Order Number 9029937

# The therapists' experience of psychotherapy with sexually abused children

Grosso, Victoria Catalina, Ph.D.

City University of New York, 1990



U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

A

# THE THERAPISTS' EXPERIENCE OF PSYCHOTHERAPY WITH SEXUALLY ABUSED CHILDREN

BY

VICTORIA GROSSO

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy. The City University of New York

1990

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy

4/16/90
Date

Laurence P. Gould
Chair of Examining Committee

4/19/90
Date

Herbert D. Saltzstein
Executive Officer

Louis Gerstman, Ph.D.

Steven Tuber, Ph.D.

Laurence Gould, Ph.D.

Supervisory Committee

The City University of New York

# Abstract

THE THERAPISTS' EXPERIENCE OF PSYCHOTHERAPY WITH SEXUALLY ABUSED CHILDREN

by

Victoria Grosso

Adviser: Professor Lawrence Gould

This dissertation examines the affective experience of psychotherapists in the treatment of sexually abused children. It examines therapist-gender differences and the impact that gender has on this patient population. The study attempts to demonstrate that therapists see the sequelae of sexual abuse and stress related factors associated with the involvement of the legal system and child protective agencies as adding significantly to the traumatic impact of the abuse.

The subjects were twenty-eight psychotherapists of diverse clinical disciplines. They participated on a

voluntary basis and were required to answer two structured response questionnaires: a background questionnaire and a therapy report which surveyed their affective experience. The subjects also rated a stress scale developed by the author which measures stress factors associated with the sequelae of the abuse.

The data indicates differences in the therapists' evaluation of their male vs female sexually abused patients. The therapists discussed their female sexually abused patients more in supervision. They attributed more stress to their female patients after parental separation following disclure of the abuse than to their male sexually abused patients.

The data also revealed differences between male and female therapists. Female therapists tended to feel more comfortable and effective in their sessions and to attribute to their sexually abused patients a positive response to their interventions, while the male therapists tended to feel more apprehensive, uncertain and annoyed with their patients.

## ACKNOWLEDGEMENTS

Many people have contributed to this work. Dr. Laurence Gould provided encouragement and most valuable advise from the onset of this project. Dr. Steven Tuber made important conceptual and editorial suggestions while providing emotional support when it was most needed. I feel particularly grateful to Dr. Louis Gerstman, who was always available and shared so many hours of his valuable time. He communicated unending enthusiasm and a commitment to see me complete this work succesfully.

My colleagues, Alexandra Woods and Sharon Kiuhara were particularly helpful in the beginning stages, while I was struggling to formulate the ideas presented in this work. Their unconditional support helped me overcome a writer's block which had been a dreaded companion for many years.

My husband, Rodger Goddard, extended himself beyond the call of duty to care for our daughter and assume more than his usual share of responsibilities in order that I may complete this project. His patience, impatience, constructive criticism and loving support were always appropriately timed. His enthusiasm and praise of my

efforts enabled me to finish this project with a sense of pride and accomplishment. Finally, I am especially grateful to all the clinicians who shared intimate details of their work with sexually abused children and made this project possible.

TABLE OF CONTENTS

# LIST OF TABLES

# CHAPTER I

# INTRODUCTION

## Introduction to the Problem

Although the problem of the sexual abuse of children has been documented throughout history (Rush, 1980), it is only in recent years that has evolved a growing awareness of the prevalence of sexual abuse cases. Evidence that sexual abuse in childhood is a common occurrence has been drawn from different sources. The Women's movement initially brought attention to the problems of rape, child pornography and child sexual abuse. Staff persons working in crisis centers for rape victims and battered wives have taken note of the high prevalence of sexual abuse in the histories of their patients (Herman, 1981; Swanson and Biaggio, 1985). Surveys of the general population have revealed that 3% to 9% of women had childhood sexual contact with an adult relative (Goodwin, 1982) and 19% of women and 9% of men had an experience of sexual victimization in childhood (Finkelhor, 1979). With increased public awareness, the courageous published accounts of adults who had been childhood victims of sexual abuse (Angelou, 1970; Brady, 1979), and dissemination of information by the media, many children came forth with their "secret". The number of reported cases of sexual abuse grew considerably in the last decade and continues to grow at an alarming rate.

Professional help for these children was rooted

initially in the Child Protective Service Agencies and subsequently included those in the mental health professions. Although some writers have tended to minimize the dangers of sexual abuse in childhood (Weiner, 1978; Storr, 1965; Pomeroy, 1978), the negative, traumatic impact of sexual abuse on children is a widely accepted notion (Finkelhor, 1984; Gelinas, 1983; Sgroi, 1985; Summitt, 1983, Herman, 1981). There is therefore a pressing need for mental health professionals to conceptualize the problem and develop effective intervention strategies.

The psychotherapist treating children who have been sexually abused faces enormous difficulties. First, although some significant contributions have been made in recent years (Finkelhor, 1984; Sgroi, 1985; Giarretto, 1981), there is a lack of a unified theory on the impact of sexual abuse on the child and implications for treatment. The literature is mostly descriptive, which poses difficulties in generalizing findings. In the empirical literature, case studies with small samples predominate. Strong divergence of opinion still prevails between those who look at sexual abuse from a feminist perspective and see the problem as rooted in the male socialization process and those who see the problem as a symptom of the dysfunctional family.

Second, the need or pressure for the therapist to advocate for the child is almost always an intricate part of

the treatment. Many states have laws regarding parties responsible for reporting suspected child abuse and neglect. Therapists are included in these "mandated" sources and are legally liable for the abuse or neglect of the child concerned if they do not comply with the state's law . Conflict often arises between the therapist's clinical judgment, ethical issues, the welfare of the child and what is required by the law. The therapist will often find himself or herself involved in court proceedings and mediating with Child Protective Services. This involvement beyond the therapist's role is often taxing and frustrating. Therapists frequently find themselves burdened with responsibility, mediating between family, attorneys, and social service agencies. While their authority as an expert opinion is always appealed to, it is not always used in the best interest of the child.

Last, the treatment of a sexually abused child evokes strong emotions and reactions in the therapist, conscious and unconscious. The sexual abuse of children is a highly emotionally charged subject since it represents violation of social taboos that are prevalent in almost every culture: sex with children, forced sex and incest. The feelings of discomfort and anger have caused health professionals to avoid the problem of sexual abuse and to underestimate its severity and extent (Jones, 1982, p.142).

Berta Bornstein (1948) has described the special

problems that the analyst faces in the treatment of children. She describes the "irrational" reactions that are inherent in the adult's relationship to children in our society. Because of their unpredictability, their highly charged emotions, their narcissism, their closeness to the unconscious, children are perceived as a threat by their parents and by society in general. Bornstein states that we find traces of these "archaic" tendencies in the analyst's relationship to children. The need to protect the young and an empathic response to the helplessness and immature appearance of the child is another tendency shared by every culture, one that has evolutionary adaptiveness. Thus, therapeutic failure with children is experienced more intensely and the fear of this failure may obstruct the analyst's professional work. Bornstein emphasizes a serious complication in the treatment of children: the danger of regression, which no one in continuous contact with children can escape:

> "This process is so insidious that its pressure accumulates unnoticed. The defenses the analyst brings into play against this pressure may block his intuition. He is especially prone to such defense reactions in two instances: when the child's sexual demands toward the analyst appear in a concealed form; and when children change their neurotic symptoms to aggressive and provocative behavior (1948. p.696)".

These complications, which apply not only to child analysis but also to other forms of psychotherapy with children, are intensified for the therapist in the treatment

of sexually abused children. The nature of the problem and the children's presentation may evoke strong countertransference reactions in the therapist and counterdefenses which interfere with the therapeutic process. Also, the difficulties arising out of legal proceedings, involvement of social agencies, resistances in the child's family, contribute to the therapist's sense of "failure" and "helplessness" in the treatment of these cases.

The present study examined the experience of psychotherapists in the treatment of sexually abused children. It was hypothesized that therapists experience strong emotions and a sense of failure in the treatment of sexually abused children and see the sequelae of the abuse and stress related factors associated with the involvement of the legal system and child protective agencies as adding significantly to the traumatic impact of the abuse. Other hypotheses involved gender differences: both male and female therapists would have more negative attitudes toward male sexually abused patients as compared to female sexually abused patients; male therapists, when compared to female therapists, would see female sexually abused patients as more seductive; female therapists would overidentify with female sexually abused patients and would exhibit more anger at the abusers when compared to male therapists. Last, it was hypothesized that differences in the theoretical

orientation of therapists would reflect in their attitudes of and experience of psychotherapy with sexually abused children. Gender differences and differences in theoretical orientation would tend to disappear as a factor of the therapists experience.

It was hoped that the investigation of the above questions a) would have practical implications for the treatment of sexually abused children, b) would contribute to the literature on the subject matter, c) might point to the impact of gender in the treatment of this patient population, d) would raise issues for future research.

Rationale of the Study

Howard and Orlinsky (1969) have stressed the importance of research on the therapist's experience of psychotherapy for the following reasons:

1) The therapist's actions in therapy are, in part, a function of his experience of the patient (and himself) in their common situation.

2) Consequences of importance for the outcome of therapy actually follow from the therapist's actions. The experiences that condition his or her actions have an eminently practical relevance.

3) The therapist is often in a position to offer opinions and to make decisions that can have far reaching effects on the life and social network of his or her patients.

4) The principal data base for theories of personality, and the theories of therapy that are associated with them, were mainly derived from the experiences of their authors in the course of working with patients.

Although research on the therapist's experience of psychotherapy can be a most valuable avenue of investigation, there are difficulties inherent in the subjective element in the therapist's report of his or her experience. When we look at countertransference, the difficulties in objectively measuring unconscious phenomena pose problems of definition for the researcher. An expanded definition of countertransference has been used for the majority of studies, resulting in the measurement of all reactions(conscious and unconscious) of the therapist to the patient. This, however, does not totally eliminate the limitations and difficulties in measuring countertransference phenomena. Singer and Luborsky (1977) reported that early attempts by the Menninger Foundation and the National Institute of Mental Health to measure countertransference met with little success. These studies relied on the self-report of therapists, usually after the therapy sessions had ended. Since then, a method of indexing countertransference has emerged from the empirical literature (Cutler, 1958; Snyder & Snyder, 1961; Howard & Orlinsky, 1970; McClure & Hodge, 1987). In this method countertransference was defined as the therapist's

misperception of the client and operationalized as the measured difference between the therapist's and patient's perception of what occurred in the therapy session.

In spite of the difficulties involved, the investigation of countertransference phenomena seems of particular value in relation to child patients, since many authors believe that countertransference problems are more pervasive in child treatment than in adult treatment. Anthony (1982) stresses that the management of countertransference and counteridentification is one of the most difficult problems in child analysis. Kohrman et al. (1977) have noted that counter-reactions in general are present to a much greater degree in the analyses of children. Sexually abused children may evoke particular emotions in the therapist which may become an obstacle to successful treatment. First, there is the notion that the child is sexually active. The child was involved in the transgression of societal sanctions: sex between adults and children and, most commonly, incest. These notions stir up conflictual, and often, unresolved material in the therapist and strong counter-reactions and counter-defenses. In addition, there is often a need or pressure to become an advocate for the child. The therapist becomes involved with court procedures, child protective agencies, and mediates between these agencies and the child's family, thus extending himself or herself beyond the therapist's role.

Although therapists of both sexes may experience helplessness and frustration and strong countertransference reactions in the treatment of sexually abused children, the possibility that gender differences impact on these experiences comes into question. This area is virtually unexplored in the literature on sexual abuse. Finkelhor (1984), Herman (1981), Groth (1979), and Rush (1980) have addressed gender issues regarding the prevalence of male abusers and other authors have explored the differences between male and female victims (Farber, 1984, Khan and Sexton, 1983). How gender issues may affect the psychotherapy process in sexual abuse cases remains to be answered.

Although Finkelhor has not looked directly at therapist gender differences in the treatment of sexually abused children, he conducted a study (1984) among the general population which led to some interesting and significant findings in the area of gender differences. In Finkelhor's study subjects had to rate the severity of sexual abuse in hypothetical vignettes. The female subjects rated sexual abuse vignettes higher than men, taking the abuse more seriously. The female subjects also saw the abusiveness inherent in the betrayal of the family bond rather than in the sexual violation. Male subjects were more focused on the violation caused by the sexual intruder.

Other evidence of gender differences that might affect

the therapeutic process results from studies of sexual misconduct between therapists and patients. In a study where 1423 Board Certified psychiatrists responded to a national survey on reporting practices regarding sexual misconduct by colleagues (Gartrell et al., 1987), female respondents (69%) were more likely than male respondents (52%) to favor mandatory reporting. Eighty-eight % of the respondents who reported having sexual contact with their patients were male psychiatrists with female patients. Similar findings among psychologists and their patients (Holroyd and Brodsky, 1977; Pope et al., 1979) suggest that there are deeper issues in the training and socialization of men that make this misconduct and abuse of power, acceptable to some.

Issues in the socialization of men have also been shown to have definite impact on the treatment of male victims of sexual abuse. Because of the definition of masculinity in our culture we expect boys to be able to defend themselves, not to be a loser in confrontation, not to be a victim. The effects of cultural bias are seen in the underreporting of sexual abuse cases among male children (Nasjletti, 1980; Finkelhor, 1984). Rogers and Terry (1984) have observed behavioral changes more unique to male victims of sexual abuse. These behavioral manifestations are: testing in the therapeutic situation; inappropriate attempts to reassert masculinity; and recapitulation of the victimizing

experience in the role of the offender. Denial or minimization and blaming the victim are more prevalent among the families of sexually abused boys.

The possibility that therapists are influenced by the same cultural biases and homophobia comes to question. The boy's presentation, which is often more aggressive and defiant as compared to girl victims, may contribute to the therapist's difficulties in the treatment of male victims. Nasjletti (1980) has observed that it is extremely difficult for sexually abused boys to discuss their experiences in individual or group treatment. There is also some evidence that boys, although they tend to complete treatment in more cases than girls, are kept in treatment for a shorter period of time (Pierce & Pierce, 1980). This suggests that therapists might feel that the abuse does not impact as much on the boy victim, or may have difficulty managing these treatment cases, terminating prematurely.

Definition of Terms

For the purpose of the present study, countertransference was defined in a totalistic way to include all responses of the therapist to his patient, conscious and unconscious. Countertransference included the reactions of the therapist to his patient's transference and to his patient as a real person, as well as those feelings arising out of the therapist's own conflict, his cultural biases and values.

Sexual abuse was defined as sexual contact between a preadolescent child and an adult person, or with a person ten years their senior, where the child was used for the sexual stimulation of the abuser and was coerced into the sexual activity by the use of threats, bribes, promise of affection, or emotionally rewarded and gratified by his or her participation in the sexual activity with the abuser. For the purposes of this study the definition did not include cases where physical force was used, such as rape.

Therapist's experience was defined as the sum of the therapist's years of clinical experience, years in personal psychotherapy treatment, as well as the number of sexual abuse cases treated by the therapist.

Delimitations of the Study

The scope of the study was delimited by the writer in a number of ways. It was restricted geographically to the New York and New Jersey areas. The sample was restricted to therapists working in community clinic and hospital settings, since therapists in private practice can be more selective in their choice of patients. Those therapists who work for sexual abuse treatment centers were also excluded from the sample. The organizational structure of sexual abuse treatment centers allows for marked role distinctions, with staff acting as advocate for the child patient and his or her family, and therapists working exclusively in their role as psychotherapists. Since one of the questions the

study explored was about the difficulty therapists experience with their various roles in the treatment of sexually abused children, the "specialized" sexual abuse therapists were excluded.

As already mentioned in our definition of sexual abuse, victims of rape were not included in the sample. Rape is a violent crime, where the victim is never an active participant. The motives and psychology of men who rape are different than the motives and personality dynamics of men who sexually abuse children. Therefore, differences exist in the dynamics involved as well as in the victim's relationship to the abuser. Limitations of the Study

The study was limited by certain conditions beyond the writer's control. The voluntary nature of respondents biased the sample since one can assume that those subjects who agreed to participate in the study had an interest, concerns or were experiencing difficulties in the treatment of the patient population studied. Their interest in participating could reflect that this sample was more willing to look at their own feelings and countertransference in the treatment situation, and in this respect might not be representative of the majority of therapists who treat sexually abused children.

As was expected, consistent with the literature and research on the subject, the majority of the abusers in the sample were male. Therefore, the findings cannot be

generalized to those cases where the abuser is a female. Also consistent with the research and literature on sexual abuse, our sample of male victims was too small for the purposes of statistical analysis.

We had expected to exclude adolescent children from our sample. One of the areas the study sought to investigate was the discomfort that therapists experience with the notion that the child they are treating has been sexually active as well as with the child's sexualized presentation. Emerging sexuality is a part of normal adolescent development, and it is not uncommon for adolescents to be sexually active. The difficulties that this might present in the therapeutic relationship are independent of whether the child was sexually abused. Furthermore, one could assume that therapists will experience more discomfort with a latency child's sexualized behavior, since the expectation is for a reshifting of the sexual drive during the latency age period.

# CHAPTER II

# LITERATURE REVIEW

## A look at the Problem

The problem of the sexual abuse of children has been recorded throughout history. It was not always seen as a problem, however, and often had society's sanction. The Bible and the Talmud encouraged sex between men and very little girls in marriage, concubinage and slavery. The Talmud held that a female child of "three years and one day" could be betrothed by sexual intercourse with her father's permission. In biblical times, young girls were purchased from their fathers in marriage, and sold and resold in prostitution. Rape was considered the "theft" of a girl's virginity which could be compensated for by payment to her father (Rush, 1980). Pederasty, a custom which advocated sexual relationships between mature and immature males was common among the Greeks.

Child marriage continued to thrive under Christendom, although Canon law ostensibly forbade it (Power, 1966). The legal age for marriage was 12 for the bride and 14 for the groom. In the Middle Ages, it was not uncommon for a girl to be a bride at ten to septuagenerian.

In 1888, Krafft-Ebing, a physician and sexologist, said:

> "Criminal statistics prove the sad fact that sexual crimes are progressively increasing in our modern civilization. This is particularly

> the case with immoral acts with children under fourteen " (Rush, 1980, P.57).
> Child prostitution was rampant in Victorian Europe.

Incest was considered to be immoral rather than criminal behavior. Until 1908 in England it was punished in ecclesiastical courts (Duddle, 1984).

