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Children's Services Practice Notes is a newsletter for North Carolina's child welfare workers produced four times a year by the North Carolina Division of Social Services and the N.C. Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!

If you would like to comment about something that appears in this or any other issue of *Children's Services Practice Notes*, please do so! Address your comments to:

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CHILD SEXUAL ABUSE AND CHILD WELFARE

If you work in child welfare, child sexual abuse affects you. This is obvious if you work in child protective services, but it is equally true for those who work in adoptions, licensing, and other areas. In this profession the dark, unsettling influence of sexual abuse cannot be escaped.

Nor should it be. As social workers and caring members of our communities, we are committed to preventing child sexual abuse. When it occurs we

face it head on, doing what we can to help survivors and their families heal. To do this effectively we need to understand as much about sexual abuse as we can.

To support you in this effort, this issue of *Practice Notes* looks at child sexual abuse—at its effects on survivors and their communities, at assessment and treatment approaches, and at the way it affects child welfare workers both on and off the job. ♦

THE EFFECTS OF SEXUAL ABUSE

Volumes have been written on the topic of sexual abuse, analyzing it from every angle. When one reads what has been written, perhaps the most striking thing about it is its power to disrupt lives: a single abusive act disrupts not just the life of a child, but dozens of lives. If we are to reduce and repair the damage done by sexual abuse, we must truly understand how sexual abuse affects children and birth, foster, and adoptive families.

THE SURVIVOR

The impact of sexual abuse on children can be devastating and long-lasting. Because children are often victimized by someone they should be able to trust and depend on, they may not realize that the abuse is wrong and not their fault. According to Faulkner (1996), sexually-abused children report feeling that something is wrong with them, that the abuse is their own fault, and that they

should blame themselves for the abuse. Many children encounter disbelief or dismissal when they report abuse because adults do not wish to acknowledge that abuse is occurring. Consequently, victims may feel inadequate, ashamed, isolated, guilty, and powerless (Faulkner, 1996). For these reasons, many people suppress what they perceive as a shameful secret until later in life.

Even after much time has passed, the effects of sexual abuse are powerful. Finkelhor and Browne (1986) found the long-term effects of maltreatment to include poor self-esteem, difficulty trusting others, anxiety, feelings of isolation and stigma, depression, self-destructive tendencies, sexual maladjustment, and substance abuse. **cont. p. 2**



Sexual abuse can undermine the trust that is the basis of family bonds.

THE EFFECTS OF SEXUAL ABUSE from page 1

In 1998, Hughes and colleagues published the results of a study of 18 adult women who reported sexual abuse prior to age 12. These women revealed that they suffered from low rates of secondary

school completion, long-term mistrust of others, illness, depression, dissociation, sleep problems, self-injury and self-mutilation, eating disorders, agoraphobia, and painful memories (Hughes, et al., 1998). These findings affirm what other researchers have found: a clear link between a history of child sexual abuse and higher rates in adult life of depression, anxiety, substance abuse, eating disorders, and post traumatic stress disorder (Mullen & Fleming, 1998).

The negative effects of incest, the most common form of sexual abuse, can be compounded by the reactions of parents, siblings, and other important people in the child's life. For example,

Evidence suggests maternal support is critical for a child's short and long term recovery from sexual abuse.

siblings of the survivor may blame the abused child, not the abuser, either because they believe the perpetrator's denials or simply because of what reporting the abuser has done to the family. And when a child wonders if her mother knew about the abuse but did nothing to stop it, she can lose trust in both parents, not just one (Sheinberg & Fraenkel, 1998).

THE SURVIVOR'S FAMILY

When a child is reported to have been sexually abused by a family member, the whole family is affected. Often family members feel they must choose whom to side with and whom to blame. Meanwhile the family is flooded with shame and invaded by police and social workers.

While this is necessary for the safety of children, social workers must do what they can to support the bonds among all family members, particularly

between siblings and between a nonoffending parent and the children.

