

Conceptual Framework

Child Sexual Abuse and Child Welfare Practice

Child sexual abuse is an important focus of child welfare practice. A significant number of referrals to child welfare agencies involve allegations of child sexual abuse. Sexual abuse is also frequently identified in families referred to the agency for physical abuse or neglect.

Only 25 years ago, child welfare agencies received few reports of alleged child sexual abuse. Pedophilia was acknowledged, but remained the exclusive purview of law enforcement. Intrafamilial sexual abuse was obscure, and when exposed, was generally not believed. In the late 1970s, adult survivors of child sexual abuse, reinforced by the anti-rape and battered women's movements, began to talk and write about their experiences. Subsequently, scholars, therapists, researchers, and child advocates have worked diligently to determine the extent of child sexual abuse, its dynamics, its causes, and its consequences. However, the field of child sexual abuse is still in its infancy, and there is much that is not known.

We do know that child sexual abuse is categorically different from either physical abuse or neglect. While sexual abuse in families may coexist with either neglect or physical abuse, it cannot be considered a subcategory or subtype of either. The dynamics and contributing factors to child sexual abuse have little in common with the dynamics and contributing factors to physical abuse or neglect. The approaches to assessment and intervention are also quite different. Child sexual abuse intervention requires highly developed skills and expertise that are not normally acquired through the more general practice of child welfare.

There are several critical differences. First, parents who physically abuse or neglect their children are a very heterogeneous group. Some are typical and essentially normal people experiencing extreme psychological, social, or environmental stress. They may have problems controlling anger or be experiencing situational depression. A second group exhibit severe mental or emotional disorders. The vast majority, however, fall within a wide middle range. Multiple factors are known to contribute to both physical abuse and neglect. Some of these are personal or characterological in nature, and some are social and/or environmental. In most cases, there are multiple contributing factors to child maltreatment, and parents exhibit varying combinations of needs, strengths, and problems.

By contrast, the basic cause of child sexual abuse is the pathology of the perpetrator. Perpetrators are sexually aroused by children and have the capacity to act on their deviant sexual fantasies, regardless of the harm it causes their victims. While social or environmental factors may affect where or when a sexual offense occurs, they do not cause the abuse. This capacity for predation and betrayal of basic trust is consistent with an antisocial and egoistic psychopathology typical of mixed personality disorder. Such pathology is often difficult to detect; thus, it is not not easy to identify potential offenders. The pathology is highly destructive and extremely difficult to treat. While we can help many physically abusive or neglectful parents learn to nurture and protect their children, the same cannot generally be said for those who sexually abuse children.

A second critical difference lies in the determination of risk and the nature of our protective interventions. The primary purpose of a risk assessment is to determine whether children are at risk of imminent and future harm if they remain with their families. Many of the contributing factors to physical abuse and neglect can be mitigated by resources already in the family system, in their extended families and communities, or by immediate and intensive casework interventions. By mobilizing internal and external resources, we can often significantly reduce, if not eliminate, the risk of immediate harm to a child,

enabling the child to remain with the parent. Services can then be provided to resolve the more complex underlying factors and ultimately reduce the risk of future harm.

In sexual abuse, children categorically remain at almost certain risk of both imminent and future reabuse if they remain in the care and custody of the perpetrator. In physical abuse and neglect, we generally try to keep the family intact while we address the underlying problems. In child sexual abuse, the only way to assure the child victim's protection is to prohibit contact of any kind with the perpetrator. This always requires that either the victim or the perpetrator be separated from the family. We prefer that the perpetrator leave the home; however, placement of the child may be necessary to prevent reabuse or retaliation. The separation must remain in force until the perpetrator successfully completes intensive therapy that enables him to control his behavior. Premature reunification almost certainly reinstates the risk of reabuse. In many cases, reunification is never possible.

Finally, while the preferred goal of intervention is to help parents, including perpetrators, become able to safely care for and nurture their children, the supportive, relationship-building process that characterizes both the investigation and ongoing casework in situations of physical abuse and neglect is not effective when working with sexual abuse offenders. Casework is a therapeutic tool that can engage and empower many abusive and neglectful parents to become collaborators in a mutual process of positive change. With child sex abuse offenders, these same methods will almost certainly feed and sustain the denial and manipulation that allow the sexual abuse to continue, and will make it impossible for the worker to protect the child. However, the principles of casework, including empowerment and collaboration, are essential approaches to working with the child victim, the nonoffending parent, and other family members in cases of child sexual abuse.

Because of the complexity and difficulty of child sexual abuse, it is impossible for the child welfare field to respond effectively without the assistance of law

enforcement, prosecutors, mental health professionals, and the court. It also requires that the child welfare worker master a variety of new, complex, and very specialized skills. This chapter is not intended to provide a step-by-step guide to the necessary activities to investigate or treat child sexual abuse. The purpose of this chapter is to provide an overview of essential knowledge about child sexual abuse – its identification, its dynamics, effective intervention strategies, and prognosis for change. Workers whose jobs require intervention in sexual abuse cases are strongly urged to read related material, attend specialized training, and work jointly with skilled and expert interventionists before trying to work independently in this field. Assigning a new caseworker, or one without specialized training, responsibility to investigate, or to intervene in a case of child sexual abuse, is akin to expecting a first-year intern in family medicine to remove a brain tumor. Yet, child welfare agencies regularly assign workers responsibility for sexual abuse without consideration of the skills needed to perform this function. In doing so, we fail to protect a significant number of the many sexually abused children in our care.

Definition of Child Sexual Abuse

The National Center on Child Abuse and Neglect defines child sexual abuse as:

"Contacts or interactions between a child and an adult in which the child is used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or is in a position of power or control over another child." (Adapted from: American Humane Association, *Child Sexual Abuse Curriculum for Social Workers* [1988]).

Cage [1988] provides an operational definition of sexual abuse as, "any sexual activity that is deemed inappropriate for the child's age and maturational level."

Sexual abuse generally consists of the following:

- *Child sexual exploitation.* This includes any activity in which an adult, or a minor in a position of power or authority over a child, uses a child as a sexual commodity. Exploitation includes involving children in sexual activities in exchange for the adult receiving money, drugs, or other rewards, as in child prostitution, or child pornography.
- *Intrafamilial sexual abuse.* Intrafamilial sexual abuse, including most instances of incest, consists of sexual activities imposed on a child by an adult family member, or by a family member under the age of 18 who is in a position of power or control over the child. Intrafamilial sexual abuse occurs any time the perpetrator is a biological relative or psychological family member of the child. Typically, the perpetrator of intrafamilial sexual abuse is the victim's father, stepfather, grandparent, uncle, or the mother's live-in boyfriend. However, mothers, stepmothers, and siblings are increasingly being identified as perpetrators of sexual abuse.

Psychological family members can include people who are not related to the victim either biologically or through marriage, but who are perceived by the child as close family members. This could include a godparent, or a very close friend of the parent, whom the children may refer to as "aunt," "uncle," "grandma," etc. Sexual abuse by siblings or cousins is also considered intrafamilial sexual abuse. Intrafamilial sexual abuse generally occurs over a long period of time.

Incest also includes private, mutually consensual, nonabusive sexual activity between related persons of similar developmental status, usually adolescents or adults. For example, in some royal families in various cultures throughout history, marriage and sexual relations between siblings or first cousins was a method used to maintain the "purity" of the family bloodlines. (With our understanding of recessive genetics, we know this to be biologically harmful). In most contemporary cultures, however, these relationships are considered incestuous, as are sexual

- activities between consenting, sexually active underage siblings or other immediate family members. While this may not be sexual abuse, it is most often psychologically and emotionally harmful, and indicative of dysfunctional family dynamics.
- *Extra-familial sexual abuse.* This includes sexual activities imposed on a child by an adult who is neither a biological nor psychological family member; or by an unrelated perpetrator under 18 years of age who is in a position of power or control over the child. Most often, perpetrators in extra-familial sexual abuse are known by the child and the family. Because of their position of respect and authority with the family, they may have frequent unsupervised access to the children they abuse. These perpetrators may include babysitters, teachers, ministers, scout leaders, neighbors, or volunteers. Extra-familial abuse typically occurs repeatedly over a long period of time.
 - *Child sexual abuse by strangers.* This is sexual abuse perpetrated upon a child by a person the child does not know. This is the least common type of sexual victimization and is generally not ongoing.
 - *Exposure to Developmentally Inappropriate Sexually Stimulating Activities and Materials.* While these children may not be physically involved in sexual activity, they are regularly exposed to sexual activity, and become sexually overstimulated. This may include the frequent and nonaccidental exposure to sexually explicit videotapes, books, pictures, and magazines; sexual toys and aids; exposure to language that communicates sexual innuendo or graphic sexual content; as well as witnessing adults engaged in various forms of sexual activity. These children exhibit a heightened knowledge and interest in sexual matters, and exhibit more frequent and age-inappropriate sexual behavior [Johnson & Feldmeth 1993]. Children do not have the developmental maturity to integrate these experiences, and they often exhibit confusion and anxiety about sexuality.

Legal statutes define categories of child sexual abuse within each state or province. These definitions, used to guide adjudication and prosecution, may differ among jurisdictions.

The Spectrum of Sexually Abusive Behaviors

Sexually abusive acts include a wide variety of behaviors. While perpetrators are usually male, women may also engage in these behaviors with a child.

According to Sgroi [1982] sexual activities perpetrated on a child by an adult may range on a continuum from exhibitionism to intercourse. A perpetrator's abusive behaviors often progress in scope and severity along this continuum during the course of abuse. These behaviors include:

- *Nudity.* The adult walks around the house nude, in front of all or some of the family members.
- *Disrobing.* The adult disrobes in front of the child, generally when the child and the adult are alone.
- *Observation of the Child.* The adult either surreptitiously or openly watches the child undress, bathe, excrete, or urinate for the purpose of the adult's sexual stimulation.
- *Genital Exposure, Exhibitionism.* The adult's genitals are exposed to the child with the objective of causing the perpetrator's or the child's sexual arousal. The perpetrator directs the child's attention his own and the child's genitals, and may request that the child touch the adult's genitals. The adult may also invite the child to look at pornography, or to watch while the adult is involved in sexual activity with another adult.

- *Kissing.* The adult kisses the child in a sexually provocative way, using prolonged and stimulating "French kissing." Even very young children sense the inappropriateness of this behavior, and may experience discomfort.
- *Fondling.* The adult fondles the child's breasts, abdomen, genital area, inner thighs, or buttocks. The child may be asked to similarly fondle the adult.
- *Masturbation.* The adult masturbates while the child observes; the adult observes the child masturbating; the adult and child observe each other while masturbating themselves; or the adult and child masturbate each other (mutual masturbation).
- *Fellatio.* The adult has the child fellate him, or the adult will fellate the child. This type of oral-genital contact requires the child to take a male perpetrator's penis into his or her mouth; or the adult will take a male child's penis into the mouth.
- *Cunnilingus.* This type of oral-genital contact requires the child to place mouth and tongue on the vulva or in the vaginal area of an adult female; or the adult will place his or her mouth on the vulva or in the vaginal area of the female child.
- *"Dry Intercourse."* This slang term describes an adult who rubs his pubic area or genitals against the child's genital-rectal area, inner thighs, or buttocks.
- *Penetration of the Rectal Opening or Vagina by Fingers or Objects.* This involves penetration of the anus or vagina by a finger (digital penetration), or inanimate objects such as crayons or pencils.

- *Penile Penetration of the Anus or Rectal Opening.* This involves penetration of the victim's rectal opening by a male perpetrator's penis.
- *Sexual Intercourse.* For female victims, this refers to penetration of the victim's vagina by a male perpetrator's penis. For male victims, this refers to the insertion of the victim's penis into the female perpetrator's vagina.

The typical progression of sexual activity is from less intimate and intrusive types of sexual activity (genital exposure, self-masturbation), to actual body contact with the child (fondling) to some form of penetration (anal or vaginal penetration).

Sexual abuse usually involves "conditioning" or "grooming" the child to accept sexual behaviors. Over time, the perpetrator gradually increases the amount and type of sexual contact, preparing the child carefully to accept the next behavior on the continuum. Such manipulation of the child by the adult is important to the progression of the sexual abuse. If the child is conditioned to accept the behavior, the threat of the child disclosing the abuse is greatly reduced. Secrecy is critical to sexual abuse, as it allows the abuse to continue.

Normal Sexual Behavior and Inappropriately Sexualized Behavior in Children of Different Ages

Children exhibit sensual curiosity, interest, and behavior from birth, and their sexual development proceeds within a fairly predictable sequence as they mature. The sexual development and sexual behaviors of individual children will also be influenced by the child's temperament, family, social environment, and culture.

While age-appropriate sexual activity is an expected component of healthy development, age-inappropriate sexual behaviors in children are strong indicators of possible sexual abuse. Child welfare professionals must understand

what constitutes normal, age-appropriate sexual behaviors in children of different ages, and must be able to recognize sexual knowledge or behaviors that are potential indicators of maltreatment.

The following describes sexual knowledge and behavior typical for children of varying ages [Adapted from Gil 1993; Johnson 1993]. These descriptions are intended only to illustrate the typical range of children's sexual behaviors. Some of these behaviors may be evident in more than one developmental stage. Whether, when, and how children's sexual behaviors are expressed will be affected by parental responses to their children's sexual expression.

Infancy (Birth-18 Months)

- Infants are sensual beings. Physical contact, including rubbing, patting, caressing, and kissing are pleasurable and soothing to the infant. Physical pleasure and comfort are associated with such caregiving. Infants also suck their own fingers and toes, and enjoy stroking textured objects, such as the fur on stuffed toys.
- Unclothed infants will explore all of their body parts, including their genitals. They may touch or rub their genitals while being diapered.

Toddlers (19-36 Months)

- Children's interest in their genitals increases. They experience pleasurable sensations when their genitals are touched or rubbed. They may touch and play with their genitals as they explore their bodies to soothe themselves, or to experience physical sensation and pleasure.
- Toilet training directs increased attention to the genitals. Children may derive pleasurable sensations from withholding urine or feces. They become more interested in bathroom activities, and may want to follow

adults into the bathroom and watch as they use the toilet. They may experiment with, and endlessly repeat "bathroom words" (pee pee, caca, poop) and slang terms for body parts ("boobies," "butt"), often with great amusement. They may not always fully understand what the words mean.

- Toddlers may explore their body openings by putting objects into them. While this more often involves their mouths, noses, ears, and belly buttons, on occasion they may discover their vaginal or anal openings and try to poke fingers or objects into them. This is often difficult, uncomfortable, or painful, and is not continued.
- Toddlers may remove their clothes and/or diapers, and may "streak" nude through the house or into the yard, either for the fun of it, or to get a rise out of their parents or caregivers.

Preschool Children (Three to Five Years)

- Preschool children may play with their genitals either in public or in private. They can usually be redirected.
- Preschool children engage in social play with other children that may incorporate sexual activities. Preschool children may disrobe and show each other their genitals, their butts, and other body parts. Playing "house" or "doctor" provides children with opportunities to assume the role of an adult, or to simulate adult relationships using dolls or toys. They may imitate what they know of their parents' intimate behaviors, such as kissing, sleeping together in bed, etc.
- Preschool girls may imitate behaviors they have observed in older girls or adult women, peers, or television stars, and practice being "pretty." They may sit close to adults, enjoy giving kisses, and act in ways that might be

considered "flirtatious" if the child were an adult. Preschool girls also play dress-up in their mother's clothes, and are fascinated by make-up and fingernail polish. These behaviors in healthy preschoolers are not indicators of sexual interest, but rather, developmental exploration of adult female roles and social behaviors. Children may be reinforced for these behaviors because adults find them cute and engaging.

- Normally curious about everything, preschoolers often ask questions about sexual issues. They want to know where babies come from, why one child has a penis and the other doesn't, and they may express curiosity about mommy's or daddy's genitals. They may "sneak" to catch a glimpse of an adult or older child who is nude.

School-Age/Latency-Age Children (Six to 12 Years)

- School-age children may discover that certain activities, which involve placing their genitals in contact with objects, feel good, and they may repeat the activity frequently.
- Latency-age children, and some early adolescents, often have an egocentric view of human sexuality. While they may masturbate often, and fantasize about sexual activity, they may believe they are the only ones so preoccupied. While they may grow to realize that their peers are also so engaged, many are fully convinced that adults, especially their parents, only rarely engage in sexual activity; and, they are often unable to describe differentiated sexual acts in any detail. While cultural differences, and the degree of openness about sexuality within families will affect the child's level of knowledge, children who seem aware of the full scope of differentiated adult sexual behavior often have been introduced to this reality through sexual abuse and/or exposure to a highly sexualized environment.

- Early school-age children may be ambivalent about adult sexual behavior, alternately fascinated and embarrassed. They may want to see pictures of nude people, but may giggle when they see people kissing on television. They often claim to be "grossed out" by sexual behavior. Some children begin to exhibit a need for privacy, and become much more shy about being undressed in front of others.
- Some children enter puberty while still in elementary school. Girls may begin menstruating as young as age 10, and some school-age boys develop pubic hair, and the ability to masturbate to ejaculation. Both boys and girls may talk about sexual issues with peers, and compare notes about their physical development. They may be interested and/or embarrassed by nudity in the school locker room. The frequency of masturbation may increase with hormonal changes.
- School-age children often find "dirty jokes" extremely humorous, even though they may not always understand them. They continue to use slang for body parts and sexual acts. They also engage in sex-related games; for example, boys may have contests to see who can urinate the farthest.
- School-age children may continue to engage in sex play. Some preadolescent children may experiment with kissing, "French" kissing, petting over or under clothes, and touching each other's genitals. Many heterosexual latency-age children will participate in sexual exploration with same sex youth. There appears to be a wide diversity in the age at which children begin to experiment with more active sexual involvement, including oral sex or intercourse. However, because of cultural, moral, religious, and health restrictions on sexuality, as well as fear of adult sexuality, many children avoid these activities until much later [Gil 1994].

Adolescence (12-18 Years)

- Adolescence is synonymous with puberty. However, youths' involvement in sexual activities develops at different rates, depending largely upon personal, cultural, and social factors. Some adolescents experiment with many forms of sexual contact, including kissing, petting, fondling, oral-genital contact, and intercourse. Others do not become involved in sexual activities until late adolescence or adulthood. Masturbation is common during adolescence. Boys may masturbate in the presence of same-sex peers.

We can summarize the following. Children acquire sexual knowledge and experience in a fairly typical sequence over a period of many years. Even though the rate of development for each child may differ depending on the child's family, social environment, and culture, the progression is fairly consistent. The sexuality of young children is expressed primarily in self-stimulation and curiosity about others. Their involvement with other children generally involves "show and tell" and exploratory touching. The sexuality of school-age children includes masturbation and curiosity about others, but some children may begin mutual exploratory sex play such as kissing, petting, and, in some cases, attempts at intercourse. For most school-age children, while they may have a general understanding of sex, and may know the fundamentals of sexual intercourse, they will not fully understand it, nor be able to describe the details. They are also less likely to understand specific sexual practices, such as fellatio or cunnilingus. The presence of sexual knowledge and behavior, which exceeds that expected for the child's age and stage of development, is a strong indicator of possible child sexual abuse.

