Incest and Child Sexual Abuse:
Understanding and Treating

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Author Information

Diana Castillo, BA, MSSW, LCSW is an Independent Clinical Social Worker currently Licensed in Florida. She specialized in treating Incest and Child Sexual Abuse. This encompasses many other diagnoses, which she sub-specialized in. These include Depression, Eating disorders, Post Traumatic Stress Disorder, and others.

She has worked as a Psychotherapist in Community Mental Health Clinic settings, in Private Psychiatric Hospitals and Independent Practice for over 20 years.
Course Summary

This course will provide mental health professionals with the knowledge to understanding and treating Incest and Child Sexual Abuse, including the definition, statistics, symptoms, diagnosis and diagnosing challenges, treatment and challenges involved in the treatment.

The course material has been collected from current literature as well as time proven materials and the author’s many years of experience in working with Incest and Child Sexual Abuse.
Course Objectives

After completion of this course the professional will be able to:

1. Define Incest and Child Sexual Abuse
2. Discuss the statistics and prevalence of Incest and Child Sexual Abuse
3. Learn some common characteristics of the perpetrator
4. Learn some common characteristics of the incestuous family
5. Identify the symptoms and aftereffects of this trauma
6. Interview and Find Diagnoses for Incest and Child Sexual Abuse and concurrent related disorders
7. Identify treatment options and modalities for the trauma
8. Learn some treatment challenges of the trauma
9. Identify concurrent disorders that can be present as a result of Incest or Child Sexual Abuse
10. Locate resources for survivors of Incest and Child Sexual Abuse
Outline

1. Definitions of Incest and Child Sexual Abuse
2. Prevalence and Statistics
3. Characteristics of the Perpetrator
4. Characteristics of Incest Families
5. Symptoms and Aftereffects
6. Interviewing and Diagnosing
7. Challenges in Interviewing the Victim
8. Treatment and Challenges to Treatment
9. Resources
10. Bibliography
PART 1: Definitions of Incest and Child Sexual Abuse

Incest was once a taboo subject but in the past almost 40 years it has come to be a widely researched topic. The women’s liberation movement, increased divorces and single working mothers brought it out in the open as children were more exposed to sexual abuse. (Crewdson, 1988, p. 25) In order to fully understand this trauma it is necessary to first learn the definitions of incest and child sexual abuse.

Some definitions of incest and child sexual abuse are: “incest is sexual intercourse between blood relatives”, “the imposition of sexually inappropriate acts or acts with sexual overtones…by one or more persons who assert authority and power over that child through ongoing emotional bonding with that child. (Blume, 1990, p. 4) The persons referred to are called perpetrators. These persons can be parents and/or other family members, siblings, peers, teachers, religious representatives, or babysitters for examples.

It has been asserted that the most prevalent form of child sexual abuse and the one with the most potential for damage and harm to the child is the incest between an adult and a related child or adolescent. (Courtois, 1988, p. 12)

The difference between child sexual abuse and incest is that in incest the perpetrator is family and with child sexual abuse it can be by anyone.

Sexual abuse of a child has been traditionally been considered incest or pedophilia but it is now viewed on a continuum rather than either or. According to (Able, 1983) 44% of incestuous men who are having sexual contact with their own children are also having
sex with other children outside the home and who they are not related to.

PART 11: Prevalence and Statistics

According to Diana Russell (The Secret Trauma) and David Finkelhor (Child Sexual Abuse), girls are abused by men 95% of the time and boys are abused by men 80% of the time. (Bass and Davis, 1988, p.96) Child sexual abuse has been written about and discussed for many years although not as openly as it is now. Freud was the first to identify mental health issues in adult survivors of childhood sexual abuse. (Russell. 1986, p. 4-6)

The late 40’s to early 50’s Kinsey studies did identify the largest number of incest cases but actually minimized the trauma that this should cause and urged the public that “children should not be upset by these experiences”. Kinsey attributed trauma as the result of adults’ own attitudes towards it as causing hysteria. The control and power aspects were ignored and were simply advocating men’s greater sexual proclivity. (Herman, 1981, p. 16-18) The public was apparently not ready to deal with this issue. (Encyclopedia or Social Work, 1987, p. 256), (Lew, 2004, pp. 100-140)

