1989

Self-esteem of sexually abused adolescent girls in group home placement

Audrey Damon
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placement**

Damon, Audrey, M.A.

San Jose State University, 1989

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SELF-ESTEEM OF SEXUALLY ABUSED ADOLESCENT
GIRLS IN GROUP HOME PLACEMENT

A Thesis

Presented To

The faculty of the Department of Social Science
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by

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July, 1989

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ABSTRACT

SELF-ESTEEM OF SEXUALLY ABUSED ADOLESCENT GIRLS IN GROUP HOME PLACEMENT

By Audrey Damon
Advisor: Diane Schaffer, Ph.D.

This thesis addresses the topic of childhood sexual abuse, and the effect such abuse may have on the self-esteem of the victim when she reaches adolescence. Sixteen girls who had become involved with the juvenile court system, either as offenders or wards of the court, were the subjects of a study which examined self-esteem, time involved in the juvenile court system, and the severity of the abuse experience as predictors of success in residential treatment.

The Piers-Harris Self-Concept Scale was administered to the subjects within the first month of their placement in a group home in San Jose, California, and then again six months later. No correlation was found between severity of abuse or self-esteem as predictors of success. Results did indicate, however, that victims who had had longer involvement in the juvenile court system were more likely to have success in treatment.

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particularly like to thank him for not picking on the content of the thesis and for being supportive of its feminist slant.

I am especially grateful to my therapist, Dr. Barbara Menoff, for her emotional support and guidance over the past few years. She taught me to nurture the child inside me; to believe that good things would happen; and to believe that I was deserving of it because I was a good person.

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myself. I would also like to thank him for his financial support. By providing me with a roof over my head and food in my belly, he freed me to focus entirely on my writing and research. God knows when, if ever, I would have had the time or the inclination for the marathon sessions at the computer terminal that were essential if I was ever to finish.

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TABLE OF CONTENTS

CHAPTER		PAGE
I	INTRODUCTION	1
	Child Sexual Abuse: History and Scope of the Problem	1
	Characteristics and Effects	8
	Separation from the Family: The Juvenile Court System	12
	The Study: Self-Esteem of Sexually Abused Girls in Group Home Placement	16
II	REVIEW OF THE LITERATURE	20
	The Incest Taboo	20
	Effects	21
	Theory	35
	Treatment	43
III	METHODS	53
	Subjects	58
	Collection of Data	59
	Severity of Abuse Index	63
	Piers-Harris Self-Concept Scale	68
	Further Limitations of the Study	77
IV	RESULTS & DISCUSSION	80
	Piers-Harris Self-Concept Scale	80
	Research Questions	86

V	SUMMARY	99
	Making the System Work	102
	Prevention	106
	REFERENCES	108
	APPENDICES	122
	Appendix A. Subject Vita Form	123
	Appendix B. Piers-Harris Self-Concept Scale and Scoring Key	124
	Appendix C. Subject Profile Forms	132

LIST OF TABLES

TABLE	PAGE
1. Frequency Distribution with Descriptors and Percentage of Sample for the Total Raw Scores on the Piers-Harris	81
2. Piers-Harris and Severity of Abuse Index Scores with Corresponding Ranks	91
3. Piers-Harris Scores and Months Involved in the Juvenile Court System as a Ward . . .	92
4. A Comparison of Piers-Harris Scores (Self-Esteem) for Graduates and Drop-Outs of the Treatment Program	94
5. Severity of Abuse Previous to Placement as a Predictor of Success in the Treatment Program	96
6. Number of Months Involved in the Juvenile Court System as a Predictor of Success in the Treatment Program	96
7. Increase in Piers-Harris Scores (Self-Esteem) after 6 months of treatment	97
8. Mean Scores on Each of the Cluster Scales of the Piers-Harris Before and After Treatment	98

LIST OF FIGURES

FIGURE	PAGE
1. Severity of Abuse Index	64
2. Frequency Distribution of Months in Juvenile Court System	87
3. Frequency Distributions of Severity of Abuse Index Scores	89

CHAPTER I
INTRODUCTION

*My vagina is too little
It knows not how to copulate
My lips are too small
They know not how to kiss*

A Sumerian tablet, circa 3000 B.C.

Child Sexual Abuse: History and Scope of the Problem

The incidence of sexual relations between adults and children dates back to antiquity. Under Babylonian law, the Code of Hammurabi declared that a man who "knew" his own daughter would be banished from the city, while a man who stole the virginity of another man's daughter might be lawfully killed (Brownmiller, 1975). In Greece and Rome, anal intercourse by adult males and teachers was frequently imposed on young boys (Rush, 1980). The Incas of Peru and the Pharaohs of Egypt routinely practiced incest to preserve the purity of the royal line. And as late as the early nineteenth century, Hawaiian nobility expected offspring of brother-sister incest as a natural condition; father-daughter and son-mother incest were also common (Kempe & Kempe, 1984).

Even the Bible and the Talmud encouraged sex between men and little girls in marriage, concubinage and slavery. The Talmud decreed that a female child of "three years and one day" could be betrothed by sexual intercourse with her father's permission. In the Old Testament, female sexuality was likewise regarded as property:

When God commanded, "Thou shalt not covet thy neighbor's house; thou shalt not covet thy neighbor's wife nor his ox, nor his maidservant nor anything that is thy neighbor's," he categorized a man's wife with his house and ox. And because the female was a sexual property, all heterosexual relationships were defined as financial transactions. Marriage was the purchase of a daughter from her father, prostitution was a selling and reselling of a female by her master ... and rape was the theft of a girl's virginity which could be compensated for by payment to her father. (Rush, pp 18-19)

In more modern times, adult-child sexual relations, and more specifically, incest, have been viewed by most societies as taboo. In fact, the incest taboo is one of the few that appears to be universally cross-cultural (Rist, 1979). Furthermore, most countries now have laws that punish adults participating in adult-child sexual relations as criminals and define the acts as sexual abuse. And yet, it has only been in the last decade that public sentiment has shifted to view child sexual abuse as a social and mental health problem.

Summit and Kryso (1978) reported that prior to 1960, psychiatric literature viewed incest as an exotic, virtually negligible phenomenon taking place between retarded, seductive girls and inadequate, sociopathic fathers. It is well known that Freud concluded that his patients' accounts of incestuous abuse were figments of their imaginations based on their own sexual desires for their fathers. As recent as 1976, a federally sponsored Child Abuse Intervention Package stated that there was neither sufficient evidence of harm nor sufficient optimism for treatment to justify legal intervention in intrafamilial sexual abuse (Schacter, 1976). In 1976, Wardell Pomeroy, made the following statement:

When we examine a cross-section of the population, as we did in the Kinsey Report, . . . we find many beautiful and mutually satisfying relationships between fathers and daughters. These may be transient or ongoing, but they have no harmful effects. (p. 9)

More current research, however, cites spiraling statistics of reported cases of child sexual abuse and sobering reports of its effects on the victims. In the last few decades we have also seen a social climate which allows for freer communication about sexuality; the women's movement, which has focused on all types of violence against women; and public sentiment which supports the rights of children. These

circumstances, combined with widespread media attention, have brought the issue recognition not only among mental health professionals, but among the general public as well.

Obtaining accurate statistics on the incidence of child sexual abuse is a difficult, and perhaps impossible, task due to the nature of the crime and the way the victim is viewed in our society.

My experience is that the vast majority of children never tell anybody and it never comes to light. I would say that 75% never get discovered, even perhaps as high as 90% never get discovered. (Finkelhor as cited in Renvoise, 1982)

The earliest estimate of the incidence of child sexual abuse appeared in Kinsey's study of female sexuality (Kinsey, Pomeroy, Martin, & Gebhard, 1953). The results indicated that 9% of the subjects had had a sexual contact with an adult before the age of 14. Beginning in 1976, the American Humane Association began gathering data on reported cases of child sexual abuse nationwide. The number of cases increased from 1,975 in 1976, and 4,327 in 1977, to 22,918 in 1982. In 1979, the National Center for Child Abuse and Neglect conducted a study which extrapolated statistics from 26 counties in 10 states to the nation as a whole. This National Incidence study estimated that 44,700 cases of sexual abuse

were known to professionals in the year beginning April 1979. Kempe and Kempe (1984) found that reported cases of child sexual abuse increased 200% since 1976. This figure is consistent with California Department of Social Services, Child Welfare Protective Services, statistics that reported an increase of 228% in the years between 1977 and 1981 -- from 3,021 reported cases to 9,911. The number of sexual abuse cases investigated increased from 9,120 in 1981, to 11,351 in 1982, to 13,214 in 1983 -- a 44% increase over the course of two years (Van de Kamp, 1985). This dramatic increase is thought to be influenced by the Child Abuse Reporting Law (Pen. Code 11166) which became effective January 1, 1981.

Despite these alarming statistics, experts recognize that the figures are misleading, and may represent only the tip of an iceberg. Incidents of child sexual abuse which are neither officially reported to police or child protection agencies, nor to mental health professionals, may constitute the majority of cases. Taking this into account, the figures above would represent a gross underestimate. Finkelhor (1984) suggests that even if no more than 10% of all girls and 2% of all boys were destined to

be sexually abused, it would lead to the prediction (based on 60 million children currently under 18) that roughly 210,000 new cases of sexual abuse occur every year.

In an effort to obtain more accurate statistics on the actual incidence of child sexual abuse, researchers have taken the approach of asking adults about what may have happened to them when they were children. Kinsey, cited above, was one of the first to take this approach; more recently Finkelhor (1979), Kercher (1983) and Russell (1983) have followed suit. Kercher mailed out questionnaires to 2000 people randomly selected from all those who held Texas drivers' licenses. In reply to one question, which asked whether the person had ever been a victim of sexual abuse as a child, Kercher found 12 percent of the females and three percent of the males (of a total of 1,054 subjects) admitted they had been sexually abused as children.

In Finkelhor's study, sexual victimization was defined as sexual experiences between a child 12 or under with a partner at least five years older, or between a child 13 to 16 with a partner at least 10 years older. Within these parameters, Finkelhor

found that 19 percent of the women and nine percent of the men had been sexually victimized. About 20 percent of the experiences were with exhibitionists.

Diana Russell's study, which is generally regarded to be one of the most thorough and scientific of studies on child sexual abuse, found the highest rate of incidence to date. From a random sample of 933 adult women in San Francisco, Russell found that 28% of the women had experienced unwanted sexual touching before age 14, 12% by a relative. When the figures for completed and attempted forcible rapes, plus all forms of unwanted contact perpetrated by relatives on victims between the ages of 14 and 17 were added, the total figure of sexual abuse before the age of 18 was 38%. If non-contact experiences, like encounters with exhibitionists and unwanted advances, were included, the figure rose to 54%. A more recent study by Russell (1986) found that one in six women had been incestuously abused before age 18, and one in eight had been incestuously abused before age 14.

In summary, gathering accurate statistics on the prevalence of child sexual abuse is difficult; figures vary depending on the operational definitions used in the study, and the geographic location of the subjects who are included. Additionally, results

gathered from adults who were abused as children cannot be generalized to the experiences of the current generation of children, which leaves us with many unanswered questions regarding today's youth. It seems apparent, however, that regardless of the official figures, child sexual abuse is a widespread problem affecting thousands, if not hundreds of thousands of children each year -- many of whom shroud their experiences and pain in secrecy.

Characteristics and Effects

Despite a growing body of knowledge in the area and the attention given to the subject by the media, the problem of child sexual abuse is still misunderstood and the victim mistreated in our society. Often the child is perceived as an "active" participant in the sexual relationship with the adult, and, therefore, not considered a "real" victim. Because blame often leads to rejection, the child may suffer more harm from the reactions of those close to her than from the sexual abuse itself (Gruber, 1981).

Sixty to seventy percent of all child abuse reported occurs within the family and in 80% of the cases the offender is known to the child (Brown, 1979). Most often the father or another man acting as parent is the perpetrator of the abuse. Girls are

the most frequent victims; boys are involved in about one out of ten cases (Finkelhor, 1984). This gender gap, however, may be a misrepresentation of the reality of the problem. The embarrassment and shame used to deter girls from reporting has even greater effect on boys since the abuse is most often homosexual; thus, statistics of the sexual abuse of boys may be severely underestimated.

The first sexual misuse may occur at any age, from infancy through adolescence, but the majority of cases are reported when the victims are nine to fifteen years old (Brown, 1979). The abuse is usually repeated and progressive and is often followed by guilt-provoking demands for secrecy and/or threats of terrible harm or consequences if the secret is revealed (Summit & Kryso, 1978). The perpetrator typically uses implicit or direct coercion to involve the child and secure compliance. Coercion may take the form of psychological pressure; exertion of adult authority; misrepresentation of moral standards (in the cases of parents who convince their children that sex with a parent is part of learning how to be an adult); gifts or rewards; and sometimes force or threats. In response, children

may cooperate because of unmet needs for love, affection and attention, a sense of loyalty to the adult, or fear.