This can be a challenge. Societal norms and expectations about the responsibility mothers bear for what happens inside their homes influence us tremendously. The degree to which our cultural values may lead us to blame nonoffending mothers "is exemplified by the findings of Dietz and Craft (1980), who reported that most social workers believed that mothers are as responsible for the sexual abuse as the offender, despite the fact that 78 percent of the mothers in their study were being physically abused by the same offender who abused the child" (Massat & Lundy, 1998).

Yet emerging research indicates that we need to support mothers more, if only for the children's sake (Corcoran, 1998). Some research has shown that a child's ability to recover from sexual abuse may be influenced by the support she receives from the nonoffending parent. Adams-Tucker (1982) and others suggest that a parent's failure to believe and support a child who reports abuse may compound a child's feelings of betrayal and isolation. Conversely, evidence is growing that maternal support is critical for a child's recovery for both the short and long term (Corcoran, 1998).

Nonoffending parents need support. Often they are in a state of shock, because their child has been sexually abused, and strained by their efforts to decide whether to report the abuse.

And as soon as they make it known what their spouses or significant others have done, the relationship between these mothers and the rest of the world changes. In their 1998 article, Massat and Lundy explored the "costs" of reporting sexual abuse for 104 nonoffending parents. They found these parents faced many issues as a direct result of reporting incest, including problems with family members (54%), a de-

NATIONAL AND NORTH CAROLINA SEXUAL ABUSE DATA

- In 1991, the National Child Abuse and Neglect Data System (NCANDS) reported 129,697 substantiated and indicated child victims of sexual abuse.
- An estimate of actual cases of child sexual abuse per year in the U.S. is 250,000 to 300,000.
- Between 6 and 62 percent of women report being sexually abused as children (Wylie). Finkelhor's study found that 27 percent of women reported being abused.
- Between 3 and 24 percent of men report being sexually abused (Wylie). Finkelhor's study found 16 percent of men reported sexual abuse.
- The median age of abuse was 9.9 years for boys and 9.6 years for girls.
- Some studies indicate that girls are far more likely than boys to be victims of sexual abuse; in 1997, 76.6 percent of sexually-abused children were female (USDHHS, 1997). However, boys may be victimized nearly as often as girls, but may not be as likely to disclose the abuse.
- In 1997-98 there were 1,453 substantiated child sexual abuse cases in North Carolina.

Guidelines for the evaluation of sexual abuse of children: Subject review. (1999, January). *Pediatrics*, 103(1), 186-192.

National Resource Center on Child Sexual Abuse. (1994, June). *Statistics in child sexual abuse*. Huntsville, AL: Author.

North Carolina Department of Health and Human Services, Division of Social Services. (1999). *Central registry reports of child abuse, neglect, and dependency*. Raleigh, NC: Author.

Sinal, S. H. (1994, December). Sexual abuse of children and adolescents. *Southern Medical Journal*, 87(12), 1242-1259.

United States Department of Health and Human Services. (1997). *Child maltreatment 1997: Reports from states to the national child abuse and neglect data system*. Washington, DC: Author.

cline in income (55%), difficulty with their job (26%) or having to find a new job (26%), and having to find a new place to live (50%).

These mothers may lack the emotional resources and support systems needed to deal with these challenges. Indeed, to protect the child's privacy, mothers may decide not to rely on the support networks they do have, let alone reach out to establish new ones (Corcoran, 1998). All of this underscores the importance of understanding each family's needs and connecting them to formal and informal supports and concrete services whenever possible.

THE OFFENDER

The fathers, uncles, and other family members who sexually abuse children are affected by the abuse, too. Most of them live double lives: one as an upstanding family man, one as an obsessed, self-loathing sex offender.

Regardless of how we feel about them, incest perpetrators are still very important to the families they have betrayed. In psychological terms they are still "central attachments" for the family. As such, the family is certain to have contradictory, confused feelings about these men.

To help children and their families heal and prevent future maltreatment, it is important that social workers try to ensure that offenders receive treatment from experienced, trained therapists.