What brought incest and child sexual abuse to the forefront in the 1970’s was the women’s liberation movement. At that time domestic violence, rape and child sexual abuse were finally in the spotlight. Diana Russell conducted a random study in San Francisco. Nine hundred women were interviewed about their sexual abuse experiences as children. The results were that 38% were abused by relatives, friends or strangers under the age of 18. (Crewdson, 1988, p. 25) In 1985, Bud Lewis conducted a “poll”. The sample was 2,627 males and females from all over the US. He found that
27% of women and 16% of men reported early sexual abuse. That was 38 million victims. (Crewdson, 1988, p. 27-28) One in three girls and one in seven boys are sexually abuse by age 18. (Bass and Davis, 1988, p. 20) The typical sexual offender molest 117 children on average, and most do not report the offense (NIMH, 1988). When incest and child sexual abuse was examined out of the United States there are staggering numbers. Many other countries however sanction incest and child sexual abuse as rites of passage or normal activities for the health or pleasure of adults, to help the child sleep better, to teach the child about sex and the justifications are numerous. These studies will not be treated in this course but mention of it is for future study by the professionals wishing to pursue studies of differing cultural behaviors and treatment of children.
PART 111: Characteristics of the Perpetrator

There are characteristics that child sexual perpetrators seem to have in common just from observation and recent attention to this factor. Some of these are: they are “dependent, inadequate and have family history of conflict, abuse, abandonment, exploitation. Alcoholism is a factor in up to 90% of the abuse cases and 46% are alcoholics. (Burns, 1982, pp. 304:8-9) Some were sexual abuse victims themselves and it seems like court action seems to be the way to assure they will obtain treatment.” (Encyclopedia of Social Work, 1987, p. 256) Sexual offenders can be men or women and some themselves have been sexually abused as children. Some perpetrators have unmet needs for closeness and affection. They do not know how to meet those needs in an intimate and close relationship so they learn to use sexual gratification to meet the needs. Emotionally immature the sexual offender does not know how to have adult sexual relationships that are gratifying and can resort to power and control to achieve the goal, sex. Alcohol and drugs can play a big part in sexual abuse of a child. Usually the person feels powerless and ineffective in daily life. Many times they were sexual abused themselves. Some are psychotic and do not know it is wrong. The same applies to sibling or another child as the perpetrator in regard to being victims themselves. (Courtois, 1988, pp. 35-75) Many other combinations of characteristics can occur and it is encouraged to seek out this information if the professional is going to engage in therapy with perpetrators.
PART IV: Characteristics of the Incestuous Family

Although there is no absolute type incestuous family, there are some commonalities. Some caveats are necessary here. The commonalities seen are mostly from study of father-daughter incest since it is the most common. Study of the incestuous family is fairly recent. There have not been many scientific studies. The characteristics are fluid since each family is different. To sum this up, incest is “multifactorial in origin…occurring under a variety of circumstances for many reasons.” (Meiselman, 1978, pp. 140-141)

That being said, these are the similarities that have been found present in incestuous families.

1. The family is found to be socially, physically and psychologically isolated from the outside and the family members are very enmeshed and overly dependent on each other to have their needs met. The interesting feature is that they also seem to be very unemotional and not very physical. Within this observation there seems to be two categories of family types, a. the chaotic family and b. the normal appearing family. (Kempe and Kempe, 1984) The chaotic family is the prototype and is characterized by problems spanning generations, low socioeconomic standing, marginal functioning of the members, i.e., criminal involvement, substance abuse, welfare involvement, low education level, vocational inadequacies for examples. The children from the chaotic family are mostly unsupervised by adults and raise themselves, care for each other, and are quite dysfunctional. The normal appearing family seems to function well and have
higher social standing, education and vocational status. Internally however the parents are unable to nurture and are needy emotionally, are alienated from each other due to almost planned differing work schedules thereby leaving the children with one or the other parent. Children in this type family often become little adults and take on adult roles in the family. (Courtois, 1988, pp. 38-40) The children are at risk of sexual abuse from family members as well as outsiders.
PART V: Symptoms and Aftereffects

Browne and Finkelhor in 1987 concluded that 40% of victims of child sexual abuse actually had serious enough trauma to require adulthood mental health counseling. Issues identified were: trust and intimacy issues, depression, suicidal ideation, substance abuse and dependency, eating disorders, low self-esteem, guilt, anger, self mutilation or destructive disorders, feelings of alienation and being different and more lonely.

