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ABSTRACT

Increasing numbers of reported cases of child sexual abuse (CSA) are leading to greater numbers of such children being placed in foster care. Findings suggest that sexually abused children and their families have a multiplicity of problems that form the basis for removal from the home. In addition, sexually abused children are returned to the home sooner than other children placed in care. Consequently, it is imperative that during placement specialized sexual abuse-specific services be made available to these children and their families in order to strengthen the child and the family system as a means of forestalling revictimization and/or a return to foster care. Specialized sexual abuse units within foster care agencies are being recommended as the vehicle for the delivery of services to CSA children and their families where placement is required. The Sexual Abuse Unit (SAU) of the Harlem Dowling West Side Center is one of these units. As a consequence of an awareness of the individual and familial complexities involved in intra-familial child sexual abuse the structure and delivery of SAU services is multidisciplinary. SAU services include placement, foster parent recruitment selection, medical examination, disclosure validation, clinical interventions of individual, group, and family therapy, case work counseling, case services, training, and reunification. (Author/ABL)

Child Sexual Abuse Units
New Direction in Foster Care

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Abstract--Increasing numbers of reported cases of child sexual abuse (CSA) are leading to greater numbers of such children being placed in foster care. Findings suggest that sexually abused children and their families have a multiplicity of problems that form the basis for removal from the home. In addition sexually abused children are returned to the home sooner than other children placed in care. Consequently, it is imperative that during placement specialized sexual abuse specific services be made available to these children and their families in order to strengthen the child and the family system as a means of forestalling revictimization and/or a return to foster care. Specialized sexual abuse units within foster care agencies are being recommended as the vehicle for the deliverance of services to CSA children and their families where placement is required.

Introduction

Despite the growing social services focus upon family preservation, and as a consequence of the continuing negative social impacts on individual and family functioning, there continues to be a need for out-of-home placement of children. Although there are many who perceive that placement outside the home represents an additional trauma for the children, there are those such as Widom (1991) who contend that appropriate placement acts as a protective factor for abused and neglected children. It is the contention of Widom that such placements mitigate against negative outcomes such as subsequent criminal behavior. Specialized sexual abuse units, within foster care are being advocated for here as being not only appropriate, but necessary. This is true if the complex needs of

incestuously sexually abused children and their families are to overcome the pattern of family dysfunction and traumatic consequences associated with the abuse.

Over 350,000 children are in foster care as a consequence of parental abuse and/or neglect, with sexual abuse involved in approximately 15% of all cases (Finkelhor, 1983). Based upon this estimate it may be assumed that approximately 52,500 children are in care as a consequence of sexual abuse. Between 1980 and 1988 there was a 322% increase of reported cases of child sexual abuse nation wide (National Center on Child Abuse and Neglect, 1988). These figures indicate the alarming rate at which this problem is growing. Still, recent estimates indicate that only 11.3% of children for whom there is substantiation of sexual abuse are actually placed in out of home care as compared to 10.3% of children across all categories of maltreatment (American Humane Association, 1988). These numbers imply that sexual abuse alone is not the rationale for placement. In sexual abuse cases, as in other instances of abuse or neglect, the decision to remove the child is based upon a number of factors (e.g. inadequacy of income, parental substance abuse and/or mental incompetence (Lindsey, 1991). In addition, in cases of sexual abuse, decisions to place are significantly impacted by the accused offenders' (in most instances a male) residential status in the home, and the level of maternal support (Hunter, Coulter, Runyan & Everson, 1990).

Consequently, in most instances of child sexual abuse where the child is removed from the home, the abuse is intra-familial with a familial relationship existing between the child, non-offending parent (most often the mother) and the accused offender (e.g. husband, live in lover, paramour). It should be noted that intra-familial sexual abuse has been found, by many professionals in the field of sexual abuse, to be more traumatic as a consequence of the complex interdependent relationships between the child, the non-offending parent and the accused offender (see Sgroi, 1982, Russell, 1986; Brier & Runtz, 1988). Boots (1986) speaks eloquently to this issue.

> A common impression and finding is that less severe sexual abuse occurring in the home of a disturbed family is much more traumatic than the sexual abuse of a child perpetrated with greater aggression, by a stranger completely outside the family. In a healthy family a child abused by an outsider can be immediately comforted and supported and helped to deal with the trauma thereby minimizing later difficulties. There is a danger in generalizing here, however, as the psychological consequences of stranger assault may well require more than just family support (p 13).

