and empathize with his need to engage in the denial process. Ultimately, abusers
must develop the skill of self-confrontation where they recognized their own attempts use denial as a way of warding off abuse-related guilt or avoiding the negative consequences of abusive behaviour. Towards the end of this phase of group therapy, the abuser may use a number of concurrent family therapy sessions to acknowledge the abuse to the whole family, to acknowledge the impact of the abuse on the abused child and other family members; to apologize for the abuse; and make a commitment not to re-offend.

When abusers have made marked progress in giving up denial and developed some self-confrontational skills, the focus of the group work shifts to developing lifestyles that include strategies for reducing the chances of relapses. Group members may develop profiles of high risk situations and related fantasies and brainstorm methods for avoiding the situations and terminating the fantasies. This may require decisions to avoid being alone with the abused child or other potential victims. In concurrent family therapy sessions, abusers may negotiate with the non-abusing family members how best to use the resources of the family to avoid re-abusing the child. This may lead on to exploring ways in which they may appropriately take on a parental role in the future. That is, how can they meet their children's needs for affection, control, increasing autonomy, intellectual stimulation, and so forth without sexualizing the interactions and without introducing secrecy.

During this part of therapy, some abusers may acknowledge the impact of early abusive experiences on themselves and identify how trigger situations reactivate internal working models of abuser-victim relationships. When these internal working models are articulated, abusers may make a pact with the group, with themselves and with their families not to re-enact the abuse they experienced.

As abusers explore ways to restructure their lifestyle within the family so as to avoid future sexual abuse, the focus shifts to ways of managing their own sexual and emotional needs. This often involves addressing marital issues within marital therapy. The central concern is to help the couples develop communication and problem solving skills and facilitate them in using these skill to address the way in which they address their mutual needs for intimacy and power sharing within the marriage.

Long-term membership of a self-help support group may be a useful way for abusers to avoid relapse. If this option is unavailable, booster sessions offered at widely spaced intervals is an alternative for managing the long-term difficulties associated with sexual offending.

CONCLUSION

The type of family based treatment described in this paper is highly effective for a minority of families in which intrafamilial sexual abuse has occurred. Family re-unification is probably an appropriate treatment goal for only a minority of cases. Bentovim et al (1988) in a 2-6 year follow up study of 120 cases treated with this family-based approach to father-daughter incest at Great Ormond Street Hospital found that only 14% of abused children remained with both parents. 38% remained with one parent. 28% went to foster or residential care or relatives. The remainder left home. In Canada, where this type of treatment has been offered within a probation departments an alternative to incarceration, almost all cases selected into the programme respond well to treatment (Giaretto, 1982).
The approach to treatment outlined in this paper is expensive, time consuming and emotionally demanding for staff. Initial high costs may pay long term dividends both in financial terms but most importantly in terms of children's wellbeing and connectedness to their families. For a service adopting this approach to treatment, in order for the service to be able to operate effectively over the long term, three requirements are essential. First, therapists or case workers must have a strict upper limit of no more than 6 active cases in treatment at any one time. With higher case loads the quality of treatment offered deteriorates due to the emotional exhaustion experienced by therapist. Second, therapist must receive intensive initial training and subsequently ongoing weekly therapy supervision. This therapy supervision may be conducted within the context of a peer supervision group or with and team supervisor. Third, a programme co-ordinator who takes on the role of planning and scheduling of the various components of the programme, i.e. family sessions and group therapy sessions. Only a subset of families in which intrafamilial child sexual abuse has occurred are able to engage in and benefit from the approach to treatment outlined in this paper. Cases that cannot benefit for this type of intervention may fare better in individual treatment or treatment which focuses exclusively on the child and non-abusing parent.

REFERENCES


Referred. The Conn were referred by probation following Martin's release from prison where he had served a sentence for abusing Martha over a four month period during which his wife Claire was suffering from postnatal depression. Martha made the disclosure to a teacher in school. And following subsequent legal proceeding the father was imprisoned. Martha was aged 15 at the time of the referral and had been attending individual counseling periodically over 3 years since the disclosure and was still very angry at the father, Martin. She was ambivalent about him returning home. At the time of referral he was living alone in an apartment. The mother Claire had been highly supportive of Martha from the start, but thought that Martin had served his sentence and deserved a chance to work towards rejoing the family. She had found it difficult to cope with the baby, Simon, over the preceding couple of years. Support offered by her brother and sister Eileen and Cecil, both of whom were still single, had helped her cope during Martin’s imprisonment.

