CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

PROBLEMS AND TREATMENT OF INCESTUOUS CHILD ABUSE IN LOS ANGELES COUNTY

A Project submitted in partial satisfaction of the requirements for the degree of Master of Arts in Education

Educational Psychology, Counseling and Guidance

by

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ABSTRACT

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by
Joy Schary Stashower
Masters of Arts in
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This study was designed to identify and then evaluate clinics in Los Angeles claiming to offer comprehensive treatment programs for incest cases. An extensive review of the literature discussing psychodynamics and treatment of incest cases indicated that incest is symptomatic of a family's dysfunctional dynamics and that comprehensive treatment requires therapy for the entire family, including siblings. Therapy should include work with each family member in individual, conjoint, family and/or group therapy. Further required are special training for staff, caseload research, coordination of services with other social agencies, public information programs and formation of self-help
support groups. Methods used in conducting this study were informal interviews and a survey form listing treatment components sought.

Only six centers were identified and subsequently surveyed for the specified services. Results indicated that no single facility provides all treatment components. The emphasis overall is on treating the "incested" child and her mother and father at least individually. Few programs emphasize conjoint therapy for parents or family therapy. None place much emphasis on inclusion of siblings. Group therapy, while valued, occurs only as caseload's sizes permit. Funding problems, smallness of staff, and newness of program combine to block aspirations for home visits, in-depth research, special training for staff, and development of public education programs. Self-help groups, recognized as important, won't be formed until caseloads produce "graduates".

It is concluded that the movement to treat incestuous child abuse in Los Angeles is disorganized though well intentioned. Each of the six identifiable programs offers valuable if not quite comprehensive services. More emphasis needs to be put on inclusion of siblings in therapy, family therapy, group counseling, development of self-help support groups, in-depth research, and public education.
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Chapter I

INTRODUCTION

The Problem of Incest and the Purposes of This Study

The problem of incest, familial sexual abuse of children, is coming out of the closet. In the early fall of 1977, there was a television special on incest which showed viewers interviews with adults who had been victims of incest as children. In August 21, 1977, the Los Angeles Times printed an article by Barry Siegel titled Incest - An American Epidemic. The article described to readers the discovery of therapist Susan Forward that at the root of many of her female patients' pathology were their childhood incestuous experiences.

Subsequent articles, radio and television interviews served to emphasize the point that not only does incest still occur, it occurs in families from all socioeconomic levels, it occurs frequently, and it is traumatic not only to the victim but to the entire family. Therefore, it is the incestuous family on which one must focus in discussing the problem of incest. It is the family on which we in the helping professions need to focus if we are going to provide effective treatment in cases of incest.
Just as a shift in focus is necessary to provide effective treatment, so is appropriation of funding to provide the new treatment programs that are being designed. Thanks in part to the media and in part to involved professionals, our national and state legislatures have begun to address themselves to the funding of treatment programs for sexually abused children and their families. Funding is as yet minimal and is directed to development of a few pilot programs. For there to be sufficient funding there must be sufficient public support. For there to be public support there must first be a "raising of consciousness". The public, including the professional community of teachers, lawyers, physicians, therapists, police, etcetera, needs to be informed about what incest is; how, where and to whom it happens; and how we can most effectively deal with it.

The primary aim of this study is to further enhance public and professional consciousness concerning the problem of incestuous child abuse. To this end I initially review the literature which discusses incestuous child abuse, as it occurs in the context of the United States today. Second, I describe what I believe to be requisite components of an effective treatment program geared to dealing with the psychological and social needs of persons involved in cases of incest. Finally, I have conducted and reported a survey which examines some of the clinics in Los Angeles County for presence of the treatment components
described in this study, and the evaluated clinics are listed. This study is available to professionals upon request.

The study itself was twofold in that first it had to be determined which clinical facilities claim to offer services to sexually abused children and their families. Second, I needed to discover which of those clinics offer comprehensive services inclusive of the treatment components described later in this report.

There are several limitations to the scope of the study. Discussion throughout the report is limited to that of cases involving children sexually abused by caretakers or significant others; not included in the discussion are cases involving molestation by persons outside the familial boundaries. (I exclude discussion of the latter because the nature of the resultant trauma is somewhat different from that involved in cases of incest. Therefore, the treatment program would differ, and thus criteria for evaluation would also differ.)

The survey contained in this study was limited to a small selection of treatment facilities in the county of Los Angeles.

The study is valuable as a summary source of information regarding services offered by the treatment facilities discussed; similarly the study may serve to indicate the directions in which Los Angeles is going in
dealing with cases of incestuously abused children. Both outcomes are considered valuable to those in the helping professions who may have to deal with the issue of sexual abuse in their clinical work. The study should provide them with at least a minimal referral source indicating both where specific help is offered and the nature of that assistance. This is considered consistent with repeated demands in the literature for greater dissemination of information regarding such services, and for the development of tools with which to evaluate them.

The first step, as I have indicated previously, in presenting this study, is to consider the problem of incest itself within the context of the United States today. What is incestuous abuse of children; why is incest traumatic and for whom? What is it that makes incest a problem? From where do our attitudes about incest come?

Incest: Myths and Facts

Many of us are familiar with the story of Oedipus, the young prince who grew up to fulfill the prophecy that he would murder his father and marry his mother. The story has its formal origin in Greece, was written by Sophocles, and was at that time seen as having tragic overtones of what might befall man were he to go against the laws of the gods. There are overtones of the Oedipal myth in many of Shakespeare's tragedies (e.g. Hamlet, King Lear). Freud
used it to illustrate some of our most profound sexual conflicts.

The crime of incest, or the presence of the incest taboo is, it seems, as old as history. Though in some cultures brother-sister unions, as well as mother-son and father-daughter unions, were permitted, this has, to my knowledge, never been a culture-wide phenomenon. These unions were elitist, permitted, as in Egypt, only to the royal family, the members of which were seen as gods, and were ritualistically performed, both in Egypt and Hawaii, to perpetuate the royal blood-line. Be that as it may, the context within which we in the United States are living today is that which frames our attitudes and laws regarding incest, and this context is strongly Judeo-Christian. Our heritage, both mythic and religious has given us a strong sense of incest as a crime against our social and moral fiber; it is a crime for which the perpetrator must be severely punished and the victim shall be shunned, just as we shun within ourselves our own unpermissible sexual fantasies.

David Walters reviews the context of modern day United States in depth in his book Physical and Sexual Abuse of Children (1975). He further directs our attention to the myths surrounding the subject of sexual abuse, myths to which many of us unwittingly adhere (e.g. - only dirty old men do such things; she, the child, asked for it; it only happens
Incest is regarded by many people as either sinful, ugly, disgusting, wrong, warped, perverted, a psychotic act, or combinations thereof. It is considered shameful. And it is a secret to be closeted away if it occurs. As for it occurring, it is commonly believed that incest probably only happens among the poor in the Ozarks or Appalachia, anywhere but next door or, worse, in one's own family.

The facts are that incestuous abuse of children occurs within all segments of society, rich and poor, old and young. It happens to infants, toddlers, older children, and adolescents of both sexes. It happens in Appalachia, New York, Los Angeles, and anyplace where families may choose to live. It happens frequently.

Perhaps due to the stigma associated with incest, reporting of incest cases is much less frequent than the actual incidence. The actual level of incidence is difficult to ascertain; but it is thought that some fairly accurate estimates of incidence have been made in various recent studies. It is through many of these same studies that we have gained some insight into the psychodynamics of the families involved in incest cases.

**Incidence of Incestuous Child Abuse**

Several studies have described the reported cases of incestuous child abuse as representing the tip of the
inceberg the nature and size of which we can now begin to estimate. The level of estimated incidence, though differing with each study, is uniformly reported as being much larger than the level of reporting of incest cases.

From a 1969 study conducted in New York City over a period of three years an estimate of 3000 cases per year for that population was drawn (Rodino, 1977). The National Center on Child Abuse and Neglect recently estimated a national average of 100,000 cases of sexual abuse each year (Rodino, 1977). The Santa Clara Child Abuse Treatment program now estimates (conservatively) a figure of 250,000 such cases per year (Weber, 1977). Helfer and Kempe (1968) reviewed two studies. The first was a pilot study conducted by Brandeis University during 1966, using as its sample population 421 Californians involved in cases of child abuse. Approximately 12 percent of these cases were ones involving sexual abuse of children. The second study reviewed was conducted by the National Opinion Research Center of the University of Chicago (NORC). Within the framework of the Brandeis study NORC endeavored to tabulate an indirect estimate of the actual incidence of child abuse (including sexual abuse). This was to be an extrapolation based on reported incidence. The results of both studies indicated the likelihood that the actual incidence of sexual abuse of children, at that time, would have been between 1.4 to 2.7 per thousand persons in 1965. Virtually
all of the studies I reviewed, though they showed discrepancies in their estimated figures of incidence, were in agreement that there is a vastly larger incidence of cases of sexual abuse of children than is reported.