Sexualized Behaviors in Young Children

Precocious sexual knowledge and inappropriately sexualized behaviors in children can be indicators that a child has been sexually abused [APRI 1988; Cunningham & MacFarlane 1991; Gil 1993].

According to Gil [1993]:

"The term 'sexualized children' refers to young children who appear to be overly focused and compulsively drawn toward sexual matters when most of their peers do not seem to exhibit similar interest. These children may be sexually preoccupied, interpreting most situations as sexually charged. Their childhood drawings or stories may be replete with sexual content; conversations include an abundance of sexual references, and interactions are directed at sexual exchanges. They disregard other normal childhood activities, and parental or caretaker limits do not succeed in decreasing the children's sexualized behaviors, interpersonal exchanges, and activities. Children appear consumed with one pressing and exclusive interest: sexuality."

Gil uses the word "sexualized" to describe these sexually traumatized children, rather than the commonly used term "seductive," which could be interpreted to imply an awareness and intent to seduce or corrupt others. This is an important distinction, as perpetrators often attempt to mitigate their own moral culpability for child sexual abuse by suggesting that the child victim "seduced" them. It is important to understand that sexualized children are too immature cognitively, socially, and emotionally to understand, integrate, and control their precocious sexuality. Sexualized children may have relatively sophisticated sexual knowledge and articulated sexual behaviors, but they do not have a well-developed social-moral faculty to modulate their sexuality. In a toxic environment, sexualized children use sexual behavior to gain attention and affection, to mitigate danger, and to relieve malignant sexual tension. Sexualized

children have been traumatized, and their sexuality has been traumatically conditioned. In short, sexualized children are not responsible for their actions; perpetrators are.

Some common characteristics of sexualized children include:

- Excessive masturbation. The operative word is "excessive," since healthy children masturbate, often frequently. However, the nature of masturbation in sexually abused children is different from that in normal children. According to Gil [1993], masturbation may be considered excessive when children do little else but masturbate, both in private and in public; when they continue masturbating, even when redirected or scolded by a caregiver; when they avoid participating in other childhood activities; and when they continue to masturbate, even when the constant irritation causes bleeding or blistering on the genitals, or secondary bacterial infections in the bladder or urethra.
- The ability to describe, in detail, articulated adult sexual activity. Children who can provide very detailed, well-integrated descriptions of adult sexual activity have probably observed or participated in such activity.
- Initiation of sophisticated sexual activities. For example, preschool children who involve other children in sexual activities such as extensive genital touching, articulated oral-sexual activities, anal or vaginal penetration, or detailed mock intercourse, should be considered for evaluation of sexual abuse. Freidrich et al. [1992] found that some sexually abused children displayed a propensity to insert objects into their rectums or vaginas. These children appeared to disregard pain or injury. They did not respond to behavioral limits, and often appeared to be experiencing significant anger or anxiety when involved in these behaviors. The behaviors appeared compulsive and driven, rather than developmentally exploratory.

- Developmentally inappropriate affect during sexual play. Age-appropriate sex play among young children is exactly that – play – and their affect usually includes giggling, laughter, naive spontaneity, embarrassment, and intermittent inhibition and disinhibition. Children often tire of sex play relatively quickly and move on to other activities. These children can be easily distracted or redirected into other, nonsexual activities.

By contrast, the affect of sexualized children involved in sexual activity is often agitated, anxious, fearful, and intense. These children have higher levels of arousal, and their activities may include elements of dominance, coercion, threats, and force. Their thoughts and behaviors are pervaded with sexuality. Their involvement in sexual activity may be habitual and compulsive, and parental attempts to limit or distract them are usually ineffective in curbing or stopping the behavior. It has been suggested that the repetitive and habitual nature of a child's sexual activity may be an attempt to gain psychological mastery over an anxiety-producing and confusing situation [Sgroi et al. 1988]. A more parsimonious explanation may be that the excessive sexual behavior is a logical result of combining precocious sexual experiences and capacity with a still immature emotional and social-moral development.

Corwin [1988] suggests that young or school-age children are generally naive about adult sexual behavior, and when asked neutral questions about adult sexuality, most exhibit some degree of embarrassment, a lack of recognition, and, occasionally, incredulity. By contrast, he describes the sexualized child as having "age-inappropriate increased awareness and altered emotional reaction to neutral inquiry about genital anatomy, or exposure to differentiated sexual experiences, such as exhibitionism, sexualized kissing, fondling, vaginal or anal penetration, child pornography, and oral copulation." Indicators of age-inappropriate sexual experience would include anxiety, fearfulness, excitement,

overdetermined denial, and/or avoidance in response to such questions. He gives, as an example, a four-year-old boy who denied ever having seen a penis. When this altered emotional reaction is combined with a child's ability to show or describe differentiated sexual practices, sexual abuse should be strongly suspected [Corwin 1988].

When children are discovered to be involved in sexual activity, the nature of the children's relationships is critical in differentiating age-appropriate sexual exploration and play from problematic sexual behavior. According to Gil [1993], professionals and parents should be concerned when:

- One of the children is considerably older or developmentally more advanced, and therefore, more knowledgeable about sexuality. The older child may also be perceived by the younger child to be in a position of power or authority, which can subtly influence the younger child to participate in sexual activities when he or she otherwise would not. The greater the age difference between the children, the more likely the younger child is being victimized.
- There is a significant difference in size and strength of the children involved in sexual activity. Even if no force is used, the larger child's size and strength alone may be experienced as a threat by the younger child, and, again, may exert subtle pressure on the younger child.
- There is a difference in status between the children. As an example, if the older child is the babysitter, and the younger child has been told to obey the sitter, the relationship is not mutual. If one child has more authority or status than the other, it compromises the younger child's ability to make free choices.

At times, precocious sexual activity that occurs during noncoercive sexual experimentation may be misinterpreted as a sign of sexual abuse [Corwin 1988]. Careful questioning to determine the origin of the children's knowledge and

experience may identify other factors, such as exposure to X-rated movies on television, that can account for the children's more extensive awareness and knowledge of differentiated sexual behavior.

Physical, Behavioral, and Emotional Indicators of Child Sexual Abuse

Because sexual abuse consists of a variety of assaultive and harmful activities, sexually abused children may exhibit a range of physical, behavioral, and emotional indicators. The nature and scope of a child's symptoms will often depend on the type, scope, severity, and duration of abuse. While many children exhibit a combination of symptoms, some children exhibit only one type, and others may exhibit no symptoms at all.

In addition, some of the symptoms associated with sexual abuse are not specific to sexual abuse, but may occur for other reasons. It is, therefore, often impossible to accurately determine whether abuse has occurred based on a single indicator. The most accurate determinations are made when: 1) a child demonstrates multiple indicators over an extended period of time, or 2) there is a sudden onset of indicators, which are a departure from the child's typical and usual behavior. The worker must assess and identify as many indicators as possible to support substantiation of abuse.

Physical Indicators

The most common physical indicators of sexual abuse are [APRI 1987]:

- Physical injury to the genitals or rectal area. These may include bruising, cuts or lacerations, bite marks, a stretched rectum or vagina, fissures in the rectum, or swelling and redness of genital tissues. These injuries may have been caused by penetration of the vagina or rectum with fingers, an adult penis, or other objects. Injuries to the genitals in older infants and toddlers may also result from physical punishment for toileting accidents.

- The presence of sexually transmitted diseases. These may include herpes on the genitals, gonorrhea, syphilis, venereal warts, or chlamydia. The presence of monilia (a yeast infection) in a female child or adolescent may not necessarily be the result of sexual abuse. Yeast infections may result from systemic antibiotics or excessive douching. A yeast infection in a preadolescent child, however, warrants a medical examination and further investigation.
- Suspicious stains, blood, or semen on the child's underwear, clothing, or body, are suggestive of sexual abuse, if the child is premenstrual and not known to be sexually active.
- Bladder or urinary tract infections typically include pain upon urination, blood and pus in the urine, and high frequency of urination. Urinary tract infections are common in sexually active women. They are uncommon in children, unless the child has an allergy to a type of bubble bath or other soap, or a physical abnormality of the urinary system (such as children with spina bifida, who often have chronic urinary tract infections as a result of neurological problems). Any urinary tract infection in a child should be medically evaluated for the possibility of sexual abuse.
- Painful bowel movements or retention of feces might indicate that the rectum has been penetrated. In boys who have experienced anal intercourse, encopresis (lack of bowel control) or fecal impaction from reduced muscle tone are common [Hepburn 1994]. However, chronic constipation can also cause painful bowel movements and retention of feces by a child.
- Early, unexplained pregnancy, particularly in a child whose history and behaviors would not suggest consensual sexual activity with peers.

At times, physical indicators alone may strongly suggest that sexual abuse has occurred. For example, the presence of a urinary tract infection or sexually transmitted disease in a preschool-aged child would strongly suggest that the child has been sexually victimized. Such physical signs may, at times, be the only indication that sexual abuse has occurred.

However, workers cannot depend upon definitive physical findings to substantiate abuse. In some cases, there will be no physical indicators. If the abuse consisted of kissing, fondling, genital exposure, or observation by the child of adult sexual activity, there will likely be no physical injuries [APRI 1988]. Moreover, even if there were injuries, they may have healed by the time the abuse is disclosed and the child receives a medical examination. Therefore, supporting data, including evidence of behavioral or emotional symptoms, is critical in substantiating abuse.

Behavioral and Emotional Indicators

Many children and adolescents who have been sexually abused exhibit characteristic emotional and behavioral indicators. However, many of these same indicators are prevalent in children who have not been sexually abused, but who are otherwise emotionally disturbed, or who have been physically abused or neglected. The presence of these indicators cannot, therefore, be considered sufficient evidence to assume that sexual abuse has occurred. Likewise, the absence of such indicators does not necessarily confirm the absence of sexual abuse, since many sexually abused children exhibit few of the indicators typically associated with sexual victimization [Corwin 1988].

The following factors, particularly when seen in combination with physical indicators of sexual abuse or a disclosure by the child, should strengthen the suspicion of sexual abuse. Some of these behaviors are typical of "sexualized children," a term used by Gil [1993] to describe the inappropriate and overtly

sexual behaviors of children who have been sexually abused. (See previous section on sexualized children.) Factors include:

- Fears and phobias (of the dark, of school, going out, going home, being left alone, or free floating anxiety);
- Aggressive behaviors, tantrums, behavioral acting out, running away from home, fighting;
- Withdrawal from social relationships, secrecy, isolation, and a prevailing lack of trust in relationships. This may be mistaken for independent activity;
- Developmentally regressive behaviors in young children, such as enuresis (urinary soiling) or encopresis (fecal soiling); thumb sucking, baby talk, head banging, rocking, and excessively clinging behaviors;
- Disturbances in eating or sleeping, gastrointestinal disturbances, and other somatic complaints;
- Generalized irritability, excessive crying, excessive activity, or an inability to concentrate;
- Generalized anger directed towards oneself or others, such as running away, stealing, lying, self-mutilation and self-inflicted injuries, inflicting harm on animals or other people; suicidal gestures; or unexplainable rages;
- Generalized symptoms of anxiety and depression; cries easily, is withdrawn, exhibits general lack of interest in others or in surroundings; or is easily agitated, fearful, and excessively watchful;

- Inappropriate and seductive behavior toward adults of the opposite sex, generally by female children toward adult men. This should not be confused with the normal, developmentally unsophisticated, immature solicitous behavior of some preschool girls toward teenage boys and men;
- Sexual acting out in preadolescent and adolescent children, including promiscuity and prostitution;
- Excessive (in excess of that which is typical and appropriate based on the child's age) and/or public masturbation;
- Enticing other children into stimulating and progressively more sophisticated sexual play. This should be differentiated from normal peer exploration of sexuality, including "doctor" games of mutual disrobing, and other age-appropriate sexual experimentation;
- Involving other children of the same or opposite sex in more extensive sexual activity. This may include enticing significantly younger or developmentally vulnerable peers into sexual activity, or using physical or psychological coercion to force other children to participate in sexual activity. Adolescent male perpetrators are, themselves, very often victims of sexual abuse;
- Creating and playing out sexual scenarios with toys or dolls (the "child" doll presses her face into the "daddy" doll's groin and says "he likes this"; or the "daddy" doll puts his hand under the "child" doll's skirt and rubs her);
- Fears or avoidance of specific males or females, of males or females in general, fear of physical contact, or unusual fear of specific places;
- Adolescent fear of sex (beyond normal adolescent ambivalence and anxiety);

- Wearing extra layers of clothing, clothing that is excessive for the weather, or large, baggy clothing, in what is believed to be an attempt to hide or protect the body; and
- Hiding clothing that is stained, bloodied, or otherwise soiled as a result of sexual activity.

The Dynamics of Child Sexual Abuse

Most of the literature on child sexual abuse describes the patterns of perpetration by adult male offenders. It is widely acknowledged that sexual abuse is also perpetrated by women. The literature is highly consistent, however, in contending that the rates of perpetration by female offenders are significantly lower than the rates of perpetration by males, even if offenses by women are underreported [Finkelhor & Russell 1984; Mathews et al. 1989; Turner & Turner 1994].

The following descriptions of child sexual abuse dynamics pertain to adult male perpetrators, unless otherwise noted. The sexual abuse literature on the dynamics of perpetration by female and juvenile offenders is not as complete. However, a brief discussion of available information is provided later in this section.

According to Sgroi [1982] the dynamics of child sexual abuse usually follow a typical pattern. In most cases, the perpetrator is someone who is known to the child and is often trusted by the child. The perpetrator must have both access to the child and an opportunity for privacy with the child before the molestation can take place. Normally, the perpetrator must engage the child to participate. A series of inducements may be used to engage the child into sexual activity, or the perpetrator may use force or threats to obtain compliance. Coercion is often subtle, but it can also be quite overt, accompanied by threats of harm to the

victim or others who are important to the victim. Regardless of whether covert or overt force is used, victims often believe they do not have the power to prevent the abuse, and they often experience a pervasive sense of helplessness and powerlessness [Briere 1992].

In general, at the onset, abuse consists of less intrusive sexual behaviors, such as fondling, exposure of the genitals, or masturbation in the child's presence. Perpetrators typically condition their victims to accept and participate in more extensive and intrusive sexual activity, including penetration. Once sexual involvement has begun, the perpetrator must rely on the child to maintain secrecy. Secrecy allows the abuse to continue. Most children faithfully keep the secret. Research shows that pressure from the perpetrator, including threats of retaliation and harm to the child or others, prevent most children from disclosing sexual abuse during their childhoods [Finkelhor 1984; Salter 1988; Russell 1983]. When sexual abuse is disclosed the reaction of the child's family, particularly the nonoffending parent, can critically affect the degree of long-term harm to the child.

Perpetrators

There appears to be no single profile to describe sexual offenders [Haskett et al.; Murphy & Peters 1992]. They are both male and female, and their ages range from juveniles to senior citizens. Some are married, some are not. They may be heterosexual, homosexual, or bisexual. They are from all cultures and socioeconomic levels, and they work in a wide variety of blue collar, white collar, and professional occupational settings. Some are not employed. They most often appear typical and normal, and do not exhibit any highly visible or easily recognizable psychopathology [Salter 1995; Finkelhor 1984.] Some were themselves victims of child sexual abuse; others report no such history. Some are amenable to treatment intervention; many are not.

Because of the extremely varied characteristics of child sexual abuse offenders, and because their underlying psychopathology does not generally manifest in obvious, distinguishing, atypical behaviors, it is not easy to identify potential offenders. However, their pathology is often extreme. Sexual abuse perpetrators have the capacity to severely physically and emotionally harm another human being, who is often powerless to defend himself/herself, and who is often dependent upon the perpetrator for the most basic care and protection. Offenders must also have the capacity to deny or rationalize their selfish and harmful behaviors to such a degree that they can be repeated again and again. Such a capacity for predation and betrayal of basic trust is indicative of an antisocial and egoistic psychopathology typical of mixed personality disorders. Such pathology can be difficult to detect, highly destructive, and extremely difficult to treat.

While we may not be able to draw valid conclusions about the precursors or origins of sexual offending, there is considerable data that describes typical patterns of perpetration by child molesters.

Salter's [1995] review of relevant research about male sexual offenders sheds light on both the nature and scope of child sexual molestation. First, child sexual offenders rarely, if ever, offend only once. The evidence documents that the majority of sex offenders, including incest offenders, have multiple victims over lengthy periods of time. While many offenders continue to deny offending, even after being convicted and incarcerated, or they admit to as few offenses as possible [Wormith 1983; Becker, Cunningham-Rathner, & Kaplan 1986], the research clearly indicates compulsivity and repetitiveness in sex offending. Weinrott and Saylor [1991] studied 67 incarcerated child molesters. While they were known to have molested 136 victims, they admitted during the research to more than 8000 sexual crimes against 959 children; and the number of victims ranged from 1 to 200 per offender, with a median of seven. A comprehensive study of convicted sex offenders by Abel et al. [1987] also found extremely high rates of child victims per offender. The average was 19.8 victims for offenders who victimized girls, and 150.2 victims for those who victimized boys. The 203

incest offenders in the group admitted to 15,668 acts against 361 victims. Salter [1995] suggests that the study methodology used by Abel and associates, which provided unusual and extensive protections to respondents, may account for the unusually high rate of admissions by offenders.

There is also considerable research confirming that sexual offenders typically do not commit a single type of offense [Abel et al. 1988; Freund 1990; Weinrott & Saylor 1991]. Crossover between sexual offenses, including intrafamilial and extrafamilial abuse, offending with both male and female victims, rape, exhibitionism, voyeurism, and other offenses, is common. Becker and Coleman [1988] reported that 44% of the men in their sample who had sexually abused female children in the home had also molested female children out of the home; 11% had molested male children outside the home as well. Of this sample, 18% had raped; 18% were exhibitionists; 9% were voyeurs; 4% were sadists; and 21% had other paraphilias. Weinrott and Saylor [1991] reported that half their sample of incest offenders had also molested children outside the family; and Faller [1990] found one third of 65 biological fathers in intact families molested children outside the home, while four fifths of the sample molested more than one child.