Assessment. The family assessment showed Martin accepted that he had abused his daughter and wished to atone for this and work towards returning home. Claire, the mother, felt guilty that she had been unable to prevent the abuse because of her postnatal depression and felt partially responsible for it. She had made amends with her daughter and developed a strong supportive relationship with her. However, she missed Martin and wanted the family back together. The family met sufficient conditions to have a good therapeutic prognosis.

Treatment. The family engaged in a treatment programme along the lines of that described later in the paper. Martin remained living outside the home for much of treatment and through marital sessions developed a good working relationship with Claire and would visit the house regularly under Claire’s supervision.

Martha never resolved her anger towards her father, despite his apology and attempts to make amends. Claire and her sister Eileen, who had a very stormy relationship with their father, during therapy hinted that they both may have been abused by him during their teens. This partial realization helped to further deepen the protective relationship between Martha and her mother.
Martin in aroused by both adult women and young teenagers

Martin believes he has a special type of father-daughter love relationship which justifies the sexual abuse.

Martin feels sexually frustrated because of Claire's unavailability and is aroused by Martha.

He deals with this by masturbating and later having oral sex with her as part of a carefully planned bedtime routine.

Claire's post-natal depression provide Martin with an opportunity to abuse Martha

Martha has been socialised to be overly responsible and conscientious, to do her duty and defer to adult authority

Martin believes he can silence Martha by combining his declaration of love with threats of family disintegration.

Martha believes she has a duty to keep the family together while her mother is unwell.

Martha protests, but Martin warns that disclosure would break up the family, upset Claire and leave Simon fatherless.

He also justifies the sexual abuse by calling it a sign of love

Martha believes that the good feelings she had when Martin caressed her mean that she is willingly encouraging the continued sex between herself and Martin

Martha feels powerless to stop Martin and guilty that she may be responsible for the abuse.
Figure 10.3. Example of a three column formulation of an exception to sexual abuse

- Martin in aroused by both adult women and young teenagers
- Martin believes he has a special type of father-daughter love relationship which justifies the sexual abuse.
- Martin feels sexually frustrated because of Claire's unavailability and is aroused by Martha. He deals with this by trying to involve Martha in a carefully planned bedtime routine.

- Martha has a good trusting relationship with her mother.
- Martha believes her mother will protect her
- Martha protests and says that her mother would disapprove

- Martha's teacher has been teaching self-protection and assertiveness skills in class
- Martha believes that her mother or teacher will protect her from the abuse
- Martha locks herself in the bathroom and thinks about telling her teacher or mother about Martin's abuse of her
### Table 10.1. Components of a comprehensive child protection assessment package for use in cases of child sexual abuse