In 1896 Freud published two treatises setting forth the radical position that childhood sexual trauma was at the root of adult hysteria. Freud anticipated his colleagues skepticism and the Victorian times were not receptive to his ideas. Although Freud believed his patients disclosures, he had difficulty accepting the notion that childhood seduction was as prevalent as his patients stories suggested. His explorations into the nature of the unconscious, which gives equal validity to reality and fantasy, and his self-analysis led Freud to abandon the seduction theory and to the formulation and elaboration of the hypotheses concerning infantile sexuality and psychosexual development. These became the foundation of psychodynamic theory. Unfortunately, the superficial application of Freud's theories regarding the role of sexual fantasy in childhood was used to establish a precedent of disbelief of the victim, maintaining that these accounts were a product of the child's imagination.

In an early and often quoted study of 16 children between the ages of 5 and 12 hospitalized following sexual molestation, Bender and Blau (1937) observed that those

children who had been molested by non-family members "undoubtedly do not deserve the cloak of innocence"... and "frequently considered the possibility that the child might have been the active seducer rather than the one innocently seduced" (p.514). A follow up study 15 years later by the senior author reaffirmed the earlier position (Bender & Grugett, 1952).

In 1932 Ferenczi read a paper before the 12th International Psychoanalytic Congress which met with disapproval by every leading analyst of the day. The main focus of his paper was the reality of sexual assaults of young children. The original title was "The Sexual Passions of Adults and their Influence on the Character Development and Sexual Development of Children" (Masson, 1985). In it Ferenczi describes how the child's desire for "tenderness" can be exploited by an adult's need for sexual gratification. The child cannot refuse the adult, because he or she is "physically and morally helpless" and "paralyzed by fear". In an identification with the aggressor, the child introjects the guilt that the parent or other adult ought to feel, since the act is perceived as wrong and there is nobody to take responsibility but the child victim. The aggressor "disappears as external reality and becomes intrapsychic instead of extrapsychic". Ferenczi addresses the denial that the child encounters from the aggressor and other people that he trusted and how the

abused child turns into a mechanically obedient being or becomes defiant, but can no longer account for the reason for the defiance. The child's sexual life remains underdeveloped or takes on perverse forms. Neuroses and psychoses may result from these situations.

Ferenczi wrote very emotionally about this subject, but spoke eloquently to the reality of sexual abuse among children and the effect that this might have on their development and future emotional functioning. He was ahead of his time. The paper was not published in English translation until 1949, in the International Journal of Psychoanalysis.

Sexual abuse continued to be regarded as an uncommon problem until the late 1970s, where official reports of sexual abuse began to mushroom at a much more rapid rate than reports of other forms of abuse. A systematic effort to estimate the number of new cases of sexual abuse known to professionals shows a figure of 44,700 for the year starting in April 1979 (Finkelhor, 1984). The problem, however, is considered to be far greater than statistics on reported cases would indicate.

Studies of the prevalence of sexual abuse in the general population suggest that it is still extremely undercounted by official reports. A mail survey in Texas of 1054 driving license holders found that 3% of male respondents and 12% of female respondents had been sexually

abused in childhood (Kercher, 1980). A survey in 1978 that used 14 separate questions regarding a variety of forms of child sexual abuse found that 28% of San Francisco women had experienced unwanted sexual touching before age 14 (Russell, 1983). Of the 930 women, 12% had been abused by a relative. Thirty-eight percent of these women had experienced an attempted or completed rape and other forms of unwanted contact by relatives before the age of 18.

Surveys of the college population have shown that from 19 to 22% of females and 5 to 6% of males report sexual victimization in childhood (Finkelhor, 1979; Fritz, Stoll & Wagner, 1981; Fromuth, 1983). Finkelhor estimates that about 210,000 cases of sexual abuse occur every year. Jones (1982) estimates a nationwide incidence of 336,000 each year. Cases of incest are more prevalent than non-familial sexual abuse. In 80% of all cases a parent or guardian is involved. Only 9% of all cases are reported (Jones, 1982).

Reported incidence of previous incest is high in young adults with a psychiatric history and substance abuse disorders (Gelinas, 1983; Krener, 1985). In a study among the psychiatric staff of 147 inpatient units, Kohan, Pothier and Norbeck (1987) found that of 1,432 children reported, 16% of boys and 48% of girls had been sexually abused.

We now know that not uncommonly abuse goes on for an

extended period of time. Most victims never tell anybody about it (Herman, 1981, Finkelhor, 1984; Summit, 1980; Gelinas, 1983; Sgroi, 1985). Abuse can leave substantial psychological scars on its victims in the form of disturbed self-esteem and inability to develop trust in intimate relationships (Meiselman, 1978; Herman, 1981; Gelinas, 1983; Summit, 1980).

Impact on victims

Since the prevalence of sexual abuse has been accepted, a subject that remains controversial is that of the impact it has on the children who have experienced this abuse. Although most researchers agree that sexual abuse has immediate traumatic impact on the child, there remains some disagreement and confusion about the long-term effects. The question whether sexual abuse is the actual cause of long-term trauma and accompanying psychopathology is difficult to address. Brown (1979) cites the case of an eleven year old boy who was admitted to a psychiatric hospital presenting with complaints of poor peer relationships, uncontrollable behavior at home and school, poor school work, enuresis and a speech problem:

> "He was sodomized by his stepfather, starting when he was seven years old and continuing until he was ten, and physically abused by his natural father from birth. As an infant he was thrown against the wall because of constant crying, and once his father put him in the dryer to silence him. Family life was always extremely chaotic, with marginal financial resources. The mother's hypochondriacal concerns bordered on the psychotic. In this environment it would be difficult to say which of

> Tommy's symptoms were attributable to neglect, , to physical abuse or to innate constitutional weaknesses (p.436)".

As is illustrated in this case, it is often difficult to separate the trauma of sexual abuse from that caused by severe pathology in the family. Often, sexual abuse occurs in a situation where there is family dysfunction, where the child is experiencing emotional deprivation and where the child is not adequately provided for and protected by parental figures.

Nevertheless, as we look more into the problem of sexual abuse in childhood, a clearer picture is starting to emerge. Finkelhor and Browne (1985) describe four "traumagenic dynamics", which make the trauma of sexual abuse unique. These are: traumatic sexualization, betrayal, powerlessness and stigmatization. These dynamics alter the child's cognitive and emotional orientation to the world and distort the child's self-concept, world view and affective capacities.

Finkelhor and Browne have found that in those experiences in which the adult offender has made an effort to evoke the child's sexual response rather than used the child as a passive sexual object can be more sexualizing and lead to inappropriate sexual preoccupation, compulsive masturbation or sex play, confusion about sexual identity. The dynamic of "traumatic sexualization" may lead the child to repeat the victimization experience as an adult, by

becoming subject to further abuse, or turning passive into active in the role of the prostitute or the abuser. It may also lead into sexual dysfunction and aversion of sex and intimacy in adulthood.

The powerlessness experienced by the child when his territory and body space are invaded, when he is unable to stop the abuse because he is afraid of or dependent on the adult abuser often leads to nightmares, phobias , clinginess, hypervigilance, and somatic complaints. The child may develop a sense of impotence and an expectation of victimization, or resort to aggressive and delinquent behavior.

The deep sense of betrayal experienced by the child is often aggravated by the family's response to disclosure. The child may experience a grief reaction and depression over the loss of a trusted figure. The child may show extreme dependency and clinging or hostility and anger. These are expressions of the loss of trust in significant others.

The dynamic of "stigmatization", as conceptualized by Finkelhor and Browne leads the child to incorporate into his or her self image the negative connotations that are communicated by the abuser and reinforced by attitudes from family and community. The child has prior knowledge or sense that the sexual activity is considered deviant and taboo. The abuser's overt or covert blaming of the child,

the pressure for secrecy, reinforces the child's feelings of shame and guilt, of "badness". Often, these feelings are reinforced after disclosure if people react with shock or hysteria. The stigmatization contributes to the child's feelings of isolation and may eventually lead into alcohol and drug abuse, criminal activity, extreme self-destructive behavior, and suicide.

In a study of 45 female paternal incest victims, with ages ranging from seven to thirty-eight, where none of the subjects had been physically abused, De Young (1982) found that 57.7% had engaged in self-injurious behavior as youngsters, ranging in type from cutting and slashing, bruising and burning to deliberate attempts to break bones. In all cases the self-injurious behavior began after the overt incestuous relationship had been initiated by their fathers or stepfathers. The average age of onset of incest was 9.7years and its average duration was 2.7 years.

Most of the respondents in De Young's study stated that they were "punishing" themselves when they engaged in the self-injurious behavior. De Young explains the behavior as a consequence of the "introjection of the parents' hostility and abuse", since the father's disavowal and the mother's denial make the victim assume responsibility for the incest. The child has a need to "punish" the body that has "betrayed" her because it responded to the sexual stimulation with pleasure. De Young's subjects reported

feeling overwhelmed by fear, anger, guilt and a sense of betrayal. The injurious acts were a way of dealing with these intense feelings, replacing them by "numbness", "unreality", "emptiness", and "dream like states". The subjects performed the self-injurious acts in front of the mirror, and the sight of the injury seemed to "free" the child from the intense feelings that led to the act.

Simpson (1977) also found self-mutilation behavior to be prevalent among incest victims. His subjects ranged in age from fifteen to thirty-three. Simpson suggests that when the tension of sexual abuse becomes intolerable, a transitional state of depersonalization occurs. The act of self-mutilation enables the victim to be "aggressor and aggressed, actor and acted upon, punisher and punished" (p.51). Simpson's findings should be taken with caution since the research presents methodological problems: the retrospective approach applied only to older participants, and his samples were small. Other authors (Herman, 1981; Shapiro, 1987), however, have substantiated the occurrence of self-destructive acts in incest victims.

Summitt (1983) classifies the most typical reactions of normal children to sexual abuse into five categories which make up the "child sexual abuse accommodation syndrome". These categories are: secrecy; helplessness; entrapment and accommodation; delayed, conflicted and unconvincing disclosure; and retraction. Summitt states that the child

is entirely dependent on the abuser for whatever reality is assigned to the experience. Of all the explanations provided by the adult for the occurrence of the abuse , the only "consistent and meaningful" impression gained by the child is one of danger and fearful outcome based on secrecy. The secrecy makes it clear to the child that what is happening is "bad and dangerous". It is the "source of fear and the promise of safety" (1983, p.181).

Summitt emphasizes the "progressive intrusion" of the adult on the child and the "overpowering, one-sided perpetrator victim relationship" which engenders continuing helplessness in the child. Faced with this experience, the child must somehow learn to achieve a sense of power and control. The child assumes responsibility for the abuse, and strives to be "good", which in many cases means being available without complaint to the parent's sexual demands and keeping the secret in order to protect the family. The child who structures her reality to protect the parent resorts to defenses such as dissociation and flight into fantasy or acts out her helplessness, rage and self-hate in acts of self-mutilation, suicidal behavior, promiscuity and running away. Summitt states that when sexual abuse is disclosed, it is usually after years of ongoing abuse and its related accommodation mechanisms. This could be a time where the child will not find understanding and will only encounter disbelief.

The model of "traumagenic dynamics" proposed by Finkelhor and Browne (1985) and Summitt's (1983) conceptualization of the "sexual abuse accommodation syndrome" focus on the impact sexual abuse had on the abused child, without differentiation of the experiences of abuse and thus avoids classification of the abuse as "more or less traumatic" as well as distinctions between intrafamilial and extrafamilial sexual abuse. Although this approach may be very useful and allows for a complex assessment and treatment planning, differences in age of onset, duration and type of abuse should not be overlooked.

In a study of children referred to a Child Guidance Clinic at a University Hospital, Adams-Tucker (1982) found differences in the children's presenting symptoms related to the age when they were first abused. Over one-half of her sample were under age seven and three quarters were under nine years old. Children who were first sexually abused at age six or seven showed marked anxiety and had diagnosis that reflected "deeper" upset: depressive neuroses, behavior disorders and one case of psychosis. Children first abused at about seven and a half years of age had diagnosis of more moderate behavior reactions, with anxiety, withdrawal and some elements of depression. Those children who were first molested at ten to fifteen years of age were most commonly depressed, withdrawn, and showed aggression against the self more often than the rest of the sample.

Most of the referrals for inpatient were offered to the latter group, although the Louisville Behavior Checklist severity levels showed that ratings were much more severe in the two to ten year olds than was suggested by the psychiatric diagnosis or case disposition. These younger children "were debilitated by a panic that affected their functioning at school, their functioning with siblings, peers and parents, and their sleep and bodily functions" (p.1254). Adams-Tucker results' also showed that chief complaints were more severe for those children who were not supported by the adults on whom they depended and where the abuse had been of longer duration.

Adams-Tucker's results are important because they bring to attention the effect that sexual abuse may have on the younger child, since it results in problems related to interference with the process of entering latency. In latency, the urgency of the sexual drive does not diminish, but rather there is a "shift" in the way the drives are discharged (Sarnoff, 1976). Phallic drives are replaced by anal-sadistic drives, which are then defended by the appearance of defenses: sublimation, reaction-formation, fantasy, regression and repression. These defenses allow the child to direct his of her energies toward cooperative behavior and learning. Normally, the child will seek outside the home for life experiences that will advance self-esteem through the mastery of learning and through

satisfactory peer relationships. The sexually abused child is not able to accomplish these developmental tasks like other children. When reality meets the fantasy, the child fails to strive, remaining overexcited, unable to form symbols and sublimate. In incest cases, the child's energy is bound up in preserving the family equilibrium and the child is thus not able to develop normal peer relationships (Summit, 1980).

Hartman et al. (1987) examined the characteristics and long-term sequelae of sexual abuse experiences in a sample of women in outpatient group psychotherapy. Their results indicate that the younger the age at the time of the first sexual abuse incident, more extensive sexual involvement during the abuse and a greater number of lifetime abuse incidents were associated with current higher levels of reported distress about the abuse. These women were more likely to have had inpatient and psychiatric hospitalizations and to have attempted suicide. The researchers concluded that

> "...sexual abuse in itself is an insufficient explanation for the long-term negative sequelae of incest. The victims' young age in the context of unhealthy family dynamics prevented them from recovering the self-esteem and sense of integrity disrupted by the abuse. This may in turn have reduced their ability to protect themselves from further exploitation by others"(p.59).

A significant finding in this study was that those subjects who had experienced familial abuse reported higher

current levels of depression and anxiety. The researchers concluded that incest victims, even more than victims of other sexual abuse, have difficulty externalizing the abuse and persist in higher levels of negative feelings about themselves.

In a study of sexually abused female children, Mac Vicar (1979) found age differences, as well as differences between "accidental" and "participant" victims. She found that the psychotherapy treatment of latency girls which involved close work with the family and allowed the girl to discuss her feelings was not sufficient to resolve the symptoms. She found that the girls' immature reality testing and fantasies about sexual matters resulted in distortions of the experience which led to high levels of excitement and severe symptomatology. The girls were more likely to interpret the molestation as a "sadistic punishment" and to then turn passive into active (p.347)

The latency girls who were "participant" victims showed more pervasive symptoms as compared to the "accidental" group. Learning disorders, behavior problems, phobias, compulsive masturbation and enuresis were frequent complaints. The adolescent girls who were participant victims tended to internalize the anger they felt toward the assailant and the mother, in order to retain an image of the "good parents". These girls were more likely to be severely depressed.

Mac Vicar (1979) proposes that the "participating" victim has much more to deal with than the "accidental" victim. Factors involved are: 1) the sexual excitement aroused, which will be of great intensity, will be phase inappropriate and will induce guilt; 2) the arousal of high levels of aggression as the molestation is seen as a sadistic attack and the girl then identifies with the aggressor; 3) guilt over hurting the mother and disrupting the family if legal action is taken; 4) fears of rejection and abandonment by the family; 5) disappointment in the trusted adult (p.349).

Gelinas (1983) proposes that the repercussions of incest may manifest themselves immediately after the abuse or considerably later in life. Very common among female incest victims are the chronic traumatic neurosis, continuing relational imbalances and increased intergenerational risk of incest. The chronic traumatic neurosis occurs only after the abuse has been disclosed. The predominant affect is fear. Denial persists, but with repetitive intrusions of certain elements of the traumatic experience. The use of dissociative defense is common: victims report becoming "part of the wall", "floating on the ceiling looking down on what was happening", "taking imaginary walks" when the abuse was taking place. Finally, there is a compulsive tendency toward repetition. Repetition takes place in thought (nightmares,

hallucinations, recurrent ideas); in emotion (weeping episodes, panic attacks); and in behavioral reenactments (compulsive verbalizations, recurrent expressions through gesture, movement or artistic production).

Gelinas states that chronic depression, guilt, poor self-esteem, feelings of powerlessness, substance abuse, chronic heightened anxiety, and suicidal attempts are observed as long-term effects of the incest experience. The abuse impacts character development and has relational implications which last throughout the victim's life. It increases the likelihood of further sexual abuse and exploitation for the victim as well as her children.

Porter, Blick and Sgroi (1984) believe that guilt, fear, depression, low self-esteem, poor social skills and a "damaged goods" syndrome are likely to affect all children who have been sexually abused. In their view, those children who were involved in an incestuous relationship or a sexual relationship with a significant adult will be more likely to show blurred role boundaries and role confusion, repressed anger and hostility, impaired ability to trust, pseudomaturity coupled with failure to accomplish developmental tasks and problems with self-mastery and control.

A study that explored the relationship between childhood sexual victimization experience and adult functioning (Gold, 1986) found significant differences

between women who had been sexually abused as children as compared to controls in their level of depression, psychological distress, self-esteem and sexual problems. Adult functioning was related most strongly to their attributional style for bad events, i.e. their internal, stable, global attributions for bad events and from expectations of having no control over the environment.

A long term effect frequently observed (Meisellman, 1978; Finkelhor, 1984; Herman, 1981) is problems with sexual self-esteem, with victims feeling sexually stigmatized. Finkelhor (1979) developed a measure of sexual self-esteem which indicates current level of sexual satisfaction and adjustment and used this with a non-clinical population of college students. He found that students who had been sexually victimized as children had lower levels of sexual self-esteem. This was independent of family income, emotional deprivation or family sexual practices.

Boatman et al. (1981) report that female incest victims experience problems with their sexuality because being sexual for these women becomes associated with being in collusion against mother. The mother's anger at the child's sexuality and her unavailability as an acceptable female role model further leads to suppression of sexual feelings. In Boatman's view, incest victims experience a damaged or inadequate sense of self since the mother is lost as an object of identification. Furthermore, these children tend

to become isolated from peers, thus loosing them as objects of identification. They argue that the incest victim, having been a winner in the oedipal situation experiences deep guilt, which is defended against by an attitude of extreme passivity, leading into problems with heterosexual relationships.