It appears that the origins of deviant offending can often be traced to the offender's youth or early adulthood. Studies have repeatedly noted a high percentage, averaging between 50% and 70% of study samples, who report deviant arousal patterns during early or middle adolescence [Abel et al. 1985; Marshall et al. 1991; Abel & Rouleau 1990; Rouleau 1990]. Similarly, a high percentage of child sexual offenders commit their first offenses during childhood or adolescence, although they are often not apprehended until much later [Longo & Groth 1983; Longo & McFadin 1981; Marshall et al. 1991; Groth, Hobson & Gary 1982]. Salter [1995] suggests this argues against theories that situational variables, such as current stress, alcohol addiction, or marital difficulties are a primary cause of child molestation.

The Deviant Cycle

After many years of research and clinical practice with sexual offenders, including perpetrators of child sexual abuse, Salter [1988, 1995] has identified a sequence of characteristic thought patterns, attitudes, feelings, and behaviors commonly exhibited by perpetrators before, during, and after their sexual offenses. Salter refers to this sequence as "the deviant cycle." While the model does not identify the causes of sexual victimization of children, it does provide a description of the dynamics associated with child sexual assault.

Salter contends that the components of the cycle are common in critical ways to both intrafamilial and extrafamilial child sexual abuse. The deviant cycle is useful in understanding the nature of child sexual abuse for both offenders and victims. The model can also help identify critical intervention points early in the abusive cycle, where the perpetrator can potentially be diverted from reoffending.

According to Salter, child sexual offending is neither impulsive nor accidental. Rather, it is a compulsive, repetitive behavior resulting from a complex, interlocking series of events that begin long before an offense occurs. Salter also contends that sexual offenses are carefully planned and well thought out, even though perpetrators typically deny that such planning occurs. They not only deny this to others; they may also deny it to themselves. They also deny any relationship between their own precursor thoughts and behaviors and the resulting sexual offenses. They generally contend that the abuse "just happened." They blame external factors such as stress, alcohol, or marital problems; or, they blame the victims.

Salter concurs with theorists who suggest that sexual offending shares many similarities with addictive behaviors. Addictive behaviors tend to be highly repetitive, are reliable ways to alter and enhance mood, are shrouded in secrecy and denial, and involve thinking errors that justify the addict's behavior.

Addicts are also compulsive and driven, even when the negative consequences are potentially catastrophic, and they are subject to frequent relapses. Salter notes that addictions can be managed, but they are most often not curable, and she suggests that a similar view be adopted for perpetration of child sexual abuse. A significant difference between sexual abuse and other addictions is that the sexual offender's behavior directly and seriously victimizes other people, usually children. However, Salter suggests that the addiction model has value for sexual abuse, since its intervention principles, such as confronting denial, acknowledging that the addiction may be controlled but not cured, and focusing on relapse prevention strategies, may help to control the sexual offender.

Arousal

A chronically deviant arousal pattern has been identified in a high percentage of offenders. They are sexually attracted to children or sexually aroused by violence. Some offenders report having elaborate sexual fantasies about children that began when they, themselves, were children or adolescents. Some offenders expressed a willingness to use anyone or anything, without regard to age or sex, to achieve sexual gratification and to assert power.

Salter notes that some offenders report an unpleasant affective state, such as anxiety, depression, anger, feelings of rejection, frustration, or boredom, prior to their sexual assaults. However, for some offenders, the validity of these reports may be somewhat suspect, since attributing actions to an affective state can be an effective way of denying responsibility for them.

According to Salter, after the development of a deviant arousal, the offender has to place himself in a situation where he can gain access to potential victims.

Accessing Victims: The "Seemingly Unimportant Decision"

Salter defines a seemingly unimportant decision as "an internal lie – an attempt by an offender to convince himself that the action he is taking to place himself in a position where he has access to and power over potential victims has nothing to do with sexual aggression." Examples are: an offender who volunteers to become a "Big Brother" or a scout master because he "really wants to help children." Or, an offender who gets married because "he wants to settle down and be part of a family," but who marries a woman with daughters who are the age and type the offender prefers to molest. Other seemingly unimportant decisions might be: pursuing an avid interest in basketball by going to a park to watch the youth teams play; befriending a sad and needy child because "the kid really needs someone to care about her;" choosing to stay at home alone with his daughter and "relax after a hard week" while his wife and son go out shopping; or developing a close friendship with adults, who then unknowingly and quite willingly entrust him with the care of their children. There are, of course, offenders who quite consciously choose to pursue certain vocations or activities to gain access to victims. The same behaviors to gain access to victims can occur either by intent or without conscious acknowledgement of intent. Regardless, being in physical and emotional proximity to potential child victims is an essential element of child sexual abuse. Salter suggests that "the easiest way to gain access to a child is to live with one."

Target Selection

Once the offender has access to potential victims, he targets one who appeals to him and one he believes he can safely victimize. Offenders may have personal preferences for children of certain ages, genders, or with particular physical attributes or personalities. Some offenders have reported that they target children who are somehow vulnerable – children who are needy, lonely, distressed, alienated from other family members, or highly responsive to adult

attention – because they are easier to victimize, less likely to tell, and not likely to be believed if they do disclose [Salter 1988].

Planning and Deviant Fantasy

Planning may begin at any point in the cycle. Once a victim is chosen, the offender must "fine tune" the approach to the child, taking situational factors into account. Salter suggests that planning may either be active, wherein the offender develops a conscious plan to manipulate or coerce the intended victim into sexual activity; or, it may be passive, in which the offender continues the "charade that [he] has some other purpose in mind."

Grooming or Force

Salter refers to "grooming" the victim as a nearly universal part of the cycle of child sexual abuse. Grooming is a type of emotional seduction that manipulates the child into sexual activity. Grooming activities are calculated specifically to develop the child's trust and confidence in the perpetrator. The necessity of a period of grooming is described by the following perpetrator:

"It was working step by step and progressively bolder, and probably if I had came right out and laid my granddaughter on the bed and undressed her and had oral sexual contact with her right now, she would have probably left the room screaming, left the house screaming" [Salter 1995].

In extrafamilial abuse, the perpetrator must first cultivate a relationship with the child. This may also occur when a new stepfather, an uncle, or another family member begins to groom a potential victim. The perpetrator uses activities such as taking the child to interesting places, showering the child with attention, and giving the child small gifts to achieve this end. The perpetrator leads the child to believe she or he is special and worthy of special attention. As the child becomes more trusting of the perpetrator, the perpetrator may initiate brief physical

contact, such as a pat on the back or a brief hug. Eventually, the physical contact becomes more intimate and may include sitting or lying close together, more prolonged hugs, and kisses. Salter suggests that incest, particularly, provides an opportunity for prolonged grooming, and offenders may groom individual children for months or years before they eventually abuse them.

Once the perpetrator has a relationship with the child, the perpetrator uses strategies to introduce the child to sexual activities, and induce the child's involvement. These strategies might include: presenting the sexual activity as a game or something that is special and fun; using positional power and authority to convey to the child that the proposed behavior is acceptable and sanctioned; offering the child bribes or tangible rewards; or offering the child incentives by promising time, attention, and affection in return for sexual acts [Sgroi 1982].

Some offenders, including most rapists, do not groom their victims, but instead use violence and force to coerce and subdue their victims. Salter concludes from the literature that a significant percentage of child molesters also utilize the threat of force or some degree of actual force with their victims. Force may range from mild levels, such as being pushed or held down, to being struck with a hand or fist, shaken violently, beaten or threatened with a weapon.

The Offense

After all the preceding parts of the cycle are completed, the sexual offense is committed. It is well documented that the type of offense progresses from less to more intrusive over time [Sgroi 1982; Salter 1985]. Salter suggests that the increased intrusiveness is in response to the perpetrator's need for increased excitement.

Maintaining Secrecy

Maintaining secrecy is the next stage of the deviant cycle. Perpetrators must prevent their victims from disclosing the abuse to avoid legal and social consequences. In addition to using threats, promises, and bribes, perpetrators exploit their close emotional relationship with the child to assure secrecy. They may instill guilt in the child, explaining the pervasive hurt and harm that would be inflicted on the perpetrator and the family if the abuse were to be disclosed. These consequences might include disruption of the family; loss of job and income by the perpetrator; incarceration of the perpetrator; placement of the child outside the home; or shame and embarrassment for the entire family. Perpetrators frequently convince their victims that even if they were to disclose, no one would believe them. Many children who "test the waters" by dropping veiled and subtle hints that abuse is occurring may not be understood, or may be discounted or disbelieved, which confirms the perpetrator's prophesy in the child's mind. Salter stresses that the manipulation of the child's trust is often so powerful a deterrent to disclosure that offenders frequently see no need to threaten the child. Some offenders say nothing, not wanting the child to conclude that there is something wrong with the sexual activity. Others ultimately take evasive action, such as leaving their jobs or leaving town, to avoid exposure.

Guilt, Remorse, Shame, and the Likelihood of Relapse

Salter says that offenders may react in a variety of ways when their sexual offenses are disclosed, ranging from sincere contrition to psychopathic indifference. The distress and anxiety associated with having been discovered is often mistaken, by family members and professionals alike, as guilt and remorse. In reality, some perpetrators are sufficiently egocentric and narcissistic that they exhibit a total lack of empathy for their victims, even though they may exhibit dismay and distress at having been caught, and appear to be contrite. Genuinely felt guilt and remorse may be motivating factors for the perpetrator to become

voluntarily involved in treatment; however, even when genuine guilt and remorse are present, they are not by themselves effective in controlling abusive behavior or preventing its reoccurrence.

Female Perpetrators

Few research studies have focused specifically on the dynamics of female child sexual abuse perpetrators. However, one exploratory study by Mathews, Matthews and Speltz [1989] provides considerable descriptive information about the characteristics of female offenders, and the circumstances surrounding their abusive activities. Because of the very small sample size (16 women), we must be guarded in our generalizations. However, the extensive descriptive information can perhaps provide a framework within which to assess and better understand female offenders, and to provide more effective case management and treatment. The data can also generate hypotheses for further research.

Mathews et al. [1989] identified several factors that were common to most or all of the women in their study sample. These factors included:

- All 16 of the women had been sexually abused as children and/or adolescents, ranging from a single sexual contact to extensive abuse of long duration, often by multiple perpetrators. Nine were victims of intrafamilial sexual abuse and seven of extrafamilial sexual abuse. Seven were also victims of physical abuse.
- The self-descriptions of all 16 women included being emotionally isolated, both in their families and socially. Most of the women felt no significant emotional attachments to other people. However, some of them were married, and stayed married to men they reportedly did not love, because they were more frightened of being alone and had been conditioned to believe they could not survive on their own.

- Most of the women felt they had very little power or influence over their own lives. They exhibited high levels of fear, low self-esteem, and low levels of confidence. They were frequently victims of verbal and physical abuse by their husbands or boyfriends.
- As adults, the women engaged in sex to get attention or to receive affection. Some reported they didn't believe they had the right to refuse sexual advances. Most reported no enjoyment of sex, and most reported having been raped.

It is not surprising that these characteristics have also been identified as typical long-term consequences of childhood sexual victimization. (Refer to discussion on the consequences of sexual abuse for victims, later in this chapter.)

Further examination revealed that the characteristics of these female perpetrators tended to consistently cluster into groups, suggesting variations in the backgrounds, personalities, and abusive strategies engaged in by the women:

- One group, labeled "Predisposed/Intergenerational" came from highly chaotic family backgrounds. Seven of the 16 women in the sample fit this typology. These women had been sexually victimized at an early age by numerous abusers, including both family members and trusted caregivers. The abuse often lasted until they were adolescents. Some reported that sexual abuse had been in their families for years, and that aunts, uncles, siblings, cousins, parents, and grandparents had also been victims of sexual abuse. Five abused alcohol or drugs, or exhibited eating disorders. All reported being in unhealthy and dangerous relationships. These women had acted alone in initiating sexual abuse. Five of the seven had sexually abused their own children.
- Eight of the women clustered into a group labeled "Male-Coerced." These women initially perpetrated in conjunction with a male sexual offender, often their husband or boyfriend. The women exhibited a pattern of

extreme dependency and nonassertive behavior. They reportedly feared their husbands or boyfriends, and were dominated by them, yet depended on them. The majority of these women initially resisted becoming involved in perpetrating sexual abuse, but were coerced or threatened by their male partners. Three of the women eventually independently initiated sexual abuse with children.

- A third category was identified and labeled "Teacher/Lover." These women were generally involved with prepubescent or adolescent males with whom they "fell in love" and related to as a peer. Their own emotional development was typically at an adolescent level. Their expressed motivation included teaching the boys about sex and sharing pleasure. They typically believed that their young partners' involvement was mutual and voluntary, and they did not understand how their own age, status, and sexual maturity could be subtly or overtly coercive, nor how their behavior could possibly be experienced as victimization. Some of these women reportedly turned to adolescent lovers because they had experienced brutality from adult men, and they believed that youth would be more accepting and kind to them in ways that adult males had not been. It is also likely they felt more control in relationships with youth than they did with adult men.

Two other general groups of female offenders have been noted in the literature. Mathews [1987] describes adolescent girls who sexually abuse children while babysitting. Labeled "Exploration/Exploitation" abusers, these girls may have no history of victimization and little prior sexual experience; they self-report a desire to experiment as the motivation for involving children in sexual activity. However, in a sample of eight adolescent abusers, Turner and Turner [1994] identified some prior victimization, as well as considerable intergenerational sexual abuse in their families of origin, including unresolved sexual victimization of the adolescent perpetrators' mothers. A group of severely psychologically disturbed abusers have also been identified [McCarthy 1981; McCarty 1986]. These individuals generally have a history of severe psychological problems or

conduct disorders since their youth, and they exhibit antisocial behaviors during adulthood.

Juvenile Perpetrators

Considering the diversity of characteristics in populations of adult sexual offenders, it is no surprise that juvenile sexual offenders are not a homogeneous group. Becker [1988] reports that some adolescents who commit sexual crimes have a true paraphilia, which consists of recurrent deviant fantasies and urges to engage in deviant sexual behaviors, with frequent preference for the deviant activity over nondeviant sexual acts. However, most juvenile offenders do not fit this category.

Becker hypothesizes a model that identifies potentially relevant individual characteristics, family variables, and social/environmental variables that may serve as precursors to an adolescent's first deviant social act. Individual characteristics of the child might include an impulse control disorder, a conduct disorder, limited cognitive abilities, and a history of physical or sexual abuse. Family variables might include: 1) parents or caregivers who engage in either coercive sexual or physical behavior toward each other; 2) parents or caregivers whose belief systems support coercive sexual behavior; and 3) parents or caregivers who lack empathy and interpersonal skills, resulting in emotional and/or physical neglect for their children. Social factors might include social norms that are supportive of coercive sexual behavior or the sexualization of children; and/or bonding with a peer group that engages in antisocial behavior.

Juvenile offenders may engage in the full range of sexual offenses. In Becker's sample, the most frequent offense was fondling, followed by anal penetration. Juvenile sexual offenses often include less intrusive acts as well, such as voyeurism, exhibitionism, obscene telephone calls, mooning, obscene letters, and frottage (rubbing one's genital area against objects or other persons to obtain sexual pleasure.) Juvenile offenders victimize both male and female children,

and tend to victimize children below the age of 12, with the majority younger than eight.

Becker suggests that adolescents who go on to reoffend after their first offense are likely to be those who have: a) found the behavior to be very pleasurable; b) experienced no or minimal negative consequences; and c) experienced reinforcement of the deviant sexual behavior through masturbation activity and fantasy. A fourth factor is the youth's inability to relate to age-appropriate peers, and who, therefore, gravitates toward social activity with younger children.

Being the victim of sexual abuse is apparently a predisposing factor for sexual offending; however, Becker stresses that the majority of male children who are sexually assaulted do not become sexual offenders. Obtaining accurate estimates of the percentage of sexual offenders who were, themselves, sexually abused as children is quite difficult, since this data is usually gleaned through self-report, and most sexual abuse is denied by the victim or remains unreported.

Victims

When we examine the dynamics of child sexual abuse from the victim's perspective, we must be cautious in remembering that "moral and factual responsibility for the victimization... lies with the offenders," who are responsible for initiating sexual activities with children in 97% of cases of sexual abuse [Finkelhor 1984]. We must, therefore, be careful not to implicate victims of child sexual abuse as somehow initiating, promoting, or maintaining the abuse. A discussion of dynamics refers to the typical experiences of victims, and the common behavioral and psychological responses to victimization.

This has not always been the prevailing view. Historically, victims have often been held responsible for sexual victimization. For example, in 1975, Henderson said, "The daughters collude in the incestuous liaison and play an active and initiating role in establishing the pattern." Sarles [1975] agreed; "Although

public and professional sentiment is generally empathetic toward the daughter and negative toward the father, there are indications that the daughters may play an active and initiating role in the incestuous relationship." In a final example, Weiner [1962] stated that the "length and frequency of these incestuous contacts and the absence of any complaints on the part of the daughters indicate that these girls were not merely helpless victims of their fathers' needs, but were gratified by the relationship, if not... active initiators of it."

While these theorists may have correctly observed and described some of the behaviors of sexual abuse victims, their conclusions regarding the meaning of the children's behaviors lacked insight into normal child sexual development and childhood pathology. As Salter says:

"A child whose interactions are sexualized by child sexual abuse may then go on to act seductively toward other adults. Her personal interactions may well be disturbed, and her ability to express nonsexual affection may be impaired. It is a stunning leap of illogic to state that these existed prior to the abuse, and in fact, were the cause of the abuse" [Salter 1988].

The most critical issues in understanding the dynamics of child sexual abuse from the victim's perspective are as follows:

- Children are taught from an early age to obey their elders. This is most often in the children's best interests. Parents are older, wiser, more powerful, and competent to protect their younger and often defenseless children from any number of potential harms. All cultures socialize their children to obey adults, particularly adults who have vested authority and responsibility to provide them with proper care. Most children learn that, while they have a range in which they are allowed to make independent choices, many things are "not negotiable." In child sexual abuse, the offender abuses the power inherent in this trust relationship with the child. The younger the child at the time of the abuse, the more likely the child is to believe she or he has no choice in the matter.

