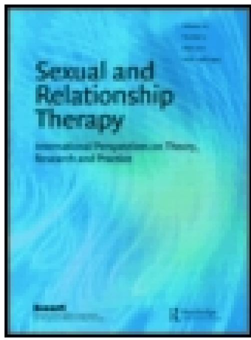

Sexual and Marital Therapy

ISSN: 0267-4653 (Print) (Online) Journal homepage: http://tandfonline.com/loi/csmt19

Sexual abuse: How far do the ripples go?

Jeya Balakrishna

To cite this article: Jeya Balakrishna (1998) Sexual abuse: How far do the ripples go?, Sexual and Marital Therapy, 13:1, 83-89, DOI: 10.1080/02674659808406546

To link to this article: http://dx.doi.org/10.1080/02674659808406546

Published online: 14 Dec 2007.

Submit your article to this journal

Article views: 34

View related articles

Citing articles: 5 View citing articles

Full Terms & Conditions of access and use can be found at
http://tandfonline.com/action/journalInformation?journalCode=csmt20

Download by: [Juliet Grayson] **Date:** 03 February 2017, At: 13:16

BRIEF REPORT

Sexual abuse: how far do the ripples go?

JEYA BALAKRISHNA
Shaftesbury Clinic, Springfield University Hospital, (in association with St George's Hospital Medical School), London SW17 7DJ, United Kingdom

ABSTRACT *Case examples from a forensic psychiatry service are described to illustrate the knock-on effects of sexual abuse, which go beyond perpetrator and victim to affect their families and friends, and professionals who deal with this problem. Society and professionals have difficulty dealing with the deviant sexuality of the abusers. An interactional model of societal, legal, agency, client and personal factors can aid an understanding of the 'ripple effects' of sexual abuse. Workers in this field need to appreciate the social context and the professionalism of the difficult work they do.*

Introduction

Sexual abuse has profound effects, affecting not only the perpetrator and victim, or their families and friends, but also impacting on professionals who work in this area, and on society at large.

In recent decades society has gone through "cycles of discovery and suppression" (Olafson *et al.*, 1993), expressing outrage and demanding action in one phase, or denying the fact of abuse happening in their midst in another phase (Masson, 1984). Public opinion has alternated between accusing professionals of "doing too little too late or too much too soon" (Morrison, 1994), which undermines professional confidence in dealing with sexual abuse.

Work in this area can affect professionals in many ways. In North America, work with sexual abuse revealed 'burnout' among professionals (Ryan & Lane, 1991). In a British survey of professional attitudes, Kelly (1990) discovered differences in views about responsibility of abusers for the sexual abuse and consequences for the abusers. McColl & Hargreaves (1993) examined a sample of probation reports and found that "those who appeared to accept offender explanations or were persuaded that other factors in the offender's circumstances made his actions more comprehensible, suggested lower culpability".

Professionals who do therapeutic work with perpetrators can feel alienated; their friends question their motivation for this work. They can become overly

Received for publication 1st September 1997; accepted 28th October 1997.

0267–4653/98/010083–07 © British Association for Sexual and Marital Therapy

responsible for the outcome of treatment, given that sex offenders tend to project responsibility onto others. Professionals might be horrified to discover sexual aspects in themselves which resemble those in the abusers they are treating. Erooga (1994) says, "we should not expect that we can be repeatedly exposed to accounts of abusive sexuality and not experience some effect on our own sexuality."

That sexual abuse creates 'ripples' is not surprising—it is about sexuality, and it is about deviant behaviour. Society is typically not comfortable with sexuality; sexuality is not visible, it is meant to be contained, it can generate guilt and shame. When it is also deviant—in whatever way this may be defined by a particular culture—it becomes more problematic (Plummer, 1975). The 'ripple effect' can perhaps be understood in terms of stigmatizing processes involving perpetrator, victim, their social circles, professionals and society in general.