Herman (1981) describes the fantasies of women who were incest victims in childhood. These fantasies involve the feeling that they had extraordinary powers over others, especially sexual powers over men, and destructive powers over both men and women. Herman explains this as a defense against the feeling of being dominated and overwhelmed by their fathers. As "guardians of the incest secret", the incest victims felt that they had the potential power to destroy their families, but also experienced a sense of specialness and privilege which they had derived from being their fathers' favorites. In adult life, 60% of the women complained of major depressive symptoms, 38% had attempted suicide, 55% reported impairment in sexual enjoyment 20% had engaged in episodic drug or alcohol abuse. These women came to expect abuse and disappointment in all intimate relationships. Rather than being abandoned, they opted for being exploited. These repeated instances of exploitation deepened their distrust of other people and increased their isolation. Although the incest victims tended to overvalue and idealize men and were on the surface hostile and

contemptuous toward other women, Herman believes that at a deeper level they were identified with their mothers, and the "ranks of fallen and worthless women". Herman states:

> "The victims of incest grew up to become archetypally feminine women: sexy without enjoying sex, repeatedly victimized yet repeatedly seeking to lose themselves in the love of an overpowering man, contemptuous of themselves and other women, hard working, giving and self-sacrificing. Consumed with inner rage, they nevertheless rarely caused trouble to anyone but themselves. In their own flesh, they bore repeated punishment for the crimes committed against them in childhood" (Herman, 1981,p.108).

Herman's passionate statement speaks eloquently for the suffering of the female victim of sexual abuse. In recent years, health professionals and researchers have looked at the problem honestly, often expressed strong emotions, and involved themselves in controversy over the issue. The problem of the male victim of sexual abuse though, remains largely surrounded in silence.

Male Victims of Sexual Abuse

Most of the literature on incest describes and attempts to explain the "typical" incest situation, that is, father-daughter incest. The few reports found in the literature on father-son incest (Lansgley, Schwartz and Fairbairn, 1968; Awad, 1976) refer to individual cases. Likewise, the majority of cases of extrafamilial sexual abuse mentioned in the literature refer to the female victim. Although most authors agree that there is a predominance of female to male victims, studies of sexual offenders suggest a far greater

proportion of male victims than is reported.

Groth's study (1979) of over five hundred male rape offenders found that 51% chose only girls, 28% chose only boys and 21% chose both boys and girls. This study of men who rape points to the dynamics of dominance, power and anger over the victim. Sex of the victim is not important.

In a study of 1,500 men convicted for a variety of sex offenses (Gebhard, 1965) 18 % of the heterosexual offenders versus children had a sexual experience with an adult male during childhood. This figure was exceeded only by the homosexual offenders versus children. More of the homosexual offenders were the recipients of approaches by adult males in preadolescence than were the members of any other sex offender group.

Howells (1981) distinguishes "preference" from "situational" child abusers. Preference abusers have a primary sexual orientation to children and are relatively disinterested in adult partners for the fulfillment of both sexual and emotional needs. Their victims are usually male children, whose role tends to be that of a substitute for an adult female partner. Groth (1982) who distinguishes between "fixated" (referring to arrested psychosexual development) and "regressed" abusers (referring to psychopathologically regressive behavior under stress) has similar observations. Most molesters of boys state that they do not have adult homosexual preferences. They are

drawn to children's immaturity and helplessness. Florence Rush eloquently addresses the dynamics underlying this preference:

> "Gender is a flexible term. Masculine or feminine does not necessarily correspond to those who are male and female. Women and male and female children are often patiently, indulgently, condescendingly or angrily seen as weak, dependent and helpless. Gender differences, unlike sexual differences, implies masculine superiority and feminine inferiority, and since the prototype of romantic or sexual love contains the formula of one dominant and one subordinate partner, men sometimes select a person of the same sex but opposite gender as a sex partner ( 1980, p.170)".

Other evidence about the prevalence of sexual abuse of boys comes from surveys of the general population. Finkelhor's (1979) survey of college students revealed that 8.7% of males had a sexual experience under the age of 13 with a partner at least five years older. Finkelhor's subjects rated their experiences as less negative than the female subjects and were more likely to cite interest and pleasure as reactions to the sexual experience. However, the boys seemed to have been affected as much if not more than the girls, as measured by impact on sexual self-esteem. This finding was significant, since it points to the different meaning of sexuality for men and women. While the men minimized their experiences, the impact of the sexual abuse showed to be serious as revealed in the long-term effects on their sexual self-esteem.

In a sample of respondents from the general population

in Boston, Finkelhor (1984) found that 3.2% of his male respondents had an experience before age 13 with a partner at least five years or older involving physical contact and labeled by the respondents as "abuse". Landis (1956) found in a retrospective study that only 17% of male victims had reported sexual abuse as compared to 43% of female victims. Finkelhor (1984) suggests that the male ethic has depicted boys' experiences with older persons and adults as much less victimizing than they actually are. He blames the male ethic of self-reliance and the stigma attached to homosexuality for the reluctance to report sexual abuse among male victims.

Although comparison studies of male and female victims do not show consistent findings, some indications of differences between male and female victims are starting to emerge. Farber (1984), in a comparison study of 81 reported cases of male sexual abuse over a three year period matched to 81 females sexually abused during the same period found few differences between factors associated with the abuse. He found that 50% of boys and girls were abused in their own home. Farber did not find differences in factors such as relationship of the abuser, who referred the child, the incidence of sexual abuse of siblings, chronicity, the use of bribes, threats or concurrent physical abuse.

In a study of 113 sexually abused children under 12 years of age, Khan and Sexton (1983) found that the greatest

vulnerability for the male child occurs after school age. Khan's findings indicated that girls are at risk earlier, and are more likely to be a victim of familial abuse. Other studies support the notion that boys are more likely to be abused in a public place (Ellerstein & Caravan, 1980; De Jong et al., 1982). These studies also found that male children reported more violence and evidenced more trauma when initially seen. Finkelhor (1984) reports that boys are less likely to be abused alone if the abuser is a parent. When a boy is abused by a parent in 60% of the cases there will be another victim, usually sisters. When a girl is abused by a parent, in 65% of reported cases she will be the only victim. Finkelhor states that boys abused alone are 2.5 times more likely to be victimized by a non-family member, and also victimized at an early age. Most abuse of boys is reported to the police -16% of all reported abuse (Finkelhor, 1984). Hospitals and child protective agencies see proportionally fewer boys compared to girls than do the police (Finkelhor, 1984).

Pierce and Pierce (1980) also report more threats and force used on boys as compared to girls and a higher incidence of sexual abuse and assault of boys occurring outdoors. They note differences in the type of abuse: boys are most often subjected to oral-genital contact. Their male sample was significantly younger (average age was 8.6) compared to the females (average age was 10.6). Some of the

differences reported in this study are interesting. Once the incident of abuse was known to the child protective agency only 4% of the male victims compared to 20% of female victims were removed from the home. This supports the assumption that males should be able to protect themselves, and the unwillingness to see the male child as helpless victim. Another important finding was that 16% of the offenders against males were imprisoned versus 1% of the offenders against females. Paradoxically, the abuse of male children was considered a more serious crime, punishable by the law. Pierce and Pierce (1980) also found that when psychotherapy treatment was recommended, boys were more likely to complete it than girls, but were seen for less time. The authors suggest that possible reasons for lesser therapy treatment for the male children might be the perception that boys would be less disturbed by the experience than girls, and that therapists might feel less competent to treat boys.

Rogers and Terry (1984) found fundamental differences in patterns of sexual victimization between girls and boys: the boys in their sample were younger (83% under 12, as compared to 70% of the girls who were under 12); more boys were threatened with physical harm (51% of the boys as compared to 37% of the girls); and only 21% of their male sample of boys were living with the abusers as compared to 42% of girl victims living with the abusers. The boys were

more likely to be abused outside the home, and a large number (56%) were abused by a juvenile.

If we look at the differences in patterns of sexual abuse between girls and boys, the question arises as to the possible sex differences in the behavioral and dynamic manifestations of the abuse. Summit (1983) suggests that the male victim of sexual abuse is more likely to turn his rage outward in aggressive and antisocial behavior. The male victim has more difficulty tolerating his helplessness than the female victim and is more likely to rationalize that he is exploiting the relationship for his own benefit.

> "He may cling so tenaciously to an idealized relationship with the adult that he remains fixed at a preadolescent level of sexual object choice, as if trying to keep love alive with an unending succession of young boys. Various admixtures of depression, counterphobic violence, misogyny ( again, the mother is seen as non-caring and unprotective), child molestation and rape seem to be part of the legacy of rage endowed in the sexually abused boy (p.185)".

Nasjletti (1980) found a consistent pattern of extreme resistance in sexually abused boys to discuss their molestation experiences in group and individual therapy. She attributes this trend to the definition of masculinity in our culture and expectations for males which do not allow expression of feelings of dependency, fear, vulnerability or helplessness. In her view, the sexual abuse of boys is underreported. When a woman is the abuser, the myth that seduction of the male child by a female is a positive sexual experience for the boy prevails. The boy may hesitate to

report if he thinks this may bring his masculinity into question. If the abuser was a male, the boy will be reluctant to identify himself as helpless or passive, and experiences shame at not having been the dominant person controlling the molestation situation. Many times boys fail to report because they fear for their own safety, since they are very likely to be threatened with physical harm if they report. Most important, the fear of being labeled homosexual and the perception that he will become homosexual haunts the male victim of sexual abuse and often stops him from disclosing the abuse.

Rogers and Terry (1984) believe that cultural bias accounts for professional neglect in cases of male victims of sexual abuse, since there is a reluctance to identify the boy as a victim. They claim that societal reaction is much different for a case involving a 12 year old girl seduced by a 35 year old man than for a 12 year old boy seduced by an older woman. They also state that most cases involving boy victims involve male perpetrators who are often juveniles themselves and these cases are often seen as "inappropriate sex play". Rogers and Terry believe that there is a cultural bias toward blaming the victims in general and to blaming the boys in particular. Passivity is seen as a lack of masculinity and there is a tendency to blame the boy who fails to forcibly resist the abuse or a bias toward assuming that the boy "initiated" the abuse. There is also a

failure to identify as victims those boys who are bribed or who prostitute themselves.

Rogers and Terry have observed behavioral changes that are more or less unique to male victims. These are: confusion and anxiety over sexual identity; inappropriate attempts to reassert masculinity; and recapitulation of the victimizing experience.

They propose that the victim of sexual abuse frequently seeks an explanation for why he was selected, internalizing the incident and blaming himself. Boys often believe that the abuse occurred because of their physical appearance: lack of muscles, small build, soft speech or because of their personality if they were warm and friendly. These "feminine" attributes are perceived as having contributed to the abuse. The boy may identify with the notion that he is effeminate or is perceived as either effeminate or homosexual by others. This could reinforce preexisting expectations for strong masculine standards and the perception that he is "not really a man" because he failed to resist. The anxiety over sexual identity will be increased if the boy found the experience pleasurable. He may misinterpret the situation as implying a latent homosexual orientation rather than understanding his normal physiological responses.

A common reaction, then, is for the boy victim of sexual abuse to attempt to reassert his masculinity through

aggressive behavior and an overidentification with the masculine stereotype. The aggressive behavior, in Roger and Terry's view, becomes a means both for the boy to convince himself that he is masculine and to reestablish his masculinity in the eyes of others. It also serves a protective function. If he acts "tough" no one will attempt to take advantage of him again. In addition boys may exhibit chronic disobedience, destruction of property and become defiant of teachers and parents. Although with these behaviors they may appear to be seeking punishment, Rogers and Terry believe that this is rather a way to project a masculine image.

Last, it is a common reaction for the boy to recapitulate the victimization in the role of the offender. Although this reaction could be conceptualized as displaced aggression, it seems that the victim turned offender is more interested in recreating a scenario similar to his own victimization, with modes of inducing compliance, specific sexual acts and even age differences being patterned after the original incident. The boy victim feels that he was "robbed of his masculinity" and in a very real sense seeks to regain it through overidentification with the offender. Rogers and Terry found that recapitulation was most common when the legal system failed to take appropriate steps toward the original offender.

The authors have also observed three harmful patterns

of parental reactions that appear to be particularly common, although not unique, in cases involving male victims: denial or minimization; blaming the victim; and unrealistic fears regarding the impact of the event.

Parental denial can take many forms, ranging from denial that the alleged incident took place, refusal to believe the particulars to denials of the impact that the abuse might have on the child. For the parents of boys, denial or minimization of the impact often stems from a need to defend against their own feelings regarding homosexual behavior.

Parents of latency age boys in particular tend to experience a great deal of anxiety and fears relating to the impact of the assault upon the child's sexual development. There is a heightened focus on observing the child that can lead to distorted perceptions where normal and routine behaviors are perceived as deviant. It is not uncommon for the parents to reinforce the boy's often inappropriate approaches to reassert his own masculinity, many times reinforcing antisocial behavior. This may lead the child to internalize the parental projections and come to see his own behavior as abnormal or homosexual.

Male versus Female Abusers

Most sexual molestation is done by adults who are not strangers to the child, and in fact are often related to the victim (Conte and Berliner, 1981). The child abuser is most

commonly a respectable, otherwise law-abiding, person. The median age of first offense is reported to be as young as 16 (Groth et al., 1982). A large number (80%) of child abusers were abused themselves in their childhood (Groth, 1986). If we consider the statistics on the sexual victimization of females, the fact that most of child abuse is done by men seems a contradictory finding. In Finkelhor and Russell's review of the literature (1984) 95% of the abusers in cases of abuse of girls were men, and men were 80% of the abusers in the sexual abuse of boys.

One popular theory is that a victimized child becomes a victimizer in an attempt to master the trauma and take on the power of the adult. Finkelhor argues, that since many more girls are victims, then there should be more women sexually abusing children. He states that if the identification with the aggressor occurs, it seems to happen differently for boys and girls. This view is supported by other experts (Rush,1980; Herman, 1981; Summit, 1983).

Karpman (1954) distinguished abusers who have a stable erotic preference for children from those who use children as "surrogates" for adult sexual partners. Howells (1981) has supported this distinction using the terms "preference" and "situational" abusers. "Preference" abusers are relatively disinterested in adult partners for the fulfillment of both sexual and emotional needs. They usually do not view their behavior as inappropriate and many

of them believe that society should allow them to meet their needs. The offenses against children are usually preplanned, have a compulsive quality to them, and do not appear to be precipitated by stress. The "situational" abusers are interested in adult partners although they may have deficits in intimate relationships. Usually the episodes of child abuse occur when there are significant life stresses present. The "situational" abusers usually view their child-related urges as abnormal. Groth (1979) makes this distinction a cornerstone of his theoretical position and offers a list of characteristics to characterize the two types. He proposes the terms "fixated", referring to those abusers who show arrested psychosexual development and "regressed", referring to those who show psychopathologically regressive behavior under stress after more or less normal psychosexual development.

Groth et al. (1982) and others have argued persuasively that child abuse and other sex offenses are best characterized as sexual behavior in the service of primarily nonsexual needs, such as affection and love and, in the case of rapists, power and anger. This view sees sexual abuse of children as theoretically and etiologically similar to other sexual deviations, and understands sexual psychopathology as a character disorder.

The behavioral or functional view of sexual abusers does not imply that all or even most sexually deviant men or

women are free of character disorder or other psychopathology. But its proponents (Abel, Blanchard and Becker, 1978; Barlow, 1974) argue that such intrapsychic difficulties have not been shown to play a causal role in the development and maintenance of the sexual deviation and are not at the root of the disorder. Sexual deviation has to be studied in its own right and the focus of treatment should be on the sexual arousal patterns.

None of these views explains, however, the fact that, although the majority of victims of sexual abuse are female, men are doing most of the sexual abuse of children. Finkelhor and Russell (1984) propose that sexual abuse can be described as a problem of "masculine socialization". Some of the reasons they give for the predominance of sexual abusers among men are:

1) Men have more difficulty distinguishing between sexual and nonsexual forms of affection, whereas women learn earlier and more completely to distinguish between these two

2) Men grow up seeing heterosexual success as much more important to their gender identities than women do

3) Men are socialized to be able to focus their sexual interest around sexual acts isolated from the context of a relationship

4) Men are socialized to see as their appropriate sexual partners persons who are younger and smaller

than themselves, persons who are innocent, vulnerable and powerless. Women are socialized to see as their appropriate sexual partners persons older, larger, more powerful than themselves and not to be in a position of dominance or authority.

Nevertheless, the assumption, that very few women sexually abuse children is beginning to be questioned. Groth (1979) who has studied extensively the psychology of sex offenders, reports that he has encountered in his professional work to date only three women out of 253 adult offenders against children. He has questioned the frequency of this occurrence. In his view, women may "mask sexually inappropriate contact with a child through the guise of bathing or dressing the victim". He believes that the sexual offenses of females "are more incestuous in nature, and the children are more reluctant to report such contact when the offender is a parent. Groth also claims that boys are more likely to be the target and less likely to report.

Other authors (Nasjletti, 1980; Plummer, 1981) support Groth's views. Plummer (1981) believes that there is a "considerable degree of adult female-child sexuality". Such activity is hidden "because of the expectations of the female role which simultaneously expect a degree of bodily contact between woman and child and deny the existence of sexuality in women (p.228)".

Studies based on self-reports, however, (Kinsey, 1948;

Finkelhor, 1979; Gebhard, 1965) show that sexual contacts between children and older women is a distinct minority of child-adult contacts. Finkelhor estimates that sexual abuse by women occurs in 5% of cases of girls and 20% of cases of boys. He emphasizes that women do not seem to use children for their direct physical sexual gratification as often as men do.

Women do not generally act as initiators in sexual relationships. Males are expected not only to take the initiative, but also to overcome resistance and sometimes even to consider resistance as a cover for sexual desire. Rather than become a sexual abuser, a sexually victimized girl may grow up to be the mother of a victim, repeating the situation indirectly, in a passive manner.

Finkelhor argues further that men appear to be more promiscuous than women and are more easily aroused by sexual stimuli divorced from any relationship context. They appear to sexualize the expression of emotions. Men and women react in different ways to the unavailability of sexual opportunities. Having sexual opportunities seems to be more important to the maintenance of self-esteem in men than in women. They may more easily turn to children when other alternatives are blocked. Because women tend to interact much more with children, they develop a bond which involves a sense of protectiveness and responsibility that few men are able to develop. They may be more sensitive to the well-

being of children and therefore inhibit from sexual contact. Finally, sexual contact with children may be more condoned by male subculture than female subculture.