It is more likely that an adolescent will reveal past sexual abuse by her behavior than by directly telling an adult (Slager-Jorne, 1978). Many victims of child sexual abuse will begin acting out in adolescence, unaware of the connection between their past experiences and their present behavior. They may project their internal turmoil onto the adults in their lives, and perceive their problems are due to the adults' unfairness or lack of sympathy (Everstine, 1987). Often these children begin acting out in the community. They may get into trouble with the law, have difficulties at school, or become involved with drugs and/or alcohol. In other cases, the child may act out within the home, ignoring curfews, stealing from her family members, or running away (see, e.g., DeFrancis, 1969; Meiselman, 1978; Reich & Gutierres, 1979; Wisconsin, 1982). Others turn their anger inward, resulting in emotional disturbances. Many times these children end up in psychiatric units after suicide attempts, self-abusive behavior or long bouts

with depression (Bagley & Ramsay, 1985; Harrison, Lumry, & Claypatch, 1984; Herman, 1981; Husain and Chapel, 1983; Tufts, 1984).

In addition to the initial effects of child sexual abuse on the victim, many long-term effects have been substantiated in the literature as well. Low self-esteem is perhaps the most frequently cited (Bass, 1988; Browne & Finkelhor, 1986; Everstine & Everstine, 1983; Kempe & Kempe, 1984; Russell, 1986; Sgroi, 1982; Slager-Jorne, 1978; Westerlund, 1983). Other long-term effects include sexual promiscuity and prostitution (Courtois, 1979; DeYoung, 1982; Herman, 1981; James & Meyerding, 1977; Meiselman, 1978; Porter, 1984); a lack of trust or an impaired ability to correctly judge the trustworthiness of others (Briere, 1984); a sense of powerlessness and stigmatization (Finkelhor, 1985); a tendency towards revictimization (Miller et al., 1978; Russell, 1983); psychosomatic complaints (Sarles, 1975; Tufts, 1984); substance abuse (Briere, 1984; Herman, 1981); negative feelings, attitudes, or beliefs about men in general along with negative feelings about sexuality (Briere, 1984; Courtois, 1979; Langmade, 1983); and anxiety and depression (Bagley & Ramsay, 1985; Briere, 1984; Sedney & Brooks, 1984). Two studies

have suggested a link between incest and hysterical seizures (Goodwin, Simms, & Bergman, 1979; Gross, 1979). The literature also supports the notion that sexual abuse in childhood has effects on social and emotional functioning in adulthood (Bagley & Ramsay, 1985; Kilpatrick, 1986; Peters, 1984; Sedney & Brooks, 1984; Woodbury & Schwartz, 1973) and that the psychological impairment is sometimes transmitted to the next generation (Brown, 1979).

Separation from the Family: The Juvenile Court System

Some victims of child sexual abuse eventually come to the attention of authorities, whether before or after the sexual abuse has been reported. Acting out in the community, getting in trouble with the law, truancy, drug or gang involvement, multiple suicide attempts or psychiatric hospitalizations are all matters in which the adolescent may come to the courts' attention.

California Welfare and Institutions Code Section 300 makes provisions for a child to be adjudged a dependent of the juvenile court if the home is found to be an unfit place (e.g., if sexual or physical abuse or general neglect has occurred, chronic drug/alcohol abuse by parents, etc.). Juveniles can also be adjudged dependents of the court if the

parents are unable to provide proper and effective parental control (e.g., the child compulsively and repetitively runs away from home, is truant, ignores curfews, or is involved in alcohol/drug abuse).

Others, who may be in need of intensive treatment that the family cannot afford, may request 300 status so that the child can receive the level of care she needs (e.g., the chronically depressed or suicidal child).

Children or adolescents who break the law are most often put on probation (602 legal status). Typical juvenile law offenses include petty theft, drug possession, car theft, shoplifting, and assault and battery.

In either of the above cases, the court may order the child to remain at home under the supervision of the Social Services Department or Probation Department; or the court may take custody from the parents and order the child be placed outside the home. Most often the placement will be in a foster home, group home, or with a member of the family. Depending on the circumstances, the child may also initially spend time in either juvenile hall or in a childrens' shelter awaiting appropriate placement.

The number of California youth who are involved in these systems is overwhelming. California incarcerates youngsters at a rate of 430 per 10,000 juveniles, twice the national average (Watson, 1989). In 1987 alone, 55,450 juveniles who were referred to probation departments were made wards of the court. Of this number, 7,880 were females.

Despite these statistics, the system conducts very little research to explore the effectiveness of its own programs. Browne & Finkelhor (1986), in a review of the literature, found only one study that examined the effect of victims being removed from their homes. The results of this study (Tufts, 1984) indicated that children removed from their homes following sexual abuse exhibited more overall behavior problems, particularly aggression, than children who remained with their families. Similarly, the literature is lacking in research examining the quality and effectiveness of treatment provided by group homes and other residential treatment centers where a large percentage of these children are placed after being removed from their families (Wilgus & Epstein, 1978).

In a phone survey of several state agencies whose function it is to collect data and conduct research on juvenile offenders (Department of Justice, Bureau of Criminal Statistics; California Youth Authority, Research & Review Program) this investigator found that no data have been collected, nor studies conducted, to examine the question of the correlation between child sexual abuse and juvenile delinquency. In fact, it was suggested by one of the researchers at the California Youth Authority that, generally, the state takes an attitude of punishment toward juvenile offenders and puts little money into treatment or into research which approaches the problem from a therapeutic slant. This attitude exists despite the fact that psychological literature reports over and over again the deleterious behavioral effects of such abuse and its relationship with juvenile delinquency (see, e.g. Benward & Densen-Gerber, 1975; Briere & Runtz, 1986; Browne & Finkelhor, 1986; Dembo, Dertke, laVoie, & Borders, 1987; Hunner & Walker, 1981; James, 1977; Meiselman, 1978; Reich & Gutierres, 1979; Wisconsin, 1982).

Spencer (1978) comments that court statistics do not adequately reflect the extent of the problem of sexual abuse for the following reasons: (1) The

child comes to the attention of the court mainly for such behavior as running away from home, promiscuity and drug abuse. Attention tends to be focused on controlling these behaviors rather than on understanding why the behaviors are occurring.

(2) The girls themselves do not understand the roots of their behavior. In those cases in which they do, they are often unable or unwilling to reveal the secret. Some fear no one will believe them. Others are sure they will be blamed, for no matter how young they were when the first incident occurred, they blame themselves. (3) The court, because it does not always understand the dynamics of these behaviors, often continues to focus on controlling them because of frustration over the compulsive and repetitive nature of the anti-social symptoms--truly a case of blaming the victim.

The tragedy is that the victim may go through the entire justice system keeping her secret and receiving little or no help. As an adult she may seek private treatment or continue her self-destructive behaviors (Spencer, p. 581).

The Study: Self-Esteem of Sexually Abused Girls in Group Home Placement

In an attempt to address the lack of information available on the effectiveness of the juvenile court system and the programs that provide treatment for the children involved in that system, a

study was conducted of sexually abused adolescent girls in one group home in San Jose, California. At the same time, the study investigated what impact the juvenile court system might have on the self-esteem of victims of child sexual abuse and whether the impact on self-esteem varied according to the severity of the sexual abuse experience. The following research questions were explored:

1. Does self-esteem at intake to group home placement correlate with the severity of the abuse experienced by the subject previous to placement?
2. Does self-esteem at intake correlate with the length of time the adolescent has been involved in the juvenile court system?
3. Does self-esteem at intake predict successful completion of the treatment program?
4. Does the severity of the abuse experienced by the subject predict successful completion of the program?
5. Does the length of time the adolescent has been involved in the juvenile court system predict successful completion of the program?
6. Is there significant improvement in the subjects' self-esteem after 6 months of treatment?

Definitions. According to California Law, sexual abuse is defined as acts of sexual assault on minors. Sexual abuse encompasses a broad spectrum of behavior and may consist of many acts over a long period of time (chronic molestation) or a single incident.

Victims range in age from less than one year through adolescence. Specifically, sexual assault includes rape, rape in concert, incest, sodomy, lewd or lascivious acts upon a child under 14 years of age, oral copulation, penetration of a genital or anal opening by a foreign object, and child molestation (California Penal Code section 1165, Subdivision [b][1]).

Incest, or sexual abuse of children within the family, is the most hidden, least publicized form of child abuse. Incestuous relations include the following persons: (1) parents and children; (2) ancestors and descendants of every degree (e.g., grandfather and granddaughter); (3) brothers and sisters of half and whole blood; (4) and uncles and nieces or aunts and nephews (California Penal Code, section 285).

Several studies have reported that the presence or absence of blood relationship between victim and offender is of far less importance than the kinship roles they occupy (Renvoise, 1982; Russell, 1986; Sgroi, 1982). Thus, for the purpose of this thesis, sexual abuse includes both incestuous and intrafamilial sexual misuse of a minor child and will be defined as "exposure of a child to sexual stimulation

inappropriate for the child's age, level of psychosocial development and role in the family" (Brant & Tisza, 1977). Intrafamilial relations includes stepparents and step siblings, foster parents and foster siblings, boyfriends of mother and "close friends of the family." Incorporating a feminist perspective, the definition includes the idea that sexual abuse of a child is based upon

the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance (Sgroi, 1982).

CHAPTER II

REVIEW OF THE LITERATURE

The prohibition of incest is less a rule prohibiting marriage with the mother, sister, or daughter, than a rule obliging the mother, sister, or daughter to be given to others. It is the supreme rule of the gift, and it is clearly this aspect, too often unrecognized, which allows its nature to be understood.

-Levi-Strauss, 1949

The Incest Taboo

The incest taboo is considered by most theoreticians to be a universally cross-cultural phenomenon:

It is ... a fundamental rule of social order. It is the primordial law, which defines the special place of human society within the natural and supernatural world. It is the mark of humanity. In many cultures, violations of the taboo are associated with a desecration of the basic social contract: with bestiality, with cannibalism, with witchcraft. (Herman, 1981, p.50)

Malinowski (1927) theorized that if incest was practiced, it would destroy the structure of the family system by confusing family roles and generational boundaries; the family could no longer function as a social or economic system.

Rist (1979) cites three main anthropological explanations for the existence of an incest taboo:

(1) it guarantees the exchange of women, the

fundamental exchange from which comes all other exchanges, which is society's most pressing need; (2) it institutionalizes exogamy to assure the continued growth of the social group, leading to a shift from familial to community dependence--a requirement for the development of society; and (3) it encourages the child's concept of self as an individual separate from the family, which is needed for the individual to function adequately within the culture.

And yet, despite the taboo, despite the threat it causes to our families, to our children and to our society, the sexual abuse of children has existed throughout history and exists in near epidemic proportions today.

Effects

As recently as 1983, some researchers have claimed that sexual abuse is not traumatic or that its traumatic impact has been greatly overstated (Burton, 1968; Henderson, 1983; Ramey, 1979; Yorukoglu & Kempf, 1966). For the most part, however, researchers and clinicians agree that sex between adults and children is harmful. Rosenfeld (1979) noted that the repercussions of incest may be

"subtle and varied" and multidetermined, and may manifest themselves "immediately after the event or considerably later in life" (p. 327).

Researchers have found that the degree of the effects varies depending on the type of abuse. Duration and frequency, relationship of the victim to the offender, the type of sexual act, the degree of force and aggression applied, the age of onset, whether the victim tells or does not tell her secret, and parental reaction are all factors that weigh on the effects to the child, both initially, and long-term. Groth (1978) asserts that the greatest trauma occurs in sexual abuse that continues for a longer period of time, occurs with a more closely related person, involves penetration, and is accompanied by aggression. MacFarlane (1978) adds to Groth's list abuse in which the child participates to some degree, where the parents have an unsupportive reaction to disclosure, and when the child is older and thus cognizant of the cultural taboos that have been violated. Most of the research concurs with these findings.

Longer duration and frequency of the sexual abuse is generally associated with greater negative effects. Russell (1986) found that, of the women

in her sample who had been sexually abused for 5 years or more, 75% rated the experience as extremely or considerably traumatic. The percentage decreased to 62% for those who had been abused for a period of one week to 5 years and 46% for those who had been abused only once. Bagley & Ramsay (1985) found that the general mental health status of adult victims was worse for longer lasting experiences. Tsai, Feldman-Summers and Edgar (1979) found similar results. Conversely, Finkelhor (1979), in a retrospective study of college students, found no association with duration. And Courtois (1979) found a reversed relation: adult victims with the longest lasting experiences reported the least trauma.

Although research generally has found that intrafamilial abuse is more traumatic than abuse by someone outside the family, Browne & Finkelhor (1986) caution against generalization:

It must be kept in mind that how closely related a victim is to the offender does not necessarily reflect how much betrayal is involved in the abuse. Abuse by a trusted neighbor may be more devastating than abuse by a distant uncle or grandfather (p. 73).

