Child Sexual Abuse:

The Ethics of Psychological Treatment

by Lori Haskell

Introduction

Possibly as many as three million women in Canada have survived experiences of sexual abuse in their childhood and will seek therapeutic assistance in healing from the damaging effects. Psychologists are involved in virtually every facet of the mental health system and are trained and expected to be skilled in psychodiagnostic assessment and psychotherapy, as well as research and evaluation. It is obvious, then, that this group of professionals must address the societal and individual problems of sexual abuse of children, and the therapeutic needs of adult women survivors. But, in fact, psychologists have often overlooked how rampant this form of child abuse is and have minimized the extent of its damaging and long term effects.

Following Freud's (now highly disputed) claim that women's reports of sexual abuse in childhood were fictitious, psychologists have failed as a profession to sensitize themselves to the politics and prevalence of child sexual abuse; consequently they have not organized to ensure that the special knowledge, skills required to work with victims of child sexual abuse (both children and adult women) be structured into the requirements of professional training or at least required of any professional working with children or in any setting that sees a large percentage of female clients. Yet the psychological code of ethics states it is essential that individual psychologists competently perform the specialized skills required to meet the special needs of specific client groups. This requirement supports the premise that professional psychologists are responsible for what they fail to do as well as what they actually do. The fact that psychologists, as individuals and as a professional group, have systematically failed to address the issue of sexual abuse adequately, has itself become an ethical issue.

The Nature and Scope of the Problem of Child Sexual Abuse

Sandra Butler defines "incestuous assault as "any manual, oral or genital sexual contact or other explicit sexual behavior that an adult family member imposes on a child, who is unable to alter or understand the adult's behavior because of his or her powerlessness in the family and early stage of psychological development" (Butler, 1978).

The wide prevalence and damaging effects of incestuous abuse have recently become salient to those working with women and children. The contemporary interest in the topic of child sexual abuse is inextricably linked to the dramatic increase in reported cases of incest, yet there is widespread agreement among researchers and professionals working in the field that incest continues to be one of the most unreported and underreported forms of abuse of children. At the same time, and despite the recent attention the subject has received in the media, the courts, the helping professions, and scholarly research, there remains an uncomfortable silence around this most pervasive form of victimization of children — as well as a still firmly entrenched tendency to deny both how widespread and how harmful incest is.

The issue of child sexual abuse, whether intra or extra-familial, raises many ethical issues; perhaps most important among them is the question of power and abuse. In T*he Secret Trauma* Diana Russell asks whether incest can ever be non-abusive. She concludes that only when brothers and sisters *who are peers* engage in sex play *that is mutually desired* can incest be non-abuse (p. 39). When sexual contact occurs between an adult and a child, however, it is *necessarily* abusive because it is predicated upon an inequality in power and life experience. Russell notes that the two parties involved in incestuous sexual encounters will typically perceive the experience in very different ways but it is "the perception of the younger and then less powerful person (which) is the more relevant one for determining whether or not sexual abuse (has) occurred" (p. 48).

Finkelhor maintains that the ethical issue of why sex with children is wrong must be approached through the issue of consent. Even apart from the empirical findings which demonstrate that a great many children are disturbed and damaged (physically and psychologically) by childhood sexual encounters with adults, sex between children and adults is morally wrong, in Finkelhor's view, because "children, by their nature, are incapable of truly consenting to sex with adults. Because they are children, they cannot consent; they can never consent" (Finkelhor, 1979, p. 692).

Finkelhor argues that for true consent to be possible a person must first be aware of what they are consenting to, must be free to say yes or no. In the absence of either or both of these two conditions, consent is not a meaningful concept. Children are relatively ignorant about sex and sexual relationships and are especially unaware of the social construction and significance of sexuality and sexual liaisons. They cannot know the consequences of a childhood sexual encounter in later life. They are inexperienced and lack complete information which would enable them to make an "informed" decision about whether or not to engage in sexual activities with an adult. Moreover, children are not free legally or psychologically to give or rescind permission about access to their sexuality. Children are typically in dependent relationships to adults; "adults control all kinds of resources that are essential to them—food, money, freedom, etc. In this sense, the child is like the prisoner who volunteers to be a research subject. The child has no freedom in which to consider the choice" (p. 695).