An important part of many treatment programs for sexual offenders are "apology sessions." In this phase of treatment the offender writes a letter to his victim and then, in the presence of the therapist, the child, and the rest of the family he reads it aloud, assuring the child that the abuse was entirely his fault and that he is sorry for what he has done (Wylie, 1998). This clarification from the person who has harmed them can be help-

ful to children struggling to come to terms with sexual abuse and the relationships it has damaged.

FOSTER & ADOPTIVE PARENTS

Foster and adoptive parents are also affected when a child is sexually abused. Down the line they must care for children in emotional turmoil because of the abuse and the disruption of their families. To do this effectively, parents must learn everything they can about the short and long term effects of sexual abuse.

A particular challenge for many families is learning how to cope with children's sexualized language and behavior. Parenting children who have been sexually abused requires knowledge about setting boundaries (e.g., about touching) and special understanding when it comes to certain behaviors, such as a child's need to masturbate.

To succeed in establishing a solid foundation with a child who has been sexually abused, foster and adoptive parents must help the child reconcile her past and present lives. As Fahlberg (1991) explains, "The success of a new relationship isn't dependent upon the memory of an earlier one fading; rather, the new one is likely to prosper when the two re-

lationships are kept clear and distinct." Helping a child build a life book is one way for foster and adoptive parents to help a child make sense of her past.

Therefore foster and adoptive parents must support birth parent-child ties. To make this possible, they may want to adopt the policy of Brenda Crider, a North Carolina foster parent. "I never run parents down to their kids," she says. "When these kids know you accept their parents, regardless of what they've done, the kids are easier to deal with. This makes sense. Kids are looking for approval, and if you disapprove of their parents then they think you disapprove of them, too" (Crider, 1998). ♦

References

- Corcoran, J. (1998). In defense of mothers of sexual abuse victims. *Families in Society*, 79(4), 358-369.
- Crider, B. (1998). Working with birth parents. *Fostering Perspectives*, 3(2), 16.
- Faulkner, N. (1996). Pandora's box: The secrecy of child sexual abuse. *Sexual Counseling Digest*, pp. 1-3.
- Fahlberg, V. I. (1991). *A child's journey through placement*. Indianapolis, IN: Perspectives Press.
- Finkelhor, D. & Browne, A. (1986). Impact of child sexual abuse: a review of the research. *Psychological Bulletin*, 99, 66-77.
- Hughes, K., Stephens, H., DiFranco, A., Manning, L., van der Toorn, N., North, C., & Taylor, M. (1998). *The health impacts on adult women of childhood sexual violence before the age of twelve years*. Ipswich Sexual Assault Service: Ipswich, Queensland, Australia.
- Massat, C. R. & Lundy, M. (1998). "Reporting costs" to nonoffending parents in cases of intrafamilial child sexual abuse. *Child Welfare*, 78(4), 371-388.
- Mullen, P. & Fleming, J. (1998). Long-term effects of child sexual abuse. *Issues in child abuse prevention* (9). Australia: Nat'l Child Protection Clearing House.
- Osmond, M., Durham, D., Leggett, A., & Keating, J. (1998). *Treating the aftermath of sexual abuse: A handbook for working with children in care*. Washington D.C.: Child Welfare League of America.
- Sheinberg, M. & Faenkel, P. (1998). Loyalty divided: Ambivalence haunts the victims of sexual abuse. *Family Therapy Networker*, 23(3), 63-78.
- Wylie, M. S. (1998). Secret lives. *Family Networker*, 22(6), 39-59.