One might at this point be prompted to ask several questions about the persons comprising the estimated populations to which the aforementioned studies refer. Who are the people involved in incest cases? Among whom, what group, does sexual abuse occur? To whom does it happen? What kinds of people do this to their children? What is the nature of this sexual abuse to which I refer? Answers to these questions were found in the works of Walters (1975), Helfer and Kempe (1968), Giaretto (1976), and an outstanding study done by the American Humane Association, Children’s Division, 1969. According to all of them, the pattern of distribution of incestuous abuse is now seen as crossing all socioeconomic and ethnic boundaries.

Incestuous abuse of children is the exclusive action of no single group of people. It happens to children of both sexes from the age of infancy through young adulthood. The nature of the abuse runs the gamut of sexual behavior from the mildest form of suggestive intrusiveness and seductive, physical arousal of the child, to oral sex, genital sex, and to the extremes of engaging children in group sex, homosexual and heterosexual in its nature, the use of children in pornography, and sadistic, physically
abusive sex (Summit, 1978, and Densen-Gerber, 1977). There is within the cases reported a notable incidence of physical trauma, particularly where infants and young children are concerned. Typically, though, the cases reported involve older children, usually females.

The American Humane Association study, as reported by Vincent De Francis (1969) was not only the most thorough one that I read; it gave the most fully illuminating "profile" of the population involved in incest cases. The study area was the New York Bronx-Brooklyn communities and used a sample of 250 cases drawn from 628 potentially useful referrals. Some of the facts brought out by this study were that:

1. The median age of the victims of sex abuse was 11 years;
2. There were 10 girls to every boy;
3. In 75 percent of the cases the offender was known to the child and/or to the child's family;
4. 27 percent of the offenders were members of the child's own household (a parent, stepparent or "paramour");
5. 11 percent were related to the child by blood or marriage, but did not live in the child's household;
6. 25 percent of the offenders were alleged by
those parties concerned to be strangers. Thus approximately 37-1/2 percent of the offenders were acquaintances or friends;

7. In 41 percent of the cases the offenses were repeated over periods of time ranging from weeks to as long as 7 years;

8. In 60 percent of the cases the child was coerced by direct use of force or by threats of bodily harm. In 15 percent of the cases the child was enticed by money or gifts, etcetera. In one fourth of the cases the lure was more subtle, being based on the child's natural loyalty and affection for the relative or near-relative.

The studies to which I've referred serve to answer the questions I asked about evidence of incest cases. The results tell us a great deal about who is abused and by whom. These same studies tell us little, though, about the psychodynamics of the incestuous family.

**Psychodynamics of the Incestuous Family**

What does the incestuous family look like, act like? Why does incest occur? To whom is incest traumatic? What's traumatic about incest? These are all questions needing answers if we desire to design appropriate, therapeutic programs for treatment of persons involved in cases
of incestuous child abuse.

I have found answers to these questions both in studies about which I've read, and also in some of the casework I've been doing while I've been completing this study. My casework, incidentally, is not directly related to the problem of incest. The cases on which I am presently working involve post-divorce, marital, and family counseling. Nevertheless, the issue of incestuous child abuse has come up in several instances: one woman accused her ex-husband of sexually abusing their infant daughter; a woman in treatment for post-divorce depression disclosed that both she and her sister were sexually abused as children by their stepfather; a young girl whom I was counseling described having had a sexual relationship with her father who had finally committed suicide. I began to see that it is not only the abused child who is the victim in cases of incest. Various members of the family are traumatized, including the so-called abuser; he too is a victim. A particularly unsettling realization was that even the unabused siblings in incestuous families may be traumatized. The story of such a case follows.

A man came to me for individual counseling, following the ending of his second marriage. During the process of recreating his personal history for me, he revealed that his sister, as a child, had been sexually abused for several years by their stepfather. The brother, my client, had
been subconsciously aware during that time that something wasn't right, that "Dad" was "doing something bad" to his younger sister whom he could hear crying out sometimes at night when her stepfather was in her room with her, and he and his mother supposedly were asleep. At some point when the girl was in her mid-teens, she finally convinced her mother of what had been happening. The mother challenged the father with the truth, which he eventually admitted. The parents got divorced. And the brother, who now understands the nature of what had been going on, and who is in his late forties, has suffered since his teens from chronic depression, situational impotency, and an inability to form meaningful and lasting relationships with women. He has himself, from his second marriage, a fourteen year-old daughter for whom he has a "barely controllable" sexual attraction, and with whom he therefore will have little contact. He feels grief at the loss of the only father he ever knew, rage at his mother, ambivalence about his sister, and an unfocused sense of guilt and lack of self-worth in himself. How much of this man's confusion and sadness is due to what happened thirty years ago is not yet known. But one can speculate on what becomes of the siblings in such families. And from the way in which he has described to me all persons concerned, it is apparent that each has suffered his or her own private hell ever since.
The case I've just described serves to illustrate the profound effect the psychodynamics of an incestuous family can have on each of its members. These effects represent a sort of boomerang phenomenon, for it is the family itself, in its entirety, which is source of the incestuous dynamic. The family becomes victim to itself.

Every one of the descriptive studies I've read (some have already been noted) seems to agree that incest is a symptom of a dysfunctional family (Browning and Boatman, 1977). Weeks (1976) refers to a system involving collusion within the family constellation, both in support of the sexual acts and of the secrecy surrounding the incestuous activities. Gowell (1973) also refers to collusion within the family and describes a "family romance" gone awry. Lustig (1966) refers to incest as being a transaction which seems to protect and in some way maintain the family in which it occurs. And finally De Francis (1969) asserts that incest often serves as a pathologic attempt to keep the family together. He sees incest as the feverish symptom of a sick, dysfunctional family in need of care.

Within these families the marital and sexual relationships of the parents are seen not only as dysfunctional but central to the problem (Molnar and Cameron, 1975). The wife is described as either resisting sex as an odious task and/or no longer being perceived as sexually attractive to
the husband. The sexual focus of their relationship is shifted subtly onto the child, through whom the parents' "romance" is acted out (Summit, 1978). The incestuous dynamic results in a defusion of roles and behavioral boundaries within the family which in turn lends impetus and often "permission" to acting out the ever present unconscious incestuous fantasies. Within such families the daughter often assumes a mother/wife identity, as the wife relinquishes hers. This adds to the illusion that she is an appropriate sexual companion for the father/stepfather. There is often sequential involvement of daughters, beginning with the oldest.

Admittedly the above constitutes only a partial, if often typical, description of families in which incestuous abuse of children takes place; it does not encompass any number of other kinds of cases, for instance those where the victims are infants. However, there seems to be in all cases an omnipresent conspiracy of silence, of secrecy. This secrecy results in the phenomenon we call "failure to report". It is failure to report that accounts for the enormous discrepancy between extrapolated estimates of incidence and the actual reported incidence.
Failure to Report

Reporting of incestuous child abuse is hindered by several factors. In cases where the child's age may be from infancy to three, there is the inability of the child to communicate. In such cases there may be physical and behavioral signs directing the attention of "responsible" adults to question what may be occurring. But their attention is either dulled by their lack of specific training to read the signs, or their biases which help them to deny what the signs indicate. Or, in the case of the mother, for instance, her attention may be diverted by her considerable feelings of guilt and fear. In fact mothers are often unconsciously or consciously aware of the abuse and contribute to its perpetuation through denial, passivity and failure to provide adequate protection for the child (Brant, 1977).

Young children, particularly those in the 3-9 age category, have problems with their all encompassing loyalty to their parents and the assumption that everything they do is right. Also a consideration here must be the child's response to sexual activity and stimulation, some of which may be quite pleasant, and which may constitute fulfillment of Oedipal fantasies. Due to her developmental stage, which is at this time still quite egocentric, the
child may feel responsible for the act and may fear punishment by the adults involved more than the sexual act, uncomfortable, painful or fearful though it may be.

As the child gets older, many of her fears about "telling" become enlarged upon. The abuser will often cite the child the various consequences of "telling". Her timidity will be reinforced by the mother's unwillingness to "hear" or "look at" what's happening. Teachers or school counselors may not believe her, and may report her "tale" back to her parents. Due to a lack of public, particularly youth, education about what resources for help may be available, the older child may feel as though she has nowhere to turn. The consequences envisioned if she were to "tell" also help stop her. They include disruption of the family, the father being sent to jail, causing a divorce, rejection by the mother and society, loss of financial support to the family, and so on.

