THE UNIVERSITY OF CALGARY

Child Sexual Abuse:
A Search for Healing

by

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A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WELFARE

CALGARY, ALBERTA
June, 1987
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ISBN 0-315-38013-6
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ABSTRACT

This thesis reviews emerging trends in the literature on child sexual abuse in search of methods, programs, and attitudes which promote healing. Historical context, definitions, ethics, and prevalence are considered. The need for a comprehensive community program is highlighted with separate chapters devoted to healing work with children, their families, and offenders. Changes in society are identified as necessary for the healing of root causes. The implication for helping professionals is a continued commitment to education and research across a spectrum of services including clinical practice, child advocacy, and social development.
ACKNOWLEDGEMENTS

Sincere appreciation is expressed to my advisor, Dr. Chris Bagley, for his enthusiasm, patience, support, and the wonderful example of scholarship and integrity he provided.

As this thesis is the culmination of my graduate work, I would like to thank the Faculty for providing a rich and valuable learning experience. Particular mention must go to Sterling Green, a previous instructor, for his encouragement and faith over the years, to Dr. Peggy Rodway and Dr. Mary Valentich for their guidance and professionalism, and to Jenifer Wilson and Laurie Morris who shared the trips from Edmonton to Calgary.

Special acknowledgement is made to Laurie Morris again and to Lorna Johansen for their proofing and editorial comments, to Daria Dann and Louise Topham for ideas and inspiration, and to Anna Huszar who accepted the arduous task of cross-checking all the references. Appreciation is also expressed to the Sexual Assault Centre of Edmonton for the valuable training and experience I gained during my years of volunteer work.

Last but not least, many thanks to my family who carried on regardless during my many hours at the library and the computer. Thanks to my Commodore 64 for typing and printing.
DEDICATION

Dedication is made to Bob Salzman who has provided continual support for my work and education.

Thank you for prompting and coaching my mastery of the computer, rereading the endless drafts, and most of all for just being a warm and thoughtful type of guy in our life together.
CHILD SEXUAL ABUSE: A SEARCH FOR HEALING

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CHAPTER ONE: INTRODUCTION

Your children are not your children. They are the sons and daughters of Life's longing for itself. They come through you but not from you, And though they are with you yet they belong not to you.

Kahlil Gibran, The Prophet

A. Personal Interest

My own interest in child sexual abuse began in September of 1980 with a workshop on the subject presented by Henry and Anna Giarretto. This powerful two day conference marked a turning point in my professional career in that it opened my eyes to a previously unrecognized dimension of human suffering and concurrently to new treatment possibilities.

Why had this topic caught my attention over so many possible others? First, I was embarrassed by my own previous blindness, albeit the result of social and professional conditioning, and wanted to develop a more sensitive and responsible base of practice. Secondly, I was fascinated by the commonality of experiences in documented testimonials and wished to further explore what differentiated the victim/survivor of child sexual abuse from a non-vicitimized child in terms of personal and social development. Sexual abuse survivors speak
poignantly of the paradox of human vulnerability, the need for healing when that vulnerability has been exploited, and the possibility of a different world view which could prevent that particular suffering.

My interest led to choosing this area of study within clinical social work practice so that I could consolidate my own knowledge base and become an increasingly effective practitioner and educator within this rapidly expanding and developing field. It is hoped this thesis will also contribute to the understanding of others.

B. Purpose and Direction

The purpose of the following thesis is to explore current theory regarding child sexual abuse in order to identify treatment needs and to suggest strategies that provide healing. This may result in guidelines for programs of treatment and prevention as well as directions for professional research.

The process of developing an effective intervention includes answering the following questions:
(1) Is child sexual abuse different from other kinds of abuse?
(2) How is it related to other kinds of abuse?
(3) What problems are there in defining and detecting
1.3

Child sexual abuse?

(4) Is sex involving children always wrong?

(5) What detrimental effects can be identified among the children to whom sexual abuse happens, both in the short term and long term?

(6) What treatments can be offered for the healing of these injuries and over what period of time?

(7) What evidence is there that such interventions do in fact heal the trauma caused to children?

(8) What motivates individuals to sexually abuse children?

(9) How can agencies intervene to protect the victims and deter the offenders?

(10) How can the sexual abuse of children be prevented?

The Oxford dictionary defines phenomenon as that which appears or is perceived, especially when the cause is in question, or "that of which a sense or the mind directly takes note." Child sexual abuse has become a major social phenomenon in the last decade in the western world. It has appeared seemingly from an abyss of silence; its cause is certainly questioned; and many levels of society are beginning to take note in a new way.

The thrust of current literature is that child sexual
abuse has a largely detrimental effect on the personal and social development of the children involved, effects which can last throughout their adult lives. The trauma to a young child, however, can be aggravated or soothed by prevailing social attitudes, the response of family and friends, and professional intervention. The following exploration will proceed on these hypotheses and attempt to sort out what is not helpful from what is healing.

This is not an empirical study. Rather, the primary source of information is a review of the literature with additional input from workshops attended, agency contacts, and anecdotal examples from personal practice. As such, the material presented is both illustrative and reflective, searching within itself for a ground of truth.

Because healing implies restoration, cure, and becoming sound and whole, it is important to formulate and understand the healthy ideal toward which movement is directed. Value statements will be outlined which provide such a focus for the dynamics of healing.

C. Value Base

The following analysis and theses about healing are colored by the assumptions of the author. Child sexual
abuse is not a dispassionate subject and it is not the intent of this paper to deal with it in a neutral context. Rather the sexual abuse of children is assumed to be a violation of their basic integrity and an exploitation of their innocence. This position, which is defended in Chapter Three, is taken as a matter of principle quite over and above the recognition of injury frequently caused.

General values relevant to this subject include principles of respect for individual integrity, self-determination, and humanistic treatment. More specific value statements leading to a formulation of children's rights include:

(1) Everyone has the right to have their own body and individuality treated with dignity and respect.

(2) Everyone has the right to be loved, valued, and nurtured.

(3) Everyone has the right to receive treatment to ensure that optimal levels of physical and emotional health are achieved and maintained.

(4) Society has the obligation to ensure that these rights are protected.

(5) Children have full individual rights as outlined above and, because of their unique position of dependency, have
the right to special protection within society.

These value statements provide criteria by which the actions of adults, treatment programs, and the intervention of society can be judged detrimental or beneficial. It is accepted that different values result in different actions. However, because abuse means "misuse" or "perversion", there must be a standard against which it can be judged. The value base defined above reflects the ethical foundation of the following presentation.

D. Assumptions, Scope, and Limitations

Certain practice tenets have also been chosen as part of the author's philosophy of intervention. These include the following beliefs:

(1) Everyone has a natural inclination towards growth and will develop if nurtured. Effective treatment involves releasing this growth potential when it has become stunted or blocked (Giarretto, 1982).

(2) Treatment can be provided to individuals, groups, and society to help heal identified problems in personal or social development.

(3) Healing as a growth process can be facilitated by therapeutic relationships. The types of intervention
offered depend on how the problem and its solution are defined by both the client and the practitioner.

It is within this framework that the previously mentioned questions will be addressed. Parameters of discussion are the history, causes, and effects of child sexual abuse with paradigms of treatment for all participants.

The frustrations of such a broad overview are that each new sub-title lends itself to new and extensive bibliographies with volumes of information. It is far beyond the scope of this thesis to do justice to all the components that make up the understanding and treatment of child sexual abuse. Rather this presentation will attempt to outline the comprehensiveness of such a project, focusing on the need for an overview. It is my thesis that the healing of children requires a framework of increased social awareness and nurturing; the problem cannot be solved by simply treating individual children one at a time.

The overall purpose of my thesis, then, is to explore the ideas that child sexual abuse is a pervasive social phenomenon, that it is both victimizing of and harmful to the children involved, that repercussions extend beyond the child to other family members, that the trauma
suffered often becomes part of a negative cycle, that healing is possible, and that a more radical change of values is necessary at the societal level for prevention to be most effective.

E. Outline

The following thesis is divided into three major components. The first provides background to the topic of child sexual abuse through a review of definitions, history, response of the professional community, and statistical studies. The second outlines a comprehensive treatment model with the needs of the child, the family system, and the offender considered in more detail. Finally, the third section identifies issues of prevention and social change as necessary components of healing.

Discussion of definitions and ethical concerns in Chapter Two reflects the variance within language and culture. The historical overview in Chapter Three touches on the history of childhood, children's services, professional response to child sexual abuse, and the impact of women's literature which exposed abuses within the family. Statistical studies reviewed in Chapter Four reinforce the reality of child sexual abuse as a social problem as well as a series of individual problems.
A comprehensive model of treatment in Chapter Five outlines the needs for early assessment, interdisciplinary education and public education. Trauma to the child victim is the focus of Chapter Six with treatment of the child survivor following in Chapter Seven. Recognizing that no child lives in isolation, healing of the family system follows in Chapter Eight. Types of offenders and their treatment are explored in Chapter Nine.

Chapter Ten goes beyond rehabilitation to issues of education, prevention, and the need for social change. The Eleventh and final chapter summarizes the development of the presented data and draws implications for social work practice. It is hoped, however, that the theories presented will not be limited to that discipline but can be incorporated into many personal and professional interest levels.
CHAPTER TWO: HISTORICAL PERSPECTIVES

If a man seduces a virgin who is not betrothed and sleeps with her, he must pay her price and make her his wife. If her father absolutely refuses to let him have her, the seducer may pay a sum of money equal to the price fixed for a virgin.

Exodus 22: 15-17

Men generally do not take sex with children seriously. They are amused by it, wink at it and allow adult-child sex to continue through a complex of mores which applauds male sexual aggression and denies a child's pain and humiliation, confusion and outrage.

Florence Rush, The Best Kept Secret: Sexual Abuse of Children

It is generally accepted that reports of child sexual abuse have increased dramatically in the last decade. Researchers, however, have not been able to establish reliable rates of occurrence and there are still many issues that require further attention. These include the accuracy of detection rates, the need for nationwide data collection procedures, the definition of sexually victimizing behavior, the identification of high-risk groups, the comparison of special populations, and the justification of new policies to deal with the problem (Painter, 1986). This thesis will attempt to provide an overview of the issues involved in developing treatment programs while so much of the information is new and
changing.

An important part of understanding the present, however, is to recognize the influence of past events and ideologies. Before proceeding forward, it is necessary to step back and attempt to view child sexual abuse from a broad historical perspective.

This chapter will look at the sexual exploitation which has been the heritage of children and illustrate how the issue has been addressed in different ways. As social values have changed, so too have definitions of and responses to sexual abuse and deviance. Brief overviews will be presented of the history of childhood, the development of child protection services in western society, early professional responses to child sexual abuse, and the consciousness raising efforts of the last two decades.

A. The History of Childhood

Anthropologists provide many examples of harsh initiations in various cultures to mark the passage from childhood to adult life. These frequently involve rites of isolation and endurance as well as the mutilation of genital organs in both male and female children (Brain, 1979). It is beyond the scope of this thesis to explore
why human societies create bizarre rituals to affirm their particular values or why sexual behavior is the focus of so much attention. These questions will simply remain in the background as history is reviewed.

Florence Rush (1900) is acknowledged as one of the first thinkers to trace the antecedents of child sexual abuse and its continuing pervasiveness from a historical rather than anthropological perspective. Her expose places child sexual abuse firmly within a patriarchal system where women and children are the property of their husbands or fathers. For example, under Talmud law a female child over three years of age could be betrothed by sexual intercourse with her father’s permission. Intercourse with a child younger than three years was considered invalid – but not a crime. Rape was interpreted as a crime of theft against the father which could be legitimized through payment and marriage. Punishment by stoning or lashing was reserved for those daughters who gave themselves in defiance of paternal authority.

Similar interpretations also existed under Canon law for Christians (Rush, 1980). For example, a sixth century papal edict decreed that, although consent was desirable, copulation was the overriding and validating factor in
marriage. Age was relevant only in that such betrothals were not valid if the female child was under seven years. A more direct and bizarre persecution of women resulted from the witch hunts which were part of the Inquisition from the fifteenth to eighteenth century. Because sex was considered integral to witchcraft, many young women were subsequently tortured for having copulated with the devil (albeit in the form of a man).

Sexual abuse was not restricted to female children nor to the European continent. Greek history included the popularity of boy brothels and the castration of young slave boys who were then bought and sold for sexual use (De Mause, 1975; Rush, 1980).

The Victorian age heralded the "cult of the little girl", white slavery, and commercial pornography. This idealization of the female child as trusting, pure, and capable of taming the savage man-beast has been perpetuated through folk lore to the present day - the maiden kisses the ugly frog who turns into a handsome prince. Rush cites Heidi and Shirley Temple as more recent examples of the same typology. "These images are seductive and it is extremely difficult for a child (or woman) to resist the promise of reward for self-sacrifice to an old man" (Rush, 1980, p.116).
Popular concern regarding child sexual abuse may be seen as a hopeful sign that society is moving toward more protective and nurturing values. De Mause is one author who interprets the history of childhood as evolutionary: "Good parenting is something that has been achieved only after centuries as generation after generation of parents tried to overcome the abuse of their own childhoods by reaching out to their children on more mature levels of relating" (1975, p. 85). A less dramatic and probably more realistic view is that abusive and healthy child-rearing practices have always coexisted in history (de Young, 1982b).

Parenting methods, of course, do not develop in isolation from social values. It is also important to consider how changing beliefs have shaped social response to children. These exist in conjunction with and in response to prevalent parenting practices.

B. History of Child Protection Services

Examples have been provided of diverse historical reactions to the recognition of children and their sexuality. This section will look more specifically at children as a unique class and the history of social efforts designed particularly to meet their needs.
It is generally accepted that children had no special status prior to the 19th century. They were seen as little adults and expected to assume the roles society provided for them, performing the various tasks and servitudes required by community life as they knew it. Western society had English common law as its socio-legal heritage, where personal relationships and custody rights were an extension of feudal property status. The doctrine of "parens patriae" from Roman law was also incorporated as a legal principle which meant that the state was the primary guardian of children rather than their parents (Giovannoni & Bercerra, 1979).

Under Elizabethan poor laws, public provision for the poor included taking their children into indenture and apprenticeship. This primary intervention was based more on reducing the public burden than on responding to the needs of the children (Giovannoni & Bercerra, 1979). Children so rescued under such a system became subject to the authority of their guardian or employer.

There was some legislative recognition of the need for child sexual protection in England in the 16th century. For example, "a law was passed in 1548 protecting boys from sodomy, and in 1576, protecting girls under 10 years of age from forcible rape" (Schultz, 1982,
Offenders were also protected, however, by the fact that rape of females over the age of ten years was merely a misdemeanor and proof of age was required before a felony could be charged (Rush, 1980).

Early nineteenth century socialization was marked by a "frenzied campaign against childhood masturbation" (De Mause, 1975, p. 87). Control efforts included sexual surgeries such as circumcision, clitorectomy, castration, and cauterization as well as various constraints for children such as canvas splints, chastity belts, spiked cages, and special gloves (Armstrong, 1983; Schultz, 1982). With masturbation seen as the primary evil and such abusive interventions sanctioned as preventative, it is easier to understand that other sexual abuses would not have been noted.

Services for children in America evolved from three separate reform movements (Pfohl, 1977). The first was the concept of preventive penology, based on the Elizabethan poor laws. This allowed houses of refuge to separate children of the poor from their parents, and reforms schools were established to meet this need. These early reformatories were later expanded to include abused and delinquent juveniles when these children were also identified as requiring custodial care.
The second reform was the humane movement which spread from Europe in the mid-nineteenth century. The American Society for the Prevention of Cruelty to Animals was formed in 1866, and was followed by the first American Society for the Prevention of Cruelty to Children in 1874. (These were the forerunners of the present American Humane Association.) The early child societies reinforced the removal of children from their parents or guardians in cases of physical cruelty. Other grounds for loss of custody, however, included "endangering the morals" of children and "exhibiting morally reprehensible behavior" (Giovannoni & Bercerra, 1979).

During the same period of history, moralist groups such as the Social Purity Alliance and the White Cross Society were formed to preserve childhood sexual innocence. They were instrumental in causing legal reforms which raised the age-of-consent for sexual activity. The result of such reforms, however, was continued discrimination against the poor and an emphasis on protecting society from sexually active girls rather than vice versa (Schultz, 1982).

The third reform was the juvenile court system which attempted to decriminalize juvenile proceedings and provide treatment rather than punishment. Social workers
of the early nineteenth century were concerned with the need to distinguish neglected and delinquent children from destitute children. Two major contributing factors were changes in ideology about child-rearing and poverty. Family was coming into vogue as the best environment for children, while economic factors were given consideration over moral weakness as causes of poverty. Revision of the poor laws, culminating in the Social Security Act of 1935, allowed poor families to remain intact while differential treatment was provided for abused or delinquent children (Giovannoni & Bercerra, 1979).

Although there is evidence that some authors had begun to document the serious abuses of children within their families prior to the twentieth century (Lynch, 1985; Masson, 1984), it was much later that physical abuse was recognized as a widespread concern. The social changes outlined above marked a beginning awareness that physical cruelty could be curtailed and that treatment could be offered as an alternative to punishment for delinquent children. Sexual abuse of children, however, received less credibility in professional literature as will be discussed in the next section.
C. Professional Responses to Child Sexual Abuse

This section will survey the response to child sexual abuse in professional literature from the beginning of the twentieth century to the 1960s. Although early references are rather sparse, these examples will illustrate the denial that existed within professional circles.

The psychoanalytical theory of Sigmund Freud, which dominated casework in the early part of this century, gave new validity to subjective experience and sexual drives in the development of personality. It is ironic that Freud first revealed and then later denied the basic experience of so many of his female patients, namely that they had been subjected to unwanted sexual experiences in their early lives (Masson, 1984; Peters, 1976).

The sensitivity of Freud to the trauma of these childhood seductions is reflected in his early work, "The Aetiology of Hysteria" which was presented to the Vienna Society for Psychiatry and Neurology in 1896:

All the singular conditions under which the ill-matched pair conduct their love-relations – on the one hand the adult, who cannot escape his share in the mutual dependence necessarily entailed by a sexual relationship, and who is yet armed with complete authority and the right to punish, and can exchange the one role for the other to the uninhibited satisfaction of his moods, and on the other hand the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility and exposed to every
sort of disappointment, and whose performance of the sexual activities assigned to him is often interrupted by his imperfect control of his natural needs - all these grotesque and yet tragic incongruities reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail. (Masson, 1984, p.283)

Unfortunately, Freud's theory was unacceptable to the professional community of his time. He was discredited by his colleagues and, over the course of his career, rescinded his original theory to posit the seduction experiences in the minds of the children rather than reality. His last words on the subject appear in 1933 in a lecture on femininity:

Almost all my women patients told me they had been seduced by their father. I was driven to recognize in the end that these reports were untrue and so come to understand that hysterical symptoms are derived from phantasies and not from real occurrences. It was only later that I was able to recognize in this phantasy of being seduced by the father the expression of the typical Oedipus complex in women. (Masson, 1984, p. 199)

Freud was limited by and served to perpetuate the social taboo that such things did not happen. This tone was to carry forward for many more years before it was seriously challenged. Of particular note among early psychiatric literature is the classical study of Drs. Lauretta Bender and Abram Blau in 1937. This study is mentioned as it was one of the first attempts to document the effects on
children who had sexual experiences with adults, and as such is a common reference in subsequent reviews.

Over half of the 16 children studied were described as having dull normal or inferior intelligence; as well, problems of developmental delay, prolonged infantile behavior, and social handicaps were noted. It would seem that such negative qualities could be interpreted as contributing to increased vulnerability or being symptomatic of previous abuse. However, the theme that has been frequently quoted in the literature and by at least one practising psychiatrist of the author's acquaintance as late as the 1980s, was that these "unusually charming and attractive" children often initiated such activities and were not harmed by them:

This study seems to indicate that these children undoubtedly do not deserve the cloak of innocence with which they have been endowed...
The emotional placidity of most of the children would seem to indicate that they derived some fundamental satisfaction from the relationship. (Bender & Blau, 1937, p. 514)

It cannot be stated whether their attractiveness was the cause or effect of the experience, but it is certain that the sexual experience did not detract from their charm. (Bender & Blau, 1937, p. 517)

The taboo was again reinforced by a follow-up study on the effectiveness of the treatments afforded these children. Most of the children were found to have
"abandoned" their sexual behavior when improved living opportunities were provided. This led the authors to conclude that childhood sexual disturbances were responsive to treatment and did not necessarily imply maladjustments in adult life (Bender & Grugett, 1952). While the response to treatment is reassuring, this interpretation suggests that the children were primarily responsible for their actions— at the tender ages of five to twelve years. This does not take into account the responsibility of any adults who previously introduced or exposed them to such behaviors.

An interesting study by Linda Gordon (1986) reviews case records of Boston child protection agencies between 1880 and 1930. Of the family violence cases in the sample, 10% contained incestuous episodes defined predominately as sexual assault of girls by older male relatives. These cases came to public attention, however, because of the girls' attempts to resist or escape for which they were most frequently arrested or sent to institutions.

Alfred Kinsey and his associates found in 1953 that one of four girls and one of ten boys were sexually assaulted before the age of 18, and that 85% of the offenders were known to their victims. Even more
interesting is that this study was drawn from a young, white, predominately middle-class, urban, educated population. The findings could have been used to dispel myths that such behavior took place only among dull or backward populations. However, the study had no more impact on the professional community than the original observations of Freud 50 years earlier.

Kinsey himself commented that "it is difficult to understand why a child, except for cultural conditioning, should be disturbed at having its genitalia touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sexual contacts" and suggested that more serious trauma was caused by the emotional reactions of adults to whom the child disclosed than by the sexual contact itself (1953, p.121). Society had not yet been sensitized to question such an interpretation.

Another example from that time is Kaufman, Peck, and Tagiuri (1954) who presented incest as acting out of the Oedipal wish: "The girls reacted to their mothers' unconscious desire to put them in the maternal role. They at the same time received gratification from the fathers as the parents who loved them in this pathologic way" (p.277). The girls reportedly showed guilt if the home
was disrupted but not over the sexual activities. A review of studies by John Gagnon (1965) summarized two major themes of the literature, these being the relatively minor effects of childhood sexual offenses on adult adjustment and the role of the child in initiating, maintaining, or concealing the offenses.

It was against this background that Dr. Kempe and his colleagues introduced the concept of the "battered child syndrome" (Kempe, Silverman, Steele, Droegemeuller & Silver, 1962) and established the medical profession as leaders in promoting legislative changes to combat child abuse. The movement received a strong lobby from the media and upper middle-class concerns as well as professional groups so that by 1966 all 50 American states had passed new legislation regulating child abuse (Pfohl, 1977). This at least set the tone for recognition of sexual abuse of children when there was medical evidence of trauma.

A background to understanding deviance is provided by Gagnon and Simon (1967). They point out that deviant behavior, defined as a violation of the collective norm, is determined by a complex interaction of legal sanctions, cultural values, and actual practice. An example of changing sexual mores is that premarital sex,
masturbation, and oral-genital sex are discussed as three main deviances. None of these are considered particularly deviant twenty years later but rather a matter of personal taste or decision. It was only in the 1970s that child sexual abuse was recognized as a widespread social phenomena and judged as deviant. The next section will review the extent to which this change was brought about by consciousness raising efforts of the women’s movement.

D. Survivors Speak Out

The emergence of children as a special class in North America was paralleled in the early 20th century by women suffragettes seeking basic legal recognition of their rights and equality. Civil rights movements of the 50s and 60s set the tone for further development of women as a group with their own political consciousness and organizing activity. The fundamental assertion of women’s right to control over their own bodies focused attention on such issues as rape, abortion, and battery within relationships. “Women’s right to verbalize their pain without self-blame created an environment in which discussing violence was less shameful” (Schechter, 1982, p.32).

As women became more vocal and articulate about their
own mistreatment, their concern spread to childhood where both little girls and boys were first socialized to the patterns of helplessness and violence that shaped their adult lives. Issues such as rape and domestic violence began to be seen as social rather than individual problems, and the social forces were questioned that permitted or perpetuated these abuses.

The following chronology provides a sampling of popular books, published during the 1970s and available in book stores across America, which addressed issues of violence against women. The examples illustrate the intertwining themes of physical and sexual violence towards women which set the tone for the exposure of sexual violence toward children.

Erin Pizzey (1974) traced the beginnings of the shelter movement in England and described the hopelessness of many abused women:

Society doesn’t recognize that you can unknowingly marry a violent man. Your marriage can be declared null and void if you find your spouse had a contagious veneral disease at the time of the marriage. You are not protected by the law if you find out ... that your spouse had a criminal record. (p.38)

She also recognized a high degree of incest among abusive families.

Susan Brownmiller (1975) in her expose of rape from
the perspectives of family, war, and criminal activity
provided a new interpretation of male-female
socialization, sex and power:

Female fear of an open season of rape, and not a
natural inclination toward monogamy, motherhood
or love, was probably the single causative
factor in the original subjugation of woman by
man... The historic price of woman's protection
by man against man was the imposition of
chastity and monogamy. A crime committed
against her body became a crime against the male
estate. (p.6-7)

Del Martin (1976) and Lenore Walker (1979) affirmed
battery of women as a widespread and highly unreported
problem and linked it to historical patterns of
socialization:

Men are seen as dominant (and thus strong,
active, rational, authoritarian, aggressive, and
stable), and women as dependent (and thus
submissive, passive, and nonrational). But
these role definitions are not natural to either
sex. (Martin, p.43)

The women interviewed in my study all stated
that their men felt it was their right to
discipline them.... They were socialized to
believe they must be doing something wrong if
their men were constantly beating them. (Walker,
p.13)

Diana Russell and Nicole Van de Ven (1976) were
editors of the First International Tribunal on Crimes
Against Women. This meeting of over 2000 women from 40
countries was heralded as the birth of international
feminism. Personal testimony was recorded on a full
spectrum of crimes including persecution, economic oppression, rape, battery, torture, and objectification.

Louise Armstrong (1978) produced the first feminist documentary on child sexual abuse, encompassing the personal accounts of 183 women who had experienced sexual abuse within their families. This was also one of the first attempts to expose the subjective trauma of survivors:

As a kid I felt... It was my fault. I was unclean. I was dirty. I was guilty. I didn’t fit in. A sense of being tainted somehow. You’re keeping so many secrets to yourself. So many skeletons in your closet. You hear other children saying my father this and my father that. But you’re so guilt stricken and so guarded you can’t say anything about your father. (p.105)

Sandra Butler in her more reflective book, first published in 1978, explored the dynamics of and society’s response to incestuous assault which she defined as both a personal and a social problem. "By understanding how and why it occurs with such discomforting frequency we can begin to develop programs and alternatives to the ineffective and often contradictory approaches presently taken in most communities" (1985, p.17).

Susan Forward and Craig Buck (1978) outlined the spectrum of abuse possible within family relationships. Examples were given from case histories of incest between
father-daughter, mother-son, siblings, grandfather-granddaughter, mother-daughter, and father-son. A comprehensive reference book on the sexual assault of children and adolescents was published the same year which addressed the need for treatment and prevention (Burgess, Groth, Holmstrom & Sgroi, 1978).

Katherine Brady (1979) and Charlotte Vale Allen and (1980) published personal memoirs poignantly describing their horror as little girls growing up with the experience of continuing sexual abuse by their fathers. The emotional complexities of these girls are explored as they attempt to carry on their lives and begin painful recoveries as adults. What is striking is that although neither girl was vaginally penetrated (as required by the legal definition of incest), their difficulty in coping with the abuse was tremendous.