INTERVENTION POINTS

- Make it clear to children their concerns are valid and that they will be believed. Help them understand that abuse is wrong and is never their fault.
- Allow children to say and feel positive things about the offender. Children must understand that they do not have to conceal their feelings to remain attached to protective, caring adults (Sheinberg, 1998).
- Offer concrete support to nonoffending parents. Due to the upheaval caused by sexual abuse, its revelation, and the investigation, they may need special help connecting with people and agencies that can support them.
- Connect family members to therapy. Often abused children feel isolated; therefore group therapy with children who have had similar experiences can be particularly effective (Osmond, 1998).
- Be aware of your own reactions to the offender, his or her victim, and other family members (see pages 6-8).
- Get additional information on this topic. Social workers should attend training sponsored by the Division of Social Services. MAPP-certified trainers should consider attending "Fostering and Adopting the Child Who Has Been Sexually Abused," a four day train-the-trainer event that teaches participants to help parents of children facing the double trauma of sexual abuse and placement. See page 47 of the Division's summer/fall 2000 training calendar for more information.

ASSESSING AND TREATING CHILD SEXUAL ABUSE

Working with cases involving child sexual abuse is demanding. Often, the temptation is to respond to children only with compassion. However, to address a problem as complex as sexual abuse, one must do more than care deeply.

To effectively address the needs of the child and the family involved in child sexual abuse, you must be motivated by your heart, but work from your head. You must evaluate your own capacity to deal with such a case (see pages 6–8), educate yourself about the impact of sexual abuse, and understand the treatment process. Following these steps will enable you to make a difference for children and families affected by sexual abuse.

PREPARING YOURSELF

Before you can adequately assess or treat children who have been sexually abused, it is important to have a solid grasp of how and why sexual abuse happens, the typical effects of abuse on children, and the child behavior and relationship problems caused by abuse (Osmond, et al., 1998). For this it may be helpful to review “normal” childhood development so that you can contrast it with the developmental problems often seen in children who have experienced abuse (Osmond, et al.).

Before developing a treatment plan, it is important to have an understanding of why sexual abuse occurred in the particular case under investigation (Faller, 1993). This background will help you make comprehensive assessments of the child’s situation and needs for help.

A good resource for developing your knowledge on these topics is “Introduction to Child Sexual Abuse,” a six-day intensive training session sponsored by the N.C. Division of Social Services Children’s Services Section. In addition to exploring how and why child sexual abuse occurs, “Introduction to Child Sexual Abuse” teaches you how to prevent burnout, interview children and adults about sexual abuse, and conduct a child sexual abuse case according to policy and best practice. For class times and registration information, see your agency’s current staff development calendar.

ASSESSING TRAUMA

Trauma assessment is the process used to understand the impact of sexual abuse on a child and the extent of the damage. It helps you gauge the child’s perceptions of the damage from the past and current impact of the abuse, and anticipates future impact (Osmond, et al.). It is not therapy, however. Trauma assessment does not attempt to “solve” problems, but rather to recognize the impact of abuse, un-

derstand the damage, and contemplate the treatment work needed (Osmond, et al.). Assessment is your “road map” for treatment (Osmond, et al.).

Your assessment must consist of age-appropriate, established questions. Assessment is not a checklist or a survey, however. Rather, it is a guide to elicit the impact of the abuse on the child—from the child’s perspective as well as your own. Because of its informal format, it will help you build rapport with the child as you gather crucial information (Osmond, et al.). It is important to keep in mind the following issues while performing the assessment, as they will influence your treatment decisions:

- What is the relationship of the child to the abuser?
- How stable is the family?
- Are alternative support systems available? (Beutler et al., 1994)
- What are the risk factors?
- Should the child remain with the family?
- Do the courts have a role in the case?
- Is there a question of visitation?

Finally, to formulate a relevant treatment plan, the assessment must evaluate all developmental issues, appraise social areas (e.g., self-understanding, self-esteem, perceptions of the family), and assess behavior according to **cont. page 5**



The sexual abuse children have experienced is not their total existence: there are other parts of their lives.