Another component of the secrecy surrounding such cases, and to which I allude in the above paragraph, is the reticence of acquaintances or of professionals in various fields to report such cases. Through ignorance about various facets of the problem of incest, including symptomology, they may either mis "seeing" what has been happening or may operate out of denial of it because it is so overwhelming or horrifying a problem to them.
They may assume that the child is lying or fantasizing; or they may feel constrained not to "butt in" to someone else's feelings; or they may not want to "get involved". Those teachers, doctors, clergymen, therapists of laypeople who are more well informed about such problems and their possible, often likely, consequences, may not want to cause the family or child further grief or trauma by reporting the case to the authorities. Instead the matter will then be dealt with on a continuum, at one end of which may be a sort of "benign" neglect whereby virtually nothing is done, and at the other end of which there may be an effort to deal with the problem through private resources.

**Reporting Laws**

Nonreporting may occur despite the fact that there are now clear laws requiring the reporting of such cases and the protection of the reporter. In addition, laws now provide for penalties for those knowledgeable parties who do not report. The 1974 Child Abuse Prevention and Treatment Act defines child abuse as encompassing acts of sexual abuse (United States Public Law 93-237, 1976). Section 273 of the California Penal Code states that:
"(1) Any person who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured, or willfully causes or permits such child to be placed in such situation that its person or health is endangered, is punishable by imprisonment in the county jail not exceeding 1 year, or in the state prison for not less than 1 year nor more than 10 years.

"(2) Any person who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any child to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of such child to be injured, or willfully causes or permits such child to be placed in such situation that its person or health may be endangered, is guilty of a misdemeanor."

Section 11161.5 of the California Penal Code states clearly that a physician, minister, social worker, administrator of child care center (and now included in AB 1058 are psychologists, Marriage, Family and Child counselors, peace officers and probation officers) who sees a minor who appears to have been physically abused or sexually molested "must report" to the appropriate authority.
State Penal Code Section 11162 provides most explicitly for consequences for failure to report: Anyone who does so shall be "guilty of a misdemeanor and is punishable by imprisonment in the county jail not exceeding 6 months or by a fine not exceeding $500 or both."

Failure to report may thus very likely result in civil liability and severe sanctions. The physician's or therapist's ethical commitment to confidentiality is furthermore to be outweighed by his or her legal and moral duty to report such cases. Reporting parties are encouraged to follow through by the protection from any civil or criminal liability provided by California Penal Code Section 11161.5.

Consequences to Reporting

Now that I have discussed the reporting laws and some of the ways in which people are ignorant or evasive of them, I will discuss some of the issues that are confronted once these cases are reported.

First we need to remind ourselves that what seems to give these cases the impact they have on all involved are several factors: an internalized socio-religious enjoinder has been trespassed; a
major disruption of object relationships has occurred; there has been a loss of identity building role definition within the family system; the nuclear family, which is, in our mobile, technological society more and more isolated, has been torn apart, leaving its members with little feeling of security or support. And last, thought not least, there is the impact of the social climate which is encountered when the matter is exposed or reported. (This is described sensitively by both Summ, 1978, and Weeks, 1976.) Benevolent though the intentions of the legal system may be, the legal process often constitutes the major source of emotional trauma to the individuals involved. The worst fears of the children and parents stand a strong possibility of being realized once the case is reported (Gowell, 1973).

The immediate concern for the law enforcement agencies involved extends, of course, further than the punishment of a crime; though the emphasis is unfortunately still heavily on this. There is also concern that such conduct does not continue and that the children involved are protected. In an effort to accomplish the latter, the family is often, if temporarily, broken up. Subsequent interrogation of both parents and children is usually repetitive,
as a succession of public law enforcement and mental health agencies is involved.

An example of the progress of a case involving sex abuse of a child may be as follows (Schulman, 1977):

1. The child has a "problem" with parents or whoever;
2. The problem is detected and reported (by school officials, doctor, neighbors, therapist, police);
3. Referral is made to Department of Public Social Services (D.P.S.S.), Protective Services, and the child is removed from home if safety is a consideration or the problem is seen as having the likelihood of recurrence;
4. The child is detained at MacLaren Hall or a Shelter Care home while D.P.S.S. investigates;
5. Petition is filed by D.P.S.S.;
6. 15 days later, there is a juvenile court hearing on the petition (during which time the child may or may not be detained, depending on the severity of the situation and charges);
7. 15-30 days following the Juvenile Court hearing there is a court disposition hearing;
8. The case is assigned to Dependency Supervisors workers and recommendations for treatment and placement of the child are made;
9. Treatment may now occur (in many cases this step gets somehow lost in the shuffle);
10. There is a follow-up court hearing within one year;
11. If there has been resolution to the problem, the child and family are released from the system.

Adult criminal proceedings may likely be in progress during this same time. Children above the age of four may be required to testify in some or all of the above mentioned hearings, besides having to tell their story repeatedly to D.P.S.S. investigators, police investigators from the Child Abuse Unit, the attorneys involved (both prosecuting and defense), and evaluating psychiatrists. (A superb, in depth report on the system as it currently operates is that
of Elaine Schulman, in her paper *The Reporting of Child Abuse in Relationship to Confidentiality, 1977*).

Given the kind of situation just described, the child, rather than being relieved by her removal from the home, or by the exposure of the problem, too often comes to perceive herself as cause of the family's break-up, and of the concomitant problems of loss of income, anger and alienation. At a time when she is in most need of her parents' support, she is least likely to be receiving it.

The father, if and when he gets past his denial of the incestuous activities and his anger at having been reported, sees himself as a sort of "victim of the system" against which he has committed an unforgiveable act for which there seems to be no possible constructive penitence. He may or may not feel guilty about the acts for which he is condemned. He often may be imprisoned for some period of time; he may likely lose his job and his ability to support his family, and with all this he loses the last vestiges of self-respect.

The mother finds herself left with the responsibility of supporting the rest of the family or dealing with welfare. She, at the same time, must deal with her own conscious and unconscious conflicting
feelings of guilt at her role in the abuse, anger at both her child and husband, grief and fear about her losses.

And the siblings, if there are any, and there often are, find themselves somewhere in a limbo of sorts, perhaps unaware fully of why what's happening to the family is happening. They are too often left to try to make sense out of things for themselves, minus much of the support system, albeit dysfunctional, previously available.

And so the tragedy, as in the case of Oedipus, or in the case of the brother which I described, seems to roll on in a steadily declining spiral of retribution and loss. But incest need not be equated with tragedy. We have learned that the trauma associated with incest comes to a great extent from the ways in which we as a society and we as professionals deal with incest cases.

There is obvious need for change in our personal and public attitudes toward incestuous abuse of children. We need to re-examine the legal system's intervention processes. We need also to adjust our therapeutic intervention programs to the reality that cases involving incestuous child abuse not only
call for treatment of an identified victim; these cases require treatment of the entire family. The reforms needed are numerous. Some of them are discussed in the next chapter of this study.
Chapter II

HUMANISTIC INTERVENTION IN CASES OF INCEST

In this chapter the focus is primarily on processes of therapeutic intervention in incest cases. Reforms in the legal, penal and therapeutic systems are discussed. Finally I describe the Santa Clara Child Sexual Abuse Treatment Program, a model treatment program designed to deal with families involved in cases of incestuous child abuse.

Reforms in the Legal and Therapeutic Intervention Systems

When I speak of a humanistic concept of intervention in cases of incestuous child abuse, I am referring to an effort to make all of the necessary intervention processes more humane, and in the process, more therapeutic for all persons involved.

There are interventions that may be far more productive than taking the uncoordinated, punitive stance that has been previously the rule. Reforms have been building slowly, and have to a large extent been a spin-off of efforts in the last thirty years to deal with child abuse in general. Actually, the fact that sexual abuse of children, and particularly incest, is now such a topical issue reflects a reform in
information services as well as in public and institutional attitudes. Reforms must continue to be made on all levels.

Reporting laws need to become more protective of the rights of children so that they are not further intruded upon and traumatized. Appropriate plans for therapy for the families involved need to be provided for somewhere in the network of laws being developed to deal with sexual abuse of children. The manner in which the legal and penal systems proceed must be changed to become more humane. In particular the primary victim, the child, must be protected from being made to see herself as guilty, destructive of the family, and abandoned. Alternatives must be found to the methods presently employed to "protect" her. Disruption of the family, which is already profoundly disturbed, needs to be minimized. Requirements for reptitious testimony by the parties involved, particularly the child, must be eliminated.

