

## Therapeutic approach to sexual abuse

Sir,

We hope that the paper of Furniss, Bingley-Miller, and Bentovim<sup>1</sup> on sexual abuse of children will help to promote an awareness of the problem among paediatricians in this country. We would, however, like to raise several points for further discussion.

Many women who have suffered sexual abuse as children have emphasised the terror of the experience and its repetition over a period of years,<sup>2,3</sup> as indeed the data in this paper indicate. In addition, the circumstances that prevent a daughter from accusing her father of sexual abuse may persist after the fact of abuse has been publicly acknowledged. Therefore, it is essential that the child should not be expected to continue living with her abuser, or necessarily to attend, as first line therapy, family sessions where the father will be present. The prime responsibility of the caring agencies involved must be to the child, and—for reasons given in the article—it is usually more appropriate for the father to live apart from the family, than for the daughter to do so. This approach produces less disruption in the lives of the victim and her family, removes the cause of the terror to which she has been subjected, and also prevents further abuse of any of the children in the family.

Although this has the seeming effect of 'breaking up' families, in fact it is merely acknowledging the true state of affairs. By virtue of abusing his daughter, the father has already abandoned his normal parenting role, and his needs should not be allowed to jeopardise further the integrity of his child's personality. The principle aim of therapy must be to help the child regain a sense of her own worth and build new relationships without the ever threatening presence of her abuser. She does not need to learn 'to relate appropriately to men in her life'; rather she requires an opportunity to develop her own personality without reference to the requirements of men.

Our approach differs fundamentally from that proposed in the paper of Furniss *et al* because of our differing models of the psychological events being enacted. We see child sexual abuse as one aspect of child abuse in the broad sense; being a manifestation of distorted power relationships within the family. We do not see it as the natural consequence of the father's sexual dissatisfaction within his marriage. Rather, we hold that the adult abuser is betraying his responsibility by an act of violence towards his child victim. When the child is a girl and the adult a man, the act of abuse will often be 'sexualised'. The view of children as sexual objects is currently enjoying a revival, and one aspect of the paper that particularly disturbs us is that 'appropriate' erotic physical contact between adults and children can even be contemplated. This only serves to perpetuate a climate within which abuse may all too readily occur.

The father-daughter relationship is referred to in this paper as a 'pseudo-marriage', rather than as rape. This cosy view of sexual abuse denies the physical and emotional violence done to the child—and often to the mother too. The role of violence and the threat of violence in perpetuating this abuse is not dealt with at all. This

implicit denial of violence and the subtle shift of blame on to the mother and child that follows, has resulted in a programme of family therapy that must ultimately be inadequate. Only when 'incest' is seen as one part of the whole spectrum of the abuse of women and children in our society will the problem be tackled satisfactorily.

### References

- <sup>1</sup> Furniss T, Bingley-Miller L, Bentovim A. Therapeutic approach to sexual abuse. *Arch Dis Child* 1984;**59**:865–70.
- <sup>2</sup> Lukianowicz N. Incest. *Br J Psychiatry* 1972;**120**:301–13.
- <sup>3</sup> Nelson S. *Incest – fact and myth*. Stramullion: Renfrew, 1982:13–28.

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Dr Furniss and co-workers comment:

We agree with the basic sentiment that in child sexual abuse within the family the prime responsibility must be to the child. This is paramount in our approach. We also agree that the danger of double victimisation of the abused child, who may be secondarily punished by removal from the family, should be avoided whenever possible.

We disagree with the contention that victims of child sexual abuse, be they girls or boys (20 to 25% of victims are boys), do not need to learn to relate appropriately to the men in their lives. Abusive relationships in the family may be very damaging; they are, however, also very intense. We know from both sexual and physical abuse that children often blame themselves for their abuse and subsequent family breakdown. Our clinical experience has also shown that for the child victim to gain, or regain, self confidence and self esteem it is important to hear from the abuser himself that he takes sole responsibility.

A family approach to child abuse does not mean that conjoint family therapy is the first line of treatment. It means putting the intervention in a family context as the relevant life setting for the child, where she or he needs parents and parenting figures to be trusted. After an initial family interview the main work is done in group sessions for girls and boys of different ages, giving the children the opportunity to communicate and share their experiences, and dealing with issues of self esteem, trust, and feelings of being a sexual object that arise from the abuse. Separating the girl or boy from the father alone, as has been the traditional approach, and as put forward in some feminist approaches has, in our experience, been shown to be not enough. We can sympathise with any professional who identifies with the victim and oversimplifies the problem by wanting to rescue the abused child and condemn the perpetrator. Merely to remove the perpetrator and become over protective and over identified with the victim alone may, however, be unhelpful to the abused child. We may have to learn that it is necessary to help the parents and the abuser to help the child come to terms with the abuse. We have learnt this over the past 20 years in physical abuse, and this is widely acknowledged now. We will have to learn this in our handling of child sexual abuse in the future.