PRACTICE TIPS

1. Be aware of your own personal reactions towards victims, perpetrators, and the families.
2. Have a solid grasp of how and why sexual abuse happens, typical effects of abuse on children, and the child behavior and relationship problems caused by sexual abuse.
3. Remember that children who have been sexually abused are not all alike, and so will not benefit from a “one-size-fits-all” approach to treatment.
4. Build rapport with the child while conducting your assessment.
5. Develop and maintain your knowledge of the treatment options available in your community and in the state.
6. Realize that the sexual abuse children have experienced is not their total existence: there are other parts of their lives as well. They do not want to focus exclusively on the abuse.

TREATMENTS

Following are approaches to treating child survivors of sexual abuse. Regardless of the mode of treatment, strengthening the relationship between the child and the nonoffending parent is critical for the child's recovery for both the short and long term (Corcoran, 1998).

Individual psychotherapy: covers a range of activities including play therapy, cognitive/behavioral therapy, expressive therapies, bibliotherapy, and psychopharmacology.

Group therapy: allows children to confront and work through experiences with a group of peers struggling with the same issues. This is powerful in the healing process, because the sexually abused child feels isolated from her peers. Sharing the experience in a group format can lessen this loneliness (Osmond, et al.).

Family intervention: because of the problems they often face, supporting abusing families must not be done alone, but through a treatment team consisting of a therapeutic caregiver, family therapist, co-therapist, clinical supervisor, and the child's therapist.

According to Hepworth and colleagues (1997), family intervention must strengthen marital coalitions, help family members define clear roles that do not blur generational boundaries, define inappropriate sexual behavior, and clarify the responsibilities of family members so they can keep within acceptable boundaries.

In cases of extra-familial abuse, the issues differ. Here it is critical to address the family's failure to protect the child, as well as survivor support to help the family avoid viewing the child as somehow "damaged" by her exposure to sexual abuse (Osmond, et al.).

Out-of-home placement: Family-based foster care provides the child a rich opportunity for observing and participating in a non-abusive family setting where relationships are not based on the commodity of sexuality. Residential therapy provides an out-of-home care environment where ordinary living experiences become vehicles for planned change.

what is developmentally "normal" (Carnes et al., 1998). Treatment based on a this assessment will address the child's needs one at a time (Osmond, et al.).

TREATING SURVIVORS

Sexually abused children are not a homogeneous group requiring identical treatment (Beutler, et al., 1994). Because the consequences of child sexual abuse vary widely in severity, duration, and form, it is unlikely a single treatment program will be suited to all children (Beutler et al.).

Treatment is the process of helping the child learn to distinguish between his healthy and destructive coping skills. With help, he can maximize strengths and actively change destructive or ineffective coping behavior (Osmond, et al.). Selecting the form(s) of treatment will depend upon the goals for the child developed from your assessment, the match between the goal and service being considered, and the child's preference and likelihood of participating in and benefiting from the treatment being offered (Osmond, et al.). Ideally, effective treatment will lessen the severity of intense symptoms and guard against delayed onset of emotional disorders (Beutler et al.). According to Osmond and colleagues, treatment goals involve:

- Providing a safe release of feelings
- Overcoming negative and potentially self-destructive behavior
- Helping the child understand what part of his thinking has been affected by the abuse and helping him correct those distortions
- Helping the child overcome self-blame and self-hatred
- Helping the child build a sense of trust in himself and in a positive future
- Enabling the child to gain a sense of perspective about the abuse and to gain the emotional distance

necessary to keep the trauma from hurting him in the future

- Supporting the child as he comes to terms with his own sexuality, including good feelings surrounding sexual behaviors and the ability to discriminate healthy sexuality from abuse

These goals can be met in a variety of ways. Typical treatment methods are individual therapy, group therapy, family intervention, and out-of-home placement (see sidebar).

Treatment of child sexual abuse is a complex process. Emotionally, it challenges you to remain objective amidst a highly charged case. Intellectually, it demands that you understand the impacts of abuse on the child and family, as well as the possible sources of the problem. Practically, it requires you to collaborate with a variety of professionals and clients in your efforts to do what's best for the child.