I could feel myself splitting, becoming two quite different little girls: one was the sharer of The Secret, who had more money than she knew what to do with, and a strange, almost unpleasant sense of power, too, because of it.... The Other heard screaming voices, couldn’t eat, couldn’t concentrate, felt scared and on edge all the time, and dreamed nonstop of a nice future, of running away, of having a loving family, of being left alone. (Allen, 1980, p.97)

To protect my public persona, to keep my life with Dad from tainting it in any way, I developed a way of relating to my friends that looked warm and friendly but seldom strayed from the most superficial level. I knew instinctively
that intimacy was dangerous for me. (Brady, 1979, p.83)

Accounts such as those mentioned above seemed to be the beginning of an avalanche as interest spread through the public media. Survivor experiences were validated (Bass, 1983); self-help groups were formed by women and for women; and the subject of child sexual abuse was adopted and promulgated within professional literature. Society began to move from collective shock and horror to wondering what could be done. The rest of this paper will be a testimonial to many attempts at documentation, treatment, and prevention that have since taken place and are continuing to evolve.

E. Summary and Conclusions

The history of childhood has revealed many and varied abuses, including the sexual use of children and punishment of their sexuality. Response to children as a special class began in western society in the nineteenth century and evolved through preventive penology, the humane movement, and juvenile courts to medical acknowledgement of child mistreatment and a more defined child protection movement. Recognition of child sexual abuse, however, continued to receive sparse attention in professional literature until the late 1970s.
Civil rights movements of the mid-century focused attention on oppressed and previously silent groups, including women and children. Consciousness raising efforts of female authors exposed abuses suffered within intimate relationships. This opened the privacy of the family to public scrutiny and challenged the previously acknowledged sanctity of the family home. Child sexual abuse was revealed as a pervasive phenomenon within families, providing the opportunity for those concerned specifically with children to extend protection to this area. Attention and concern focused first on incestuous families. However, as the dynamics of secrecy and seduction were explored, more and varied examples of the sexual exploitation of children became evident.

At this point more fundamental questions need to be answered. These include a common understanding of the meaning and scope of what is referred to as child sexual abuse, and the values by which such activities can be judged. These issues will be addressed in the next chapter.
CHAPTER THREE: DEFINITIONS AND ETHICS

The most devastating result of the imposition of adult sexuality upon a child unable to determine the appropriateness of his or her response is the irretrievable loss of the child's inviolability and trust in the adults in his or her life.

Sandra Butler, Conspiracy of Silence: The Trauma of Incest

A. Raising the Question of Health

Before the definition of child sexual abuse is discussed, a valid question would be: what is child sexual health? General health is defined as the state of being sound in mind, body, or soul, especially free from disease or pain (Webster, 1959). One can intuitively envision a general state of health as encompassing a body free from illness and handicaps, a mind free from ignorance and prejudice, and a soul free from guilt and fear. Based on this general concept, sexual health could mean a body free for expression, a mind free for decision, and a soul free for enjoyment. Sexual health for children would include the same values along a developmental continuum.

Following through on that thought, defining health as a capacity or potential for development is a much more dynamic concept than defining it as a freedom from disease. This is especially fitting for children as the
The essence of health is that their original impetus for life and growth is protected and nurtured. Healing is necessary when that process has been thwarted and there are limitations or obstacles to be overcome.

The concept of freedom, however, leads to the dilemma of individual rights being defined and tempered by communal standards. There is a continual process of flux as persons are born into and receive a cultural heritage, adapt and develop language and values to their own end, and in turn leave their impact on a new generation. The question for sexual health is how sexual freedom can best be defined for a child in the beginning stages of socialization and how the child can be taught personal values to affirm or challenge the very process of socialization itself.

It is not the intent of this paper to provide definitive answers to these questions. Rather, they provide a framework within which discussion will take place. A range of definitions and ethical positions will be presented in an attempt to clarify child sexual abuse in relation to the optimum health and development a child can achieve.
B. Discussion of Definitions

The literature on child sexual abuse tends to focus on the aberrations without stating the norm. The following section discusses the scope of deviations that have been identified. Child sexual abuse will be distinguished from incest; the spectrum of abusive activities will be presented; and child sexual abuse will be differentiated from rape and physical abuse.

Limitations of the concept of incest.

It is important to distinguish between incest and child sexual abuse as the terms have frequently been used interchangeably within the literature. Incest traditionally refers to sexual relations between family members and has been forbidden by taboo in most societies in recorded history.

"The laws of most countries frown upon incest. Yet by no means all countries punish incest" (Manchester, 1979). This mild understatement underscores the contradictions of legal sanctions. Legislation forbidding consanguineous marriage or intercourse does not necessarily distinguish victim from offender. For example, the Criminal Code of Canada prohibits sexual intercourse between persons who are, by blood
relationship, parents, children, brothers, half-brothers, sisters, half-sisters, grandparents, or grandchildren of each other. Although both parties are technically guilty, the Code does stipulate the female person is to be spared from punishment if the court is satisfied that she participated under duress (Badgley, 1984, Vol.1).

Another interesting interpretation is provided by the Alberta Child Welfare Act. Section 64(2) stipulates that "when an adoption order is made the adopted child ceases to be the child of his (sic) ... biological mother and biological father." Sections 64(6) and 64(7) go on to explain, however, that 64(2) does not apply for the purposes of laws relating to incest and to the prohibited degrees of marriage, although the marriage prohibitions extend to adoption as well as biological relationships. This double sanction reinforces that there are both social and biological components to the incest prohibition.

Interpretations of the etiology of this taboo include the social reason of ensuring that growing children look outside the nuclear family for marriage partners, the psychological reason of encouraging children to individuate from their family, and the biological reason of avoiding abnormalities that result from inbreeding (Herman, 1981a; Maisch, 1973; Meiselman, 1978; Rist,
Whether the biological connection was recognized by earlier societies or the prohibition developed as natural selection, recent medical studies have confirmed the increased risks of malformation for children born from incestuous unions (Baird & MacGillivray, 1982).

Although the forms vary, some sort of incest prohibitions exist within all societies. Judith Herman refers to this commonality as the mark of humanity:

The particular forms of the incest taboo, the types of the behavior forbidden, the range of persons to whom the prohibition applies, and the punishments that attend its violation vary endlessly from one society to another. What is common in most cultures, however, is the seriousness with which the taboo is regarded. It is commonly understood as a fundamental rule of social order. It is the primordial law, which defines the special place of human society within the natural and the supernatural world. (1981a, p.50)

Robin Fox, on the other hand suggests that human beings are "naturally" non-incestuous and that the systems of incest avoidance reflect instead the human passion for rules, the evolution of the control of sex and aggression, and the power relationships between generations and sexes (1980, p.14).

Whatever meaning and peculiarities are accepted regarding the evolution of the incest taboo, the prohibitions do not address the discrepancy of behavior between mothers and fathers toward their children or the
range of sexual activities other than intercourse to which children may be subjected. A useful distinction is made by Bagley:

Incest is a concept which should be defined in anthropological or socio-biological terms, and concerns the aversion towards and the rules and taboos concerning continued sexual relations between closely related people that are likely to result in pregnancy and an alternative family. (1984a, p.17)

This usage of the term will be adopted except for references by other authors, in which case their meaning will be noted.

It is the intent of this thesis to present child sexual abuse as a much more universal phenomena. Children are exposed to a wide range of sexual exploitation by a wide range of adults both within and outside of their families. The discussion to follow looks at the range of sexually abusive activities of which incest, as defined above, is a relatively small part.

Spectrum of child sexual abuse.

Sexual misuse, rather than abuse, of children was described in medical literature by Brandt and Tisza as a symptom of family dysfunction. They adopted the general definition that sexual misuse was the "exposure of a child to sexual stimulation inappropriate for the child's age,"
level of psychosexual development, and role in the family" (1977, p.81) and pointed out that sexual misuse of a child, whether by a stranger or a family member, affected the entire family system.

Summit and Kryso (1978) presented a ten point spectrum for clinical analysis of child sexual abuse. Their categories included (1) incidental sexual contact, which is accidental or unplanned, (2) ideological sexual contact, where the adult allows or encourages sexual exposure sincerely believing it to be for the child’s developmental benefit, (3) psychotic intrusion, where the adult suffers from reality confusion, (4) “rustic” environment, where there is no cultural value contradiction, (5) true endogamous incest, where a father chooses to eroticize the relationship with his daughter, (6) misogynous incest, where the relationship is characterized by hatred or fear, (7) imperious incest, where men act out their authority, (8) pedophilic incest, where there is an erotic fascination with children, (9) child rape, where the abuser needs to feel power and is violent towards the child, and (10) perverse incest, which is the most bizarre and destructive with emphasis on multiple partners and ritualistic torture.

Kempe and Kempe, champions of the "battered child
syndrome”, only briefly mentioned sexual abuse in their first book on child abuse (1978). Their later book borrowed an earlier definition of Schechter and Roberge (1976) that sexual abuse is “the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give informed consent or that violate the social taboos of family roles” (Kempe & Kempe, 1984, p.9). While the possibility of consentual sexual activity among children is not addressed, this definition is clear in outlining that activities are abusive which do not consider the developmental level of the child.

Categories of sexual abuse are listed by the Kempes (1984) as (1) incest, sexual activity between family members, (2) pedophilia, the preference of an adult for prepubertal children as sex objects, (3) exhibitionism, the exposure of genitals by an adult male, (4) molestation, behaviors such as touching, fondling, kissing and masturbation, (5) sexual intercourse including oral-genital, anal-genital or penile-vaginal contact, (6) rape, sexual or attempted intercourse without consent of the victim, (7) sexual sadism, the infliction of bodily injury as a means of obtaining sexual excitement, (8) child pornography, the production and distribution of
material involving minors in sexual acts, and (9) child prostitution, the involvement of children in sex acts for profit. These categories are obviously not mutually exclusive and illustrate the mix of activities to which children may be subjected.

Both spectrums include interpretations of etiology, levels of intrusion and trauma, and victim-offender relationships as well as descriptions of various acts in their attempts to categorize types of child sexual abuse. This illustrates the many factors to be considered in such an analysis.

**Differences from rape and physical abuse.**

Is child sexual victimization another form of child abuse or is it another form of rape? David Finkelhor (1979a) feels the three are distinct phenomena. He chooses the term victimization to differentiate sexual from physical abuse in "that the child is victimized by age, naivete, and relationship to the older person rather than by the aggressive intent of the abusive behavior" (p.17) and includes intercourse, genital fondling, exhibitionism, sexual embraces, and overt or frightening overtures in his analysis.

A similarity between physical and sexual abuse of
children by adults is that both frequently extend over time. However, they do not tend to occur simultaneously. Differences outlined are that with sexual abuse, the trauma is primarily psychological rather than physical; motivation of the perpetrator is more toward sexual and psychological gratification than physical harm; society is less overtly tolerant of sexual abuse than physical abuse; and preadolescents are most vulnerable to sexual abuse while younger children and infants are more vulnerable to physical abuse (Finkelhor, 1979a).

Sexual victimization of children is distinguished from rape, according to Finkelhor (1979a), by the profiles of victims and circumstances of the offense. While both are most frequently perpetrated by male offenders and cause a similar trauma, child victimization is directed towards male as well as female victims. Children are more often victimized by friends or family members than are rape victims; child victimization more often consists of repeated incidents; less physical force and violence are used; the specific sexual act is usually not intercourse; family members tend to be more emotionally involved in the aftermath; and intervention happens more frequently via social agencies rather than legal agencies (Finkelhor, 1979a).
Child sexual abuse overlaps the dynamics of both physical abuse and rape. Children are naturally vulnerable because they are small, dependent, powerless and defenceless. It is necessary, therefore, to look at offenders rather than their victims for a more complete understanding of why abuse happens.

C. Diagnostic Interpretations

The diagnosis of the "battered child syndrome" in the late 1950s secured a role for medical expertise in face of a serious social problem and established abuse as an illness, paving the way for treatment based legislation (Pfohl, 1977). This allowed the community to focus on the pathology of abusive parents rather than their criminality. Valid as this approach may be, it lends itself to a diversity of diagnoses and treatment philosophies.

This mental health model has carried over to the management of child sexual abuse to a large extent. The intent at this point is simply to illustrate how different philosophical orientations shape definitions and vice versa. Two popular orientations reflected in the literature are what can be called the humanist and feminist positions. Definitions from each of these
perspectives will be outlined.

**Humanist perspective.**

Humanism can be described as the study of human nature and human ideals (Webster, 1959). Its fundamental concerns are with the values of life and what it means to be human. Humanistic expression has been associated with art, literature, philosophy, religion, and most recently psychology. Humanistic psychology is orientated to the growth and development of the whole person.

The humanistic literature on child sexual abuse, in keeping with this philosophy, shows compassion towards both the offender and the victim. Both are seen as reacting to forces of socialization and personal crisis. Groth (1978b) described child sexual assault as equivalent to a symptom which "serves to gratify a wish, to defend against anxiety, and to express an unresolved conflict" (p.11).

Probably one of the most widely mentioned services is the Child Sexual Abuse Treatment Program piloted by Henry Giarretto in Santa Clara County, California in 1971, which has become synonymous with humanistic treatment. The program is restricted to treatment of incest, defined for their use as "sexual activity between parent and child or
between siblings of a nuclear family” (Giarretto, 1976, p.143). Although the program is limited to family treatment, many of the concepts can be applied universally. The basic premise is that offenders must accept total and personal responsibility for their actions. The difference is that they, as well as the victims, are seen as requiring strong self-identity and self-esteem as prerequisites to responsible social attitudes and actions.

Family therapist Cohen also provides a humanistic interpretation of sexual abuse within the family:

The incestuous family cannot be viewed only as a sexually abusing and deviant unit, nor can the psychoanalytical explanation suffice in understanding the phenomenon. It appears that perhaps all of the members ... are emotionally deprived and that the tabooed sexual relationship is a manifestation of a basic search for warmth, comfort, and nurturance. (1981, p.497)

While the above example is limited to family dynamics, the underlying humanistic principle recognizes the need of all persons for emotional security and acceptance.

Feminist perspective.

Feminism is aptly described as "the theory, cult, or practice of those who advocate such legal and social changes as will establish political, economic, and social
equality of the sexes" (Webster, 1959). Feminism can be interpreted as a development of humanism in that it recognizes the same principles of full personal development. However, feminism tends to focus more specifically on defining and overcoming the various ways in which women have been oppressed with emphasis on helping them regain a sense of power (Collins, 1986).

The feminist literature on child sexual abuse tends to be polarized, drawing a strong distinction between the innocence of the female victim and the responsibility of the male offender. While this position may seem extreme at times, it must be remembered that feminism was reacting to an established tradition of woman-blaming. For example, Kempe (1978) in attempting to enlighten the pediatric community about child sexual abuse within families commented: "Stories by mothers that they 'could not be more surprised' can generally be discounted. We have simply not seen an innocent mother in cases of long-standing incest" (p. 385). The following excerpts illustrate the feminist perspective.

Louise Armstrong, one of the first feminist authors to expose father-daughter abuse, deliberately used the word "diddling" to emphasize the gratuitous and unnecessary nature of that abuse:
Repeated sexual abuse of a child by a needed and trusted parent or stepparent is the most purely gratuitous form of abuse there is. It requires thought. It does not arise out of anything as uncontrollable as rage... It does not stem from physical addiction. Rather, it arises out of an assumed perogative, super-structured with rationale, protected by traditions of silence, and, even more than in rape, an assurance of the object's continuing fear, shame, powerlessness, and, therefore, silent acquiescence. (1978, p.277)

Another author of the same time period, Judith Herman, also looked specifically at the abuse of daughters by fathers; pointing out that this dynamic depended on the relative helplessness of the female family members in face of the father's expectation of continued nurturance. "It is this attitude of entitlement - to love, to service, and to sex - that finally characterizes the incestuous father and his apologists" (1981a, p.49).

The characteristics of the father, daughter, and mother dynamics within incestuous families can be extrapolated to represent their roles in the larger society. Elizabeth Ward speaks of the incestuous family as "a microcosmic paradigm of the rape ideology which operates in the macrocosm of society" (1984, 193). Fathers exert their power publicly and privately; daughters passively carry the shame of their humiliation; while mothers share in the betrayal by their own silence and helplessness. Both daughters and mothers do what they
believe they must do to survive in a patriarchal social structure (Ward, 1984).

Such strong statements were perhaps necessary to counter early incest literature which tended to blame the mothers for "deserting" their husbands (Justice & Justice, 1979) or the daughters for being "seductive" (Bender & Blau, 1937) with little fault directed toward the offending father. A more humanistic view looks at the strengths and weaknesses of all involved without denying the immediate responsibility of the offender.

Definition chosen.

The humanistic model fits most closely with the concept of sexual health mentioned earlier. Child sexual abuse is seen as any activity which diminishes or damages the budding sexual development of a child. The most comprehensive definition, borrowed from Sandra Butler, is "any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma" (1985, p.5).

This model is chosen as a basic working definition because it recognizes the wide range of abusive activities which follow a continuum rather than distinct categories. The resultant trauma may depend on the degree and duration
of intrusion as well as the age and developmental level of
the child to whom it occurs and the nature of relationship
between the child and the offender. Patricia Mrazek
(1983b) outlines a fourth factor that must be considered
in a clinical definition, namely, the culture in which the
abuse occurs.

The key concepts in the above definition are embodied
in the words "imposed" and "trauma" which mean that sexual
activity is considered abusive when it is not wanted and
when it causes harm. A more detailed discussion of these
ethical considerations will follow.

C. Exploration of Ethical Considerations

Ethics are rules or principles of conduct which guide
social behavior. They have a connotation of morality, of
absolute values of right and wrong. A major task in
defining the ethics of sexual health for children is
identifying moral principles vis-a-vis social behavior,
for it is ultimately within society that individual values
are shaped and formed. Civilization is a continual
process of persons being born into and receiving a
heritage of language, culture, and values, adapting and
developing these to their own end, and in turn leaving
their impact on a new heritage. Some changes happen
slowly over many generations; other times one individual can change the course of history.

Many of the dramatic changes in recent years suggest that western civilization is undergoing a revolution in terms of sexual values. As with any revolution, there is a stage of conflict and turmoil until new patterns of conduct are accepted and firmly established. Factors to be considered in developing an ethical charter for children's sexuality include the role of the taboo, issues of trauma and consent, and definition of the best interests of the child. The following section will discuss these issues and formulate an ethical position.

The role of taboo.

The incest taboo is one consideration frequently mentioned in discussing the morality of child sexual abuse. The question is whether the taboo reflects a biological imperative or constitutes a moral stand. As a biological imperative, the taboo is described functionally in terms of ensuring biological fitness and measured in terms of biological issue. Sexual abuse of children could be tolerated as long as there were no pregnancies resulting in deformed offspring (Shepher, 1983).

Lawton-Speert and Wachtel (1982) suggest the incest
taboo has the status of a natural law, where breaches result in automatic penalties. This, however, does not explain the social controls that have developed around sexual activity.

Mary de Young suggests the incest taboo can not be separated from other rules and regulations that shape each individual culture:

The taboo which assures the biological survival of the human race is inextricably bound to the taboo which assures the cultural survival of the society in which the race lives and with which it interacts. To insist that the incest taboo serves only one component and not the other is to be ignorant of the complex interaction of the two. (1982b, p.8)

This means that trauma results from the secrecy and shame associated with breaking the taboo over and above the possible trauma from the activity itself. In other words, sexual activity which is not socially tabooed will not cause guilt and shame though it may cause physical trauma.

Goodwin and Divasto (1979) give the example of three different tribes where mothers routinely masturbate their nursing infants. Supposedly such children are not traumatized when they realize they have participated in this cultural norm. An example of the opposite extreme is the circumcision rituals of both male and female children in various cultures. Although this involves varying
degrees of physical pain and trauma, the suffering of these children is expected and accepted as part of culturally specific socialization.

On the other hand, while those who choose to violate social taboos may be acting out of denial or defiance, those who are victimized by such an experience suffer shame and guilt at having participated in a forbidden act. It may be argued that younger children suffer less from sexual abuse than older children who are more aware of the taboo. However, this overlooks that the child will still have to deal later with new knowledge and old memories.

One author advocates lessening the impact of the taboo to make it easier for both victims and offenders to overcome their guilt (Lempp, 1978). Society, nevertheless, continues to define itself through cultural mores. The impact of sexual taboos must be considered as an integral component of sexual development. A more fundamental question, then, is what other values can be considered in challenging the importance of existing taboos.

**Ethics defined by trauma.**

An important humanist value is respect and esteem for the integrity and intrinsic worth of other human beings. This means that any activity is wrong which harms or
threatens to harm the lives of others. While children are not necessarily harmed by sexual contact from adults, evidence confirms a vast range of possible trauma.

Physical trauma resulting from child sexual abuse includes such possible effects as vulvar lacerations, genital lesions, syphilis and gonorrhea, gonococcal tonsillopharynitis, and genital herpes infection (Blumberg, 1978). Early onset of cervical cancer is also mentioned as a possible result of infections the prepubescent vagina is unable to neutralize (Densen-Gerber & Hutchinson, 1979).

Psychological effects are more numerous and often have long-term repercussions. Symptoms and behavior manifest by victimized children include depression, guilt, poor self-esteem, and feelings of inferiority (de Young, 1982b; Herman, 1981; Justice & Justice, 1979; Meiselman, 1978) plus increased suicide attempts and self-destructive behavior (Bagley & Ramsay, 1986; Briere & Runtz, 1986). This whole area will be discussed in much more detail in Chapter Five, which looks at trauma and symptoms.

The social costs of child sexual abuse must also be considered. Studies have shown a high correlation between child sexual abuse and interpersonal problems, delinquency, and substance abuse (Herman, 1981a) as well
as orgasmic dysfunction and confusion about sexual preference in adult women (Meiselman, 1978). Childhood sexual experiences have also been cited as antecedents to prostitution (Silbert & Pines, 1981 & 1983).

Ethics based on trauma are reinforced by such studies which confirm a wide range of immediate and long-term disruptions of individual functioning, interpersonal relationships, and social behavior. Any activity which has the potential of causing so much damage to another human being must be curtailed.

The issue of consent.

Another important value is that of consent. "For true consent to occur, two conditions must prevail. A person must know what it is that he or she is consenting to, and a person must be free to say yes or no" (Finkelhor, 1979b). Children can not give informed consent to sex with adults because they lack the information about the full social and biological meanings of sexuality, plus they are legally and psychologically under the authority of an adult. Part of the process of socialization for children is for them to slowly assume responsibility for their own decisions and actions with the guidance of those to whom their care is entrusted.
This is related to the issue of right relationship which implies "it is the responsibility of the person with the greater power and authority to avoid misusing the power to take advantage of the vulnerability of the less powerful person" (Fortune, 1983, p.82). This rule governs professional and parental relationships and means, among other things, that adults have no right to have their sexual needs met at the expense of children.

Although Finkelhor (1979b) argues that the consent issue is the stronger argument against sexual abuse of children, this author disagrees. Children traditionally have little or no consent in decisions affecting their early life and upbringing. These decisions are left to parental authority for one of the very reasons quoted, that being that children do not have the capacity to make these decisions for themselves. A superior definition must come from the community if parental responsibility is to be overruled and must include the value of prevention from trauma.

Ethical clarity is essential in dealing with child sexual abuse. This means that society needs a consistent value framework from which to work and by which it can justify interference in the private lives of victims and perpetrators (Finkelhor, 1979b). However, ethical clarity
requires a broader base than consent. More important considerations are the prevention of harm and its corollary, the nurturance of health. Normal healthy development assumes that personal security is provided and personal boundaries are respected so that a child's sexuality may evolve as an integral part of his or her personality.

**Ethics chosen.**

The chosen statement of ethics regarding child sexual abuse is multi-dimensional. It is important to remember the chosen definition: Child sexual abuse is any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma.

Sexual abuse of children is wrong in so far as it violates communal and cultural prohibitions developed by society to protect the physical and mental health of children. It is particularly unfortunate that children often bear the brunt of the taboo as well as their abuse.

Sexual abuse of children is wrong because of the potential for immediate or future harm to a developing child. This includes a wide range of emotional, physical, and sexual trauma.

Sexual abuse of children is wrong in so far as their
vulnerability is misused by a person of greater power or authority. It is recognized that children can not give informed consent to many decisions of their young lives. However, society has a right to expect that authority is exercised in the best interests of children and a right to intervene if those interests are violated by parents or guardians.

Sexual abuse is wrong in so far as it disrupts or detracts from a child's assumed right for safety and nurturance in personal development. Part of the long term challenge is to define more clearly what is normal and healthy from a child's point of view.

Fortune's (1983) multi-dimensional interpretation of sexual violence fits equally well for child sexual abuse and adds a further dimension for consideration. Within this model, sexual abuse is seen as an offense against the victim in that "it denies and violates the personhood of the victim"; an offense against self in that it is "a destruction of relationship with another and a distortion of one's own sexuality"; an offense against the community in that it creates "a hostile, alien environment which diminishes the possibility of meaningful relationships"; and an offense against God in that "it is a violation of God's most sacred creation, a human being" (p.85-86).
This adds the concept of spirituality to ethics, the idea that persons are responsible not only to each other as individuals and as a society but as well to another level of being, whether this is seen as life force or Being or Spirit. This heralds the ideal of a respect for life that goes beyond social and professional roles and calls for an experience of healing which encompasses mind, body, and spirit.

F. Summary and Conclusions

The question of child sexual abuse was posited against the largely undefined ideal of child sexual health. It is not enough to define abuse as mistreatment and injury. It is that, surely, but also an impediment to optimal growth and development.

The question of how to define sexual abuse was raised. Meanings of incest were discussed but found to be wrought with biological and legal complications. It was felt the term "incest" was best restricted to anthropological interpretations of the taboo prohibiting sexual relations between consanguineous adults. A more general term free of these connotations was required to express the range of sexual activities to which children are subjected. The spectra of such activities were
presented as developed by different authors. Child sexual abuse was also differentiated from rape and physical abuse.

Awareness of child sexual abuse was further examined from the perspectives of humanism and feminism. Finally, a definition was chosen from the material presented which incorporated lack of consent, resultant trauma, and the continuum of abusive activities.

The ethics of child sexual abuse were raised, taking into account the role of the taboo, the issue of trauma, and the issue of consent. The need for ethical clarity was emphasized and a final position formulated which encompassed these three components. The primary ethical consideration was seen to be the best interests of the child, as defined by nurturance towards optimum health.

Child sexual abuse is a violation of a child’s body, mind, and spirit. Healing, the process of making sound and whole, needs to look towards that which is described as health. A sexually healthy child is one who is protected from abuse, nurtured to pride in his or her sexuality, and free to express or share it in a manner consistent with optimal personal and social development.

The prevalence of child sexual abuse in society will be the subject of the next chapter.
CHAPTER FOUR: STATISTICAL DIMENSIONS

The findings of the National Population Survey constitute a baseline for estimating the extent to which sexual offenses have been committed against Canadian children, youths and adults. The main findings of the survey are that at sometime during their lives, about one in two females and one in three males have been victims of unwanted sexual acts. About four in five of these incidents first happened to these persons when they were children or youths.

While it is recognized that the findings of a retrospective analysis may be affected by an erosion in the ability of persons to recall events, for this reason, the results obtained are likely to be an underestimate rather than an overestimate of the occurrence of incidents of this kind.

Report of the Committee on Sexual Offenses Against Children and Youths (1984)

The intent of this chapter is to illustrate the prevalence of child sexual abuse as determined by recent population surveys. Characteristics of victims and offenders that can be derived from these studies will be presented and the need for further research identified.

A. Setting the Stage

Most of the early literature regarding the sexual abuse of children was based on clinical samples, that is, persons were studied who had already been identified as having been victimized. While this information is useful and necessary within a treatment perspective, it is
generally agreed that those cases which reach public attention are the "tip of the iceberg", visible evidence of a hidden and potentially more dangerous reality. A more fundamental question is to what extent sexual abuse occurs, undetected or unreported, in the larger population.