As a consequence of such perceptions many theorists in the area of child sexual abuse have focused upon the family system, as opposed to individual pathology in the delineation of abuse and in related clinical interventions (Giaretto, 1982; Sgroi, 1982; Summit, 1983). Most would agree that it is within the family, in interaction with significant others that the child's sense of self develops. Therefore, the

sexual victimization of a child, by someone in a parenting role, involves an assault upon the child's basic trust, thereby triggering the development of defensive strategies needed to re-establish the sense of security (see Gelinas, 1983). This may include accepting the role of caretaker for the family as a means of obtaining a sense of control. It is also true that incestuously abused children (children abused by a parental figure) have frequently been placed in the role of substitute parent (parentification) where they are expected to meet the needs of their parents as well as parenting the other children in the family (Sgroi, 1982).

In incestuous families the parent(s) inability to nurture and parent may be due to individual pathology, substance abuse, mental incompetency, or simply a lack of basic parenting skills (Lie, Gwat-Yong & McMurtry, 1991). In addition, and of importance, the nonoffending parent's dependency (economic, emotional) upon the offender may lead to the rejection of the child, refusal to acknowledge the abuse and/or the blaming of the child for his/her sexual victimization once the victimization is disclosed or uncovered. There are, therefore, numerous issues that negatively impact the relationship between the nonoffending parent and the child victim. Consequently, intra-familial sexual abuse intrudes upon the child's experience and development in a manner that other forms of abuse do not.

In addition, the experience of incestuous abuse is confusing for the child victim due to the intimate and conflictual nature of the experience. Incestuous offenders seduce and manipulate their victims into both compliance and secrecy, using deception, coercion and sometimes force. It is not unusual for the offender to be the person that is emotionally available to the child victim and the source of the majority, if not all, of the nurturance the child receives (Sgroi, 1982). For such children sex may become central to the experience of being loved and nurtured while being associated with guilt and self-blame. This latter response may occur due to either the child's awareness of the negative connotations associated with such experiences, the demands for secrecy made by the offender and the association of disclosure with negative outcome (e.g. threats of physical violence to the child or family members, loss of love, the disruption of the family through placement for which the child may feel responsible).

It is therefore, apparent that children placed in foster care, as a consequence of intra-familial sexual abuse, require an extensive range of services directed towards the resolution of both intra-personal and familial conflicts. Such services require foster parents, social work staff members and clinicians trained in the dynamics of child sexual abuse as related to the victims themselves and to the families to which most of these children will return. In

addition, service delivery must be structured in a manner that encorporates all of the disciplines involved in servicing the child victim and his or her family. It is for this reason that the establishment of sexual abuse units within foster care agencies is being recommended. The Sexual Abuse Unit (SAU) of Harlem Dowling West Side Center for Family and Childrens' Services (HDWC), a New York City foster care agency, is being offered here as a model of such a service, with the staffing structure and all services from initial referral to final disposition, being delineated.

The Sexual Abuse Unit

Cultural Implications in Structuring Service Delivery:

Harlem Dowling West Side Center for Children and Family Services (HDWC) services a predominantly Black and Hispanic population with a small, but growing number of White children and families being referred for service. HDWC has found an increased need for an awareness of both within group differences (e.g. American versus Island Black, Puerto Rican versus Cuban) and between group (Black versus White) to the successful delivery of services. The Agency is, therefore, attuned to the impact of culture. It seems apparent that the culture of the individual being serviced in any bureaucratic setting must be addressed, with cultural nuances being encorporated into the structure and process of service delivery. Although we are all impacted by the dominant culture, it is within our own families, extended

families and communities that the sense of self, within a cultural framework, develops and grows. Therefore, those of us working with members of cultures that are significantly different from our own must be open to, become knowledgeable of, and respect the cultural traditions of the children and families we service.

Cultural differences can be observed in many areas of existence and experience such as differences in language including the differing meaning given to words, definitions of family (nuclear, extended), issues of family hierarchy, deference and respect, communal responsibilities, nutrition, health care and religion, to name just a few. These cultural differences would include the belief systems of both clients and caregivers (religion, belief in the paranormal, voodoo, espiritismo). In order to accommodate these differences mutual respect between care giver and receiver of services is essential. We (deliverers of service) must develop our listening skills if we are to become attuned to differences in a positive and accepting manner. This attunement will allow us to better understand the "meaning" of experience as expressed in behavior (see Greene, 1992) for those with whom we are working, thereby further enhancing our ability to be of real service.