Were treatment reather than punishment the rule, persons in a position to or having a duty to warn or to report suspected sexual abuse would undoubtedly experience less conflict about doing so. The best instincts of society and the individuals involved could
be served simultaneously (Schulman, 1977). It is believed that humanistic revision of the laws would serve to increase or encourage the likelihood of professionals, laypersons and incested families to report.

Improvement in the detection and reporting aspects of the problem would be felt were doctors, emergency room staffs, psychotherapists, teachers, etcetera made more aware of the overt and covert symptoms of sexual abuse, particularly those found in young children, who are least likely to be able to tell their story themselves. This specialized training would help professionals to know what to look for or recognize and when to report. Brant (1977) cites social and cultural taboos and values, personal anxiety, and downright ignorance as culprits in failure of professionals in various fields to recognize cases of sexual abuse. What is called for, it is suggested, are special training programs designed to help professionals become both more aware of the problem itself, of their legal and ethical obligations, and also of their personal attitudes towards and feelings about sexual abuse.

Even if reforms in the legal and penal system, and in professional's attitudes, were to occur overnight,
there would still be much to do. The major reform discussed by those in the field of treating incestuous child abuse cases is one of institutionalized attitude; efforts are being made to shift it from punitive to therapeutic and rehabilitative. As this is done, implications for treatment of such cases must be addressed, and centers to coordinate and offer people such treatment need to be created.

To this end, in 1977, California Assembly Bill 2288 proposed establishment of three child abuse treatment centers in the State of California. One concern of such centers would be the treatment of cases of sexually abused children. While I find the idea commendable in general, if minimal, I have reservations about the appropriateness of "lumping" sexual abuse cases with other forms of child abuse. I believe the problem needs to be addressed in a highly specialized manner. While much of the literature to be found concerning these cases can only be found as a subheading under the topic of child abuse, I believe, as do most of the people I've cited in study, that when we talk about incest we are dealing with a somewhat different syndrome from that of physical abuse or neglect, and that the treatment plan for incest cases needs to be specially designed.
Such plans inevitably call for special training programs and a staff trained to deal specifically with cases of incestuous child abuse.

Plans for therapeutic interventions need to address the issues of both what is needed by whom as well as when it is needed. It is clear to me that therapeutic interventions need to begin at the outset, at the moment the report is made to the appropriate authorities, rather than leaving it to the end of the legal process, as is now the rule. Such interventions should include crisis counseling for the family and referrals to appropriate sources of legal and social assistance. When the court hearings have been completed, and the legal issues resolved, the therapeutic intervention process should accelerate and should include the entire family constellation.

**Therapeutic Intervention: The Design for Treatment of Incest Cases**

The rationale for inclusion of the entire family in the treatment plan comes out of the observation that incestuous child abuse occurs within a family context, and is itself symptomatic of a dysfunctional family process. The problem has origin not just in the
psychological disturbance of the "offending" parent, but also more broadly in his relationship with his partner, as has been previously discussed. The effects of this disrupted relationship gradually reach out to include in one way or another, all members of the immediate family. Whether actively involved in the sexual activities themselves or not, all of the children within the nuclear structure of the family will be affected. The approach, then, should not be toward just treating the "incested" child, but also, from the beginning and throughout the progress of the case, it must involve evaluation and treatment of the family problem, which is usually compounded and made worse by both the acting-out which has occurred and by the reporting of it (May, 1977, and Cormier, 1962).

The Santa Clara Child Sexual Abuse Treatment Program

The treatment modality of preference is exemplified by that designed and implemented by the Child Sexual Abuse Treatment program in Santa Clara County, which is directed by Henry Giaretto (Giaretto, 1976).

The program has been sponsored by and works within the context of the Santa Clara Juvenile Probation Department. This factor helps to provide for optimal coordination of efforts to assist the family
as it proceeds through the different stages of the initial crisis, the subsequent court proceedings, the practical and psychological disruption of family life, and the time spent in therapy, wherein, it is hoped, the family is reconstituted.

While counselor/client therapy in a variety of forms is utilized, it is deemed as not sufficient for the recovery of the family. Close collaboration between various agencies is encouraged so as to provide for assistance in locating community resources to address such pressing needs as housing, financial and legal aid, job relocation, etcetera. Self-help groups (e.g. Parents United and Daughters United) provide a safe haven free of public stigma and an opportunity to rebuild identity and self-esteem. They provide an important source of social support which enables the members to reconstruct their lives, even in the face of majority censure of their pasts.

The treatment plan provides for the following, not necessarily sequentially:

. individually counseling for the incested child, mother, and father;
. mother/daughter counseling;
. marital counseling (a key if the family wishes to be reunited);
father/daughter counseling;

- family counseling (including siblings);
- group counseling.

All components are deemed requisite for family reconstitution. In addition the program seeks to provide information to the public at large and the professional community. It has recently introduced training programs for professionals as well, and is developing demographic data recording forms for future analysis (Giaretto, 1976).

The data that the Santa Clara program reports so far indicates a high degree of success on several different levels. Referrals have increased dramatically, a fact which is attributable, it is thought, to the existence of the program itself (where previously there was none), its humanistic nature, its interconnection with other agencies, and its dissemination of information on the issues with which it is dealing. Data about the cases themselves indicates that, of 300 families who have received a minimum of ten hours of treatment and whose cases have been formally terminated, no recidivism has been reported (Giaretto, 1976).

The two support groups referred to previously, Parents United and Daughters United, have been initiated and have expanded to a point where they are increasingly self-sufficient, with several of the older members of both groups acting as group co-leaders. These groups,
in addition to being supportive to their members during the family crisis and reconstitution processes, are beginning to interface with the larger community and thus may have a great effect on expanding public awareness and understanding of the problem.

Of all the therapeutic programs I was able to find described in the literature, the Santa Clara program seems the most appropriate. It addresses itself to most of the issues involved in cases of incestuous sexual abuse of children as well as to the individual needs of the family members and the family dynamic itself. This fact, in addition to the program's reported effectiveness, has encouraged me to use it as a base upon which I have built a frame of reference for my evaluation of the clinics in Los Angeles county which state as their purpose the treatment of cases involving sexual abuse of children, including incest.
CHAPTER III

An Evaluative Survey of Treatment Centers
in Los Angeles County

In describing my evaluation of clinics in Los Angeles county which work with cases of incestuous child abuse, it is necessary to remind ourselves that these cases involve dysfunctional families. The entire family needs to be involved in the treatment program. The evaluation instrument must therefore reflect this need for family involvement.

Limitations of the Survey

The survey as undertaken has what could be referred to as external and internal limitations. The external limitation is the lack of any primary source of public information identifying the clinics in Los Angeles county which are presently dealing with cases of incestuous child abuse. (A list of treatment facilities is now being compiled by the Interagency Council on Child Abuse and Neglect and should be published in the winter of 1978.)

According to persons I consulted at the Department of Public Social Services (D.P.S.S.), the District Attorney's office, and the Interagency Council on Child
Abuse and Neglect, the cases to which I've referred are for the most part treated individually as they come in to public or private mental health clinics or professionals. Usually there is no specific program provided for these cases by these resources.

Briefly, there are no more than a handful of clinics which have as a stated purpose a specific program designed for treatment of cases involving incestuous abuse of children. It is this handful of clinics that has been surveyed.

The internal limitations have to do with the purposes of the survey. The evaluation as I've designed it has been created primarily to determine the presence of those components deemed necessary to allow for the occurrence of effective, comprehensive treatment. (The idea is that without the presence of these components effective therapy is unlikely to occur, or to put it positively, within the context created by these components effective therapy is most likely to occur.) This evaluation is not designed to be qualitative and therefore will not include data on recidivism, reconstitution of families, or the felt or measurable results of therapy. (The degree to which effective therapy does in actuality occur in the clinics evaluated would be a fine subject for further study.)
Methods

What follows is a description of the method used in the evaluation. I have already indicated that the clinics evaluated have been identified with great difficulty. When I finally had compiled as complete a list as seemed possible, I contacted the appropriate spokesperson at each clinic to be surveyed. These contacts were made by telephone, and during these initial conversations each interviewee was informed by me of the nature of both the interview and the project.

It was explained that I would be evaluating the clinic in which the interviewee works for the presence of certain treatment components and practices. Further they were informed that my intention was to collate the data of all the clinics evaluated and that I planned to review it in this study which would be available to professionals in the mental health field. Following the initial discussion a data was set for the actual interview. Due to severe time limitations of some persons who were to be interviewed, telephone interviews rather than on-site meetings were arranged as needed.

Despite the inherent difficulties of limited time and energy of both interviewer and interviewee, I
chose the personal interview technique (rather than that of a mailed questionnaire) because it leaves room for more flexibility in dealing with the information sought. The semi-structured format of the interviews I designed allowed not only for the giving of the information sought on the checklist which guided my inquiry (Appendix A), but it allowed also for a spontaneity which can address itself to questions unasked. I wanted to insure as much as possible that any unique characteristics of the clinics being evaluated could be disclosed.