- According to Salter [1988] in many cases, children "intuit" from an early age that the type of touching the offender seeks is inherently wrong or bad. However, few children know what to do about it. Giving children options, which is the purpose of assault prevention training, clearly increases children's ability to prevent or stop sexual abuse by teaching them strategies to protect themselves and eliminating barriers to disclosure. In Sorensen and Snow's [1991] study of disclosure, 24% of the sample disclosed abuse after having been involved in child assault prevention training.
- Offenders routinely use their more advanced cognitive abilities to psychologically coerce children both into sexual activity, and into maintaining secrecy. Again, children do not expect their parents, or other adults they trust and depend on, to lie to them. Therefore, when the offender says he will harm the child or other family members if the child discloses, the child is likely to believe him. Or, when the offender tells the child that sexual activity is a secret game reserved only for the most special of children, or an expression of the highest level of love and caring, the child lacks the cognitive ability or experience to discount what she or he is being told. As time passes, the child may become more and more confused, ambivalent, and anxious because of the dissonance between what she or he is being told by the perpetrator, and what she or he is learning from other socialization experiences.
- Sexual abuse is often experienced by children as both pleasurable and painful. Some of the behaviors used by offenders early in the sexual abuse sequence are inappropriate extensions of healthy parenting behaviors. For example, healthy parents often use physical contact with a child to provide comfort and reassurance, to reward good behavior, and to communicate affection. Such healthy touching often includes liberal stroking of the child's head, face, arms, back – in fact, all body parts but the child's genitals. Mothers often pat their infants and young children

rhythmically on the butt to help them go to sleep, or blow bubbles low on their bellies or tickle them in the ribs to make them laugh. Parents kiss their children goodnight, kiss to say hello, and kiss in the context of a hug and squeeze. Children sit close on their parents' laps, and when tightly hugged or held, their entire body may be pressed closely against that of the adult. A sleepy child may place his head and his hand on his mother's breasts. However, in healthy families, these behaviors promote bonding and attachment, which are necessary for healthy personality development. In sexual abuse, these same, and similar physical behaviors, serve a very different purpose – the sexual arousal and sexual satisfaction of the offender. The young child may not understand the difference. When these "healthy" behaviors become sexualized, the child is conditioned to accept them in the context of a close emotional relationship with a trusted adult. In doing so, the child's normal sexual feelings are inappropriately stimulated, and the child's own behaviors become more sexualized. As the abuse progresses, and the sexual involvement becomes more intrusive, the child may experience pain as well, particularly related to oral, anal, or genital penetration. It should be no surprise that sexually abused children learn to equate sex with both pain and affection, typically sexualizing their relationships with other people, and equating emotional closeness with both sex and pain.

- The most puzzling aspect of child sexual abuse for many people is the unwillingness of victims to disclose, particularly when the child becomes old enough to understand that sexual abuse is harmful and wrong. The reasons can be grouped into two general categories. First, disclosure places the child at significant risk of psychological harm. In addition, disclosure can, and often does, tear apart the family. Because of the secrecy imposed by the offender, sexually abused children often feel that their abuse is an isolated and unique event. The child feels tremendous shame, embarrassment, and often, guilt. Perpetrators will, in a calculated manner, teach the child that he or she is responsible for the abuse, knowing that the child's shame and guilt will support secrecy. Some

perpetrators threaten physical harm to the child, to themselves, or to other family members, if the child discloses. Perpetrators also convince children that no one would believe them if they did tell. Therefore, the child who discloses faces an experience of being publicly shamed, rejected, and ostracized by his or her family, and perhaps physically harmed. With these potential consequences, maintaining secrecy most often seems the lesser evil. When they do disclose, victims' worst fears often materialize. One parent may be removed from the home and jailed; the other parent may hold the victim responsible, blaming both for the abuse and its consequences. The family may suffer serious economic problems. Or, the victim will not be believed, particularly if the abuser is a well-respected member of the community. Again, it is no surprise that such a high percentage of victims recant their allegations.

It must be understood that sexual victimization for children is an extremely destructive situation with no clear alternatives for the child victims. Few children have the developmental or psychological capability to cope on their own. The long-term effects of sexual victimization can be extremely damaging to the victim's development and emotional health. It requires comprehensive and sensitive intervention to protect the child from further abuse, to help the child cope constructively with the abuse experience, and to help the child relearn and master important developmental tasks, including healthy sexuality.

Nonoffending Parents

Nonoffending parents are a diverse group who may respond in a variety of ways to the disclosure or discovery of intrafamilial sexual abuse. A large percentage of parents who learn their children have been sexually abused not only believe their children, but take immediate action to protect them. These parents exhibit significant concern for their child's emotional and physical well-being. If their spouse is the abuser, some take immediate action to move out of the home

and/or to seek divorce. Others seek ways to protect the child from further abuse, while trying to promote reunification of the family [Salter 1988].

Some nonoffending parents express strong disbelief, and deny that the abuse could have occurred. A parent learning for the first time that his or her child has been sexually abused, and that the abuser is a loved and trusted spouse or family member, experiences a traumatic shock. An initial phase of disbelief and denial is a natural and expected psychological response. Denial by the nonoffending parent cannot, at this phase, be automatically equated with collusion. Rather, intrafamilial sexual abuse can be a traumatic and pervasive betrayal of the nonoffending parent as well as the child victim, and emotional acknowledgement may take some time. Workers must be sensitive to the crisis experienced by nonoffending parents, and must provide supportive services to help parents come to terms with the abuse.

Other parents may first become aware of the abuse at the time of disclosure, but will remain loyal to the perpetrator, and blame the child for the abuse. Some mothers may express feelings akin to sexual rivalry and jealousy. They become extremely angry with their daughters, and act as if their daughters have somehow betrayed them. According to Salter [1988], this inappropriate blaming of the daughters is more typical for mothers who feel dependent upon their spouses, and are frightened of potential loss, or who relate to their daughters as peers.

In some cases, assessment reveals that the nonoffending parent knew about the abuse, either by their child's report, or by witnessing the sexual behavior themselves, but they failed to act to stop it. There are many reasons this might occur. The mother may be psychologically dependent upon the spouse, and may believe herself to be helpless and powerless to do anything. The mother may be afraid of retaliation from the perpetrator, in much the same way as the child victim. Some mothers may have been victimized themselves as children [Turner & Turner 1994], and may respond to their child's abuse with the same passive accommodation as they did their own.

Finally, a small percentage of nonoffending parents may help to set up the abuse and/or become active participants in it. At times, mothers may begin such activity as a result of pressure and coercion by their spouses or male partners [Mathews et al. 1989]. Gil [1993] also describes seriously dysfunctional families from her clinical practice, in which mothers literally "turned over [the] child to an abusive incestuous father as a replacement.... In these cases, mothers refuse to participate sexually with their spouses and offer up their daughters to provide the service."

Families affected by child sexual abuse can exhibit a wide range of strengths and pathology, and each family must be assessed carefully and individually before judgments can be made about family members. The nonoffending parent, particularly, plays a pivotal role in protecting the child from future abuse, in preventing retaliation against the child, and in helping the child cope with the trauma resulting from sexual victimization. It is critical that workers and therapists carefully assess the needs and strengths of the nonoffending parent at the time of disclosure. Many parents have strengths that, with support and assistance, can be used to cope with the crisis and come to the most appropriate resolution for the family.

Consequences for Victims

Child sexual abuse is not just acutely traumatic for victims. It also has a pervasive negative effect on the child's future development and emotional health. The deleterious and debilitating effects of child sexual abuse often persist throughout adulthood [Russell 1984; Finkelhor 1988; Briere, et al. 1988; Conte, et al. 1988; Briere 1992; Salter 1995].

The long-term consequences of child sexual abuse vary among victims, depending upon the scope of abuse, the severity, and the destructive circumstances surrounding the abuse. Certain factors have been correlated with

increased trauma and long-term negative outcomes for the survivor. Three factors appear to be correlated with the most severe negative outcomes. These include: 1) when the offender is the child's father, or a primary father figure, rather than another relative, such as a brother, uncle, or grandfather; 2) when the molestation involves direct contact with the child's genitals, particularly oral, anal, or vaginal penetration; and 3) when the perpetrator uses physical force or verbal threats accompanying the molestation [Friedrich 1988; Russell 1988].

According to Briere [1992], additional factors that increase the negative outcomes include:

- The child experiences a high frequency of abuse over a long period of time;
- The child is abused by multiple perpetrators;
- The child is of a young age at the time of the abuse;
- The child is molested by a perpetrator who is substantially older than he or she;
- The child is physically abused, as well as sexually molested;
- The sexual abuse involves bizarre activities;
- The child experiences feelings of personal responsibility for the molestation at the time of its occurrence; and
- The child feels powerless, betrayed, and/or stigmatized at the time of the abuse. [Briere 1992].

There is considerable consistency in the literature regarding the consequences of child sexual victimization on the personality development and mental health of victims. Briere [1992] and Salter [1995], among others, summarize these potential negative outcomes. They include:

- Depression is the most commonly reported symptom among survivors of child sexual abuse. Depression may include dysphoric mood, pervasive feelings of hopelessness, a preponderance of negative thoughts and beliefs, and feelings of worthlessness. Some survivors may be suicidal.

Other common affective disorders include chronic and sometimes severe anxiety, and phobias.

- Many survivors exhibit various forms of psychological withdrawal and dissociation, particularly in stressful situations. These symptoms can include inattentiveness and mentally "separating oneself" from the environment [often described as "spacing out"]; emotional detachment and repression of feelings (described as "being numb"); depersonalization (described as "standing outside myself and watching"); or amnesia, in which painful memories are hidden from conscious awareness. These are believed to be defensive attempts to cope with overwhelmingly painful memories, thoughts, and feelings.
- Not unexpectedly, sexual acting out and sexual dysfunction are common in both child and adult survivors of sexual abuse. Many adult survivors report fear or anxiety and "serious problems" during sexual contact, including pain during intercourse, lack of sensation during sexual activity, and lack of sexual desire or responsiveness. Many women report chronic pelvic pain. By contrast, some survivors may be preoccupied with sexual thoughts, may sexualize nonsexual relationships, may have a history of multiple, superficial, and brief sexual relationships, or may engage in prostitution. Sexually abused children are more likely to display heightened sexual awareness, or compulsive and inappropriate sexual acting out that can include: repetitive and excessive masturbation or masturbating in public; sexual aggression; promiscuity; age-inappropriate and sexually provocative behavior toward adults or other children; sexual play with dolls; sexual play with peers, that can include anal, oral, or vaginal penetration; and inappropriate sexual behaviors to gain attention.
- Guilt, shame, and self-blame are common. Young children typically believe themselves to be responsible for things that happen to them, and they interpret negative or painful experiences as evidence that they were, somehow, "bad." Children also internalize other people's judgments or

negative statements about them, particularly when these people are trusted authorities. Comments from the abuser or other family members, such as, "You asked for it;" "Why didn't you just stop it?" "You started it;" or "You deserved that;" serve to intensify the child's self-perception of responsibility, blame, and low self-worth. Sgroi [1982] refers to this dynamic as the "damaged goods" syndrome. Sexual abuse survivors typically feel damaged by their experiences, even in the absence of force or physical injury. Children are often fearful that the abuse may have caused substantial and permanent damage to their bodies, even when pain is absent or transient, and injuries were minor. Negative responses to the child after she or he has disclosed the abuse frequently reinforces the child's sense of shame and guilt.

- There is a high preponderance of symptoms similar to those of post-traumatic stress disorder (PTSD) in both child victims and adult survivors of sexual abuse. The most distressing of these include intrusive and uncontrollable "flashbacks" that can be triggered by any number of factors, including sensory stimuli (odors, sounds); environmental cues (a table that resembles one in the room where the abuse occurred); or exposure to particular events (riding in a car, when the victim was assaulted in a car). Flashbacks may consist of visual images of the abuser, or aspects of the assault; somatic symptoms, such as choking sensations (as experienced during forced oral sex), or perceiving someone's hands on one's body; or a sudden, jolting rush of negative affect, including feelings of despair, fear, desperation, anxiety, or disgust. The victim may not recognize what precipitates these flashbacks, and they are often experienced as "bolts out of the blue." The survivor may be unable to control the overwhelming and debilitating feelings of pain and despair associated with these events. Many survivors also have frequent and recurrent nightmares.
- The abuse of drugs and alcohol, and eating disorders, particularly bulimia, are also associated with sexual victimization.

- Hypervigilance to both physical and psychological danger, and "learned helplessness," can develop as a result of sexual abuse. Sexual abuse survivors often perceive themselves to be in chronic danger, and they may believe themselves incapable of coping with threatening circumstances. Many are quite passive and more vulnerable to sexual revictimization throughout life. They may also be more accepting of abusive relationships. Studies report that women who were sexually abused as children are twice as likely to marry men who batter them than women who were not so victimized [Russell 1984].
- Some survivors respond to feelings of fear and helplessness by attempting to exert rigid control over themselves, other people, and their environments, or by physically and psychologically distancing themselves from others. Accepting help or support from others may be perceived as demeaning. This often results in isolation and alienation.
- Sexual victimization seriously interferes with the survivor's ability to become involved in intimate interpersonal relationships. Survivors often feel betrayed by people who are important to them, looked up to, trusted, needed, and loved. Survivors often lack trust in others and themselves, they often feel worthless, and they expect to be hurt. Many are emotionally withdrawn, or their relationships with others are superficial. They may go to great lengths to avoid intimacy.

Effects on Male Victims

The literature suggests that many traumatic outcomes of child sexual abuse may be common for both male and female victims. However, some consequences pose particular problems for male victims of sexual abuse [Hepburn 1994].

These include:

- Sexual abuse, particularly by male perpetrators, can create conflicts for male victims about their sexual identity. The very act of same-sex abuse implicates the victim as a participant in homosexual activity. Any experience of physiological arousal or pleasure during the sexual abuse can lead the victim to question his sexual orientation. [Hepburn 1994; Johanek 1988]. For various reasons, this is ego dystonic (dissonant with self-concept) for a majority of males, and can cause severe emotional distress.
- Male survivors are more likely to externalize their anger through aggressive and antisocial behaviors. This is recognized as one of the key factors that distinguishes male from female victims [Hepburn 1994]. Many cultures and subcultures expect men to mask their feelings of vulnerability and shame, to remain in control, and to respond to conflict through the assertion of strength and power. In response to the vulnerability and anxiety experienced during sexual abuse, some victims may deny trauma, dismiss the resulting emotional stress, and staunchly refuse treatment. Hepburn cautions that this is not a sign of resilience or recovery, but an attempt to accommodate to the trauma of the abuse. These victims may subsequently be threatened by interpersonal closeness, and experience it as dependence and vulnerability. They may victimize their partners, use aggression to establish control and engender respect, and work to maintain emotional distance. Some victims may become sexual offenders.

Johanek [1988] suggests that many male victims do exhibit signs of psychological distress. They are often "confused, frightened young men exhibiting a bewildering combination of guilt and rage, and presenting with suicidal behavior." Other common symptoms are major depression; generalized anxiety disorder, often with panic attacks or social phobias; concerns about their sexual identity; alcoholism; and suicidal gestures or threats.

Johanek suggests that societal attitudes and misconceptions about male victims of sexual assault contribute to both their distress and their unwillingness to disclose their abuse. Commonly perpetrated myths include:

- Any "real" man (or male child) would fight to the death rather than become a victim of sexual abuse;
- If normal males are victimized, they will not be sexually aroused by the assault;
- Male children are assaulted by male homosexuals, and the young male victims are psychologically and morally despoiled by this contact; and
- Sexual assault by a female perpetrator cannot be traumatic.

Male victims, like female victims, are subtly engaged or coerced into participating in sexual activity by the perpetrator, and then are "groomed" into more intense sexual activity. The perpetrator is normally known to and trusted by the boy, and is often in a position of power or authority. Victimized youth may fear retaliation or harm to themselves or others if they resist or fight. Male victims are often aroused and made to respond sexually by the perpetrator during victimization [Johanek 1988]. And, boys who are victimized by adolescent or adult women often feel used and exploited, and believe that the sexual activity is morally wrong. Boys who are abused by their mothers generally have severe emotional problems as adults. Yet, Johanek contends that because of the prevailing myths, some may not even recognize victimization of young males by females as sexual molestation.

Effects on Children

Children can experience a wide range of physical, emotional, and behavioral problems as a result of sexual abuse, including many problems that are common

to adult survivors. However, sexually abused children are not a homogeneous group. Sexually abused children experience abuse of different types, severity, and duration. They also have widely varying relationships with the perpetrators, and varying degrees of family and other adult support that can help or hinder their recovery. The amounts and types of manipulation, and the threats and force used to obtain children's compliance can differ as well [Friedrich 1988].

The ways children express their distress depends upon their age, level of development, and temperament. They may be very aggressive with other children, or extremely withdrawn and overly compliant. They may have somatic complaints such as headaches, stomachaches, or other physical ailments. They may regress in their behaviors, wet the bed, suck their thumbs, or wake frequently with nightmares. They may try to deal with feelings of powerlessness by trying to control others. They may express rage by lashing out verbally and/or physically, by destroying property, or by hurting animals. They may abuse drugs or alcohol, engage in prostitution, or run away.

According to Thompson, Authier and Ruma [1994], the problems typically seen in young, sexually abused children are different from those of older children and teens. Young children are more likely to exhibit aggressive or clinging behavior, to suffer from nightmares or eating problems, to wet the bed, and to have school problems, while suicide attempts, drug and alcohol use, self-mutilation, and promiscuous sexual behavior, are more typical of adolescents.

Johnson [1990] suggests that children who act out sexually often have a variety of other behavior problems as well. However, it appears that a child's sexual acting-out behavior is the most distressing to adults, and the most difficult to handle [Partridge, Hornby & McDonald 1986]. Smith and Howard [1994] determined that sexual acting out behaviors were directly tied to placement disruption, as "even mild sexual behavior precipitated strong feelings of discomfort or even revulsion from some adoptive parents." They also found that sexually abused children experienced more moves when in care, were more

likely to disrupt from placements, exhibited greater behavioral difficulties, and had more serious attachment problems.

The Genesis of Trauma

Finkelhor [1988] proposes a model, the Four Traumagenic Dynamics of Sexual Abuse, that attempts to explain the development of the most commonly seen symptoms. The model suggests that sexual abuse alters a child's cognitive or emotional orientation to the world, and causes trauma by distorting the child's self-concept, world view, or affective capacities. The model has had some empirical support [Friedrich 1988]. The four key dynamics in Finkelhor's model are:

- 1) Traumatic Sexualization. The child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways. For example, sexually abused children are often rewarded by offenders for sexual behavior that is inappropriate to their level of development. They may thus learn to use sexual behavior as a strategy to manipulate others to get their needs met. Certain parts of the child's anatomy are given a distorted level of importance because of the attention they receive during sexual activities, and children often acquire misinformation about sexual behavior and morality because of the perpetrator's distortions. Finally, frightening and unpleasant memories become associated with any sexual activity.
- 2) Betrayal. When they are sexually abused, children often experience harm at the hands of people they trusted and depended upon. They may also feel they were tricked into wrongful or harmful acts through the perpetrator's use of lies and misrepresentations. They can experience profound feelings of betrayal and a violation of basic trust. They may also feel betrayed when their mothers or other family members do not

believe them or are unwilling or unable to protect them from reabuse or retaliation.