Herman (1981) also conceptualizes the problem of sexual abuse of children as a consequence of male socialization. She cites the feminist revisions of psychoanalytic theory such as those of Juliet Mitchell, Helen Lewis and Nancy Chodorow, to explain the difficulty that the male has establishing and maintaining his masculine identity, since it rests on the repudiation of the person who first cared for him, his mother. The boy discovers that his first love is both an inferior and unlike himself, and thus suppresses his capacity for nurturance and for affectionate identification with women. His masculine identity is "forever in doubt". Herman argues that sexual contact with a woman of inferior status affords to the male the only permissible outlet for expression of a wide range of emotional needs: the need for intimacy, comfort and reassurance.

Herman states:

> "The tendency in men toward sexually exploitative behavior of all sorts, including rape, child molestation and incest, thus becomes comprehensible as a consequence of male socialization within the patriarchal family. The adult male's diminished capacity for affectionate relating prevents him from empathizing or identifying with his victim; without empathy, he lacks a major internal barrier to abusive action...Hence it is that adult men so frequently seek out sexual relationships not only with adult women who

are younger and weaker than themselves, but also with girl children (1981, p.56)".

Treatment Issues

When we consider the impact that sexual abuse has on a child, two major dynamics come into focus: a) the child has been betrayed by adults and has been exploited by an adult or adults in a sexual relationship; b) the child has learned to get attention and affection from adults by participating in sexual acts and his or her initial presentation could be seductive. This poses the main difficulties for psychotherapists involved in the treatment of sexually abused children.

In a candid account of his treatment of a fourteen year old schizophrenic girl, Christ (1964) proposes that the therapist's response to the expression of sexual drives in psychotic children may be characterized by actual denial or suppression of awareness of the sexual content of the child's behavior. Christ's patient had been hospitalized since the age of six and had experienced serious loss, including the loss of many therapists. Christ felt that when he was beginning to make contact with this girl, her seductive and masturbatory behavior interfered with the therapeutic process. After one incident where Christ became "enraged" at his patient when she started to masturbate in the playroom and immediately realized that he was really enraged at himself for "being sexually aroused", he was able to feel empathy for his patient, and make the appropriate

therapeutic intervention.

Christ discusses that when a sexual response is aroused in the therapist, the reaction may be especially angry and retaliatory. He also addresses the "feeling of chaos before clarity ensues" and the importance for the therapist to accept the feeling of chaos without anxiety.

Many sexually abused children are "uncommonly erotic" and they display seductive and inappropriate sexual behaviors. These behaviors could be interpreted as a compulsion to repeat, counterphobic or an attempt to test the therapist's integrity. They are disturbing to the therapist and provoke strong countertransferential reactions. The fact of the child's premature and inappropriate sexual experience, if acknowledged, becomes a trigger for the conflicts, ambivalence, guilt and fear regarding human sexuality which are harbored by members of his or her family and community. The child is likely to be viewed with intense curiosity, pity, disgust, or hostility, depending upon the perceptions and hangups of the people who learn about the sexual abuse (Sgroi,1985, p.113). The therapist is subject to similar conflicts, ambivalence and hangups.

Yates (1982) believes that incestuous children are easily aroused, highly motivated and readily orgasmic. He sees a relationship between the degree of eroticization and the intensity and duration of the incestuous union. Yates

feels that the "erotic activity often seems to assume the soothing, comforting function of a transitional phenomenon". As such, it has adaptive or maladaptive potential. Some children, for example, will calm themselves by masturbating in the bedroom, whereas others continue to make inappropriate advances, which might bring them further rejection and blame. For these children, affectionate and sexual relationships may not be differentiated, so that they continue to be aroused by physical or psychological closeness (Yates, 1982, p.484)

Krieger (1980) feels that emotional deprivation is the basic conflict which underlay the sexual concern for the sexually abused child. In this view, earlier developmental issues are at the core. The sexual form may have become the child's typical way of gaining attention and nurturance, a method he or she carries into the therapeutic situation. Krieger believes that this is a possible identification of the child with the adult aggressor, and that by reversing passive into active, in the role of the initiator, the child feels less helpless. The sexualized behavior might stem from the need to control the intimacy in the therapeutic situation, and may represent "the working through" of the sexual abuse in the transference situation. The child is testing the therapist "perhaps asking, is this place safe? Will you protect me from dangerous and frightening impulses in a way that my parents could not? Can I feel helpless and

needy without having to take care of you?" (p.85). Krieger emphasizes that if the therapist is able to pass this test and provide a safe environment for the child, it will enable the child to express the more basic fear, anger and sense of deprivation.

Lamb (1986) warns therapists not to confer "victim status" on sexually abused children since this might diminish a feeling of power. Clinicians and researchers generally hold the adult solely responsible for the abuse. Lamb argues that although it is imperative that social institutions continue to hold adults responsible for their behavior toward the young, it is not clear that emphasizing the adult's responsibility to the child is particularly useful in therapy (1986, p.304). She believes that to emphasize the helplessness may remove any sense of efficacy the child may have experienced. Often therapists view of the child as a helpless victim stems from their own unresolved conflict and overidentification with the child. Boatman (1981) cautions therapists to suspend value judgments and "avoid jumping to conclusions" about how the child feels, since the child may not view the abuse as all bad.

Ehrenberg (1987) proposes that the victim's own participation and responsiveness in the sexual relationship is often the most devastating aspect of childhood sexual abuse and the one most usually dissociated or denied by her

or him. Most often the relationship serves as compensation for lack of affection and nurturance in the family. The child may have a sense of power and control since she is aware of her appeal to the abuser. The child experiences sexual pleasure in the relationship which leads to a sense of "badness". Thus, the child feels confused by both her power and helplessness. Ehrenberg discusses four levels of evolving experience for the child: 1) internal fantasies and desires that mesh with fantasies and desires of the other, 2) actual events and interactions, 3) secondary fantasies and ways of coping with what has occurred, that influence how it is perceived, interpreted and integrated, confused or denied, 4) the impact of these on the child's continuing and developing relation to his or her own subsequent experience with self and others.

Thus, Ehrenberg proposes that fantasy and reality converge and overlap and stresses the importance of clarifying the ways and motives for perpetuating confusion in the treatment situation. Reclaiming responsibility for her own disavowed participation often involves some appreciation of the reparative and healthy aspects of the victim's own strivings in these abusive relationships. It is this reclaiming of their active participation and "the recognition of the degree to which they were indeed victimized and the ways in which their vulnerability was exploited, (that) becomes the basis for an ability to work

through these difficulties" (1987, p.603).

Issues to be dealt with in the therapeutic relationship center around the difficulty that the victim of sexual abuse has developing intimacy since she has the ingrained belief that the nature of closeness is one of threat and exploitation. Wishes and fears about been dominating or being dominated also prevail in the treatment of sexual abuse victims.

In a study among psychiatric inpatient staff members who reported on their experience with sexually abused children, Kohan et al. (1987) found that their subjects experienced extreme personal distress which was classified in three different categories: a) discomfort, particularly fear and anxiety; b) shock or surprise; c) anger.

Responses of staff in the first category included: feeling uncomfortable with the children's symptomatic behavior. This behavior was highly sexualized: characterized by exhibitionism, seductiveness, masturbation, and sex play with others. The staff also reported being "put off" or distanced, having difficulty dealing with their own feelings of being touched by children who have been sexually abused. They were shocked about their sexual acting out and surprised by the frequency and intensity of the children's sexual behavior.

Kohan's subjects also exhibited anger at the children's parents. They tended to see themselves as "rescuers",

creating barriers to therapeutic interaction with the abusing parent. The subjects also reported pessimism about the prospect of effecting change in children with a history of sexual abuse. Some countertransferential responses of the staff toward the sexually abused children were withdrawal, avoidance, expression of disgust, restriction, punishment, involvement in power struggles and overprotection.

Kohan's findings are very important, since they point to the disturbance in sexually abused children in a setting (inpatient) where the expectation is for serious psychopathology. One might argue that the knowledge that the children were sexually abused biased the staff's perceptions and attitudes. If this were the case, the implications are still very important, since they would indicate the presence of countertransference interfering with an objective assessment and adequate treatment intervention.

Krieger et al. (1980) interviewed therapists who were treating sexually abused children . The therapists reported that they found the children's behavior sexually arousing. "Often after the interview had ended the therapists found themselves having an increased amount of sexual fantasies." The "insincerity" and "passivity" of the children who had a homosexual involvement irritated and annoyed the therapists. The reactions troubled the therapists because

they were directed toward the children with whom they felt they should empathize (p.86). Krieger emphasizes the need for therapists to be "extra careful" and aware that their actions could be interpreted as seduction or that they may distance from the patient excessively because of their discomfort. The therapist should not allow his or her feelings to interfere with clinical judgments, especially those concerning placement and parental incarceration.

Krieger proposes that it might be harder to be empathic with these patients than with some others, since many therapists use their own associations and personal experiences in individual ways in the treatment of their patients. Krieger proposes that "dealing so directly with such a strong taboo impedes access to this resource, an impediment stemming from numerous sources, for example, repudiation of the therapists own early wishes, desires, fears and internal prohibitions" (1980, p.87).

Gender Issues in Psychotherapy

There is increasing support for the position that there are major and significant ways in which men and women live psychologically in "worlds apart". Men and women have different values by which moral reasoning is constructed (Gilligan, 1982). They vary widely in certain modes of communication both verbal and non-verbal. They have different definitions and experiences of success and achievement. They differ in their expression of intimacy

and sexuality and they may have fundamentally different courses of psychological development (Chodorow, 1978; Gilligan, 1982).

Do these differences affect the psychotherapy process? It appears that forms of psychotherapies that are more limited in scope and duration, might be more likely to be affected in course, duration and outcome by patient therapist fit, including therapist gender. Mogul (1985) has suggested that therapist sex matters least in traditional psychoanalysis with neurotic patients; however, this is not as true for face to face psychotherapies, which are less intensive, involve more partial transference reactions and are more oriented to symptom alleviation, and for patients with developmental defects involving impaired ego functions or object relations (Mogul, 1985, p.5).

Although it has not been definitely advocated that women who need crisis help concerning an abortion, rape, or physical abuse should be seen by women, this is frequent in practice, since women patients feel more immediate rapport with female therapists or counselors. It has also been suggested that women fare better in psychotherapy with women practitioners because of the therapists presumed ability to understand and empathize with the female experience, and a lesser tendency to sex-role stereotype (Rice & Rice, 1973). Mogul (1985) warns, however, that countertransference manifestations involving projection and identification can

be mistaken for empathic understanding leading to misguided interventions.

Kaplan (1985) proposes that gender differences may influence the psychotherapy relationship, since differences in status and sense of self, key differences between men and women, play a central role in the experience of psychotherapy. She believes that female therapists bring to their role some sense of their core self as a "relational" being and some internalized experience of being in a subordinate position. Male therapists bring to their role some sense of a core self as a "separate, autonomous" being and an internalized experience of being in a dominant position.

Howard, Orlinsky and Hill (1969) have found that male therapists report more discomfort with their female patients' erotic transference, whereas female therapists reported more discomfort with their female patients heightened dependency needs. The problem with psychotherapy research with adult patient population is that it generally compares male and female therapists in relationship to their female patients, since males are underrepresented in the outpatient population. Nevertheless, it has led to important formulations on the impact of gender in the psychotherapeutic process.

Herman (1981) states that countertransference reactions can be the major obstacles to successful therapy with female

incest victims. Reactions of avoidance and denial are widespread among therapists. Herman has pointed out differences in the countertransference reactions of male and female therapists. Female therapists tend to identify with the victim's feelings of helplessness and despair. The patient's history may also revive the therapist's memory of seductive elements in her own relationship with her father. Herman believes that if the female therapist has not sufficiently mastered her feelings about incestuous elements in her own childhood she may communicate to the patient that the incest secret is too special or too frightening to hear. This may aggravate the patient's feelings of isolation and reinforce the patients's sense of herself as a "dangerous, contaminated person who frightens other people away" (1981, p.183).

Another error that female therapists commonly make is to express anger at the offender and try to deflect the patient's anger from her mother onto her father. Herman has observed that many times the fathers are perceived by the patients as the only source of caring and affection in their lives. The avoidance or denial of the patient's positive feelings toward her father reinforces the patient's belief that these feelings are wicked and shameful. The relationship with the therapist may become hostile and competitive if the patient assumes that the therapist is trying to "rob" her of a "precious" relationship.

In Herman's view, male therapists tend to identify with the abuser. They have difficulty allowing the patient to express anger at the abuser. Male therapists tend to focus on the sexual aspects of the relationship and to ignore the issues of protection and caretaking. They tend to focus on the behavior on the victim's part which may exonerate the abuser. Herman sees the effect of these common mistakes as extremely detrimental to the patient, since they make her feel that she is reliving the incestuous situation. Herman points out that the male therapist also runs the risk of becoming sexually involved with the patient, in fantasy or reality. He may find himself becoming excited by the " "victim's narrative of forbidden sexual activity" (p.186).

Herman overlooks the fact that a "narrative of forbidden sexual activity" may be sexually arousing for female therapists as well. The incest situation may also be relived in the therapy situation with a female therapist. For example, the therapist may fail to report the sexual abuse, thus recreating a situation of secrecy, and perpetuating the denial that surrounded the patient.

The major obstacles to forming a good working alliance with the female patient with a history of incest, are her feelings of shame and hopelessness and her fear of betrayal in intimate relationships (Herman, 1981). It is important to communicate to the patient an attitude of acceptance but also that the damage that she suffered need not be

permanent. Herman believes it is important to foster the development of a new and more positive image of womanhood with which the patient can identify. This will enable the patient to see the relationship with the father in a different light. She will be able to see that " the favors, the excitement, the privileges she may have enjoyed were poor compensations for the childhood which was stolen from her" (p.192).

If, as was mentioned above, it is important to foster the development of a positive feminine identity in the treatment of the female sexual abuse victim, the treatment of the boy victim requires an understanding of sex-role development in shaping the boy's personality and particularly the formation of gender identity, with its psychological and cultural components. Kagan (1964) discussed three kinds of experiences that determine the degree to which a boy establishes a stable gender identity. First, there is the identification with the same sexed parent and other same-sex adults, peers, siblings. Second, the boy needs to acquire the attributes and skills that define masculine behavior. In our culture, the expectation is for boys to be physically competent, assertive, competitive. These attributes are learned mainly in peer group play. Lastly, experiences with other people in ways that are congruent with masculine sex-typed standards solidify the establishment of gender identity.

Rogers and Terry (1984) stress the importance, when working with sexually abused boys, to assess their own cognitive understanding and interpretation of the event and to identify ongoing or emergent confusion about sexuality. They emphasize the need to provide direct reassurance and a thorough cognitive framework to enhance the child's own understanding. It is important to work with the parents and their unrealistic fears and feelings regarding homosexuality. Parents of latency age boys in particular tend to experience a great deal of anxiety and fears relating to the impact of the abuse on the child's sexual development. The child may internalize the parental projections and come to see his own behavior as abnormal or homosexual. Rogers and Terry also propose that the therapist should help the child channel the need to reassert his masculinity in socially acceptable ways, for example, to encourage the child to involve himself in contact sports, or self-defense courses. This, however, should be approached with caution, since the child may perceive these attempts as further criticism or pressure.

Treatment Modalities

Giarretto (1981) has pioneered the familial treatment approach for incest, using the weight of legal authority to induce parental participation. Giarretto reports that 90% of children have been reunited with their families, with a recidivism rate of less than 1% in families that have

completed the program. The different members of the family are seen individually at first, since family treatment is considered to be more effective at a later stage. The emphasis is on enhancing self-awareness and self-concept in the participants. An important goal is for the father to assume responsibility for the incest and to apologize to his daughter as well as for the daughter to confront her father.

Hoorwitz (1983), who models his treatment approach after Giarretto's, views treatment of incest cases as a series of interventions intended to meet the different needs of the family. Intervention is thus planned in stages: immediate, intermediate and long-term. He employs a comprehensive treatment approach, including a combination of individual, marital, child-parent, family and possibly group sessions.

In the first stage the therapist needs to deal with the parents denial and work toward their commitment to therapy. Basic life needs may interfere with the therapeutic process and need immediate attention. The father may have lost his job as result of the disclosure of incest. The family may have need of new housing arrangements and may be in need of concrete services. Thus, referrals to community and social services may take priority at this time. The focus of treatment at this time are the individuals' emotional reactions. The child is experiencing guilt and shame and concerned about disrupting the family. She might feel

pressure to "recant". The child will also need support and preparation to deal with the legal system. The father will be concerned about public exposure, loss of employment and family disruption. The therapist needs to support the father at this time without condoning the father's incestuous behavior. The mother will be experiencing shock and anger and will feel torn between her daughter and her husband.

In the second stage the focus of treatment for the child is around the role confusion she experienced in the family and the effect this confusion may have on her sense of identity. The child has internalized negative feelings toward her parents, which has damaged her self-esteem. She mistrusts others and is uncertain about moral standards. She experiences guilt over disrupting the family, having been treated as "special", and having experienced sexual pleasure in the incestuous relationship. The child lacks an adequate female role model. She experiences intense anger at her mother for not protecting her and for depriving her of maternal nurturance. In Hoorwitz view, the mothers of incest victims have also experienced maternal deprivation. He emphasizes the need for sex education, a focus on social skills and assertive behaviors. Anger, depression, mistrust and poor self-esteem are common among these mothers. In the second stage, it is important to address the father's anger toward his wife, to explore his feelings of deprivation and

to look at alternative methods for obtaining emotional support and acceptance without having to abuse his power in the family. In some cases, Hoorwitz proposes specific treatment such as covert sensitization or other behavioral methods, intended to inhibit impulse dominated compulsions for the father.

In the third stage, Hoorwitz advocates mother-daughter sessions to foster an alliance, and help the mother to play a protective and nurturant role. At the same time, marital sessions will address the underlying anger and modify distribution of responsibilities and role behaviors. The marital sessions will also prepare the parents for the father's eventual apology to his daughter and the last stage of treatment.

Hoorwitz states that at least one father-daughter session should be held to allow the father to apologize to the daughter and to clarify the new role relationships which will be necessary between them. It will be important to address their discomfort in each other's presence and their ambivalent feelings. This will lead into the family treatment, where the therapist need to continue to address protective concerns toward the child and counter forces of denial and family alliances. The focus is on enhancing the mother's power and reducing the daughter's, while enriching the mother-daughter relationship.