Courtois in her book Healing the Incest Wound elaborates on the many effects of incest and child sexual abuse. Victims can have unhealthy sexual behaviors, inability to engage in normal sex, confused sexual identity, and inability to enter relationships. There can be social aberrations, such as rebelliousness, inability to connect with others emotionally, or for that matter to feel at all, and a penchant for entering dysfunctional relationships. (Courtois, 1988, pp. 100-115) The victims can experience profound loss and inability to feel safe or loved, flashbacks and recurring memories or nightmares, or they may have impaired memory for the abuse due to dissociation. Whatever the symptoms, they are always painful and stressful and necessitate long and difficult treatment.

Incest and child sexual abuse can leave the victim with many long-term effects. This information is from many sources, from reports from victims, empirical studies to clinical studies. They are variable with each victim and have many other factors making it critical that the clinician access each case individually. Briefly, the symptoms can be summarized as follows: acute anxiety, rage, guilt, fear, compulsive behaviors, rebelliousness, fear of sleeping, or sleeping alone or in the dark, sadness, lethargy,
memory impairment, confusion, delinquent behavior, depression, lack of trust, low self esteem, denial, blunted emotions, abandonment issues, multiple personalities, social withdrawal, acting out behaviors, nightmares, sleep disturbances, suicidal feelings or acting out, eating disorders, sexual acting out, borderline and psychotic states, post traumatic stress disorder, sex play and sexual aggressiveness, seductiveness, fear of sexual behavior, self mutilation, substance abuse, and others.

Physical effects can range from genital lacerations, cuts, bruises, sexually transmitted diseases (STD’S), swelling, internal damage from insertion of objects, difficulty urinating or bedwetting, GI symptoms, pain, nausea, ulcers, stomach cramps, insomnia, nightmares, night terrors, migraines, startle response, dissociation, fear of being trapped or attacked, inability to concentrate, signs of self-injury.

Long term, the victims can suffer many effects such as lack of ability to bond or form healthy relationships, post traumatic stress disorder, depression, sexual dysfunction, low self worth, physical scarring or damage, many types of physical illnesses and disorders, feelings of alienation and being different and more. (Courtois, 1988, pp. 90 – 117), (Blume, 1990, pp. 1-100), (Gil, 1988, p. 28). Courtois in her book Healing the Incest Wound elaborates very well on the many effects of incest and child sexual abuse.
PART V1: Interviewing and Diagnosing

Incest and child sexual abuse victims constitute a large portion of those in therapy, but diagnosing them can be difficult. Disclosure is difficult for the majority of the victims. Many factors are involved in this difficulty. Victims might have been threatened and fear disclosure. Some might have guilt feeling that they somehow caused or asked for the abuse, some might be in denial due to a loyalty of the abuser, fear of the abuser, inability to remember the abuse due to dissociation, confusion about what was real and what was not. Diagnosis can involve not just the initial interview but also possibly many weeks of questioning. A clear-cut diagnosis may not emerge easily, however, the skill of the professional can predict the success or failure of the treatment. Not every professional is qualified to treat such profound trauma. In order to diagnosis the victim much data needs to be gathered. It will be necessary to elicit memories that are accessible and pertinent. The victim must feel safe disclosing. This is a challenge for the professional. Probing must be gentle and non-threatening for the victim. There must be reassurance and validation, information giving, and support. The victim must feel and hear that they are believed and accepted. The professional who is calm and does not rush the client, who does not remain a blank screen, who is not uncomfortable hearing or discussing the abuse and who is very validating is preferred. (Renshaw, 1982), (Josephson & Fong-Beyette, 1987, pp. 475-478)

There are guidelines for the professional who is interviewing the victim. Important is that the professional gives reassurance that the victim is believed, that they are not at
fault, that the perpetrator is responsible for the abuse, that the victim was not in control of what happened to them, that their confidentiality will be protected, that they can heal and that nothing they say will change the professional’s feeling toward the victim.