- Stigmatization. Sexually abused children receive many negative messages about themselves. The perpetrator often blames or denigrates the victims; the perpetrator's pressure for secrecy supports the "wrongness" or "badness" of their activities; and child victims may hear censure in the attitudes and judgments of people around them, and in society at large. They may be referred to, and ultimately believe themselves to be, evil, shameful, worthless, or responsible for the abuse.
- Powerlessness. Finally, victims of sexual abuse experience a pervasive sense of powerlessness. Abused children's wishes are repeatedly overruled and frustrated, and they often experience threats of injury, violence, and coercion. The most basic form of powerlessness for children is the experience of having their bodies misused repeatedly against their wishes. If children try to resist by fighting back, running away, or trying to outsmart the abuser, they may experience more serious harm, or threat of harm. Ongoing vulnerability, entrapment, and feelings of fear and anxiety contribute to feelings of powerlessness. Finally, sexually abused children are often unable to control the events that follow discovery or disclosure of the abuse, including police investigation, family break-up, possible prosecution, and the other pervasive disruptions in their lives.

Factors that Mitigate the Effects of Sexual Abuse

A number of factors appear, for some victims, to have the potential to mitigate the negative effects of child sexual abuse. A positive and supportive response by adult caregivers to victimized children is critical. Support of the victimized child by parents and other adults, and validation that a traumatic event has occurred, appear to lessen self-blame. In addition, supportive adults can help children understand the sexual abuse experience, and provide opportunities for

the children to ventilate angry and painful feelings. It is also essential that children receive therapeutic and medical help at the time of the abuse, or at the time of disclosure [Wyatt & Mickey 1988].

The Dynamics of Disclosure

Disclosure by victims of sexual abuse can be either intentional or circumstantial. In intentional disclosure, the victim makes a conscious decision to tell someone about the abuse. This decision is most often a purposeful one, meant to obtain help and protection, or to relieve feelings of anger, guilt, fear, or anxiety. By contrast, in circumstantial disclosure, the victim does not intend to disclose, but does so because external circumstances conspire to facilitate, pressure, or beguile the victim to disclose. Preschool children are most likely to disclose circumstantially. School-age children are equally likely to disclose intentionally or circumstantially. Adolescents are most likely to disclose intentionally.

Intentional Disclosure

Several factors can precede, influence, and support a victim's decision to willfully disclose sexual victimization. These factors can include the following:

- It is of significant interest that educational awareness and touch prevention programs for children prompted disclosure in 24% of the sample in a recent study by Sorensen and Snow [1991]. These programs appeared to have the greatest impact on early school-age children.
- Anger at the perpetrator is a significant impetus for purposeful disclosure among adolescents. Particularly in intrafamilial sexual abuse, the perpetrator often restricts the victim's participation in peer group and social activities outside the home, and pressures the child to remain home to meet his needs. The youth often becomes angry, and perhaps because of the youth's increased size, maturity, or independence, the fear of

continuing abuse is greater than the fear of retaliation. Some youth may disclose to protect younger siblings, or because of fear of pregnancy.

- Peer influence among teens may also promote disclosure. The strong support and encouragement of friends, in whom the youth may have confided, may help the victim make a formal disclosure to a trusted adult or to the authorities.
- The proximity of the perpetrator may affect the disclosure process. A child may experience increased anxiety because of a planned visit with the perpetrator, and may disclose to prevent the visit. Or, the departure of the perpetrator may make the child feel sufficiently safe to disclose.

Most victims are, at best, ambivalent about disclosing, and at worst, afraid to. Overt or covert pressure from the perpetrator to maintain the secrecy of the abuse, threats of retaliation and harm to the child or others, and the child's resulting fear and anxiety prevent most children from disclosing during their childhoods [Finkelhor 1984; Russell 1983].

Circumstantial Disclosure

Unlike the factors that support an intent to disclose, the factors of circumstantial disclosure undermine the victim's intent to maintain secrecy. These factors can include the following:

- The child may be known to have spent time with an alleged or convicted sex offender, and is questioned directly as a result. In Sorensen and Snow's [1991] study, this was the most frequent type of disclosure for all age groups, and accounted for disclosure for 28% of all subjects.
- The child may have characteristic physical injuries, such as a bladder infection, sexually transmitted disease, encopresis or fecal retention, or

- vaginal or rectal bleeding; or, the child may become pregnant. Upon questioning, when confronted with the physical indicators, the child may disclose.
- The child may disclose to a friend in confidence, expecting the friend to maintain secrecy, and the friend tells an adult.
 - The child may display precocious or inappropriate sexualized behavior that is witnessed by others. Upon questioning, the child discloses. In Sorensen and Snow's [1991] study, sexual abuse was discovered in this manner for 14% of the sample.
 - The child may make spontaneous utterances or unplanned comments because something triggers an association. The child may make these remarks either in conversation or to himself. Examples might be saying, "He sucks my pee pee" when the child's genitals are being bathed, or "Suck on my pee pee, Mommy." Preschool children can also be overheard "conversing" with dolls or toys, or talking to themselves. Of the abused children in Sorensen and Snow's [1991] study, 19% were identified in this manner.
 - Someone else, such as another family member or a friend, may unexpectedly observe the child and/or the perpetrator engaged in inappropriate sexual activity and may tell someone about it. Upon questioning, the child may disclose.

The process around disclosure may take from weeks to months. While some children move from denial to active disclosure in a single interview, most children need considerably more time, and a series of supportive interviews with a trusted interviewer before they fully and accurately disclose the specifics of the abuse. A child's initial denial should never be the sole basis of a conclusion that no abuse occurred. This can place children at increased risk of further abuse.

de Young [1987] suggests that developmental variables may also affect the clarity and coherence of a child's disclosure. Preschool children's thinking is at a preoperational level, and young school-age children think very concretely. Neither is capable of abstract thinking, nor of logical thinking to adult standards. Their immature cognitive development affects their understanding of sexual abuse, and limits their ability to communicate about it. Young children also have a somewhat distorted perception of time, and have difficulty discriminating differences between periods of time, such as weeks, months, or years.

The act of sexual abuse is a complex behavior which typically occurs over a long period of time, and which includes many elements a young child cannot comprehend, much less define and describe. Also, young children are egocentric, and they presume that others already know what they know. A young child is, therefore, likely to leave elements out of a description that may be essential to a complete understanding of the circumstances surrounding the abuse. Their descriptions of events are also likely to be out of sequence, disconnected, and vague, and the child will not always be able to identify exactly when the events occurred. This often results in an unclear or unconvincing accusation.

These factors are critical in determining the credibility of the child's disclosure. If the interviewers do not fully understand the nature of children's cognitions, and how this affects their disclosures of sexual abuse, the lack of clarity and consistency will often be used to impeach the child as a credible witness [de Young 1987].

Recantation

As indicated above, recantation is often a common, expected, and unfortunate part of the process associated with disclosure. An allegation of sexual abuse usually precipitates a family crisis. The perpetrator and other family members generally deny the allegation and try to protect the family from intrusion,

humiliation, and potential incarceration of the perpetrator. Family members will often pressure the child to retract the allegation. Even without such pressure, the child may feel confusing and conflicting emotions, including fear of retribution or personal harm, guilt about family disruption, disloyalty for betraying the perpetrator or other family members, shame, and embarrassment. These dynamics increase the likelihood of recantation.

While caseworkers should anticipate this and take steps to promote truthful disclosure, false recanting is likely to occur in some cases. This should not, however, mark the end of the investigation, since with the proper follow-up inquiry, a high percentage of children eventually reaffirm the allegation [Sorensen & Snow 1991]. The following activities can encourage valid disclosures, and may help prevent false recantations:

- The worker should minimize the number of times the child must repeat the same information to different people. The caseworker and the law enforcement officer should jointly conduct the investigation interviews. These initial interviews can also be videotaped for later use by law enforcement officers and prosecutors.
- The worker and law enforcement officer should be prepared to interview the child victim more than once, if necessary, and perhaps several times over a period of weeks. The same interviewer or team should work with the child throughout the interview process.
- Early in the investigation process, the worker should establish and implement a safety plan for the child to prevent the perpetrator from obtaining access to the child, and, whenever possible, assure strong support of the child by the nonoffending parent and other family members. This is more likely if the abuse has been extrafamilial, if the perpetrator is not an immediate biological or psychological family member, and if the nonoffending parent or another key family member

believes the child. If the nonoffending parent does not believe or support the child, the likelihood of recanting is increased.

- If the child has made a strong disclosure early in the investigation process, the worker should advocate for court processes to occur as quickly as possible. The longer the wait for resolution in court, the longer the child can be subjected to pressure to recant. A special advocate may also be appointed by the court early in the process to support the child through the court process [Reiser 1991]. (Specific suggestions to make the court process less traumatic and intimidating for children are discussed later in this chapter.)
- Both the caseworker and law enforcement officers should identify and gather as much additional evidence as possible to support the child's allegation. This may include physical evidence, documentation from medical exams, or testimony from witnesses.
- Rieser [1991] suggests that immediate and skilled clinical intervention for sexually abused children and their families can help to prevent recantation. If the child receives help in coping with the trauma of disclosure, and family members, particularly the nonoffending parent, can receive support and guidance in coming to terms with their situation, this may reduce the likelihood of recantation.
- Caseworkers can help to inform law enforcement officers, court personnel, and other professionals about the realities of children's testimony, and help explain recanting as a possible part of the disclosure process. Fully understanding the sequence can help prevent a premature termination of the investigation process.

Application

Investigating Child Sexual Abuse

The investigation is a detailed fact-finding process with four primary goals:

1) to determine whether the allegation of child sexual abuse is founded; 2) to determine the degree of ongoing risk to the child; 3) to develop and implement a plan to protect the child; and 4) to gather evidence to support criminal prosecution and other judicial proceedings, where indicated.

The objectives of the investigation include:

- To determine the nature and scope of the abuse, to assess the child victim's physical and emotional condition, and to determine whether the child needs immediate medical services and/or crisis counseling.
- To determine whether the perpetrator is dangerous, and whether legal and court involvement will be necessary to protect the child during the investigation phase.
- To determine whether the nonoffending parent believes the child victim, and whether the parent is willing and able to protect the child from the perpetrator.
- To provide the child victim with support and reassurance, and to help family members support the child, thereby lessening the likelihood of retribution, and reducing the chance that the child will falsely recant.
- To determine the capacity of the nonoffending parent and other family members to provide the child with emotional support and help the child with recovery.

- To identify the immediate needs of the nonoffending parent, and initiate supportive services that enable the parent to stabilize the family and maintain the child in the home.

Whenever possible, the investigators should strive to obtain an admission of guilt from the perpetrator. With a confession, a trial can often be avoided, and the child is protected from the stress and anxiety of testifying in court [Cage 1988]. A confession also permits law enforcement personnel and the prosecutor to utilize the legal system, if necessary, to prevent the perpetrator from contacting the child victim.

Many of the investigation objectives involve engaging family members to jointly identify their strengths and needs, and to plan immediate services. In this regard, a sexual abuse investigation is similar to a family assessment at intake in situations of physical abuse and neglect. However, child sexual abuse is a felony offense. Legal prosecution and conviction are generally necessary to prevent the offender from reabusing the child or other victims, and to assure his participation in treatment [Salter 1988]. Legal prosecution also communicates to the victim that she or he was not responsible for the abuse, and that the offense was sufficiently serious to warrant serious consequences for the offender. Therefore, sexual abuse investigations are most effective when they are collaboratively planned and conducted by child protection and law enforcement [Cage 1988; Pence & Wilson 1994].

The roles and responsibilities of child protection and law enforcement are different in many respects, yet complementary. Law enforcement can: obtain search warrants to gather physical evidence to substantiate the abuse; petition the court to order the perpetrator out of the home; file criminal charges and arrest the perpetrator, when necessary, to protect the victim; protect the worker and other family members if the perpetrator is potentially dangerous; and use specialized investigative interviewing methods to generate a confession. Without these supports, child protection workers are often limited in their ability

to substantiate sexual abuse, protect current and potential victims, and involve the offender in treatment.

Social workers have a different set of skills that enhance the quality of the investigation. They are often better able to engage child victims and nonoffending parents into supportive casework relationships. They can assess the child victim's developmental level, and recognize signs of emotional distress. Trained workers can use a variety of interviewing and communication-through-play strategies that help document the child's credibility, and help the child communicate details of the abuse without increasing the trauma experienced by the child. The caseworker can also gather specific data to identify the family's service needs.

It is essential that the prosecutor also be involved in the investigation. The prosecutor can help design the overall investigation strategy, provide guidance on legal issues, and draft search warrants. The prosecutor may participate in the investigation interviews. Once the evidence has been collected, the prosecutor will usually assess its potential utility in court, will determine the most appropriate charges, and will design the best course of legal action. The prosecutor may also prepare witnesses for court, and present the state's case at trial [Pence & Wilson 1994].

Most child protection agencies use formal interagency protocols to delineate each agency's respective roles and responsibilities, and to regulate investigation activities in situations of child sexual abuse. Some communities have established interagency task forces, whose members also include service providers such as mental health and rape/crisis agencies. This greatly facilitates a coordinated multi-disciplinary response to conducting the investigation, and to providing needed services.

Sources of Data

There are several general categories of information that can be used to substantiate an allegation of child sexual abuse. They are:

- The child's disclosure and description of the abusive activities;
- Corroborating or substantiating information from the nonoffending parent and/or siblings;
- Physical evidence gathered from the environment where the abuse occurred;
- Findings from a medical exam of the child victim;
- Corroboration from witnesses, including siblings and other children who have been victimized, or persons who observed or overheard the abuse activities;
- Emotional and behavioral indicators in child victims, including overly sexualized behavior; and
- Direct confession of the offender.

In general, consistent and corroborating evidence from several data sources increases the likelihood of substantiation and of criminal conviction. The most solid evidence is a confession by the offender. However, offenders often continue to deny the abuse until they are confronted with clear and compelling evidence from the other data sources [Cage 1988]. Therefore, the investigation strategy must gather as much evidence as possible from all the data sources. Each of these will be discussed individually.

Disclosure by the Child Victim

A high percent of child sexual abuse allegations are the direct result of a purposeful or circumstantial disclosure by the child victim. Haskett et al. [1995] contend that "the child's report is probably the single most compelling evidence of abuse." Current statistics also indicate that children rarely lie about sexual abuse [Cage 1988; Corwin 1988]. Therefore, a child's disclosure should, by all rights, be viewed as one of the most valid and reliable indicators of child sexual abuse. However, this is not always the case.

As described earlier in this chapter, it is very common for children's disclosures of sexual abuse to be equivocal, inconsistent, and confusing [Sorensen & Snow 1991; Corwin 1988]. Many sexually abused children initially deny the abuse; some falsely recant after having made a strong initial disclosure. Other children are unable to clearly and convincingly communicate their experiences because of emotional factors such as fear, shame, and embarrassment, and/or developmental limitations. They may exhibit "fluctuating recall," and inconsistencies from one telling to the next [Corwin 1988]. They are often confused by complicated vocabulary or grammar, lack adult reasoning and logic, and often do not fully or accurately understand the questions they are asked [Saywitz 1994].

Yet, according to Sorensen and Snow [1991], protocols to investigate child sexual abuse typically expect a detailed, coherent, first-person account of the abuse to substantiate. Less clear and inconsistent disclosures by the child are often attributed to contamination of the child's story or false allegations. Initial denial by the child, failure to provide immediate detail, or recantation may result in the dismissal of a valid complaint [Sorensen & Snow 1991]. Haskett et al. [1995] found that the most often-reported reason that workers did not substantiate abuse allegations was the child's failure to confirm the abuse.

During the investigation process, several strategies are necessary to prevent "false negatives," or premature termination of the investigation. The investigators must construct the interviews to help child victims provide the most accurate accounting possible of the abuse events. Strategies would include:

- Disclosure must be seen as a "process" rather than an "event" [Sorensen & Snow 1991]. More than one interview, perhaps several, may be necessary. The interviewers must expect an initial stage of denial and a tentative disclosure before the child provides a full and detailed first-person account of the abuse. The interviewers must continue to simultaneously reassure and question the child. Safety planning for the child is critical, since the interviews may have to take place over a period of days or weeks.
- The investigators must use interview strategies that are appropriate for the child's age and developmental level. This may include using short sentences; simple vocabulary and words with few syllables; simple grammatical construction; and concrete names for objects rather than words that reflect broad categories ("gun" rather than "weapon"). With young children, the interviewers should avoid asking the child to use measurements (feet, pounds, hours, dates, years) and abstract or hypothetical reasoning [Saywitz 1994].
- Investigators must educate professionals in their own and other disciplines to understand the nature of children's disclosures, and to be sensitive to the high risk of continued victimization when their allegations are dismissed because of an inconsistent disclosure, an initial period of denial, or false recantation.

Corroborating Information from the Nonoffending Parent

One purpose of interviewing the nonoffending parent is to determine whether the parent has information to corroborate the allegation of sexual abuse.

Questions should be asked to determine the following:

- Whether the nonoffending parent believes the child's disclosure to be true, and why;
- Whether the nonoffending parent had prior suspicion or knowledge of the abuse; whether she questioned the child or the offender about her suspicions; and how the child or offender responded;
- Whether she fears the offender, particularly, whether she fears physical or emotional harm to the child or to herself as a result of the disclosure;
- Whether the child has previously displayed indications of abuse, such as: avoiding the offender; receiving special treatment from the offender; complaining about the offender's behavior; sexual acting out; running away from home; inappropriate sex play with other children; any physical signs of abuse such as bleeding or bladder infections; frequent nightmares; and other behavioral indicators of abuse;
- Whether, and when, the offender has had access to the child, and whether the offender has had opportunity to be alone with the child;
- Whether the nonoffending parent is either physically absent from the home or emotionally detached from the family; and whether she works long hours, goes out often, or assigns responsibility for child care and other household responsibilities to her spouse or older children;

- Whether there has been a history of substance abuse, domestic violence, marital problems, or prior sexual abuse in the family;
- Whether there are family rules with regard to privacy in bedrooms or bathrooms; the degree to which family members are clothed in each others' presence; and sleeping arrangements in the home;
- Whether the nonoffending parent can corroborate or verify specific information from the child's allegations; such as, the offender took the child camping for a weekend last month; the offender plays poker and other card games with the child; the offender threatens to ground the child if she dates; the offender has a Polaroid camera; and
- Whether there are other children in the home or immediate neighborhood who may have been victimized or are at potential risk of victimization.

In situations of extrafamilial abuse, the child victim's parents should be asked similar questions. They should also be asked to share as much information as they can about the alleged offender, including their knowledge of his contacts with other children.