**Description of Information Sought**

The checklist was used to record the presence or absence of the various treatment components essential to an effective treatment program designed to deal with incest cases. Each program was surveyed for the treatment components summarized as follows:

1. Initiation of therapeutic intervention at the time the report is filed, or at least at the time of detention;
2. Home visits by a case worker;
3. Either Psychological or Psychiatric evaluation of the family and its members;
4. Medical help accessible through the clinic for the abused child;
Individual counseling for the abused child or children;
Individual counseling for the father;
Individual counseling for the mother;
Conjoint counseling for the parents;
Father/victim counseling;
Mother/victim counseling;
Family counseling (including siblings);
Group counseling for mother;
Group counseling for father;
Group counseling for victim;
Involvement in or referral to self-help support group;
Follow-up to treatment.

It was to be determined not only if each of these components is available at the clinic in question, but also if each is utilized (regardless of sequence or combination) at some point in the therapy.

Additional information sought included data concerning caseload (size and nature), sources of and rates of referral, interaction with other social agencies (such as D.P.S.S., the Probation Department), and the development, presence of, or access to self-help support groups. It was ascertained whether the therapists involved have received special training
preparing them for work in cases of sexual abuse of children, and whether there are training programs offered by the facility in question. Similarly, it was important to determine whether there is data being collected regarding such cases and whether there is being offered public or professional education on the issues.

It is these latter facets of the clinical program which provides for changes in the attitudes and practices of the community at large. If these changes occur, the stigma generated by societal attitudes and customs may be lessened, and thus a major component of the child's, in fact of the family's trauma, could be eliminated.
Chapter IV
RESULTS OF THE SURVEY

I was able to discover only six clinics which had as an expressed purpose a formal program of treatment for cases of incestuous child abuse. These were subsequently surveyed for the presence of the treatment components listed in Chapter III. In the course of my "investigations" I also discovered that cases of incestuous child abuse are being treated without a comprehensive or specific treatment program by numerous facilities and individual therapists; this was an outcome I had expected.

In the following sections of this chapter I present the outcome of my survey. First I list and discuss each of the facilities which has a specifically designed treatment program for incestuous child abuse. Second I review two significant discussions I had with persons who are deeply involved with and concerned about the problem of incestuous child abuse.

For the reader's convenience I begin by listing the treatment centers surveyed (A list complete with addresses and phone numbers is found in Appendix B):

Cedar House, Long Beach;
D.P.S.S. Belvedere Project, Los Angeles;
Friends of the Family, Van Nuys;
U.C.L.A.: Incest Program, Los Angeles;
U.C.L.A.: Section on Legal Psychiatry Child
Sex Abuse Clinic, Los Angeles;
Valley Child Guidance Clinic, Northridge.

Cedar House, which is a facility located in Long Beach, California, originally had a program designed to deal with cases of physical abuse and neglect of children. The treatment program included a play therapy component. Therapists observed numerous sexual overtones in some of the children's play and therefore began to investigate these children's families for the possibility of incidence of sexual abuse. The therapists' suspicions were confirmed; several of the cases of child abuse included incidences of incestuous abuse. Subsequently a program was designed to deal with incest cases.

Cedar House's incestuous child abuse treatment program, which is non-residential, presently has a caseload of approximately 12 to 15 families. About one-half of the incestuously abused children are teenagers; the remainder are preschoolers. All the victims are female. Referrals to the program have come in prior to the filing of a police report, at the time the report is file, or following resolution of court proceedings. Cases have been self-referred, referred by D.P.S.S., or a local Head...
Start program. Due to Cedar House's active community education program, several high school teachers working in the Long Beach Area are now alert to the problem of sexual abuse and have also successfully referred a few teen-age girls to the program.

Treatment components available in the Cedar House treatment program include individual and group counseling for both parents, abused child, and siblings. There is no facility for medical treatment, or psychiatric or psychological evaluation. Both services would have to be acquired through referrals, which are made as necessary. Home visits, though not routine, are conducted as needed, particularly in cases where the family is in crisis and the home is the scene of stress.

Initially the mother, father, and child are seen individually. When it becomes appropriate to their progress in treatment the entire family, including siblings (unless they are too young), is seen in family therapy. As needed, marital counseling is provided. Finally, the parents are introduced to group therapy for parents, and the child enters a group of her own. Follow-up to treatment is planned, although at this time all referred cases are still in treatment. There is at this time no affiliation with Parents United or Daughters United, as there is no chapter of either group presently active in the vicinity
of Long Beach. Courses in effective parenting and homemaking, funded by Long Beach City College, are taught at Cedar House and may be attended by parents of families involved in sexual abuse of children.

Cedar House has and requires no specific training for its staff in treatment of incestuously abused children and their families. However, it has conducted several in-house seminars and workshops which have been addressed to treatment of incest cases. The staff, which is small, is composed of two social workers, one clinical psychologist, three para-professionals and several volunteers.

Record keeping and research is presently being done on a very limited basis. It primarily consists of program evaluation (tabulation of the numbers of sessions of which kind occur in treatment of sexual abuse cases). Some effort is being made to keep track of the number of referrals sent by the various sources of referral to Cedar House. No demographic or psychodynamic studies are currently being performed.

One of the outstanding features of the Cedar House program is its effort to reach the general public. A crisis-intervention hotline operates 24 hours a day. There is an active speaker's bureau, often represented by Clara Lowry, the director of Cedar House. An active
auxiliary helps provide funds for local radio spots. Much work is done through the speaker's bureau at local schools and P.T.A. chapters to make people aware of the problem of incestuous child abuse. In addition, there are weekly Tuesday afternoon public information sessions offered on the premises.

In review, the Cedar House treatment program focuses tightly on treatment of the entire family and on educating the public about the problem of sexual abuse. These are praiseworthy characteristics. The program design seems to lend itself to effective treatment of incest cases. Components lacking are follow-up, self-help groups and plans for research. Traditionally, self-help groups materialize out of therapy groups as cases are resolved. Since self-help groups may be crucial in re-socialization of families and reduction of recidivism, it would behoove Cedar House to be thinking along the line of developing such groups. Further, "now" is the time to begin case research. Much needs to be done in the way of research in general on the topic of incestuous child abuse. It is the clinics which directly deal with incest cases that are the best resources for both demographic and psychodynamic information.

The next facility to be reviewed is that being sponsored by D.P.S.S. (the Department of Public Social
Services). This is the first in-house treatment facility dealing with child sexual abuse to be operated by D.P.S.S. It is headquartered at the Belvedere office in Los Angeles county and is titled the Child Sexual Abuse Project, for short, the Belvedere Project.

The Belvedere Project is a brand new facility which will serve the areas of Long Beach, Montebello, Lakewood, and East Los Angeles. Six D.P.S.S. workers plus one supervisor comprise the staff. At the time of my interview with the project spokesperson, there was just the beginning of a caseload. While it is hoped that cases will begin in treatment at the time the initial police report is filed, at this point it is likely that cases will come into treatment following detention. Referral sources are, of course, as yet unknown, though it is to be expected that there will be both community and police referrals. Much of the project's program is still in the "planned for" stage, as is evident in the following report. Treatment components routinely provided will include home visits and individual counseling for each of the parents and the abused child. Components provided for on an as-needed, if appropriate basis will include conjoint counseling for the parents, father/child counseling, mother/child counseling, and family counseling. There may also be group
counseling for the parents and/or child. There will be available a self-help group for teen-age girls. Likewise a parents' group will be formed at the end of treatment. (There is as yet no Los Angeles chapter of Parents or Daughters United.) Follow-up to treatment is planned thought not as yet defined.

Training for staff, which is requisite, has been facilitated by the Santa Clara Child Sexual Abuse Treatment Program. Staff is composed entirely of social workers. There are no clinical psychologists, psychiatrists, or Marriage, Family and Child Counselors. There is no in-house resource for medical assistance, or psychiatric or psychological evaluations. Cases needing such services would be referred out for them. At present there is no specific link formed with any community center where medical or psychiatric services would be available.

The Belvedere Project staff is preparing for detailed record keeping and research on its cases of incestuous abuse of children. It will be accumulating data not only on the size and source of its caseload but also has plans to do research on the population treated. This latter research will be both demographic and psychodynamic in its orientation. Likewise, there are plans for the development of a public information/education program which will be developed once the treatment
program is actually underway.