This paper will describe case examples to show the 'ripple effect' of sexual abuse. Some of the difficult issues faced by professionals in this field are addressed with a view to promoting an evaluation of professional practice and of self. Clinical, legal and sociological perspectives are commented upon in an attempt to aid an understanding of the different reactions to sexual abuse.

Mr A

Mr A was 40 years old and married when he indecently assaulted the school friends of his 12-year-old daughter in his home while they visited her. In personal history, Mr A alleged childhood sexual abuse by a male friend of his father. His father never really wanted to know, even when Mr A finally disclosed this as an adult. Mr A's father died shortly afterwards, leaving him to feel an incomplete resolution of this matter; he offended in the months after his father's death.

In court, the author represented the views of the sex offender clinic which had assessed Mr A, pointing to significant life events to explain his offending, the presence of depressive symptoms at the time of offending, and Mr A's willingness to engage in psychological treatment.

The Judge appeared to want to reflect public opinion in his disposal. In his judgement, he said "little girls have a right to be protected against people like you ..." The public gallery in court contained a restless crowd of parents and adult relatives of the victims. They heckled and jeered when the author was giving evidence in the box.

Mr A was imprisoned for six months and thereafter engaged in psychotherapy, but his progress was adversely affected by other developments. Mr A's two children suffered derogatory gossip in their schools. They lost friends, as did Mr and Mrs A among their neighbours. Their marriage was on the rocks when social services embarked on child protection proceedings against Mr A.

This case draws attention to the clinical approach to sex offending in terms of identifying psychopathology. There is a body of opinion which suggests that such offending behaviour is a disorder in itself. However, the Mental Health Act 1983 does not allow 'sexual deviancy' to be construed as 'mental disorder'. This could be

interpreted as Parliament's attitude to sex offending, as a reflection of public opinion.

The public has never really been enthusiastic about sex offender treatment. Proponents of the treatment model have to guard against the risk of a public backlash should anything go horribly wrong. In Canada, the assault and murder of a woman by a man attending treatment triggered a public inquiry into the future of such treatment (Cormier, 1988).

Mr B

At the age of 15, Mr B was cautioned for indecent assault of his 12-year-old sister. A psychiatrist giving an opinion then spoke of "sexual activity between a brother and sister at a time when both parents were depressed ..." His parents had financial and marital difficulties and Mr B presented with conduct problems in school. He felt rejected by his family before and after his offence. He developed problem drinking over his teenage years, interspersed with depressive episodes and overdoses. Then at 18 years, he indecently assaulted a teenage female on the street whom he said he was attempting to befriend. The victim said "I thought I was going to be raped ..." The court sent Mr B to prison.

It is not surprising that the agencies involved had differing views on the needs of this young offender. The clinicians commented on the theme of rejection arising in early life as a factor in his developing psychopathology. Social services expressed concern about the family dynamics and potential risk to the now 15-year-old sister. The probation service contemplated community supervision in partnership with the mental health service, but both services were uncertain about Mr B's motivation to comply.

The agencies were agonizing over two conflicting views. On the one hand, this was a young offender with a problematic background who could possibly be prevented from becoming a career criminal. On the other hand, there was a sense of outrage about this young person's behaviour, sexually abusing his little sister and then, only three years later, nearly raping a total stranger, apparently because she had rebuffed his advances.

It is interesting that Mr B, like Mr A, presented with significant events in early life which could have influenced his offending behaviour. But the clinicians saw Mr A as a child victim becoming an adult perpetrator, more willing than the public to offer therapy. In Mr B's case, the professionals' reactions were not unlike public revulsion at a young offender with anti-social traits persisting in his offending.

Ms C

Ms C, 37 years old, married, with two young sons, had been working for more than 15 years in a council office. A young female colleague in the office alleged that she had been repeatedly raped by her male boss. Ms C became embroiled in the ensuing investigations and inquiries. She was asked to provide moral support to her colleague and to be a source of information as this colleague confided in her. Ms C

suffered post-traumatic stress symptoms and recurrent depressive episodes over the next two years as the stories of horrific sexual offending unfolded. She encountered problems in marital relations and in parenting. She was subsequently medically retired by her employers.