We do think that it is important for every child to have experience of warm physical contact, and we hope that young children of both sexes will continue to be cuddled by parents of both sexes. This contact is the ingredient for healthy development in any child. It has, however, nothing to do with 'sexualisation' of relationships and we entirely agree with Clarke *et al* on the abusive nature of sexualist parent-child interaction.

Simple concepts of power do not quite fit when dealing with clinical issues of sexual abuse of children in the family. We have found it much more helpful to talk about the notion of parental responsibility and structural dependence of the child. Whatever happens between parents and children, parents are responsible for protecting their children and are in any circumstance held responsible for their actions towards the child. This also clarifies the issue that however seductive the child may in fact be, she or he can never in any way be responsible or to blame for the abuse.

Child sexual abuse within the family has been brought up mainly by professionals of both sexes and is only now being taken up again by feminists, usually being put on very much the same level as rape. In child sexual abuse there are certainly some cases similar to rape. The presentation and dynamic, however, of long term child sexual abuse within the family has otherwise very different characteristics from those of rape in terms of structural dependence, intergeneration of boundaries, parental care, and issues of trust, as well as violence. The context of dependency on a parent accounts for the fact that actual physical violence is comparatively rare in long term child sexual abuse within the family. This does not, however, mean that we do not find powerful threats of violence and that the abusive interaction may not be as damaging, or even more damaging, than rape is. It makes, however, for a very different form of abusive dynamic and interaction that require different forms of intervention.

Finally, we certainly do not have a 'cosy view' of sexual abuse and we regard this statement, among others in the last paragraph, as emotive and unhelpful. Nor do we in any way deny the facts of violence or the threat of violence. On the contrary, these issues were very much behind our taking the suffering of sexually abused children seriously, and starting the present programme. Feedback from the girls and boys involved, and from the parents, has satisfied us that our approach is to some degree helpful. We agree, however, that this approach may have to be modified as our own experience increases and that of others is added. In addition, as we indicated in our paper, careful evaluation will have to be undertaken in future.

## Pulmonary interstitial emphysema

Sir,

The paper by Greenough *et al*<sup>1</sup> is very useful in stating in a trial form what has been suspected anecdotally. We have, however, just completed our own much smaller series of preterm infants with pulmonary interstitial emphysema and far from being able to point a finger at high ventilatory pressures, we were rather concerned to note that in several

cases the peak inspiratory pressure was low, that is less than 22 cm of water, and the length of ventilation was often short—sometimes less than three days. In no case did we have a major problem with malposition of the endotracheal tube. Fortunately we did not have the problem of a large percentage of these children developing pneumothoraces when pulmonary interstitial emphysema had developed and we continued on a low rate ventilatory regimen.

There are two points of concern. Is it really justifiable to take all babies from the age of 24 to 35 weeks of gestation and claim that they are all suffering from the same problem and therefore the aetiology of pulmonary emphysema in all of them is the same. Secondly, the conclusion that because they found a positive correlation between pulmonary interstitial emphysema and high peak pressure ventilation, a controlled study using fast rate ventilation from birth is indicated, is not justifiable. They looked at only four aetiological associations, only one of which was significant. Surely they are falling into the trap of assuming that the aetiological factor with positive correlation is the most important, whereas they may not actually have looked for the relevant aetiological factors.

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Dr Greenough and co-workers comment:

We thank Dr Rose for his interest in our paper,<sup>1</sup> it is unfortunate that we can make no comment on his results which are not stated. We would, however, point out that it is particularly dangerous to draw negative conclusions, for example concerning the possible aetiological associations of pulmonary interstitial emphysema, using the small numbers he states were investigated in Inverness.

In our own study of the possible aetiological factors associated with pulmonary interstitial emphysema—gestational age, birthweight, type of resuscitation, timing of ventilation, endotracheal tube position, and use of high peak pressures—only the latter two were found to be significantly associated with the development of the disease. Dr Rose is mistaken in stating that we implied that the aetiology was the same in all infants.

Unlike the experience of Dr Rose, there are now several reports suggesting, as we had done, that fast rate, low pressure ventilation was beneficial in pulmonary interstitial emphysema.<sup>2-4</sup> Recently Field *et al*<sup>5</sup> showed that infants ventilated at fast rates (greater than 100/min) tend to be apnoeic and as a consequence are easier to ventilate. Certainly the infant's spontaneous respiration during ventilation can be disadvantageous<sup>6</sup> and its suppression may be another reason why fast rate, low pressure ventilation in so many cases seems to be beneficial in pulmonary interstitial emphysema.<sup>1-4</sup> In view of those reports and the high mortality and morbidity of pulmonary interstitial emphysema, surely it is justifiable to suggest that a different form of ventilation should be considered in an attempt to reduce the incidence.