"Public and professional acknowledgement that significant numbers of children are sexually abused by their relatives and caretakers did not really begin to emerge until the mid-70s" (Sgroi, 1982b, p.1). Historical and social factors setting the stage for such recognition have been discussed. As more and more survivors chose to reveal their stories, their trauma was identified and disseminated by public media. Validation by other survivors gave strength to self-help groups, plus professional groups began to hear and believe that childhood sexual abuse was a serious and widespread phenomenon. This shift of public and professional attitudes led to a greater accumulation of clinical and population studies, although the latter are still relatively rare.

The power of prevalent social attitudes to shape professional research has already been demonstrated. Freud (1933) developed his theory of the Oedipal complex to repudiate his own evidence that childhood sexual abuse
had contributed to the symptoms of his women patients. Bender and Blau (1937), who have been quoted ad nauseam in subsequent literature, studied 16 children of rather tragic circumstances and somehow determined that their exceptionally "charming and attractive" demeanors reflected their complicity in sexual activities with adults.

Even Kinsey (1953), who revolutionized his own times by openly discussing sexuality, discounted the high percentage of persons who reported histories of childhood sexual encounters. It is interesting that his figures of "one out of four girls and one out of ten boys" were later resurrected and quoted extensively in reports and workshops.

One of the first authors on the topic within social work circles was De Francis (1969) of the American Humane Association who published a study of 1100 known cases in New York City. At the time he estimated a national occurrence of 100,000 cases annually. Limited though this study was, it marked the involvement of Child Protection agencies, distinguished child sexual abuse from physical abuse, and was one of the first attempts to predict occurrence at a national level. He also revealed that 75% of the offenders were known to the children they
assaulted.

The American National Center for Child Abuse and Neglect commissioned a more comprehensive study in 1979, which estimated that 44,700 cases of child sexual abuse were known to professionals, almost twice as many as would have been known to official reporting agencies (Finkelhor, 1982). Another author (Sarafino, 1979) estimated 336,200 annual incidents in the United States of America. This, however, was still considered a drastic undercount in light of beginning prevalence studies (Finkelhor, 1984b).

Surprising results were revealed in a reader survey undertaken by Cosmopolitan Magazine (Wolfe, 1981) which asked readers about their sexual experiences and morals. Eleven percent of the 106,000 women who responded reported they had experienced sexual relations with a relative as a child and that those experiences were often traumatic. While this figure could not necessarily be considered representative of the population, it certainly reflected the widespread nature of the problem.

The two primary factors which determine the outcome of any study of child sexual abuse are the definition of abuse used and the population base of the study. For example, intrafamilial abuse tends to be reported more to Child Protection agencies, while stranger abuse tends to
be reported more to legal authorities (Badgley, 1984).
The prevalence studies which follow are attempts to sample the general population. Differences in definitions, methodology, and sample selection will be seen to cause a variance of results.

B. Recent Prevalence Studies

Prevalence is taken to mean the distribution of victimization within the general population, as opposed to incidence which is the number of occurrences over a period of time (Kercher & McShane, 1984). Clinical studies and mandated agencies can provide reports of incidence based on those cases which come to their attention. Because so many cases are unreported however, a much broader population study is required to determine actual prevalence. A disadvantage of such studies, on the other hand, is that data is determined by the subjective recall of participants.

Eight recent studies will be reviewed which represent major attempts to sample non-clinical populations and illustrate how different methodologies, definitions, and cultures influence data results. This section will outline the studies and look for comparative prevalence figures. More detailed information regarding victims and
offenders will be developed in the following section.

**Finkelhor (1979) - New England students.**

David Finkelhor’s 1979 study of college students has received widespread publicity because of his detailed breakdowns of the statistical information and his comprehensive theoretical interpretations. The population was college students in social science classes in six different New England universities and colleges. Participation rate was 92% for a sample consisting of 796 students, 530 female and 266 male. The disproportionate number of females was treated as an advantage in that more reports of victimization were anticipated from this group.

Limitations of the sample were that 75% were 21 years of age or younger so that the survey reflected a relatively limited segment of the general population. It could also be argued that persons whose social functioning had been seriously affected by childhood sexual abuse would probably not be numbered among university students.

Participants were asked to complete a questionnaire which contained questions about childhood, incestuous, and coercive sexual experiences. Sexual abuse was defined as a sexual experience between a child and an older person.
Sexual experiences included a range of behaviors from intercourse and attempted or simulated intercourse to fondling, exhibitionism, sexual touching, and overt sexual overtures. Three categories of older partners were considered: those legally defined as adults, adolescents at least 5 years older than victimized children, and adults at least ten years older than victimized adolescents.

The results were that 19.2% (close to 1/5) women and 8.6% (close to 1/11) men reported having had childhood sexual experiences defined by the study as abusive.

Russell (1983) - San Francisco women.

Diana Russell (1983) in the summer of 1978 attempted one of the first representative studies, a random sample of adult women in San Francisco. The sample was drawn by a public opinion research firm using customary random procedures, modified slightly to avoid a bias against high-density neighborhoods.

Selected women were informed of the subject matter of the survey only after an interview had been arranged. While an initial 17% declined to participate, a further 19% declined after being informed of the subject area. In addition interviewers were unable to access a further 14%
of the selected women so that the actual participation rate was 50%. Unfortunately, this is below what would be expected for a valid random sample.

The survey was completed with a base of 930 adult women, who were questioned by trained interviewers about any experience of sexual abuse they may have had. Russell differentiated between extrafamilial and intrafamilial abuse with the former defined as:

one or more unwanted sexual experiences with persons unrelated by blood or marriage, ranging from petting (touching of breasts or genitals or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted forcible rape experiences for the ages of 14 to 17 years inclusive,

and the latter as "any kind of exploitive sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old" (1983, p. 135).

With both categories of sexual abuse combined, 38% (over 1/3) of the women reported at least one experience of sexual abuse before the age of 18 years, with 28% (over 1/4) reporting such an experience before the age of 14.

Russell emphasizes that her definitions of child sexual abuse were narrower than other researchers, such as Finkelhor, who included exhibitionism and non-contact experiences. Russell did not request information about
non-contact experiences, but so many women volunteered such information that it was included in tabulations:

When applying these broad definitions ... that include experiences with exhibitionists as well as other unwanted non-contact sexual experiences, 54% (504) of the 930 women reported at least one experience of intrafamilial and/or extrafamilial sexual abuse before they reached 18 years of age, and 48% (450) reported at least one such experience before 14 years of age (p.138).

The narrower definition will be retained for uses of comparison in this chapter.


Glen Karcher and Marilyn McShane (1984) attempted a representative survey of the adult population in Texas by drawing a systematic random sample of persons holding a valid Texas driver's license. Questionnaires were mailed to each of the 2000 names drawn. The return rate was 53% with responses completed by 593 female and 461 males.

The definition of abuse used by the authors was:

Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may be committed by a person under the age of 18 when that person is significantly older than the victim or when the perpetrator is in the position of power or control over another child. (p. 497).

In addition, sexual abuse was said to include pornography, rape, molestation, incest, prostitution, and other such
Forms of sexual exploitation.

A total of 7.4% of the respondents, 11% of the females and 3% of the males, indicated having been sexually abused as children.

These may be conservative figures as another 7% did not answer the question about sexual victimization. The reported rates were based on the percentage of the total survey. Other reasons mentioned by the authors for the relatively low rates are the biases inherent in driver’s license files, general difficulty in dealing with sex-related issues by mail, and the rather lengthy survey booklet used.


A further study was conducted by David Finkelhor (1984) the spring of 1981 in the Boston metropolitan area. This study looked at public attitudes, whether the parent population knew of children who had been sexually abused, and whether the adults themselves had been abused as children. Parents were chosen from an area probability sample and screened for children between the ages of 6 and 14. A response rate of 74% resulted in 521 interviews from a possible 700. The parent sex ratio was somewhat skewed with 187 men and 334 women. This was due to the
predominance of single-parent families headed by women. The parents had a combined total of 1428 children.

Twelve percent (15% of the women and 6% of the men) reported having been sexually abused. These figures are somewhat lower than his earlier student sample. The reason may be that, in the Boston survey, respondents were asked generally if any sexual things were done to them and if they considered the experiences to have been sexual abuse. Only those experiences so considered were reported as sexual abuse, whereas the earlier study had used more general criteria and had not asked for a subjective judgment.

An even smaller number, 9% of the parents, reported knowing of a child who had been the victim of abuse or attempted abuse. It is interesting, however, that only 39% of the victimized parents had told anyone about their abuse within a year of its happening. It may well be that children of the present generation are following a similar pattern of concealment.


The National Population Survey, commissioned by the Badgley Committee on Sexual Offenses Against Children and Youth, undertook a representative sample of Canadians
living in all regions of the country. The survey took place in January - February of 1983. A 94% compliance rate resulted in 2008 responses for analysis. Interviewers from Canadian Gallup Poll personally delivered the questionnaires and waited for them to be completed but were not allowed to discuss the contents with the respondents.

Questions dealing with unwanted sexual acts elicited specific information through multiple choice answers about exposures, threats, touching, and attacks. The questions asked were:

* Has anyone ever exposed the sex parts of their body to you when you didn’t want this?
* Has anyone ever threatened to have sex with you when you didn’t want this?
* Has anyone ever touched the sex parts of your body when you didn’t want this?
* Has anyone ever tried to have sex with you when you didn’t want this, or sexually attacked you? (p. 179)

In other words, respondents were asked to judge which actions were unwanted rather than which were abusive. The advantage of this wording was that abuse was defined by the subjective trauma of the respondent rather than by arbitrary age differences as set by other researchers.

The Badgley Commission found that just over 1/2 (53.5%) of female and just under 1/3 (30.6%) of males in the total population had been the victims of some kind of
unwanted sexual attention in their lifetime and that approximately 4/5 of these incidents had happened to them as children. The more exact figures are that 37% of females and 23% of males had been victims of unwanted sexual acts before the age of 18. These figures are higher than Finkelhor’s but similar to Russell’s (which sampled only women).

Direct comparisons are not possible as the data was tabulated differently. However, the breakdown of contact abuse (touches and assaults) versus non-contact abuse (exposure and treats) for the Badglej data is as follows: 34.4% of the total population (23.4% of males and 46.6% of females) reported contact abuse while 22.1% of the population (14.9% of males and 30.4% of females) reported non-contact abuse. This proportion is similar to Russell’s. What is also striking about the Badglej data is that the ratio between females and males is consistently about two-to-one for the different types of abuse.

Wyatt (1985) - Afro and white American women.

Gail Wyatt (1985) examined the prevalence of child sexual abuse in women of Afro and white racial origin, 18 to 36 years of age, in Los Angeles County. Subjects were
obtained by random-digit dialing of telephone prefixes with women from each ethnic group matched for demographic characteristics. In total 126 Afro-American and 122 white American women were interviewed. Interviews were conducted by highly trained women who matched the subject’s ethnicity.

The definition of sexual abuse included a range of behavior from non-body contact to fondling, intercourse, and oral sex which had occurred prior to age 18 by a perpetrator 5 years older or involving some degree of coercion. Lack of consent was assumed for children under 12. For children ages 13-17 experiences were considered abusive if the perpetrator was older and if the experience was unwanted.

Findings were that 62% of the women reported at least one incident of sexual abuse prior to age 18. A slight ethnic difference of 57% Afro women and 67% white women was not statistically significant. Neither were ethnic differences regarding the categories of non-contact and contact abuse. 17% Afro and 16% white women experienced non-contact abuse while 40% Afro and 51% white women experienced contact abuse. Generational differences, specifically, ages 18 to 26 compared with ages 27 to 36, were not significant for either group.
Baker & Duncan (1985) - British study.

Anthony Baker and Sylvia Duncan (1985) conducted the first national prevalence study of child sexual abuse in Britain. A compliance rate of 87% resulted in a sample of 969 men and 1050 women aged 15 and over. Interviews were conducted in respondents' homes in the context of a more general attitude survey. The following definition of child sexual abuse was printed on a card and presented to each respondent, who was asked if they had ever had such an experience:

A child (anyone under 16 years) is sexually abused when another person, who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal. This might involve intercourse, touching, exposure of the sexual organs, showing pornographic material or talking about sexual things in an erotic way.

Ten percent of those interviewed (12% of females and 8% of males) reported they had been sexually assaulted before the age of 16. Another 13% refused to answer. It must be noted that the cut off age of 15 years for childhood experience is younger in this study than in the others reviewed. It must also be noted that respondents were not questioned further if they replied negatively or refused to answer. This is strikingly different from the surveys of Russell and Badgley who approached the topic
several times in different ways.

Fromuth (1986) - Female college students.

Mary Ellen Fromuth (1986) studied the relationship of childhood sexual experiences to later psychological adjustment. Her subjects were female students from undergraduate psychology classes at Auburn University in Maine.

Of the 482 who completed the questionnaire, 22% reported at least one sexually abusive relationship while they were a child. Unfortunately, 99 of the women did not complete the full questionnaire so that further analysis was based on the 383 full questionnaires. While this results in a disappointing compliance rate, Fromuth notes there were essentially no demographic differences between the smaller sample and the full sample. The qualifications already mentioned regarding a college sample apply as well to Fromuth's study.

Summary.

The major prevalence studies from the last eight years have been presented. The samples include 8058 persons from three different countries.

A summary of the study results are as follows:
(1) 19.2% of female and 8.6% of male college students reported having been sexually assaulted as children (age 16 or less) by an older partner. The majority of respondents were 21 years of age or younger (Finkelhor, 1979).

(2) 38% of San Francisco women reported at least one experience of sexual abuse before the age of 18 years, with 28% occurring before age 14. These exclude non-contact experiences (Russell, 1983).

(3) 11% of female and 3% of male Texas residents reported having been sexually abused as children (age not specified) in a mailed survey (Kercher & McShane, 1984).

(4) 15% of female and 6% of male Boston parents identified experiences from age 16 and under which they considered to have been childhood sexual abuse (Finkelhor, 1984).

(5) 37% of female and 23% of male Canadians reported having been the victims of unwanted sexual acts before the age of 18 (Badgley, 1984).

(6) 62% of Los Angeles women reported at least one sexual abuse experience before age 18. There was no significant difference between Afro and white respondents (Wyatt, 1985).

(7) 12% of female and 8% of male residents of Britain reported having been sexually abused before the age of 16.
(Baker & Duncan, 1985). This represents the youngest cut-off age of the surveys presented.

(8) 22% of female college students reported at least one sexually abusive experience as a child age 16 or younger (Fromuth, 1986).

See table 4.1 for a depiction of these comparisons.

If the Kercher and McShane (1984) study is not considered due to their acknowledged difficulty with compliance, the rest show a range of similarity. The chances of a female being sexually assaulted before age 17 are from 15% to 22%, with 12% before age 16 in Britain. This increases to 37% to 51% before age 18 which indicates that ages 16-17 are times of considerable risk for young women.

The chances of a male being sexually assaulted before age 17 are from 6% to 8.6%, with 8% before age 16 in Britain. This increases to 23% before age 18 which indicates that ages 16-17 are also a time of risk for young men.

Females are assaulted more than men with ratios ranging from 3:1 to 3:2.

Discussion.

The higher figures reported by Russell and Wyatt are
<table>
<thead>
<tr>
<th>Study</th>
<th>Definition of Childhood</th>
<th>Females Abused</th>
<th>Males Abused</th>
<th>Ratio</th>
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<tr>
<td>Finkelhor (1979)</td>
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<td>19.2%</td>
<td>8.6%</td>
<td>2:1</td>
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<td>Russell (1983)</td>
<td>under 18</td>
<td>38%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kercher &amp; McShane (1984)</td>
<td>?</td>
<td>11%</td>
<td>3%</td>
<td>over 3:1</td>
</tr>
<tr>
<td>Finkelhor (1984) parents</td>
<td>16 &amp; under</td>
<td>15%</td>
<td>6%</td>
<td>5:2</td>
</tr>
<tr>
<td>Badgley (1984)</td>
<td>under 18</td>
<td>37%</td>
<td>23%</td>
<td>3:2</td>
</tr>
<tr>
<td>Wyatt (1985)</td>
<td>under 18</td>
<td>40/51%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Baker &amp; Duncan (1985)</td>
<td>under 15</td>
<td>12%</td>
<td>6%</td>
<td>3:2</td>
</tr>
<tr>
<td>Fromuth (1986)</td>
<td>16 &amp; under</td>
<td>22%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
credited to personal interviews which allowed a level of trust to be established and to open-ended questions which allowed the respondents to recall information in different ways (Wyatt & Peters, 1886b). How sexual abuse was defined also impacted the outcomes. For example, Wyatt and Russell had similarly high total figures of 62% and 54% respectively. However, when Wyatt reanalyzed her data using Russell's slightly more restrictive definitions, the overall dropped to 53% (Wyatt & Peters, 1986a).

The Badgley study, which received the highest compliance rate, established procedures to ensure respondents of legitimacy and confidentiality, combined self-report questionnaires with personal contact, and provided multiple choice answers to standardized questions. Having a choice of answers probably helped to stimulate recall as well as to normalize some of the more embarrassing or personal responses. Even this study, however, was representative only of those people who were functioning well enough to have a fixed address, the ability to read and write, and social interaction skills (Painter, 1986).

Given the qualifications noted, the above mentioned studies are the best attempts to date at non-clinical population surveys. They are further reviewed in the
following section to compare different characteristics of the victims and offenders.

C. Victim Profiles

This section will review the ages at which a child is most likely to be victimized and what will most likely be the nature of the assault.

Finkelhor (1979) found the average age of victims to be 10.2 for girls and 11.2 for boys, with the most vulnerable age for both to be between 10 - 12 years. Of the children who reported having had experience with older partners, 47% of the girls and 41% of the boys were in that age range. The next most vulnerable age for girls was 7 - 9 (23%) with 13 - 16 for boys (32%). Girls rated their experiences more negatively than boys (66% compared to 38%). Finkelhor found that touching and fondling were the most common sexual activities. Fifty five percent of the children reported having force or threats used against them.

Russell (1983) breaks her sample into six categories, under 18 years and under 14 years, intrafamilial and extrafamilial assault, and excluding and including non-contact experiences. As mentioned earlier, 28% of women reported contact assault before age 14. This rose
to 38% before age 18. When the broader definition was accepted, the figures rise to 48% and 54% respectively. Russell does not provide a further breakdown regarding the ages of the victims.

Neither do Kercher and McShane (1984) present an age breakdown but they do confirm that the racial/ethnic distribution of their sample paralleled that of the 1980 Texas census. This may be interpreted as evidence that child sexual abuse can be found at all levels of society.

In Finkelhor's second study (1984) the parents reporting for themselves had been abused most frequently between the ages 7 - 12 (65%). The children they knew came from the same age group (44%) but with a surprising number (37%) below that age. The parents reported touching and fondling as the most frequent activities (26% and 27%) when they had been abused. Exhibition and sexual requests, however, were reported as more common (26% and 28%) for the children who they knew to be abused.

The Badgley Report (1984) provides seven age categories: under 7, 7-11, 12-13, 14-15, 16-17, 18-20, plus 21 and over. The two older categories are not considered for discussion as they are not children. Generally speaking, girls are at most danger of being victims of exposure at ages 7 - 11, of being touched at
ages 12 - 15, of being assaulted at ages 14 - 15, and of being threatened at ages 14 - 17. Boys are at danger of being exposed to at all ages, in most danger of being assaulted at ages 12 - 17, and of being touched or threatened at ages 16 - 17. This would tentatively suggest that children are more able to handle threats as they become older teenagers.

Wyatt (1985) did not look at the ages at which abuse occurred. The most common type of abuse was fondling, reported by 40% of Afro and 38% of white women. This was followed by intercourse (15% and 18%), and forced fondling of the perpetrator (10% and 14%).

Baker and Duncan (1985) used only two age categories, 10 or below and 11 or above. They found that the average age of victimization for girls was 10.74 with 54% of abuse reported in the older age range. The average age for boys was 12.03 year with 73% of the abuse occurring in the older age group. Females reported 55% no contact abuse, 40% contact, and 5% intercourse. Boys reported 48% no contact abuse, 49% contact, and 5% intercourse.

Fromuth's (1986) study focuses on family backgrounds and later adjustments so does not provide any data useful for this comparison.

What summary can be made from this material? It
would certainly appear that children of both sexes are at risk at all ages of their childhood. Because the studies used different groupings for analysis, direct comparisons are difficult. Preadolescence appears to be the developmental period during which children are at the highest risk for sexual abuse, with 10 - 11 the average age for girls and boys a year older. Touching and fondling appear to be the most common form of contact abuse with exhibitionism also common as a form of non-contact abuse.

D. Offender Profiles

Who are the offenders and what is their likely relationship to their victim? In the words of Sandra Butler, "sexual abuse has a gender and it is male" (1985, p. 211). Gender will be briefly reviewed as presented by the same eight studies, followed by an analysis of offender-victim relationships.

Finkelhor (1979) found 94% of the abusers of girls and 84% of the abusers of boys were men. Russell (1983) found 96% male offenders in both intrafamilial and extrafamilial abuse. Badgley (1984) found 98.8% of the suspected offenders were males and 1.2% were females. Wyatt found that "97% of the incidents reported by Afro-American women
and 100% of the incidents reported by their white peers involved abuse by male perpetrators” (1985, p. 516).

Kercher and McShane (1984), Finkelhor (1984), and Baker and Duncan (1985) did not specify percentages although they refer to the perpetrators as male.

The rest of the section will primarily review the relationship of the offender to the victim. Other significant characteristics outlined by the studies will also be presented as they arise.

Finkelhor (1979) found 24% of the offender were strangers while 76% were known to the child. A further breakdown of those known is 6% parent figures, 37% other relatives, and 33% friends or acquaintances. Included in the relatives were siblings for 15% of the girls and 10% of the boys.

Russell’s (1983) analysis found that only 15% of extrafamilial perpetrators were strangers while 42% were acquaintances and 41% more intimate family friends. Unfortunately, she used different measures of comparison for intrafamilial and extrafamilial perpetrators. Her data has been reinterpreted by comparing the number of reported perpetrators in each sub-category against the total number of perpetrators. See table 4.2 for these figures.
### TABLE 4.2
PERPETRATORS' RELATIONSHIP TO VICTIM
COMBINED INTRAFAMILIAL AND EXTRAFAMILIAL
DATA FROM RUSSELL (1983)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stranger</td>
<td>71</td>
<td>10.9%</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>201</td>
<td>31.0%</td>
</tr>
<tr>
<td>Friends</td>
<td>189</td>
<td>29.2%</td>
</tr>
<tr>
<td>Family</td>
<td>186</td>
<td>28.7%</td>
</tr>
<tr>
<td><strong>Family includes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Father figures</td>
<td>44</td>
<td>6.8%</td>
</tr>
<tr>
<td>- Uncles</td>
<td>48</td>
<td>7.4%</td>
</tr>
<tr>
<td>- Cousins</td>
<td>28</td>
<td>4.3%</td>
</tr>
<tr>
<td>- Brothers</td>
<td>26</td>
<td>4.0%</td>
</tr>
<tr>
<td>- Other relatives</td>
<td>40</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>TOTAL PERPETRATORS</strong></td>
<td><strong>647</strong></td>
<td><strong>99.8%</strong></td>
</tr>
</tbody>
</table>
In Russell’s (1983) study the number of perpetrators exceeds the number of women reporting abuse (186 intrafamilial offenses on 152 women and 461 extrafamilial offenses on 357 women). This indicates many women were abused by more than one person, approximately 60% of the time extrafamilially and 20% of the time intrafamilially. This may mean that having been victimized increases one’s vulnerability or that certain conditions predispose some women to continued assaults. These concepts will be discussed further in following chapters.

Russell later (1984 & 1986) provides evidence that having a stepfather increases a women’s risk of being sexually assaulted six fold. She found 17% of women who had a stepfather were abused by him as compared to 2% who were abused by their natural fathers. She also found that abuse by stepfathers involved more serious violations. These dynamics will be discussed in more detail in Chapter Eight.

Kercher and McShane (1984) did not address offender characteristics.

Finkelhor (1984) found 8% parent figures, 24% relatives, 35% acquaintances, and 33% strangers among perpetrators in parent self-reports with 2% parent figures, 8% relatives, 45% acquaintances, and 45% strangers
among the child reports. He also found a variance in the ages of the perpetrators. While the majority (79%) were over 21 in the parent self-reports, 23% were under 13, 27% ages 14 - 20, and 50% over 21 in the child reports. This may indicate that parents are simply more aware of the younger perpetrators.

The Badgely report (1984) used slightly different categories of relationship. The National Population Survey breakdown of the offender population is as follows: 9.9% incest relationship (parents, siblings, grandparents), 8.4% other blood relatives, 3.0% guardianship position, 2.5% other family members (including step, foster, and common law relationships), 48.0% friends and acquaintances, 9.4% other persons known to the victim, and 17.8% strangers.

Wyatt (1985) did not report on ages but found that 81% of both Afro and white women were abused by a perpetrator from their own ethnic group.

Baker and Duncan (1985) found 51% of abuse was by strangers, 35% extrafamilial, and 14% intrafamilial. This varied for males and females with boys experiencing 43% stranger abuse, 44% extrafamilial and 13% intrafamilial, and girls experiencing 56% stranger abuse, 30% extrafamilial, and 14% intrafamilial.
Fromuth (1986) did not address characteristics of offenders.

In summary, the findings confirm that perpetrators are predominately male, with statistics ranging from 94% to 100% for offenders of female victims. A slightly lower figure of 84% was noted for offenders of male victims, although it must be remembered there are also fewer male victims.

A graphic representation of relationship comparisons is presented in table 4.3. The chances of an assaulter being a stranger range from 11% to 51%. The chances of an offender being intrafamilial range from 10% to 43% with father figures identified as 2% to 8% within that category. The chances of an offender being known and extrafamilial range from 33% to 49%. It must be stressed that these figures represent the percentages within the offender population, not the degree of risk these categories represent for the general population.

E. Summary and Conclusions

The figures represented in this chapter are intended to illustrate that the sexual abuse of children is a widespread social phenomenon. Prevalence rates reported by these population surveys confirm that many children,
### TABLE 4.3
COMPARISON OF OFFENDER-VICTIM RELATIONSHIPS ACROSS FIVE STUDIES

<table>
<thead>
<tr>
<th>Study</th>
<th>Stranger</th>
<th>Acquaintance</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finkelhor (1979)</td>
<td>24%</td>
<td>33%</td>
<td>43%</td>
</tr>
<tr>
<td>Russell (1983)</td>
<td>10.9%</td>
<td>60.2%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Finkelhor (1984) parents</td>
<td>33%</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>Finkelhor (1984) children</td>
<td>45%</td>
<td>45%</td>
<td>10%</td>
</tr>
<tr>
<td>Badgley (1984)</td>
<td>17.8%</td>
<td>57.4%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Baker &amp; Duncan (1985)</td>
<td>51%</td>
<td>35%</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Notes**

1. Finkelhor's (1979) family includes: 6% parents, and 10 - 15% siblings.

2. Russell's (1983) family includes: 6.8% fathers, 7.4% uncles, 4.3% cousins, and 4.0% brothers.

3. Finkelhor's (1984) families include 8% and 2% parent figures respectively.

4. The other authors do not provide detailed breakdowns.
up to one in two girls and one in four boys, have been subjected to different forms of sexual abuse. While some of these children also show up in clinical and victim statistics, it is still not clear why some are more traumatically affected than others. These questions will be addressed in following chapters which discuss issues of intervention.
CHAPTER FIVE: A COMMUNITY MODEL

To criticize and find remedies for one part of the system while ignoring the others is an unfulfilling exercise in futility, besides being a waste of money and effort.