Porter, Blick and Sgroi (1979) emphasize a family

treatment approach for all child sexual abuse victims. They find, however, that many of these families are unusually resistant to treatment. They believe that much can be achieved by working with the child alone, individually and in group setting. They stress the importance of stating very authoritatively that physical damage is absent or has been treated, since it is very common for the children to have a distorted perception that they have been physically damaged by the experience. They view the therapist's tasks as a) conveying to the child that he or she was not responsible for the abuse and the disruption of the family after disclosure; b) anticipating that the child will be depressed to some degree and being aware of suicide potential; c) helping the child express repressed rage and anger in a healthy and non-destructive fashion. The therapist needs to help the child to resolve role confusion, to relinquish inappropriate responsibilities and assume a more child-like role. Porter et al. (1979) emphasize the importance of self-mastery and control issues. Since these children have been objectified and used, and made to believe by the abuser and sometimes by family members that they have no rights and are not entitled to their privacy, it is important that the treatment address issues of accountability, behaving responsibly, developing of independence and freedom to make one's own choices.

Porter et al. (1979) describe three different phases of treatment: crisis intervention, short-term and long term therapy. The crisis intervention phase is especially taxing to the therapist, since the therapist must be prepared to assist the child and family to cope with investigative interviews, medical examinations, visits to and from chil- protective services and law enforcement personnel, interviews with attorneys, court appearances and the like. Porter et al. stress that the situation will remain in crisis unless all of these case management tasks are addressed, and until an initial management plan is implemented.

Following crisis intervention, short-term therapy will suffice for many of these cases. In Porter et al.'s (1979) view, children who have not been subjected to severe physical or emotional trauma, who are not related to the abuser, and who are supported by significant others will benefit from short-term therapy and will not need further treatment.

They believe that a critical psychodynamic goal between the therapist and the child in the course of long-term treatment is the establishment of a trust relationship. They also stress the importance of group treatment, particularly to help with self-esteem issues, and believe that group is the treatment of choice with adolescents.

Other authors have emphasized the importance of group

treatment. Herman states that in the group setting, the "special, almost conspiratorial dyadic relationship of patient and therapist is not recreated" (1981, p.194). Herman sees an important function of the group as that of "absolving" the incest survivor from guilt and responsibility, since it is easier to identify how others were coerced and victimized. Swanson & Biaggio (1985) advocate the use of male-female co-therapists in groups since they provide figures for transference and working through feelings. The male-female team provides a model of a caring relationship that is not sexualized.

Sturkie (1983) describes a model for structured, time limited, group treatment developed at the Pulaski County Child Sexual Abuse Treatment Project. Following Giarretto's model, members of an incestuous family are initially seen individually and then progress to meetings involving critical family dyads. Treatment terminates with conjoint sessions involving all family members. Throughout this progression, the family members are concurrently involved in group treatment.

The children in Sturkie's study were latency age females, since the Center saw a limited number of male children. The groups were composed of incest victims, children who had been abused by non-family members known to them and children abused by strangers. The groups met in eight-week cycles with one week break in between and were

open ended. The themes discussed in the course of the cycle included: believability; guilt and responsibility; body integrity and protection; secrecy and sharing; anger; powerlessness; other life crisis, tasks, and symptoms; and court attendance. Sturkie describes successful results, with no recidivism among the twenty-four participants in the first year. Of the seventeen participants who were involved in court proceedings none failed to provide the court with the information required or change her story.

Mc Millen Hall (1984) also proposes the use of structured group therapy in the treatment of sexually abused children. In her model, one educational session is followed by an open session. She stresses the importance for the child to see that he or she is not unusual or odd, since there are others who have shared the same experience. Group process relieves the isolation and heaviness of the situation. Issues explored are: understanding why this happened to them; what the activity meant to them; education on body parts and sexuality; understanding the reasons the abuser had; responsibility; alternative ways of handling these situations in the future. A mother's group is held concurrently.

The treatment approaches reviewed above neglect discussing issues of transference and countertransference. This is partly due to the authors' theoretical orientation and possibly the fact that most of these approaches have a

strong family component. The lack of a more specific focus on the therapist's feelings in the treatment of sexually abused children, in view of the strong emotions that the nature of the problem and the child's presentation engender in the therapist, seems in itself to be an expression of countertransference. In analytically oriented therapy, intuition or emotional understanding is often as important as logical conclusions or active thinking. Insight into the patient's concerns is often arrived at by using the therapist's own unconscious by a process of partially or temporarily identifying with the patient. When an unconscious conflict on the part of the therapist is activated in the hour, it can affect his ability to listen, to understand, to concentrate and to respond correctly to the patient and not to the therapist's own needs.

Kernberg (1965) proposes that when the therapist identifies with the patient who is regressed and consequently undergoes some regression himself, some of his own early identifications and the mechanism of projective identification become activated, severely interfering with the therapy. The therapist experiences anxiety and primitive impulses which can become directed toward the patient, arousing a need to control the patient. While he clearly advocates utilizing this primitive transference countertransference phenomena, he does address himself to the need not to let these powerful forces get out of

control. Kernberg stresses the importance to have a constant critical attitude toward what one is doing. As Anthony (1982) has pointed out:

> "Whether one is an adult analyst, a child analyst, or both, our primary duty to our patients is to be constantly in touch with ourselves, with our past, with our dreams, with our fantasies, and with our own feelings and thoughts stimulated by the patient. One has no business exploring the inner world of childhood or adulthood without constantly looking inward into ourselves (1982, p.366)."

This study explored the therapist's feelings and experience in the treatment of sexually abused children. The experience of treatment with a sexually abused child can be taxing for the therapist. In the process the therapist is likely to feel helpless, overwhelmed and highly conflicted about his strong reactions to the patient. Thus, he or she might overidentify or resort to rigid defenses and detachment. Because of the gender differences in developmental lines and socialization process, and the different meanings that sexuality takes for men and women, we expected to find that gender has a particular impact on the treatment situation with the sexually abused child.

# CHAPTER III

## METHODS AND PROCEDURES

This chapter will present the methods and procedures of the study. For the purpose of presentation it has been divided into five sections, namely, description of the subjects, description of the research instrumentation, description of the procedures, treatment of the data and description of the null-hypotheses.

### Subjects

The study sample consisted of psychotherapists at community mental health clinic, and private and public hospital settings in the New York and New Jersey areas. These mental health facilities provide comprehensive outpatient mental health services of a similar nature, including psychotherapy, testing and evaluation. The subjects participated on a voluntary basis. Of the therapists approached, 8% refused to participate due to situational factors. Sixty-five therapists volunteered to participated in the study, and thirty-one subjects returned questionnaires by mail. Three of those subjcts were eliminated because of insufficient data.

Of the selected sample of 28 subjects, 12 were male and 16 were female. Their ages ranged from 26 to 63 years of age. The median age was 34. The therapists were from various disciplines which included: psychologists, psychiatrists, social workers, nurses and creative arts

therapists. Although it was expected that the therapists would have different levels of experience, 92 % of the subjects had three or more years of experience in the practice of psychotherapy and 57% had treated more than five sexually abused children. Of the therapists sampled, 96% had personal psychotherapy treatment in the past and 61% were in treatment at the time they volunteered for this study. It was also expected that the volunteer sample would show a diversity of theoretical orientation. However, 66% reported a psychodynamic orientation.

Each therapist reported on the treatment of one sexually abused child. The patients ages ranged from 3 to 16 years of age, with 89% of the patients below age 12. Of the patient sample, 20 were female children and 8 were male. Eighty-nine percent of the children had been sexually abused before age 8.

Research instrumentation

This study used three questionnaires. The description of the three questionnaires follows.

Therapist background questionnaire. The therapist background questionnaire was used to obtain demographic and background information from the subjects, as well as information on the patients the subjects reported on. It consists of 18 background questions (e.g. therapist's level of training and experience, sex, whether they were supervised on the case they reported; 6 questions on the

nature, duration, type of abuse and disclosure of abuse; 12 questions relating to report of abuse and the involvement of the therapist with legal and justice system, social service agencies; and 11 questions on treatment (e.g. length, modality, frequency of sessions).

An example of the questionnaire can be found in Appendix A.

Therapy Session Report, Form T. The therapist session report (see Orlinsky and Howard, 1966b) is a structured response questionnaire which enlists the therapist as a participant-observer of the therapy session and draws a systematic quantitative report of his or her experiences. It contains sections which survey the affective experience of the therapists. One section of the form asks: "What were your feelings during this session?" Following this there is a list of 27 feelings. The therapist is asked to circle a b number after each feeling to indicate the extent of its relevance (0:no; 1: some; 2: a lot). Another section of the form asks: How did your patient seem to feel during this session? Following this is a list of 32 feelings with a number after each feeling to indicate its relevance. See table 1.

Table 1

| Patient feelings | Therapist feelings |
|---|---|
| confident | pleased |
| embarrassed | thoughtful |
| relaxed | annoyed |
| withdrawn | bored |
| helpless | sympathetic |
| determined | cheerful |
| grateful | frustrated |

relieved
tearful
close
impatient
guilty
strange
inadequate
likeable
hurt
depressed
affectionate
serious
anxious
angry
pleased
inhibited
confused
discouraged
accepted
cautious
frustrated
hopeful
tired
ill
sexually attracted
involved
playful
demanding
apprehensive
effective
perplexed
detached
attracted
confident
relaxed
interested
unsure
optimistic
distracted
affectionate
alert
close
tired
sexually stimulated
headachy or ill

Therapists were also asked to report on other facets of the therapy, such as therapeutic relationship, exchange and session development. An example of the Therapy Session Report, Form T may be found in Appendix B.

Post Sexual Abuse Disclosure Stress Scale. This instrument was developed in an attempt to measure the therapist's evaluation of the stress that their patient experienced after the sexual abuse was disclosed. It consists of a list of events that commonly take place after sexual abuse is disclosed, such as medical examinations, interview by police or court personnel, interviews by personnel from child protective agencies, removal of child from the home and placement in foster care. The therapists were asked to rate

these events on a seven point scale, ranging from "no stress" to "high stress". An example of the PSADSS may be found in Appendix C.

Procedure

The procedure for gathering the data from psychotherapists was as follows. After obtaining approval from the institutions' research review boards, the principal investigator met with the staff psychotherapists at their regular scheduled team meetings to inform them about the general nature of the study, the time that would be required on their part to fill out the questionnaires, requesting their voluntary participation. Therapy staff was kept blind to the study's exact nature, being informed only of its general purpose as research investigating the psychotherapy process with sexually abused children, and specifying that no rape cases should be included in the study.

Participating staff was then asked to fill out the Therapist Background Questionnaire, the Therapy Session Report and the Stress Scale in their free time. The investigator provided self-addressed, stamped envelopes, in order that the subjects could return the questionnaires by mail. The rate of return was %.

Treatment of the Data

Frequency distributions, means and standard deviations were the principal descriptive statistics calculated for all variables. The first set of variables in the background

questionnaire involved background information on the therapist as well as the sexually abused child the therapist was reporting on. The second set of variables involved questions regarding the sexual abuse and the disclosure of sexual abuse by the child patient. The third set of variables involved the reporting of the sexual abuse to the official channels, and the fourth set of variables involved factual questions regarding the treatment of the sexually abused patient.

Other variables related to the therapists' report on the occurrence of certain events after the disclosure of the sexual abuse by their child patient, (e.g. interview by police), the therapists' rating on how stressful these events were for their child patient and the therapists' evaluation of the psychotherapy treatment with their sexually abused patient. Another set of variables included the therapists' report on their own feelings, and the feelings they attributed to their sexually abused patient. The last set of variables included the therapists' report on how often they had thought about their patient's family since their last session with their patient and how often they had consulted with peers, and supervisors about their sexually abused patient.

The sample was divided into groups on the basis of sex. The Mann-Whitney U Test was used for comparisons between the following groups: male vs female therapists

(N=28), male vs female sexually abused patients (N=28), and male vs female therapists reporting on female patients only (N=20).

Using the entire therapist sample, Pearson Correlation coefficients were computed for all variables and the correlation matrix was analyzed for reliability. The therapists' feelings were clustered into the following factors: "expansive confidence"(pleased,cheerful, playful, effective, -detached, confident, relaxed, optimistic); "uncertain"(frustrated, apprehensive,perplexed, unsure); "intimate"(sympathetic, affectionate, close); "involved"(thoughtful, -annoyed, involved, demanding, interested) and "tired"(bored, distracted, -alert, tired). The patients feelings were clustered into the following factors: "confident"(confident, -embarassed, relaxed, close, accepted, pleased, hopeful); "depressed"( -likeable, hurt, depressed, angry, confused, discouraged); "relieved" (-withdrawn, determined, grateful, relieved, -impatient), and "anxious"(helpless, strange, inadequate, anxious, tired, ill). Twenty-three variables relating to the therapist's evaluation of treatment of their sexually abused patient were clustered into three. A t-test was computed to analyze differences between male vs female therapists, male vs female patients, and male vs female therapists reporting on a female patient.

Statement of the Null Hypotheses

Following are the null hypotheses which were poised for testing in this study.

H1: There will be no significant differences between male and female therapists in their view of the traumatic impact that the sequelae of the abuse has on the sexually abused child.

H2: There will be no significant differences between male and female therapists in their acknowledged difficulties in the treatment of sexually abused children.

H3: There will be no significant differences between male and female therapists in their feelings toward male sexually abused children.

# CHAPTER IV

## RESULTS

This chapter of the dissertation will deal with the presentation of the results. The chapter has been divided into three major sections: Analysis model, Descriptive Statistics, and Summary of Findings by Instrument. The first section summarizes the statistical procedures employed to analyze the data. The second section presents relevant descriptive findings for all the instruments used in this study: the Therapist Background Questionnaire, the Therapy Session Report and the Post Sexual Abuse Disclosure Stress Scale. The third section summarizes statistically significant results and trends for the Therapy Session Report and the Post Sexual Abuse Disclosure Stress Scale. The Therapy Session Report section was divided into the following subsections: Comparisons between male and female therapists, Comparisons between therapists' report on male vs. female sexually abused patients, Comparisons between male and female therapists reporting on female sexually abused patients, and Comparisons between groups after reduction of data.

### I. Analysis Model

Frequency distributions, means and standard deviations were the principal descriptive statistics computed. The sample was divided into groups on the basis of sex: male vs female therapists, therapists' report on male vs female

sexually abused patients, and male vs female therapists' report on female sexually abused patients. The Mann-Whitney U test was used to analyze statistical differences between these groups for all variables in the Therapy Session Report and the Post Sexual Abuse Disclosure Stress Scale.

In order to lessen the number of variables, Pearson Correlation coefficients were computed for all variables in the Therapy Session Report and the resulting matrix was analyzed for reliability. A t test was computed to analyze the differences between groups for the clusters of variables.

II. Descriptive Statistics

Of the therapists sampled, 50% reported personal involvement with the legal proceedings involving their sexually abused child patients as well as helping the children's families understand the legal proceedings. Seventy-nine percent of the therapists had frequent contact and acted as consultation for the child protective agencies responsible for their patients' supervision, and 72% reported frequent contact and consultation with lawyers and prosecutors involved in the sexual abuse cases. Only 22% of the therapists sampled reported feeling uncomfortable with their advocacy role.

The majority of therapists (86%) were treating their child patients in a combination of individual and family therapy. Fifty-four percent of the therapists were treating

their child patients in long-term treatment, that is six months or longer.

The therapists evaluation of the treatment with their child patients was overall very favorable. Seventy-nine% evaluated the overall treatment as very good and 80% reported the patients were doing well as of the last time they were seen. A large proportion of the therapists ( 96%) reported being in rapport with their patients' feelings and 75% reported feeling pleasant anticipation to their sessions and looking forward to seeing their child patients. Seventy-one percent of the therapists reported feeling helpful to their patients and felt they understood their patients well: 82% understood from "a great deal" to " everything" that their patients said and did and 18% reported they understood "a fair amount" of what their patients said and did.

Of the therapists who were supervised in the treatment of their sexually abused child patients, 91% reported feeling supported by their supervisors. Therapists tended to consult with colleagues frequently about their sexual abuse cases: 96% of the therapists reported consultation with colleagues.

The therapists thought frequently about the families of their sexually abused patients between sessions: 46% reported thinking about their patients' mothers to some degree; 54% reported thinking " a lot" about their

patients' mothers. Sixty-one per cent of the therapists reported having some thoughts about their patients' fathers between sessions and 18% reported thinking " a lot" about their patients' fathers. Sixty-one per cent of the therapists reported thinking "a lot" about the relationship between parents and children in the families of their child patients while 36% reported having "some" thoughts about this relationship between sessions with their child patients. Ninety-two percent of the therapists reported thinking about "the family as a whole" between their sessions with their child patients.

When asked how much they had discussed or expressed their own feelings about their sexually abused patient since their last session with that patient, 36% of the therapists reported some discussion and 32% "a lot" of discussion with their supervisors; 61% reported "some" discussion and 25% "a lot" with a fellow therapist; 39% reported "some" expression of their own feelings and 7% "a lot" of expression of their feelings about their child patient to their personal therapist since their last session with their child patient. The therapists also seemed to be sharing their feelings about their child patients with personal friends and spouses: 29% of the therapists reported discussing their child patient with friends and 46% reported discussing their child patient with their spouse since their last session with that child patient.

These findings seem to contradict the therapists' overall evaluation of the treatment of their sexually abused patients and the fact that a large number of therapists (96%) reported that their own state of mind or personal reactions interfered very little with their therapeutic efforts in the treatment of their sexually abused cases.

III. Summary of Findings by Instrument

Therapy Session Report

Using the entire therapist sample Pearson Correlation Coefficients were computed for all variables involved and the correlation matrix was analyzed for reliability. For a summary of the reliability coefficients see table 1.

Table 1

Reliability Coefficients

| Treatment Evaluations | Alpha | Therapist Feelings | Alpha | Patient Feelings | Alpha |
|---|---|---|---|---|---|
| EVALRX | .77 | | | | |
| | | | | RELIEVED | .76 |
| | | EXPANSIVE CONFIDENCE | .86 | CONFIDENT | .84 |
| | | INVOLVED | .66 | DEPRESSED | .82 |
| | | UNCERTAIN | .80 | ANXIOUS | .87 |
| | | ALERT Vs TIRED | .81 | | |
| | | INTIMATE | .75 | | |

The t-test analysis of the differences among the mean scores indicated significant differences between male and female therapists in their overall evaluation of treatment (EVALRX) of their sexually abused patients. The male therapists evaluated the treatment less favorably. The t

value for this analysis was 2.57 and the degrees of freedom were 26 (p=0.02). For a summary of the mean scores see table 2.