Therefore, the philosophy of the Sexual Abuse Unit encorporates a holistic view of individuals and families

requiring an approach to service delivery that recognizes that the individual, the family and their culture as interacting systems affecting and being affected by oneanother. Interventions that do not consider all of the systems involved are doomed to fail.

History of the Unit:

In 1988 3,255 cases of child sexual abuse were reported in New York City with 631 cases being reported in the borough of Manhattan where HDWC is located. The Sexual Abuse Unit (SAU) of Harlem Dowling West Side Center (HDWC) was established in 1988 with a grant from the Manhattan Borough President's office as a four year pilot project, in response to the growing number of reported cases of child sexual abuse in the New York City area. The Unit was originally funded to offer 48 beds to sexually abused children referred for placement by the Child Welfare Administration. Over the years the number of children serviced has grown to a varying enrollment of 100 to 120 children. As a consequence of the awareness of the ongoing need for such services, at the end of the four year grant, HDWC added the SAU to the agency's list of ongoing specialized programs.

As a consequence of an awareness of the individual and familial complexities involved in intra-familial child sexual abuse the structure and delivery of SAU services is multidisciplinary. As stated earlier, the children and

families are perceived to be interacting units, therefore, requiring a multiplicity of coordinated services with service deliverers (e.g. social workers, clinicians, sexual abuse specialist) collaborating in both the development, delivery and monitoring of services and related individual and family functioning. In addition, a central focus of all interventions is the empowerment of the child as a means of ameliorating the experience of helplessness central to the experience of sexual victimization (Summit, 1983).

SAU Staff Members:

The staff of the SAU consists of two social work supervisors, six case workers, four parent aides, a coordinator, a sexual abuse specialist, and mental health services being provided by consulting psychologists and a consulting psychiatrist. In addition, medical, educational and independent living skills services are delivered to the SAU by those specific units within the HDWC structure.

The Referral Process

Referrals to the SAU may originate from a number of sources such as (a) Child Welfare Administration (CWA), (b) area hospitals, (c) foster care agencies, (d) mental health and social service agencies, (e) HDWC foster care and preventive units. It should be noted that all outside agency referrals are allocated from CWA to HDWC Home Finding Unit even though the original referral may be made directly to

HDWC. It is at the point where all referrals are allocated through the Home Finding Unit that the interaction and collaboration between service deliverers begins.

Services: Structure and Timetable

Placement Procedures:

For new placements (out of agency referrals) CWA refers the child(ren) to HDWCs Home Finding department from which the sexually abused children are then referred to the SAU for placement. Within agency referrals (Foster Care, Prevention, Substance Abuse) to the SAU are referred back to the Home Finding department for certification of the placement.

Foster Parent Recruitment Selection:

A concerted effort is made to recruit foster homes chosen specifically for sexually abused children. Churches, Day Care and Head Start centers and other community organizations (e.g. schools) are contacted as sources of foster parent recruitment. Sexual abuse orientation workshops are offered in the community as a means of fostering participant interest in becoming foster parents for the SAU. Foster homes for the Sexual Abuse Unit are carefully selected with prospective SAU foster parents being interviewed by the Sexual Abuse Specialist, utilizing interviewing instruments designed to assess those skills relevant to parenting sexually abused children (e.g. education, professional and work history, awareness of the

issue of child sexual abuse, appropriateness of their responses to sexual abuse specific scenarios, degree of flexibility as indicated by responses to the interview questionnaire). An attempt is made to match parent and child based upon cultural imperatives (as outlined earlier) and temperament (e.g. sexually acting out children are not placed with foster parents whose religion causes them to be rejecting or judgemental in their response compulsive sexual behavior). In addition, the homes of prospective foster parents are assessed as to sleeping arrangements, and the presence or absence of opposite sex children and adults. This latter assessment is important as a consequence of the vulnerability of child victims of sexual abuse to revictimization and the fact that a small percentage of CSA victims become victimizers of other children. Therefore, such potentialities are thoroughly investigated prior to placement, and carefully monitored once a decision to place has been made. In addition, SAU children receive child sexual abuse prevention training as a means of prevention of, or early intervention into possible within care abuse.