Vincent Fontana, When Systems Fail: Protecting the Victim of Child Sexual Abuse

This chapter will provide a framework in which community agencies can address and respond to child sexual abuse. It will also provide the context for following chapters which deal more specifically with treatment issues.

The need for early identification and comprehensive services is paramount (Shamroy, 1980; Topper, 1979). Community agencies of control and change must intervene cooperatively to ensure that society becomes more safe for children. The three primary types of intervention, as identified by Porter (1984), are: (1) protection of children - traditionally administered by social services, (2) change treatment - traditionally the realm of therapy, and (3) punishment - traditionally administered by the police. Each of these components will be discussed with focus on their contribution to an interdisciplinary model.
A. Protection of the Child

Case management tasks.

Conte and Berliner (1981) outline the necessary objectives to be accomplished from a social work or child protection perspective following a disclosure of child sexual abuse. The first is to protect the child from further abuse; the second is to assure the child and family that the child is all right and that required treatments are available; the third is to assist the child and family in resolving their emotional reactions. It is important that initial interviews have a therapeutic purpose as well as gathering information (Burgess & Holmstrom, 1978c). As well, the worker has a fourth mandate to help ensure that institutional responses are supportive to the victimized child (Conte & Berliner, 1981).

Sgroi (1982b, p.96) lists the ten essential tasks in case management of child sexual abuse as: reporting, investigation, validation, child-protection assessment, initial management planning, diagnostic assessment, developing a problem list, formulating a treatment plan, treatment intervention, and monitoring and reassessment. Although Sgroi feels it is essential for statutory child-protection agencies to be involved in all cases to
ensure protection of the child, she also acknowledges: "In the absence of adequate preparation, it is totally unrealistic to expect the average police officer, child-protection services worker, counselor, or therapist to be able to work effectively with child sexual abuse cases" (1982b, p.384). Child protection protocol will not be addressed in detail as it is beyond the scope of this thesis. Special attention will, however, be given to validation as that is crucial for identification of treatment needs to be explored in Chapters Six and Seven.

**Validation.**

Validation depends on the ability of the investigator to interpret behavior, physical signs, and information gathered in the initial investigation period. It is worth reviewing some of the symptoms which may be indicators that a child has been sexually abused.

Justice & Justice (1979) list such cues as frequent depression, the child functioning as parent to family, secretiveness, venereal disease, genital infections, pregnancy, genital irritation, and behavioral cues of enuresis, soiling, hyperactivity, sleep disturbance, fears, phobias, compulsive behavior, learning problems, compulsive masturbation, precocious sex play, excessive
curiosity about sexual matters, separation anxiety, and excessive seductiveness.

The health care setting is a frequent partner of child protection work. A specific allegation may be made which requires medical attention, or medical assistance may be requested for validation of an alleged abuse. On the other hand, health care professionals may request the cooperation of child protection workers when sexual abuse is uncovered as an underlying cause of other complaints under investigation (Thomas & Rogers, 1981, p.180).

Hunter, Kilstrom and Loda (1985) emphasize the importance of looking beyond symptoms in the medical setting. Physical complaints such as sexually transmitted disease, genital trauma, physical abuse and neglect, depression, decreased school performance, and suicide attempts can all be masking a history of sexual victimization. Somatic effects such as ulcers, colitis, and migraines may also be the result of repressed memory (Halliday, 1985).

De Jong (1985) adds vaginitis to the list of possible cues. Hysterical seizures have also been associated with a history of incest (Goodwin, McCarthy & DiVasto, 1981; Gross, 1979). Regressive or inappropriate behaviors such as nightmares, bedwetting, clinging behavior,
inappropriate sexual behavior, anxiety, and sadness are noted by Mannarino & Cohen (1986).

In summary, an allegation of child sexual abuse is given credence by behavioral indicators of distress in the child. A more firm diagnosis is achieved from a clustering of the symptoms described (Frederickson, 1986). The possibility of sexual abuse needs to be considered in all medical histories (Cantwell, 1981). "An acute awareness of the problem as well as a high degree of suspicion and willingness to consider sexual abuse as a possibility are the first steps towards identifying and helping ... potentially victimized children" (Thomas & Rogers, 1981, p.180).

**Corroboration.**

Corroboration refers to evidence that may be required for court purposes. One limitation of the child protection system is that it has no control over offenders. Child protection workers and clinicians must work closely with police and legal authorities by providing evidence and expert opinion.

Sgroi (1982b) emphasizes that corroboration by confrontation is not appropriate until the safety of the child is assured. It is also not recommended that a
clinician or health professional confront an alleged abuser without police protection. An alternative would be to hospitalize the child pending assessment of his or her safety in the home (J. Jones, 1982).

It is equally inappropriate to rely on physical findings for validation or corroboration (Sgroi, Porter & Blick, 1982). Thorough medical exams can be helpful in that an enlarged vaginal opening is frequently correlated with sexual abuse (Cantwell, 1983) and a colposcope can be used to detect microscopic scratches or tears (Woodling & Heger, 1986). However, lack of medical evidence is not sufficient reason to discount alleged sexual abuse.

Strategies of corroboration include statements made by the child victim to parents or relatives; use of play with pictures, stories, and dolls; sexual knowledge inappropriate to the child's age or developmental status; and inappropriate sexual behavior ranging from masturbation and seduction to aggressiveness with other children (Faller, 1984).

Goodwin (1982) outlines age differentials for verbalizations and developmental symptoms. For example, the infant to age four child will be clinging and fearful and cannot be expected to make any definitive statement other than about "hurting"; the age four to six child
often exhibits symptoms of neglect or abandonment and is inclined to make simple and cryptic off-hand statements; the latency age child will present with somatic complaints or school problems and will either refuse to disclose or be very graphic; adolescents typically present with behavioral problems and tend to blame themselves, while their fears can cause them to discount the seriousness of the complaints.

Adams-Tucker (1985), in a study of 27 children referred for psychiatric evaluation, found similar age differences. Denial and sexualization were the most common defense mechanisms of school age children while acting out and introjection were more common among adolescents.

"It is extremely important to realize that children rarely lie about sexual experiences, except to minimize their involvement" (Stone, Tyler & Mead, 1984, p.77). Children will also be anxious about the consequences of their disclosure, both for themselves and the offenders. A helpful rather than punitive attitude towards the offender is often reassuring to the survivor, particularly if the offender is known to the child (Stone et al, 1984).

The role of the social worker or client advocate in court is three-fold: (1) to provide support, (2) to
interpret courtroom procedure to the family, and (3) to neutralize stress between the victim and people involved in court process (Burgess & Holmstrom, 1978b). Another important role, which can be filled by a number of professionals, is that of expert witness regarding a child's credibility (Ordway, 1983). All of these underline the need for specialized training of workers and clinicians who will be involved with sexually abused children in the court system (Pierce & Pierce, 1985a).

B. Therapeutic Interventions

Needs of the victim, family, and offender.

Society must care for the needs of all people, to meet them nonjudgmentally as evolving human beings (Giarretto, Giarretto, & Sgroi, 1978). The child, family, and offender will all have unique and sometimes seemingly contradictory needs following a disclosure of child sexual assault.

The primary focus is the child-victim who needs a guarantee of protection, and assurance that he or she is believed, cared about, and supported (Spencer, 1978). The possibility of additional physical abuse must not be overlooked. In one study of 80 sexually abused children, 67% had also suffered physical abuse (de Young, 1982b).
Sgroi (1978) adds that while insertion of foreign bodies into children is a recognized variant of child abuse, any genitourinary or rectal insertion may also be a sexual assault.

Family members often need support in understanding practical ways of being most helpful to the victimized child. The sexual assault may be experienced as a crisis for the family as well as the child and all members may require help with functional disruptions and the possibility of court (Burgess, Holmstrom & McCausland, 1978). If the offender was a father figure in the home, separation from the child is an important component of the treatment program. If he does not agree to leave the home, the family may be forced to relocate. They will often need concrete services such as financial assistance or shelter until they are able to rebuild their own resources.

Another important consideration is that the allegation or disclosure of child sexual abuse often triggers a profound crisis for adult members of the family who were also abused as children but never acknowledged it (MacFarlane & Korbin, 1983). Needs of the family and treatment of intrafamilial abuse are discussed more fully in Chapter Eight.
The offender needs assurance that he will be treated with compassion within legal system with the option of treatment available. Such reassurance may work to reduce his denial. If the offender can be encouraged to cooperate with the legal system, the child is spared the further trauma of the court process. However, the limitations of treatment must also be appreciated. While all persons deserve compassion, the risk to society of severely sadistic and anti-social offenders must be weighed against the qualified effectiveness of any treatment program.

An important attribute of a clinician is the ability to focus on the sexual assault in the midst of other quite legitimate problems (Groth, 1982). To do so, it is vital that workers be comfortable with their own sexuality (Renvoize, 1982). Too many agencies seem to believe that treatment of sexual offenses can happen by osmosis if other dysfunctional dynamics such as poor communication or impulse control receive treatment attention (Schlesinger, 1982).

It is equally important in confronting an offender that clinicians operate from a strong power base. It is unrealistic to expect that individuals who depend upon abuse of power will respond to non-authoritative
intervention. "The fact that the offender has victimized a child implies that adults are intimidating in some respect to him" (Groth, 1982, p.232). The clinician gains power from knowledge and authority. Knowledge is required both of the specific offenses and general theory. Authority is provided by the clinician’s adulthood and professional position (Groth, 1982). Offenders are discussed more fully in Chapter Nine.

Trauma of disclosure.

The act of disclosure carries significant trauma of its own. Consideration must be given to whether the disclosure is deliberate or accidental, the developmental stage at which disclosure is made, and reasons for the disclosure (Berliner & Stevens, 1982; Sgroi, 1982b).

Whatever triggers a person to reveal an incident of childhood sexual abuse is clinically significant and the emotional repercussions must be considered. Burgess and Holmstrom (1975) comment on the stress of letting go of a secret:

One notable feature when the silence is broken is the characteristic of the unresolved issue phenomenon. The incident has been encapsulated within the psychic structure for so long that when the person finally discloses the secret, the emotional affect can be quite strong. (p.561)
The act of disclosure demands new coping strategies from both the victim and family members. This can be particularly disruptive when the sexual abuse has happened within the family and over a period of time. "Disclosure disrupts whatever fragile equilibrium has been maintained, jeopardizes the functioning of all family members, increases the likelihood of violent and desperate behavior, and places everyone, but particularly the daughter, at risk for retaliation" (Herman, 1981a, p.131).

**Dualistic model.**

The dualistic model of crisis intervention and advocacy as outlined by Holmes (1981) is helpful for child sexual abuse. Crisis interventions are appropriate at the crisis stage in that they can reduce the impact, help the victim regain control, and strengthen future coping mechanisms. However, the problem is widespread enough that effective programs need to look beyond simply treating individual children. It is also important to ensure that social systems become more responsive to the needs of those they are supposed to serve and that society become less tolerant of the abuse within its midst.

Client advocacy can take place at many levels. The
public needs more information about children's rights and the many ways in which they are violated. Families need to be strengthened so that problems that have been identified as risk factors can be alleviated. As well, professionals need to become more sensitized to the needs of victims and more knowledgeable about services available to strengthen their advocacy positions (Justice & Justice, 1979).

This thesis adopts the humanist position that a person cannot become an effective clinician without attending to self-realization and that a person's self-realization includes striving for social conditions that foster the same for others (Giarretto, 1981). The basic humanist philosophy is that the strongest human drive is for people to feel good about themselves and their relationships. To work effectively with sexual abuse offenders, one must believe the same is true and possible for them.

Clinicians and investigators must also be willing to assess critically the experience base of any so-called expert of child sexual abuse (Sgroi, 1982b). This implies that clinicians first have an obligation to become familiar themselves with the dynamics of child sexual abuse.
C. Dealing with the Offender

Need for ethical clarity.

The ethical clarity advocated refers to the premise that child sexual abuse is wrong, that the offender must bear moral and legal responsibility for the act, and that treatment is not a substitute for responsibility (Berliner, 1985). While opinions will vary among professionals and the general population, an effective community program can not be achieved until there is at least a functional agreement regarding these issues.

Deviance is a fact of human nature and social life. It exists in social systems as a "necessary complement to conformity" (Gagnon & Simon, 1967, p.62). The concept of deviance is closely tied to that of social roles. All social systems function because of the willingness of members to conform. Sources of pathology are not sought unless behavior is considered socially deviant (Giovannoni & Becerra, 1979).

A frequent debate is the degree to which sexual abuse is an act of illness or a crime (Armstrong, 1983; MacFarlane & Bulkley, 1982). The corresponding discussion is how offenders could best be brought to treatment or how they could best be dealt with by the legal system. Child sexual abuse must be seen as both a mental health problem
and a criminal problem (Mrazek, Lynch & Bentovim, 1983). Offender programs need to seek an approach that combines positive client motivation with authoritative leverage (Wachtel & Lawton-Speert, 1983).

An example contrary to the proposed ethical statement is provided by Borgman who in a study of victims felt the sexual assaults had not been "consciously intended" in a number of cases (1984, p.182). These included activities resulting from corporal punishment of teenage girls, sexual contacts which occurred only when the offenders were inebriated, activities that occurred when men had been having sex with adults and turned to children who happened to be present, and prostitution arranged by the girls' mothers. The author suggests that such acts are not accidental and that reasons such as those listed above allow the offender to escape the consequences of criminal behavior. This, however, demonstrates the need for clear standards.

**Impact of legislation.**

The interface between criminality and mental illness is such that a consistent criminal code is unlikely to emerge until there is agreement on aims of the law (Wheeler, 1967). The criminal code reflects the mores of
the community but popular sentiment regarding deterrance, rehabilitation, and punishment will determine actual enforcement. These are the issues to be answered by the legal system in cooperation with child protection and clinical consultants.

The challenge for legislation is to match sanctions with community standards. If the courts are too lenient, offenders are not deterred and citizens may resort to private vengeance; if they are too harsh, citizens may be unwilling to aid prosecution (Taylor, 1981).

An important consideration is that child abuse legislation aimed at assuring protection of the child may also have negative effects. These include the possibility of driving abusive families further underground and confusion caused by different cultural and social interpretations (Rolde, 1977). Other considerations are that multiple services can become self-defeating because of confusion of focus. The state can not guarantee better care of children following intervention when physical care is given priority over psychological needs (Goldstein, Freud & Solnit, 1973). As well, the rights of children may be denied or overshadowed by the whole bureaucratic process (Rolde, 1977).

On the other hand, there will always be cases that
defy legal containment. "If public agencies abandon the family when it becomes clear that a legally proveable case can not be made, their actions become part of the problem" (Taubman, 1984).

**Adaptation of police and court systems.**

The importance of the role played by the police is evidenced by the following two statements. The first person to confront the offender will likely get at least a partial confession; therefore, it is important for that person to be a police officer (Halliday, 1985). "Sensitive handling of the sexual abuse investigation by the police officer can be the single most important issue in maintaining successful treatment of the child" (Stone et al, 1984, p.82).

It is important that investigations and interviews be adjusted to the developmental level of the child involved (Graves & Sgroi, 1982). It is even more important that the police work to build cases which do not require testimony of the child (Frost & Seng, 1986). Cases are more likely to go to court when victims are seven to twelve years of age. Younger victims are often not considered credible witnesses; older children may be suspected of complicity (Finkelhor, 1983).
The challenge is for the court system to become more flexible in meeting the needs of younger children. Jones & Krugman (1986) document how legal procedures were adapted to accommodate a three year old victim-witness. The major adaptation was that the treating psychiatrist also acted as court interviewer. This allowed the psychiatrist to communicate at the child's developmental level as well as being available to quickly identify and attend to any signs of distress.

Sgroi (1982b) quotes Nova Scotia and Israel as examples of jurisdictions where child evidence can be given by proxy. De Francis (1969) warns, however, that this violates the basic rights of the alleged offender to face the accuser, cross-examination, exclusion of hearsay, and equal protection under the law. A balance must be achieved whereby traditional legal rights are incorporated with procedures more responsive to the developmental needs of children.

D. Prevention and Social Change

Children at risk.

Lack of affection predisposes many children to sexual abuse as they may indiscriminately relate to adults in affection seeking ways (Johnston, 1979). Several other
Factors have also been identified.

Finkelhor (1980a) in his study of college students identified the following risk factors: low income group, socially isolated background, stepfather families (this was strongest factor in that stepfathers were five times more likely to abuse than natural fathers), having lived at one time apart from mother, mother with substantially less education than father, and mother punitive about sexual matters. These factors were noted to have an accumulative effect in that over 50% of girls with four or more factors had suffered sexual victimization as a child.

Similar factors were identified by Gruber & Jones (1983) who found that victims were more likely to have been living with parents who experienced marital strife, more likely to be living with a step or foster father, and conversely, less likely to be living with both biological parents.

It is not typical for sexual abuse to occur independently of other aspects of family dysfunction. It occurs with greater frequency in homes disrupted by the child's separation and parental coldness. Sandra Butler (1985, p.214) emphasizes that the "good" child is more vulnerable. Attempts to equalize the power imbalance are
necessary components of preventative education and action. Poor self-esteem in the child contributes to their inability to resist abuse and lack of confidence about reporting (Bagley & Ramsay, 1986).

There are many suggestions in the literature of ways to improve services for victimized children. The need for more comprehensive Child Welfare legislation and more consistent statistics are outlined by Badgley (1984). International computers systems are suggested by Frost and Seng (1986). A practical suggestion for providing non-threatening information to adolescents is the use of recorded telephone messages with provision for personal back-up and face-to-face interviews if the caller wishes either alternative (Thomas & Johnson, 1979).

**Education of the public.**

Finkelhor (1984a) notes factors of vulnerability from his preconditions model. These are that the child is emotionally deprived, socially isolated, acquainted with the adult, fond of the adult, vulnerable to incentives, helpless and powerless, ignorant, sexually repressed and curious, and coerced. These concepts need to be incorporated into safety education for children as well as into information programs alerting parents to the
possibilities of child sexual abuse.

The credibility and vulnerability of children are themes which need constant reiteration. These premises have never been firmly established and another movement is arising to challenge them further. People who feel they have been wronged by child protection agencies or the courts are forming VOCAL groups (victims of child abuse legislation) to protest the right of society to intervene for protection of children (Conte, 1986; Summit, 1987). While there may be adults who have been wrongly accused and suffered public embarrassment, the danger of such groups is that they perpetuate the purported myth that children's stories are often not credible.

Education of professionals.

The need for a cooperative model is stressed by Anderson & Shafer (1979). It is critical that agencies avoid mixed messages to their clients and to each other. Recognition of the different roles of mandated agencies is important for casework management (Sgroi, 1982b). It is essential that each program sort out its own complexities of system interplay (Bander, Fien & Bishop, 1982; Zefran, Riley, Andersen, Curtis, Jackson, Kelly, McGury & Suriano, 1982).
Porter (1984) suggests time frames for the initial stages of intervention: (1) suspicion and disclosure - the first 24 hours, (2) preliminary investigation - one to three days, and (3) long term management - up to 21 days or longer. A multidisciplinary approach is required with the different professionals knowing their specific roles and tasks at each stage. The proportionately greater risk of suicide among survivors adds to the urgency of early identification and treatment by human service professionals (Briere & Runtz, 1986).

Any complete family violence program must include prevention, identification, intervention, referral, and follow-up. Accountability and quality assurance are essential components of any child protection program. Multi-disciplinary systems rely on clear organizational lines and well defined roles and responsibilities. An example of all these components working well together is the U.S. Navy Family Advocacy program for offenders of family child sexual abuse. The program is based on the assumption that it is more cost effective to deter or rehabilitate offenders than to dismiss them and is designed so that families receive quality service with a philosophically and legally consistent response between posting locations (Rosswork, 1985).
Each professional discipline has its own unique perspective and strengths. Professionals need to stimulate discussion to reduce their differences and maximize understanding (Wilk & McCarthy, 1986). Further discussion of improved services, prevention and social change is presented in Chapters Ten and Eleven.

E. Summary and Conclusions

"An effective treatment program provides group work, professional clinical therapy, advocacy for the protection of the victim in the legal system and a supportive network of community professionals" (Reed, 1985, p.17). This kind of supportive professional network has been shown to be a complex undertaking.

Many tasks are involved in casework management of child sexual abuse. Awareness and willingness to accept it as a possibility are the first steps toward identification, reporting, and treatment. Knowledge of the signs and symptoms of sexually abused children are important in validating reports of child sexual abuse. Whenever possible, it is advantageous for the police to be the first to confront the offender. This is in case of a partial confession which may later be required as evidence in court. As well, this allows those working directly
with the child to assess his or her safety and plan alternate placement if necessary.

Crisis intervention is seen as an important component of child sexual abuse treatment, particularly following initial disclosure. The emotional impact of disclosure is an important clinical consideration. The child, family members, and the offender all have unique needs to be met during this crisis period. The professionals responding in such a situation need to be comfortable with their own sexuality, committed to the personal development of their particular client without compromising the integrity of the child, willing to confront the sexual assault directly, and able to confront the offender authoritatively. Crisis intervention, however, is not complete without victim advocacy.

The need for ethical clarity is paramount in dealing with offenders. The sexual abuse of children must be seen primarily as a criminal offense with treatment offered as a complement to rather than a substitute for punishment. If the offender is punished without treatment, he will continue to be a risk to society. However, the denial and secrecy dynamics of child sexual abuse are such that without strong external motivation such as a legal imperative, many offenders would simply avoid treatment.
The responsibility of legislation is to hold the offender accountable while providing treatment options. The challenge for community agencies is to develop a model of working together so that each has a complementary and nonconflictual role. This is best achieved by focus on the victimized child.

Prevention programs are an important part of advocacy. A three pronged approach is presented. Education programs about children's rights and safety are important to sensitize the public. Identification of risk factors for children allows preventative work in strengthening families. Finally, professional education and dialogue are seen as necessary to improve common understanding and interdisciplinary cooperation.
CHAPTER SIX: TRAUMA TO THE CHILD VICTIM

There seemed to be a memory deeper than the usual one, a memory in the tissues and cells of the body on which we tattoo certain scenes which give a shape to one's soul and life habits. It was in this way she remembered most vividly that as a child a man had tortured her; still she could not help feeling tortured or interpreting the world today as it had appeared to her then in the light of her misunderstanding of people's motives. ...it was his behavior which she did not understand as a child which destroyed her faith in life and in love.

Anais Nin, Winter of Artifice & House of Incest

A. Victimology.

Victimology is the study of victims and how they respond to major disasters or disruptions in their lives. Disasters can include anything from natural calamities such as floods and hurricanes to accidental injury or loss and violent acts such as war or crime. Victimology looks at the response of possible helpers as well as of the victims. This broader perspective is helpful in understanding sexual abuse from a child's point of view.

Patterns of typical victim behavior have been identified which are common to victims across different kinds of disaster. These kinds of reactions among victims of childhood sexual abuse attest to the traumatic impact of the experience as well as explaining some of the behaviors. The components of victimization to be
discussed are universal rejection, victim-precipitation, learned helplessness, attribution and locus of control, disaster syndrome, traumatic infantilism, and traumatic bonding.

**Universal rejection.**

Alexandra Symonds (1979) describes the universal reaction of the animal kingdom and humans to reject an injured or sick member: "This need to blame and reject the victim is so universal that it extends to the medical and mental health fields" (p.163). This is caused by the fact that exposure makes unharmed members feel vulnerable by a primitive fear of contamination. Blaming the victim satisfies a need of the blamer to dissociate from responsibility and the possibility of a similar fate. Understanding of the factors leading to a child's participation is an important part of understanding the child's innocence (Gruber, 1981).

The silence of professionals encountered by Sandra Butler (1985) in her beginning research may have represented a similar kind of dissociation.

**Victim-precipitation.**

Victim-precipitation proposes that victims somehow
cause their own assault by lack of precaution or by unintentionally or otherwise provoking their abuser. For example, victim-blame models of rape attempt to identify characteristics or victims in comparison to successful resisters (Rabkin, 1979). This is in contrast to the victim-perpetrator model which sees the young child as a helpless victim of an aggressive adult (Rosenfeld, 1979). Rosenfeld feels the victim-perpetrator model is too simplistic for many situations of sexual abuse within the family such as when force is not used and the victim has an important relationship with the offender.

Certainly children who are already insecure or lonely can be more vulnerable to the advances of a sexual abuser. Katherine Brady describes the vulnerability of her own loneliness at the time of her father's attentions:

My father and I came to each other out of great neediness. I wanted emotional sustenance, and assurance of love, an obliteration of the fear of abandonment. He wanted sexual gratification, perhaps to ease the pain of his own emptiness, to deny the inexorable movement of time, to assuage his bruised ego. And in a sense, at that time we served each other very well. (1979, p.41)

The danger of the victim-precipitation model is that vulnerability may be confused with responsibility. Children who are more vulnerable because of damaged self-esteem or insecurity are doubly victimized.
**Learned helplessness.**

Lenore Walker (1979) in her studies of battered women borrowed from the work of experimental psychologist, Martin Seligman, with animal subjects. The basic hypothesis was that subjects' motivation to respond would be lessened by unpredictable adverse stimuli over which they had no control. For example, dogs were placed in cages and given electrical shocks at random intervals. At first the dogs attempted to escape but when nothing changed, they became passive and submissive. When an escape route was later made available, the dogs still did not respond and had to be dragged repeatedly to the escape before they relearned voluntary responses.

Similarly when children are operating from a belief of helplessness, their perception becomes their reality and their behaviors are determined by this belief. Feelings of helplessness are also carried from one aversive situation to another so that the child's task becomes survival rather than escape (Browne, 1980). This explains why children often remain passive participants for so long and also suggests that other family members, who are unable to come to the child's defence, may experience similar helplessness.
Attribution and locus of control.

Attribution, the act of granting authority, is seen psychologically as the need to provide a rational explanation, to make personal sense of a trauma suffered. Examples are children who feel that their silence is serving a function such as keeping the family together. Even self-blame can provide an explanation and give the victim some perception of control as again illustrated by Brady:

"If I was capable of manipulating circumstances so they'd pay off for me, maybe it was all my fault. Or at the very least, how could I blame Dad for everything if I got what I wanted from it? My status as victim was called into question. (1979, p. 81)"

Locus of control is the degree to which a victim feels control over the misfortune suffered. Examples are children who grow up feeling that their only worth is in the sexual appeal of their bodies. Another example of a young child learning control over their adverse environment is given in one of the testimonials of Sandra Butler:

"I learned very young that if I were to survive whole in this family I could not be angry. So I certainly couldn't be angry at my father's sexual advances because that would surely have caused me to be dead - at least in my child mind. Likewise, all strong emotions were not allowed.

I remember being about four years old and
standing in front of the house, just before I was going to go in from playing, and I decided that the only way I was going to make it with my crazy parents was to shut myself off. I don't know if I thought about it in those terms, but I felt they were just too crazy, just too sick, just too unable to relate to me in a helpful manner. So I had to preserve myself by locking it up. (1978, p.50)

**Disaster syndrome.**

Another kind of reaction is described by Angela Browne (1980) as the disaster syndrome or battle reaction and is based on the study of victims across various trauma. Her three stages of impact, reorganization, and recovery overlap the three stages of impact, terror, and depression described by Alexandra Symonds (1979) for victims of violent crime.

Following impact, the victim characteristically experiences shock, denial, and disbelief. This may be accompanied by feelings of helplessness and self-blame in the face of natural disasters as well as criminal acts. During this second phase the victim is particularly vulnerable, so may minimize the personal damage or threat. It is during this time, which Martin Symonds previously identified as a state of terror, that a condition he calls "traumatic psychological infantilism" occurs (1978, p.210). This is a reaction during which the victim is
reduced to coping mechanisms of early childhood and becomes obediently compliant. This would explain the increased vulnerability of sexually abused children to continued abuse through their adult years and their increased guilt in retrospect.