Table 2

Summary of the Mean Scores for the Male and Female Therapists Evaluation of Treatment (EVALRX) of their Sexually Abused Patients

| Therapist Sex | N | Mean | SD |
|---|---|---|---|
| Males | 12 | 29.8 | 5.6 |
| Females | 16 | 25 | 4.3 |

Male therapists reported feeling more uncertain in their sessions with their sexually abused patients when compared to female therapists. The t value for this analysis was 2.25 and the degrees of freedom 26 (p=0.03). The female therapists reported feeling more intimate during sessions with their sexually abused patients. The t value for this analysis was -2.19 and the degrees of freedom 26 (0.04). For a summary of the mean scores comprising this interaction see table 3.

Table 3

Summary of the Mean Scores for the Therapist Feeling Scales Uncertain and Intimate

| Therapist Sex | N | Uncertain | SD | Intimate | SD |
|---|---|---|---|---|---|
| Males | 12 | 4.5 | 2.2 | 3.4 | 1.3 |
| Females | 16 | 2.9 | 1.6 | 4.4 | 1.1 |

No statistically significant differences were found

when the male patients where compared to the female patients in the therapists' overall evaluation of treatment and the feeling clusters.

When comparisons were made for the sample that reported on female patients only, male therapists were found to evaluate the overall treatment of their female sexually abused patients less favorably when compared to female therapists ($t=2.70$, $p=0.015$).

The Mann-Whitney U Test was used for comparisons between male and female therapists, the therapists' report on male and female child patients, and male versus female therapists'report on their female child patients for each of the variables involved in the questionnaire. These variables included the therapists' evaluation of the treatment of their child patients, the 27 therapist's feelings and 32 patient's feelings, the therapists' report on the extent to which they had discussed feelings about their patients with supervisors, colleagues and other significant people and their report on the extent to which they had thought about different members of their patient's family since their last session with their child patient.

Comparisons between male and female therapists

In the comparisons of the male vs female therapists in the total sample, no significant differences were found for the 9 evaluation of treatment variables. Some trends were observed for the female therapists who reported feeling more

in rapport with their patients' feelings than their male counterparts (z= -1.81, p= 0.07). Female therapists also reported understanding more of what their patients said and did in their sessions (z= -1.67, p= 0.09) and feeling more helpful to their sexually abused patients than the male therapists (z= -1.82, p= 0.07).

For a summary of the scores for the comparisons between male and female therapists' report of their patients' feelings see table 4.

Table 4

Summary of the z scores for the Therapists' Report of their Patient's Feelings

| Feeling | z score | p |
|---|---|---|
| Confident | -0.69 | 0.49 |
| Embarassed | -0.31 | 0.75 |
| Relaxed | -1.30 | 0.19 |
| Withdrawn | -1.11 | 0.26 |
| Helpless | -1.53 | 0.13 |
| Determined | -0.50 | 0.62 |
| Grateful | -1.93 | 0.05 * |
| Relieved | -2.36 | 0.02 * |
| Tearful | -0.52 | 0.60 |
| Close | -0.99 | 0.32 |
| Impatient | -1.51 | 0.13 |
| Guilty | -1.14 | 0.26 |
| Strange | -1.11 | 0.26 |
| Inadequate | -0.96 | 0.34 |
| Likeable | -0.30 | 0.76 |
| Hurt | -1.34 | 0.18 |
| Depressed | -0.37 | 0.71 |
| Affectionate | -0.48 | 0.63 |
| Serious | -0.05 | 0.96 |
| Anxious | -1.14 | 0.25 |
| Angry | -1.83 | 0.07 * |
| Pleased | -0.75 | 0.45 |
| Inhibited | -0.75 | 0.45 |
| Confused | -2.78 | 0.005 * |
| Discouraged | -1.17 | 0.24 |

| | | |
|---|---|---|
| Accepted | -1.55 | 0.12 |
| Cautious | -1.36 | 0.17 |
| Frustrated | -2.24 | 0.02 * |
| Hopeful | -1.22 | 0.22 |
| Tired | -0.03 | 0.98 |
| Ill | -0.21 | 0.84 |
| Sexually Attracted | -0.18 | 0.88 |

---

Although five of the above comparisons showed differences between male and female therapists, we should interpret the results with caution, since we would expect some of these findings by random. Female therapists reported their patients as feeling more relieved in sessions as compared to male therapists (z=-2.36, p=0.02). Male therapists reported their patients feeling more confused in sessions as compared to female therapists (z= -2.78, p=0.005). Male therapists also reported their patients as feeling more frustrated in sessions (z= -2.23, p= 0.03).

Other findings showed that female therapists attributed the feeling "grateful" to their patients more than the male therapists (z=-1.93, p= 0.0534). Male therapists reported their sexually abused patients as feeling more angry (z=-1.83, p= 0.07) in sessions.

For a summary of the z scores for the comparisons between male and female therapists reporting on their own feelings during sessions with their sexually abused patients see table 5.

Table 5

Summary of the z Scores for the Therapists Report of their own Feelings

| Feeling | z score | p | |
|---|---|---|---|
| Pleased | -1.20 | 0.23 | |
| Thoughtful | -1.10 | 0.27 | |
| Annoyed | -1.78 | 0.07 | |
| Bored | -0.47 | 0.63 | |
| Sympathetic | -0.80 | 0.42 | |
| Cheerful | -0.40 | 0.69 | |
| Frustrated | -1.59 | 0.11 | |
| Involved | -0.14 | 0.89 | |
| Playful | -0.92 | 0.36 | |
| Demanding | -1.12 | 0.26 | |
| Apprehensive | -1.77 | 0.08 | |
| Effective | -0.69 | 0.09 | |
| Perplexed | -2.04 | 0.04 | * |
| Detached | -1.02 | 0.30 | |
| Attracted | -0.10 | 0.92 | |
| Confident | -0.94 | 0.35 | |
| Relaxed | -0.77 | 0.44 | |
| Interested | -0.84 | 0.40 | |
| Unsure | -0.94 | 0.35 | |
| Optimistic | -1.29 | 0.20 | |
| Distracted | -0.69 | 0.49 | |
| Affectionate | -1.94 | 0.05 | * |
| Alert | -0.99 | 0.32 | |
| Close | -2.19 | 0.03 | * |
| Tired | -0.52 | 0.60 | |
| Sexually Stimulated | -1.31 | 0.19 | |
| Headachey or Ill | -1.88 | 0.06 | |

The above comparisons between male and femaletherapists reporting their personal feelings during sessions with their sexually abused patients showed male therapists as feeling more perplexed in their sessions with their sexually abused patients ($z=-2.04$, $p= 0.04$). Female therapists reported feeling more close ($z=-2.19$, $p=0.03$) to their sexually abused patients as compared to male therapists. Male

therapists reported feeling more annoyed during sessions with their sexually abused patients (z=-1.78, p= 0.08) as well as more headachey or ill(z=-1.88, p=0.06). The female therapists, on the other hand, reported more positive feelings during sessions with their sexually abused patients. The female therapists reported feeling more effective (z= -1.69, p=0.09) and more affectionate (z=-1.94, p=0.05) as compared to the male therapists. Again, these findings should be interpreted with caution because of the large number of variables involved.

Comparisons between therapists' report on male vs female sexually abused patients

When the patient sample was divided into two groups on the basis of sex, therapists of both sexes reported discussing their female sexually abused patients more than their male sexually abused patients in supervision (z=-2.49, p=0.0128).

For a summary of the z scores for the therapists' report on their male vs female patients' feelings see table 6.

Table 6

Summary of the z Scores for the Therapists' Report on their Male vs Female Patients' Feelings

| Feeling | z score | p |
|---|---|---|
| Confident | -0.96 | 0.34 |
| Embarassed | -1.66 | 0.10 |
| Relaxed | -0.44 | 0.01 |

| | | | |
|---|---|---|---|
| * | Withdrawn | -1.40 | 0.16 |
| | Helpless | -0.50 | 0.61 |
| | Determined | -1.09 | 0.28 |
| | Grateful | -0.08 | 0.93 |
| | Relieved | -1.62 | 0.10 |
| | Tearful | -0.68 | 0.49 |
| | Close | 0.0 | 1.00 |
| | Impatient | -0.49 | 0.63 |
| | Guilty | -2.49 | 0.01 * |
| | Strange | -1.46 | 0.14 |
| | Inadequate | -0.83 | 0.40 |
| | Likeable | -1.83 | 0.06 |
| | Hurt | -0.73 | 0.46 |
| | Depressed | -0.22 | 0.83 |
| | Affectionate | -0.70 | 0.48 |
| | Serious | -0.94 | 0.35 |
| | Anxious | -0.92 | 0.36 |
| | Angry | -1.88 | 0.06 |
| | Pleased | -0.65 | 0.52 |
| | Inhibited | -0.06 | 0.95 |
| | Confused | -0.90 | 0.37 |
| | Discouraged | -0.17 | 0.86 |
| | Accepted | -0.55 | 0.58 |
| | Cautious | -1.73 | 0.08 |
| | Frustrated | -1.49 | 0.14 |
| | Hopeful | -1.02 | 0.31 |
| | Tired | -0.90 | 0.37 |
| | Ill | -0.55 | 0.58 |
| | Sexually attracted | -0.70 | 0.48 |

The above comparisons showed differences for the therapists' report on their male vs female sexually abused patients which are worth noting even though they should be interpreted with caution. Therapists of both sexes found girl patients to feel more relaxed during their sessions ($z=-2.45$, $p= 0.014$). Therapists of both sexes found boy patients to feel more guilty during their sessions ($z=-2.49$, $p=0.0128$). The therapists also reported their male sexually abused patients as feeling more embarrassed ($z=-1.66$, $p= 0.09$) and more angry ($z=-1.88$, $p=0.06$) than female

patients during sessions. Therapists of both sexes tended to see their female patients as feeling more strange ($z=-1.84$, $p= 0.07$) and more cautious ($z=-1.73$, $p=0.08$) during sessions.

For a summary of the z scores for the therapists report of their own feelings for the comparisons between male and female patients see table 7.

Table 7

Summary of the z Scores for the Therapists' Report of their feelings toward their Male vs. Female Patients

| Feeling | z score | p | |
|---|---|---|---|
| Pleased | -0.09 | 0.93 | |
| Thoughtful | -1.27 | 0.20 | |
| Annoyed | -0.70 | 0.48 | |
| Bored | -0.65 | 0.52 | |
| Sympathetic | -0.35 | 0.72 | |
| Cheerful | -0.79 | 0.43 | |
| Frustrated | -1.16 | 0.25 | |
| Involved | -0.61 | 0.54 | |
| Playful | -1.67 | 0.09 | |
| Demanding | -1.93 | 0.05 | * |
| Apprehensive | -1.36 | 0.17 | |
| Effective | -0.44 | 0.66 | |
| Perplexed | -0.83 | 0.41 | |
| Detached | -1.12 | 0.26 | |
| Attracted | -0.34 | 0.73 | |
| Confident | -0.52 | 0.61 | |
| Relaxed | -0.31 | 0.76 | |
| Interested | -1.68 | 0.09 | |
| Unsure | 0.0 | 1.00 | |
| Optimistic | -0.99 | 0.32 | |
| Distracted | -0.85 | 0.40 | |
| Affectionate | -0.68 | 0.50 | |
| Alert | -0.72 | 0.47 | |
| Close | -0.06 | 0.95 | |
| Tired | -1.99 | 0.05 | * |
| Sexually Stimulated | -0.29 | 0.77 | |
| Headachey or Ill | -0.65 | 0.52 | |

The analysis of the differences among these scores indicated that therapists of both sexes reported feeling more tired during sessions with their male sexually abused patients ($z=-1.99$, $p= 0.05$) than their female sexually abused patients. Therapists of both sexes reported feeling more playful in their sessions with their male sexually abused patients as compared to their female patients ($z=-1.67$, $p=0.09$). In contrast, the data showed therapists to feel more demanding ($z=-1.93$, $p=0.053$) with their female patients during sessions.

Comparisons between male and female therapists reporting on the treatment of female patients

Comparisons between male and female therapists who reported on the treatment of a female patient (N=20) showed significant differences. Female therapists reported feeling more helpful to their female patients than their male counterparts ($z=-2.01$, $p= 0.04$) and understanding more of what their female patients said and did ($z=-1.96$, $p= 0.05$). The analysis of this data also revealed some interesting trends. Female therapists reported revealing their spontaneous reactions to their female patients more than male therapists ($z=-1.68$, $p=0.09$). Female therapists also reported feeling more in rapport with their female patients when compared to male therapists ($z=-1.90$, $p=0.06$).

For a summary of the z scores for the comparisons of the male vs female therapists' report on their female

patients' feelings see table 8.

Table 8

Comparisons Between Male and Female Therapists Reporting on their Female Patients' Feelings

| Feeling | z score | p | |
|---|---|---|---|
| Confident | -0.19 | 0.85 | |
| Embarassed | -1.86 | 0.06 | |
| Relaxed | -0.82 | 0.41 | |
| Withdrawn | -0.72 | 0.47 | |
| Helpless | -1.26 | 0.21 | |
| Determined | -1.63 | 0.10 | |
| Grateful | -1.66 | 0.09 | |
| Relieved | -1.78 | 0.07 | |
| Tearful | -1.28 | 0.20 | |
| Close | -1.26 | 0.21 | |
| Impatient | -1.66 | 0.09 | |
| Guilty | -2.15 | 0.03 | * |
| Strange | -0.76 | 0.45 | |
| Inadequate | -1.89 | 0.06 | |
| Likeable | -0.97 | 0.33 | |
| Hurt | -0.73 | 0.47 | |
| Depressed | -0.32 | 0.75 | |
| Affectionate | -0.43 | 0.67 | |
| Serious | -0.75 | 0.45 | |
| Anxious | -0.67 | 0.50 | |
| Angry | -1.12 | 0.26 | |
| Pleased | -0.88 | 0.38 | |
| Inhibited | -0.68 | 0.49 | |
| Confused | -2.02 | 0.04 | * |
| Discouraged | -0.55 | 0.58 | |
| Accepted | -1.34 | 0.18 | |
| Cautious | -1.20 | 0.23 | |
| Frustrated | -1.62 | 0.10 | |
| Hopeful | -1.01 | 0.31 | |
| Tired | -0.25 | 0.80 | |
| Ill | -0.82 | 0.41 | |
| Sexually Attracted | -0.63 | 0.53 | |

Female therapists perceived their female patients as feeling more close during sessions ($z=-2.15$, $p=0.03$). The male therapists reported their female patients as feeling more confused during sessions ($z=2.02$, $p=0.04$).

Female therapists, when compared to male therapists also attributed to their female patients the feelings embarrassed (z=-1.86, p=0.06), inadequate(z=-1.89, p=0.06), grateful (z=-1.66, p= 0.09) and relieved (z=-1.78, p=0.07).

No statistically significant differences were found on the therapists' report on their own feelings during sessions with their female patients. Male therapists tended to feel more apprehensive (z=-1.88, p=0.06) and perplexed (z=-1.76, p=0.08) as compared to female therapists.

Post Sexual Abuse Disclosure Stress Scale. The Mann-Whitney U Test was used for comparisons between male and female therapists, male and female sexually abused patients and male and female therapists who reported only on female patients on their ratings of severity of stress for the different items in the questionnaire. Both male and female therapists attributed more stress to the female patients when compared to the male patients after parental separation following disclosure of the sexual abuse (z= -2.01, p=0.04).

The analysis showed trends for therapists of both sexes to attribute to their female patients more stress as a result of police interview after disclosure of the sexual abuse when compared to the male patient group (z=-1.83, p=0.07). Male therapists attributed more stress to their female patients if the sexual abuser was removed from the home after disclosure of the abuse when compared to female

therapists (z=-1.82, p=0.07). Likewise, male therapists attributed more stress to their male and female sexually abused patients after removal of the sexual abuser from the home as compared to female therapists (z=-1.65, p= 0.09).

# CHAPTER V

# DISCUSSION

The fifth chapter has been divided into six sections. The first section will briefly review the purpose and objectives of this dissertation and the emphasis of the past literature in the area of sexual abuse of children. The second section will review the hypotheses of this dissertation. The third section will briefly review the methods of this study. The fourth section will discuss the present findings. The fifth section will review the problems and limitations of this study. The last section will summarize the clinical implications and suggest areas of future research in this field.

## I. Review of the purpose and objectives of the study with reference to past literature

The purpose and objectives of this study were to examine the therapist's experience of psychotherapy with sexually abused children. Reported cases of sexual abuse have increased in recent years as well as the notion that sexual abuse in childhood can have negative traumatic impact on the child. There are inherent difficulties in the treatment of a sexually abused child. First, there is a lack of a unified theory on the impact that sexual abuse has on the child and implications for treatment. Second, the therapist often becomes involved in court proceedings and mediates with families and child protective agencies. He or

she may experience conflict between his or her clinical judgment, ethical issues and what is required by the law. Third, the treatment of sexually abused children may evoke strong emotions in the therapist since sexual abuse represents violation of social taboos. One of the objectives of this study was to show that therapists experience difficulty and a sense of failure in the treatment of sexually abused children.

Since it has been suggested that differences in the socialization of men and women may play a role in the nature and occurrence of the sexual abuse of children, this study attempted to explore the impact that gender differences might have in the treatment of sexually abused children. It has been noted that the sexual abuse of male children is underreported due to cultural biases. There is an expectation for the male to be able to defend himself and not be a victim. Denial and minimization and blaming of the victim are more prevalent among the families of sexually abused boys. An objective of this study was to show that therapists of both sexes would have more negative attitudes toward their male sexually abused patients. These findings would support the observations that the male sexually abused child's presentation in therapy is often more aggressive and defiant as compared to the female child's presentation, that male sexually abused children have extreme difficulty discussing their experiences in individual or group

treatment, and that male sexually abused children are kept in treatment for shorter periods as compared to female sexually abused children.

This study also attempted to show that male and female therapists would differ in their views and evaluation of treatment of their female sexually abused patients. The findings would support the view that sex related therapeutic errors may occur in the treatment of female sexually abused victims. Female therapists may overidentify with the patient and show anger at the patient's father. Male therapists may overemphasize the importance of sexual details and may identify with the abuser, while blaming the victim for her seductiveness.