The author and Ms C's General Practitioner were involved in providing supportive and specialized therapies for Ms C. Her husband was frustrated by the sense of being left out of his wife's experiences—she would not even talk to him about the sessions with doctors in therapy. He threw himself into the task of defending Ms C's employment rights, consulting with union representatives about potential claims for compensation.

The employers were busy with damage limitation, and it appeared that they considered Ms C, who was on prolonged sick leave, as a burden. Ms C's accounts to the author suggested that many of the employer's senior managers involved in the inquiries were very disturbed by the victim's traumatic experiences.

This case illustrates the 'ripple effect' on the victim's workplace where the abuse allegedly occurred. It shows the effects of sexual offending on third parties, providing a parallel for professionals who do this work and who could become sexually or psychologically vulnerable. There is a lesson here about the need for structured and supervised support for these professionals.

Mr D

At age 14 years Mr D triggered local media outrage when he was convicted of indecent assault on a three-year-old girl and a seven-year-old girl. A psychiatrist at the time expressed the view that he had "no emotional empathy ..." The victims' families subsequently relocated. At age 20 years, Mr D, now employed and self-sufficient, married a 19-year-old woman who was petite with a child-like appearance. She discovered Mr D's past when social services began child protection proceedings for their three-month-old son. She was 'shocked and upset'. She expressed, with great difficulty, her reservations about leaving her son alone with Mr D. She felt could not confide in her own family, who did not get on with Mr D in the first place.

The author and his clinical colleagues were struck by the partner's petiteness and wondered about Mr D's choice of a marital and sexual partner, bearing in mind his offending against young girls. The partner revealed in interview that Mr D had indicated his preference for a baby boy and had appeared relieved when the boy was born. This raised questions about Mr D having anxieties about his ability to deal with his sexual feelings towards young girls.

There was concern about the relatively isolated lifestyle which the couple led—little contact with families and few friends. The couple, and the partner in particular, would have benefited from supportive counselling. In fact, Mr D's partner looked to the social services for support, but instead found herself an object of scrutiny in terms of her ability to protect her son from Mr D.

Social services have to abide by the Children Act 1989, which emphasizes the welfare of the child at risk. This could include placing the child in care if it was felt

that the parents were not able to provide for the child. The Act promotes a partnership approach between social services and parents, but says little about improving the skills of the parents. Social workers have expressed doubt about being able to engender such partnership in a family setting where there are persistent apprehensions about an abusive adult still living with the family (Thoburn *et al.*, 1995).

There is some similarity here to the case of Mr A in the consequences for the perpetrator's immediate family in terms of child protection proceedings. The difference is in the time scale—Mr D's case shows the impact of a past history of sex offending on later life.

Discussion

It is worth looking at the different perspectives on sexual abuse from sociology, clinical sciences and the law. Sociological theories talk about such deviant behaviour as a product of social forces, or state that such behaviour is labelled deviant according to a particular social context (Plummer, 1975; Endleman, 1990). The clinical approach in psychology and psychiatry considers that there must be something wrong with a person to commit such sexual abuse. Probation officers, the police and the courts operate in a legally defined framework to promote social control and order.

It is not surprising that sociological theories of sexual deviance are at odds with clinical and legal approaches, both of which are seen as stigmatizing by sociologists. Sociology attempts to be objective, avoiding the values and ideals which animate society. Endleman (1990), however, promotes a complementary approach:

> We need to know what on the individual psychological level makes the persons who are considered 'deviant' act the way they do ... We also need to ask, if the stigmatizers subject the deviant to stereotyping, discrimination ... how do they, the stigmatizers come to be acting this way? What are *their* intrapsychic processes? (p. 5)

Morrison (1990) has described an interactional model of factors contributing to occupational stress in child protection workers, which can be used to understand better the 'intrapsychic processes' of professionals and society in their reactions to sexual abuse. There is an interplay of issues—societal (gender, sexuality, religion); legal (criminal justice, legislation about mental health and child protection); agency and interagency (management processes, procedures, collaboration, colleagues); clients (perpetrator, victim, families, social and work circles) and personal (knowledge, skills, values, beliefs, life experiences).