This is even more true when the adult

who approaches the child sexually is a parent, relative or other important figure in the child's life, and this is typically the case in incestuous abuse. The emotional and psychic dependence and ties to the adult in these instances exacerbate the child's inability to say no and perhaps correspondingly exacerbate the moral gravity and the damaging effects of child sexual abuse. The critical components which make all instances of child-adult sex a moral problem, then, are the child's lack of knowledge and the child's relative position of powerlessness. The betrayal and trauma which accompany incestuous sexual encounters between adults and children serve only to accentuate this vulnerability and powerlessness. Alanna Mitchell makes the point that "sexual assault of a child is an indelible lesson in powerlessness for that child and enforces that her role in life is to be helpless and ineffective" (Mitchell, 1985, p. 99). Sexual abuse of children, then, and the failure to address it socially and politically, is a widespread and damaging problem which truly does represent "society's betrayal of the child."

Yet, still today, when a situation of ongoing sexual activity between an adult and child is uncovered, psychologists are often confused about how to respond (i.e. how to judge the appropriateness of the involvement or how to intervene). With victims, especially young children, there is an attitude that sexual abuse is not a serious enough mental health problem to justify intervention or that intervention may cause trauma which outweighs the abuse (Conte and Berliner, 1981). Berliner, with over ten years of extensive experience working with victims of child abuse, found that many professionals (including psychologists) promote the idea that sex between a man and a child is acceptable in some subgroups, or results from peculiar cultural or socio-economic conditions like poverty, overcrowding or rural isolation. If the child demonstrates severe emotional problems s/he becomes the focus of the intervention process. The worker may even concentrate on some aspect of the child's personality or behavior that is assumed to be responsible for the victimization. The abusive behavior is ignored or is treated as a relatively unimportant symptom of deeper psychological problems in one or more actors in the situation. Treatment plans have addressed marital discord, alcoholism, stress, family conflict, or child behavior problems, instead of the sexual abuse, with the assumption that the abuse will disappear if the other problems are cured. All these responses fail to validate the child's experience as well as violate the child's ethical rights to effective treatment.

Prevalence of Child Sexual Abuse

Until recently, information that sexual abuse of children is common and damaging to individuals came from women's own accounts and preliminary findings of specialized sexual abuse treatment programs. There was a skepticism and reluctance among scientists and clinicians to accept claims from such biased samples. But Diana Russell's work has verified what many clinicals (who were already knowledgeable enough about sexual abuse to recognize the symptoms) always suspected, that is, that child sexual abuse is both pervasive and extremely damaging.

Russell (1986) in a random survey of 930 women in San Francisco found that *of the 930 women, 54 % (504) reported at least one experience of incestuous and/or extrafamilial sexual abuse before they reached eighteen years of age, and 48 % (450) reported at least one experience before they reached fourteen years of age"* (p. 620). A Canadian study (Badgley et al, 1984) looking at a sample of more than 2,000 people from across Canada found that 34% of the women surveyed and 13% of the men have been victims of sexual abuse before they were sixteen years old. These statistics show the problem to be of staggering proportions and suggest that an awareness of and the response to this issue needs to be addressed in public education, social policy, social services, the "helping professions," the medical establishment, and the legal system.

Prevalence of Childhood Sexual Abuse Histories in Clinical Populations

These findings have been supported by the results of research into the history of child sexual abuse in clinical populations. Judith Herman (1980) in an exploratory study to determine if there is a connection between experiences of sexual abuse and psychiatric patient status, found, in a sample of one hundred and ninety patients (105 women and 85 men), that 13% of the women had a history of childhood sexual abuse. Briere (1984) carried out a study on a random sample of 153 female "walk-ins" to the counselling program of a local community health centre and found that 44% of women in this group had a history of sexual abuse before the age of 15. These women presented with significantly higher rates of dissociation, anxiety, isolation, sleep disturbance, anger, sexual dysfunction, substance addiction, and self-destructiveness than did a control group of female clients with no history of sexual abuse. An important finding noted by Brier (1984), however, is that only 39% of these women who ultimately reported sexual abuse in childhood referred to sexual abuse when describing their presenting problems. Regardless of whether Briere's (1984) sample is entirely representative of abuse cases in clinical populations, the data does strongly suggest an over-representation of sexual abuse victims in therapy-seeking groups of women. For example, in Briere's (1984) study of the clients who did refer to sexual abuse as part of their presenting problems were removed from the sample, the identified abuse rate would still be nearly 27%.