## II. Review of the hypotheses

The following hypotheses were posed for testing in this study:

Hypothesis I: Therapists experience strong emotions and a sense of failure in the treatment of sexually abused children.

Hypothesis II: Therapists see the sequelae of the sexual abuse and stress related factors associated with the involvement of the legal system and child protective agencies as adding significantly to the traumatic impact of the sexual abuse.

Hypothesis III: Male and female therapists have more

negative attitudes toward male sexually abused patients as compared to female patients.

Hypothesis IV: Male therapists will differ from female therapists in their views of their female sexually abused patients.

Hypothesis V: Female therapists as compared to male therapists will tend to overidentify with female sexually abused patients and will show more bias toward the abusers.

Hypothesis VI: Differences in the theoretical orientation of the therapists will reflect in their attitudes of and experience of psychotherapy with sexually abused children.

Hypothesis VII: Sex differences and differences in theoretical orientation will tend to disappear as a factor of the therapist's experience.

III. Review of the methods

The subjects for the present study were twelve male therapists and sixteen female therapists who participated on a voluntary basis. The therapists worked in community mental health facilities and private and public hospital settings in the New York and New Jersey areas. They were kept blind as to the exact nature of the study. The therapists were instructed to report on one sexually abused patient, and to select a patient that they were presently treating. The subjects reported on eight male and twenty female sexually abused patients. The study utilized three

questionnaires: the Therapist Questionnaire, the Post Sexual Abuse Disclosure Stress Scale, and the Therapy Session Report (Orlinsky & Howard, 1966b) to examine the subjects' background information, evaluation of treatment of their sexually abused patients, reporting on their feelings as well as feelings they attributed to their patients during their therapy sessions, and rating of severity of stress experienced by their sexually abused patient after disclosure of the abuse.

Frequency distributions, means and standard deviations were computed for all variables involved. The sample was divided into groups on the basis of sex and comparisons were made between the following groups: male vs female therapists (N=28), therapist's report on male vs female children (N=28), and male vs female therapists reporting on a female patient (N=20). The Mann-Whitney U test was used for these comparisons to analyze the differences in the therapists' evaluation of treatment, reporting of feelings and rating the severity of the post-disclosure stress on their sexually abused patients.

In order to lessen the number of variables, Pearson correlation coefficients were computed using the entire therapist sample and the resulting matrix was analyzed for reliability. The therapists' evaluation of treatment (11 items) was clustered into three variables, the therapist's feeling list (32 items) was clustered into five variables

and the patient feeling list (27 items) was clustered into four variables. A t test was computed to analyze differences between the groups involved.

An attempt was made to rank the severity of trauma within the group of therapists reporting on sexually abused female patients (N=20) and examine differences within this group but no significant effects were found.

IV. Discussion of the results

The analysis of the data collected relative to the principal objectives of the study indicated significant differences in the therapists' evaluation of their male vs female sexually abused patients. The therapists discussed their female sexually abused patients more in supervision. They attributed more stress to their female patients after parental separation following disclosure of the abuse than to their male sexually abused patients. The data also showed a trend for therapists to attribute more stress to females if they had been interviewed by police after disclosure of the sexual abuse.

The therapists attributed to their male sexually abused patients the feelings "guilty", "embarrassed" and "angry" more than to their female patients. The therapists reported feeling more tired during sessions with their male patients. The therapists reported their female patients more relaxed during their sessions as compared to their male patients. These findings suggest that, as was posited in

Hypothesis 3, therapists of both sexes may show more negative attitudes and bias toward their male sexually abused patients. The attribution of the feelings guilty, embarrassed and angry may be an objective observation of the male patients' presentation during sessions, since it has been proposed that male victims of sexual abuse present with aggressive, "hypermasculine" behaviors and experience shame and conflict about their sexual identity. The fact that therapists discussed more their female sexually abused patients in supervision than their male sexually abused patients and that they attributed more stress to the females after the events of a police interview and parental separation following disclosure of the abuse suggests that the therapists were more involved in the treatment of their female patients, and tended to minimize the impact of the sexual abuse and sequelae of the abuse on their male patients.

The statistical analysis also revealed significant differences between male and female therapists. Female therapists reported the scale "intimate" which included the feelings sympathetic, affectionate and close more than the male therapists. The female therapists, as compared to male therapists, attributed the feeling relieved more to their sexually abused patients during their therapy sessions. Male therapists reported feeling more perplexed during sessions with their sexually abused patients, and

attributed to their patients the feelings confused and frustrated more than the female therapists. The male therapists reported the scale "uncertain" more than the female therapists. This scale included the feelings frustrated, apprehensive, perplexed and unsure. The male therapists reported a lower evaluation of the overall treatment of their sexually abused patients. There were trends for female therapists to feel more effective and affectionate during sessions with their sexually abused patients and to attribute to their patients the feeling grateful more than male therapists. Male therapists tended to feel more annoyed, more headachey or ill during sessions with their sexually abused patients and to attribute the feeling angry to their patients more when compared to the female therapists.

The above findings reflect that female therapists tended to feel more comfortable and effective in their sessions and to attribute to their patients a positive response to their interventions, while the male therapists tended to feel more apprehensive, uncertain and annoyed with their patients. It is not clear, however, whether these findings reflect gender differences in relation to the sexual abused patient or gender differences that might apply to any patient population. If one considers the differences in the socialization of men and women and the idea that men tend to sexualize the expression of emotions and have more

difficulty distinguishing between sexual and nonsexual forms of affection, the possibility that the male therapists' discomfort and apprehension during sessions with their sexually abused patients could be due to the patients' seductive presentation comes into question. The notion that the child had been sexually abused could have been more disturbing to the male therapists, and they might have experienced more difficulty differentiating between the child patient's needs for emotional and physical contact.

Also, when looking at the findings discussed above one should take into account that the male sexually abused patient sample was small (N=8). Therefore, the results might reflect therapist gender differences in relation to their female sexually abused patients. To support this notion, in the group of therapists who reported on the treatment of female patients, female therapists tended to evaluate their treatment of their sexually abused female patients in a more positive way. They reported feeling more in rapport with their patients feelings, understanding more of what their patients said and did and feeling more helpful to their patients than their male counterparts. Female therapists attributed to their female patients the feeling "close" during sessions more than the male therapists. Again, the female therapists reported the scale "intimate" more than the male therapists.

The male therapists attributed to their female patients

the feeling "confused" more than the female therapists. The male therapists reported the scale "uncertain", which included the feelings frustrated, apprehensive, perplexed and unsure during sessions with their sexually abused female patients more than the female therapists. Male therapists reported a less favorable evaluation of the treatment of their sexually abused female patients. These findings support Hypothesis 4, where it was posited that male and female therapists would differ in their attitudes toward their female sexually abused patients and their evaluation of treatment of their female sexually abused patients. One could also assume that the female therapists' optimistic view of their treatment of their sexually abused female patients might reflect countertransference manifestations involving projection and overidentification which should not be mistaken for empathic understanding and effective interventions. The finding that male therapists attributed more stress to their female patients if the abuser was removed from the home as compared to female therapists further supports Hypothesis 5, where it was posited that female therapists may overidentify with their female sexually abused patients and show more bias toward the abuser.

No comparisons between more experienced and less experienced therapists were possible since the therapist sample showed therapists to have several years of clinical

experience as well as years of personal psychotherapy treatment. The therapist sample was also homogenous in terms of their theoretical orientation, with a large proportion of the therapists reporting a psychodynamic orientation. Therefore, hypothesis 6, where it was posited that differences in the therapists' theoretical orientation might reflect in their evaluation of treatment of their sexually abused patients, and hypothesis 7, where it was posited that therapist gender differences and differences in the therapists' theoretical orientation would tend to disappear as a function of the therapists level of experience could not be tested.

Hypothesis 1, where it was posited that therapists would experience a sense of failure in the treatment of their sexually abused patients was rejected. The therapist sample tended to evaluate their treatment of their sexually abused patients very favorably. The therapists' report of frequent consultation of their sexually abused patients with colleagues and supervisors as well as their report that they discussed their sexually abused patients often with personal therapists and significant others in between sessions seems to contradict their favorable evaluation of treatment of their sexually abused patients and the therapists'report that their own state of mind had little interference in the treatment. These findings suggest that therapists were preoccupied or experiencing difficulty in the treatment of

their sexually abused patients. On the other hand, and maybe because the therapists' reported feeling supported by their supervisors and because they resorted to others for advice and consultation at times of doubt and difficulty in the treatment, it enabled them to conduct the therapy treatment objectively and effectively.

Furthermore, even though the therapists were very involved in the legal proceedings after disclosure of the abuse and reported involvement with child protective agencies, they reported feeling comfortable with their advocacy role. This involvement beyond the therapist role could have helped the therapists sampled feel more in control and therefore more effective in their treatment of their sexually abused patients.

It should be noted that the therapists sampled underreported feelings of sexual attraction during sessions with their sexually abused patients as well as attribution of sexual feelings to these patients. This seems unusual in view of what has been observed in past literature and research about the sexually abused child's presentation in therapy. Sexually abused children have learned to get attention and affection from adults by participating in sexual acts. They also exhibit sexualized behaviors which could be interpreted as a compulsion to repeat, an attempt to test the integrity of the therapist or an attempt to work through the sexual abuse in the transference. It is also

common for the sexually abused child to be sexually aroused by physical or emotional closeness with an adult, since their affectionate and sexual needs remain undifferentiated. The failure of the therapists sampled in this study to report sexual feelings might be interpreted as countertransference. It is possible, however, that the therapists were aware of their own feelings but were reluctant to report these feelings for a research instrument.

V. Problems and Limitations of the Study

There were a number of problems and limitations that were encountered in the process of implementing this research study which should be considered when interpreting this data. To begin with, the number of subjects examined was limited due to voluntary participation of the subjects and the difficulty in recruiting subjects who are treating the sexually abused population. Second, the number of male patients that the subjects reported on was small for the purpose of statistical analysis.

Another problem encountered were the ages of the sexually abused patients, which ranged from 3 to 16 years old. There are wide differences in the cognitive and emotional development in the different age groups. It should be noted, though, that 89% of the patient sample were under the age of 12. Also, for most of the patient sample (26 of the 28 cases) the sexual abuse had started before

age 9. This seems important in view of the literature and research which suggest that differences exist in patterns of pathology for sexual abuse occurring in early versus late childhood.

In terms of the instruments utilized in this study, questions may be raised concerning the adequacy of the Post Sexual Abuse Disclosure Stress Scale. This instrument has not been standardized. Consequently, its validity and reliability are untested. One major problem encountered in using this scale was missing data. There were cases where, even though the sexual abuse had been disclosed by the child to a relative or therapist, the abuse was never reported to the authorities. In other cases, where the sexual abuse was reported, the children involved did not go through all the different events listed in the instrument.

Finally, the homogeneity of the sample in terms of their theoretical orientation and their level of experience did not allow for testing of two of the initial hypotheses.

## VI. Clinical Implications and Suggestions for Future Research

The findings of this study, as stated above, suggest a tendency for female therapists to overidentify with their female sexually abused patients and deny to some degree the patients' conflict and anger. The findings also suggest that male therapists experience more uncertainty and discomfort in the treatment of their female sexually abused

patients, possibly in reaction to the notion that the patient has been sexually active and to the patient's seductive presentation.

The underreporting by the therapists of feelings of sexual attraction and the absence of attribution of sexual feelings to their sexually abused patients seems to further support the notion that countertransference reactions might be interfering with an objective assessment of the treatment of their sexually abused patients. The obvious clinical implications are that these countertransference reactions might interfere with the therapeutic process and outcome. The group treatment modality for sexually abused patients led by male and female cotherapists has been advocated by some of the experts in the field, claiming that it provides the patients with adequate adult role models. The present findings further support this approach to treatment, since male and female therapists working together would be more able to provide feedback to each other, thus avoiding therapeutic errors.

The findings of the present study also suggest that the therapists were comfortable advocating for their sexually abused patients and extending themselves beyond their role as therapists. The fact that the therapists felt supported by their supervisors and consulted frequently with colleagues and significant others may account for this finding. Because they were experienced they seemed to have

resorted to their available resources. This seems to suggest that it would be important to provide opportunities for beginning therapists and therapists in training to discuss their sexual abuse cases with experts and more experienced therapists.

Suggestions for future research are comparisons between male and female therapists treating sexually abused children and controls to see if the gender differences outlined in this study apply to other patient populations or are specific to sexual abuse cases. It would also be worthwhile to investigate the differences between therapists' experience of the treatment of sexually abused children comparing those patients who have been in long term vs short term treatment. The majority of the sexually abused patients in the present study had been in long-term treatment, which may account for the therapists' overall favorable view of the treatment.

The therapists sampled in this study had several years of clinical experience, had treated a significant number of sexually abused children and had years of personal psychotherapy. It is likely that because they were experienced therapists they reported feeling comfortable with their advocacy role and great involvement with their sexually abused patients. Future research might compare experienced vs inexperienced therapists in their feelings, attitudes and evaluation of treatment of their sexually abused patients.

abused patients.

# APPENDIX A
# THERAPIST QUESTIONNAIRE

I) BACKGROUND INFORMATION

1) Are you a
a) psychoanalyst b) psychologist c) psychiatrist
d) nurse e) social worker f) other:_____

2) Are you a) male b) female

3) How old are you?_____

4) Do you have any children? a) yes b) no

5) What is the highest degree you presently hold?_

6) How many years of professional experience doing therapy do you have?
a) less than one b) one to two c) three to five
d) five or more

7) If you are in training, how far along are you in your training?_____

8) What best describes your orientation?
a) psychoanalytic b) family systems c) humanistic
d) cognitive/behaviorist e) other_____

9) Are you presently having personal therapy ?
a) yes b) no
Psychoanalysis? a) yes b) no

10) Please state length of time you had personal psychotherapy in the past_____
Length of time in psychoanalysis?_____

11) How many sexually abused children have you treated?
a) one b) two c) three d) four e) five or more

12) If you have treated more than one child, please report on a child that you are presently treating or on the child that you treated most recently. How old were you when you began treating this child?
_____

13) If you are/were supervised on this case, is your supervisor a) male b) female

14) Do you feel supported by your supervisor?
a) yes b) no

15) Have you consulted this case with colleagues?
a) never b) sometimes c) frequently

16) Were you pregnant during the time you treated your child patient? a) not applicable b) yes c) no

17) How old was the child patient when you began treatment?_____

18) Is the child, a) male b) female

19) Do you feel the child was a "typical" case of sexual abuse? a) yes b) no c) not sure

II) ABUSE AND DISCLOSURE

1) Was the child sexually abused by
a) father b) stepfather c) mother d) sibling
e) stepmother f) male relative g) female relative
h) other male_____ i) other female_____
If you checked other, was this person known to the child
a) yes b) no

2) What was the nature of the abuse?(Check all that apply)
a) fondling b) oral-genital contact
c) anal intercourse d) vaginal intercourse

3) How old was the child when the abuse was initiated?_____

4) What was the duration of the abuse?
a) single episode b) less than six months c) six months to a year d) one year or more

5) Was the abuse disclosed prior to the child entering treatment?
a) yes b) no

6) Did the child disclose the abuse? a) yes b) no
If the child diclosed the abused, who did he or she disclose it to?
a) mother b) father c) sibling d) teacher
e) therapist f) other _____

III) REPORTING

1) Was the abuse reported? a) yes b) no

2) How soon after disclosure was the abuse reported?
a) immediately b) a few months later
c) over a year after disclosure

3) Who reported the abuse?
a) yourself b) other therapist c) abused child
d) sibling e) non-abusive parent f) teacher
g) abusive parent h) hospital personnel
i) other_____

4) Was the child removed from his/her home after reporting? a) yes b) no

5) Was the abuser removed from the home after reporting?
a) yes b) no

6) Was the abuser imprisoned? a) yes b) no

7) If the answer to the above question is yes, do you feel it was appropriate to imprison the abuser?
a) yes b) no

8) If the Justice System was involved at the time that you treated the child, did you provide assistance in understanding the developmental and psychological needs of your child patient?
a) no assistance provided b) very little c) some
d) a lot

9) Did you assist the child's family understand the implications of reporting and prosecution? the legal process?
a) no assistance b) very little c) some d) a lot

10) Do you feel your child patient was protected by the Justice System?
a) not at all b) very little c) some d) a lot

11) If social agencies were involved, do you feel your child patient was protected by them?
a) not at all b) very little c) some d) a lot

12) How comfortable were you with your advocacy role?
a) very uncomfortable b) somewhat uncomfortable
c) comfortable d) very comfortable

IV) TREATMENT

1) Was your patient in therapy prior to your treating

him/her? a) yes b) no

2) If your patient was in therapy before, what was the length of treatment?
a) a few sessions b) less than three months
c) three to six months d) six months to one year
e) one year or more

3) What was the length of your treatment of the patient?
a) a few sessions b) less than three months
c) three to six months d) six months to one year
e) one year or more

4) What was the frequency of sessions?
a) bi-weekly b) weekly c) twice a week
d) more than twice a week

5) What was the treatment modality? Check all that apply
a) individual psychotherapy b) family therapy
c) group d) collateral parental counselling
e) other _____

6) Was the abuser in treatment with yourself?
a) yes b) no

7) Was the abuser treated by another therapist?
a) yes b) no

8) Do you feel the abuser was motivated for treatment?
a) yes b) no c) does not apply

9) Was the treatment of your child patient terminated?
a) yes b) no

10) Was termination (Check all items that apply)
a) natural b) initiated by parent c) due to unusual circumstance affecting you (e.g.job transfer) d) due to unusual circumstance affecting child (e.g. moved to a different location)
e) against your recommendation

11) If you have other comments that you feel might be helpful please use the space provided below.

## APPENDIX C
## POST SEXUAL ABUSE DISCLOSURE STRESS SCALE

1) Was your child patient interviewed by a worker from child protective agency? a) yes b) no
c) do not know

2) In your opinion, what was the effect of the interview on the child

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| not stressful | | | | | | | | highly stressful |

3) Was the child medically examined following disclosure of the abuse? a) yes b) no c) do not know
Was the child examined by
a) private physician b) emergency room personnel
c) other

4) Please rate the effect of the above procedure on the child?

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| not stressful | | | | | | | | highly stressful |

5) Was the child interviewed by the police?
a) yes b) no c) do not know

6) Please rate the effect of the interview on the child

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| not stressful | | | | | | | | highly stressful |

7) Was the child removed from his home following disclosure of the abuse?
a) yes b) no c) do not know

8) If the child was removed from the home, what was the length of time that the child remained outside the home?_____

9) In your opinion, what was the effect that being removed from the home had on the child?