Abuse by a father or stepfather has been found to be the most traumatic (Finkelhor, 1979; Tufts, 1984; Russell, 1986).

Bagley & Ramsay (1985), in support of Groth, found penetration to be the single most powerful variable explaining severity of mental health impairment. Russell's data gives a more detailed breakdown of relationship of type of sex act to extent of trauma. Fifty-nine percent (59%) of those reporting intercourse, fellatio, cunnilingus, analingus, or anal intercourse said they were extremely traumatized, compared with 36% of those who experienced manual touching of unclothed breasts or genitalia, and 22% who experienced unwanted kissing or touching of clothed body parts.

The relationship between age of onset and degree of effect is less clear. Some argue that younger children are more damaged because of their impressionability. Others feel their naivete of the social stigma associated with sexual abuse protects them from negative effects. Meiselman (1978) found that 37% of the subjects who experienced incest prior to puberty were seriously disturbed, compared with only 17% of those victimized after puberty. Courtois (1979) also found more effects from prepubertal experiences. Tuft's (1984), however, concluded that the age of onset had no relation to the degree of disturbance exhibited by the child.

Although the study did find that latency-age children were the most disturbed, it concluded that this finding was more related to the age at which the children were first evaluated than the age at which they were first abused.

In support of MacFarlane's findings that more negative effects are associated with a parent's non-supportive reaction to disclosure, Estroff (1986) found that a major determinant of the adjustment of the abused child was the degree to which the parent's version of the incident matched that of the child. Children at greatest risk had a version of the incident that was at odds with that of the parent.

Initial Effects. Browne and Finkelhor (1986), in a review of the literature, found the initial effects on the victims of child sexual abuse include fear, anxiety, depression, anger and hostility, aggression and sexually inappropriate behavior. DeFrancis (1969) reported similar effects. Additionally, he found that 64% of the subjects expressed guilt about the abuse, although more about the disclosure than the actual molestation. Kohn (1987) reports immediate effects of sleeping/eating disturbances, anger, withdrawal, guilt, sexual preoccupation and physical problems or complaints. Horowitz (1985)

points out sudden massive weight loss or gain, sudden school failure, truancy, loss of self-esteem and social isolation as signs that a child has been sexually abused. Several studies have found that childhood incest is frequently followed by chronic post-traumatic stress disorder, a condition characterized by the reliving of thoughts, feelings or actions related to earlier traumatic experiences (Donaldson & Gardner, 1985; Goodwin, 1985; Herman, Russell, & Trocki, 1986).

Borgman (1984) found that the most usual consequence was the initiation of deviant genital contact with other children. Of sixteen girls admitted to a children's institution, four had begun sexual activity with a younger sibling immediately after the sexual experience with the adult; four had initiated genital relations with much younger children outside their family; and three others had begun coital activity with youths three or more years older. Tuft's (1984) also found evidence of sexually inappropriate behavior as an effect of sexual abuse.

Other studies have found a direct relationship between intrafamilial child sexual abuse and juvenile delinquency and runaway behavior. Wisconsin (1982) found that 32% of the juvenile offenders in the study

had been sexually abused by a relative or other person close to them. Herman (1981) compared a clinical population of adults who had been victims of father-daughter incest in their childhood with a group who had seductive, but not incestuous fathers. Thirty-three percent (33%) of the incest victims reported they had run away from home as adolescents, as compared to only 5% of the comparison group. Similarly, Meiselman (1978) found that 50% of a clinical sample of adults who were incest victims left home before age 18, compared with only 20% of women in the nonvictimized comparison group. Reich & Gutierres (1979) found that 55% of the children in one county in Arizona who were charged with running away, truancy, or were listed as missing persons, were incest victims.

Anderson, Back, and Griffith (1981) reviewed the charts of 155 female adolescents treated in a medical center for sexual assault and abuse. They compared patients who were victims of intrafamilial abuse with those in which the offender was not in the family. They found that 67% of the intrafamilial victims, compared with only 49% of the extrafamilial victims, exhibited some form of internalized psychosocial sequelae, such as sleeping/eating disturbances,

fears/phobias, depression, guilt, shame and anger. Sixty-six percent (66%) of the intrafamilial victims also exhibited some form of externalized sequelae such as school problems and running away. Only 21% of the extrafamilial victims exhibited these symptoms.

Long-term effects. The long-lasting negative effects of child sexual abuse are abundant in the literature. Low self-esteem, depression, self-abusive behaviors, problems with sexuality (including promiscuity, prostitution and sexual dysfunction), and substance abuse are among the most commonly cited. Eating disorders, borderline pathology, feelings of isolation and stigmatization, a tendency towards revictimization, a lack of trust in relationships and negative feelings about men are some other frequently noted sequelae.

Gelinas (1983) reported that relational imbalances inherent in the sexually abusive family are to blame for impairment in self-esteem. Victims are taught that they have no rights, particularly to needs of their own.

Nothing is owed them, inherently or because of their contributions, and they are allowed no claim to needs, reciprocity or even acknowledgement (p. 313).

Summit & Kryso (1978) describe the results of this low self-esteem over time:

Deprived of self-worth and self-esteem, forsaken by parents, betrayed by other adults, cursed with a destructive concept of their own sexuality, many of these girls spend their lives searching for a redeeming relationship, yet retreating from positions of trust or intimacy. They expect rejection, betrayal, and punishment (p. 244).

Bagley & Ramsay (1985) studied a randomly selected clinical population of 387 females. Their results found that subjects with a history of child sexual abuse were more depressed on the Centre for Epidemiological Studies Depression Scale than nonabused subjects. Sedney & Brooks (1984), in a sample of 301 college women, found a greater likelihood for subjects with childhood sexual experiences to report symptoms of depression (65% versus 43% of control group) and to have been hospitalized for it (18% versus 4%). And Peters (1984), in a random sample of 119 women in a clinical population, found that sexual abuse victims had a higher incidence of depression, a greater number of depressive episodes over time, and were more likely to be hospitalized than nonvictims. There are several studies, however, which refute these findings. Herman (1981) found an insignificant difference, with 60% of incest victims versus 55% of

comparison group exhibiting depressive symptoms. Meiselman (1978) noted depressive symptomology in 35% of victims versus 23% of comparison group.

DeYoung (1982) postulates that some child victims of sexual abuse believe they deserve punishment for their involvement in the abuse. She theorizes that they may self-mutilate in order to prevent further abuse, to punish themselves, or to unconsciously attempt ego reintegration (psychological calm that follows the energy discharge of self-mutilation). Briere's research (1984) supports DeYoung's theory. In a study of 153 "walk-ins" to a community counseling center, 51% of sexual abuse victims versus 34% of nonabused clients had a history of suicide attempts; 31% versus 19% exhibited a desire to hurt themselves. In a later and similar study, Briere and Runtz (1986) examined the relationship between childhood sexual abuse and subsequent suicidality in 195 women presenting to the crisis intervention program of a community health center. As predicted, former sexual abuse victims were considerably more likely to have made at least one suicide attempt in the past (55% of the 133 subjects) than were nonabused clients (23% of 62 subjects) and were more likely to report suicidal ideation at

intake. Additionally, they found greater suicidality correlated with multiple perpetrators, concurrent physical abuse, and sexual intercourse. Harrison et al. (1984), Herman (1981), Bagley and Ramsay (1985), and Sedney and Brooks (1984) have also found a high incidence of suicide attempts, suicidal ideation and self-abusive behavior by victims of child sexual abuse.

The effects of child sexual abuse on sexuality generally fall into three categories: sexual adjustment or dysfunction; promiscuity; and prostitution. Browne and Finkelhor (1986) report that nearly all clinically based studies show later sexual problems among child sexual abuse victims, particularly among the victims of incest. They note, however, that there have been no community based studies and that clinical populations may offer a biased sample.

Meiselman (1978) found the highest percentage of incest victims reporting problems with sexual adjustment. In her sample, 87%, versus 20% of a comparison group, reported serious problems with sexuality. Problems included indiscriminate sexual activity (promiscuity), prostitution, orgasmic dysfunction and confusion about sexual preference.

Langmade (1983), in a comparison of women in therapy, found that incest victims were more sexually anxious, experienced more sexual guilt and reported greater dissatisfaction with their sexual relationships than nonvictims. Briere (1984) found 45% of women sexually abused as children reported difficulties with sexual adjustment as adults, compared with 15% of a control group. Briere also noted a decreased sex drive in 42% of the victims versus 29% of nonvictims. Giarretto (1976) and Westermeyer (1978) report sexual dysfunctions as the most frequently described problems of adults abused as children, especially orgasmic dysfunction and difficulty with sexual contact. But, as early as adolescence, effects on sexuality are apparent. Borgman (1984) found girls in his sample exhibited inappropriate sexual behavior and confused sex with violence. They viewed males as violent and abusive toward women. None of the subjects viewed sex as affectionate or loving.

Courtois (1979), DeYoung (1982), Herman (1981) and Meiselman (1978) all report promiscuity as a long-term effect of child sexual abuse. Herman noted that 35% of the incest victims in her sample reported promiscuity and observed that some victims

seemed to have a "repertoire of sexually stylized behavior" that they used as a way of getting affection and attention (p. 40).

A correlation between child sexual abuse and later prostitution is well-documented in the literature. James and Meyerding (1977) interviewed 136 prostitutes and found that 55% had been sexually abused as children. Of the adolescents in their sample, 65% had been forced into sexual activity before age 16. Similarly, Silbert and Pines (1981) found 60% of the prostitutes they interviewed had been sexually abused before age 16 by an average of two people and for an average of 20 months. The mean age of the subjects at the time of their first victimization was 10.

A correlation between child sexual abuse and later substance abuse has been gaining recognition in recent literature. Dembo et al. (1987) explored this correlation among 145 males and females in a juvenile detention center where the mean age of the adolescents was 15 years. The results suggested that, for both gender groups, sexual victimization had a primarily direct effect on drug use. Rohsenow, Corbett, and Devine (1988) compared the rates of reporting child sexual abuse among inpatient

substance abusers before and after the question was routinely asked. Before routine inquiry, 4% of the men and 20% of the women disclosed such abuse. After routine inquiries began, the rates for adult men quadrupled, up to 42% of the teenaged boys reported such abuse, about 75% of adult women admitted such abuse, and 71-90% of teenage girls disclosed histories of child sexual abuse. Earlier studies have also found a correlation (Briere 1984; Herman, 1981).

Some other generally accepted long-term effects of child sexual abuse are feelings of guilt (Gelinas, 1983); feelings of isolation and alienation (Briere, 1984; Courtois, 1979; Harter, Alexander, & Neimeyer, 1988; Herman, 1981); mistrust and fear of men (Borgman, 1984; Briere, 1984; Courtois, 1979; Meiselman, 1978); and increased vulnerability for later revictimization (Miller et al., 1978; Russell, 1983). As adults, the experience is likely to affect the way incest victims rear their children, particularly the way they socialize them sexually (Russell, 1986). Recently, suspicions that child sexual abuse may play a significant part in the

etiology of eating disorders (Sloan & Leichner, 1986) and borderline pathology (Gartner & Gartner, 1988) have been investigated.

Theory

Finkelhor (1984) states that two types of theory currently prevail in the field: a collection of partially developed ideas about what creates a child molester and a highly specific family-systems model of father-daughter incest. This discussion will include the theories Finkelhor alludes to, with an emphasis on the family-systems model and current feminist theory.

Early psychiatric literature generally presented two theories of the etiology of child sexual abuse: a psychopathological explanation (Gebhard, Gagnon, Pomeroy, & Christenson, 1965) and a theory which blames the mother (Lustig, 1966; Kaufman, 1954). Psychopathological theories described sexual interest in children as a specific deviant psychological state that afflicted a small group of men who had traumatic developmental experiences. This theory has been dispelled recently as incidence studies have documented widespread existence of sexual abuse, indicating that normative factors are involved, not psychopathology. Theories which blamed the mother

for the abuse hypothesized the following dynamics: the mother in the incestuous family had unmet dependency needs as well as a need for closeness and nurturing resulting from deprivation during childhood. Initially, the mother is overprotective and indulgent, but as she begins to identify with her daughter an ego fusion occurs. The daughter comes to represent a narcissist extension of the mother's ego. As the daughter grows older, she takes on the role of "little mother". The role reversal occurs; mother becomes dependent on daughter; daughter assumes mother's role in communicating with father. Eventually, the lack of sexual fulfillment between mother and father leads the father to turn to the daughter for sexual gratification. The theory was also easily amended in cases where the father lost his wife through death, divorce or separation (Machotka et al., 1967).