Whether the third phase is characterized by passivity and depression or recovery depends on whether the victim has been overwhelmed by the threat of danger or has the opportunity to reintegrate. Feelings of self-blame may be increased by remembrance of previous compliance with the victim retreating into silence and shame. These reactions can all be part of post sexual assault trauma, depending on the degree of violence and terror experienced.

**Traumatic bonding.**

The final component of victimology to be discussed is that of traumatic bonding as described by Don Dutton and Susan Painter (1982). This refers to the development of strong emotional attachment under conditions of intermittent maltreatment. Experiments with dogs showed that those who were treated intermittently with indulgence and punishment showed higher degrees of bonding than dogs who had been consistently either indulged, punished, or isolated.
The prerequisites of this kind of bonding are first, a power imbalance so that a cycle of dependency is established and secondly, periodicity of abuse so that times between are characterized by normal or pleasant behavior. This explains the strong attachments many abused children have for their parents (Kempe & Kempe, 1978) and the tendency of many sexual abuse victims to deny their own hurt in sympathetic understanding of their abuser. "Feeling 'guilty' about punishing your oppressor is a classic response of oppressed peoples, particularly females, whose oppression is based in putting others before themselves" (Ward, 1984, p.145).

Relation to child sexual abuse.

The sexually abused child may share any or all of these conditions common to victims of disaster. The child is frequently helpless because of the imbalance on the adult power relationship. Infantile coping mechanisms may well carry over to adult life as the young child cannot comprehend escape as an alternative to survival. It is a poignant irony that historical silence has served to perpetuate this victimization and reinforce the feelings of helplessness.
B. Symptoms of Sexual Abuse

Definition of symptom.

Symptomatic behavior is a way of coping with expectations. "Many children become unlovable as a result of having had exceedingly little offered to them, of having known a life of bare survival or utter hate" (Kempe & Kempe, 1978, p.27). Loewenstein (1979) describes a symptom as an unconscious compromise between communicating and not communicating certain thoughts. All behavior is an interactive process; the onus is on the clinician in a therapeutic setting to decipher what is being communicated. "Once the idea that all behavior is interactional and situation-bound is accepted, the diagnostic framework has to be revised to include the social environment, beginning with the diagnostician" (Loewenstein, 1979, p.23).

Alice Miller (1986) expresses the same idea most profoundly:

It has been my experience that a therapist makes much more therapeutic progress if he or she tries to understand patients' sexual problems as a result of sexual abuse by adults. I do not interpret the seductive behavior of a so-called hysterical patient as an expression of her sexual desires but as an unconscious message concerning an event she has completely forgotten, which can be approached only by way of this reenactment. I believe that in her active role the patient will repeatedly demonstrate that which once—or more than once
happened to her but which she cannot remember because it was too traumatic to retain on a conscious level without the aid of an empathic support figure. Instead, she reenacts the unconscious childhood trauma that caused her illness. (p.121)

An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time. In a supportive environment the wound can become visible and finally heal completely. (p.182)

An understanding of symptomatic behavior as the expression of unresolved trauma provides a necessary background for discussion of specific post sexual assault syndromes that have been identified.

**Rape trauma syndrome.**

Burgess & Holmstrom (1974, 1979) describe symptoms typical of adult women following a single sexual assault. The acute phase immediately following the attack is characterized by disorganization. The initial reaction is one of shock, anger, fear, and disbelief. Somatic reactions, other than expected soreness and bruising, may include muscle tension and headaches, gastrointestinal irritability, and genitourinary disturbance. Emotional reactions during the first few weeks include humiliation, anger, revenge, and self-blame.

Reorganization is a long-term process often characterized by increased motor activity (moving, travel,
changing phone number, seeking out support persons), nightmares, and phobic reactions such as fear of indoors, fear of outdoors, fear of being alone, fear of crowds, and fear of people behind them depending on the circumstances of their attack. Sexual fears associated with flashbacks are also a common reaction.

It is important to consider that these reactions are typical of adult women who can verbalize their experience, who have an objective understanding of reality and access to peer support, and whose experience is acknowledged as traumatic. The impact is considerably magnified for a young child who still has a limited understanding of the world and no words to explain what is happening, who is not sure if this experience has ever happened to anyone else, who has no one to tell, and who often must carry the trauma alone and many times over (Butler, 1986).

Accommodation syndrome.

Summit (1983) developed a simple model to help explain the child's position following a sexual assault. The child's reaction is typically characterized by secrecy, helplessness, entrapment, delayed disclosure, and retraction.

Secrecy can take on monstrous proportions for a
child, who is often threatened and dependent on the reality defined by the offender. The child may be silenced with such threats as punishment, being removed from the home, the family breaking up, or the offender going to jail, all of which are terrifying for a child who has no way of testing reality. The burden of the secret may become an integral part of childhood experience. For example, de Young (1982b) found in a study of 80 victims that the secrecy stage lasted between two and seven years.

Children are normally expected to show obedience and affection to adults, especially those in positions of authority, so that the child is at a power disadvantage from the beginning and will typically cope silently. A natural reaction is to develop survival skills which embody a sense of power and control over themselves. Such an alternative is for the abused child to believe they somehow caused their own pain and to adapt strategies to cope with it.

The above reactions often result in a delayed or unconvincing disclosure. Summit (1983) points out the double bind in which children are too often caught. If they have survived by acting out their anger in various delinquent activities, they are discredited for causing
Further problems. On the other hand, if they had attempted to hide their pain and shame under a serene or perfect exterior, they are equally discredited for causing a disturbance when they were not seemingly affected. Once again, pressure is put on the child to assume responsibility for the situation and a fabricated "retraction" carries more credibility than the original disclosure.

Thus, the cycle of accommodation is completed and the child continues to carry the burden of the abuse. "When reality is denied, there is nowhere to go except into a reality of one's own which, by definition, cannot be shared and is called madness" (Ward, 1984, p.117).

**Clinical predictors.**

A post-traumatic stress disorder has been recognized as a specific pattern for war veterans. This is characterized by "nightmares, intrusive recollections of the event, acting as if or feeling that the event is recurring in response to a situational cue, memory lapses, anxiety, problems with relationships, and a feeling of detachment from other" (Blake-White & Kline, 1985, p.396).

A pattern of very similar symptoms are identified by
Gerald Ellenson (1985, 1986) as clinical predictors of a history of incest. Incest is defined by Ellenson (1985) as physical contact of a sexual nature between a minor and a sexually mature person whom the minor perceives as trustworthy. These symptoms, unique to and shared by adult female incest survivors, may be classified as thought disturbances and perceptual disturbances.

Among thought content disturbances are recurring nightmares with violent themes, recurring and unsettling intrusive obsessions such as the impulse to harm a child or the fear of a child being harmed, recurring dissociations, and persistent phobias.

Perceptual disturbances include recurring illusions such as a feeling of evil in the person's home or body as well as auditory, visual, and tactile hallucination. Auditory hallucinations are described as a child crying, an intruder in the home, or booming sounds. Common visual hallucinations are movement in one's peripheral vision, furtive shadows, and dark figures experienced as male and dangerous. Examples of tactile hallucinations are the feeling of being touched or of feeling one's clothes being pulled. Other less common examples are kinesthetic hallucinations such as the bed moving across the floor, somatic hallucinations such as choking or feelings of a
weight on the body when in bed. Olfactory hallucinations are distinct smells.

"An incredible amount of anxiety and suffering can be associated with some of these symptoms" (Ellenson, 1985, p.528). As a result, clients tend to deny or minimize them. Ellenson suggests a symptom is significant if it has happened two or more times a month. Any combination of seven or more symptoms is predictive of a history of incest. A combination of five, including at least one perceptual disturbance, is highly predictive, as are any two perceptual disturbances. "Not only was it rare for survivors to reveal their perceptual disturbances voluntarily, they almost never connected the disturbances with their histories of incest after the disturbances were revealed (1986, p.156).

C. Effects of Childhood Sexual Abuse

Some children will have fewer scars than others, just as some soldiers return from war with fewer wounds. Very few, however, will be unchanged by the experience (Justice & Justice, 1979). This section will look at the effects of child sexual abuse and some of the factors affecting trauma.
Factors affecting trauma.

Burgess and Holmstrom (1975, 1978a, 1978d) devised three diagnostic categories of sexual assault. These are rape trauma, accessory-to-sex, and sex-stress. Rape trauma has already been discussed. The accessory-to-sex syndrome refers to a situation where the victim is pressured into sexual activities. An emotional reaction stems from the pressure and tension of the secret. Sex-stress results from a consentual situation that goes wrong.

Groth (1978b) considers the amount of trauma experienced to be a function of four factors: (1) the nature of the victim’s relationship with the offender, (2) the duration of the relationship, (3) the type of activities endured, and (4) the degree of aggression or force involved. Mrazek and Mrazek (1981) add two additional factors: (5) the age and developmental maturity of the child and (6) the age difference between the victim and the perpetrator.

A more comprehensive list was compiled by the Nanaimo Rape Assault Centre (1984). The factors listed are as follows: the child’s age and developmental status, individual characteristics of the child, the relationship with the offender, the frequency and duration of
activities, the frequency, intensity, and duration of abuse to other family members, the degree of shame, fear, and guilt in the child, the types of threats used to silence the child, the reactions of parents and family, the reaction of professionals, and the type of treatment if any that was offered. A one time incident which may be experienced as unpleasant can be exacerbated by the horror of family or professionals (Sanford, 1980).

Finkelhor and Browne (1985) provide a model of factors affecting trauma by interpreting the psychic process rather than external criteria. The four factors outlined are traumatic sexualization, betrayal, powerlessness, and stigmatization.

Traumatic sexualization refers to the "process in which a child's sexuality (including both sexual feelings and attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (p.531). Children so traumatized may cope by becoming promiscuous or developing an aversion to sex.

Betrayal is the dynamic in which "children discover that someone on whom they were vitally dependent has caused them harm" (p.531). This is related to an impaired ability to trust.
Powerlessness is the dynamic of rendering the victim powerless, "the process in which the child's will, desires, and sense of efficacy are continually contravened" (p.532). Repeated invasion of the child's territory and body space reinforce his or her self-perception as victim.

Stigmatization refers to the process by which negative connotations, such as badness, shame, and guilt, "are communicated to the child around the experience and then become incorporated into the child's self-image" (p.532). "Keeping the secret of having been a victim of sexual abuse may increase the sense of stigma, since it reinforces the sense of being different" (p.533).

Continuum of abuse.

Judith Herman (1981a) distinguishes between seductive and incestuous fathers. Seductive behavior is described as behavior that is clearly sexually motivated but which does not involve physical contact or a requirement for secrecy; incestuous behavior involves both physical contact and secrecy. "Covert incest fosters the development of women who overvalue men and undervalue women, including themselves. Overt incest fosters the development of women who submit to martyrdom and sexual
slavery" (p.125).

Sgroi (1982b) describes sexual activity between an adult and a child often progressing through the following spectrum of behavior: (1) nudity, (2) disrobing, (3) genital exposure, (4) observation of the child, (5) kissing, (6) fondling, (7) masturbation, (8) fellatio, (9) cunnilingus, (10) digital penetration of the anus or rectal opening, (11) penile penetration of the anus or rectal opening, (12) digital penetration of the vagina, (13) penile penetration of the vagina, and (14) "dry intercourse", rubbing of the penis against the child's genital-rectal area.

The typical scenario is a progression from less intimate types of sexual activity (such as exposure and self-masturbation) to actual body contact (such as fondling), and then to some form of penetration. Oral penetration may be expected to occur early in this progression, which is often followed by digital penetration of the anus or vagina. Ejaculation by a male perpetrator, sometimes against the child's body can occur at any time in this progression. (Sgroi, 1982b, p.12)

Rape combines the double taboos of sex and aggression so doubles the sense of shame for victims (Lee & Rosenthal, 1983).

The range of abuses described above could be called private in that they typically occur away from public interest. Street children are more vulnerable to an
additional range of exploitation which takes place within a restricted sub-culture (Frost & Seng, 1986). This includes sex rings (Burgess, Groth & McCausland, 1981), child prostitution, and pornography (Pierce, 1984).

**Short-term effects.**

Short term in this context refers to the state of childhood itself, that which interferes with a child’s ability to be a free and healthy child. The trauma of a child’s pain in his or her immediate situation is as important a consideration as impairment of later adult development.

The possible effects of child sexual abuse are multi-faceted. Categories include genetic (deformities in children born from incestuous unions), physical (somatic complaints), psychological (impairment of functional ability), cognitive (memory loss), and social (impaired relationships and continued victimization due to confusion about intimacy and abuse).

Mrazek and Mrazek (1981) provide a descriptive overview of characteristics noted in various populations studied in the literature to that time. This information is available in Appendix A at the end of this chapter. Such a listing does not describe which effects are most
common and under what circumstances. Nevertheless, it does reflect the beginning documentation of the traumatic effects sexual abuse can have on the children involved.

The following review will focus on more recent literature. Sexual abuse of children has been found to be highly correlated with deliquency, acting out behavior, depression, self-mutilation, chemical dependency, and eating disorders.

Justice & Justice (1979) identify low self-esteem, guilt, depression, alienation, distrust, self-destructive behaviors, and a search for nurturing. Children of incest remain a high risk group because of their continued struggle for nurturance.

Jones, Gruber and Timbers (1981) found a 50% incidence of previous victimization among delinquents. Silbert and Pines (1981) found a 60% incidence among prostitutes. McCormack, Janus & Burgess (1986) found 38% of male and 73% of female runaways reported previous sexual abuse. Mary de Young (1982b) found that effects during or immediately following sexual abuse included isolation in the family, acting out, sexual victimization by others, psychological disturbances, and physical complaints.

Revictimization of abused children is a common theme
in the literature (Adams-Tucker, 1981; DeJong, Hervada & Emmett, 1983). Mary de Young (1984) explains counterphobic behavior as a possible cause. Young children have few resources for dealing with their anxiety following an assault and may develop phobic reactions. The counterphobic response is described as one "in which the children unconsciously attempted to gain mastery over their phobias by engaging in the very behavior that caused them anxiety in the first place" (p.338). This understanding is critical because it explains why some children may be molested more than once and reinforces the need for compassionate intercession in the lives of molested children.

**Long-term effects.**

The effects of child sexual abuse are often not short lived. Long term refers to that which is unresolved in childhood and continues to mar the adult life.

Mrazek & Mrazek (1981) also provide an overview of possible long-term effects. These are listed on the second page of Appendix A. The following review will focus on other authors and more recent studies.

Giarretto (1976) summarizes three earlier studies which found that 22% of prostitutes, 90% of women unable
to accept their own sexuality, and 44% of female drug abusers had been sexually assaulted in childhood. Meiselman (1978) found the most striking results among child sexual assault victims were the frequency of sexual problems, including frigidity, promiscuity, confusion about sexual orientation, and sexual masochism.

Goodwin, McCarthy and DiVasto (1981) note that inhibitions about tenderness resulting from child sexual abuse will impact later decisions about marriage and children. Long-range effects described by de Young (1982b) include family disturbance, psychological and sexual problems, victimization, prostitution, and repeated illegitimate pregnancies.

Halliday (1985) lists migraine headaches, back problems, stomach problems, infections (27% of sample had hysterectomies), anorexia, obesity, asthma (especially among male victims of oral sex), epilepsy, three levels of multiple personality, addictions, depression, self-mutilation, and increased tolerance of pain. She found that male victims tend to be more aggressive while females tend to be more self-destructive.

The most significant and long lasting effects are emotional impairments according to Lindberg & Distad (1985a). Briere (1984) describes post sexual assault
symptomatology which parallels the psychiatric diagnosis of borderline personality.

The effects of child sexual abuse are intertwined with but distinguishable from other childhood traumas such as separation from a parent and emotional or physical abuse: "Physical abuse and neglect have long-term adverse outcomes particularly in terms of psychoneurosis, while sexual abuse influences adverse outcomes in terms of poor sexual adjustment, depression and diminished self-esteem (Bagley & McDonald, 1984, p.25).

**Dissociation and multiple personalities.**

Personality multiplicity is noted as a form of dissociation and survival in cases of extreme abuse (D. Jones, 1986). Bowlby (1979) describes the normal cognitive process of persons to exclude much of the information they receive after unconsciously assessing and evaluating its relevance. The need of children to be desired and loved can similarly lead them to shut off feelings and memory their parents do not wish them to have.

One of the most well known multiple personalities is probably the character Sybil, based on a true and fully documented case history (Schreiber, 1973). Although Sybil
was not publicized as a sexually abused child, the
dynamics of her survival strategies shed light in
retrospect on the dissociative process of many victimized
children. This is the story of a woman who had been
tortured physically, emotionally, and sexually throughout
her childhood and developed sixteen separate personalities
as a coping mechanism. The process was described as
follows:

Normal at birth, the doctor speculated, Sybil
had fought back until she was about two and a
half, by which time the fight had been literally
beaten out of her. She had sought rescue from
without until, finally recognizing that this
rescue would be denied, she resorted to finding
rescue from within. First there was the rescue
of creating a pretend world, inhabited by a
loving mother of fantasy, but, the doctor
hypothesized, being a multiple personality was
the ultimate rescue. By dividing into different
selves, defenses against not only an intolerable
but also a dangerous reality, Sybil had found a
modus operandi for survival. Grave as her
illness was, it had originated as a protective
device. (p. 207)

Dissociation does not necessarily have dysfunctional
or tragic consequences. Goldwert (1986) suggests
sublimation of sexuality as a possible result of male
childhood seduction and presents Carl Jung and Otto Rank
as models of his hypothesis.

D. Summary and Conclusions

The study of victimology helps put child sexual abuse
in perspective. Many of the traits often quoted as evidence of a child's compliance are in fact symptomatic of victim behavior. These include such dynamics as vulnerability, learned helplessness, self-blame, post trauma reactions, and traumatic bonding.

Symptomatic behavior is seen as a survival strategy, communicating the pain of the child to those who would hear the message. Specific patterns of behavior that have been identified and named are the rape trauma syndrome, accommodation syndrome, and predictive syndrome of child sexual abuse. Understanding of these syndromes helps both the clinician and client anticipate the range of possible reactions.

The effects of child sexual abuse have been documented as pervasive and numerous. There are several classifications of the factors affecting the degree of trauma. From an objective point of view, these include the child's age, developmental status, relationship to offender, frequency and duration of abuse to the child and other family members, types of threats used, reactions of family and professionals following disclosure, and type of treatment received. From a subjective point of view, traumatic sexualization, betrayal, powerlessness, and stigmatization are described.
The effects of child sexual abuse are differentiated between short-term, and long-term, the former pertaining to childhood and the latter carrying over to adulthood. Within both time frames, disruptions are noted in psychological functioning, sexual adjustment, and interpersonal relationships. Dissociation and multiple personality are seen as two of the more extreme survival symptoms.

Understanding of the full range and intensity of the possible trauma suffered by a sexually victimized child is an important prerequisite to developing or implementing treatment programs. These are discussed in the next chapter.
APPENDIX A: EFFECTS OF CHILD SEXUAL ABUSE

Mrazek and Mrazek (1981, p.242-3) provide an overview of the effects of child sexual abuse documented in studies to that time. The information from their tables is reproduced below with the qualification that references not used elsewhere in this paper have not been listed. Also, the items have been regrouped according to author.

Review of Possible Short-term Effects

Problems in Sexual Adjustment
- Preoccupation with sexual matters,
- Premature development of adolescent interests,
- Despair regarding inability to control sexual urges (Bender & Blau, 1937).
- Homosexuality,
- Increased masturbatory activity,
- Sudden rush into heterosexual activities,
- Venereal disease,
- Pregnancy,
- Impaired feminine identification,
- Acting out sexual delinquency,
- Prostitution (studies, 1932 - 1979).

Interpersonal Relationships
- Bewilderment concerning social relations (Bender & Blau, 1937).
- Frightened by contacts with adults (Kinsey et al, 1953).
- Running away from home (Browning & Boatman, 1977).
- Hostile, dependent interactions with older women,
- Shocked by parental reaction,
- Increased affection seeking from adults,

Education Problems
- Mental retardation (Bender & Blau, 1937).
- Learning difficulties,

Other Psychological Symptoms
Loss of self-esteem,
Personal guilt or shame (DeFrancis, 1969).
Pessimistic or callous attitude,
"Infantile stage" prolonged or reverted to,
Tendency to withdraw from activities of normal childhood (Bender & Blau, 1937).
Obesity,
Anxiety states and acute anxiety neuroses
(Meiselman, 1978)
Somatic symptoms,
Behavior problems and delinquency,
Suicidal ideation,
Character disorder (Maisch, 1973).
Nervous symptoms,
Sleep problems including nightmares,
Impulsive self-damaging behavior,

Review of Possible Long-term Effects

Problems in Sexual Adjustment
Sexual dysfunction including frigidity,
Promiscuity (Lukianoowicz, 1972).
Impulses to brutally sexually assault a child
Aversion to sexual activity,
Unsatisfactory sexual relationships,
Conceiving illegitimate children,
Homosexuality,
Prostitution,
Having other incestuous relationships,
Not protecting own children from sexual abuse,

Interpersonal Problems
Conflict with or fear of husband or sex partner
(Meiselman, 1978).
Conflict with parents or in-laws
(Herman & Hirschman, 1977).
Social isolation and difficulty in establishing
close human relationships
(Steele and Alexandra, 1981).
Other Psychological Symptoms
Low self-esteem and long-lasting sense of helplessness (Steele & Alexander, 1981).
Somatic symptoms,
Obesity,
Masochism,
Neurosis (Meiselman, 1978).
Character disorder (Lukianowicz, 1972).
Chronic depression,
Non-integrated identity,
Psychosis/schizophrenia,
Suicidal ideation,
CHAPTER SEVEN: HEALING OF THE CHILD SURVIVOR

Healing, and the belief we can heal ourselves and desire to heal, and the decisions to move toward healing are all radical acts which transform us in and of themselves ... because by the process of caring for ourselves, we become more and more ourselves.

Susan Griffin, Rape: The Power of Consciousness

The purpose of this chapter is to review how treatment can best respond to the child survivors of sexual abuse. Goals of treatment, principles of intervention in response to specific traumas, and various methodologies or tools of practice will be discussed. As well, different therapeutic philosophies will be reviewed in relation to how they impact the treatment process. Although the focus of this chapter is the child, it must also be remembered that many children do not receive treatment at the time of their trauma. The principles of healing are equally relevant to the hurting child who may still be part of the adult personality.

A. Treatment Implications

Goals of therapy.

Giarretto (1976) lists the four goals of therapy as emotional catharsis, confrontation and assimilation, self-identification, and self-management. Each of these
will be briefly explained.

Emotional catharsis is the process of releasing pent-up emotional energy. "Feelings of despair, shame, and guilt must be listened to with compassion, as natural expressions of inner states. Awareness and acceptance of current feelings, without evaluation, allows the clients to assimilate them and to move on with their lives" (Giarretto, 1976, p.152).

Confrontation is the process of facing and expressing feelings associated with the sexual assault. Once the buried feelings are brought to the surface and handled, they lose their power to hurt in the future.

Self-identification is the process of becoming aware of all components of the individual personality. This is a necessary condition of self-esteem, for only that which is known can be valued.

Self-management is the process of learning to control one's own behavior and take responsibility for the course of one's own life. "A major milestone is reached when the client acknowledges that all ... past experiences are available ... for personal growth" (Giarretto, 1976, p.154). Karin Meiselman (1978) outlines essentially the same goals, naming the steps as catharsis, reassurance, confronting issues of responsibility, complicity, and
guilt, and finally self-acceptance.

Forward and Buck (1978) describe prior steps that are necessary for children who have suffered intra-familial abuse. These involve enabling the survivor to make a commitment to treatment and to break the pattern of secrecy. Subsequent steps, similar to those described above, include externalizing feelings, placing responsibility where it belongs, and making new choices in life.

Six considerations for the treatment of sexual abuse victims are outlined by Dawson (1983). These are: (1) reduction of guilt at all stages of participation, reporting, disruption, pleasure, and anger, (2) reduction of fears regarding further abuse, permanent damage, and the legal process, (3) resolution of ambivalent feeling through identifying, verbalizing, understanding the difference between feelings and actions, and accepting them as normal, (4) improvement of self-esteem, (5) improvement of assertive skills, and (6) teaching of appropriate sexuality.

A helpful frame of reference is provided by Faria and Belohlavek (1984) who outline the goals of therapy in practical terms. These are to help the client: (1) establish commitment for involvement, (2) identify old
patterns which interfere with present relationships, (3) grow in self-control, (4) build self-esteem about survival, (5) encourage constructive expression of anger, (6) identify and gain control over self-destructive and self-defeating behavior, (7) network with other support systems to develop meaningful relationships, and (8) increase self-esteem through improving body image and understanding human sexual response.

The strengths of these models are the emphasis on empowering survivors to choose more healthy relationships. Healing is accomplished through releasing pent-up emotional energy, putting the abuse in perspective, and restoring or rebuilding a core belief of self-worth.

Treatment of male victims.

The bulk of the literature has assumed that the majority of child sexual abuse survivors were female. This is consistent with the large number of adult women who came forward in the last decade to share testimonials of their secret victimizations. However, it is becoming more evident that male children too are often the victims of sexual abuse (Badgley, 1984; Chandler, 1982).

Maria Nasjleti (1980) speculates that male children are less likely to disclose because they are socialized to
be more physically aggressive, self-reliant, and independent. They are not encouraged to seek help so are less inclined to do so if sexually abused. Many fears arise to threaten the self-concept of boys following an incident of sexual abuse. These include fear of ridicule or rejection, fear of homosexuality, fear that their complaint will be interpreted as abnormal, fear of mental illness, fear of non-belief, shame, fear that nothing will be done, and fear of risking their personal safety or well-being as a consequence of disclosure.

Pierce & Pierce (1985b) found that male victims are more likely to be younger than females and less likely to have a father figure in the home. They point out that treatments which are successful for female children are not necessarily so for male children and that much more needs to be known about young male victims.

This qualification must be kept in mind for the duration on this chapter, if not for the whole thesis. The word "children" is used to encompass both boys and girls. However, most of the studies have predominately female populations with few attempts made to distinguish differences in trauma or treatment between boys and girls.
B. Treatment of Specific Traumas

The categories of sexual abuse trauma and treatment have been described in different ways. Courtois and Watts (1982) cluster them in eight main spheres including social, psychological, physical, sexual, family relations, self-esteem, relations with men, and relations with women. Lee and Rosenthal (1983) use the more general areas of affective, cognitive, and operational with the different methodologies of empathy, restructuring, and problem-solving required for each area respectively.

The following section will use slightly different categories and discuss treatment concepts appropriate to each. Relationship, emotional, and sexual healing will be discussed first. It is in relationships that children learn or lose their self-esteem; emotional integration depends on a trusting relationship; and only after these are in place is a child free to develop his or her sexual response. Dissociation and self-destructive behavior will be discussed as separate categories.

**Relationship healing.**

Relationships refer to the ways in which a child encounters and communicates with the world. What the developing child learns in interaction with care-givers
sets the tone for his or her emotional health as an adult. A child's ability to trust and explore is based on the security and congruence of past relationships. The child who has been loved, nurtured, respected, and allowed to develop creativity and independence will be a more secure adult and able to nurture those same traits in others. A negative cycle is created when those who were not nurtured are unable to trust and so receive no further nurturance (Courtois & Watts, 1982).

Summit & Kryso (1978) note that the children abused within their family often experience three levels of betrayal - by their father from whom there is no escape, by their mother from whom there is no support, and by helping institutions which punish instead of protect. It is important that the therapeutic milieu not betray the child further. Responses to the child must be made as honestly as possible with no false promises attached.