The implications of these findings are important since recent research shows that 38% of the female population may suffer trauma as a result of sexual abuse in childhood. Yet, as noted by Butler (1978), Herman (1981), and Rush (1980), mental health practitioners are unlikely to routinely ask about sexual abuse, and when they *are* told of such a history, may discount or even disbelieve their client.

The reason for this tendency to disbelieve children is that many psychologists in their training are still taught Freud's traditional psychoanalytic theory that fosters a strong mythical belief that children tell fantasy stories about being sexually involved with adults. Using too liberal an interpretation of Freud's Oedipal stages of development, it has been possible for professionals to rationalize that children often fantasize about reports of coercive sexual activities with adults (Peters, 1976; Herman and Hirshman, 1977). In her research on Freud's cover-up of the seduction theory, Rush (1977) reports that Freud himself admitted an error in conceptualization due to the fact he was emotionally unable to acknowledge that the numerous histories of sexual abuse female patients reported to him were actually real.

Following in Freud's footsteps, far too many psychologists, in both their research and their practice, have denied and/or covered up children's and women's reports of childhood sexual abuse. In the face of the substantial body of research which indisputably documents the astonishing prevalence of the sexual abuse of children, this discrediting

of victims' own accounts of their abuse is itself an ethical issue. That is, it is incompetent, unjustifiable and unethical for researchers and practitioners so frequently and so sweepingly to disregard the very real and pervasive problem of child sexual abuse.

Psychological Effects

The full impact of childhood sexual abuse is not known. The term sexual abuse or sexual victimization appears to suggest that there is one type of experience that is similar to all children. Yet sexual abuse varies from a single assault to years of ongoing abuse. Research has found that the relationship of the perpetrator is significant; for example, the abuse is often more traumatic if it is the child's father or step-father, rather than a neighbour or distant relative. The abuse should not be prioritized in a hierarchal order, although the actual sexual abuse could include anything from fondling, masturbation, fellation and/or intercourse. Considering how many of the different variables are present will assist in understanding the range of differential effects on children. Some children demonstrate the immediate effects of distress during the period of their life when they are being abused, others do not show symptoms until disclosure, and some have a delayed response that may not surface until a later developmental stage. Many children are seriously and permanently damaged. Recent research has shown an association between runaways, prostitution, drug abuse, sexual dysfunction and other adjustment problems and a history of sexual abuse (James and Meyending, 1977; Benward and Densen-Gerber, 1975; McGuire and Wagner, 1978; Tsai, 1978). Most children do recover from the observable effects of sexual abuse and grow up to function adequately, but the insidious and often long-term effects on life choices are difficult to measure.

Finkelhor and Browne (1985) developed a conceptual framework in which to understand the harmful effects of incestuous abuse. They identify four traumagenic dynamics: traumatic sexualization, betrayal, stigmatization and powerlessness, which constitute the psychological injury imposed on sexually abused children:

> *Traumatic sexualization refers to a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a afashion as a result of sexual abuse... Betrayal refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm... Powerlessness—or what might also be called disempowerment, the dynamic of rendering the victim powerless—refers to the process in which the child's will, desires, and sense of efficacy are continually contravened... and Stigmatization... refers to the negative connotations — e.g. badness, shame and guilt — that are communicated to the child around the experiences and that then become incorporated into the child's self-image* (Finkelhor and Browne, 1985, p. 532).

These four dynamics are helpful in explaining the complex cluster of injuries which the incestuously abused girl suffers. These categories are not static and may be experienced in different ways and degrees depending upon the nature and duration of the sexual abuse. But they do begin to capture the damage to children's self-esteem, sense of efficacy and self-worth, and the development of their sexualities, as well as provide ways to understand how these effects are lived out in later life. That childhood sexual abuse has persistent damaging effects which negatively affect women's adult lives is supported again and again throughout the literature. There is an abundance of clinical evidence demonstrating links in the lives of adult women who were sexually abused as children to later substantial psychological and sexual problems.

Typical Symptoms

Many female survivors suffer depression, intense guilt, markedly poor self-esteem, and self-destructive drug and/or alcohol abuse. Anxiety, somatic complaints and learning difficulties were also frequently present. Finally, marital difficulties have been disproportionate (Meiselman, 1979; Herman, 1980), and there is increased risk of physical and emotional abuse toward the children of incest victims (Summitt, Kyrso, 1983) and an increased intergenerational risk of incest among the children of the victim by her spouse (Rosenfield, 1979).