Recent research criticizes this early psychiatric point of view and has downplayed unconscious motivation and pathology and maternal blame. Meiselman (1978) has argued that the role reversal between mother and daughter is not universal in incest cases, but only the most well-studied pattern. Herman and Hirschman (1981) point out the excessive

power of the father -- a power that allows him to believe that when not satisfied by his wife, he can seek sex from his daughter. The mother is viewed as powerless; she puts up with it because she is dependent on the husband, does not feel she can influence the situation, or is fearful of violence or retaliation.

Social and cultural forces in American society have been brought to focus as causal factors as well. Sexualization of children in the media and films (Rush, 1980; Vermeulen, 1981; Winn 1981) and child pornography (Baker, 1978; Densen-Gerber & Hutchinson, 1978) have been suggested as elements that may stimulate adult sexual interest in children. To date, however, there is no empirical evidence to support these theories (Finkelhor, 1986). Rush offers commentary on Hollywood's contribution to the problem:

Hollywood found the combination of childishness and sex extremely popular and lucrative. . . . The popular Hollywood sex goddess . . . as illustrated by . . . Marilyn Monroe and Jayne Mansfield were satisfyingly synonymous with the helpless, needy woman-child . . . [they] were appreciated . . . for their childlike fragility in a well-developed body . . . Innocence in a child or a woman is sexy not because it evinces the vigor of integrity but because it betrays the weakness of dependency. For the man who enjoys a sense of power over female companions, whether

childishness emanates normally, from a little girls or abnormally, from a grown woman is a matter of personal taste. (p. 117)

Other researchers have argued that child sexual abuse has nothing to do with sexual desires. Groth and Burgess (1977) argue that sex with children is motivated by power and control issues, hostile and aggressive impulses and affiliation needs. Sgroi (1982) supports the notion that the sexual abuse of children is a power problem and that the dynamics involve a sexual expression or acting out of nonsexual issues.

Inevitably, the offender's power position in relation to the child victim and the child's perception of his or her subordinate role are the principal determinants of what occurs between them, how it occurs, where, when, and why it occurs . . . (pp. 1-2)

Finkelhor (1984) refutes the power theory pointing out that

. . . all sexual behavior, not just child sexual abuse, is laden with nonsexual motivation . . . Sex is always in the service of other needs. Just because is it infused with nonsexual motives does not make [it] different from other kinds of behavior we readily call "sexual" (p. 34).

Russell (1986) also disagrees. She argues that the analysis fails to recognize that males are socialized to sexualize power, intimacy and affection, and sometimes hatred and contempt as well.

Russell's theory of child sexual abuse fits among the feminist analyses of the problem. She cites two major causal factors in incestuous abuse: the way males are socialized to behave sexually; and the power structure within which they act out this sexuality. She asserts that society's notion of masculinity predisposes men to violence, to rape, to sexually harass and to sexually abuse children.

As long as males are socialized with a predatory approach to obtaining sexual gratification, and as long as this is seen as so acceptable that to point it out is considered offensive, we will make little progress in our efforts to stop sexual assault. (p. 392)

Finkelhor (1986) supports Russell's theory that the sexual abuse of children is in part a problem of masculine socialization. He calls attention to the fact that sexual abuse is committed predominantly by men: 95% of the perpetrators in cases of abuse of girls and 80% in cases of abuse of boys. Molestation by females, however, may be underreported.

Other feminists have placed the issue of child sexual abuse within a framework of patriarchal society (Herman, 1981; Rush 1980; Swink & Leveille, 1986). Rush asserts that abusive treatment of children is inherent in the basic inequality of the sexes:

. . . the sexual abuse of children . . . is part and parcel of the male-dominated society which overtly and covertly subjugates women. (p. 73)

Rush also attributes it to the way in which males and females are socialized:

. . . the abuse of female children is not regarded seriously by society, is winked at, rationalized, and allowed to continue through a complex of customs and mores that applaud the male's sexual aggression and denies the female's pain, humiliation, and outrage . . . [it] is permitted because it is an unspoken but prominent factor in socializing and preparing the female to accept a subordinate role: to feel guilty, ashamed, and to tolerate, through fear, the power exercised over her by men. (pp. 73-74)

Historical perspectives of the institutionalization of male power and female oppression are offered by Armstrong (1981), Brownmiller (1975) and Rush (1980). Brownmiller draws historic parallels between the dynamics of the intrafamilial sexual abuse of children and rape of women:

The unholy silence that shrouds the interfamily sexual abuse of children and prevents a realistic appraisal of its true incidence and meaning is rooted in the same patriarchal philosophy of sexual private property that shaped and determined historic male attitudes toward rape. For if woman was man's original corporal property, then children were, and are, a wholly owned subsidiary. (p. 281)

Family-systems theory takes a less negative, less judgmental view of men, holding all members of the family partly responsible for the abuse.

Giarretto (1976) proposes that the family is an organic system and that each family member's behavior attempts to maintain the system balance or family homeostatis. Mrazek and Bentorim (1981) describe the incestuous family as a dysfunctional system in which roles are confused and parents fail to meet the children's needs for nurturing and socialization. DeYoung (1982) and Slager-Jorne (1978) present incest as a product of family pathology in which all family members are active in perpetuating the abuse. Renvoize (1982) portrays incestuous families as tightly knit:

They bind themselves together with ropes of mutual dependence, fear of separation, and secrecy, and if any one member tries to break away, the bonds are tightened. (p. 100)

The concept of the family as a system dominates current literature both as a theory and as a treatment model. It seems to have captured the attention of a large number of clinicians who have searched for answers on how to treat the families that come to them for help. Even the members of the judicial system have grabbed hold of the theory to support their contention that the best thing is to keep the family together. And yet, criticism of the theory abounds.

One of the most persistent criticisms of the family-systems theory is that it tends to take responsibility for the abuse away from the offenders and displaces it onto either victims, third parties or society as a whole (Armstrong, 1978; 1983; Conte, 1983). Rush (1980) puts the blame back on the offender:

The molester is not the product of a disturbed or dysfunctional family and may be as normal or abnormal as the rest of the so-called normal male population. The reason he seeks out a child as a sexual partner is because a child, more than a woman, has less experience, less physical strength, is more trusting and dependent . . . and therefore can be more easily coerced, seduced, lured or forced. (p. 2)

Russell (1986) adds that family-systems theory ignores perpetrators outside the nuclear family. Finkelhor (1986) agrees, stating that the theory developed almost exclusively from work with father-daughter incest, excluding older brothers, uncles and neighbors. Russell's research found that sexual abuse by uncles is actually slightly more prevalent than father-daughter incest. If these uncles are living outside the home, the family-systems theory would fail to account for a majority of sexual abuse.

Finally, family-systems theory neglects sociological factors which need to be included in any theory of child sexual abuse, as it is clearly a widespread social problem. Finkelhor (1986) outlines a socialization of male sexuality which limits opportunities to practice nurturing and to express dependency needs except through sex, encourages males to prove their masculinity through sexual prowess, and socializes them to see as their appropriate sexual partners persons who are younger and smaller than themselves. As stated earlier, Russell's view of male socialization alludes to a "predatory approach to obtaining sexual gratification", and Rush talks of a society which applauds male aggression:

One way or another, child molesters get permission for what they do. Adult-child sex is not a phenomenon that emerges from nowhere but is a legacy from the past which continues on in our everyday life. (p. 15)

Treatment

Much has been written about treatment of the abuser. Recently, the issue of treatment versus punishment has been debated. Clinicians, judges and law enforcement agencies are questioning which alternative more successfully rehabilitates and which is in the best interest of the child and her family (Conte, 1984; Dawson, 1986; Giarretto, 1976; Krieger

& Robbins, 1985; Kroth, 1979). This discussion, however, will focus on the treatment of the victims, except in so much as the offender is included in family-systems therapy. This approach is consistent with the focus on the victim throughout this thesis.

The literature offers some general guidelines for counseling and treatment of victims of child sexual abuse. Broadly speaking, the focus should be on strengthening the child's ego, improving her self-image, and helping her to learn to trust again (Sgroi, 1982). Everstine and Everstine (1983) suggest that the issue of trust be the primary treatment issue as it is the base on which all future love and trust relationships will be built. Other treatment goals include reducing the sense of guilt and fear, resolving repressed feelings of anger and hostility, encouraging self-mastery and control, improving assertive skills and teaching appropriate sexuality (Dawson, 1984; Porter, Blick, & Sgroi, 1982).

There is some debate over whether counselors should encourage clients to discuss the abuse itself. Borgman (1984) is concerned that direct encouragement may perpetuate the girl's image of herself as a deviant person or as a sex object. Slager-Jorne

(1978) cautions that if a child does not bring up the sexual abuse herself, the counselor should not, because the child's silence may indicate an inability to deal with the feelings that are aroused. Peters (1976) and Burgess, Holmstrom, and McCausland (1978) take the opposite approach. Peters believes victims should be encouraged to talk in order to stimulate the child's expression of anger toward the offender, to provide opportunity for them to distinguish between the sexual abuse and positive experiences in the past with the offender, and to correct misconceptions about men and sex which may affect adulthood. Burgess et al. advocate talking about the abuse as a method of relieving feelings of guilt and to indicate to the child that the counselor takes the situation seriously so that the child will feel she has an ally with whom she can share painful feelings.

There is also some debate in the literature as to whether removing the victimized child from the home is an effective treatment approach. Shamroy (1980) uses family-systems theory to support his contention that removing the child from the home is not only ineffective, but could make matters worse. The sexual abuse is viewed as a family problem, not an

individual one, and thus requires participation by all family members in treatment, with the ongoing relationship problems being exposed as they occur. Furthermore, maintaining the family intact is thought to prevent the abused child or the parents from feeling singled out as deviant. Zaphris (undated) also believes that removal of the child may contribute to her victimization by exacerbating feelings of blame and recommends it only in those cases where serious pathology exists in the family (which is seldom the case) or if the incest is concurrent with physical abuse. Anderson and Shafer (1979) also warn professionals that placing the victim in a foster home reinforces the victim's sense of responsibility and guilt and provides little incentive for the parent to accept his responsibility for the abuse. They concede, however, that in situations in which the father is not charged, and/or the mother is unsupportive of the daughter, removal from the family may be the only way to guarantee protection.

The issue of safety is most often raised as a counterargument to keeping the child in the home and the family intact. Conte and Berliner (1981) remind us that one of the objectives of social work services

is to protect the child from additional abuse. And there is evidence to suggest that in many cases sexual abuse continues when victims remain with their families, even after the original perpetrator has left. Mothers sometimes remarry men or bring home live-in boyfriends who later sexually assault their daughters (Borgman, 1984). Borgman suggests that the issue of placement should be decided individually, based upon whether the male offender will have subsequent access to the child, the presence of other forms of neglect and abuse, the quality of the placements available, and the wishes of the child.

Server and Janzen (1982) point out that many of these families have only remained intact prior to the disclosure of the sexual abuse due to the social isolation and dependency that is characteristic of the incestuous family. They advocate intervention that supports alternative life styles, long-term treatment groups for spouses who choose to separate, and referrals to facilities such as shelters for battered women. For those families who do wish to stay together, or reunite, they offer more specific guidelines as criteria for reconstitution, with a focus on the future safety of the child:

1. The offender has acknowledged responsibility for the sexual abuse and does not project blame onto the daughter.
2. The therapist and all family members express reasonable assurance that the child is safe from repeated abuse.
3. The daughter expresses and demonstrates the ability to seek professional help in the event she is again approached.
4. The mother has demonstrated a greater ability to protect her children and herself from abuse.
5. The mother/daughter relationship has improved and the mother does not hold the victim accountable for the molestation.
6. Generational boundaries have been strengthened resulting in more appropriate family roles and improved marital relationship.

Giarretto's (1978) treatment model stems from family-systems theory and the philosophies of humanistic psychology. His Child Sexual Abuse Treatment Program (CSATP) in San Jose, California, has received widespread attention and claims unprecedented success. This multi-focal, outpatient program works in collaboration with the probation department to provide a treatment alternative to prosecution and imprisonment of the offender. It operates on the premise that productive case management of the molested child and her family calls for procedures that alleviate the emotional stress of the experience, enhance the processes of

self-awareness and self-management, promote family unity and growth and engender a sense of responsibility to society. The program utilizes a combination and progression of counseling approaches, which include individual counseling of all concerned in the family, followed by counseling of significant pairs (e.g., husband and wife, mother and daughter, father and daughter), and finally, family counseling. Group counseling is employed conjointly in the form of self-help support groups such as Parents United, Daughters and Sons United, and separate all women, all men and couple groups. Anderson and Mayes (1982) report on a similar program based on the work of Giarretto. Porter et al. (1982) agree that treatment is best accomplished when directed toward the entire family.