Physical Evidence

Several types of physical evidence can strengthen allegations of child sexual abuse. These may be gathered from the home of the perpetrator and/or at the specific site where the abuse occurred. In extrafamilial sexual abuse, it is common to find an abundance of physical evidence. According to Cage [1988] pedophiles, who may molest hundreds of children over a lifetime, tend to be "collectors," and such relevant physical evidence is often overlooked. Physical evidence can be critical to support an allegation of intrafamilial abuse as well. Physical evidence may include [Cage 1988]:

- Camera and video equipment, pornographic videotapes, home movies, slides, magazines, books, photographs, or undeveloped film depicting nudity or sexual activity; photographs of the victims in nude poses or engaging in sexual activity;
- Telephone and address books, correspondence, diaries, tape recordings, letters, or papers with names that may identify victims;
- Sex toys, sex aids, dildos, and vibrators;
- Articles of personal property belonging to the child victims, including toys, drawings, crayons, or clothing;
- Safe deposit box keys, or bills and checks showing the location and identity of safe deposit boxes and storage facilities; and rent receipts, cancelled mail, utility bills, or phone bills that show the identity of the occupant of the residence (in extrafamilial abuse).
- Sheets, pillowcases, towels, the child's pajamas and underwear, and other clothing that might contain sperm and seminal fluid. The presence of sperm and seminal fluid in fabric can often be identified using an acid phosphatase enzyme test, even if the test is run weeks, months, or sometimes years after the offense. Sperm and seminal fluid, like blood, can seldom, if ever, be completely washed out of fabric.
- Items specifically described by the victim as used in sexual activities, including toys, games, and sexual paraphernalia. The offender's and/or the child's fingerprints on these objects can support the child's descriptions.
- Semen, pubic hair, and other evidence may be found near the site where the abuse occurred, such as in the child's blanket or bed spread, in the carpet around the bed, or wherever the child stated the abuse occurred.

Cage also suggests that statements made by the child during disclosure can often provide clues to physical evidence. Examples might be:

"Daddy used a green towel to wipe the yukky off."

"Grandpa got my pajamas all wet. It was sticky."

"Once he tore my underwear off."

"He made me dress up like Mommy and took my picture."

"He showed me a magazine and said we should do this."

"He read me a book about sex."

In addition to helping support the case, if the offender is confronted with material evidence gathered during a search, or even if the offender knows that police are gathering such evidence, this may lead to a confession of guilt [Cage 1988].

Medical Findings

In many cases of child sexual abuse, there are no medical findings. However, medical exams are often recommended. The child's health may depend upon early identification of medical conditions that resulted from the abuse. In addition, certain types of medical evidence can strengthen or corroborate the abuse allegation. A medical exam can do the following:

- Screen for sexually transmitted diseases, such as gonorrhea, chlamydia, syphilis, venereal warts, and HIV. Cultures of the child's genitals and throat should be obtained if STD is suspected. Untreated STD may lead to serious and permanent physical harm.
- Document physical evidence of sexual abuse which may assist with the prosecution of a court case. This may include genital injuries, abrasions,

and lacerations; stretching of the anus and rectum with fecal impaction or incontinence; urinary tract infections; and other injuries.

- Identify the presence of sperm and seminal fluid, if the medical exam occurs within 48 hours of sexual contact; and screen for pregnancy, where necessary.
- Elicit and record information made by the child in statements to the physician during the medical exam. These may provide additional information about the abuse, or may expand what the child has already disclosed.
- Alleviate the child's fear that she or he has been permanently damaged by the sexual activity, and help the child understand the type and scope of any sustained injuries.

Workers may be uncomfortable referring sexually abused children for a medical exam. The exam can be embarrassing for the child. At worst, it can be traumatic. This may be especially true when the exam requires anal or vaginal penetration by medical instruments. Children should be fully prepared for the exam to alleviate their anxiety, and to help them understand the examination activities. They should be accompanied and supported by a trusted adult during the exam. Examining physicians should display a warm and respectful attitude, and should answer all questions asked by children. The physicians must have specialized knowledge and expertise in child sexual abuse, and must be highly sensitive to children's emotional needs. Specialists can often be found in abuse clinics operated by pediatric hospitals.

Perpetrators, parents, and others who deny or disbelieve the abuse may believe a medical exam without positive findings disproves the allegation. However, the absence of physical findings does not mean that sexual abuse did not occur. In less intrusive types of abuse, such as touching, fondling, or mutual masturbation,

there may be no discernible physical injuries. In other cases, injuries may have healed by the time the medical exam takes place.

Corroboration from Witnesses

In intrafamilial abuse, siblings should be interviewed to determine if they, themselves, have been victimized; if the child victim disclosed any information to them; or if they saw or overheard the abuse. Siblings may be able to describe a "special relationship" between the offender and the child victim, or other activities that suggest grooming. The siblings should be interviewed before the perpetrator knows about the investigation. This will prevent the perpetrator from pressuring the children to keep the abuse a secret, or to deny their own victimization.

Interviewing collateral sources and witnesses can elicit additional information to corroborate the victim's allegations. All persons who live in the home with the child should be individually interviewed. In addition, the investigators may want to interview extended family members; the child's teachers; therapists or counselors; day care providers; ministers; and others who have frequent contact with the child. While these people may not have been aware of sexual abuse, they may have relevant information about the child or the family. For example, a teacher may have observed that the child has developmentally inappropriate sexual knowledge. A day care provider might have observed the child repeatedly dressing and undressing a doll and trying to insert a pencil into the doll's "bottom." While they may find such behavior strange, they may not have understood the potential relationship of the child's behavior to sexual victimization.

The investigators should determine if any of the child's immediate or extended family knew about the abuse, but failed to protect the child due to fear of retaliation or for other reasons. Their failure to report may provide insight into

their relationship with the child and/or the offender, and their willingness and ability to protect the child.

Emotional and Behavioral Indicators

According to Haskett et al. [1995], the presence of emotional and behavioral indicators cannot validate sexual abuse. However, these indicators may be used to support other more concrete findings. Behavioral and emotional responses to child sexual abuse are also common in children who have been physically abused, neglected, or who are severely emotionally or behaviorally disturbed, while many sexually abused children display no obvious behavioral or emotional indicators of their abuse.

Yet, Haskett and colleagues [1995] found that caseworkers often used "clinical judgment" to substantiate sexual abuse, and they based these judgments largely on such affective and behavioral factors. They caution against over reliance of behavioral/emotional indicators and behavior "checklists" in substantiating sexual abuse.

Highly sexualized behavior and developmentally inappropriate sexual knowledge, as described earlier in this chapter, may be more reliably correlated with various forms of sexual abuse, including exposure to a highly sexualized environment [Faller 1994; Johnson & Feldmeth 1993].

Confession by the Offender

An admission of guilt by the offender is the primary goal of the investigation. A confession validates the child's allegations, and can be extremely helpful to recovery. A confession also facilitates prosecution, and prevents the child from having to testify in court. However, obtaining a confession is not easy. Most perpetrators categorically deny having committed the abuse, and often maintain their denial in the face of convincing evidence [Salter 1988]. However, a skilled

investigative interviewer can sometimes elicit a confession, particularly if other substantiating evidence is gathered first. The success of an investigative interview often depends on the proper phrasing, sequencing, and timing of the interviewer's questions and responses. Investigators who interview the alleged offender must have highly specialized training and skill.

Other Objectives

Other purposes of the investigation include assuring that the child victim is believed and supported, establishing a collaborative casework relationship with the child and other family members, and beginning the delivery of crisis intervention and supportive services. Specific objectives include the following:

- *To determine the nature and scope of the abuse, to assess the child victim's physical and emotional condition, and to determine whether the child needs immediate medical services and/or crisis counseling.*

The investigators must determine if the child has been physically harmed; if the child fears retaliation or punishment for having disclosed; and the degree of emotional distress the child is experiencing. The investigators must also identify children who are severely emotionally disturbed, potentially suicidal, or developmentally delayed or disabled. Immediate medical or psychological services may be needed for some children. This assessment can also help investigators identify when specialized interviewing strategies may be needed to communicate with nonverbal, mentally retarded, or developmentally delayed children.

- *To determine whether the perpetrator is dangerous, and whether legal and court involvement will be necessary to protect the child during the investigation phase.*

- *To determine whether the nonoffending parent believes the child victim, and whether the parent is willing and able to protect the child victim from the perpetrator.*

It is widely agreed that sexually abused children remain at extremely high risk of reabuse if the perpetrator continues to have contact with them. Therefore, the investigators must determine the necessary steps to assure that the perpetrator has no access to the child. Several factors must be explored. If the perpetrator voluntarily leaves the home for the duration of the investigation, can he be trusted not to return? Does the nonoffending parent have the ability and emotional strength to prevent him from having contact with the child if he should return? Is the nonoffending parent loyal to the offender? Does she disbelieve the child? If so, it is not likely that she will take the necessary steps to protect the child. In these cases, other measures must be taken to assure the child's safety, including restraining orders, arrest and incarceration, or placement of the child.

- *To provide the child victim with support and reassurance; and to help family members support the child, thereby lessening the likelihood of retribution, and reducing the chance that the child will falsely recant.*

The process of disclosing sexual abuse is always uncomfortable for children and may, at times, be traumatic. Children typically experience feelings of shame, guilt, anxiety, confusion, and fear during the investigation. Divulging the explicit and intimate details of sexual abuse often increases the stress and trauma of disclosure. It is therefore necessary for the investigators to build rapport with the child early in the interviews, and to continue to strengthen their relationship throughout the investigation. Children are more likely to disclose the details of sexual abuse to an interviewer who is perceived as warm, caring, and friendly than to an "authoritarian" adult. The support and encouragement of the interviewers is essential in prompting a full disclosure. The investigators should also reassure children that they will be protected from the perpetrator, that they

are doing the right thing to disclose the abuse, and that they are not in any way responsible for the abuse.

The investigators must also determine whether the child is at risk of retaliation for having disclosed. The attitude of the nonoffending parent is critical. If the nonoffending parent believes the child, and supports the child's disclosure, siblings and other family members are also likely to do so. The reverse is also true. If the nonoffending parent and other family members blame the child, and if the child is threatened or punished for disclosing, the likelihood of recantation is greatly increased. Family members should be encouraged to commend the child for telling the truth, communicate that it was the right thing to do, and encourage the child to disclose the full details of the abuse. If family members are unable to do this, the investigators might engage extended family or the child's therapist to do so.

If children do recant, the investigators should respond with support and understanding. They should communicate that children are often made to feel guilty and responsible for both the abuse and the disruption in the family; they sometimes believe it's all their fault; they often don't want to upset their parents any further; and they want things to be as they were before the disclosure. So, they change their story. Children must be reassured that this is normal, and that we understand it means they are upset and scared, but they deserve to be protected, have a right to protection, and that our job is to make sure they are protected, but we need their help. With the proper support, the majority of victimized children who falsely recant eventually reaffirm their original allegations [Sorensen & Snow 1991].

The investigators must also protect children from retaliation by perpetrators. Perpetrators must, therefore, be prevented from contacting their victims, including by telephone, letter, or messages through other family members.

- *To determine the capacity of the nonoffending parent and other family members to provide the child with emotional support and help the child recover from the abuse.*

The nonoffending parent is a key figure in helping the child recover from the abuse, and in assuring the long-term protection of the child. However, most nonoffending parents, including the parents in cases of extrafamilial abuse, may need considerable supportive intervention themselves to help them with their own issues before they will be able to help their child. The investigators must be sensitive and responsive to the nonoffending parent's own needs and feelings, while simultaneously reinforcing their importance to the child's recovery. The investigators can describe and model actions the parent can take to help the child, and can support the parent and other family members in these efforts throughout the investigation.

- *To identify the immediate needs of the nonoffending parent, and to begin supportive services that enable her to stabilize the family and maintain the child safely in the home.*

The investigators must often assist the nonoffending parent to deal with the crisis that results from the disclosure of abuse. This often requires an assessment of the family's immediate needs, and provision of crisis counseling and intensive in-home supportive services. If the family is in chaos, it will be impossible for the nonoffending parent to provide the child with the necessary consistency and support.

The investigators must also assess the family's potential for future victimization. Sexual abuse may occur in families where neglect, physical abuse, domestic violence, and drug use are also present. A complete risk assessment can identify factors in the family that may have directly or indirectly contributed to the child's victimization. Risk assessment can also identify the needs and problems that must be addressed if the home is to be safe for the child in the future.

However, unlike physical abuse and neglect, which have multiple and interacting causes, sexual abuse has a single cause; a perpetrator who derives sexual gratification from children. While we must assess the child victim's family situation, we are cautioned not to conclude that the family's circumstances caused the sexual abuse, or that the family should have been able to prevent it. The risk assessment is most relevant in identifying factors that increased the child victim's vulnerability to sexual victimization, and in building family strengths to reduce this vulnerability in the future.

The investigation in child sexual abuse consists of a series of intensive interviews with the child victim, the nonoffending parent, siblings, other family members, and the perpetrator, usually in that order. It also involves collection of a wide variety of supporting data, and carefully documenting the findings to support substantiation and subsequent legal action. The investigation, substantiation, and prosecution of child sexual abuse may take weeks, and at times, months. A delineation of the specific activities, methods, and strategies used by effective investigators is well beyond the scope of this chapter. Workers who have responsibility for sexual abuse investigations will need extensive and specialized training, and close supervision, to achieve competence in this extremely complicated undertaking.

Casework and Therapeutic Interventions

Supportive and therapeutic interventions for family members in cases of child sexual abuse cannot wait until the investigation is completed. Victims and their families usually need intensive help as soon as the child victim discloses the abuse, or as soon as an investigation begins. The disclosure of child sexual abuse, and the subsequent involvement of child protection and law enforcement create a crisis for almost all families, in both extrafamilial and intrafamilial abuse. Early intervention enables the worker or therapist to minimize the traumatic effects of the disclosure on the child, and to provide essential support and guidance to nonoffending family members.

In extrafamilial abuse, crisis intervention services for the whole family, and individual treatment of the child victim are usually necessary. Counseling with the parents, or with the family as a group, can facilitate the victim's recovery, and can strengthen the parents' ability to help and support the child, and assure that he or she is protected from reabuse or retaliation from the perpetrator.

Intervention in situations of intrafamilial abuse can generally be divided into four phases. During the crisis intervention phase, the worker and therapist support the victim and assure protection, help stabilize the family, engage the nonoffending parent and siblings to support the victim, and help the nonoffending parent to manage the family. Family members who can be engaged during the crisis intervention phase will be more likely to participate in intensive individual and family treatment at a later time.

The second intervention phase includes individual therapy for the victim, the offender, the nonoffending parent, and at times, siblings. The primary goals of therapy for the victim, the nonoffending parent, and siblings are to constructively manage their emotional responses to the abuse, and to recover from the resulting trauma. The goal of therapy for the offender is helping him to recognize the traumatic implications of his assaultive behaviors, accept moral responsibility for his actions, deal with the legal consequences, and develop his ability to control his behavior and prevent his reoffending.

In the third stage of intervention, conjoint or family sessions, which may or may not include the offender, are held to develop and strengthen family relationships, to help family members develop healthier patterns of interaction, and to educate family members in strategies to prevent future abuse.

During the fourth and final intervention phase, the family is restabilized as a unit, with or without reunification of the perpetrator. If the perpetrator is to be reunited with the family, intensive family counseling must be done to educate and prepare the family to prevent reabuse.

Each of these four intervention phases will be examined separately.

Phase I: Crisis Intervention

The objectives of crisis intervention services include:

- Assure protection of the child victim from further abuse or retaliation;
- Help the nonoffending parent or parents to acknowledge that abuse has occurred, believe the victim, recognize their responsibility to protect the child, and provide consistent parental support to the victim;
- Decrease the offender's power, control, and psychological influence over the child victim and other family members; and
- Encourage and enable the child victim to fully disclose the details of the abuse, and prevent the child from false recanting.

In intrafamilial sexual abuse, there are two additional objectives of crisis intervention services:

- Support and empower the nonoffending parent to manage the family in the absence of the perpetrator; and
- Help siblings understand the situation, and help them refrain from blaming the victim for the family's problems.

These objectives cannot generally be met if the perpetrator remains in the home, or if he has contact or communicates with the child victim in any way. The perpetrator is very likely to deny or greatly minimize the abuse; to pressure the victim to recant; to retaliate for the disclosure by physically or psychologically

punishing the victim; to manipulate, threaten, or coerce the nonoffending parent to disbelieve the child and maintain loyalty to him; to block involvement by outside agencies and professionals; and, very possibly, to reabuse the child.

Before any therapeutic work can occur, the child victim must be fully protected from reabuse, retaliation, or harmful involvement with the perpetrator. The perpetrator must also be held fully accountable for offending. In intrafamilial abuse, it is most appropriate for the offender to leave the home voluntarily, or to be ordered out of the home by the court. Removing the offender, rather than the victim, reaffirms the perpetrator's responsibility for the abuse. Legal prosecution and a period of incarceration communicate the seriousness of the offense, and further reinforce the perpetrator's accountability.

However, removing the offender may have negative consequences for the family. The nonoffending parent may be overwhelmed by the full responsibility of home management and child care, resulting in considerable family disorganization. The children may act out their distress behaviorally or emotionally, which may further disrupt the family. The family may also experience serious financial stress, particularly if the offender is incarcerated or loses his job as a result of the disclosure. The nonoffending parent is particularly vulnerable during the crisis phase. Intensive support and concrete assistance are essential to prevent the family from pressuring the victim to recant in order to reestablish stability and eliminate agency involvement.

If the perpetrator will not voluntarily leave the home and the court will not restrict his contact with the family, other measures will be necessary to protect the child victim. One option is to help the nonoffending parent and siblings relocate, which assures the child protection while allowing him or her to remain with the family. In some cases, the family may temporarily stay with friends or relatives until they can establish a separate residence. Relocation can increase the stress for all family members, thereby potentially exacerbating the crisis.

Removing the child victim from the family is the least desirable alternative, but may be necessary to assure the child's protection. Many children are placed at high risk of either reabuse or retaliation if they remain in the home. This is most likely when the nonoffending parent does not believe the victim, and refuses to protect the child, or cannot control the perpetrator sufficiently to guarantee the child's safety. The victim may also be at risk of physical or emotional harm from siblings or other extended family members. However, removal of the child victim may leave other children in the family vulnerable to sexual abuse, even if they have not previously been victimized. A safety plan for any children remaining in the home is essential.

Placement into out-of-home care is universally stressful and often traumatic for children. (Refer to Section VII-B, "The Effects of Traumatic Separation on Children.") Children commonly experience placement as a punishment for some perceived fault or failing. In situations of sexual abuse, the child may have been covertly or overtly blamed for the abuse by the perpetrator and other family members. Removing a sexually abused child from the family can strongly reinforce the victim's feelings of responsibility, guilt, shame, and worthlessness. This contradicts therapeutic goals for the victim, which include reducing feelings of responsibility and culpability, and minimizing emotional stress.

If placement of the child is necessary, the worker and therapist must help the child understand that placement is the only way to assure protection, and that the child is not being punished, regardless of what she or he might hear from family members. The worker should use placement strategies that properly support the child and minimize trauma during placement. (Refer to Section VII-C, "Placement Strategies to Prevent Trauma.")