Porter, Blick and Sgroi (1982) describe the inability to trust and blurred role boundaries as part of the same process. Learning to trust once that ability has been lost involves a slow process of recovery. Children need to experience appropriate and satisfying interpersonal relationships, whether these can be developed within their natural environment or created within a therapeutic
milieu.

It is preferable that at least one parent be coached in providing a trustworthy role model and appropriate role boundaries when a child has been sexually abused. If parents are unavailable to provide adequate support, special attention must be paid to persons such as relatives, foster parents, siblings, child care workers, peers, and counsellors who can provide a caring relationship to the abused child. Choice of an adult partner will also play an important role in later life (Orzek, 1983).

Emotional healing.

Porter, Sarnacki and Sgroi (1982) elaborate many feelings typical of the abused child and suggest treatment responses appropriate to each. These will be outlined in the following paragraphs.

"Damaged goods" refers to the fear of having been harmed indelibly. A physical exam is important to reassure the child of bodily integrity. The clinician needs to state authoritatively that physical damage is absent or being treated.

Guilt is often very diffuse. The child may feel guilty about the abuse itself, guilty about disclosure,
and guilty about any resultant family disruptions. It is important to convey to the child that they are never responsible for the initiation of the abuse. With older children, it may be important to identify those elements of behavior for which they were responsible and separate them from the abusive act. For example, a child who stayed out past curfew or went to a forbidden party will have to accept responsibility for those actions but not for an assault which happened as a result.

Libow & Doty (1979) provide the interesting comment that it is not clear whether self-blame is a normal or pathological variant of the grieving process. Either way the guilt and grief need to be resolved.

Fears are also pervasive. Children need assistance in identifying their fears and encouragement in expressing them. Safety mechanisms need to be identified and utilized so that the child feels more in control.

Depression is often associated with post sexual assault trauma. Use of medications can be helpful as a complement to other therapy.

Low self-esteem is often reflected by poor social skills. Children need to be believed and supported as they learn to feel better about themselves. They also need education and modeling for healthy and age
appropriate communication and social skills. Sanford states that "feeling good about yourself is the most important feeling in the world" (1980, p.13). All children need to believe they are lovable and worthwhile.

Repressed anger and hostility are often bottled up, particularly in children who have been coerced into keeping the secret. Children need help to learn to get in touch with their repressed rage and to express their anger in a healthy and non-destructive fashion.

Pseudomaturity or regression refer to inappropriate developmental stages. Part of treatment is to allow the child to experience and appreciate age-appropriate feelings and behaviors. This includes relinquishing of adult responsibilities and, conversely, becoming confident enough to let go of infantile securities.

Self-mastery and control are important ingredients for the child whose power had been taken away. The child needs to be given opportunities to develop new skills and to learn through their own mistakes. If there was more than one assailant, survivors need to settle their feelings regarding each one independently (Burgess & Holmstrom, 1978b).

The treatment needs of children have been summarized as their traumatic penetration, the threat to their sense
of individual being, their neglect and emotional abuse, their sense of exploitation at having been used, and the adaptation of their survival tactics (D. Jones, 1986).

**Sexual healing.**

Sexuality is the primary mode of individuation for the human person. All people are socialized to relate to each other as male or female quite apart from whatever sexual activities they chose. Freely chosen sexual expression is dependent on emotional health.

Meiselman (1978) notes a frequency of sexual problems among child sexual abuse survivors. These include frigidity, promiscuity, confusion about sexual orientation, and sexual masochism.

The drift theory of Vitalino, James and Boyer (1981) helps explain this phenomenon. This can be summarized briefly as a movement toward deeper integration of badness. Primary deviance is described as acting out behavior that can be normalized. Secondary deviance, on the other hand, happens when the person’s identity becomes organized around the acts of deviance. The labeling process, whereby the child assumes the negative associations of the behavior, must be overcome to restore a feeling of self-confidence.
Many children who have been sexually abused have difficulty distinguishing sex and affection and are unable to separate themselves from the connotations of the offense. They may attempt to sexualize the therapy relationship in an attempt to test their beliefs (Courtois & Watts, 1982). Acknowledgement of these feelings, boundary setting, and sex education are important roles of the clinician at this point.

Dissociation.

Some children succeed in keeping their trauma out of their consciousness by dissociating themselves from the act when it occurs. This is a process by which a child "when faced with a situation that has aroused overwhelming grief, despair, or anxiety may respond by a total repression of the memories of the disturbing event, accompanied by a disappearance of the painful event" (Blake-White & Kline, 1985, p.397).

Surface emotions, such as guilt and shame, can be accessed relatively easily. The repressed material, however, is more carefully protected and requires a slow process of gaining access to memory through the repressed emotions. The child needs to trust and to experience the pain while remaining in control. Blake-White and Kline
speak of the process in this way:

Stronger emotion of terror, despair, abandonment, and fear of pain and the feelings of being totally alone and overwhelmed are often denied. ... The problems never disappear; they continue to manifest themselves in serious depression, panic attacks, "free-floating" anxiety, and angry outbursts. The client is unable to form close relationships and has difficulty trusting others. (1985, p.397)

The essence of treatment is to teach the client to accept the child inside, allow expression of childhood experiences, and provide assurance of present safety.

Blake-White and Kline (1985) also describe the stages of group experience in dealing with repressed histories of sexual abuse. While they speak of adult women, there would most probably be some similarities with a group of adult male survivors:

(1) Awareness of the problem usually begins when some incident triggers an overwhelming anxiety and childhood fears come flooding back.

(2) The decision to seek help is surrounded with anxiety as the adult is cautious about acceptance by the therapist and group.

(3) Anxiety increases after several sessions as childhood terror begins to surface. These symptoms need to be normalized so that they are not seen as a result of group participation.
(4) The decision to continue weighs present anguish against the disruptions caused by unresolved memories of the assault.

(5) Dealing with the memories is often accompanied by terror and despair. It is important to teach "grounding" during this period. This is any method of keeping in touch with reality such as touching the ground with one's feet, rubbing one's hands on the arm of a chair, or repeating one's name, age, or children's names.

(6) Coming through the first memories increases confidence in adult abilities and reduces the power of the perpetrator. Creative expression of anger is an important part of work at this stage, as sadness and guilt frequently turn to rage.

(7) Breaking down further blocks involves becoming more organized about reconstruction of the memories. The initial recollections are often more emotional than accurate.

(8) Integration of memories with present adult behavior is a continual process of recovering the memory, working through it, and coping with it. When the memory can be seen as existing in the past, its present effects can also be assessed and put in perspective.

(9) Resolution is the final stage of giving up the victim
Self-destructive behavior and suicide.

Goodwin (1981) warns the practitioner to be alert to the possibility of suicide. Attempts were made in over 5% of the families she treated.

Reasons for self-injurious behavior were developed by de Young (1982a). She based her hypothesis on a study of 45 female victims of paternal incest of whom 26 had engaged in self-injurious acts. Reasons include (1) primitive thinking, such as the girl believing the injury would somehow prevent further abuse, (2) self-punishment due to introjection of hostility or feeling of betrayal by her body, and (3) ego reintegration, whereby the injurious act releases the person from a depersonalized state of dissociation, decreases tension and restores the ego defenses.

Briere and Runtz (1986) studied 195 women seeking help from a community health center and found that former sexual abuse victims were more than twice as likely to have attempted suicide than non-abused clients. Factors of impaired self-esteem and blame, powerlessness including vulnerability to depression, interpersonal dysfunction, and attempts to escape were suggested as variables.
C. Treatment Methods

The relative paucity of information on unique treatment methods for child victims is perhaps reflective of the general state of knowledge. Much has been written about identification and the need for innovative community programs; yet very little is available to the clinician who wants to work directly with victimized children. When sexual abuse happens within a family, it can be treated within the family to a certain extent. Family treatment is discussed more fully in Chapter Eight. This section seeks to review treatment methods available specifically for children.

Individual work with children.

Basic clinical principles prevail as with any client. It is important that children and their responses not be stereotyped based on a factual account of their experiences. Rather they need to be listened to as individuals. It is also important for the clinician to maintain a balance between (a) feeling the child is "special" and so needs to be referred elsewhere and (b) focussing on the sexual abuse to the neglect of other concerns.

Individual counseling or therapy is contraindicated
for a number of reasons. "Because of its confidential nature, the therapy relationship does not lend itself to a full resolution of the issue of secrecy" (Herman & Hirschman, 1977, p.755). Whatever transpires in sessions is still a secret between the child and therapist and not tested in the real world. Beverly James (1967) emphasizes that the child's care-givers be involved as part of the treatment team. This helps to overcome the dynamic of something secret happening to the child and to normalize healthy relationships with the rest of the world.

David Mrazek (1980) suggests that a child psychiatrist can help provide an understanding of the psychological impact of the sexual abuse experience on the child and family. Yet the approaches he suggests deal as much with the family as the child. These include assessment of the developmental needs of the child, whether factors which allowed the assaultive situation are still present, and if so, what are the parents' motivation and capacity to change. These evaluations are important in helping plan the child's treatment.

Any work with children involves play for it is in play that children combine the concrete and symbolic experience of the world. Therapists must be open to the meanings of symbols used by the child (Naitove, 1982).
Art work can also be a wealth of information from children. Drawings, paintings and sculptures can be used imaginatively in a free association type of process or subjected to more objective analysis. For example, impulse control and the quality of repression were found to be significant factors that could be measured in drawings (Yates, Beutler & Crago, 1985).

Sexually explicit dolls are another tool which can be used to help children demonstrate what they cannot describe verbally. There is some controversy, however, that such dolls inappropriately stimulate children (James, 1987). More work is required to compare the reactions of abused and non-abused children to the dolls (White, Strom, Santilli & Halpin, 1986).

Group work with children.

Work with children in groups has a number of important advantages. First, it provides the peer normalization that is particularly crucial for older children. Groups allow them to experience a reduction in isolation and to receive direct support and encouragement from each other.

Cognitive restructuring can also be part of the group process. This is based on the premise that beliefs have a
significant influence on feelings and actions (Jehu, Gazan & Klassen, 1986). Examples of unhealthy beliefs include dichotomous thinking, overgeneralizing, and mislabeling. Activities to teach alternative beliefs include provision of information, logical analysis, decatastrophizing, distancing, and reattribution.

Delson & Clark (1981) describe the needs of girls to experience their bodies on many levels and suggest movement and body exercises be incorporated into group experiences. Blick & Proter (1982) see the issues for groups as ventilation of anger, socialization, preparation for court, and sexual education.

James and Nasjelti (1983) provide a very helpful chapter on treatment exercises for therapists working with children. These exercises fall into eight different categories with delightful suggestions of how to engage children at different stages of the treatment process. The categories are making contact, ambivalence, putting responsibility where it belongs, getting to feelings, self-image, mastery, sex education, and promoting intimacy and communication. Detailed examples will not be provided. The underlying theme is for therapists to allow themselves to play freely with the children and, at the same time, to direct the play towards healthy
Adults molested as children.

The growing demand for treatment by adults who were molested as children confirms the sad reality that the needs of many children were not met at the time of their abuse (Daugherty, 1984; Gordy, 1983). It is beyond the scope of this paper to explore in detail the treatments available for adult survivors. However, this is a significant population which warrants a brief review.

Group participation is often more empowering than individual therapy for adult survivors. The social process of bearing witness allows additional recognition and validation of past sufferings (Loewenstein, 1978).

Specific techniques for group work include structured interviews, writing exercises, journal keeping, guided imagery, "divorce" rituals, hypnosis, and psychodrama (Courtois & Watts, 1982; Faria & Belohlavek, 1984).

The power of language is emphasized by Sandra Butler (1986) who facilitates individual work within a group setting by the use of structured writing exercises. She believes that moving from victimization to survival is paralleled by the process of moving from silence to language. Individual healing is seen as the beginning of
a new stage of development as language becomes action and survivors become warriors.

Another important option for survivors is the development of self-help groups. Linda Halliday (1985) outlines the goals for such a group. The structure of the group needs to enhance feelings of safety and to encourage the use of personal power. Disclosure within the group will often parallel how the person as a child handled the initial assault. For example, adult survivors will often experience fear of how others will react and so minimize their own pain in anticipation. All groups go through stages of an initial sense of belonging, power and control over feelings, questions of boundaries, fear of consequences of change, grief over loss of what was and what could have been, and finally the transition to continued intimacy.

D.Therapy Reviews

This section will attempt to review major therapeutic approaches in relation to child sexual abuse. This is by no means a comprehensive overview but simply an illustration of how clinical orientation can shape client response. The four areas of thought to be discussed are psychoanalysis, family systems, humanism, and feminism.
Psychoanalysis.

It is, of course, most unfair to attempt to describe psychoanalysis in a brief paragraph. It has been referred to as a method of psychotherapy as well as a theory of personality (Hall, 1979). Sigmund Freud is considered the father of psychoanalysis with his theories of the dynamic forces that make up the human personality. Freud was one of the first theorists to explore the unconscious depths of the mind and to explain the development of personality through the complex interactions of unconscious forces and reactions.

Psychoanalytical theory tends to deal with the unresolved intrapsychic conflicts of the sexually abused child and is responsible for such characterizations as the "seductive" daughter and "collusive" mother.

Psychoanalytical theory explains the occurrence of incest as a result of losing emotional control over unconscious incestuous impulses. More specifically, it suggests that incestuous behavior between sibling or between parent and child is a displacement, and that the underlying fantasy is still that of the oedipal strivings. (Cohen, 1981, p.495)

Psychoanalytical interpretations are prevalent in early studies of "incestuous" families characterized by abuse of the daughter by the father. Incest is frequently described as symptomatic of family dysfunction and indicative of a role reversal between parents and child.
An example is provided by Lustig, Dresser, Spellman and Murray (1966):

Father-daughter incest may be viewed as serving the parents' pregenital dependency needs, as a defence against feelings of sexual insufficiency in both parents, as a mechanism for revenge by the daughter against the mother for her lack of nurturance, as a method of reducing separation anxiety for all protagonists, and as a method of maintaining a facade of role competence for both parents. (1966, p.39)

The right to sexual intercourse is implied as a male perogative; the right of the woman to her own sexuality is a non-issue. A later critic noted that none of the studies addressed why women might want to avoid sexual activity with their husbands (Lindemann, 1983).

On the other hand, it is natural that family members have sexual feelings for each other because of the intense passion of their love and caring. Pincus & Dare (1978) explain it this way:

It is ... inevitable that incestuous fantasies are part of the secret life of every family. For children to develop into health, loving, and sexual adults, these fantasies are necessary, but their overt expression has to be controlled by the parents. (p.82)

In infancy and early childhood, close physical bonds of love with parents are vitally important, but we need to recognize that the child's healthy development involves growing free of these bonds. If the difficulty in attaining this freedom, both for the children and for the parents, can be acknowledged, then their secret longings can be more clearly understood, and the acting out of incestuous
Fantasies stemming from the infant's earliest feelings is much less likely to occur. (p.88)

The points above are well taken; however, it has been amply demonstrated that the acting out is seldom on the initiative of the child. The trauma of child sexual abuse, however, is that the child experiences stimulation for which he or she is developmentally unprepared (A. Freud, 1981).

**Family systems therapy.**

Again it is hardly fair to describe family therapy in a paragraph. It can be described as a model which puts the family as the unit of attention and believes that individuals can only be understood and helped within the context of the systems of which they are a part (Hartman & Laird, 1983). For most people, their immediate family is the primary system in which they relate and define their identity. The family and the treatment process interact with each other in a two-way process (Furniss, 1983).

Family systems therapy assumes participation of all members of family in child sexual abuse and so looks for responsibility in each. The focus is on family dynamics rather than sexual history with the intent to distribute responsibility and to place guilt in perspective (Machota, Pittman & Flomenhaft, 1967). Another author states the
Father is often unjustly given the label of tyrant to explain away involvement of other members (Walters, 1975). Jorne (1979) suggests that the symptom of incest (sexual abuse within the family) be treated as any other stress problem.

Within the modality of family therapy, team interventions are seen as useful in changing the balance of power in a so-called "abusive family" (Bander et al, 1982). This assumes that the person doing the abusing has too much power, which may well be true, but also presumes the responsibility of other family members to hold the abuser in check. While this may be a useful intervention, it is misplaced if it holds all family members liable.

Other authors recognize that offenders are responsible for their own actions over and above whatever family problems may exist. "Attention to family dysfunction should not permit the pathology of the incestuous offender to be masked or minimized" (Groth, 1982, p.218). A family assessment, however, in most circumstances can identify the strengths and weaknesses of family members in regard to their contribution to the offense and to intervention outcomes (Sgroi, 1982a).
**Humanist therapy.**

Humanist theory has already been introduced in Chapter Three. Humanism is fundamentally concerned with the value of life and what it means to be human. Humanistic psychology developed in reaction to psychoanalysis and behaviorism, seeking a more holistic understanding of personality and social adjustment. Each person is seen as striving for growth and development, having responsibility for their own actions, and responding to stress when their own growth efforts have been thwarted.

An optimistic view is maintained by humanist theory, namely that persons are essentially good, free and autonomous with an infinitely expandable human nature. "The self is a unique entity which is more than the changing functions of mind, body, and spirit. A strong sense of self-identity must be internalized by an individual before he (sic) can experience self-esteem" (Giarretto, 1976, p.154).

Therapy is client-centered with change created through a process of openness, awareness of immediate experience, communication, and personal decision. The central hypothesis of treatment is that the growth potential of an individual is released in a relationship
of realness, caring, and non-judgmental understanding. Only by understanding the meaning of the clients' experiences can the clinician join them in a search for greater understanding and creative solutions (Goldstein, 1986).

Two major criticisms of the humanist approach are that it cannot operate without a humanistic society, which does not exist, and that it is preoccupied with self-awareness and self-actualization over social inequality (Butler, 1986). The focus on personal development, while valuable from an individual point of view, does not address the right and need of society for protection from certain offenders. Nor does it question the structure of society or provide an orientation to prevention. The political realities of the social and cultural values which shape our lives need to be recognized so that social changes can be integrated with personal changes. This presents a challenge to those committed to humanistic development and equality.

Feminist therapy.

Feminist theory was also introduced in Chapter Three. "A feminist approach to the process of sexual assault resolution combines therapeutic intervention skills with
the underlying knowledge that sexual assault, harassment, and exploitation affect all women in our society and are extensions of sexism" (Yassen & Glass, 1984, p.253).

The feminist analysis encompasses all existing theories and examines them in the context of gender relations (Herman, 1981b). Patriarchy and male socialization are seen as causes of female oppression:

Only a basic change in the power relations of men and women can ultimately prevent the sexual abuse of children ... If daughters are to be protected, they must find in their mothers and other women, images of strength rather than weakness. Daughters must learn from their mothers that they have the right to fight and the capability to walk away from situations that are degrading and shameful to them. Presently, too many daughters learn from their parents that oppression is their destiny. (Herman, 1981b, p.79)

This perspective brings into focus the extraordinary power that is exerted by fathers as perpetrators within their families (Wattenberg, 1985).

Recovery of mental health includes the component of consciousness raising on the premise that the need to be understood can be as urgent as self-understanding. The intent is to move from private healing to public impact. The goal is to increase public awareness so that women and children are seen as the responsibility of the entire social community with an absolute right to safety (Herman, 1981b).
A major criticism of feminist theory and therapy is that it fails to clarify at what point the victimized male child becomes the adult male offender. Men are not given the same opportunity as women in responding to change the forces of socialization.

Another challenge for feminism is to overcome that degree of mother-daughter estrangement that occurs when there has been abuse within the family (Herman & Hirschman, 1977). While daughters may learn to understand the forces that victimized both them and their mothers, there is still too often an anger and resentment rather than a reaching out in compassion.

Therapy overview.

Whatever philosophy of therapy is adopted, there are certain guidelines which must be addressed. Karin Meiselman states quite emphatically that a value statement is one of the underlying principles:

It is preferable to emphasize the basic point that nothing that a child does justifies sexual approaches from a parent, for parents are adults and are expected to be fully responsible for their actions. A corollary to this statement is that the patient is now an adult who must assume responsibility for her own behavior in the present regardless of her past misfortunes. (1978, p.347)

Forseth & Brown (1981) stress the need for clinicians
to become skilled through diverse modalities. No particular sequence of treatment was preferred among the professionals they surveyed with individual, group, marital, and family therapy all listed among the most common chosen methods.

The outreach component must not be overlooked in healing. Pierce (1984) suggests street workers as an intervention model for street children, stressing that we need not wait for them to seek help on their own.

E. Summary and Conclusions

This chapter has reviewed treatment responses to survivors of child sexual abuse. Treatment is required for children who are traumatized by their experiences and for adults who did not have the opportunity to heal their childhood memories.

Healing is the process of learning to enjoy living with oneself in the world. "Effective coping with victimization requires not only coming to terms with a world in which bad experiences happen to oneself, but also restoring a damaged self-image" (Russell, 1986, p.166). Transformation is a process of becoming conscious of and accepting inner strengths (Leonard, 1982).

The goals of therapy are to help survivors express
and accept the full range of their affective responses, put the abusive experience into a more freeing historical and emotional perspective, and empower them by rebuilding their own self-esteem and confidence. "Once the experience is given language - language to name it as an assault and to hold the perpetrator responsible - the first irrevocable steps towards healing have begun" (Butler, 1985, p. 209).

Male victims are a new population coming into recognition. Boys are believed to have particular difficulty with disclosure because they are socialized to be more independent and self-reliant. Most of the existing treatment methods have been developed with female populations. More research is needed to confirm information about male victims and which treatments are most successful for them.

Healing of child abuse survivors involves work with relationship, emotional, and sexual aspects of their lives. Learning to trust once a relationship has been betrayed can be a slow process, yet it is only through a caring relationship that the victim is able to resolve confused and repressed feelings. Sexual healing represents the ability to make a free personal decision about one's sexuality. Dissociation and self-destructive
behaviors are also symptoms of child sexual abuse which require specialized treatment.

Treatment of children can happen in individual and group modalities. Individual work with children by its nature encompasses the theory and techniques of play theory. It is important, however, that care-givers are incorporated as part of the treatment team. Group work with children has many advantages such as reducing isolation, providing concrete support, and improving social skills. Adults molested as children are a significant population whose needs must not be overlooked. Group therapy is a popular method of treatment for the same reasons mentioned above.

Finally, a review of four major therapeutic approaches illustrates how different orientations treat the phenomenon of child sexual abuse. Psychoanalysis contributes an understanding of intrapsychic dynamics but often overlooks the very real helplessness of the child. Family systems theory explains how persons interact with each other within a system but risks further victimization of the child by assigning mutual responsibility. Humanist theory looks at the growth potential of all persons, including both victim and offender, but often overlooks the social realities of inequality which perpetuate
victimization. Feminist theory incorporates clinical intervention with political advocacy to increase the power of women and children in society. A criticism is that it tends to create a duality of offenders versus victims.

'It is the belief of the author that the experience of victimization is a continuum within society, and healing a continual process for all persons. Without intervention, those who are wounded remain helpless or turn to aggression. Healing involves reconciling the helplessness and vulnerability of childhood with choosing a path of survival for adult life. Those who have learned not to transfer pain to others are valuable members of society, and some of those persons are male.

The next chapter will look at the impact of child sexual abuse on all family members with suggested treatment responses.
CHAPTER EIGHT: HEALING OF THE FAMILY

To assign to each family member a role in causing the incestuous assault is to imply that whatever happens to women and children in our homes can be traced back to something that is our fault. The promise held out to us ... is that once we figure out as mothers and children what we have done wrong, our victimization will stop.

Sandra Butler, Conspiracy of Silence: The Trauma of Incest

A. Sexual Abuse of Daughters by Fathers

Families are inclined to rally to the support of a child who is sexually abused by a stranger; the dynamics are much more confused and ambivalent when the assault happens within the family, particularly by the father (Berliner & Stevens, 1982). Much of the early treatment literature focussed on what was called father-daughter incest. The review of this material will be brief as it is assumed that this basic knowledge has been well summarized and is readily available to most practitioners. As well, it must be remembered these cases represent only one type of intra-familial abuse and a small fraction of all child sexual abuse (Finkelhor & Hotaling, 1984).

"Because classic incest represents only about 30% of the cases, the excessive attention to this type of abuse ... has not only retarded the development of professional understanding but has also failed to help the largest
number of victims" (Conte, 1984a, p.259). The statistics outlined in Chapter Four suggest that fathers make up an even lower percentage of all offenders. The following sections must be read with that qualification in mind. Although there may well be overlaps between the dynamics of abuse within families and outside of families, these can not be assumed.

**Early theories.**

Maisch (1973) argued that incest was not the cause but a symptom of family disruption. He felt the discovery and punishment of the offense were more dangerous than the activity itself in that more stress was added to an already disturbed family. Lukianowicz (1972) described the fathers' behavior as an expression of aggressiveness, accommodated by poor inhibitions and overtolerant wives. The average duration of incest was found to be eight years in the 26 cases he studied.

Browning and Boatman's (1977) study of 14 families reported an excessively high degree of alcoholism in abusive fathers with a corresponding degree of depression in mothers. They suggested the fathers' tendency to violent behavior contributed to their wives' passivity, and that the genetic defects of several of the children
may have added to their vulnerability.

Justice & Justice (1979) described the effects of incest on the family as role confusion, poor parenting, and social isolation. They also reported that parents in incestuous families had higher stress levels than those in both nonincestuous and nonabusive families.

It appears the sexual abuse of daughters by fathers can be both a response to stress and the cause of more disruption. This was summarized by Meiselman (1978) whose position was that in the absolute sense, the effects of incest can not be separated from family pathology. A similar interpretation is provided by Cohen:

The dynamics of the classic incestuous family indicate that all family members are emotionally deprived, that the sexually taboo relationship is a manifestation of the basic need for warmth and nurturance, and that its contribution provides a defence against possible family break-up. (1983, p.161)

Incest has also been described a collective pathology of the family (Jorne, 1979), a developmental failure (Gaddini, 1973), and the father's narcissistic reaction to abandonment (Hirsch, 1986).

Herman and Kirschman (1977, 1981) develop the theory that incestuous behavior springs from the socialization of men to be served and women to serve them. This results in fathers being unable to assume a nurturing role when
mothers are not available:

Customarily, a mother and wife in our society is one who nurtures and takes care of children and husband. If, for whatever reason, the mother is unable to fulfill her ordinary functions, it is apparently assumed that some other female must be found to do it... The father does not assume the wife's maternal role when she is incapacitated. He feels that his first right is to continue to receive the services which his wife formerly provided, sometimes including sexual services... This view of the father's perogative to be served not only is shared by the fathers and daughters in these families, but is often encouraged by societal attitudes. (1977, p.749)

Special concerns of step-families.

Diana Russell (1986) provides the most comprehensive study of sexual abuse within the family. The definition of incestuous abuse used for her study was:

any kind of exploitive sexual contact or attempted contact that occurred between relatives, no matter how distant the relationship, before the victim turned eighteen years old. Experiences involving sexual contact with a relative that were wanted and with a peer were regarded as nonexploitive and hence nonabusive. (p.41)

One of the most startling findings of Russell's survey was that "women who were raised by a stepfather were over seven times more likely to be sexually abused by him than women who were raised by a biological father" (1986, p.234). This comparison is based on the data that "one out of approximately every six women who had a
stepfather as a principal figure in her childhood years was sexually abused by him before the age of fourteen" whereas only "one out of every forty-three women who had a biological father as a principal figure in her childhood years was sexually abused by him" before the same age (p.234).

Another finding was that stepfathers also tend to indulge in more intrusive sexual acts. "When stepfathers sexually abused their daughters, they were more likely than any other relative to abuse them at the most severe level in terms of the sex acts involved" (Russell, 1986, p.237).