The family-systems treatment modality has been criticized for the same reasons as its theory has been, mainly because it takes responsibility off the offender and puts it on to the child and the mother, and because it does not address the social issues involved. An attempt to "fix" the dysfunctional family is inadequate as a solution as it fails to address the larger, global problem. Real change can only come when society alters its views on the rights of children and

the way in which it socializes males and females. In addition, family systems interventions have been criticized for containing sexist biases against women (Bograd, 1986) and for the difficulty inherent in treating resistant clients:

Mental health professionals are accustomed to working with individuals who are 'motivated' and who actively seek help . . . they generally do not have outreach strategies for highly resistant families, and their scheduling practices cannot handle families who frequently miss appointments or come late. (Holmes et al., 1977, p. 375)

A support group therapy approach for victims of incest has grown out of the feminist concept of consciousness raising and feminists' redefining of victims as survivors. Generally, these self-help groups are directed by professional group facilitators, which distinguishes them from other mutual support groups. Models for group design exist for adult survivors of childhood incest (Cole, 1985; Swink & Leveille, 1986; Westerlund, 1983), as well as for adolescent survivors (Blick & Porter, 1982; Hall, Kassees, & Hoffman, 1986; Gagliano, 1987). Both models seek to minimize the isolation and stigma felt by the survivors by providing a safe environment for the sharing of the experience and the feelings it arouses, as well as for the development of feelings of empowerment. Adult groups tend to focus on

educating the members of the group about the myths and facts of incest, exploring the consequences of the abuse in their present life (e.g. relationship difficulties, self-destructive behavior, physical manifestations), explaining the probable phases of recovery and discussing practical coping skills. Adolescent groups are more preventative in nature, with the goal of minimizing the negative affects of the incestuous experience in adulthood. Sex education and assertiveness training are included. The group also provides an opportunity for socialization with peers.

A multi-agency, community approach to treatment is also supported in the literature. Sgroi (1982) suggests that "nowadays it is practically 'un-American' for a community to lack a multidisciplinary team of professionals to review cases of child maltreatment" (p. 335). Anderson and Shafer (1979) describe child sexual abuse as a multifaceted social problem that invariably and appropriately must involve multiple agencies with differing professional orientations, roles, goals and expectations. Effective case management demands a cooperative endeavor among the various agencies (Duncan, 1987). An interdisciplinary support system

which includes physicians, social workers, attorneys, judges and governmental child protective agencies is recommended by Brant and Tisza (1977). Fontana (1984) warns that lack of coordination and communication between and among the responsible agencies will only add to the failures of the system that already exist due to large caseloads, too much paperwork, faulty supervision and poor judgment.

And finally, a few alternative methods of treatment have been documented in the literature. Naitove (1982) recommends art, play, and movement and dance therapy for quick, inexpensive and dynamic access to vital information as well as to facilitate assessment and treatment of sexual abuse victims. Holmstrom and McCausland (1978) have shown the benefits of play therapy with children in facilitating the communication of emotions. MacKay, Gold, and Gold (1987) have demonstrated that drama therapy with adolescent girls can result in lessened hostility and depression, and fewer psychotic symptoms.

CHAPTER III

METHODS

This thesis reports the results of a study of sexually abused adolescent girls who were wards of the court and had been placed at Palomares Group Home in San Jose for treatment. Palomares is a private, non-profit organization, established in 1971, that provides intensive treatment for severely emotionally disturbed adolescent girls. The program is based on a psychiatric model of residential care and is eclectic in its treatment approach. A combination of individual, family and group therapy, combined with a behavior modification program and a broad utilization of community services and support, is employed. The treatment is short-term, but can range from 6 months to 1 1/2 years depending on the particular resident, her level of motivation and the extent of her emotional problems.

The program is highly structured, with a primary focus on stabilizing the resident's behavior sufficiently to enable her to re-enter the community in a living environment requiring a lower level of care. The structure provides a safe and nurturing setting where the adolescent can experience crisis in

a therapeutic setting to enable new learning and personal growth to occur. Upon successful completion of the program, the resident may return home, if appropriate, or be placed in a foster home or a less structured, less therapeutic group home.

Residents of the program are referred from social service and juvenile probation departments throughout the state of California. In order for an individual to be accepted into the program, she must first go through an intake procedure. Usually, the court's representative (a social worker or probation officer) will call Palomares inquiring whether there is an opening and give a brief history of the girl's problems and summarize her needs and current situation. There are several basic criteria for her acceptance into the program. In addition to the age requirement (12-18 years), Palomares does not work with girls who are mentally retarded, developmentally disabled, alcohol or drug addicted (active), psychotic (active) or who have histories of violence. If a girl meets these basic criteria, the court representative will be asked to send an intake packet which includes court reports, school records, and any reports from previous placements or psychiatric hospitalizations.

Upon receipt, the intake packet is reviewed by the Program Director. Sometimes, although the girl may meet the basic criteria for selection, her particular needs may be better met in a different kind of program. For example, a residential treatment program with an on-grounds school may better meet the needs of a girl who has difficulty interacting in the community or who needs stricter limits and controls than can be offered at Palomares, where some degree of community involvement is expected. A group home in a rural setting, far away from the girl's home "turf", may better meet the needs of someone with an extensive history of running away from placements. In some instances, just the opposite may be true, as in the case of a girl who needs the proximity of her family and friends for support and/or for their involvement in her therapy.

The second step in the intake procedure is an interview with the girl, her court representative and a Palomares social caseworker. Depending on the particular case, parents, relatives (or close friends of the family), lawyers, and/or child advocates may also attend. At this time, the girl is screened to determine whether the program will fit her needs. She is asked what she perceives to be her problems, what

areas she would like to focus on while in treatment, and she is probed about her motivation to do so. Palomares is given an opportunity to interact with the girl in person, which is very important for clinical assessment, as written reports can often be biased and incomplete.

Parents and other advocates who may attend the meeting are given an orientation to the program and an opportunity to meet the people who will have major responsibility for the child's care. Furthermore, the girl is given an opportunity to ask questions about the program and visit the group home, at which time she can meet the residents and the counseling staff. This serves both to relieve some of the girl's anxiety about the unknown (and allay her parents' fears) and to make her transition into the program less traumatic in the event that she is accepted. In some cases, if a girl's appropriateness for the program is questionable, if she is coming from a distant location, or if she is extremely anxious, an overnight to several days' visit may be arranged.

Once a girl enters the program, she is given access to a wide variety of services. Initially, medical, psychiatric and educational evaluations are

given to determine more specifically what her particular needs are. She is oriented to the behavior modification program, which is based on five phases of achievement. Rules and expectations are clearly defined; appropriate behavior is reinforced with rewards and increased independence. Over the course of treatment, the resident is exposed to recreational, athletic, social and cultural activities to expand her experience and awareness. She can also participate in community self-help, peer support groups for alcohol, drug and sexual abuse. Independent living skills training and youth employment and vocational assistance are also available.

Each group home employs five and one-half counseling staff (including a senior supervising counselor and a recreation coordinator) and a social caseworker, providing a 1:1 staff to resident ratio. The group home is staffed 24 hours a day, 365 days a year. During the hours when the residents are in the group home and active (3:00 p.m.-11:00 p.m. and weekends) there is a minimum staffing ratio of 1:3. Counseling staff are carefully chosen to provide positive role modeling for the residents, and trained in crisis intervention counseling, adolescent development, effective discipline, and social skills

training. The social caseworker is a trained therapist (masters' level) who provides individual and family therapy, leads group therapy in the home twice each week and manages the casework.

Subjects

The subjects were sixteen adolescent girls, ages 12-17, who had been placed at Palomares Group Home between February, 1987, and May, 1988, who had histories of intrafamilial sexual abuse. They represented eleven counties throughout California; twelve were referred from social services and the remaining four from juvenile probation. They represented a cross-section of ethnic backgrounds: six Hispanics; seven Caucasians; one American Indian; one Black; and one Asian. Their involvement in the juvenile court system ranged from 0 to 3 years; the number of previous placements ranged from 0 to 7. Nine of the subjects had histories of psychiatric hospitalizations; two of the subjects had been hospitalized on four separate occasions; three were hospitalized at least once while in placement at Palomares.

There were two major categories of intake diagnosis: eight of the subjects were diagnosed with some form of depression (dysthymic disorder, atypical

depression, post-traumatic stress disorder); seven were diagnosed with a conduct disorder. One subject had been diagnosed both as conduct disordered and atypically depressed. Additionally, six of the subjects had a dual diagnosis of substance abuse in remission; five had a dual diagnosis of borderline personality traits.

Collection of Data

Information from the subjects' records on file at Palomares were utilized to collect the history of sexual abuse data. These records included the intake packet (court reports, school records and reports from previous placements and psychiatric hospitalizations) as well as the Palomares treatment plan, quarterly reports and incident reports. Individual Educational Plans (I.E.P.'s), more current court reports and a few child abuse reports were also available. In cases where information was missing from the reports available in the files, the subject's social caseworker at Palomares was asked to fill in the gaps based on verbal reports over the course of treatment by the subject, members of her family, or other professionals involved in the case (for example, probation officer, social worker, therapist, etc.).

The length of time the subjects had been involved in the juvenile court system and how the subjects left their placement at Palomares (e.g., graduation, runaway, voluntary or forced termination) were also extracted from the records in order to explore research questions 2 through 5, outlined in Chapter I. Additional data was collected for the purpose of developing profiles of the subjects for further insight and future research. For example, the length of the subject's placement at Palomares, date of birth (age), race, legal status, county of origin and intake diagnosis were noted. Their age at first placement, number of previous placements and number of psychiatric hospitalizations were also included. An example of the Subject Vita form designed by this author for the purpose of collecting the above data can be found in Appendix A.

This method of data collection presented some problems in the reliability of the data and prevented the inclusion of some variables that might have added important information to the study. Most notably, the written reports of the girls' sexual abuse or abuses were often brief and scant. On a number of occasions it was simply mentioned that a girl had been sexually abused by someone without any mention

of the extent of the abuse (severity and duration), the aftermath of the abuse, whether or not the perpetrator was prosecuted or even questioned, whether the girl's story was corroborated with evidence, etc. Perhaps the most dramatic illustration of this was in the case of Subject #16. The records available, which included court reports and reports from five previous placements, cover a period of 3 years involvement in the juvenile court system. Five incidents of sexual abuse from ages 7 through 12, including a suspected molest by the subject's mother, (which is described in one sentence), are included. However, the only details presented in the reports are the relationship of the perpetrators to the subject; her age at the time of the abuse (four of the incidents occurred when the subject was 11); and in two instances the type of sexual act was reported. Apparently, either none of the people involved in this case felt that more in depth information would be important to record for future reference by professionals who would be working with the child, or they never bothered to ask.

Considering that the information on the incidents of abuse that was available throughout the subjects' records was lacking in content, it possible that in some cases there may have been incidents reported by a

given subject to authorities that were not included in the records. In this case, information obtained on the severity of the subjects' abuses could be inaccurate. Additionally, it is possible that information that is included is inaccurate; in general the reports do not indicate how the information was obtained or from whom. In any case, the facts are clearly incomplete. With only pieces of the puzzle available, the reliability of the data must be questioned.

Furthermore, as the files include minimal information on investigations and/or prosecutions of the reported abuses (it seems as though only a few perpetrators were formally charged), there is no guarantee that the reports made by the subjects are true or accurate. Research has shown, however, that reports of sexual abuse by children are generally true (Westerlund, 1983; Fontana, 1984). In fact, incest victims generally are reluctant to disclose the incest, attempt to protect their abusers and often blame themselves for the experience (Donaldson & Gardner, 1985; Gelinas, 1983; Goodwin, 1985). The same consideration must be given to verbal reports made to the Palomares' caseworkers. In addition, these verbal reports have the added problem of the reliability of the human memory. In some cases,

months had elapsed between the caseworkers' interactions with the subjects and their reports to this investigator.

Severity of Abuse Index

The variables measured in the Severity of Abuse Index were chosen for two reasons. First, the impact the variable may have had on a child's self-esteem was considered. Brown and Finkelhor (1986) found that the kinds of abuse that appear to be most damaging are experiences involving father figures, genital contact and force. The duration and frequency of abuse, age of onset, the child's reporting of the offense, parental reaction and institutional responses also influence the degree to which a child will be affected. Russell's studies (1986) report similar findings. Secondly, whether or not the data was available was considered. For example, information on the length of the abuse suffered by the child was usually not obtainable. Similarly, data on whether or not the perpetrator was punished and the family's reaction to the report of abuse (supportive or blaming of the victim) were not accessible.

A Severity of Abuse Index was then developed which rated the severity of the child's abuse based on: the number of incidents (by separate

perpetrators, as opposed to separate incidents, same perpetrator); the age of onset (at first abuse); the relation of the perpetrator(s) to the child; and the type(s) of abuse (fondling, digital penetration, intercourse, etc.). For each variable, a value of 1, 2 or 3 was assigned: 1 for the least severe, 3 for the most severe. The total score, with a maximum of 12 and a minimum of 3, indicated the severity of the child's history of sexual abuse. An illustration of the Index is presented in Figure 1.