Regardless of how the family is separated, the nonoffending parent and/or siblings may continue to blame the victim for disrupting the family. The already ambivalent child victim is highly vulnerable to guilt, anxiety, depression, and confusion. Being blamed by family members greatly increases the risk of the child recanting. The importance of supporting and empowering the

nonoffending parent during the crisis phase, and helping her to believe and support the child victim, cannot be overemphasized.

When the Offender and Victim Do Not Live in the Same Home

When the abuse is extrafamilial, or the perpetrator is not a member of the child's immediate family, the worker and the parent or parents must determine how to best protect the child from reabuse or retaliation. A safety plan that prevents the perpetrator from having either access to or contact with the child must be developed and implemented. The plan may include supervision of the child at all times by a responsible adult. If the offender is a close and trusted family member or friend, or a well-respected member of the community, the child's family may not know whether to believe the allegation. They may need considerable support and help to acknowledge the abuse, and support and protect the child. Family members may also be vulnerable to pressure from the offender, and they should be educated and coached on handling phone calls and other attempted communications. A court order may be needed to prohibit contact by the offender.

Intervention at the time of the initial crisis can be provided by the child welfare caseworker, and by therapists specializing in child sexual abuse. The caseworker must be sensitive to the severe family disruption caused by the disclosure and removal of the perpetrator. The family's distress can be heightened further if criminal prosecution is pursued, if the child must testify in court, and if the perpetrator is incarcerated. The worker must respond empathetically and supportively, but must not compromise the investigation. A team approach to intervention enables qualified professionals to provide essential family support, while others are investigating and substantiating the abuse, and preparing for legal action.

Casework at the time of crisis sets the stage for later interventions with the family. A family that believes the child victim, acknowledges the seriousness of

the offense, is willing to act to protect the child, and responds positively to initial therapeutic support, will be more easily engaged into individual and family treatment. Conversely, the prognosis for constructive family change is lessened when:

- The nonoffending parent does not believe or support the child, even after considerable casework and therapeutic support;
- The nonoffending parent is emotionally or physically dependent upon the perpetrator, and cannot act independently, even with consistent casework support;
- The nonoffending parent fails to hold the perpetrator responsible for the abuse, or lies to protect the offender; and
- The offender totally denies the sexual abuse and refuses to leave the home, even when there is strong evidence to support the allegation.

Phase II: Individual Therapy

A variety of therapeutic approaches have been developed for perpetrators, victims, and families in situations of child sexual abuse. The majority of treatment programs for sexual abuse use a combination of emotional support, cognitive restructuring, behavior modification, and family systems interventions. An optimal treatment approach appears to include a combination of individual, group, and family interventions in a carefully planned sequence. Therapy for intrafamilial sexual abuse requires the coordinated and long-term involvement of all family members in treatment. The plan for each family must be developed specifically to meet the family's unique problems, strengths, needs, and circumstances.

In general, the victim and the perpetrator should be seen by different therapists. The skills needed to effectively counsel victims are quite different from the treatment strategies most effective with perpetrators, particularly when working on individual issues. Separate therapists are also less likely to become entangled in loyalty conflicts and other dynamics that may exist between the perpetrator and the child victim. However, therapy for all family members must be coordinated, which requires close collaboration between treatment providers. This is especially important in the later stages of treatment, when joint work by the victim and other family members, including the perpetrator, may occur.

Treatment of child sexual abuse is a highly specialized field, and therapists must have special expertise and experience. This section provides a brief overview of treatment goals, methodologies, and desired outcomes for victims, perpetrators, and other family members. This should help child welfare workers identify professionals with the competence and experience to treat child sexual abuse, and to monitor and evaluate the family's progress in treatment.

Treating Perpetrators

The primary goal of any offender treatment program is to help offenders take responsibility for their behavior and prevent reoffending. However, denial, in its many forms represents the "single greatest obstacle to treatment" [Salter 1988]. According to Salter, this denial may take many forms:

- The offender may vehemently deny having committed the sexual offense. In a study of 205 sex offenders, Wormith [1983] found that 35% of them continued to deny having committed the offense, despite having been charged, prosecuted, convicted, and incarcerated. Other studies have shown similar results [Salter 1995]. Families of some offenders fabricate an alibi and staunchly defend it. Offenders often contend they don't have the psychological capacity to commit the abuse, even in the face of irrefutable evidence that they did [Salter 1988].

- Offenders may acknowledge the single offense for which they are caught, but will deny other sexual offenses. A prominent theme in the sexual abuse literature is the high number of sexual offenses committed by most perpetrators, and how few of these the perpetrator ever admits to committing.
- Offenders may admit to only part of the alleged activity. For example, an offender may admit to having fondled a child, but will deny penetration, or another may admit to having abused his daughter for six months, but not six years. Sometimes offenders admit to the sexual act, but deny any planning or forethought, claiming "it just sort of happened."
- Offenders may admit to committing a sexual offense, and even admit its inappropriateness, but will assign responsibility to "circumstances," including subjective internal states like depression, loneliness or anxiety, or external factors like alcohol, family stress, their wives' lack of sexual interest, problems at work, or the victim's "seductive" behavior.
- Offenders often deny the seriousness of their behavior, and minimize the effect of the abuse on the victim. Comments such as, "She'll get over it," "She never said anything, so I'm sure she didn't mind," and "It's not a big deal," are symptomatic of a total lack of empathy for the victim. These attitudes also reflect egocentric attempts to avoid shame or censure.
- Offenders may greatly minimize the difficulty of changing their behavior. Most contend they do not need treatment. They may insist they have learned their lesson and "just won't do it again." Some offenders insist they have been changed through a religious or a moral conversion, and they are no longer a threat, since they have adopted new values. Sometimes the offender may believe his own rationalizations. Often these claims are a calculated means of manipulating others to avoid punishment, or to reduce treatment obligations.

Traditional counseling strategies, such as insight-oriented psychotherapy, have proved to be ineffective in controlling offenders' behavior [Salter 1988]. Other strategies have been used with greater success. Treatment of perpetrators is generally a long-term and difficult process, requiring an honest commitment to change, and full participation by the perpetrator.

Treatment will have little chance of success unless:

- The offender is able to honestly and fully admit the nature and extent of his sexual deviancy. His story must be consistent with that of his victim(s).
- The offender admits to all components of the sexual abuse, including antecedent thoughts, fantasies, and events. He must acknowledge having groomed and manipulated the victim(s).
- The offender recognizes the continuing temptation to reabuse, and sincerely believes that relapse is highly likely.
- The offender fully understands the seriousness of the consequences to the victim, feels empathy for the victim, and feels genuine guilt for the harm he has caused.

It must be stressed that most perpetrators will not demonstrate these feelings at the time of the disclosure, nor will they quickly move from an initial, tentative admission to a full acknowledgment of responsibility and guilt. It may take considerable time in therapy before the offender can do so. Many, if not most, offenders never will.

Treatment Methodologies

Successful therapies for sexual offenders have been patterned after therapy for other addictions, particularly to alcohol and other drugs. There are many similarities between sexual offending and other addictions. Both involve highly repetitive behaviors that are shrouded in secrecy and denial. The addict's behaviors usually involve cognitive distortions ("thinking errors") that justify the problematic and antisocial behavior. Addicts are compulsive and driven to maintain their addiction, even when there are negative and potentially catastrophic consequences. And, addicts are subject to frequent relapses. Most therapists believe that addicts can sometimes be managed and controlled through treatment, but their addiction cannot be cured [Salter 1995].

Several interventions, including group therapy, individual behavior modification, and family therapy, have been used to treat sexual offenders. The goals of these interventions vary somewhat, but together they attempt to address the multiple contributing factors to sexual offending. Salter [1988] describes several of these therapeutic approaches.

Group therapy appears to be an intervention of choice for sexual offenders. Involvement in a heterogeneous group comprised of offenders at different stages of treatment reduces the offender's invisibility and isolation, and undermines the secrecy and denial that are an essential dynamic of sexual abuse. Group norms should be stringent and rigidly enforced. In effective group treatment, therapists and group members must be relentless in seeking out and challenging each offender's cognitive distortions and thinking errors. Rationalizations, excuses, and other strategies used by the offender to lie to himself must be quickly confronted and disallowed. Offenders must not minimize the scope or seriousness of their offenses. They must not use euphemisms, such as "we had sex" to describe nonconsensual and forced sexual acts. They must be explicit and graphic when describing their offenses. The group should model alternative thought patterns and behaviors that are acceptable replacements for those the

offender must relinquish. These strategies are designed to break down denial, develop the offenders' personal responsibility for their offending behaviors, and develop each offender's awareness of his own unique pattern of offending. By understanding the abuse cycle, including the predictable sequence of thoughts and behaviors that precede abusive acts, offenders may learn to interrupt the cycle early in the sequence and divert their behaviors before committing a sexual offense. Offenders may be in group therapy for months to years. They do not "graduate" until they have demonstrated an ability, over time, to manage their behavior to prevent reoffending.

Individual behavior therapy may be used to modify arousal patterns and reduce or extinguish deviant arousal. Methods include reconditioning, satiation, desensitization, and positive reinforcement for alternative behavior. The interventions may become quite complex. The offender may be required to develop an appropriate sexual fantasy that involves consensual adult sex. Offenders may also be instructed to change the ending of a deviant arousal fantasy before they achieve sexual contact with the imagined victim, replacing the ending with a highly aversive and frightening imagery. The offender must audiotape behavior modification and "self-talk" sessions, which are later listened to and monitored by the therapist. The intent of these activities is to pair inappropriate thoughts, feelings, and behaviors with aversive stimuli or consequences, and to provide strong positive reinforcement for socially acceptable alternatives. The offender learns to reward himself for interrupting the inappropriate thoughts and feelings that precede offending, and to exit the risky situation [Salter 1988].

A third component of offender treatment may include training in social skills, assertiveness, and healthy adult sexuality. This is particularly useful for offenders who have poor interpersonal skills, who are threatened by adult intimacy, and who cannot meet their social and sexual needs in adult relationships. Some offenders may also benefit from concurrent individual treatment, where the offender can learn to prevent or manage strong negative

affective states such as anger, depression, or anxiety, that are at times associated with, and may portend, an offense [Salter 1995].

Finally, treatment for offenders must include relapse prevention strategies to help the offender maintain changes in addictive behaviors [Pithers et al. 1988]. The offender must fully understand that he is not, and may never be, cured of his dysfunctional sexual inclinations. He must be prepared to work to prevent reoffending every day of his life. When an offender is to be reunited with his family, a goal of therapy is to help family members recognize the early signs of the offender's cycle, and intervene to help him redirect his thinking and behavior.

Treatment for Victims

Child victims of both intrafamilial and extrafamilial sexual abuse generally need some level of therapy to prevent lasting harm and to promote continued healthy development. In most situations of extrafamilial abuse, and when the victim's family is highly supportive and protective, crisis intervention and short-term therapy may be sufficient to help the child deal with the molestation, and help the family support the child. In situations of chronic intrafamilial abuse, where families often exhibit more pervasive dysfunction, long-term therapy is often necessary for both the child and other family members.

The point at which sexual abuse victims receive treatment can have a significant effect on the long-term outcomes. Early identification of the abuse and immediate treatment can prevent some of the more dysfunctional thought and behavior patterns typical of adult survivors [Sgroi 1982]. However, victims may need therapy periodically throughout their lives. Short-term treatment can help a child deal with current issues. However, new issues may emerge as the child reaches new developmental stages. For many victims, sexual abuse is not disclosed until adulthood. Therapy for adult survivors of child sexual abuse

must often undo the pervasive psychological damage that results from chronic victimization.

Not all families support therapy for their sexually abused children. In incestuous families, barriers to treatment are obvious. Often, the entire family system has been structured to maintain secrecy, coercion, and the other dynamics that allow the abuse to continue. It is harder to understand why many families of extrafamilial abuse victims resist therapy for their children. Sgroi [1982] suggests that the parents' own feelings of embarrassment, guilt, and responsibility predispose them to minimize the negative consequences, deny their child's need for treatment, and attempt to forget about the incident as quickly as possible. However, their children may be severely emotionally traumatized and in need of professional help.

Treatment for child victims generally consists of intensive individual therapy with a trusted and skilled therapist, supplemented at times by participation in therapy groups. There are several goals of individual therapy with child victims [Salter 1988; Sgroi 1982; de Young & Corbin 1994]. These include:

- Assuring the child's perception of safety. Even if no longer at risk of reabuse or retaliation, sexually abused children may feel unsafe. Therapy must help children develop confidence that they will be protected and will not be further harmed. If they are encouraged to communicate their fears, the therapist can respond with reassurance, or can generate changes in their environment to insure their safety.
- Identifying children with severe emotional disturbance. Some child victims of sexual abuse exhibit symptoms of severe depression. They may act out by threatening or attempting suicide, or through self-mutilation. Early contact with a skilled clinician can help identify these children, and provide hospitalization, medication, and intensive therapy as necessary.

- **Empowerment.** Child victims of sexual abuse frequently feel helpless, powerless, anxious, and fearful. Therapy can help them develop constructive, age-appropriate coping and self-protection skills, including assertiveness, and an ability to seek help and protection. This helps child victims establish a measure of control in what has previously been a chaotic and dangerous environment.
- **The identification and expression of feelings.** Enabling the child to constructively express and deal with painful feelings in a safe and supportive atmosphere is a critical component of therapy. The therapist provides the child with an accurate interpretation of the circumstances surrounding the abuse, which relieves the child of responsibility, and reinforces his or her right to safety and protection. This helps reduce or eliminate feelings of shame and guilt. The child also learns to express anger in constructive ways. Expression and discussion of painful feelings reduces the need for psychological defenses, such as repression and dissociation. These symptoms are often seen in adult sexual abuse survivors who have not received treatment.
- **Reducing the child's fear of permanent physical damage.** Many children believe they have sustained permanent damage from the abuse. Therapists can reassure children that they are not permanently damaged, or can help them more accurately understand the nature and scope of any injuries that may have occurred.
- **Educating children about healthy sexuality.** Many sexually victimized children exhibit inappropriately sexualized behaviors, and have a distorted perception of sexuality. Therapy can help them learn more appropriate, nonsexualized ways of seeking and giving affection, and engaging in interpersonal relationships. Older children and adolescents can be helped to develop appropriate values about sexuality to guide sexual behavior later.

- Promoting the development of trust. Trust is an essential component of the therapeutic process. As these children confront important concerns and issues with a supportive, consistent, and caring therapist, they learn to trust a trustworthy adult. They can begin to redevelop a realistic basic trust in people and in their world.

Concurrent group therapy is a valuable option for older school-age children, and is a preferred option for adolescents [Sgroi 1982; de Young & Corbin 1994].

While many of the goals are similar, group treatment can provide benefits that individual therapy cannot. Involvement with other children and youth who have had traumatic sexual experiences reduces the child's feelings of isolation and alienation. The group provides members with essential peer support and acceptance, and validates the child's feelings as normal and expected. Group members reinforce each others' right to protection and safety, which may support disclosure and help to prevent recanting. The group also provides victims with opportunities to learn appropriate peer relationship skills.

Therapy for adult survivors of child sexual abuse is an essential component of any sexual abuse treatment program. Workers must understand the goals and methods of adult treatment, since a percentage of the adult clients served by child welfare agencies were sexually molested as children, including female sexual offenders [Mathews et al. 1989] and nonoffending mothers in intrafamilial sexual abuse [Turner & Turner 1994]. In some instances, treatment for family members may require individual therapy for the adult survivor on issues related to her own victimization.

The primary goals of therapy for adult survivors include:

- Helping the survivor understand that her problematic thoughts, fears, feelings, and behaviors are normal and expected responses to her experience of sexual victimization;

- Increasing the survivor's feeling of safety and control. This is accomplished through a safe, supportive, predictable, and reliable therapeutic environment; by clearly defining the expectations for the therapeutic relationship; and by teaching the survivor specific techniques to manage and modulate her own painful emotional states.
- Helping to correct the survivor's misperceptions, cognitive distortions, and feelings of guilt and personal responsibility by reexamining the circumstances of the abuse from a more realistic adult perspective.
- Promoting personal growth, identifying and building on strengths, and developing more effective, satisfying, and safe ways of relating to other people.

According to Briere [1992] many of the survivor's symptoms, such as dissociation, repression, amnesia, and avoidance of intimacy, are psychological attempts to avoid and deny psychic pain. Flashbacks and generalized depressive or anxiety states may occur when these defenses fail. Many survivors retain conceptual distortions, developed during their childhoods, about the sexual abuse and the world in general. To be effective, therapy requires a reexamination of past events, and confrontation of painful feelings in order for cognitive restructuring and other learning to occur. Unfortunately, survivors must first uncover and relive experiences that may have been repressed for years. Therapy for adult survivors requires exceptional skill on the part of the therapist, and exceptional bravery on the part of the survivor [Briere 1992]. As with adolescent victims, group therapy can be a powerful and effective adjunct to individual therapy with adult survivors.

Treating the Nonoffending Parent

Nonoffending parents in child sexual abuse cases are a very diverse group. Their responses to the abuse may range from providing the child with immediate

support and protection, to totally denying that abuse ever occurred and rejecting the child. Their treatment needs, responses to treatment, and prognoses depend upon a variety of personal, interpersonal, and social factors. For some parents, crisis intervention and short-term counseling may be sufficient to help them cope with the trauma and disruption, and provide their victimized child with needed protection and support. Other parents may need much more extensive individual and group therapy.

Part of the caseworker's role during the initial phase of service delivery is to establish a relationship with the nonoffending parent, and to support and encourage the parent to accept the reality of the situation. An initial phase of shock, disbelief, and denial is a natural and expected psychological response to the disclosure of sexual abuse. Nonoffending parents may feel conflicted and confused, and may not know whom or what to believe. Most will need time and emotional support to come to terms with the situation. If the worker can offer consistent and empathetic support during the crisis phase, and can provide concrete assistance to stabilize the family, the likelihood that the parent will participate in therapy is increased.

A supportive parent is extremely important to the recovery of the child victim. Helping the parent help the child is one of the primary objectives of therapy for nonoffending parents. However, to achieve this, some parents may first have to deal with personal issues related to the abuse. The parent's responses and feelings may be influenced by several factors, including: the nature of the personal relationship between the offender and the nonoffending parent; the degree to which the nonoffending parent trusted or depended upon the offender; whether the parent feels personally and sexually betrayed and rejected by the offender; the nonoffending parent's own history of childhood abuse; and the expected risks, threats, and losses if she acknowledges the abuse and supports the child.