Russell uses the four questions introduced by Finkelhor (1984a) to help explain the differences between biological and stepfather incest. The questions are:

First, what predisposes a person to want to sexually abuse a child? Second, what undermines his or her internal inhibitions against acting out this desire? Third, what undermines the social inhibitions against sexually abusing a child? And fourth, what undermines the child's ability to avoid or resist such sexual abuse? Since this fourth question suggests that the child can avoid or resist the sexual abuse if his or her capacity is not undermined, it will be rephrased as follows: What increases the child's vulnerability to sexual abuse? (Russell, 1986, p.256)

In answer to the first question, it is suggested that men with an active sexual interest in children may be
overrepresented among stepfathers, that is, these men seek and marry women who have children who match their sexual interest. Another reason may be that men who have difficulty maintaining long-term relationships with women are more likely to be divorced and so may be more prevalent among stepfathers.

The second question, regarding internal inhibitions, is answered three ways. Stepfathers may not feel as bound by the incest taboo because they are not consanguinely related to their daughters; the bonding between the two may be weaker if the stepfather did not share the daughter's early years; and there may be a smaller age disparity between stepfathers and daughters.

Two possibilities are presented to explain differences in social inhibition which was the third question. One is that mothers in stepfamilies are more apt to work outside the home, thereby affording the stepfathers more opportunity. Another theory is that mothers in stepfamilies have less power than in biological families. Neither of these were supported by Russell's data.

The fourth question was regarding factors that increased the vulnerability of stepdaughters. Several suggestions are presented. The incest taboo may also be
weaker from the daughter's perspective, who may not feel the same sense of betrayal if approached by a stepfather. Stepdaughters may also be more vulnerable because of previous victimization, greater neediness, and family dynamics whereby the daughter is competing with her mother for the stepfather's attentions.

These dynamics overlap an early study of Giles-Sims and Finkelhor (1984) who found that stepfathers constituted a third of the fathers who were perpetrators of child physical abuse in officially reported cases. Some of the theories they discussed to match that data also apply to child sexual abuse. For example, stress is related to abuse and step-families experience the added stress of two family systems coming together. As well, people with problems in impulse control, alcoholism, and self-esteem are more likely to have difficulties in marriage and, therefore, more apt to be in a position to marry again.

B. Family Reconstruction Model

Family reconstruction is one response to child sexual abuse within the family. It is argued that such diversion programs can be cost effective both socially and financially, with the costs of treatment offset by the
costs of foster care for the child, prosecution and incarceration for the offenders, and social assistance for the mother if she is not able to support herself (Tyler & Brassard, 1984).

Meiselman (1978) notes several reasons why incestuous families do not fare well with family therapy; namely the offender is often uncooperative, sexual problems that exist between the parents are not appropriate for discussion involving the children, the victimized child experiences increased guilt as a result of the sharing of responsibility, and different crisis interventions are required by the different family members. These problems are overcome by the reconstructive model whereby the members are dealt with individually first and marital issues are handled by the parents alone. The family is brought together in therapy and actuality only if both parents are prepared to assume responsibility and show appropriate support to their child.

Philosophy of treatment.

The initial pilot project by Henry Giarretto for the treatment of incestuous families was based on the growth model of humanistic psychology and conjoint family therapy as developed by Virginia Satir (1967). It was discovered
that conjoint family therapy alone was inadequate and could not be applied during early stages of crisis. The family was frequently so fragmented following disclosure that each person needed individual support before they could even decide what they wanted to do as a family (Giarretto, 1976).

The methodology of reconstruction includes counselling at the progressive levels of individual, mother-daughter, marital (if the parents have chosen to work on their relationship), father-daughter, family, and group (Giarretto, 1976, 1981, 1982a, 1982b; Anderson & Mayes, 1982, 1987a, 1987b).

Empowering the non-offending spouse is the foundation of reconstruction work (Anderson & Mayes, 1987a). This corresponds with Sandra Butler's (1985) warning that the increasing focus of reunifying families after a sexual assault can further trap the mother and children into a closed system with the offender. Care must be taken to strengthen the women and children within the family. The possibility that the mother herself is a past victim must also be considered.

Other authors have developed therapeutic principles for the treatment of father-daughter abuse which fit within the Giarretto model. Herman (1981a) outlines three
essential objectives in treatment of the incestuous family. These are (1) to restrict and control the power of the father, (2) to reinforce and foster the power of the mother, and (3) to restore the mother-daughter relationship. This parallels the recommended procedure for approaching the family, that is, to first obtain the child’s statement, secondly to encourage the mother’s support, and only then to confront the perpetrator (McCarty, 1981).

Reconstruction is a time of extreme anxiety for all family members, especially the father who may not be able to conceive that a new way of life is possible. "He cannot be expected to give up his accustomed power and privileges without a fight... Desertion, suicidal gestures, and homicidal threats are not uncommon during this time" (Herman, 1981a, p.144). Family murder-suicides are sometimes suspected as a response to the disclosure of sexual abuse within the family (Sgroi, 1978; Ward, 1984).

Kathleen Faller (1981) presents a four part model for dealing with incestuous families. The determining factors for treatment and prognosis are whether the mother was collusive or independent and whether the father was psychotic or non-psychotic. She also mentions it is important that the therapist not end up in a power
struggle with the father for control of the family. This can be averted by individual alliances that are established before the family is brought together.

It must also be emphasized that the professional components of a successful child sexual abuse treatment program include all the officially responsible members of the community, namely police, social workers, mental health workers, probation officers, defence and prosecuting attorneys, judges, and rehabilitation officers (Giarretto, 1982a). Co-operation of the offender cannot be assumed without a legal imperative (Hoorwitz, 1982).

The overall program can be summarized as encompassing four stages (Hoorwitz, 1983). The first is to clarify professional roles to ensure protection of the child. This may include such seemingly extreme measures as foster placement, court orders outlining access, and supervision of family visits. The second stage is to attend to the individual needs of all the family members. The third is to strengthen the mother-daughter liaison and the marital bond if the couple so chooses. Bringing the father together with his daughter and the whole family is reserved for the fourth stage, at which time such dynamics as role boundaries, communication, sex education, external resources and self-esteem are also addressed.
Another essential component of the original humanistic treatment model is the formation of self-help groups, which have become known as Parents United (Giarretto, 1976). As well as providing self-help and support, this organization gives group members an opportunity to be a strong voice in the community.

Contraindications to family reconstruction.

The paradox is noted by Armstrong (1983) that substantial attempts are often made to keep abusive and incestuous families together when divorce is generally accepted as part of normal life. This is one of the basic dilemmas to be resolved by professionals offering treatment and by the non-offending partners of abusive parents. "Domestic violence is unique among criminal behavior in that the victim is not only likely to feel love for the offender but also is often aware of the offender's personal torment and suffering" (Taubman, 1986).

Reunification of the family must be examined in the context of the child's right for protection (Smyth, 1986). Reconstruction is generally not appropriate when the incestuous assault is not believed by the mother, denied by the father, the nonabusive parent is unable to protect
the child, and one or both parents are not motivated to change (Server & Janzen, 1982). There is also poor prognosis in working with a family if the father is psychotic and the mother collusive and dependent. Faller (1981) suggests that termination of parental contact is the preferred course of action in such a situation. Working with a reconstructed single parent family is a viable alternative if the non-offending parent is responsive.

The reconstruction model does not apply to intrafamilial offenders who are not part of the nuclear family, such as grandfathers (Goodwin, Cormier & Owen, 1983). Treatment of men who are not suitable for family reconstruction work and those who abuse outside of their family will be discussed in Chapter Nine.

C. Treatment Needs of Mothers

Mothers are the key factor in the reconstructive work of families marred by abusive fathers. Their availability for treatment, however, must not be confused with their culpability (Wattenburg, 1985).

Mothers have not received support in the early literature. Louise Armstrong expresses her sympathy for the confusion of their predicament:
An open declaration of expectations must be made to women. What will gain a mother praise and support for society and the law, should her husband prove to be unsocialized or unsocializable; should he abuse her or abuse their children? What do we expect? That she leave? That she stay? That she go into therapy? That she kill him? (If the law will not help her, if she is outside its borders - is it legitimate to condemn her for what she does to help herself of her children?). (1983, p.202)

The question of responsibility versus blame is a common theme of the literature. For example, the finding that incestuous fathers were also physically violent was interpreted as casting new light on their wives' behavior (Tormes, 1972). This was perhaps the beginning of a realization that mothers too were victimized in many ways. Yet the literature remains ambiguous. Sgroi and Dana (1982) state mothers are responsible for "failing to protect" their children (p.193) and "largely responsible for poor communication" within the family (p.194).

Women are frequently chastised for not performing traditional roles. They are expected to be the source and center of emotional nurturance for their family; they are accused of "escaping" responsibility by taking care of their own needs; they are accused of not satisfying their husband sexually; and finally, they are blamed for not stopping the incest after it is discovered (McIntyre, 1981). Kroth (1979) in his evaluation of Giarretto's
program found that women were able to resolve their own feelings very quickly in therapy, either accepting responsibility for their role in a failing marriage or, in other cases, realizing they were in no way responsible for their husband's actions.

The complexity of this dilemma is clarified by understanding that people tend to marry spouses with similar levels of differentiation. Both spouses project concerns to distract themselves from their own pain; at the same time both need to prevent abandonment and settle into equilibrium waiting for the other to change (Taylor, 1984). Because the mother is often a victim herself of wife abuse or previous sexual abuse, the continuation of her learned victimized behavior is an important consideration in understanding her inability to protect her own children (Truesdell, McNeil & Deschner, 1986). For example, a woman who feels helpless and unworthy is inclined to marry a man who also has damaged self-esteem. Her sense of helplessness is increased by his abusive acts, while his acting out is aggravated by her continuing passivity.

Initial intervention with mothers following disclosure needs to include a functional assessment, that is her need for concrete services such as interim safety,
financial needs and support in living independently (Byerly, 1985). It is "impossible to reach out effectively and engage mothers of incest victims in treatment without using the modality of individual therapy" (Sgroi & Dana, 1982, p.191).

Treatment needs of the mother in therapy are often similar to those of the child (Sgroi & Dana, 1982; Myer, 1985). A mother's inability to trust needs to be re-established through the sharing process of therapy and group work. Impaired self-image can be repaired through teaching women to recognize and respond to their own nurturance needs. Denial is confronted as they learn to ventilate conflicting loyalties. Focus on universalizations can help shape reasonable expectations of their husbands and children. Practice in limit-setting is required to overcome failures in establishing and enforcing limits. Anger needs to be recognized and validated with appropriate outlets found. Impaired communication can be improved through role-playing. Assertiveness is part of incremental training. Impaired socialization can be addressed through improved social skills.

Maternal hospitalization is also recognized as possible stress response of women not able to deal with
vicimization of their child (De Jong, 1986). This additional dynamic may have to be considered as part of the treatment process.

D. Treatment Needs of Siblings

The primary consideration for siblings is multiple victimization, the possibility that other children in the family have also been abused or are at risk for future victimization. Assessment of this aspect is a necessary part of any investigation following disclosure of child sexual abuse and needs no further commentary. This section deals with two other related issues, the reactions of nonvictimized siblings and sexual abuse among siblings.

Reactions of nonvictimized siblings.

Attention must also be given to the needs of children within the family who may not have been sexually victimized but who suffer the consequences of the family dynamics. An example is the resentment of a young boy who was physically abused but not receiving the same treatment opportunities as his sister who was "only" touched sexually (James, 1987).

The characteristics which foster sexual abuse within a
Family cause other negative effects as well. "The incestuous family is a character-disordered family that typically features a patriarchal structure with role reversals, collusion, and a secretive, enmeshed quality" (de Young, 1981, p.562). Abuse is often transmitted within families because of the rules children learn about relating (J. Taylor, 1986).

The results to other siblings can be numerous. Rivalry and jealousy may result from all children craving attention and not realizing the price of special favors. Collusion may result from other children fearing to be the next victim; similarly, they may experience a combination of guilt and gratitude that they are not chosen. Premature sexual stimulation within the family may result in the children being more susceptible to victimization by older persons outside the family. Younger siblings may respond with confusion and resentment to role reversals and poor parenting models (de Young, 1981).

Suzanne Sgroi and her colleagues present a similar diagnosis of the incestuous family and the resultant liabilities to family members:

The incestuous family ... is a closed and generally pathological system, constantly draining more and more energy from the individuals who comprise the family and offering little that is positive in return. At the same time the individual family member’s dependence
on this pathological system is enormous and the difficulty in extricating himself or herself and maintaining a healthy independent existence is equally great. These families and their members develop few skills for coping with the outside world that are effective or adequate to meet the complex demands of daily living. (Sgroi, Blick & Porter, 1982, p.32)

The needs of other family members are parallel to those of the mother, the issues being failure to protect, failure to set limits, and abuse of power (Sgroi, 1982b). The goals for survivors outlined by Deighton and McPeek (1985) apply equally well to siblings; these are "to achieve a more functional relationship with family members, to be less emotionally reactive and thus more objective, and to gain more control over their own adult relationships with others" (p.408).

**Sexual abuse among siblings.**

Some earlier studies suggest that sexual activity among siblings produces few or no ill effects (Lukianowicz, 1972). However, more recent studies take a different view.

Finkelhor's (1980b) student sample found that 15% of the females and 10% of the males reported having had sexual experiences with siblings, many of which could not easily be categorized as incest or play. The activities appeared age specific in that younger children
participated more in genital exhibition and adolescents in intercourse or attempted intercourse. In terms of perceived effects, 30% rated the experiences as positive, 30% as negative, with the rest having no strong feelings either way. Age difference was found to be the most important factor with the more negative reactions associated with the larger age difference. Girls who had sibling sexual experiences were found to be more sexually active as adults, although this does not imply that their adult experiences were better or more healthy.

Laredo (1982) comments on the difficulty of identifying what is typical or normal sexual behavior among siblings. While he rightly states that norms are relative to cultural, ethnic, geographic, and individual differences, he denies a cross-cultural concept of abuse.

A further study by Sorrenti-Little, Bagley & Robertson (1984) found that three aspects of sexual activity among peers affected adult self-concept. The greater the age difference, the more "advanced" the contacts, and the more threats and force were used, the worse was the prognosis in terms of self-concept. "It is an unexplored possibility that girls with poor self-concept were the most likely to be selected out by males for sexual abuse; or girls with poor self-concept
were the least able to resist abusive pressures" (p.50). This is a variation of the theme that poor self-esteem increases children’s vulnerability and victimization contributes to diminished self-esteem.

While mutual exploration among siblings close in age may be considered natural or developmentally appropriate, this is certainly different than sexual activities forced on a young child by a much older sibling. Sexual activity among children occurs along a continuum so that factors of age differential, coerciveness, and the nature of the acts must be considered in determining the abusiveness of the behavior.

Russell’s (1986) study shed more light on sibling sexual activity. Two percent of her sample reported at least one abusive experience with a brother before age 18. It is important to remember that wanted experiences were excluded by definition. The average age of the brothers was 17.9 years compared to the sister 10.7 years. This is an age disparity of more than seven years, quite above the questionable five year period used by most researchers to differentiate peer from abusive experiences. Russell adds:

Because mutuality is most frequently presumed to occur with siblings, brother-sister incestuous abuse is the most discounted of all forms of sexual abuse by relatives... Sisters are even
more likely than daughters to be seen as responsible for their own abuse. (1986, p.292)

E. Summary and Conclusions

This chapter has examined issues of treatment for the families of sexually abused children. The first consideration was abuse within the family, of daughters by fathers.

This typology has been in the forefront of sexual abuse awareness and the development of treatment programs. It is important to remember, however, that this represents only a fraction of all child sexual abuse. Professional understanding and response must not be restricted by this narrow view.

Within the area of abuse by fathers, the special concerns of stepfamilies are noted. Women are over seven times more likely to have been sexually abused by a stepfather than by a biological father. This may be related to many factors including the active seeking out of women with children by stepfathers, a weaker taboo and less bonding, smaller age discrepancy, and the different dynamics between mothers and daughters within a stepfamily.

The reconstruction model is presented as an alternative for family treatment, whereby all members of
the family are treated individually and slowly brought back together in a new way if they so desire. Principles of treatment include having the father assume responsibility for the assault and agreeing to leave the home. The non-offending spouse is empowered to provide support to her child and the self-esteem of both are strengthened. Treatment is provided for the mother-father dyad and the father-daughter dyad before the whole family comes together in therapy. This model is contraindicated, of course, if the abuse is denied by the offender and the other parent is unable to protect the child.

The role of mothers has been ambiguous in that they are often held responsible for allowing the abuse of their children. The primary treatment issue is their own previous and/or past victimization. Other treatment needs are much the same as those previously discussed for the child. These include such problems as impaired ability to trust, damaged self-esteem, denial, anger, lack of assertiveness and social resources, and poor social skills.

There are two major treatment issues for siblings over and above their own risk for victimization. The family dynamics which fostered the sexual victimization of one child can have damaging effects on the adjustment of
other siblings even if they weren't abused themselves. Another major concern is the continuation of learned sexually abusive behavior among siblings. Mutual exploration among children close in age is developmentally appropriate. However, there is also a range of more coercive activities by older siblings which may be considered abusive.

In summary, the treatment of child sexual abuse includes being able to respond to a variety of needs in the parents and siblings. Treatment of the father-offender has been discussed in this chapter. A more general overview of offenders and treatment considerations will follow in Chapter Nine.
CHAPTER NINE: HEALING OF THE OFFENDER

It is not these men who are monstrous; rather it is the society that has defined them and taught them to define themselves as a consequence of their gender. When all else in their lives fails, they have been led to believe that the exercise of the power of their genitals will assure them of their ultimate competence and power.

Sandra Butler, Conspiracy of Silence: The Trauma of Incest

The sexual abuse of children is a crime, first and foremost. Treatment can and should begin after that recognition and an appropriate legal response has been made.

Sandra Butler, The Problem Revisted (in second edition of above)

Treatment of offenders is recognized as one of the most crucial issues in the prevention of child sexual abuse at the individual level. However, this is a very new and experimental field. It is beyond the scope of this chapter to review all of the beginning clinical efforts in this area. Rather this chapter will attempt to review the types of offenders, theories of etiology, and implications for treatment while underscoring that this aspect of clinical practice must not be forgotten.

A. TYPES OF OFFENDERS

Early theories.

Early categorizations looked mainly at sexual abuse
within the family. While this represents a narrow view, it is consistent with what was first reported in the literature.

Christopher Bagley (1969) was one of the first authors to attempt to categorize incest offenders. His study of 1025 cases from 50 publications uncovered 425 offenders with sufficient data for comparison. The typology of incest developed included functional (the wife's role given to the daughter), disorganized (total chaos in the family), pathologic (one parent psychotic), fixated (the father attracted to the child because of early orgasmic experience) and psychopathic (the parents having no sexual boundaries). It was emphasized that treatment and prevention must take into account these various types.

Justice & Justice (1979) describe different but overlapping categories for incestuous fathers: (1) The symbiotic offender wants closeness and intimacy but cannot verbalize his needs and knows no other way of achieving them other than sexually. He may be a tyrant, rationalizer, introvert, or alcoholic in acting out his needs. (2) The psychopathic offender is driven by hostility and the need for pleasure. He may be promiscuous (heterosexual) or pansexual (attracted to both
boys and girls). (3) The pedophile has an erotic craving for children because of arrested sexual development. Most pedophiles present no physical threat to children. (4) Other offenders include those who may be psychotic or whose behavior is culturally sanctioned.

More recent authors such as James and Nasjelti (1983), Sanford (1980), and Russell (1984b) adopt the distinctions of fixated and regressed offenders used by Nicholas Groth (1978a). These are part of a larger typology Groth developed regarding sexual offenses in general although it may also be applied to child sexual abuse. These definitions, which will be described below, focus on the dynamics of the offense from the offender’s perspective and so are more useful for treatment purposes than differentiations such as intra or extra familial (Groth, 1987).

**Molester / rapist typology.**

Sexual offences can first be categorized generally as molestation or rape. Molestation is characterized by seduction or persuasion and passivity with the offender displaying positive emotional involvement and seeking an ongoing relationship with the child. The child becomes part of the offender’s fantasy; behavior is confined to
non-genital acts or gradually progresses to more overt sexual acts; and the offender wants the child to enjoy the activity (Groth, 1987). Molesters can be sub-divided into fixated or regressed.

Fixation refers to an arrested development. "A fixated child offender is a person who has, from adolescence, been sexually attracted primarily or exclusively to significantly younger people, and this attraction has persisted throughout his life, regardless of what other sexual experiences he has had" (Groth, 1978b, p.6). Fixated offenders are characterized by persistent interest and compulsive behavior with offenses often pre-planned. Male (same sex) victims are the prime targets (Groth, Hobson & Gray, 1982). Treatment of these offenders is difficult as they are fixated at an earlier developmental stage and have limited functional experience of sociosexual peer relationships.

Regression refers to a move backwards in maturity.

A regressed child offender is a person who originally preferred peers or adult partners for sexual gratification. However, when these adult relationships became conflictual in some important respect, the adult became replaced by the child as the focus of this person's sexual interests and desires... At the time of the sexual activity, this offender is usually in a state of depression, in which he doesn't care, and/or a state of partial dissociation, in which he doesn't think about what he is doing - he suspends his usual values, his controls are
weak, and he behaves in a way that is, in some respects, counter to his usual standards and conduct. (Groth, 1978b, p.9)

Regressed offenders are generally reacting to stress; their offenses are impulsive; and females (opposite sex) are the primary targets (Groth, 1987). Most are more amenable to treatment programs as the goal is to restore a level of functioning that was once experienced but lost.

Both types of molesters relate to the child as a peer. However, "psychologically the fixated offender becomes like the child, whereas the regressed offender experiences the child as a pseudoadult" (Groth, 1982, p.217).

Rape is the other major category of sexual abuse. Although rape is often more associated with adult victims, the dynamics also fit the behaviors of some child abusers. Rape is characterized by attack, assault, threats, intimidation, and aggression with the child the object of hostility or domination. Rape is more typically a one-time offense with different victims; the child is depersonalized and subjected to penetration and/or overt sexual acts or rituals (Groth, 1987). Rapists can be further classified into those motivated by anger, power, and sadism.

Anger rapists are described as using more force than
necessary to overpower the victim. The offender's mood is one of anger and depression with victim selection determined by availability. Children are usually at risk for this type of rape within their own family (Groth, 1978a, 1987).

Power rapists are described as using only whatever force is necessary to gain control of their victim. Assaults are premeditated and often preceded by fantasies. The offender's mood is one of anxiety with victim selection determined by vulnerability (Groth, 1978a, 1987).

Sadistic rapists are those for whom aggression and physical force have been eroticized. If power was primarily eroticized, the child is subjected to ritualistic acts and bondage; if anger was eroticized, the child is subjected to torture and sexual abuse. Assaults are calculated and preplanned with the offender’s mood one of excitement and dissociation. Victim are usually strangers with selection determined by specific characteristics or symbolic representations (Groth, 1978a, 1987).

It is important to remember that these distinctions while useful are not mutually exclusive. For example, Sgroi (1978) reported an emerging profile of mixed types
and Dreiblatt (1985) stated that 40% of offenders have more than one diagnosis. It is also noted that psychiatric terms, such as those mentioned above, have limited use for law enforcement. It is important that terminologies required for legal purposes not be confused with those used for treatment (Lanning, 1986).

The gender component.

Diana Russell (1984b) brings together several factors to explain the gender gap among perpetrators, namely, why the majority are male. Summaries of her points are as follows:

(1) "Women are socialized to prefer partners who are older, larger, and more powerful than themselves"; while men "are socialized to prefer partners who are younger, smaller, innocent, vulnerable, and powerless" (p.229). This increases children's attractiveness to men and decreases it for women.

(2) Males "are not only expected to take the initiative, but also to overcome resistance" regarding sexual relationships (p.229). Women are conditioned to be more passive, and sexual abuse is unlikely to be initiated by children.

(3) "Men appear to be more promiscuous than women"
This may be related to biological factors which will be discussed in the next section. Whatever the reason, the choice of multiple partners is more likely to include children.

(4) "Men seem able to be aroused more easily by sexual stimuli divorced from any relationship context... Women, on the other hand, rely more on a totality of cues, including the nature of the relationship with the sexual partner" (p.229). Women are more likely to have a relationship with children which precludes sexual arousal.

(5) "Men appear to sexualize the expression of emotions more than women do" (p.230). Women seem better able to express affection and intimacy in ways that do not involve sex.

(6) "Having sexual opportunities seems more important to the maintenance of self-esteem in men" (p.230). Women look to other ways to enhance their self-esteem.

(7) Men interact less frequently with young children so do not develop the kind of protective bonding that would make them sensitive to the harm of sexual contact. Women’s social role includes maternal responsibilities.

(8) Men may be less able to empathize with the potential harm because they are less likely to have been victimized.
(This theory will be refuted in the next section; it is suggested instead that male assault often represents a dissociation from childhood victimization.)

(9) "Sexual contact with children may be more condoned by the male subculture" (p.230). This is reflected by the historical evidence presented in Chapter Two.

Although female offenders do exist, they remain a minority in the male dominated sexual abuse of children.

**Female offenders.**

Reasons that support the male preponderance among offenders apply as well to contraindicate sexually abusive behavior by females. Because it is uncharacteristic behavior, females who do offend are believed to be more severely disturbed or even psychotic (Forward & Buck, 1978). This profile certainly fits the bizarre representation of Sybil's mother who is probably the most widely known female offender (Schreiber, 1973).

A more complete psychological profile is sketchy. From the limited information available, female offenders are believed to have the following characteristics in common: "a spousal relationship that is absent or emotionally empty; extremely possessive and overprotective attitudes toward child victims; alcohol used as a crutch
and as a disinhibitor to the expression of sexual feelings" (James & Nasjelti, 1983, p.23). When these women choose male victims, the boys are cast into the role of the absent male partner. Girl victims, however, become an extension of themselves so that the sexual activities have a masturbatory quality (Forward & Buck, 1978; James & Nasjelti, 1983).

Russell (1986) addresses the fact that clinical reports of female offenders are increasing. This must be considered in proportion as all reports are increasing. In Russell's San Francisco study only 1% of the women reported sexual abuse by a female. From a review of other studies she concludes "only about 5 percent of all sexual abuse of girls and about 20 per cent of all sexual abuse by boys is perpetrated by older females" (Russell, 1986, p.308). This corrects the erroneous assumption that women never abuse but does not change the fact that sexual abuse of children is predominately a male behavior.

Juvenile offenders.

Sexual offenses by children need to be seen as equivalent to a symptom of emotional disturbance (Groth, Burgess & Holmstrom, 1978). Juvenile offenders present a special concern for treatment programs as they are often
both victim and offender.

Molestation of younger children has been found to be one of the most consistent indications of a child's own sexual victimization. Three dynamics may account for this behavior: (1) it is a way of channeling aggression and turning anger at one's own victimization into power, (2) it provides a means of creating mastery over remembered events, and (3) it is a means of validating heterosexuality, particularly for a young boy who was abused by a male (James & Nasjelti, 1983).

The high incidence of untreated sexual victimization in the histories of adult offenders suggests that lack of treatment may be related to their later abusive behavior (Ryan, 1986). Treatment of young offenders up to and including adolescence is crucial in breaking the cycle of abuse because permanent adult preferences may not yet be formed.

As discussed in Chapter Eight, there is a continuum of sexual behavior among children, some of which may be exploratory and developmentally appropriate. It is important, however, that the context of all sexual behavior be considered to determine if it is masking a trauma on the part of the young offender.