Chronic Traumatic Neurosis

Gelinas (1983) outlines how during treatment women survivors of severe abuse show definite, clear-cut traumatic neurosis relating to the sexual abuse, especially with regard to what occurred physically and sexually during the abuse. Gelinas emphasizes that these traumatic neuroses merge only after disclosure and some discussion of what actually occurred. Discussions about age of onset and termination, identity of the offender, initial incidents and actual types of contact are almost invariably accompanied by the emergence of very intense emotional reactions with vivid recall of information. Recognition of the patient as an incest victim allows the therapist to see the affect and memories as the potentially curative cathartic emergence of a long-buried traumatic neurosis rather than as a decompensation into psychosis, or even as a negative reaction to verbal therapy (Gelinas, 1987).

Relational Imbalances

Gelinas (1983) emphasizes that child sexual abuse is relationally based sexual abuse; for its victims, the traumatic events occur within the family, often by the father or step-father. Sexual abuse takes place within the context that is supposed to nurture, protect and care for the child, where she should be able to get a reasonable interpretation of reality and relational life, and upon which she is utterly dependent. Instead the child grows up abandoned, betrayed, with no perspective, no language, no experience base with which to understand the sexually exploitative relationship with her own father or other trusting male relative.

Women usually seek treatment later in life because of the secondary elaborations related to the problems in her relational life, due to the inability to trust or maintain intimacy. To understand these negative effects it is essential to understand the dynamics of child sexual abuse and the profound trauma to the child. Therapy that fails to link the present symptoms to a history of child sexual abuse is looking at the interpersonal difficulties in isolation and will tend to view the problem as some inadequacy of the female clients.

Recognition and Identification of Sexual Abuse Victims

Given the prevalence and extent of the negative effects of sexual abuse it appears irresponsible that clinicians and therapists don't inquire about the possible history of sexual abuse with all female clients. Sexual researchers have documented that victims of sexual abuse rarely disclose spontaneously and therapists don't ask (Briere, 1984; Gelinas, 1983; Butler, 1978). This is particularly prob-

lematic since presentation in treatment by adult survivors of sexual abuse is often characterized by a "disguised presentation" (Gelinas, 1983). The usual disguised presentation of the undisclosed victim is a characterological depression with complications, and with atypical, impulsive and dissociative elements.

The presence of depressive complications with impulsive and dissociative elements can lead to multiple and erroneous diagnoses; the most common misdiagnoses are borderline personality disorder, latent schizophrenia, and bipolar affective disorder (Gelinas, 1983).

Diagnosis of borderline personality disorder and substance abuse disorder are particularly common in women with a history of sexual abuse in childhood (Herman, 1980). Of the twelve women in Herman's study who received the diagnosis of borderline personality disorder, eight had been sexually abused in childhood or adolescence and of the nineteen women with substance diagnoses, ten had a history of sexual abuse.

Herman (1980) found that women with a history of sexual abuse in childhood were four times as likely to be given a diagnosis of borderline personality and twice as likely to be given a substance abuse diagnosis as those who have not been sexually abused in childhood. Herman explains that women receiving these diagnoses are expected to have poor prognosis and as a result are shut off from further help.

Briere (1984) theorizes that sexual abuse might be seen as a series of highly aversive disruptions of normal childhood development, resulting in the formation of schemata, beliefs and "symptoms" which may present as extremely negative, but which were appropriate to the original abuse situation. For example, many children report dissociating from his or her body in order to escape the trauma during the actual sexual assault. Dissociation often gets generalized to other aversive and anxiety provoking experiences, creating a relatively permanent clutter of "maladaptive" responses to threat (Briere, 1984). Similarly, incest victims, who often develop poor self-concepts as a result of their victimization, may later engage in behaviors reflecting self-hatred and intrapunitiveness such as self-mutilation or suicidality. Briere proposes defining a "Post-Sexual Abuse Syndrome" (PSAS), consisting of symptomatic behaviors which were originally coping mechanisms or conditioned reactions to a childhood characterized by victimization. Occurring so early in psychosexual development, such symptomatology would become an integral component of the victim's personality structure as it developed into adulthood.

Briere believes that the chronology of symptom development may explain why sexual abuse victims receive the diagnoses of "Borderline" or less frequently "Histrionic" Personality Disorders when they come to the attention of both psychological and psychosomatic establishment.