Supposedly one of the advantages the D.P.S.S. Belvedere Project should have over most of the other facilities planning to treat cases of incest is that it is part of the legal system through which most cases must be processed. This fact would theoretically facilitate earlier involvement of families in treatment. In actuality, according to the D.P.S.S. spokesperson, this advantage may not exist for in-house cases anymore than for other clinics' cases. Confounding issues remain in that families may be unwilling to enter treatment prior to court pressure; attorneys may be unwilling to have clients submit to treatment prior to legal resolution of the case; it may even be unfeasible to connect the family to a treatment program prior to resolution of the case because the abused child may be in detention at Maclaren Hall, and the father may be separated from the family.

In brief summary, the D.P.S.S. Belvedere Project must be recognized as so new that it is not fully formed. At this time its intended emphasis seems to be on separate treatment for the parents and abused child, with not enough emphasis on treating the family as a whole. There is no formal plan for inclusion of siblings. The project has laudable plans for research on its caseload, and to the extent that it carries out these plans, should have an
effect on the public and professional community.

Friends of the Family, a non-profit counseling and family education center, was founded in 1972, and is located in Van Nuys. The center recently received funding from Los Angeles County to initiate and operate its new child abuse prevention and treatment program. This funding is minimal, but serves to pay the salary of the program staff, which includes the program director and two, part-time interns.

The program's caseload, similar to that of most clinics, it seems, is relatively small. It must be remembered that this is a program-within-a-program; the child abuse project operates under the aegis of the Friends of the Family center. Approximately 10 percent of the cases in the child abuse program involve incidences of incestuous abuse. Cases are referred primarily through the private sector, though some are referred by D.P.S.S.

While the emphasis in the clinic's practices is generally on dealing with family dynamics, the emphasis so far in the treatment of incest cases is on work with individual members of the family. No provisions are made for on-site medical assistance or psychiatric or psychological evaluation. (Cases requiring any of these services would be referred to Olive View Hospital or private resources.) Similarly, home visits are not part
of the treatment program. Treatment components utilized may include: individual counseling for the abused child, the mother, and the father; conjoint counseling for the parents; some family counseling, though by no means is this routine. At this time, due to the small size of the caseload, there is no group therapy.

The project makes an effort to involve both mothers and fathers in Parents Anonymous (a self-help group which addresses itself to the needs of parents involved in child abuse). Referrals to children's groups are made primarily to the Valley Child Guidance Clinic in Northridge. Follow-up to treatment is planned; cases are to be reviewed at the three, six, nine and twelve-months stages. Crisis intervention is provided for through the center's Family Help Line, which offers immediate, if general assistance.

Though the staff has had and is required to have had no specific training in counseling cases of sexual abuse, some workshops on sexual abuse have been attended. The staff is composed of Marriage, Family and Child Counselors (two of whom are interns). Facility resources, though limited in terms of actual services available on-site, include an extensive file of community resources to which clients can be referred for auxiliary services.

One of the drawbacks of the program, in terms of my evaluation, is that aside from the minimal record
keeping required by the county, virtually no formal research, either demographic or psychodynamic, is being done. However, an effort is being made through the media and public speaking engagements to inform the public about the overall problems of child abuse.

In all, it seems that the service provided in cases of sexual abuse of children by the Friends of the Family child abuse project is partial, and therefore probably somewhat limited in its effectiveness. Improvement of services in this case would to some extent come through an increase in caseload, which would allow for group therapy, and through a greater emphasis on family therapy inclusive of siblings appropriate in age.

The U.C.L.A. Incest Program is located at the Neuro-Psychiatric Institute of U.C.L.A. in West Los Angeles. It is, as are most similar programs in Los Angeles, a brand new program which is as yet not quite in high gear. Unlike many similar programs, the staff is in close contact with the probation department, D.P.S.S., and the County Interagency Council on Child Abuse and Neglect. This is due largely to the efforts of Morris Paulson, Ph.D., who is director of the U.C.L.A. program. Meetings of the U.C.L.A. program staff and D.P.S.S. investigators, treatment workers and supervisors are held monthly.
Referrals occur mainly through D.P.S.S. and the Juvenile court system, though there are also some self-referrals. At present the caseload includes approximately twenty-five families, thus involving about fifty to sixty persons.

All patients are registered in the program through the U.C.L.A. Medical Center. Part of the intake procedure, therefore, includes a requisite medical history inventory for everyone who is to be treated. (Physical examinations as well as psychiatric evaluations are only done as indicated necessary, except in the case of the "primary patient", the child. She is required to undergo a complete physical and psychological examination.) Home visits are routine in cases where the child has not been placed and/or the father is still at home.

Treatment components most often utilized are individual counseling for the abused child and for each of the parents as well; for the adults group therapy is considered the primary therapy, with individual counseling used as a complement; group counseling for the victim is available only at present to adolescents. Inpatient care is available to patients, if needed. Conjoint counseling for the parents is rare and is provided only if the offender is a participant in parenting activities involving the primary patient. No provision is made for father/child
counseling; mother/child counseling is not routine. Family counseling is provided as a treatment component routinely and may include siblings.

A Parent-Aide program uses volunteers to provide families in treatment with a sort of peer support, modeling resource which can be a very effective aid to re-socializing the family and defusing its isolation. Efforts are being made to form a chapter of Parents United; it is hoped that the group therapy which is primary treatment for the mother and father will encourage the parents to join a self-help group. There is at present no U.C.L.A. hotline or crisis intervention component to the treatment program, so the program works closely with the Santa Monica Listening Line, 828-CALL, directed by Laura Jacoby. Follow-up to treatment will occur when there are "graduates" to follow.

The staff is composed of social workers, clinical psychologists, three registered nurses who have master's degrees in nursing, and a few psychiatrists and physicians. Prior training in dealing with cases of sexual abuse is not requisite. One of the nurses has attended the Santa Clara training program, and the entire staff is privileged to consult with Roland Summit, M.D. two hours a week. (Summit is a leading authority on sexual abuse of children and treatment of incest cases.)
Research and self-evaluation are important components of the program. Data is presently being accumulated on sources of referral (e.g. the number of cases originating through D.P.S.S., private physicians, self-referrals). Likewise demographic and psychodynamic data are being collected, and there are plans to track cases following treatment in order to obtain data on recidivism. The program has a budding outreach component, largely in the form of Dr. Paulson, who does a great deal of public speaking and community and professional consultation.

In all, the U.C.L.A. Incest Program seems fairly complete in its treatment design. It certainly has an advantage over other facilities in that it is a part of a medical center and has access to all the services that implies. Paulson's connectiveness to the professional and public community augments the program's ability to interface with D.P.S.S. etcetera. The emphasis on group therapy as the primary treatment component seems appropriate, as long as individual therapy is an auxiliary, which it apparently is.

The program is faulted, in terms of this evaluation, for its lack of emphasis on conjoint or marital counseling. As difficult as this may be to get underway, marital counseling is imperative if the family is to remain
intact, if recidivism is to be avoided, and if the family romance is to be reconstituted in a healthful way. Conjunctive counseling is important even if the parents separate to deal with the way in which the parents will cope with separate parenting, if that is to exist. The lack of a conjoint counseling component is the one major drawback that I can see to the U.C.L.A. program offering an effective treatment program for incestuous child abuse.

The Valley Child Guidance Clinic has no program specifically or separately designed for treatment of incestuous sexual abuse of children. However, the clinic has several, well developed programs of family and individual therapy and community and patient education. Clinic programs deal to a great extent with cases of physical, emotional and sexual abuse of children. In addition, the Clinic is a favored referral source in the San Fernando Valley. The Clinic is presently designing a proposal for creation of a specific program of treatment for incest cases. Due to the impressiveness of the services provided for families involved in incestuous abuse cases, even though these services are not separately defined from the rest of the treatment programs provided, I chose to include the Clinic in my evaluation. The results follow.
Incest cases come into the Clinic through referrals from therapists, physicians, hospitals, police, the courts, D.P.S.S., schools and private parties in the community. As stated previously, the Clinic has several different programs which are presently utilized in the treatment of incest cases. The Family Stress Program, designed for treatment and prevention of child abuse and neglect, offers services for families where the child or children are 5-1/2 years old or younger. A second program, similarly designed, serves families with children who are 5-1/2 to 10 years old. There are two programs providing services to teenagers: "Project Heavy" and "Youth Help". Cases of incestuous abuse have been involved in treatment in each of these programs.

Medical assistance is not provided for on-site; referrals are made for medical services on an as-needed basis. Home visits are conducted in many cases. Psychiatric or psychological evaluations are not utilized unless specifically indicated in individual cases.