Medical Examination:

HDWC medical personnel have received training in the area of child sexual abuse. Therefore, all of the children receive a thorough medical examination upon placement with any sexually transmitted diseases (STDs) being diagnosed and receiving appropriate treatment. The presence of sexually

transmitted diseases and physical evidence of sexual contact (e.g. vaginal or anal trauma) are documented in the child's record and are reported to CWA. It should be noted that in most cases of child sexual abuse there are no physical findings such as those described here, which makes cases of CSA more difficult to prove. It is for this reason, and others, that the disclosure process must be formally structured so as to meet the rigorous scrutiny of the legal system.

The Disclosure Validation Process:

Either upon placement or prior to placement in the SAU (where the child is being referred from within HDWC) the child is referred to the Sexual Abuse Specialist to be interviewed in reference to the allegations or suspicions of sexual abuse. The Sexual Abuse Specialist has specialized training and experience in the area of child sexual abuse and utilizes a Sexual Abuse Validation Protocol, designed by ner, and the anatomically correct drawings of the Forensic Mental Health Association, to assess and document the child's disclosure, or lack of disclosure of sexual abuse. It is important to note that anatomically correct dolls are not used in the disclosure validation process as a consequence of legal questions being raised as to their validity. The validation process occurs, whenever possible, prior to clinical intervention, and with the validator having no prior knowledge of the content of the allegations or suspicions.

These steps are taken as a means of avoiding possible contamination of the child's statements. The documents completed by the validator (Child Sexual Abuse Specialist) become a part of the record and are made available to all appropriate parties (Child Welfare Administration (CWA), the Criminal and Family Court, the child's law guardian and defense attorneys) upon subpoena. In addition, both the anatomical drawings and the protocol form the basis of the expert witness testimony of the Sexual Abuse Specialist upon subpoena to testify in either Family or Criminal Court. This formal structuring of the disclosure process gives added validity to the child's statements of sexual victimization within the legal process. It should be noted that the Disclosure Validation Protocol has been instrumental in a number of successful prosecutions and has been commended by the Brooklyn, New York District Attorney's office (and other agencies). In addition to facilitating legal decisions in the best interest of the child this process enhances the child's experience of empowerment, which is a central focus of all SAU interventions and services. Upon completion of the disclosure validation process the validator makes recommendations for psychological services (assessment; individual, family, group therapy).

Clinical Interventions:

A psychological evaluation is completed for each of the children in those instances where no current psychological is

made available from the referring agency. This is done as a means of assessing the level of the childrens' cognitive and emotional functioning and the degree to which they have been traumatized by the experience of the abuse and related consequences (e.g. separation and loss through family disruption). The psychological evaluation and the psychosocial (completed by the case worker) form the basis of the treatment plan, through the collaboration of the case worker and the clinician in its development.

Clinical interventions consist of Individual, group and family therapy, all of which are delivered either inhouse or by outside clinicians.

Individual therapy focuses upon the individual dynamics of the child or natural parent as specific to the sexual abuse (e.g. guilt, responsibility, blame, low self-esteem) or individual pathology or deficits (e.g. neurosis, unresolved dependency needs), and the child's development of a sense of personal power as a means of resolving the experience of helplessness and of forestalling future victimization.

Group therapy (child) focuses upon sexual abuse specific issues such as the child's perception of him/herself as damaged, sexual behavior and feelings, identity and esteem related issues and issues related to social functioning (e.g. peer group identification).

Family therapy focuses upon family issues such as roles and role boundaries, parent/child relationships, the re-

establishment of trust and the reunification process where appropriate. In addition the social skills of individual family members and the family as a whole are addressed.

Case Work Counselling:

The case worker assigned to the case completes the psychosocial, documenting the developmental history of the child and family history through interviews with the natural parent(s) when available and through family members when natural parents cannot be contacted. As stated earlier, the case worker and the clinician collaborate in the development of the treatment plan, utilizing both the psychological evaluation and the psychosocial to formulate treatment strategies (therapy, case work counselling, parenting skills training, referrals to and monitoring of substance abuse programs for addicted parents, offender programs for parental offenders). Case workers assist natural parents in obtaining public assistance and appropriate housing where indicated. In addition, the worker makes home visits, school visits and observes the interaction between both natural parent and foster parent and child.

It is important to note, as can be observed by the process outlined above, that the case worker and the foster parent bear the greatest responsibility for meeting the needs of the children and families being serviced by the Sexual Abuse Unit. Therefore, the resources of the agency are

consistently directed toward supporting them in the endeavor to meet these responsibilities.