Therapy should help nonoffending parents do the following:

- Acknowledge the abuse and its impact on the family;
- Accept that the abuse was the responsibility of the perpetrator, and that other family members are not at fault;
- Verbalize and understand their own feelings of anger, betrayal, loss, rejection, vulnerability, guilt, and loss of self-esteem, and realistically assess the validity of these feelings;
- Understand their role in protecting the child victim and the other children in the family; learn strategies to protect and support the child;
- Develop empathy for the child victim; assist in the child victim's recovery;
- Deal with any unresolved personal issues, including those related to a personal history of sexual victimization; and
- Strengthen their capacity to manage the family in the absence of the offender, take steps to permanently separate from the offender, or learn what will be required if reunification of the family is desired.

Both individual and group therapy are valuable treatment options. Initially, group involvement may be more effective. A group can provide nonoffending parents with immediate support from others in similar situations. According to Salter [1988], "The presence of other women who have been through the same ordeal and who have survived affords women in the early stages of treatment a vivid sense of hope... they can see the futility and inappropriateness of taking all the blame and responsibility...on themselves." The group can also educate parents regarding the typical dynamics of child sexual abuse, the consequences for the victim and other family members, and the role and responsibility of nonoffending parents to support and protect their children.

Treatment for Siblings

Siblings of the child victim may react in several ways to a disclosure of sexual abuse. These reactions may include:

- They may become anxious and fearful that they, too, will be abused;
- They may not believe the victim, and may be angry and blame the victim for the disclosure and the resulting chaos in the family;
- They may feel disillusioned and depressed;
- They may feel guilt for not having protected their sibling. This is particularly likely if the siblings were aware that something was occurring, whether or not they fully understood it; and
- The victim's disclosure may prompt a sibling to disclose that she or he also has been victimized. This possibility should always be fully explored by the caseworker and therapist.

Supportive individual or group counseling can help siblings deal with their feelings, and help them cope with their distress. They can also learn how to be supportive and helpful to the child victim.

Phase III: Strengthening Family Relationships

The goal for this stage of therapy is to help family members reestablish or strengthen their relationships. This is especially important in situations of intrafamilial sexual abuse. Considerable work is often necessary to strengthen the child victim's relationship with the nonoffending parent, and with siblings. If the offender is actively participating in therapy and the family desires reunification, considerable work between the offender and the nonoffending

parent, and eventually between the offender and the victim, will also be necessary.

The objectives of relationship therapy will vary, depending on each family's unique composition, structure, strengths, problems, and needs. Joint therapy for the nonoffending parent and a school-age or adolescent victim is often necessary. Objectives might include:

- Developing honest and clear communication, and an ability to negotiate differences and jointly solve problems;
- Strengthening the child's confidence and trust in the parent's ability to protect him or her;
- Strengthening the parent's confidence and esteem as a competent parent, and teaching the parent to more effectively parent the child;
- Discussing the circumstances surrounding the abuse, and their feelings about it; helping the child victim make a full and honest disclosure to the nonoffending parent;
- Identifying dysfunctional relationship patterns, such as secrecy, imbalances in power relationships, or role reversals; and
- Helping the parent learn to provide emotional support to the child in dealing with the consequences of the abuse.

When reunification of the perpetrator into the family is planned, marital therapy for the parents is essential. Issues to be addressed might include:

- Helping the nonoffending parent communicate feelings of betrayal, anger, jealousy, mistrust, and powerlessness;

- Helping the offender develop empathy for the nonoffending parent, understand the scope of her distress, and identify strategies to correct some of the problems he has caused;
- Helping the nonoffending parent understand the offender's abuse cycle, and learn to recognize the component behaviors and symptoms; negotiating ways the nonoffending parent can help and support the offender in controlling his behavior;
- Helping the couple establish healthier ways to communicate, negotiate, and resolve problems, and meet each others' needs for intimacy, including addressing sexual issues; and
- Establishing appropriate parenting roles and responsibilities that enable the offender to make a contribution to the family and support the nonoffending parent, but which do not place him at high-risk to reabuse.

Joint treatment of the offender and the child victim is also necessary prior to reunification, and may even be helpful for the child victim if reunification is not the plan. However, assuring that these contacts remain safe and helpful for the child victim is difficult. These sessions must be very carefully planned and the plans strictly followed. The child victim must be fully prepared for the sessions, and supported both before and after. The offender must be fully committed to assuring the sessions are in the child's best interests, and must have developed sufficient self-control and self-awareness to avoid involving the child in past dysfunctional dynamics. Objectives might include:

- Empowering the child victim to communicate directly to the offender feelings of anger, betrayal, fear, and loss of trust;
- Enabling the offender to develop greater empathy for the pain and harm he has caused the child;

- Enabling the offender to communicate his full responsibility for the abuse and all the grooming activities that led up to it; to exonerate the child of any blame; to communicate genuine feelings of guilt and regret; and to provide the child with a sincere apology for his actions; and
- Clearly defining appropriate and inappropriate behaviors and interactions between the perpetrator and the child, and empowering the child with strategies to confront and stop the perpetrator if he violates any of these norms.

The initial contacts between the offender and the child should consist of carefully monitored and controlled communications by letter, video, or audiotapes, or in messages delivered through the therapists. Face-to-face contact should occur in the office of the child's therapist, with the therapist present, only when the child is ready and feels strong enough to handle the contact. Joint therapy between the perpetrator and victim may need many sessions.

In some situations, the child may refuse contact with the offender. The victim should be supported until the underlying dynamics are fully understood. Forced contact with the offender can be very traumatic for the child and should not occur.

Phase IV: Reunification

The decision to pursue reunification depends upon the family's success in therapy, and particularly, the perpetrator's success in achieving necessary behavioral control. In general, the following must have occurred for the child victim to be safe at home:

- All family members must have acknowledged the abuse and must hold the offender accountable.

- The offender must be highly motivated to stop offending.
- The child victim must be able to talk openly about the abuse with the nonoffending parent.
- The child victim must have communicated feelings about the abuse to the perpetrator, and must feel empowered and strong enough to enact strategies to protect himself or herself.
- The offender must understand the damage to other family members resulting from his offenses, and must have apologized to the victim, and to the nonoffending parent.
- The offender must fully understand his offending cycle, and must have discussed high risk situations, grooming behaviors, and safety plans with all family members.
- The nonoffending parent must have developed an appropriate parent-child relationship with the victim, and must have the ability to be confrontive and assertive as needed to protect the child.
- The family must have established appropriate physical and personal boundaries for its members, and delineated family rules to assure appropriate privacy and the safety of the children. Therapists often recommend family rules such as: restricting the offender from being alone with a child; curtailing physical expressions of affection between the offender and the children; installing locks on doors; preventing the offender from helping a child dress or bathe, or taking a child to the restroom; and limiting the offender's involvement in disciplining the children [O'Connell 1994].
- Family members must have developed effective and appropriate communication techniques, and ways to express anger and other feelings.

- The parent couple can identify, express, and respond to adult needs for intimacy.
- Substance abuse or psychiatric disorders will have been identified and treated.
- All family members acknowledge that they will remain vigilant to the potentials for reoffending, and view reporting of any inappropriate behavior by the offender as a positive act to help the family, not as a negative act that could slow down reunification.

Prior to making the decision to reunify a family, the child's safety should be assured by conducting an assessment of risk of future abuse. The decision of whether to reunify a family is largely dependent upon the offender's ability to monitor and control his abusing behavior, and his willingness to use others to help him do so. Specifically, the following risk factors must be examined prior to considering reunification (adapted from Petrusek [1994]):

1) *Does the perpetrator accept that there continues to be risk of his reoffending?*

High Risk: The perpetrator feels that he is no threat to children, and that he can never be tempted to sexually abuse a child again. This type of response indicates a lack of acceptance of the abuse dynamics, and misjudgment regarding the vigilance necessary to keep it under control.

Moderate Risk: The perpetrator agrees that it is possible he will abuse again, but he has not developed and implemented a safety plan.

Low Risk: The perpetrator understands that there is a continuing risk of reoffending, and he has developed and has demonstrated an ability to implement a safety plan to prevent reabuse.

- 2) *Has the perpetrator developed and used strategies to reduce or stop sexual thoughts and fantasies about children?*

High Risk: The perpetrator denies that he has sexual thoughts about children, or has not stopped or reduced sexual thoughts and fantasies about children.

Moderate Risk: The perpetrator knows methods to monitor his deviant fantasies and divert or stop them, but is not always successful in doing so.

Low Risk: The perpetrator can clearly describe his strategies and thought processes that control his deviant sexual fantasies, and can describe situations in which he has used these methods.

- 3) *Does the perpetrator accept that to control his deviant thoughts and abusive behaviors, other people must monitor and help him control his abuse cycle?*

High Risk: The perpetrator resents having his sexual thoughts and behavior monitored by professionals and others, views this as an intrusion on his privacy, and expresses this either overtly or subtly in response to other peoples' monitoring activities.

Moderate Risk: The perpetrator doesn't like external monitoring but "puts up with it" because he knows it is necessary.

Low Risk: The perpetrator acknowledges the need for external control, and recognizes that this protects potential victims from the trauma of abuse, and helps protect him from offending.

- 4) *Does the perpetrator believe the consequences of his offending, including prosecution and incarceration, were fair, considering the nature of his offense? Does he believe this was necessary, in spite of the disruption it may have caused?*

High Risk: The perpetrator continues to direct anger at what "the system" did to him, and blames the involvement of child protective services, law enforcement, and the court for his own problems and those of his family.

Moderate Risk: The offender verbally acknowledges that legal consequences were appropriate for his actions, but concurrently complains about the extent of punishment and the "unfairness" of consequences.

Low Risk: The offender accepts the legal consequences for offending, and believes that the punishment was fair and just, considering the offense. He also acknowledges that similar consequences would be appropriate, if he were to reoffend.

- 5) *Does the offender accept sole responsibility for the abuse?*

High Risk: The offender continues to project blame for the offense, and the resulting consequences onto others, including the victim, other family members, the court, the caseworker, the police, etc.

Moderate Risk: The offender verbally acknowledges responsibility for the abuse at times, but periodically reverts back to blaming others.

Low Risk: The offender consistently acknowledges his sole responsibility for the offenses.

Gathering accurate information to answer these questions is largely the responsibility of the therapists who have worked with the perpetrator to achieve these goals of behavioral control. If the offender has not been in therapy, it is

almost certain that the risk remains very high, despite any self-report of reduced risk. Without a clear and consistent demonstration of low-risk behaviors by the perpetrator, reunification should not be considered, since the offender remains at high risk to reabuse.

Even when all family members have completed treatment goals and are fully committed to reunification, effecting reunification is a complicated and difficult process. Activities toward reunification must be carefully planned, sequenced, and consistently monitored by the caseworker and the therapists. Family members should remain in regular therapy throughout the reunification process and for a significant period of time afterward. Prior to beginning reunification activities, the following must occur:

- The family must have a safety plan, developed by the family as a group, with the assistance of the therapists. Family members must be fully aware of and able to recognize the cycle of sexual abuse in their family, and be able to identify the particular dynamics, events, or situations that triggered abuse in the past. The safety plan identifies specific actions to be followed whenever any of the precursor events are noted. Responses might include calling the agency or therapist; seeking help from a trusted adult; telling the nonoffending parent; or, if necessary, calling the police. The perpetrator and nonoffending parent must make it explicitly clear to the children that they have permission to enact the safety plan, and that these actions are helpful to the family. The safety plan should also identify events and situations that constitute "high risk," and enact family rules to assure they do not occur. The safety plan should protect all potential child victims in the home, not only the child who has previously experienced abuse.
- The offender must have a carefully thought out relapse prevention plan, which is shared with all family members. The perpetrator assumes full responsibility for monitoring his own thoughts, behaviors, and activities, and engaging in strategies learned in therapy to divert the abuse cycle,

including calling the therapist when necessary, and continuing in regular group therapy. Family members must understand and support these self-monitoring strategies.

Reunification is effected only after a series of family visits, both in and outside the home, which are carefully planned and monitored by the family's therapists. Reunification is a gradual process which may occur over a considerable period of time. Family members may have regular family therapy sessions during this time to discuss their progress, and to identify and resolve problems.

Successful reunification is often not possible. There are many therapeutic goals that must be achieved before a family can live safely together after intrafamilial sexual abuse. Many families will not have the capacity to fulfill the therapeutic requirements to achieve these goals. Regardless, participation in therapy as described above can help family members restabilize and recover from sexual abuse, even if reunification never occurs.

There is a dilemma of family dynamics inherent in treatment strategies used to preserve families in which intrafamilial sexual abuse has occurred. In most cases of incest, the male head of household is the perpetrator, and his daughter, or daughters, are the victims. A normal and important aspect of any parent-child relationship is a locus of power and authority with the parent. From a family systems perspective, it is culturally sanctioned and systemically necessary that the male head of household assume at least a portion of the power and authority necessary for the parent dyad to provide leadership, protection, care, and nurturance for children. Many cultures expect a major portion of this responsibility to rest with the male head of household. Children require and expect their fathers to assume this responsibility. The state sanctions this trust relationship, and the power and authority of the parents to carry out their parenting responsibilities.

In situations of incest, the power and authority inherent in the position of male head of household has been misused. In the best of circumstances, treatment

would result in ameliorating the personal problems and pathological dynamics that resulted in incest, and maintaining the normal and appropriate locus of power and authority with the reformed abuser. However, this is almost never possible. In the vast majority of intrafamilial sexual abuse cases, the only way to adequately protect the child is to reduce the power and authority of the perpetrator, usually the male head of household, and transfer and enhance the power and authority of the nonoffending parent. In other words, we must significantly alter the dynamics within the family, greatly reducing the involvement of the perpetrator. Therein lies the dilemma. Most often, the intervention strategies we must use to safely reunify these families so restricts the family's adaptive dynamics that it may preclude the development of a healthy family system. These necessary and appropriate protective efforts often, as an unavoidable side effect, create the situation where the perpetrator becomes not an empowered, authoritative, and reformed family leader, but a powerless, ineffectual, even superfluous family appendage.

Closing the Case

The outcomes in cases of child sexual abuse will vary, depending upon the unique circumstances of each case. The overriding goal for sexual abuse cases is to insure that the child victim is protected from further abuse and from retaliation. There are several ways this can be achieved:

- The nonoffending parent has terminated the relationship with the perpetrator and has demonstrated an ability to protect the child from further abuse.
- The perpetrator has been incarcerated, has relocated, or for other reasons has no access to the child victim, and the nonoffending parent understands her responsibility to protect her child from further abuse.

- The family has completed treatment, has met the treatment goals that assure protection of the children, and has been reunified.
- The child is permanently living with a relative or guardian who has demonstrated the capacity to protect the child from the offender.
- Parental rights have been permanently terminated, and the child has been placed in an adoptive family.

In many cases, the case outcomes may be more equivocal. For example, the worker may not be certain whether the termination of the relationship between the parents will really be permanent. The perpetrator may continue to influence the nonoffending parent through regular contact, even though he is in prison. The case may have to be closed at the intake level because the child's disclosure was not sufficiently convincing to override the perpetrator's and nonoffending parent's denial. Or, the case may be closed by an order of the juvenile court after the family has attended therapy for a prescribed period of time, whether or not significant change has occurred in the family.

In equivocal circumstances, the decision to close a sexual abuse case is always more difficult. In general, the team of professionals who served the family should jointly make the decision by reviewing all the risk factors associated with the abuse, and assuring that they have been addressed.

Even though some cases must be closed in spite of concern about continued risk to the child, certain interventions while the case is open can lessen the likelihood of reabuse. Individual therapy, group therapy, and educational programs can teach the child victims strategies to avoid high risk situations, to protect themselves if they find themselves at risk, and to report problematic or abusive behavior. Similarly, education for nonoffending parents can help them recognize risk early in the cycle and seek appropriate help. The following conditions can potentially reduce the likelihood of reabuse for a child:

- The nonoffending parent fully understands her responsibility to protect the child, knows whom to call, and knows that services will be available to help her, if the need arises in the future.
- The child victim and siblings believe that sexual abuse is wrong. They have learned to differentiate appropriate from inappropriate touching.
- The child victim and siblings know that they have a right to safety and protection, and feel empowered to act in ways to protect themselves.
- The nonoffending parent, the child victim, and siblings have been taught to understand the perpetrator's abuse cycle and to recognize the early signs of reabuse.
- The child victim and siblings have been trained and coached in age-appropriate self-protective strategies. These may vary, depending upon the age of the child. Strategies could include: telling the nonoffending parent; telephoning an extended family member or other supportive adult; going to a relative's, friend's, or neighbor's home; refusing to be left home alone; enlisting sibling support; and being appropriately assertive in the presence of the perpetrator.

Conclusion

Sex is a biological phenomenon with profound adaptive significance. The adaptivity of the human species is dependent upon the successful sexuality of its members. The pleasures of sex are a strong incentive and a procreative necessity for the continuation of the human species. Unfortunately, when manifested within a selfish immorality or characterological psychopathology, this powerful drive can be a potent destructive force.

Child sexual abuse is such an immoral and pathological phenomenon. It is a contravention of human biology and of the sociomoral structures that define our humanity. In this framework:

- Developmentally premature and inappropriate sexual activity is biologically and developmentally destructive to children. Mature sexual activity before sexual organs have developed structural capacity can be physically harmful. Mature sexual activity before children have the capacity to understand, emotionally integrate, and morally assimilate its implications and consequences can have devastating psychological and developmental outcomes.
- Premature sexualization as a consequence of incest can confound and disrupt the child's future relationships with adults and other children. The betrayal of trust by an adult caregiver in parent-child incest can result in serious and persistent social dysfunction for the child victim, often lasting a lifetime.
- Incest is genetically destructive. Offspring are more likely to have genetic weaknesses and defects. Malformations and morbid biological consequences are common. This inherent biological destructiveness has resulted in the evolution of psychological and behavioral schemas to avoid incestuous sexual relations. These are the basis of strong social, cultural, and legal sanctions against incest. No healthy society or culture sanctions incest.

Ethical responsibility, moral duty, and empathy are the products of community. Only within a social context do our behaviors take on a moral quality. From a purely selfish perspective, the only limits on sexuality are biological and circumstantial. However, humankind is a profoundly social species, and within this context, the purely selfish perspective that countenances child sexual abuse is categorically pathological and immoral. The negative social and moral

consequences of child sexual abuse are reflected in the normative sanctions of our societies, communities, cultures, religions, and laws.

Humankind's social and cultural evolution has superseded our antiquated biology. Even though 14-year-old children are biologically capable of procreativity, in today's world, they are cognitively, emotionally, and socially unprepared. In today's protean, highly technical, sophisticated, and unbridled society, children require an extended developmental period in a protecting and nurturing environment to acquire adaptive competence. These social realities are reflected in our customs and laws. Thus, our children are culturally and legally protected from adult exploitation and abuse until they reach the age of majority.

Within our society, the child welfare profession has been delegated the responsibility to protect children from sexual abuse. We must strengthen our capacity to do so.