Sexual abuse raises difficult issues for society. There is debate about criminalizing such abuse—convicting abusers and locking them away to protect the public—versus views that these persons must be disordered in some way and need treatment to be made less dangerous. This debate generates further questions—whether prison is counter-productive, whether sex offenders are treatable, whether existing treatment methods are successful or have adverse effects.

Professionals doing therapeutic work with sexual abusers must realize that the community is their client as well. "Because the community has a stake in the outcome, it has a legitimate right to know that evaluation and treatment are being conducted in a way that has a reasonable chance of accomplishing the primary purpose of preventing further victimization." (O'Connell *et al.*, 1990).

Professionals have to be aware of the wider influences of social forces and public interest as the context for their professional practice. They have to consider personal values and beliefs which can cast judgement on such behaviour. Such awareness will help professionals to understand and deal with the contradictory expectations of involved individuals, agencies, personal friends and family, and society.

Concluding remarks

The case examples in this paper draw attention to some of the strong feelings which both professionals and society have in response to sexual abuse. Anger and distress are manifest as punitive responses, or suppressed by denial, altruistic intentions to right the wrongs, or even collusion. Psychological and sociological perspectives will, in combination, inform a better understanding of the 'ripple effects' of sexual abuse.

Professionals who are exposed to such traumatic aspects of sexuality have to ask themselves if their individual practices are defensive, or persecutory, or voyeuristic. Questions such as these must be addressed as part of constant self-evaluation to help professionals appreciate the nature of the work, and to learn more about themselves as individuals.

References

CORMIER, B. (1988) *The Management and Treatment of Sex Offenders: Report of the Working Group* (Correctional Service of Canada).

ENDLEMAN, R. (1990) *Deviance and Psychopathology: the Sociology and Psychology of Outsiders* (Florida, Krieger Publishing).

EROOGA, M. (1994) Where the professional meets the personal, in: T. MORRISON, M. EROOGA & R.C. BECKETT (eds) *Sexual Offending Against Children: Assessment and Treatment of Male Abusers* (London, Routledge).

KELLY, S. (1990) Responsibility and management strategies in child sexual abuse: a comparison of child protective workers, nurses and police officers, *Child Welfare*, 68, pp. 43–51.

MASSON, J.M. (1984) *The Assault on Truth* (New York, Farrar, Straus & Giroux).

MCCOLL, A. & HARGREAVES, R. (1993) Explaining sex offending in court reports, *Probation Journal*, 40, pp. 15–21.

MORRISON, T. (1990) The emotional effects of child protection work on the worker, *Practice*, 4, pp. 253–271.

MORRISON, T. (1994) Context, constraints and considerations for practice, in: T. MORRISON, M. EROOGA & R.C. BECKETT, *Sexual Offending Against Children: Assessment and Treatment of Male Abusers* (London, Routledge).

O'CONNELL, M.A., LEBERG, E. & DONALDSON, C.R. (1990) *Working with Sex Offenders: Guidelines for Therapist Selection* (Newbury Park, CA, Sage).

OLAFSON, E., CORWIN, D. & SUMMIT, R. (1993) Modern history of child sexual abuse awareness: cycles of discovery and suppression, *Child Abuse and Neglect*, 17, pp. 17–24.

PLUMMER, K. (1975) *Sexual Stigma: An Interactionist Account* (London, Routledge).

RYAN, G. & LANE, S. (Eds) (1991) *Juvenile Sex Offending: Causes, Consequences and Corrections* (Lexington, MA, Lexington Books).

THOBURN, J., LEWIS, A. & SHEMMINGS, D. (Eds) (1995) *Paternalism or Partnership? Family Involvement in the Child Protection Process* (London, HMSO).

Contributor

JEYA BALAKRISHNA, MB, BS, MRCPsych, *Senior Registrar in Forensic Psychiatry*