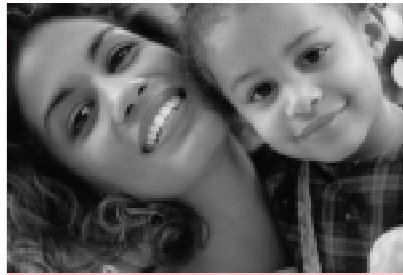
However, if you meet the challenge, you will give back hope and a future to a child scarred by sexual abuse. ♦

References

- Barrett, O. W., Miller-Perrin, C. L., & Perrin, R. D. (1997). *Family violence across the lifespan*. Thousand Oaks: Sage Publications.
- Beutler, L. E., Williams, R. E., & Zetzer, H. A. (1994). Efficacy of treatment for victims of child sexual abuse. *The Future of Children: Sexual Abuse of Children* 4(2), 156–175.
- Carres, C. N., Wilson, C., & Nelson-Gardell, D. (1998). *Extended forensic evaluation when sexual abuse is suspected: A model and preliminary data*. [On-line]. <<http://www.ncac-hsv-org/foreval.html>> [1999, Nov. 20].
- Corcoran, J. (1998). In defense of mothers of sexual abuse victims. *Families in Society*, 79(4), 358–369.
- Faller, K. C. (1993). *Child sexual abuse: Intervention and treatment issues*. US Department of Health and Human Services, Administration on Children, Youth and Families, National Center for Child Abuse and Neglect. [On-line]. <<http://www.calib.com/nccanch/pubs/usermanuals>> [1999, Nov. 20].
- Hepworth, D., Rooney, R. H., & Larsen, J. (1997). *Direct social work practise theory and skills*. 5th Edition. Pacific Grove: Brooks Cole Publishing.
- Osmond, M., Durham, D., Leggett, A., & Keating, J. (1998). *Treating the aftermath of sexual abuse: A handbook for working with children in care*. Washington D.C.: Child Welfare League of America.

PERSONAL RESPONSES TO WORKING IN THE FIELD OF CHILD SEXUAL ABUSE

Personal reactions to child sexual abuse are to be expected. Despite professional training and education, child sexual abuse often stirs intense emotions regarding the child, the offender, and nonoffending parent. The key is to recognize these emotional reactions and prevent them from interfering with professional judgment or role performance.



Simply being a parent can significantly affect one's reaction to sexual abuse.

The enormity of sexual abuse often provokes two opposing responses—disbelief or belief with a strong desire for retribution (Faller, 1993). These are universal emotional reactions that may influence child welfare workers, other professionals, and lay persons because it is frequently difficult to comprehend that an adult could sexually abuse a child. According to Faller, “the rather universal tendencies to want to explain away or minimize the sexual abuse or to desire ‘a pound of flesh’ are also reflected in reactions specific to gender, socioeconomic and professional status, and personal experiences.”

GENDER AND SOCIOECONOMIC STATUS

Regarding the impact of gender, the issue is gender identification—in other words, seeing the offender, nonoffending parent, or child victim as “like me.” This may result in either greater empathy or greater rejection of the person of the same sex. While both female and male professionals have empathy for victims, they may be more sensitive when the victim is her/his gender and have stronger negative attitudes towards the offender (Faller, 1993).

Socioeconomic and professional status of the offender can also affect one's attitudes regarding middle or higher-income families versus lower-income families. If most professionals working in sexual abuse identify themselves as middle class, the potential for class bias may exist if professionals do not recognize over-identification as an issue. Professionals may also experience external pressures from advocates for the accused due to his or her role in the community. These issues and influences may make the already difficult job of working with a sexually abused child and her family even harder (Faller, 1993).

IMPACT OF PERSONAL EXPERIENCES

A professional who has experienced sexual abuse in childhood should address these issues in counseling, continue to be aware of countertransference issues (emotional reactions on your part that affect your work), and be alert to your own mental health needs.