<u>Variable</u>	<u>Scoring</u>
Number of Perpetrators	3 = 3 or more 2 = 2 1 = 1
Relationship of Perpetrator	3 = father 2 = step-father, or blood relative other than father 1 = non-blood relatives other than step-father
Type of Abuse	3 = intercourse 2 = oral copulation 1 = fondling, attempted intercourse
Age of Onset	3 = 0-6 years 2 = 7-13 years 1 = 14 + years
Total Severity of Abuse Index = number + relation + type + age	

Figure 1. Severity of Abuse Index

The first variable of the Index is the number of incidents of abuse and refers to the number of perpetrators the girl had been victimized by, as opposed to the total number of episodes. It was hypothesized that multiple victimizations would have a more dramatic impact on the child's self-esteem. Thus, if the subject's history indicated she had been sexually abused by only one perpetrator, a value of 1 was assigned; a value of 2 was assigned if she had been sexually abused by two perpetrators; and a value of 3 was assigned if her history indicated she had been sexually abused by three or more perpetrators. For example, Subject #1 was first abused at age 8 by a half-brother on one occasion; and then abused by her father beginning at age 11 and continuing for some time. (The records do not indicate exactly how long, but it appeared to be several years). This subject was assigned a value of 2 for this variable. (Note: Subject #1 was also abused by a friend of her sister's at age 8; however, this incident could not be included in the data as it did not fit the operational definition of intrafamilial sexual abuse being used in this study).

The second variable, age of onset, refers to the age of the girl when she first experienced sexual abuse. It was hypothesized that the younger the victim was when first abused, the more impact the abuse would have on her self-esteem. Therefore, a value of 1 was assigned to those subjects who had first been abused at age 14 or older (adolescence); a value of 2 was assigned to those first abused at ages 7 through 13 (late childhood, pre-adolescence); and a value of 3 to those first abused at ages 0 to 6 (early childhood).

The value assigned to the third variable reflected the closeness of the relationship between the child and the perpetrator, both socially and consanguineously. It was considered that being sexually abused by the natural father would be the most harmful to a child's self-esteem. Thus, subjects abused by their natural fathers were coded with a 3. Subjects abused by any other blood relatives (e.g. uncle, brother, grandfather) or a step-father (or boyfriend of mother) were coded with a 2; and all other, non-blood relations were coded with a 1 (for example, a foster or step-brother). In those instances where a child was abused by more than one perpetrator (which 50% of the subjects were) the

perpetrator with the closest relationship was coded. For example, Subject #5 was sexually abused by her father, an uncle and mother's boyfriend. A value of 3 was assigned.

The final variable, type of abuse, was coded based on the degree to which the child was exposed to sex and genitalia. It was hypothesized that the less serious and severe experiences would be less traumatic and thus have a smaller impact on the child's psychological health. If the subject had been fondled, or there had been an unsuccessful attempt at sex, a value of 1 was assigned. A value of 2 was assigned for oral copulation or cunnilingus; a value of 3 was assigned for intercourse. All of the incidents of abuse for this population fell in one of these three categories. In those cases where the subject had been victimized by more than one perpetrator, or over a period of time with increasing severity, the most severe type of abuse experienced was coded. For example, Subject #5 was fondled by an uncle, but had intercourse with her natural father. A value of 3 was assigned in this case.

The scores for each variable were then added together to produce the Severity of Abuse Index for each subject, with a maximum of 12 points possible, and a minimum of 3.

Piers-Harris Self-Concept Scale

The Piers-Harris Self-Concept Scale is a self-report measure of children's feelings about themselves. It focuses on children's conscious self-perceptions, rather than inferring how they feel about themselves from their behaviors or the attributions of others. Although the authors of the scale use the term "self-concept" in the title, the test is designed to aid in the assessment of self-esteem. The term "self-esteem" is defined as "a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behavior and attributes" (Piers, p. 1).

The scale consists of 80 test items, written at a third grade level and appropriate for children in grades 4-12, ages 8 to 18 years. A copy of the instrument can be found in Appendix B. It is a paper-and pencil questionnaire designed to be administered individually or in small groups with verbal instructions from the examiner. Children

taking the test mark either "yes" or "no" in response to each of the 80 statements reflecting whether or not the statement is true most of the time.

The scale measures self-concept as it is addressed through children's evaluations of their behavior, intellectual and school status, physical appearance and attributes, anxiety, popularity, and happiness and satisfaction. These sub-scales, or cluster scales, make possible a more detailed clinical interpretation of the child's self-concept. All cluster scales are scored in the direction of positive self-concept so that a high score on a particular cluster scale indicates a high level of assessed self-concept within that specific dimension.

The Piers-Harris Scale has been found to be appropriate for use in both educational and clinical settings and is best used for screening possibly at-risk children and for determining a child's self-concept in relation to peers (Piers, 1984). Cosden (1985) reports that the Piers-Harris, in conjunction with other tests, observations and interview data, can also be utilized to generate hypotheses about the impact of the child's environment on confidence and capacity to function. Additionally, the test has been used extensively in

research as a pre- and post- test measure in studies of factors affecting self-esteem (Wanat, 1983), and in studies evaluating the relationships of other factors to self-concept (Grayhill, 1978).

The subjects were administered the Piers-Harris within the first week of placement at Palomares, when possible; three of the subjects took the test within the first month of placement due to various delays. The test was administered by the Program Director, a clinical psychologist on staff at Palomares; all subjects were given the same introduction to the test (see Appendix B). The testing took place at the Palomares Administrative offices. Residents admitted to the program between February, 1987, and May, 1988, were administered the Piers-Harris. The main purpose for its use was as a clinical assessment tool for the Palomares staff and as an indicator of the effectiveness of the program in increasing a resident's self-esteem. Only those who had a history of sexual abuse that was documented in their records were used in this study. In one case, the subject came into the program with no documented history of sexual abuse; when sexual abuse was reported during placement, she was included in the study (Subject #4).

All the tests were scored by this author, who was on staff at Palomares at the time as Assistant Director of the program. To score the scale, a transparent scoring key was placed over each page of the booklet in turn. The numbers printed next to some of the holes in the scoring key indicate the scales on which that item is scored. For example, if the numbers 4 and 6 are printed next to an item on the scoring key, it means that item belongs to both cluster scales IV and VI (Anxiety and Happiness and Satisfaction). That item is scored for both cluster scales, however, only if a marked response shows through the hole in the scoring key. The response could be either "yes" or "no". The cluster score for each of the six scales is the sum of the marked responses showing through the holes in the scoring key for those items with that scale number. A copy of the scoring key is included in Appendix B.

The total raw score is the total number of responses marked in the positive direction. To determine that score, the total number of circled responses showing through the holes in the scoring key for all 80 items is counted. The total raw score cannot be obtained by adding all the cluster scores, as some items are scored on more than one cluster

scale, and some items are not included on any of the cluster scales. Omitted and double responses are not included in the total raw score or in any of the cluster scales.

A profile form was used for graphing the scale results for each subject (see Appendix C). The cluster and total raw scores are marked in the space provided at the bottom of the profile. Then the score is circled over the corresponding raw score in the column for each scale. Next the circles are connected to complete the profile. Corresponding T-scores and percentiles appear on the sides of the profile for easy reference.

Only 7 of the 16 subjects were still in the program after 6 months of treatment. These seven were re-tested at the 6 month date and the results scored. The subjects at this time were shown the profiles of the before and after scores, and given explanations of what the scores meant.

Limitations. Piers (1984) warns that since assessing a child's self-concept is a complex task requiring clinical sensitivity and a thorough knowledge of the clinical and research literature on children's self-evaluations, the Piers-Harris scale should not be used simplistically or in isolation.

Another method of assessing self-esteem, such as clinical interviews or observation of the child in a variety of settings, could have been used to supplement and corroborate the scale results obtained in this study.

Piers also notes four major types of validity considerations of the Piers-Harris: (a) "faking," (b) acquiescence and negative response set, (c) random responding, and (d) special populations. "Faking" refers to a more or less deliberate attempt by a child to distort her answers in order to produce a given effect. "Faking good," is the tendency to distort answers in what is felt to be a positive or socially desirable direction. "Faking bad" is the tendency to present oneself in a negative light. This is usually interpreted as either a bid for attention or a means of avoiding some undesired attention. Because children are generally less knowledgeable about any benefits of presenting an unfavorable picture of themselves, however, low scores on the Piers-Harris generally reflect truly low self-esteem. Piers recommends that as a general rule, total scores which deviate 1.5 or more standard deviation units in a positive direction ($>65T$) should be interpreted cautiously. This corresponds to a total raw score of

70 or above. Although a few of the subjects scored unusually high on several of the subscales, none of the subjects' total raw scores exceeded 63.

Acquiescence is the tendency to say "yes" to all or almost all of the items. Its opposite, a negative response bias, is the tendency to disagree with the items regardless of their content. The Piers-Harris was constructed with approximately half the items phrased in the direction of higher self-concept and half phrased in a lower self-concept direction to minimize this bias. The Scale does, however, provide a Response Bias Index to test this bias. It is a simple measure which consists of the number of items to which the subject responded "yes." Thus, it has a theoretical range of 0 (based on all "no" responses) to 80 (based on all "yes" responses). The scores are compared to a standardized sample with a mean of 36.73 and a standard deviation of 6.58. The cutoff points are set at ± 2 , which correspond to scores of 23 or less and 53 or more, respectively. When applied to the subjects in this study, a mean of 38.6 was found. Only one subject scored lower than 23; no subjects scored higher than 53.

The reliability of low scores on many self-concept tests has been raised as a critical issue by Wylie

(1977). Because most self-concept scales produce a negatively skewed distribution, with scores piling up above the scale's midpoint, a randomly answered scale might produce a low self-concept score.

Piers-Harris provides an Inconsistency Index to differentiate between low scores due to random response patterns and those which truly reflect lowered self-esteem. The Index is based on the supposition that certain pairs of responses are inconsistent, contradictory, or at least statistically unlikely. To score the index, 25 item pairs are scanned and 1 point is credited for each pair in which both items are responded to in the specified direction. For example, a "yes" response to Item 1: "My classmates make fun of me" paired with a "no" response to Item 58: "People pick on me" would be scored 1 on the Inconsistency Index. To interpret the scores, they are compared to a standardization sample with a mean of 1.47, and a standard deviation of 1.80. The cutoff score is set at +2 standard deviation units or 5.07 which, rounded to the nearest whole number, is 5. When the Index was applied for each subject in this study, the mean was found to be 2.38. Only two of the subjects' scores were suspect, with raw scores of 5 or above.

In regard to special populations, it should be noted that the original norms of the Piers-Harris are based on data from one Pennsylvania school district. Although subsequent studies suggest that the findings generalize to more diverse school populations in the United States, generalization should not be assumed. This is especially true for children whose ethnic or cultural background differs significantly from that of the standardization sample. As over half of the subjects in this study were members of minority groups, the possibility that their ethnic or cultural background was a factor in their assessed self-esteem must be considered.

A final limitation of the Piers-Harris noted by Cosden (1985), and of particular interest for the subjects used in this study, is the use of denial or other psychological defenses which may guard against the perception of negative events in the environment. In this case, subjects may report positive self-evaluations that conflict with what one would expect, given their stressful life events. This dynamic was suspected by this investigator for several of the subjects in this study. For example, Subject #5 was diagnosed with atypical depression and a personality disorder with borderline features. She

had the most severe history of sexual abuse among the sample, with a score of 12. She had had two psychiatric hospitalizations for suicide attempts, one just previous to her placement at Palomares. She also had two incidents of hospitalization for self-abusive behavior and suicidal ideation while in placement. And yet, her total raw scores on the Piers-Harris were unexpectedly high: 56 at intake, and 57 after 6 months of treatment. Both are above average scores when compared with the standardization sample and when compared with other subjects in this study.

Extrapolating from Cosden's research, this author suggests the further possibility that lower scores after 6 months of treatment might signify positive results, if the lower scores are indicative of reduced denial of problems. Investigation of these response styles in the data, however, would require advanced clinical assessment outside the scope of this study.

Further Limitations of the Study

Although the size of the sample used in the study was relatively small, the statistical tests that were utilized took this into consideration. It should be

noted, however, that a smaller sample does make it more difficult to achieve statistically significant results.

There were two limitations of using the Piers-Harris as a measure of treatment outcome: the size of the sample (only seven of the sixteen subjects were in treatment after 6 months), and the lack of a control group. It is difficult to know whether the changes noted in the subjects' self-esteem at the 6-month follow-up resulted from the Palomares program or some other variable, such as a result of attention alone. Piers suggests that it is desirable that a control group which is engaged in some alternative program be included, as well as a no-treatment control group. These options were outside of the scope of this project but certainly warrant consideration for future research.