The professional should validate that there may be worse feelings after disclosure, that they have the right to feel anger, grief, loss, loyalty toward the perpetrator, that progress in healing may be in little steps, that there is no rush, that they are valuable and strong. During the counseling direct questions should be asked and a complete history should be taken including sexual history. Mention of symptoms are typical of other victims’ symptoms and that they are not alone. The professional should define incest or child sexual abuse to the victim and should be persistent in the probing of the sexual abuse history. The abuse should be identified to the victim as a main source of the pain and difficulties in their life. The incest or child sexual abuse should be acknowledged as serious, not be minimized and the victim should be urged to “dwell” on the abuse.

During the process the professional should remain aware of his or her own reactions. (Courtois, 1979, pp. 140-144)

Previously there was no single diagnosis for incest or child sexual abuse. The professional had to search for all the separate diagnoses that the victim displayed, such as PTSD, Anxiety Disorder, Panic Disorder, Eating Disorder, Substance Abuse Dissociative Disorder, Depression, Sexual Dysfunctions, etc. Sexual dysfunction, Now the DSM V does have several diagnoses for incest and child sexual abuse. (Courtois, 1988, pp. 145-175) The professional is encouraged to spend time getting familiar with the diagnoses and also the other concurrent disorders that can occur with the incest or child sexual
abuse diagnosis. It will not be treated here, as understanding and treatment are the author’s main focus of this course.
PART V11: Challenges in Interviewing the Victim

For the clinician getting the client to disclose sexual abuse can be a difficult task. There are several challenges when interviewing a victim of sexual abuse.

1. No conscious memory of the abuse
2. Denial of the abuse
3. Fear of punishment or not being believed
4. Lack of trust in the therapist
5. Guilt that it was their own fault and they asked for it
6. Confusion of whether it is their imagination that it happened
7. Minimizing the abuse
8. Loyalty to the abuser
9. Fear of what will happen to the family

Let us look at each of these.

The victim may have no conscious memory of the abuse: The victim may have been dissociating and not emotionally or mentally present for the abuse. The trauma being so painful or overwhelming may have caused the child to go into an altered state so as not to experience the pain. These memories may be repressed or may not be there at all. Eliciting them can be a long drawn out processes and may involve hypnosis or medication to access the subconscious.
The victim might fear punishment or not being believed if they tell about the abuse:

Many times the victim was warned, threatened, coaxed or rewarded for not telling about the abuse. This can become a very imbedded rule and the fear that what was promised will happen can keep the victim silent forever.

Lack of trust of the therapist can keep the victim silent: A child who is abused and robbed of their innocence can learn that the world is not a safe place. They find it hard if not impossible to trust anyone. They trusted and were harmed in the worst way so this is very scary for them.

Guilt is a very strong emotion that can keep a victim silent: They might have been told that they asked for what happened, or that they wanted it or liked it. Sex could have been used to get a reward or prize that they wanted and further reinforced that they asked for it, or that they allowed it. The inability to resolve this guilt may keep the victim silent.

Confusion of weather the abuse really happened can keep the victim silent: The victim might have been told that they were dreaming or imagining it, that it never happened and eventually since the abuser might have been threatening or loving, convinced the victim of being crazy or lying, and the victim may truly not be sure if it did happen.

The victim might feel that the abuse was not that bad and therefore might not identify it as a problem for themselves: They might not link their distress as being caused by the abuse.
The victim might love the perpetrator and may want to protect him or her: If it was a person who the child usually got rewards from or treated well by, then they might suffer in silence, believing that the perpetrator loved them and needed their protection.

The victim might fear that the family will be broken up: They might have been told that if they tell they will cause the perpetrator to go to prison and then they will not have a home anymore, or some story that puts the victim in a position to stay silent or be plagued by more guilt and worse. To prevent a terrible break in the family they might stay silent.
PART VII: Treatment and Challenges to Treatment

Treatment of incest or child sexual abuse can be very slow and difficult for the victim.