While it is neither feasible nor appropriate to exclude professionals who have history of being sexually abused from child welfare work, it is vital that they recognize the warning signs that their own victimization may be impeding their work performance. Warning signs might indicate the need for additional counseling or clinical supervision. The following are potential warning signs:

- Feeling so overwhelmed by fear, anxiety, disgust, anger, or strong desires for retribution that it interferes with sound decision-making or appropriate intervention
- Experiencing flashbacks or intrusive thoughts at work
- Recalling previously repressed memories of childhood sexual abuse while working on a sexual abuse case
- Exhibiting overly punitive responses to either the perpetrator or nonoffending parent (Faller, 1993)

Simply being a parent can also significantly affect one's reaction to sexual abuse. First, parents are more aware that many situations in which children's behavior and parenting responsibilities can present risks for sexual activity (e.g., sleeping in the same bed as parents, assisting child with bathing, toileting, and teaching about anatomical gender differences). These experiences could lead to over-identification with the offender and minimization of the alleged abuse by accepting a parent's explanation of the nature of the contact.

On the other hand, child welfare workers who are parents may experience particular horror in the face of sexual abuse because they personally understand that the perpetrator has violated not only a child, but the sanctity of the parental role.

Additionally, work with sexual abuse cases can influence a professional's own parenting style. For example, it may heighten an awareness of risk for your own child being sexually abused and thereby increase suspicion towards family

DEALING WITH CONFLICTING FEELINGS IN CHILD SEXUAL ABUSE WORK

- Be aware of any personal biases
- Use supervision and consultation with colleagues in order to maintain objectivity
- Collaborate on a case whenever possible (team approach)
- Strengthen your ability to cope with stress
- Seek personal social support

members, baby-sitters, friends of the family, neighbors, childcare providers, and school personnel. Parents may also be hyper-alert to physical and behavioral indicators of sexual abuse. While concern is an appropriate and positive parental response, it is important not to jump to immediate conclusions that something terrible has happened without a considered investigation of your suspicions (Faller, 1993).

COPING WITH PERSONAL ISSUES

“The best way to prevent personal reactions from undermining the quality of professional work is to be aware of their existence” (Faller, 1993). Dealing with personal feelings in professional practice requires an awareness of typical emotions and personal reactions, followed by self-reflection. Self-talk, in which professionals remind themselves of personal biases and reactions, is recommended as a regular activity. Ultimately, professional intervention should be guided as much as possible by practice principles, policy guidelines, and research.

“The best preventive measure and remedy for burnout is collaborative work” (Faller, 1993). Working in the field of sexual abuse is stressful for many reasons: 1) the acts are terrible, they violate social norms, and they can have devastating effects on the victims; 2) cases are fraught with uncertainty—it is difficult to know if abuse occurred and difficult to determine future risk of abuse; 3) professionals might do harm while attempting to do good (retraumatization, intrusive medical exams, court testimony, and separation from family; and 4) intervention may be unsuccessful and victims are not made safe and/or offenders may not be held accountable for their actions.

All of these negative experiences can result in rage, frustration, a sense of helplessness, and then giving up. Burnout might be avoided by collaborative efforts such as working with a partner (as police often do) or working with a team that has regular staff meetings. Sharing the burden of making difficult decisions can be helpful and, as always, consultation and supervision are key.

Professional involvement with cases of sexual abuse can also have an impact on personal sexuality. To learn more about this, consult Katharine Colburn Faller’s excellent resource *Child Sexual Abuse: Intervention and Treatment Issues*, available on-line at <<http://www.calib.com/nccanch/pubs/usermanuals/sexabuse/sexabuse.pdf>>.

RESOLUTION BY PROXY

Professionals who find themselves in conflict with one another may be reflecting the intensity of feelings and conflicts

THE IMPACT OF WORKING WITH OFFENDERS

Evidence exists that therapists who work with sex offenders are significantly affected personally by their work (Farrenkopf, 1992). Over half of participants in a study had diminished hopes and expectations in working with sex offenders and felt their outlook had become more cynical and pessimistic after having seen the darker side of humans. The study survey revealed four phases of impact that resemble the trauma/grief process.