It is also important to note that the subjects used in the study were screened for this particular group home program, so the results may not be representative of all sexually abused girls in group home placement. In addition, it must be emphasized that the author was not attempting to generalize about all residential treatment programs when examining the factors that may have contributed to

successful completion of this particular program.
Although some of the elements of the research may be
generalized, this is for future studies to explore.

CHAPTER IV

RESULTS & DISCUSSION

Piers-Harris Self-Concept Scale

The total raw scores on the Piers-Harris were used as a measure of the subjects' self-esteem. This variable was controlled in order to examine whether it was impacted by severity of abuse or length of time in the juvenile court system and whether it had any influence on a subjects' successful completion of the program. Before a more detailed review of the research questions is addressed, however, an overview of the results of the Piers-Harris alone will be presented.

The total mean score on the Piers-Harris was 42.6 with a standard deviation of 15.2 which, according to the Piers-Harris standardization sample, is slightly below average but within the normal range. The median was 45.5, an average score. Seven of the subjects scored in the below average range; seven scored in the average range; and two scored above average (see Table 1). These skewed results were expected considering the subjects' histories, psychodiagnoses and the stressful conditions of their life at the time of testing.

A few results on the subscales, or clusters, deserve mention. On the Behavior cluster scale the

mean score was 8.8, which corresponds to a total score of 40, which falls in the slightly below average range when compared to a standard sample. On the Anxiety cluster, the mean score was 5.5, which corresponds to a total score of 39, which falls in the below average range. On the Happiness and Satisfaction cluster, the mean score was 4.4, which corresponds to a total score of 33, which falls in the much below average range. These results are all consistent with the literature which cites behavioral disturbances, anxiety and depression as initial and long-term effects of child sexual abuse (Anderson et al., 1981; Browne & Finkelhor, 1986; DeFrancis, 1969; Tufts, 1984).

Table 1

Frequency Distribution, With Descriptors and Percentage of Sample for the Total Raw Scores on the Piers-Harris Self-Concept Scale

Descriptor	Frequency	Range of Scores	% of Sample
Slightly above average	2	63-66	12.5
Average	7	45-58	43.8
Slightly below average	2	38-41	12.5
Below average	1	33	6.0
Much below average	4	20-25	25.0

That victims of child sexual abuse perceive themselves as different from other people and feel isolated and stigmatized (Briere, 1984; Courtois, 1979;

Herman, 1981) was supported by the subjects' answers to Item #77. In response to the statement "I am different from other people, "88% of the subjects answered "yes." Whether or not the subjects' responses support the research that claims victims of child sexual abuse experience feelings of shame and guilt (Anderson et al., 1981; DeFrancis, 1969), is unclear. In response to the statement "I think bad thoughts," 62% of the subjects responded "yes." And only 42% of the subjects answered "yes" when asked "I like being the way I am." Conversely, 75% of the subjects responded "no" to item #13, "It is usually my fault when something goes wrong".

The family systems theorists and clinicians have warned against the negative effects of the removal of these children from their homes, arguing that it contributes to their victimization by exacerbating feelings of blame. (For a more in depth discussion, refer to the Treatment section in Chapter II). It would be expected, then, that the subjects in this study, having been removed from their homes, would feel guilt and responsibility for the problems in their families. The individual responses to items concerning the family support this. In response to item #14, "I cause trouble to my family, 56% answered "yes." In

response to item #17, "I am an important member of my family," only 44% answered "yes." And 62% responded affirmatively to the statement, "My family is disappointed in me."

On a positive note, the subjects scored well on the Popular cluster with scores falling in the average range with a mean of 7.5. Upon closer examination of the individual items in the cluster, some interesting results were found. In response to item #3, "It is hard for me to make friends," 75% of the subjects answered "no." In response to item #51, "I have many friends," 75% answered "yes." Only 30% responded affirmatively to the questions "I am unpopular." Thus, it appears that the a large majority of the subjects in this sample felt good about their relationships with their peers. These findings appear to contradict research findings which report that victims of incestuous relationships usually have histories of alienation and isolation from their peers. Blick and Porter (1982) offer a possible explanation for this contradiction. In their research they found that, although the girls would report they had lots of friends, when questioned further it was discovered that they only saw these friends at school. Time at home was usually spent alone, watching television. Thus, it

is possible that the contrary findings in this study could have resulted from inaccurate reports by the subjects. On the other hand, it is also possible that this sample of sexual abuse victims does, in fact, feel good about their peers; perhaps this is due to the opportunities for socialization in the group home, and at alternative schools, with girls who have backgrounds similar to their own.

In response to questions about school and intellect, the subjects also generally answered in the direction of positive self-concept. For example, in response to item #21, "I am good in my school work," 56% answered "yes." Seventy percent (70%) answered affirmatively to item #5, "I am smart." Comparably, only 12% answered "no" to item #53, "I am dumb about most things." From this small sample, it would appear that, in general, the subjects felt good about their intellect and their school performance. The overall score on the Intellectual and School Status cluster fell in the average range with a mean of 10. Nearly all of the subjects in this study were enrolled in alternative school programs which offer high staff to student ratios, one-on-one counseling, and allow students to work at their own pace. This could be one explanation for their high self-regard in this cluster.

There were also some items that in and of themselves showed unexpected results. To the statement "When I grow up I will be an important person," 68% of the subjects responded "yes." This would indicate that these subjects still have hope for their future, despite their difficult and traumatic pasts. In response to item #15, "I am strong," an overwhelming majority, 80%, answered "yes." This indicates an acknowledgement by the subjects of their survival skills, which seems an important attribute for them to hold dear considering all of the trauma and disappointment they have experienced at such an early age.

These positive findings, or strengths, are important to point out for several reasons. First, both the clinical and empirical literature on child sexual abuse tends to focus on the negative effects. No one asks, "What are the positive effects of surviving the abuse? or Is it possible that these kids have developed some common strengths from their experiences?" These questions certainly warrant a more in depth examination. Similarly, information about strengths will provide important information to clinicians and other helping professionals who work with these kids. Too often, what is "wrong" with the

child is the focus of treatment. Beginning from what is "right" with the child seems a better jumping off point.

Research Questions

Before an in depth look at the results of each research question, the data which was collected in order to answer the questions will be presented; these variables include success (whether or not the subject graduated from the treatment program), months involved in the juvenile court system as a ward, and the severity of abuse index.

The subjects' cause for termination from the treatment program fell into one of four categories: graduation; termination by Palomares or placing agency; voluntary termination by the subject; or running away (AWOL). This variable was important in order to examine what factors, if any, might contribute to a subject's success in treatment. Of the 16 subjects in the study, six, or 38%, were successful (graduated from the program). Of the remaining ten subjects, three were terminated by Palomares; two voluntarily terminated themselves, and four ran away.

The length of time (number of months) the subject had been involved in the juvenile court system ranged from 0 to 36 months. The mean time was 16.2 months,

with a median of 18, and a standard deviation of 11.8 (see Figure 2). It was expected that longer involvement in the system would be detrimental to self-esteem and that this might have some impact on the subjects' chances of successfully completing the treatment program.

Figure 2. Frequency distribution of months in juvenile court system

The severity of abuse index was developed based on four variables of the subjects' history of abuse: age of onset; incidents of abuse; type of abuse; and relation of the perpetrator. This data was important to determine whether the severity of the abuse the subjects had experienced previous to placement would have any impact on their self-esteem at intake or their success in the program. The onset of the abuse was divided into three age groups. One subject was first

abused as an adolescent (14 years or older). Ten of the subjects (62.5%) were first abused in late childhood or latency (7-13). The remaining five subjects (31%) were first abused in early childhood (0-6).

The number of perpetrators each subject had been victimized by ranged from 1 to more than 3. The majority of the subjects (56%) had been victimized by only one perpetrator; five of the subjects (31%) had been victimized by two perpetrators; and the remaining two (12.4%) had been victimized by three or more perpetrators.

The type of abuse was divided into three categories, based on the degree to which the child was exposed to sex and genitalia. The majority of the subjects (75%) experienced intercourse; one had experienced oral copulation; and the remaining three (19%) had experienced fondling or attempted intercourse.

The relationship of the perpetrator to the victim was also divided into three categories, based on the closeness of the relationship between them, both socially and consanguineously. One subject had been abused by a foster sibling; nine of the subjects (56%)

were abused by a blood relative, stepfather or mother of boyfriend; and the remaining six subjects (37.5%) were abused by their natural fathers.

All of the information collected regarding the subjects' sexual abuse history was combined in the severity of abuse index, with possible values ranging from 0 to 12. The actual values for the 16 subjects ranged from 5 to 12, with a mean of 8.6, a median of 9 and a standard deviation of 1.74 (see Figure 3).

Figure 3. Frequency distributions of severity of abuse index scores

Research Questions #1. That child sexual abuse has a negative effect on self-concept is supported by the literature (Bagley & Ramsay, 1985; Courtois, 1979; Herman, 1981; Russell, 1986; Sgroi, 1982).

This investigator wanted to know if the degree to which the self-concept was damaged correlated with the severity of the abuse. This was determined by computing a Spearman rank order correlation between the scores of each of the 16 subjects on the Piers-Harris Scale and the severity of abuse index. The data on these two variables, and their ranks, are presented in Table 2. At the $p \geq .05$ level, no correlation was found.

It is possible that there are too many other variables which influence the self-esteem of child abuse victims to effectively measure any correlation of these two variables in isolation. Additionally, comparison between subjects may not have been an effective method. Measuring and comparing the degree of damage to self-esteem following sexual abuse and over time for each subject would provide a clearer indication of whether there is any correlation between the severity of the abuse and damage to self-esteem. Collecting this kind of information, however, is most likely impossible, and was certainly unattainable by this investigator.

Table 2

Piers-Harris (P-H) and Severity of Abuse Index
Scores with Corresponding Ranks

Subject	P-H Score	Severity Index	Rank P-H	Rank Sev Indx
1	41	10	7	13
2	20	9	1.5	9.5
3	58	7	14	3
4	46	9	9.5	9.5
5	56	12	13	16
6	38	11	6	15
7	22	8	3	6
8	25	8	4	6
9	33	10	5	13
10	63	7	15	3
11	46	7	9.5	3
12	50	9	11	9.5
13	20	9	1.5	9.5
14	66	8	16	6
15	53	5	12	1
16	45	10	8	13

Research Questions #2. Browne & Finkelhor (1986), in a review of the literature, found only one study that examined the effect to victims of being removed from their homes. This issue was addressed in this study by asking whether the subjects' self-esteem had been affected by their involvement in the juvenile justice system. It was thought that longer involvement in the system would be detrimental to self-esteem because of the punishment aspect of being separated from their families (blaming the

victim) and because of the multiple placement failures the subjects had experienced. This was determined by computing a Spearman rank correlation between the scores of each of the 16 subjects on the Piers-Harris and the number of months the subject had been in placement. The data on these two variables, and their ranks are presented in Table 3. No correlation was found at the $P \geq .05$ level.

Table 3

Piers-Harris Scores and Months Involved in Juvenile Court System as a Ward

Subject	P-H Score	Months in JCS	Rank P-H	Rank JCS
1	41	24	7	12.5
2	20	6	1.5	4.5
3	58	0	14	1.5
4	46	2	9.5	3
5	56	0	13	1.5
6	38	12	6	6.5
7	22	36	3	15.5
8	25	6	4	4.5
9	33	18	5	9.5
10	63	18	15	9.5
11	46	18	9.5	9.5
12	50	12	11	6.5
13	20	30	1.5	14
14	66	18	16	9.5
15	53	24	12	12.5
16	45	36	8	15.5

These findings could indicate that longer involvement in the juvenile court system does not further damage a child's self-esteem, but such a conclusion seems inappropriate considering the

problems inherent in the methodology. First, it should be kept in mind that the sample size was very small. Additionally, comparison between the subjects may not have been an effective method of measuring the correlation. Baseline data on the subjects' self-esteem before their involvement in the juvenile court system may have provided more insight into the system's effect on self-esteem. Although this was outside the scope of the this study, the question is an important one for future research. A comparison study with a control group of victims who are involved with the system but have not been separated from their families might produce more significant results. Longitudinal studies which track the course of a child's self-esteem from intake into the system to return home or emancipation would also provide important information on the effects the juvenile court system has on its wards.

Research Questions #3, 4, and 5. Wilgus and Epstein (1978) comment on the lack of literature available on the effectiveness of group home placement. Several research questions were asked in this study to address this issue. First, it was investigated whether a subject's self-esteem at intake to the treatment program would predict

successful completion of the treatment program. It was suspected that the better a subject felt about herself, the better would be her chances of success. A Mann-Whitney U Test found nonsignificant differences in self-esteem between the group of dropouts and the group of graduates. The results can be seen in Table 4.