There is a fourfold philosophy of treatment.

1. Treat the incest or child sexual abuse directly along with its original and compounded effects. Treat the related disorders and symptoms along with the abuse memories and facts.

2. Use the traumatic stress and family systems models to understand the incest or child sexual abuse, its effects, and symptoms and to plan and implement treatment. The family interactions should be explored with the victim in terms of how the family placed the victim in that role.

3. Individualize the treatment for the victim. Speed of healing is very person specific as are the methods each person will respond to as homework or processing for example. Hypnosis and regression, journaling, collages, psychodrama may be helpful for some victims and not for others. Support groups are also suggested.

4. Foster the development of the therapeutic relationship in a safe environment. Build the trust over time and create the safety and support the victim’s needs.

After the interview and diagnoses are completed then the treatment plan is formulated with the input of the client. This begins the development of the therapeutic relationship, which is critical. (Blume, 1990)
The next step is deciding which of the presenting symptoms take priority. These are symptoms that might be life threatening and need immediate attention to stabilize the victim. In working with the victim the child within will need to be addressed and this may cause some regression at times during the healing process and treatment. (See Inner Child work. John Bradshaw is an excellent source for this).

Resistance, denial and self-defeating behaviors should be addressed and confronted gently. The work with the adult part of the victim stresses strengths and positives, but also involves working on eliminating self-defeating behaviors. During the treatment there will be a point that the adult self that has been strengthened will nurture the helpless inner child in effort to integrate them. This will create a new family model for the victim, one that is nurturing and healthy. This phase may be very long and drawn out. The professional should press with persistence.

At some point confrontation of the family and perpetrator may be important for the victim’s healing. The power the victim can gain from this is valuable. In time the victim will heal and will learn new ways to deal with the past and future. (Courtois, 1988, pp. 145-175)

During treatment, the victim may present with challenges to the therapy. These can come in the form of:

1. Denial: minimizing the trauma.
2. Sabotaging: engaging in self-defeating behaviors, regressing, substance abusing
3. Resistance: forgetting to do the homework, refusal to do the homework, dissociating.
4. Unable to move forward due to guilt, fear or loyalty to the perpetrator.

5. Distracting: finding things to avoid dealing with their issues.

These are things for the professional to be alert to and have a plan for working with the challenges. Clients may become more erratic with their compliance the close they get to the core of the pain. The professional may have to go back to earlier phases of treatment in order to deal with the challenges and then once again move forward. (Blume, 1990)
PART IX: RESOURCES

This list is short but accurate and will provide professionals with many more lists of resources for victims included in some of them on the websites or by calling them. It is a current list and all phone numbers are working and correct.

1. **Rainn (Rape, Abuse & Incest National Network)**, 1-800-656-hope

2. **The Awareness Center** – Resources for Jewish Survivors of Childhood Sexual Abuse (JCASA) PO BOX 65273, Baltimore, MD 21209, 443-857-5560 For a comprehensive list of resources for all races, religions denominations, email groups, and more. The list is too long to include here but you will find all the resources you need on this list. The author was very impressed with the center and the resources after speaking with them. Please utilize this resource list, as it will provide many benefits.

3. **Incest Resources (I.R.)** - all-volunteer non-profit organization. Founded in 1980 it was the first survivor resource in this country. It offers recovery, educational resources and materials to survivors and professionals. 46 Pleasant St., Cambridge, MA 02139-3899.

4. **PAVSA** (Program for Aid to Victims of Sexual Assault, a center with comprehensive Programs, materials and other resources. 1-866-2297425
5. **Voices in Action** – international organization providing assistance to adolescent victims of child sexual abuse and sexual trauma. 1-800-7voice8

6. **PROTECT.ORG** 828-350-9350 List of many links and resources for victims
HIGHLY SUGGESTED READING


In conclusion, victims are survivors and the quality of the professionals’ assessment and treatment of the incest or child sexual abuse trauma will determine the success the survivor has in complete healing and living a better quality of life.
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Thank you for giving me the opportunity to share with you years of experience in working with incest and child sexual abuse victims. If you choose to specialize in this area it will be very difficult at times and very rewarding over time.