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| not stressful | | | | | | | | highly stressful |

10) Was the abuser removed from his home after disclosure?
a) yes b) no c) do not know

11) Please rate the effect that removal of the abuser from his home had on your child patient?

1 2 3 4 5 6 7
not stressful highly stressful

12) Was the child interviewed by the prosecutor?
a) yes b) no c) do not know

13) In your opinion, what was the effect of the interview on the child

1 2 3 4 5 6 7
not stressful highly stressful

14) Was the child interviewed by attorney(s)?
a) yes b) no c) do not know

15) What was the effect of the interview on the child?

1 2 3 4 5 6 7
not stressful highly stressful

16) Did the child testify in court?
a) yes b) no c) do not know

17) Please rate the effect that testifying in court had on the child?

1 2 3 4 5 6 7
not stressful highly stressful

18) Was the abuser incarcerated:
a) yes b) no c) do not know

19) In your opinion, what was the effect that the imprisonment of the abuser had on the child?

1 2 3 4 5 6 7
not stressful highly stressful

20) Did the child's parents separate or divorce after the abuse was disclosed?
a) yes b) no c) not apply

21) Please rate the effect that the parents separation had

on the child?

1 2 3 4 5 6 7
not stressful highly stressful

22) In your opinion, how does the stress suffered by this child after disclosure of the abuse compare to the stress suffered by other sexually abused children after disclosure?
a) below average b) average c) more than average
d) not sure

BIBLIOGRAPHY

Adams-Tucker, C. Proximate Effects of Sexual Abuse in Childhood: A Report on 28 Children. American Journal of Psychiatry, 1982, 139:10, 1252-1256.

Adams-Tucker, C. Early Treatment of Child Incest Victims. American Journal of Psychotherapy, 1984, 37:4, 505-515.

Anderson, L.M., Shafer, G. The Character-Disordered Family: A Community Treatment Model for Family Sexual Abuse. American Journal of Orthopsychiatry, Jul 1979, 49:3, 436-445.

Angelou, M. I Know why the Caged Bird Sings. New York: Random House, 1970.

Anthony, J. E. The Comparable Experience of a Child and Adult Analyst. Psychoanalytic Study of the Child, 1982, 37, 339-366.

Awad, G.A. Father-Son Incest: A Case Report. The Journal of Nervous and Mental Disease, 1976, 162:2, 135-139.

Baum, E.O. Countertransference. Psychoanalytic Review, 1969-70, 56, 621-637.

Bell, D.H. Being a Man, the Paradox of Masculinity. Vermont: The Lewis Publishing Co., 1982.

Bender, L., Blau, A. The reaction of Children to Sexual Relationships with Adults. American Journal of Orthopsychiatry, 1937, 7, 500-518.

Bender, L., Grugett, A.E. A Follow-up Report on Children who had Atypical Sexual Experience. American Journal of Orthopsychiatry, 1952, 12, 825-837.

Boatman, B., Borkan, E., Schetky, D.H. Treatment of Child Victims of Incest. The American Journal of Family Therapy, 1981, 9:4, 43-51.

Bornstein, B. Emotional Barriers in the Understanding and treatment of young Children. American Journal of Orthopsychiatry, 1948, 18, 691-697.

Brady, K. Father's Days: A True Story of Incest. New York: Seaview, 1979.

Bregman Ehrenberg, D. Abuse and Desire: A Case of Father-Daughter Incest. Contemporary Psychoanalysis, 1987, 23:4, 593-604.

Emslie, G.J.and Rosenfeld, A. Incest Reported by Children and Adolescents Hospitalized for severe Psychiatric Disorder. American Journal of Psychiatry, 1983, 140, 708-711.

Farber, E.D. et al. The Sexual Abuse of Children: A Comparison of Male and Female Victims. Journal of Clinical Child Psychology, 1984, 13:3, 294-297.

Fenton, W.S., Robinowitz, C.B., and Leaf, P.J. Male and Female Psychiatrists and their Patients. American Journal of Psychaitry, 1987, 144:3, 358-361.

Finkelhor,D., Hotaling, G. Sexual Abuse in the National Incidence Study of Child Abuse and Neglect. Report to the National Center for Child Abuse and Neglect, 1983.

Finkelhor, D. Child Sexual Abuse: New Theory and Research. New York: The Free Press, 1984.

Finkelhor, D., Browne, A. The Traumatic Impact of Child Sexual Abuse: A Conceptualization. American Journal of Orthopsychiatry, 1985, 531-541.

Freud, S. The Aetiology of Hysteria (1896). Complete Psychological Works, Standard Edition, 3. London: Hogarth Press, 1962.

Freud, S. Further Remarks on the Neuro-psychoses of Defence (1896). Complete Psychological Works, Standard Edition, 3. London: Hogarth Press, 1962.

Fritz, G., Stoll, K., Wagner, N. A Comparison of Males and Females who were Sexually Molested as Children. Journal of Sex and Marital Therapy, 1981, 7, 54-59.

Gartrell, N., Herman, J., Olarte, S. Feldstein, M., Localio, R. Reporting Practices of Psychiatrists who knew of Sexual Misconduct by Colleagues. American Journal of Orthopsychiatry, April 1987, 57:2, 287-295.

Gebhard, P.H., et al. Sex Offenders: An Analysis of Types. New York: Harper & Row & Paul B. Hoeber, Inc., 1965.

Gelinas, D. The Persisting Negative Effects of Incest. Psychiatry, Nov 1983, 46, 312-332.

Giarretto, H. A Comprehensive Child Abuse Treatment Program, in Sexually Abused Children and Their Families. Mrazek, I.B., Kempl, C.H. (Eds.) New York: Pergamon Press, 1981.

Gilligan, C. In a Different Voice. Harvard University Press, 1982.

Greene, L.R., Rosenkrantz, J., Muth, D.Y. Borderline Defenses and Countertransference: Research Findings and Implications. Psychiatry, 1986, 49, 253-264.

Groth, N. Men Who Rape: The Psychology of the Offender. New York: Plenum Press, 1979.

Gold, E.R. Long-Term Effects of Sexual Victimization in Childhood: An Attributional Approach. Journal of Consulting and Clinical Psychology, 1986, 54:4, 471-475.

Harter, S., Alexander, P.C., Neimeyer, R. Long-Term Effects of Incestuous Child Abuse in College Women: Social Adjustment, Social Cognition, and Family Characteristics. Journal of Consulting and Clinical Psychology, 1988, 56:1, 5-9.

Hartman, M., Finn, S.E., Leon, G.R. Sexual Abuse Experiences in a Clinical Population: Comparisons of Familial and Non Familial Abuse. Psychotherapy, 1987, 24:2, 154-159.

Herman, J.L. Father-Daughter Incest. Cabridge: Harvard University Press, 1981.

Holroyd, J.C., Brodsky, A.M. Physical Contact with Patients. American Psychologist, 1977, 32, 843-847.

Hoorwitz, A.N. Guidelines for Treating Father-Daughter Incest. Social Casework: The Journal of Contemporary Social Work, Nov 1983, 515-524.

Howard, K., Orlinsky, D., Hill, J. The Therapist's feelings in the therapeutic process. Journal of Clinical Psychology, 1969, 25, 83-93.

Howard, K., Orlinsky, D., Hill, J. Affective Experience in Psychotherapy. Journal of Abnormal Psychology, 1970, 75: 3, 267-275.

Howells, K. Some Meanings of Children for Pedophiles. In M. Cook and G. Wilson (Eds.) Love and Attraction. London: Pergamon Press, 1981, p. 57-82.

Husain, A., and Chapel, J.L. History of Incest in Girls admitted to a Psychiatric Hospital. American Journal of Psychiatry, 1983, 140, 591-593.

Jones, E., Krupnick, J., Kerig, P. Some Gender Effects in a Brief Psychotherapy. Psychotherapy, 1987, 24:3, 336-352.

Jones, J.G. Sexual Abuse of Children: Current Concepts. American Journal of Diseases of Childhood, 1982, 136, 142-146.

Kaplan, A.G. Toward an Analysis of Sex-role Related Issues in the Therapeutic Relationship. Psychiatry, May 1979, 42,112-120.

Kaplan, A.G. Female or Male Therapists for Women Patients: New Formulations. Psychiatry, May 1985, 48, 111-121.

Kercher, G. Responding to Child Sexual Abuse. Huntsville, TX: Sam Houston State University, Criminal Justice Center, 1980.

Khan, M. Sexton, M. Sexual Abuse of Young Children. Clinical Pediatrics, 1983, 22:5, 369-372.

Kinsey, A. Sexual Behavior of the Human Female. New York: Pocket Books, 1953.

Kohrman, R., Fineberg, H.H., Gelman, R.L., Weiss, S. Technique of Child Analysis: Problems of Countertransference. International Journal of Psychoanalysis, 1971, 52, 487-497.

Krafft Ebing, R. Psychopathia Sexualis. New York: Putnam's, 1965.

Krener, P. After Incest: Secondary Prevention? Journal of the American Academy of Child Psychiatry, 1985, 24:2, 231-234.

Kohan, M.J., Pothier, P., @ Norbeck, S.J. Hospitalized Children with Histories of Sexual Abuse: Incidence and Care Issues. American Journal of Orthopsychiatry, April 1987, 57:2, 258-264.

Krieger, M.J., Rosenfeld. A.A., Gordon, A. Bennett, M. Problems in the Psychotherapy of Children with Histories of Incest. American Journal of Psychotherapy, 1980, 34:1, 81-88.

Lamb, S. Treating Sexually Abused Children: Issues of Blame and Responsibility. American Journal of Orthopsychiatry, April 1986, 56:2, 303-307.

Landis, J. Experience of 500 Children with Adult Sexual Deviation. Psychiatric Quarterly, 1956, 30, 91-109.

Langsley, D.G., Schwartz, M.N., Fairbairn, R.H. Father-Son Incest. Comprehensive Psychiatry, May 1968, 9:3, 218-226.

Lanyon, R.I. Theory and Treatment in Child Molestation. Journal of Consulting and Clinical Psychology, 1986, 54:2, 176-182.

Mac Vicar, K. Psychotherapeutic Issues in the Treatment of Sexually Abused Girls. Journal of the American Academy of Child Psychiatry, 1979, 18, 342-353.

Manosevitz, M. Early Sexual Behavior in Adult Homosexual and Heterosexual Males. In Perspectives on Human Sexuality, Wagner, N. (Ed.) New York: Behavioral Publications, Inc., 1974, p.224-239.

Marcus, I.M. Countertransference and the Psychoanalytic Process in Children and Adolescents. Psychoanalytic Study of the Child, 1980, 35, 285-298.

Marlowe, M. Boyhood Sex-Role Development: Implications for Counseling and School Practices. Personnel and Guidance Journal, 1981, 210-214.

McClure, B., Hodge, R. Measuring Countertransference and Attitude in Therapeutic Relationships. Psychotherapy, 1987, 24:3, 325-335.

Mc Millen Hall, N. Group Treatment for Sexually Abused Children. Nursing Clinics of North America, 1984, 13:4, 701-705.

Meiselman, Incest: A Psychological Study of Causes and Effects with Treatment Recommendations. San Francisco: Jossey Bass, 1978.

Mogul, K.M. Overview: The Sex of the Therapist. American Journal of Psychiatry, January 1982, 139:1, 1-11.

Molner, G. and Cameron, P. Incest Syndromes: Observations in a General Hospital Psychiatric Unit. Canadian Psychiatric Association, 1975, 20, 373-377.

Mrazek, P.B. Kempe, C.H. (Eds.) Sexually Abused Children and Their Families. New York: Pergamon Press, 1981.

Mrazek, P. Sexual Abuse of Children. In B. Lahey and A.E. Kazdion (Eds.) Advances in Child Clincial Psychology. New York: Plenum Press, 1984, p. 199-215.

Nachmani, G. Fathers who Mistake their Daughters for their Mothers. Contemporary Psychoanalysis, 1987, 23:4, 621-631.

Nakashima, I.I., Zakus, G.E. Incest: Review and Clinical Experience. Pediatrics, 1977, 60, 696-701.

Nasjleti, M. Suffering in Silence: The Male Incest Victim. Child Welfare, 1980, 59:5, 269-275.

Overholser, J.C. Beck, S. Multimethod Assessment of Rapists, Child Molesters, and Three Control Groups on Behavioral and Psychological Measures. Journal of Consulting and Clinical Psychology, 1986, 54:5, 682-687.

Perlmutter, L.H., Engel, T., Sager, C.J. The Incest Taboo: Loosened Sexual Boundaries in Remarried Families. Journal of Sex and Marital Therapy, 1982, 8:2. 83-96.

Peters, J.S. Children who are Victims of Sexual Assault and the Psychology of Offenders. American Journal of Psychotherrapy, 1976, 30, 398-421.

Pierce, R., Pierce, L.H. The Sexually Abused Child: A Comparison of Male and Female Victims.

Plummer, K. Pedophilia: Constructing a Sociological Baseline. In M. Cook and K. Howells (Eds.) Adult Sexual Interest in Children. London: Academic Press, 1981.

Pomeroy, W. A New Look at Incest. The Best of Forum, 1978, 92-97.

Pope, K., Keith Bpiegel, P., & Tabachnik, B. Sexual Attraction to Clients: The Human Therapist and the (sometimes) Inhuman Training System. American Psychologist, 1986, 41, 147-158.

Power, E. Medieval People. New York: University Paperbacks, 1966.

Proctor, J.T. Countertransference Phenomena in the Treatment of Severe Character Disorders in Children and Adolescents. In L. Jessner & E. Pavenstedt (eds.), Dynamic Psychopathology in Childhood. New York: Grune and Stratton, 1959, 293-309.

Racker, H. Transference and Countertransference. New York: International Universities Press, 1968.

Rogers, C.M., Terry, T. Clinical Intervention with Boy Victims of Sexual Abuse. Victims of Sexual Aggression. I. Stewart & J. Greer, Eds., Van Nostrand Reinhold, N.Y., 1984, 91-104.

Rosenfeld, A.A., Krieger, M. Incest and Sexual Abuse of Children. Journal of the American Academy Child Psychiatry, 1977, 16, 327-335.

Rosenfeld, A.A. Incidence of History of Incest among 18 Female Psychiatric Patients. American Journal of Psychiatry, 1979, 136, 791-795.

Rosenfeld, A., Nadelson, C., Krieger, M. Fantasy and Reality in Patient Reports of Incest. Journal of Clinical Psychiatry, 1979, 40, 159-164.

Rush, F. The Best Kept Secret: Sexual Abuse of Children. McGraw-Hill Book Company, 1980.

Russell, D. The Incidence and Prevalence of Intrafamilial and Extrafamilial Sexual Abuse of Female Children. Child Abuse and Neglect, 1983, 7, 133-146.

Salinger, R.J. Conduite a Tenir pour le Praticien qui trouve un cas d'inceste dans sa Clientele. Neuropsychiatrie de l'Enfance, 1985, 33:6, 217-220.

Salisbury, J. Ginorio, A.B., Remck, H., Stringer, D.M. Counseling Victims of Sexual Harassment. Psychotherapy, 1986, 23:2, 316-324.

Saltman, V., Solomon, R.S. Incest and the Multiple Personality. Psychological Reports, 1982, 50, 1127-1141.

Sarnoff, C. Latency. New York: Jason Aronson, 1976.

Schultz, L.G., Jones, P. Sexual Abuse of Children: Issues for Social Service and Health Professionals. Child Welfare, 1983, 62:2, 99-107.

Scott, R.L., Stone, D.A. MMPI Profile Constellations in Incest Families. Journal of Consulting and Clinical Psychology, 1986, 54:3, 364-368.

Sgroi, S. Handbook of Clinical Intervention in Child Sexual Abuse. Lexington Books, D.C. Heath & Co., Lexington, Mass: 1985.

Shapiro, S. Self-Mutilation and Self-Blame in Incest Victims. American Journal of Psychotherapy, Jan 1987, 41:1, 46-54.

Shrier, D.K., Steiner, G.L. Sexual Abuse of Children: Rape and Incest. The Journal of the Medical Society of New Jersey, 1983, 80:10, 837-840.

Simpson, M.A. Self-Mutilation and Borderline Syndrome. Dynamische Psychiatrie, 1977, 42, 42-48.

Singer, B.A., Luborsky, L. Countertransference: The Status of Clinical versus Quantitative Research. In A. Gurman and A. Razin,(eds.), Effective Psychotherapy. New York: Pergamon Press, 1977, 433-457.

Snyder, W.U., Snyder, B.J. The Psychotherapy Relationship. New York: Mc Millan, 1961.

Springmann, R.R. Countertransference: Clarifications in Supervision. Contemporary Psychoanalysis, 1986, 22:2, 252-276.

Stein, R. Incest and Human Love: The Betrayal of the Soul in Psychotherapy. New York: Third Press, 1973.

Stoller, R. Perversion: The Erotic Form of Hatred. New York: Pantheon Books, 1975.

Storr, A. A Sexual Deviation. London: Heineman, 1965.

Strupp, H.H., Wallach, M.L., Wogan, M. The Psychotherapy Experience in Retrospect: Questionnaire Survey of Former Patients and their Therapists. Psychological Monographs, 1964, 78: Whole 588.

Sturkie, K. Structured Group Treatment for Sexually Abused Children. Health Social Work, 1983, 8:4, 299-308.

Summitt, R. The Child Sexual Abuse Accomodation Syndrome. Child Abuse and Neglect, 1983, 7, 177-193.

Swanson, L., Biaggio, M.K. Therapeutic Perspectives on Father-Daughter Incest. American Journal of Psychiatry, 1985, 142:6, 667-674.

Terr, C.L. Psychic Trauma in Children and Adolescents. Psychiatric Clinics of North America, 1985, 8:4, 815-835.

Vander Mey, B., Neff, R.L. Adult-Child Incest: A Review of Research and Treatment. Adolescence, 1982, 17:68, 717-735.

Weiner, I.B. A Clinical Perspective on Incest. American Journal Diseases of Childhood, Feb 1978, 132, 123-124.

Yates, A. Children Eroticized by Incest. American Journal of Psychiatry, 1982, 139:4, 482-484.

Zivney, O.A., Nash, M.R., Hulsey, T.L. Sexual Abuse in Early vs Late Childhood: Differing Patterns of Pathology as Revealed on the Rorschach. Psychotherapy, 1988, 25:1, 99-106.