<table>
<thead>
<tr>
<th>Subsystem</th>
<th>Evaluation methods and areas</th>
</tr>
</thead>
</table>
| Child                          | • Child's account of the abusive incidents and beliefs about these  
• The location of the abuse  
• The frequency and duration of the abuse  
• The use of violence or threats  
• The presence of other people during the abuse  
• The use of drugs or alcohol by the perpetrator or the child  
• Whether photographs or recordings of the abuse were made  
• Impact of the abuse on the child and traumagenic dynamics of sexual traumatization, stigmatization, betrayal and powerlessness  
• Child's perception of risk factors  
• Child's perception of the non-abusing parents capacity to be protective  
• Coping strategies and personal strengths and resources, particularly assertiveness  
• Child's wishes for the future.                                                                                       |
| The non-abusing parent(s)      | • Reconstruction of factors surrounding the abusive incidents  
• The degree to which the parent believes the child's allegations  
• The degree to which the parent aids the child's disclosure  
• The degree to which the parent emotionally supports and empathizes with the child  
• The degree to which the parent views the abuser and not the child as solely responsible for the abuse  
• The degree to which the parent pursues options that will separate the abuser from the child and protect the child  
• The degree to which the parent co-operates with statutory agencies such as social services  
• The degree to which the parent is prepared to discuss the abuse with other family members such as siblings or grandparents  
• The degree to which the parent has protected themselves from sexual abuse  
• The degree to which the parent can enlist other supports to help them  
• Relevant risk factors (abusers motivation and overcoming internal and external inhibitions)  
• Personal resources and problems (particularly history of personal abuse)  
• Parenting skills and deficits                                                                                       |
| Abuser                         | • Reconstruction an account of the abusive incidents  
• Denial of the abuse (It never happened)  
• Denial of the frequency or severity of the abuse (it only happened once or twice and all I did was touch her once or twice.)  
• Denial of the abusers addiction to the abusive acts (I didn't feel compelled to do it. It was a casual thing)  
• Denial of the effects of the abuse effects (It will not do any harm)  
• Denial of the abuser's responsibility for the abuse (She provoked me. She was asking for it)  
• Relevant risk factors (motivation and overcoming internal and external inhibitions)  
• Personal resources and problems (particularly history of personal abuse)  
• Parenting skills and deficits                                                                                       |
| Marital couple                 | • In father-daughter incest - the non-abusing parents ability to confront the denial of the abusing parent  
• In father-daughter incest - dependence of non-abusing parent upon the abusing parent  
• In sibling abuse - degree to which parents can set limits on abuser without scapegoating                                                                                      |
| Siblings                       | • Possibility that they may also have been abused.  
• Perception of risk factors  
• Perception of the non-abusing parents capacity to be protective  
• Wishes for the future.  
• Perception of routines of family life.                                                                                      |
| Role of extended family        | • Acceptance or denial of the abuse  
• Perception of risk factors  
• Perception of the non-abusing parents capacity to be protective  
• Wishes for the future.  
• Perception of routines of family life.  
• Child-care skills and deficits  
• Potential for contributing to a long-term child-protection plan                                                                                                               |
| Role of other involved         | • Health, education, social services and justice professionals expert view of risks and resources within the family  
• Potential future involvement in supporting the family and protecting the child in future  
• Community resource people's potential for supporting the family and protecting the child in future                                                                                   |
| professionals                  |                                                                                                                 |

| 1. Acceptance of responsibility for abuse |   • Do the parents accept responsibility for abuse (or neglect)?  
   • Do parents blame the child for provoking the abuse?  
   • Do the parents deny that the abuse occurred? |
|-----------------------------------------|---------------------------------------------------------------|
| 2. Commitment to meeting their child’s needs |   • Do the parents accept that they have to change their parenting behaviour in order to meet their child's needs?  
   • Are the parents committed to using therapy to improve their parenting skills?  
   • Can the parents place the child’s needs ahead of their own needs? |
|-----------------------------------------|---------------------------------------------------------------|
| 3. Commitment to improving their own psychological well-being |   • Do the parents accept that their own psychological problems (depression, substance abuse, anger management problems, marital discord) compromise their capacity to meet their child’s needs?  
   • Do the parents deny that they have psychological problems?  
   • Are the parents committed to using to improve their psychological well-being? |
|-----------------------------------------|---------------------------------------------------------------|
| 4. Ability to change |   • Do the parents have the ability to learn the skills necessary for meeting their child’s needs?  
   • Do the parents have the personal flexibility to change their parenting behaviour?  
   • Do the parents have the emotional strength to follow through on therapeutic tasks which require considerable tolerance for frustration?  
   • Do the parents have the capacity to maintain a co-operative relationship with the therapy team? |

<table>
<thead>
<tr>
<th>Will definitely benefit from treatment</th>
<th>4 conditions are met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will possibly benefit from treatment</td>
<td>3 conditions are met</td>
</tr>
<tr>
<td>Unlikely to benefit from treatment</td>
<td>2 or less conditions are met</td>
</tr>
</tbody>
</table>

**Note:** Adapted from Skuse and Bentovim, 1994.