This should be a major concern to psychologists considering that there is little emphasis on training on sexual abuse trauma. Yet a significant proportion of "Borderline" diagnosis involve symptomatology arising from sexual abuse. These misdiagnosed sexual abuse victims receive treatment that is inappropriate to the actual psychological difficulty and prognoses which are usually not as hopeful as a more informed and accurate evaluation would have implied.

This failure to address childhood sexual abuse in traditional approaches to treatment of chronic sexual abuse trauma (whether designated "PSAS" or "Borderline") could explain the common assumption that such cases "rarely get better." Although the outcome data is incomplete in this area, it is quite probable that treatment approaches which directly deal with the abuse, somewhat in the way that Rape Trauma Syndrome is treated by "working through" the assault (Burgess and Holstrom, 1979), will be more successful with such clients (Herman, 1981).

Implications

If psychologists systematically continue to fail to interview or question all clients or patients when taking histories, about whether clients have been sexually abused in their lifetime, the sexual abuse history will remain hidden. Research demonstrates that victims rarely disclose spontaneously and therapists typically don't ask. Thus, the negative effects of the sexual abuse are not available for treatment. Treatment continues to focus on the disguised presentation but becomes increasingly frustrating and relatively unsuccessful. The untreated negative effects continue to throw up symptoms, problems and repetitions so that the therapy goes nowhere.

The details of the sexual abuse are often very painful for the clients, and its aftereffects can test both the psychologist's ability to handle such material, and the therapeutic conviction that it is essential and curative to do so. Many psychologists unknowledgeable about the dynamics of sexual abuse and the accompanying disturbing and painful material, have often avoided or dismissed the disclosure, and in the process, have not treated the issues. This not only reinforces the client's belief that their experience is too shameful to speak about, but as well, does not offer them any relief from their suffering and leaves them at risk for further emotional difficulties. Considering that research has demonstrated that a large percentage of women seeking therapy or being treated for psychiatric disturbances most likely have a history of sexual abuse, it then must be considered an ethical issue, and a question of psychologists' competence, to encourage the disclosure of a childhood history of sexual abuse and to be able to make an appropriate referral to a colleague thoroughly trained in the area.

Education for Psychologists

Psychology is a particularly appropriate profession for addressing the complex, social and clinical problem of child sexual abuse in the lives of children and adult women. However, to fulfill this responsibility change in psychology education is necessary.

In order for psychologists to be effective in helping sexually abused children, a willingness to believe the child and support him/her must be present. That belief and support can only be developed from a real understanding of the dynamics of sexual abuse and the different ways children handle the situation. One child might deny and dissociate the experience, others might be defiant and fight back, while another might accommodate and participate. The basic ethical principle that must be integrated by psychologists is that whenever there is sexual contact between an adult and a child, it is always the adult's responsibility. Psychologists also need to examine their personal values about child sexual abuse. It is not possible to understand child sexual abuse without the backdrop of a full understanding of the range of functional human sexual response and associative values. The value of consent as a critical component of sexual relationships is a point for education and values clarification.

Equally as important is the need for professional awareness of the commonness and debilitating effects of sexual abuse in a client's history, and the need for a treatment technology which directly deals with the "core" victimization in the woman's early life. Psychologists need to confront the barriers to learning about this serious mental health and social problem;

this could be done in conjunction with the study of other types of violence against women. Courses addressing wife battering, abuse of the elderly, rape and general child abuse as well as sexual abuse, need to be added to the basic psychology curriculum. These courses must be contextualized in an analysis in the social reality that violence against women and children by men is pervasive in our society.

The psychological profession needs to educate itself to learn the facts about sexual abuse of children and its impact on the female population so the profession as a whole can take more responsibility for creating awareness of the problem, stopping abusive behavior and offering appropriate and sensitive treatment.

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DEBBIE NIFAKIS

she and i

we have made a pact
she and i
she will look after me
and i will try not to hurt her

it is a fair pact

i watch her
and envy her leanness
i think i know what it
must be like to
live within her body
it is small
but it is not confining
mine is expansive
and feels so binding

yet today it feels different
she is smiling at me

for months we have suffered
endless hungers
and cried

it seemed a cruel thing to do
to starve ourselves
she and i

but through it all
we also laughed
she and i

i knew that one day
a spirit like hers would
escape from my fat body

she knew that one day
a spirit like hers would
escape from my fat body

we looked into the mirror
together that day
and a warmth enveloped us
we could only hug each other

for we felt the gentle truth
she and i

she and i
were really only ME