Table 4

A Comparison of Piers-Harris Scores (Self-Esteem)
Between Graduates and Drop Outs of the Treatment
Program

	Graduates	Drop-Outs			
N	6	10			
Mean	40.500	43.900	t=0.422	df=14	P<0.6790
S.D.	14.502	16.155	U= 27.5	Exact	P<0.7925
Mean Rank	8.083	8.75	Z=0.272		P<0.7860

Whether the severity of the abuse experienced by the subject previous to placement could predict successful completion of the program was also investigated. The mean severity of abuse index was 9 for those subjects who graduated; it was 8.5 for those who did not. Again, a Mann-Whitney U Test showed no significant differences between the two groups. These results can be seen in Table 5.

Statistically significant results were found when the length of time the adolescent had been involved in the juvenile court system was used as a predictor of successful completion of the treatment program. The mean number of months in the system for those subjects who graduated from the program was 12.8; whereas the mean number of months for those subjects who "dropped out" (terminated or runaway) was 4.0. The Mann-Whitney U test found this difference significant at $P \geq .05$ level, as shown in Table 6. These results indicate that girls who have been in a number of placements previous to Palomares will have a greater chance of success than those who are new to the juvenile court system, or just recently removed from their homes. This could be important information for the system that places these children, for Palomares in assessing its program and for the staff at Palomares involved in making decisions about intakes. However, the limitations in methodology should be noted here. The significant results could have been influenced by the small sample size. In this case, any generalization to other groups or this clinical population in general must be made carefully and tentatively.

Table 5

Severity of Abuse Previous to Placement as a Predictor
of Success in the Treatment Program

	Graduates	Drop-Outs			
N	6	10			
Mean	9.000	8.500	t=0.543	df=14	P<0.5955
S.D.	1.673	1.841	U= 27.5	Exact	P<0.7925
Mean Rank	8.917	8.250	Z=3.103		P<0.7828

Table 6

Number of Months Involved in the Juvenile Court System
as a Predictor of Success in the Treatment Program

	Graduates	Drop-Outs			
N	6	10			
Mean	12.833	4.025	t=5.622	df=14	P<0.0001
S.D.	2.787	3.163	U= 1.5	Exact	P<0.0005
Mean Rank	13.250	5.650	Z=3.103		P<0.0019

One possible explanation for these findings is that the treatment at Palomares may be at a level of intensity that is not necessary for youth who are new to the system. Foster homes or less structured group homes may be more appropriate alternatives. On the other hand, it could be that youth who have been involved with the juvenile court system and who have experienced a string of other out-of-home placements may "know the ropes." They may be more familiar with what it takes to succeed in a program or perhaps they

have just learned how to better manipulate the system. And it could be that they are more motivated to succeed so that they can get out of the system altogether.

Research Questions #6. It was an original goal of this study to investigate whether the Palomares program was effective in increasing the self-esteem of the population of youth it is designed to help. Unfortunately, only seven of the 16 subjects stayed in placement long enough to be re-tested at the 6 month mark. With this small sample, however, some exciting results were found. The mean total raw score on the Piers-Harris for the seven subjects at intake was 39.4. After 6 months of treatment the mean rose to 49.7. A Kruskal-Wallis One-Way Analysis of Variance found this difference approached significance at the .05 level ($P \leq .07$) as shown in Table 7. A breakdown of the mean scores on each cluster scale before and after treatment is shown in Table 8.

Table 7

Increase in Piers-Harris Scores (Self-Esteem) after 6 Months of Treatment

	N	Mean	S.D. Diff	T (P-Val)
After	7	49.714	12.539	2.17 (.0732)
Before		39.429		

Table 8

Mean Scores On Each of the Cluster Scales of the
Piers-Harris Before and After Treatment

Cluster Scale		Mean Before Treatment	Mean After Treatment
I.	Behavior	9.429	12.0
II.	Intellect/School	9.429	10.714
III.	Physical Appear.	5.857	7.714
IV.	Anxiety	4.857	7.429
V.	Popularity	6.571	8.286
VI.	Happiness	3.286	6.286

The results suggest that in all areas of self-esteem, the subjects felt better about themselves after 6 months of treatment at Palomares Group Home. Whether these results are directly attributable to the treatment program, however, cannot be answered without a control group for comparison.

CHAPTER V

SUMMARY

The study presented in this thesis grew out of professional experiences with victims of child sexual abuse and a frustration with the "system" that is set up to help them. It is a system that is overburdened, staffed with professionals who are overworked and underpaid, attempting to provide support and treatment to thousands of kids and their families, many times without the resources or the knowledge to enable them to do so. Russell (1986) has cautioned that any prevention or therapeutic strategies to combat the problem "must be based on sound knowledge of the true nature of incestuous abuse" (p.387). And yet, Browne & Finkelhor (1986) remind us that our knowledge about child sexual abuse is based on a "body of research that is still in its infancy" (p. 75).

This study endeavored to examine the effectiveness of one residential treatment program that provides services to troubled teenagers who are part of this system. Regardless of their good intentions, group homes are treatment programs in which, for the most part, the clients are ordered to participate. Group home beds are filled by children who do not have the

power, or the right, to go elsewhere for help if they are not satisfied with the services provided. The taxpayer pays the bill and the State licenses the homes; and yet, assessments of the effectiveness of these programs are rarely made.

With this in mind, the study presented in this thesis asked six questions. Three of the questions addressed the issue of self-esteem. The first of these asked whether the severity of the sexual abuse had any correlation with self-esteem at intake to the program. The second asked whether the length of time the adolescent had been involved with the juvenile court system had any correlation with self-esteem. The last asked whether self-esteem was a predictor of success in the program. The data demonstrated no statistically significant correlations for any of these three. Problems with methodology, in particular the lack of a control group, were explained as a possible contributor to these results.

Two additional research questions addressed possible predictors of success in the group home program: severity of the abuse experienced previous to placement and the length of time the adolescent had been involved in the juvenile court system. No correlation was found when the severity of the abuse

was examined; however, some surprising results were found when the length of time in the system was considered. It was discovered that the longer the girl had been involved in the system, the better her chances were for success in treatment. It was hypothesized that the level of treatment in this particular program was probably too intense for those who were new to the system; the jump from a home environment to a highly structured and controlled environment may have been too much for them. Additionally, it was concluded that the more seasoned veterans of the system had "learned the ropes" and so were more familiar with what it would take to succeed, and were probably more motivated to do so because of their lengthy involvement in the system. They may also have had more insight into their problems and been more "ready for therapy."

The last research question addressed whether the program was actually helping: Was the treatment effective? The results were clear, at least in regard to self-esteem, that the subjects in the study showed marked improvement after only 6 months of treatment. These were exciting findings for the program, and for the girls, who were shown their individual profiles after the 6 month re-test. The graphic illustrations of their individual results provided tangible proof

that all of their effort had paid off (see Appendix C, Subject Profile Forms). The small sample size, however, must be taken into consideration here. Further research is indicated to substantiate these preliminary findings on the effectiveness of the Palomares treatment program.

Making the System Work

A review of the literature clearly indicates a correlation between child sexual abuse, juvenile delinquency and runaway behavior. Such a correlation makes sense when we look at the long list of effects the abuse has on its victims, such as behavior disturbances, defiance, substance abuse, difficulty in school, low self-esteem, aggression and hostility. And yet, the California Youth Authority does not seem to be interested in any correlation between criminal behavior among adolescents and child sexual abuse. Instead, research money is put into correction and punishment.

California incarcerates youngsters at a rate of 430 per 10,000 juveniles, which is twice the national average. Politicians, and professionals in the corrections field, have responded to this alarming fact by calling for the construction of more jails (Watson, 1989), rather than asking why our teenagers are acting out criminally and violently. It is

apparent that research is needed for a closer examination of the juvenile court system and its subsidiaries. This research would provide critical information and insight into teenage delinquent behavior, its precipitating factors and effective treatment and/or correction measures. For example, James (1977) conducted a research endeavor that spanned a three year period in one juvenile correction institution in the state of Washington. She found that about 12% of the female residents presented a traumatic incest relationship as one of the precipitating factors of their delinquency. The teenagers shared some behaviors and presenting problems, such as runaway, low tolerance to self-disclosure, deprecating statements about themselves, and sexually provocative behavior around males. Group treatment during incarceration proved successful in helping the victims in alleviating the fear, anger, guilt and shame which had contributed to their acting out behaviors. More studies like this one are needed. Longitudinal follow-ups should also be mandated.

It is a sad commentary on our society that victims of child sexual abuse are sitting behind bars in correction facilities and warehoused in children's shelters. Another group of these children and

adolescents is on the streets, and yet another group remain in their homes, subjected to further abuse because the system has failed to protect them. Perhaps the system failed because there was too much paperwork, not enough staff, because someone exercised poor judgment or just didn't know any better (Fontana, 1984). Perhaps the system failed because the government refused to provide adequate funding for mental health programs to meet the needs of it's clients.

Failures in the system must be addressed. Greene (1977) argues for more thorough documentation in juvenile court reports. Difficulties in data collection that arose in the study presented in this thesis support Greene's recommendations. Additionally, better training for professionals involved with the victims of child sexual abuse must be a priority. A systematized training program may best meet this challenge. Certainly, more money is needed for social programs, to meet the needs outlined above and to offer better salaries for social workers, so as to attract the more talented and experienced professionals. We should insist on only the best care for our children.

Investing money for the treatment of victims as children and adolescents may save money in the long run. To achieve this result, however, would dictate that the treatment be effective. The review of the literature seems to imply that it is not. A large number of child victims of sexual abuse end up in the mental health system as adults. How many of them end up in jail? How many of them end up on welfare? How many of them end up marrying men who abuse them and their children, perpetuating the cycle? -

These questions are important ones for educators, judges, probation officers, law enforcement officers, social workers, physicians, therapists, counselors and child care workers. But they should be important to every American. Research is needed to critically examine the programs and institutions that are currently housing and warehousing hundreds and thousands of victims of sexual abuse each year.

Most of the current social programs addressing the issue of child sexual abuse seem to employ short-term strategies. Society must begin to consider the long term consequences of such a short-sighted perspective. True social change and a cost effective system will only come with a strategy which considers the results in the long run.

Prevention

Cohn (1986) argues that prevention efforts in child sexual abuse should focus on potential perpetrators and on the cultural and societal values that allow the problem to persist. Gilgun and Gordon (1985) have suggested sex education for the offenders. They assert that the current focus on what children can do to prevent child sexual abuse overlooks the power of the offender in determining whether the abuse takes place. They recommend a program for offenders that addresses the issues of self-esteem, human equality, caring, masturbation, sexual thoughts and fantasies. Gilgun (1986) also recommends sex education and sex abuse education, but for the victims and potential victims. She found in interviews with sexually abused females that most had received little or no information from parents or the schools on these matters. Kraizer (1986) contends that programs aimed at child sexual abuse prevention must have a developmentally appropriate approach that emphasizes the difference between concept and action so that they help to make children responsible and confident without taking away their right to grow up without being afraid or anxious. Horowitz (1985) urges educators to back legislation requiring teachers and other child care workers to have

their fingerprints taken and to pass polygraph tests. Fewster and Bagley (1986) also advocate a school-based strategy for detection and prevention, to include screening instruments and child abuse curriculum.

More important than any program or legislation, however, is the need for society to change the manner in which men are socialized. Finkelhor (1986) suggests how we might accomplish this. Men must practice affection and dependency in relationships that do not involve sex, such as male-to-male friendships and nurturing interactions with children. The accomplishment of heterosexual sex must be deemphasized as the ultimate criterion of male adequacy. Men must learn to enjoy sexual relationships based on equality so they will feel comfortable relating to women at the same level of maturity and competence and will be less likely to exploit children sexually. Lastly, he advocates men take a more active, equal role in the care of our children.

Diane Russell (1984) sums it all up:

If this culture considered it unmasculine for men to want sexual or romantic relationships with partners who are not their equals--partners who are younger, more innocent, vulnerable, less powerful, deferential, and uncritical--then the prevalence of child sexual abuse would also be likely to decline (p. 290).

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APPENDICES

APPENDIX A.

SUBJECT VITA

SUBJECT # _____ DOB: _____ DOP: _____ DOT: _____
 Length of placement: _____ Date tested: _____ Re-tested: _____

Age: _____ Race: _____ Legal Status: _____

Referral Agency: _____

Diagnosis: _____

ABUSE INDEX DATA

<u>Variable</u>	<u>Code</u>
Incidents of sexual abuse: _____	_____
Age when abuses first occurred: 1 _____	
2 _____	
3 _____	
4 _____	_____
Relation of perpetrator: 1 _____	
2 _____	
3 _____	
4 _____	_____
Type of abuse: 1 _____	
2 _____	
3 _____	
4 _____	_____

Total = _____
 (Severity of Abuse Indx)

Placement History:

Length of time in the system: _____
 Age at first placement: _____
 # of placements: _____
 Psychiatric hospitalizations: _____

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