Individual counseling is provided for the abused child, mother, and father, as is conjoint counseling for the parents (whether married, unmarried, or separated). Mother/child counseling, and when possible, father/child counseling are provided. The emphasis, in most cases, is on family counseling, which includes siblings. In addi-
tion, there is heavy emphasis on group counseling for the mother, father and child. There have been developed as yet no self-help groups. Follow-up to treatment is a component in each of the treatment programs.

The Clinic staff is composed of psychologists, social workers, M.F.C.C.s (Marriage, Family and Child Counselors), specialists in child development, family aides, research aides, interns from various therapeutic disciplines, and several volunteers. Training, though not specifically addressed to cases of incestuous abuse, is an on-going requisite component of staff development. Training has included some workshops on sexual abuse of children. Greater in-depth training is being planned.

Record keeping is an important part of the clinic's program. Unfortunately, at this time there has been no attempt to statistically isolate cases of incestuous abuse, so there is no data as to the specific number of incest cases treated in each treatment project, nor is there data on the demographic or psychodynamic characteristics of the incestuous abuse cases. However, plans are presently being made to collect data once the incest treatment program is underway.

In all, though there is no treatment plan specific to incest cases presently in operation, the services provided by the Clinic are so extensive and appropriate to
the needs of parties involved in incestuous child abuse cases that the Valley Child Guidance Clinic is an outstanding treatment resource.

The U.C.L.A. Section on Legal Psychiatry provides the courts and related agencies, as well as the general public, a resource for the evaluation and treatment of families involved in cases of incest. Unique to this program are the separate services of evaluation and treatment.

Evaluation services are provided post-adjudication or post-conviction in order to assist the court with the disposition. The evaluation consists of psychological testing and a series of clinical interviews with the adults and children (conducted individually and jointly) aimed at determining the needs of the children and the family as a whole (including the offending adult). Specific recommendations for disposition are made and court testimony concerning the case is available.

The treatment program is accessible through court, agency or private referral. All cases must first undergo a psychological evaluation (another unique feature of this program). The treatment plan itself is tailored to fit the individual needs of the family involved and may include individual, joint, family and group therapy for both adults and children. Ongoing support groups are provided
(when there is a sufficient caseload) for both adults and children, to give prompt interim assistance to families during the course of the evaluation until the individual family's treatment plan is developed. Throughout, the emphasis is on consideration of the problem as a symptom of a dysfunctioning family and therefore the entire family, including siblings, is considered in development of the treatment plan.

The staff consists of psychiatrists, clinical psychologists, Marriage, Family and Child Counselors, and social workers. Included are several highly trained interns in the disciplines just mentioned. Specific training programs in treatment of sexually abused children and their families have thus far consisted largely of seminars and individual research. Of particular value to the program as designed is that Legal Psychiatry has had for several years a Post-Divorce Clinic, the staff of which is intensively trained in working with families in crisis, an experience which lends itself to working with incest cases.

It is not known yet what kind of research or record keeping of these cases will be conducted, if any. Due to the program's newness there has been little effort as yet to provide the public information.
Part of the research I had to do in order to locate the treatment centers surveyed involved discussions with persons active in a variety of ways with the treatment and handling of incest cases. Two discussions were so significant in terms of determining what is happening in Los Angeles regarding the problem of incestuous child abuse, that I decided to include a brief report of them.

A discussion I had with Los Angeles Police Sergeant Joan Wolf was particularly thought provoking. Sergeant Wolf has worked for many years in the west San Fernando valley area; her field of expertise is in cases of child abuse. In her experience she has had opportunity to follow and investigate cases involving runaway teen-age girls. In most of the runaway cases with which she has dealt she has had reason to believe that incestuous abuse may have been a precipitating factor to the girls leaving home. They are often fairly well adjusted socially, performing well in school with their peers and siblings. Complaints center around some form of trouble with their parents. In several cases there has been physical abuse, the nature of which has had heavy sexual overtones. In some cases the girls have revealed to Sergeant Wolf that they have been sexually abused at home.
Wolf's suspicions, which seem firmly grounded in her casework, direct our attention to the need for more in-depth investigation of cases involving runaways and a possible connection between their action and incestuous abuse. Attention also needs to be paid to treatment of runaway cases which is at present, due to lack of sufficient funding, facilities and staff, grossly inadequate. Wolf's informal, personal research also serves to intensify my belief that the incidence of incestuous child abuse is far greater than is currently estimated.

Incidence of incestuous child abuse and the long term psychological trauma to which the abuse gives rise were the principle topics of a discussion I had with Susan Forward. Forward is a psychiatric social worker on staff at Van Nuys Psychiatric Hospital who has a private therapy practice as well. Her work, described in the Los Angeles Times (August, 1977), includes leading at least a dozen therapy groups for women each week. In her work she has noted a continuous pattern. In the course of self-revealment, in most of the groups she has run, there are several women who end up revealing that their greatest problem is not the disturbed relationships, sexual dysfunctions, severe depressions, migraine headaches, repressed rage, guilt or self-loathing which may have been the presenting symptom bringing
them to therapy. The greatest problem is often revealed to be one held in common; these women were sexually abused, were child/victims of incest.

Forward's work is significant and relevant to the purpose of this study because, first, it once again helps us to have a clearer sense of what the actual incidence of incestuous child abuse must have been and must be now; second, her work gives us a unique opportunity to see the results, the scars that incest can cause, and thus helps us understand those feelings, thoughts and psychological processes with which we must deal to work effectively in incest cases; third, Forward shares her knowledge and experience generously and actively with both the professional and public communities. (She has written a book, due to be published late in July, 1978, titled Betrayal of Innocence, which reviews her experience working with incest cases.) Voices like Susan Forward's add momentum and depth to the movement in Los Angeles toward dealing with the problem if incestuous child abuse.
Chapter V

SUMMARY AND CONCLUSIONS

In this chapter I summarize the results of my research, and provide an overview of the direction in which Los Angeles County seems to be going in confronting and dealing with incestuous child abuse.

It must be remembered that the purpose of my research was to first locate treatment centers in Los Angeles County which have as an expressed purpose a formal program of treatment for incestuous child abuse. Second, the identified treatment centers' programs were to be evaluated for the presence and use of specific treatment components. Third, through analysis of the results of my survey, it was hoped that I could perceive a direction in which Los Angeles is going in terms of treatment of incest cases.

One of the main problems confronting me, as it turned out, was that the facilities in question were extremely difficult to locate in any organized way. There was, as I had suspected, no master list of them to which I could refer. This fact served to validate one of my original reasons for doing this study, which was that a byproduct of it might be such a master list. Apparently the Interagency Council on Child Abuse and
Neglect is similarly concerned and plans to publish a guide to sexual abuse treatment centers towards the end of 1978.

Another confounding factor, I thought, might be unwillingness on the part of clinical personnel to have their facility evaluated. This was happily a phantom factor; thought a few spokespersons insisted on being interviewed on the telephone, all were more than willing in the end to spend whatever time was necessary to complete the interview.

**Summary of Results**

The results of the interviews conducted indicate an awareness on the part of the evaluated clinic's personnel of the unique problems involved in incest cases. There is a general sense that incest involves an entire family and that to some degree it is to the functioning of the family as a unit that therapy should be addressed.

The treatment components most neglected are those having to do with medical treatment and evaluation. All but one facility (U.C.L.A. Incest Program) have no on-site provision for medical treatment and have only vague ideas of what they would do if a case were to require medical attention. Psychiatric or psychological
evaluation is requisite for the entire family only in the Legal Psychiatry Sex Abuse Clinic program and the U.C.L.A. Incest Program; neither Cedar House, Friends of the Family, nor the D.P.S.S. Belvedere Project have staff for testing or require it. Valley Child Guidance tests only "as needed", not routinely. It would appear, therefore, that there is some disagreement on the necessity of psychological evaluation as a treatment component; it is also possible that the absence of this component reflects staff limitations of several of the facilities.

There seems to be similar disparity in regard to provisions for home visits, and again it is difficult to discern whether this is due to differences of treatment philosophy or to lack of appropriate staff. The Valley Child Guidance Clinic, U.C.L.A. Incest Program, and D.P.S.S. Belvedere Project make provisions for home visits at least semi-routinely. Cedar House, Friends of the Family, and Legal Psychiatry do not.

Individual counseling for the mother, father, and abused child is a component of all the programs surveyed. Conjoint counseling for the parents is similarly available, though it is most routinely utilized by Legal Psychiatry, Valley Child Guidance and Friends of the Family. Father/child counseling is
routine in none of the settings. It is planned for, if feasible and appropriate, by each program except U.C.L.A. Incest Program, which doesn't provide for it at all at this time. Mother/child counseling is conducted by each program, again on an as needed, as appropriate basis. Family counseling is emphasized by each program with the exception of Friends of the Family, which seems to emphasize individual therapy for the abused child and parents more than any other treatment component.