Case Conferences:

Case conferences are central to a multidisciplinary approach to service delivery. They are interdisciplinary team conferences participated in by representatives from all of the servicing disciplines (e.g. social work, mental health, medical). A modified case conference, in which only pertinent personnel participate, is held prior to placement, at which time foster home selection is made. A full case conference is held within 90 days of placement, with subsequent case conferences being called on a quarterly basis or in response to a crisis situation. The case worker calls case conferences and brings to the conference information gathered from observations. The case worker, then collaborates with the clinician and other relevant personnel in reviewing the case and developing recommendations designed to address issues requiring intervention (e.g. natural or foster parent/child conflicts, school related problems). Input from all relevant staff is solicited for incorporation into the case conference process (e.g. medical, mental health, education, independent living) with written recommendations being submitted when the physical presence of the professional is not possible. This process assures that the needs of children and families are addressed holistically (not in isolation from relevent factors).

Training:

Central to the efficacy of the Sexual Abuse Unit (SAU) is the level of skill of both foster parents and staff. This requires that they be knowledgeable of the individual and family dynamics related to child sexual abuse, the legal implications, and the relevant skills necessary for parenting or servicing the children and families of the SAU. Therefore, separate core curriculums of foster parent and staff sexual abuse specific training are developed and implemented. The training is designed to address the particular knowledge and skills areas relevant to their responsibilities (case work, parenting). This training is in addition to agency wide training in which all staff and foster parents participate (e.g. child development, foster care guidelines, AIDS/HIV).

Foster parent training workshops include (a) Child Sexual Abuse Orientation, (b) Child Sexual Abuse and the Courts, (c) Child Sexual Abuse and the Therapeutic Process, (d) Family Life and Family Systems, (e) Natural Parents versus Foster Parents.

Staff training workshops include (a) Child Sexual Abuse Orientation, (b) Child Sexual Abuse and the Courts Child Sexual Abuse, (c) Individual and Family Dynamics, (d) Family Systems Theory and Sexual Abuse, (e) Child Sexual Abuse and the Therapeutic Process, (f) Sexual Abuse and the Special Child.

In addition there is Child Sexual Abuse Prevention Training for the children and foster parents.

Reunification:

The reunification process begins at the time of placement with all of the service deliverers actively involved in preparing the family to come together again as a unit. This requires that the case worker address social work issues relevant to this process (e.g. housing, parenting skills development, substance abuse recovery, clinical intervention for parental offenders) assuring that the natural parents be referred to and participate in those programs targeted to meet their specific needs. The servicing clinician works with the children and the natural parents to resolve both intra-psychic trauma and intra-familial conflicts associated with both the sexual abuse, individual and familial deficits and social inadequacies. The process includes, (a) supervised agency family visits, (b) unsupervised agency family visits, (c) unsupervised weekend family visits, (d) prolonged, unsupervised family visits, (e) Trial Discharge, (f) Final Discharge.

The reunification process, from placement to Final Discharge, is closely monitored by the caseworker who conferences with the servicing clinician (therapist) with the continuation or disruption of the process being decided based upon the needs of the child(ren) and with the consent of the

Child Welfare Administration (CWA). At Trial Discharge the family is referred for preventive services to an agency within their community.

Conclusions

As a consequence of the growing institutional emphasis upon family preservation, the foster care population is rapidly changing. Families, at risk for disruption, are being identified and given the preventive and supportive services needed to heal and maintain them. This process is intended to avoid family disruption through the out of home placement of the children. Therefore, the majority of children currently being placed in care are extremely complex in their needs having families that require more than supportive and preventive services to render their homes the nurturing and safe havens they must be. Consequently, the move of foster care should be toward the establishment of specialized units, designed to meet the special needs of the children being placed (e.g. sexually abused, special needs, AIDS/HIV). These units must be designed to approach the delivery of service from a multidisciplinary perspective, with a central focus of all of the disciplines involved being the delineated area of focus (e.g. sexual abuse). Consequently, service delivery must be planned and coordinated through the participation of representatives from all relevant disciplines acting in concert within a unifying construct. The effectiveness of Harlem Dowling West Side

Center's Sexual Abuse Unit (SAU) in servicing sexually abused children and families can be observed in its increasing designation by community hospitals and mental health and child welfare agencies as a preferred choice for placement of children requiring removal from the home. This speaks to the need for such units within foster care agencies. Therefore, the intent of this paper is to initiate a proliferation of such units, through the expansion of an awareness of the need for them, and a delineation of the efficacy of the form of intervention being advocated.

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