1. **Shock:** highlighted by feelings of fear and vulnerability
2. **Mission:** client empathy, non-judgmental work, and desensitization to the offenses
3. **Anger:** intolerance of offending behavior, loss of idealism
4. **Erosion:** resentment, thoughts of futility, exhaustion, and depression leading to burnout; or **Adaptation**, more detached attitude, lowering of expectations, tolerance of human dark side.

of families dealing with child sexual abuse. Families can project a range of fears onto different professionals—fear of loss, fear of suicide, and fears of abandonment can be transformed into anger and frustration with those same professionals. Different professionals on a team may identify with different family members (conflicting loyalties) and fear that a colleague may be incompetent or have the wrong idea, or wish that their particular viewpoint be accepted as the correct one. Because there is the potential for family pathology to be mirrored in the professional network, there is an increased need for open and frank discussions early on within the child welfare team where professionals feel comfortable voicing their concerns and viewpoints about a case (Bentovim et al., 1988).

There is “the need for professionals to have adequate training and supervision in working with sexuality so that feelings aroused in themselves do not become defensively blocked and inhibit sensitive work, or become projected (negatively) onto the child or perpetrator in an overtly protective or punitive way” (Bentovim, et al., 1988). ♦

References

- Bentovim, A., Elton, A., Hildebrand, J., Tranter, M., & Vizard, E. (Eds.). (1988). *Child sexual abuse within the family: Assessment and treatment*. London: Butterworth & Co.
- Faller, K. C. (1993). *Child sexual abuse: Intervention and treatment issues*. [On-line.] <www.calib.com/nccanch/pubs/usermanuals/sexabuse/sexabuse.pdf> [2000, May 2].
- Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? In Coleman, E., Dwyer, S.M., & Pallone, N.J. (Eds.), *Sex Offender Treatment: Psychological and Medical Approaches* (pp. 217–223). New York: Haworth Press.
- Hetherington, J. & Beardsall, L. (1988). Decisions and attitudes concerning child sexual abuse: Does the gender of the perpetrator make a difference to child protection professionals? *Child Abuse & Neglect*, 22(12), 1265–1283.

DO WE TREAT FEMALE SEXUAL OFFENDERS DIFFERENTLY?

Some women sexually abuse children. Although intellectually we may know this to be true, many of us find it hard to believe that a woman would harm a child in this way. Yet the impulse to give women the benefit of the doubt may affect how we conduct ourselves professionally.

In 1988, researchers Hetherington and Beardsall conducted a study to examine whether the gender of a perpetrator of child sexual abuse influenced child protection professionals. Both female and male social workers and police officers participated in the study.

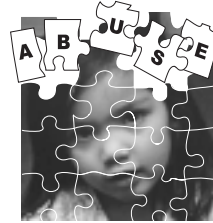
What they found was that social workers and police officers were more likely to minimize reports of child sexual abuse when the alleged perpetrator was female. Even when the abuse was substantiated, the professionals participating in the study considered it less appropriate to register the incident as a case of child sexual abuse if the perpetrator was female.

These findings suggest that child welfare agencies and individual workers should closely examine their attitudes and practices when working on cases in which alleged the sexual offender is female. ♦

References

Hetherington, J. & Beardsall, L. (1988). Decisions and attitudes concerning child sexual abuse: Does the gender of the perpetrator make a difference to child protection professionals? *Child Abuse & Neglect*, 22(12), 1265–1283.

Introduction to
CHILD SEXUAL



WANT TO KNOW MORE?

Attend “Introduction to Child Sexual Abuse Investigations,” developed by the Jordan Institute for Families and the N.C. Division of Social Services. For class times and registration information, consult your agency’s current staff development calendar.

Read *Practice Notes* online at
< <http://www.sowo.unc.edu/fcrp/Cspn/cspn.htm> >

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