All six of the programs surveyed intend to include group therapy for parents, either as couples or individually, at some point in treatment; but all of the programs, except for U.C.L.A. Incest Program and perhaps Valley Child Guidance, have not yet been able to fully implement their plans for group therapy due to low caseloads. Group counseling for the abused child is also provided for as there is sufficient caseload to support it.

Involvement in or referral to self-help support groups, which are strong treatment components of Giaretto's Santa Clara treatment program, are the last treatment components being considered in Los Angeles. Both Valley Child Guidance and U.C.L.A. Incest Program have a parent's aide component wherein specially trained adult volunteers offer support to the families being
treated, which is particularly helpful during the initial crisis period and early in treatment. But parent's aide programs do not offer the kind of self-support that is offered through Parents United and Daughters United. Morris Paulson, director of the U.C.L.A. Incest Program, is an active proponent of efforts in Los Angeles to establish chapters of both Parents and Daughters United. It would be encouraging to see the other treatment centers similarly involved.

Follow-up to treatment is being planned by all the agencies I interviewed; it is not yet underway simply because each of the programs is so new there are as yet no "graduates" to follow.

The composition of each center's staff varies greatly. In some there is heavy emphasis on utilizing volunteers; in some no volunteers are used. All programs, save the Valley Child Guidance programs and Legal Psychiatry, seem to be suffering from problems of understaffing; this situation results directly from lack of government funding and also, in some cases, from an unwillingness to use professional interns.

Training for staff involved in treatment of incest cases seems to be a highly variable component of each program. Here it may be helpful to recall that delineation of incestuous child abuse cases came out of
the movement to identify and treat child abuse in general. Similarly, staff experience in working with child abuse in general is being tapped as a training experience in dealing with incestuous child abuse. Morris Paulson agrees with me that this tactic may well represent a specious rationale, as incestuous child abuse represents a somewhat different dynamic, in most cases, than does physical or psychological abuse or neglect. To some extent the distortion to which I just referred is being addressed by each clinic through seminars and workshops focusing on incestuous child abuse. In general there is a need for greater commitment to specificity and depth in the training experience offered at each center.

Finally, each treatment center was surveyed for the ways in which it was handling record keeping and public education. The former is considered vital in terms of developing a greater clarity, particularly among mental health professionals, concerning the actual incidence of incestuous child abuse, and the demographic and psychodynamic characteristics involved. Without this data the public cannot be properly informed, the myths cannot be soundly challenged, and the stigmatizing process cannot be effectively defused. Some of the clinics interviewed seem to recognize the urgency of the need for record keeping more than others. Each clinic's activity
in record keeping is again limited by some or all of
the following factors: lack of funding, lack of suffi-
cient staff, smallness of caseload, newness of program,
or simply a lack of focus on record keeping or public
information as services requisite to effective treatment
program planning.

Conclusions and Recommendations

In general it seems that the movement towards
effectively dealing with cases of incestuous abuse of
children in Los Angeles County is well intentioned but
woefully disorganized. The Interagency on Child Abuse
and Neglect, itself a neonate, promises to help pull
efforts together. The Interagency's effectiveness will
depend to a large extent on the willingness of treatment
centers to support its work, to make use of its resour-
ces, and to cooperate with each other. The liveliness
and unity of the movement will also depend largely on
the willingness of the police, the courts, the depart-
ments of probation and D.P.S.S. to cooperate with the
efforts of treatment centers in developing their pro-
grams.

It is shocking that so many of the treatment
programs suffer from lack of referrals. Although report-
ing of cases still lags far behind levels of actual
incidence of sexual abuse, there are still more cases reported than are actually referred for clinical treatment. Somewhere within the legal and public social work system there is a log-jam which should not be occurring.

Another observation comes from conversations I have had with physicians, clergymen and private therapists during the nine months in which I've been studying the problem of treating incest cases. Several of these persons have expressed general concern about the problem of incest, and specific concern for some of their clients who have been directly involved in some way in an incidence of incestuous child abuse. Because of their concern, the professionals mentioned have become involved in treating cases of incest, usually on an individual basis. This is not unethical. (It is not required that incest be reported in cases where it is no longer occurring.) But I believe that in cases where children are involved, individual treatment alone is not the most effective or thorough way of dealing with the trauma of incestuous abuse.

It is my belief, as I have previously stated, that effective treatment of incestuous child abuse cases must have several components, including individual treatment, conjoint counseling for parents, family therapy which includes siblings as appropriate to age,
group therapy and support group experiences. It is almost impossible for any single therapist to provide all the services mentioned. It is improbable that one therapist will be able to provide any more than a couple of services to a given family, simply because of the time and expense involved. Therefore, I propose that incest cases are most properly dealt with in a clinical setting where there is a specific, multifaceted design for treatment of incestuous child abuse. It would be encouraging to me to see more recognition among private counselors that incest cases require treatment in a clinic setting. Further, it would enhance caseload sizes at said clinics were there to be more private referrals; I also hypothesize that were clinic caseloads to have more representation from the private sector we would begin to see emerge a more accurate demographic and psychodynamic profile of incestuous families.

My last comment on the situation in Los Angeles takes the form of a reminder, rather than a criticism. We must remember that the movement in Los Angeles to clinically deal with, on a specialized basis, incestuous child abuse is new; the effort is in its infancy. I have hope, which comes from my direct contact with involved professionals, that treatment programs, given time, funding, and community support, will multiply, will
expand, and will eventually include responsible follow-up, research and public education components.
Bibliography

BOOKS


ARTICLES


Larsony J. H., & Reynolds, K. E. County Council Communication to Department of Health Services, August 19, 1977.


Parents studied for clues to potential child abuse. Los Angeles Times, October 8, 1977.


UNPUBLISHED MATERIAL


APPENDIX A

Survey Instrument

Interviewee: __________________________

I Initiation of Therapeutic Interventions:

_____ when report is filed
_____ at time of detention
_____ following detention
_____ following resolution of court proceedings
_____ other:

II Treatment Components

<table>
<thead>
<tr>
<th>Available</th>
<th>Utilized Routinely</th>
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<tbody>
<tr>
<td>_____ medical assistance/examination</td>
<td></td>
</tr>
<tr>
<td>_____ home visit (treating personnel? ______________)</td>
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| _____ psychological or psychiatric evaluation
  Family
  Victim (only)
  Offender (only) |
<table>
<thead>
<tr>
<th>Service</th>
<th>Available</th>
<th>Utilized</th>
<th>Routinely</th>
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</thead>
<tbody>
<tr>
<td>Individual counseling for victim</td>
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<td></td>
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<tr>
<td>Individual counseling for mother</td>
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<td></td>
<td></td>
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<tr>
<td>Individual counseling for father</td>
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<tr>
<td>Conjoint counseling for parents post-divorce</td>
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<tr>
<td>Father/victim counseling</td>
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<tr>
<td>Mother/victim counseling</td>
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<tr>
<td>Family counseling</td>
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<tr>
<td>Group counseling for mother</td>
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<tr>
<td>Group counseling for father</td>
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<td></td>
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<tr>
<td>Group counseling for child</td>
<td></td>
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<tr>
<td>Involvement in or referral to self-help support groups, which ones:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up to treatment</td>
<td></td>
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### III The Clinic

<table>
<thead>
<tr>
<th>Available</th>
<th>Utilized</th>
<th>Routinely</th>
</tr>
</thead>
</table>

- Training for counselors
  (specific to cases of sexual abuse of children)
  _____ requisite?

- Composition of Staff:

- Facility Resources:
  - _____ Medical
  - _____ Psychiatric Evaluation
  - _____ Counseling Staff
  - _____ Investigative/ Evaluation Staff
  - _____ Self-help Groups
APPENDIX B

Treatment Centers: Listed

Cedar House
605 Cedar
Long Beach, CA 90802
Director: Clara Lowry
(213) 436-8276

D.P.S.S.: The Belvedere Project
5427 East Whittier Boulevard
Los Angeles, CA
(213) 575-4255

Friends of the Family
Child Abuse Treatment and Prevention Program
14522 Kittridge Street
Van Nuys, CA 91405
Program Director: Barbara Rock
(213) 988-4430
U.C.L.A. Incest Program
NPI - U.C.L.A.
Los Angeles, CA 90024
Director: Morris Paulson, Ph.D.
(213) 825-0429

U.C.L.A. Section on Legal Psychiatry
Child Sex Abuse Clinic
10966 LeConte Avenue
Los Angeles, CA 90024
Director: John Suarez, M.D.
(213) 825-0763

Valley Child Guidance Clinic
9650 Zelzah Avenue
Northridge, CA
Director: Norma Gordan
(213) 993-9311, 873-5334