The first step in addressing the juvenile sexual offender is recognizing that the problem exists
and that the youngster himself is struggling with this problem in silence because it appears it is too uncomfortable for others to listen to and to respond to. Instead, his behavior is minimized or dismissed on the supposition that either it is not serious, or, if it is, it will, with time, spontaneously self-correct. Unless intervention is forthcoming, the juvenile is in fact being professionally neglected or abandoned with the result that not only will there be more victims, but ultimately, when he reaches adulthood and faces the serious legal consequences of his behavior, rehabilitation may no longer be possible. (Groth & Loredo, 1981, p.39)

Young sexual offenders are children in need of treatment and protection. The good news is that childhood or adolescence is a more opportune time for therapeutic change than later adulthood.

B. ETIOLOGY OF OFFENCES

Underlying questions.

Much is still unknown about the relationship of personality, sexuality, and gender identity. Two peculiarities impact the development of human sexuality.

The first is the diaphasic sexual cycle, which means that humans are in heat all the time. Rather than instinctual drives for procreation being activated by regular biological cycles, humans depend on random signals which can occur in haphazard fashion. This phenomenon is unique in the animal kingdom to primates and, within the
human culture forms the basis of personality and social organization (Becker, 1971; Brain, 1979).

The second phenomenon is the intrusive quality of the penis in the development of male personality and socialization. Reference is made to studies which have validated that "erectile measures are the most accurate description of sexual arousal in males" with an assessment time of less than two minutes required (Marshall, Barbaree & Christophe, 1986). This female author can not help but wonder if the immediacy of such an obvious physiological response has contributed to the myth that male sexuality is more impulsive. There are certainly vast implications as social mores determine how males may exercise their gratification in regard to such persistent biological responses.

It is interesting that the theory of penis envy was developed by a male. This author concurs with Jackson (1982) that young female children would be just as likely to regard the penis as a deformity rather than an object of envy. An alternate hypothesis is that patriarchy developed in response to what could be called "womb envy". Women are biologically destined to produce and nurture their offspring. An element of faith is involved for men, even under the best of conditions, to know who are their
own lineage. It may be this envy within the male community that was compensated by defining relationships in terms of power and control.

These philosophical questions about the differences between male and female sexuality are intrinsically bound with definitions of sexual health and the treatment of offenders. By definition, treatment of offenders implies that their deficits and handicaps are overcome so that they can express acceptable sexuality within society. It is important that such expression be respectful to both the male and female perspective.

**Preconditions.**

Russell (1984b) attempts to explain the predisposition of male offenders by reasons of socialization; others looked at inhibitions (Frude, 1982). These theories are integrated by Finkelhor (1984a) who outlines four preconditions that must be met before sexual abuse actually occurs. The model he developed is as follows:

1. A potential offender needed to have some motivation to abuse a child sexually.
2. The potential offender had to overcome internal inhibitions against acting on that motivation.
3. The potential offender had to overcome external impediments to committing sexual abuse.
Further explication of the model is provided below.

Finkelhor (1984a) suggests there are three components to motivation. These are that the child meets an emotional need of the offender (emotional congruence), that the child becomes a source of arousal (sexual arousal), and that alternative sources of gratification are less available or satisfying (blockage). Each of these components may or may not be present, although they are often found in combination.

The potential offender must not only be motivated but must overcome internal inhibitions to allow his motivation to be expressed. In this way, disinhibition is a requirement for sexual abuse. The third precondition concerns external inhibitors in the environment, such as family dynamics which make a child more vulnerable. The final precondition is the capacity of the child to avoid or resist abuse. For example, children who are emotionally abused or who have poor relationships with their parents are at higher risk because they will feel unsupported and be more afraid to tell.

The advantage of this model is that, while it recognizes risk factors, these are relevant only after the
offender has already taken steps towards the offense. This represents a more realistic allocation of responsibility.

Socialization theory.

One factor that determines adult adaptation is childhood socialization (Gelles, 1973). Adults will respond to relationships and challenges in ways they learned as children. A popular interpretation is that men as well as women are victimized by the culture in which they grow:

These men are victims, not only of their particular parents, school systems and economic circumstances, but of something more pervasive than the sum of all these things. They are the victims of male-defined standards of appropriate behavior that leave little room for the acknowledgment of deeply felt and repressed needs for love, acceptance, nurturing and warmth; victims of not being permitted to feel and express the full range of human feelings and of not being taught to understand the strength in admitting weakness; victims of not being able to open their arms or hearts to others, never having experienced arms in which they were encircled and made to feel safe. (Butler, 1985, p.76-77)

Socialization theory believes that both men and women can learn new values and behaviors based on mutual support.

Social deviance theory.

Dreiblatt (1985) presents three models for
understanding child sexual abuse. These are family dysfunction, power, and learned sexual deviance. These distinctions are not the most helpful for the purposes of this chapter. The family dysfunction model, which assumes sexual abuse is caused and sustained by family dynamics, is not applicable to the wide range of abuse outside the home. Variations of this were discussed in Chapter Eight. The power model, which assumes sexual assault is an expression of a power disorder, may apply to certain types of sexual assault but again not to the wide range of child sexual abuse.

The sexual deviance model developed by Dreiblatt (1985) provides a useful overview for understanding deviant sexual behavior as a learned phenomenon. Basically, the model states that an offender somehow develops a vulnerability which is acted out through an initial offense. The behavior is reinforced by such dynamics as a sexual release, excitement, or a sense of power. This is followed by a refractive stage where the offender feels guilty or fearful, which in turn is followed by suppression. This period of denial must not be confused with a change in orientation. The offender then experiences renewed temptation, the offense is repeated, and the cycle just described is strengthened.
Treatment according to the sexual deviance model requires attention to the original vulnerability and the process of denial.

**Addiction theory.**

The addiction model was developed by Patrick Carnes (1983) who describes sexual addiction, like any other addiction, as the pathological dependence on a mood-altering experience. The sexual addict passes through a four-step cycle which intensifies with each repetition:

1. **Preoccupation** - the trance or mood wherein the addicts' minds are completely engrossed with thoughts of sex. This mental state creates an obsessive search for sexual stimulation.
2. **Ritualization** - the addicts' own special routines which lead up to the sexual behavior. The ritual intensifies the preoccupation, adding arousal and excitement.
3. **Compulsive sexual behavior** - the actual sexual act, which is the end goal of the preoccupation and ritualization. Sexual addicts are unable to control or stop this behavior.
4. **Despair** - the feeling of utter hopelessness addicts have about their behavior and their powerlessness. (p.9)

Carnes (1983) suggests four levels of addictive sexual behavior. Level One behaviors are generally tolerated by the public but can be devastating when indulged in compulsively. Examples are masturbation, heterosexual and homosexual relationships, pornography,
and prostitution. Level Two behaviors have the consequence of someone being victimized and usually involve legal sanctions. Examples are exhibitionism, voyeurism, indecent phone calls, and indecent liberties. Level Three behaviors represent profound violations of cultural boundaries. Examples are rape, incest, and child molesting.

Sexual addiction is characterized by preoccupation with sexual thoughts, ritualization, compulsive and secretive sexual activities, abusive sexual acts devoid of a caring relationship but with a pain relieving quality, despair and shame following the activities, often progression through the levels of activities, and massive denial (Blanchard, 1985a). A negative spiral of behavior is created encompassing the early psychosexual trauma, early repression, compulsive behaviors, and the inability to experience pleasure.

Developmental theory.

Groth & Burgess (1977) describe rape as having the function of a symptom in that it expresses conflict, defends against anxiety, and partially gratifies an impulse. When adults are deprived of affection as children, other children can become the resource for their
own infantile needs (James and Nasjelti, 1983).

Freeman-Longo (1986) from his work with offenders observes that the majority were sexually abused as children but very few overcame their own victimization. While most still harbor the feelings experienced as a child, they do not associate their feelings at having been abused with abusing others. They lack empathy and tend to focus on the positive aspects of their own abuse while repressing the traumatic aspects.

Nicholas Groth (1987) summarizes two major sets of risk factors in the etiology of sexual offenders. The first is the presence of biological flaws such as genetic or hormonal defects as discovered by the Sexual Disorders Clinic of John Hopkins University in Maryland. Other authors have found significant patterns of neuropsychological impairment (Hucker, Langevin, Wortzman, Bain, Handy & Chambers, 1986).

The second major factor is developmental trauma due to a history of childhood sexual abuse in the offender. All offenders studied in the last ten years have displayed one or both of those factors, with a history of sexual abuse considered significant in up to 80% of adult offenders and 100% of juvenile offenders (Groth, 1987).

A third factor which is not mutually exclusive to
the other two is a sexually repressive upbringing. The awakening of sexual urges at puberty can be a very troublesome time if all sexual activity is considered impure and evil (Groth, 1987).

C. Treatment Implications

It is important to incorporate treatment programs wherever offenders are identified. If they go through the judicial system with punishment alone, they will probably return to society unchanged. If they are systematically stigmatized and rendered helpless, this may even lead to greater insensitivity or aggression. Nor is it enough to prepare society to be vigilant. Attempts must be made to curtail the behaviors of the offenders themselves.

The "dangerousness" or risk of an offender to society is a composite of many factors (Macdonald, 1981). Groth (1970a) lists the areas to assess as impulse control, tolerance for frustration, emotional stability, contact with reality, interpersonal relations, self-awareness and self-image, and adaptive strengths.

The importance of these functional skills is underlined by the consideration that one's sexuality is discovered rather than chosen. Groth (1987) emphasizes that a person's sexuality is different from their
personality and character. While sexual preference is not volitional, how one chooses to express it and act upon it is. Sexuality is arrived at through a process of biology, genetics, and early experiences. Everyone does not arrive by the same route or at the same end, although everyone has a responsibility to contain their own sexuality within the mores of the society in which they live. The challenge to an offender to accept responsibility for handling deviant drives becomes an empty statement, however, if society does not provide suitable treatment programs (Groth, 1987).

The goal of treatment for offenders is to have them accept responsibility for their actions and a program of self-management (Giarretto, 1976). Sensitizing them to the pain of their victims presupposes helping them get in touch with their own pain and victimization. Offenders also need to learn to take responsibility for their own nurturance and stress management (Justice & Justice, 1979).

Similar concepts are reinforced by Herman (1981a) who sees the components of treatment as teaching offenders (a) the distinction between sexual impulses and the desire for tenderness and affection and (b) a rudimentary awareness of the effects of their behavior on other people. She
emphasizes that sobriety be a precondition for participation in a treatment program and that offenders can never be considered cured.

Groth (1987) outlines that the three conditions that preclude an offense. First, a person must be capable of the behavior. Secondly, the offender must have the inclination or intent and thirdly, the opportunity must be available. Incarceration certainly restricts opportunity but is a rather short-sighted option unless the offender is put away for life. The forces of socialization which reduce internal inhibitions have been discussed. These include subtle cultural norms such as the view of female or child sexuality as a commodity and the predatory nature of male sexuality.

Personal capability is related to self-management skills. Offenders will be more likely to have poor impulse control and the inability to defer gratification, to perceive of themselves as powerless, and to be frustrated in their sexual relationships (Russell, 1984a). While Russell also mentions alcoholism and psychopathology as contributing factors, Groth (1987) emphasizes that these are separate problems which may present at the same time but which are not generally the cause of child sexual abuse.
D. Treatment Methodologies

It is beyond the scope of this chapter to review treatment techniques in great detail. A brief summary of treatment philosophies will be presented instead with the underlying comment that much more work is needed in this area. The models to be discussed can be roughly divided into behavioral, addiction, and developmental.

Behavioral model.

This approach deals with changing the behavioral manifestation of sexual preference. Behavioral principles include four major objectives: (1) establishment of rewarding adult sexual relationships, (2) improvement of sexual functioning within adult sexual relationships, (3) increased self-control over sexual behavior, and (4) adjustment to innate sexual preference (Yaffe, 1981). Techniques aimed specifically at sexual arousal include aversion, aversion relief, systematic desensitization, masturbatory conditioning, and biofeedback.

Brian Taylor (1981) suggests that offenders have difficulty with adult sexuality because of general lack of interest, lack of sexual responsiveness, anxiety, and difficulty maintaining relationships. The success of such
a program seems to depend on the distinctions between regressed and fixated offenders. While regressed offenders may be conditioned toward resuming sexual behavior with adults, it is unlikely the same would apply to fixated offenders whose sexual preferences are permanently established. Behaviorial conditioning with these offenders needs to focus on control or sublimation of erotic impulses toward children rather than changing basic orientation.

The use of fantasy training can be part of the treatment process. Sexual offenders are often unable to make constructive use of their fantasy functions and can be taught this process to help reduce identified behaviors (Matek, 1966). An example is to have the offender include a police intervention in an imagined scene of child seduction. This acts as an additional internal inhibitor to following through on the anticipated action.

Technology measuring erectile responses to various sexual stimuli can be useful in terms of assessment and confrontation. For example, Marshall et al (1986) report that several molesters, who denied having offended against children or having used coercion, admitted their guilt after being shown their results which confirmed significant arousal to those stimuli.
Chemical castration is another method available for use in extreme situations. Anti-androgen drugs reduce the availability of circulating testosterone which reduces the sex drive, decreases the ability to sustain an erection, and reduces sperm production. Because these medications is still at an experimental stage, there are not yet established protocols. The medication must be used voluntarily with careful follow-up assured (Frost and Seng, 1986).

Addiction model.

The addiction to sexual offenses is treated essentially like any other addiction. Assessment includes developmental delays, motivation (pain relief, loneliness, tension, power), other coping mechanisms, predictable trigger mechanisms, the presence of other addictions (work, alcohol), distorted thinking, and the presence of a co-addicted partner (Blanchard, 1985b).

The principles of counseling the sexually addicted offender have been outlined by Carnes (1983) and Blanchard (1985b). The starting point of therapy, as with any addiction, is a point of "drying out" or in this case celibacy. The focus of therapy is to bolster the offenders' fragile self-esteem, improve their ability to
delay gratification, teach new coping skills, expose the process of using pleasure to reduce pain, and assist in the recovery of early life traumas which started the whole process. The recovery process is maintained and strengthened through group work, as with the Alcoholics Anonymous model. The group provides a sense of connectedness, concrete acceptance and support, motivation through seeing others change, and a forum for issues of trust and the confrontation of denial and minimization.

As with any addiction, the focus must be on control rather than cure. “The offender must accept his own responsibility for maintaining a conscientious and lifelong effort to keep sexually abusive behavior under control” (Groth, 1982, p.235).

**Developmental model.**

The developmental model responds to the idea that the sexual offender has been developmentally delayed, most probably because of childhood trauma which may or may not have included sexual abuse. This model does not exclude the others mentioned above. “The addict who focuses on children usually has suffered some interruption in his or her own development” (Carnes, 1983, p.45).

A developmental assessment includes many of the same
questions used to trace patterns of social deviance or addictive behavior. Developmental skills and learnings need to be assessed; repressed emotions need to be brought to the surface and explored; and early sexual identifications must be recognized as well as choices resulting from those experiences. The offender’s self-esteem and confidence must be restored within a relationship context so that a sensitization to the needs and feelings of others is incorporated with increased self-awareness.

This model includes recognition and acceptance of the wounded child plus nurturance of the developing person to a more mature and responsive adult. This means that offenders accept responsibility for their own abusive behavior by making appropriate restitution and learning new skills for gratification and impulse control (Groth, 1978a).

E. Summary and Conclusions

This chapter looked at types and causes of abusive behavior. Treatment for offenders was also reviewed.

Early theorists tend to categorize offenders according to family dynamics. This is consistent with the first wave of awareness which focussed on intra-familial
abuse, particularly of daughters by fathers. The typologies developed by A. Nicholas Groth are much more useful from a treatment perspective and in understanding the full spectrum of sexual offenders.

Child sexual abuse can be categorized first as molestation or rape. Molestation is the crime of offenders who seek an emotional relationship with the child and want to believe that the child enjoys the touches or progressive sexual activities. There are two types of molesters, fixated and regressed. Fixated molesters are those with arrested sexual development who seek to return to the child’s developmental level. Regressed molesters are those who have achieved a level of adult functioning but under stress seek out a child partner whom they see as a pseudo-adult.

Rape is the crime of those whose assault is characterized by hostility or dominance. There are three types of rapists. Anger rapists act out their aggression and hostility in a sexual way. Power rapists act out their need for control and acceptance. Sadistic rapists are those for whom either anger or power have become eroticized and are part of the sexual excitement.

The sexual abuse of children is predominately a male offense. Several factors are reviewed which contribute to
this predisposition. These include the socialization patterns of men to prefer partners who are younger, smaller, and more vulnerable; to take the initiative in sexual relationships; to be more promiscuous; to be more easily aroused by stimuli outside of a relationship context; to sexualize the expression of their emotions; to use sexual opportunities to maintain self-esteem; to have less sensitivity to the needs of young children; to empathize less with the impact of victimization; and to be more accepting of child sexual abuse within their own sub-culture.

Female offenders do exist but are generally considered more disturbed than male offenders. The presence of this minority does not change the underlying gender dynamics.

Juvenile offenders are an area of special concern for they represent the turning point of the abusive cycle in that they are typically acting out their own victimization experiences. The treatment of these children is very important because their adult sexual preferences may not yet be formed. Values and behavior that can still be shaped in childhood or adolescence will be much more rigid in adulthood.

Several theories are presented to explore the
etiology of sexual offenses. These are prefaced by comments on the diaphasic sexual cycle and the role of the penis in male socialization.

Socialization theories which explain male dominance in sexual abuse are complemented by the precondition model developed by David Finkelhor. This model outlines that an offender must be motivated, must overcome internal inhibitions, must overcome external inhibitions protecting the child, and finally must overcome the child's own resistance. This puts risk factors for children in perspective by placing responsibility primarily with the offender.

The socialization theory is alluded to throughout the chapter. Basically, it is the process by which both males and females learn their social roles and expectations.

The social deviance model presents deviant sexuality as learned behavior in response to a cycle of vulnerability, offense, release and reinforcement, denial, and repeat of the original offense.

The addiction model sees dependence on sexual act as a mood-altering experience, with dynamics similar to any other addiction.

The developmental model sees sexual offenses as a dysfunctional response to childhood trauma. Studies have
shown this to be a consideration for the large majority of identified sexual offenders. Another cause believed to effect about 20% of offenders is the presence of biological flaws such as genetic, hormonal, or neurological deficits.

Methods of treatment chosen will depend on the type of offender and the model of etiology which seems to best explain the behavior. The goal of treatment is for offenders to accept responsibility for controlling their own behavior. It is recognized that there is no cure for sexual deviance, just as there is no cure for addictions. Rather new skills can be taught to overcome old stresses, self-esteem strengthened and social supports improved. Individuals, while not irrevocably cured, can be given a new range of alternatives for coping with and enjoying life.

The behavioral model looks at reinforcing or extinguishing certain behaviors. The addiction model looks at the dynamics which initiated and support the addictive behavior. The developmental model, which does not necessarily exclude the other two, looks at the original childhood traumas and endeavors to lead the offender through missed developmental stages to integrated adult responsibility.
The impact of socialization has been an underlying theme of this and previous chapters. The issue remaining is how this process can be improved to prevent child sexual abuse in future generations. That is the focus of the next chapter.
CHAPTER TEN: HEALING OF SOCIETY

It is easy for those who have never become aware of having been victims, since they grew up believing in the principles of being brave and self-controlled, to succumb to the danger of taking revenge on the next generation because they themselves have been unconsciously victimized. But if their anger is followed by grief over having been a victim, then they can also mourn the fact that their parents were victims too, and they will no longer have to persecute their children. The ability to grieve will bring them closer to their children.

Alice Miller, For Your Own Good: Hidden Cruelty in Child-rearing and the Roots of Violence

Child sexual abuse will continue as long as we simply focus on individual children one at a time. It is important but not enough that children and families and offenders are healed after sexual abuse happens. A more general healing of society is required to change attitudes which promote and condone sexually abusive behaviors. This chapter will look at prevention in this broader sense and identify some of the social values that must be changed for prevention to be effective.

A. Levels of Prevention

Three levels of prevention are identified by Bagley (in press). These are (1) primary - which aims to address the root causes and cultural values around an identified problem, (2) secondary - which aims to reduce the
prevalence of a problem within the status quo, and (3) tertiary - which intervenes only after the fact and is basically rehabilitative. These will be reviewed in reverse order, moving from the individual treatment philosophies presented in preceding chapters to the more difficult challenge of social change.

This can also be described as a movement from micro to macro orientation. Individual treatment programs are the building blocks of a comprehensive and multi-disciplinary model; each contributes to the larger program but also depends on the work of the other disciplines for improved effectiveness. Similarly, community programs depend on social acceptance but also shape and change social awareness.

Tertiary prevention - rehabilitation.

The treatment programs presented in Chapters Seven to Nine were a review of what could be called tertiary prevention at a micro level. This type of healing recognizes the vast numbers of wounded persons and the need to restore them to a more functional and integrated level of health. Individual healing embodies the humanistic principles of respect for and development of human potential and contributes to prevention by helping
people become more responsible members of society. The more comfortable and confident a person feels about their own development, the more he or she will be able to provide support and nurturance to others.

This is particularly relevant when considering the intergenerational aspects of child sexual abuse. Studies have indicated that the reactions of sexually abused children are dependent on gender differences. Victimized girls are more likely to internalize their own trauma, engage in self-destructive behaviors, and become the wives of abusive men. As mothers they are often helpless to protect their own children just as they were unable to help themselves. Victimized boys, on the other hand, are more likely to act out their trauma and dissociate from their own pain by imposing it on another. Healing of both male and female children will help break these generational cycles by giving them new alternatives for their own life and role in society.

Healing of offenders is important because of the tendency for offenders to have multiple victims. To prevent offenders from acting again helps curtail the potentially exponential growth of victims and to that extent makes society safer for other children. What is frustrating, however, is that new cases are being
uncovered faster than existing resources can respond. This emphasizes the need for another approach which can prevent the problem before it requires treatment.

**Secondary prevention - awareness.**

Secondary prevention or the reduction of prevalence involves healing at the community level and can be accomplished through many different means. Education, improved community awareness, earlier identification, comprehensive community programs, and legal change have all been mentioned as ways of meeting the challenge. The need for a strong community model incorporating these changes was summarized in Chapter Five.

It is argued that this kind of prevention makes good financial sense. The costs for services such as child protection, prosecution, incarceration, and treatment could be applied to more general services such as family life education and screening and support for high-risk families (Gentry, 1978).

Strengthening children is one component of secondary prevention. This has become a major thrust of parent education and personal safety programs. A number of helpful books have been produced in the last decade with guidelines for parents wanting to talk with their children
about sexual abuse (Fay, 1979; Adams & Fay, 1981). Books developed specifically for children introduce such concepts as teaching them to recognize their "private zones" (Dayee, 1982), to resist "uncomfortable touches" (Freeman, 1982; Hart-Rossi, 1984), to "trust their feelings" (C.A.R.E. Productions, 1984), and not to keep secrets (Wachter, 1983). Other books for teenagers include such self-explanatory titles as "Top Secret" (Fay & Flerchinger, 1982) and "NO is not enough" (Adams, Fay, & Loreen-Martin, 1984) which provide guides for discussion during the confusing time of adolescent sexuality.

While the above mentioned books were accumulated with considerable diligence a few years ago, the author is pleased to note there are currently many new books of similar content available in public book stores. Even cartoons and coloring books are coming into vogue as teaching aids for young children.

The education of children includes the introduction of personal safety programs into school curriculum. Brassard, Tyler and Kehle (1983) emphasize that school programs need to be complemented by a parent teaching component to ensure that parents have the opportunity to discuss and understand the concepts that will be taught in the classroom. Suggested information for parents includes
a philosophy of children's rights and background information about the reality of child sexual abuse as well as specific program content. Follow-up programs are needed regarding the practicality of these education programs as change in knowledge does not necessarily imply a change in behavior (Wolfe, MacPherson, Blount, & Wolfe, 1986).

Education of professionals is another major thrust of community awareness. Studies of attitudes indicate there is much work to be done before the common understanding referred to in Chapter Five is achieved. For example, one study of professionals found those with more clinical experience tended to view child sexual abuse as less damaging to survivors (LaBarbera, Martin & Dozier, 1980). While this is contrary to what would have been expected, this finding may reflect a symptom of helplessness or desensitization among professionals as a result of non-existent or ineffective treatment programs. Another study found that psychiatrists were the professional group most likely to consider children's accusations as fantasies (Attias & Goodwin, 1985). This unfortunate dichotomy may also reflect the fact that much of contemporary theory was developed independently of traditional psychiatry.
A comprehensive approach is advocated which includes public education, professional training, institutional changes, and media sensitization (Cohn, 1986). Education needs to extend to children, parents, and high risk offender groups. Healing at the community level needs to incorporate public service programs with messages coupling treatment with positive power rather than shame. Concern needs to extend beyond those who have already been victimized to reaching all potential offenders. Society is healed by channeling community awareness to avoidance of abusive interactions.

Strongly voiced protest, however, is still lacking in the public arena. The above mentioned changes take place within existing society rather than challenging the social structure itself. The final level of prevention and healing requires change of cultural values to eliminate the need for community programs such as those described above.

**Primary prevention - social change.**

The primary level of prevention takes a macro political view in that it strives to eliminate the root causes of child sexual abuse. Taubman (1984) identifies four aspects of western society that contribute to the
sexual victimization of children. These are cultural attitudes towards sex, the patriarchy system, depersonalization within culture, and compartmentalized lifestyles. The writer suggests these can be contained within the more general categories of power imbalance and objectification with violence as an additional contributing factor. These will be discussed in more detail in the following section, which outlines these components of the socialization process as targets for prevention.

Primary prevention challenges the social foundations of learning and behavior. This is difficult as society is built on habit and tradition. Particular vision and commitment are required to move from an accumulated heritage along an uncharted path. Yet healing is possible only when society is able to look back as a collective entity at its own development, acknowledge rather than deny its own liabilities, and overcome its limitations by determining new directions to incorporate chosen values.

The major change required is at the level of social identity and the process of defining ourselves through our differences rather than our commonality. Children have been isolated from full recognition as persons by subtle variations of this process. Ways in which socialization
supports this dichotomy and how that contributes to child sexual abuse will be discussed. Changes required for social healing will also be addressed.

B. Socialization Issues

Since it is the function of a society to shape the motives and energies of its members, each social structure leaves as little to conscious behavior and thinking as possible, but tries to direct individuals to comply with and even find gratification from the standards established by each society. (Rush, 1980, p.105)

Social life is a cultural achievement with social order created and maintained through symbolic learning and each person motivated to participate by the human need of respect from others (Harre, 1979). Yet part of that symbolic interaction is the ritual stigmatization of groups and individuals by others within society. The writer identifies power imbalance, sexual objectification, and violence as expressions of this process. All of these prevent full personal and communal development, and must be addressed to ensure social healing at a macro level.

Power imbalance contributes to child sexual abuse in that children are victimized as members of a defenceless and vulnerable social strata. Sexual objectification, which includes stereotyping and pornography, curtails the development of both boys and girls as full persons.
Violence, which refers to a wide range of insensitive to abusive responses to child sexuality, destroys the trust and self-esteem of developing children.

While these are isolated as separate dynamics for the purpose of discussion, it must be remembered they exist in interaction with each other. For example, sexual objectification and violence are both expressions of a power imbalance. Similarly, violence can include sexual degradation and stigmatization, and sexuality can be used as an expression of power and violence.

These dynamics, however, also interact with the more humanistic norms of society and become confused with concepts such as erotica, authority, and discipline. Healing is achieved by moving toward expressions of socialization which embody mutuality, respect, and nurturance.

**Power imbalance.**

The power imbalance exposed and challenged by feminist thinkers is patriarchy (Gordon, 1985). Patriarchy is quite simply a system of society ruled by males as the heads of family and government. Characteristics relevant to child sexual abuse include the legal tradition of women and children as property, the
marriage contract whereby women and children become legal dependents, and the social endorsement of continued economic subordination of women and children to male wage earners for the purpose of ongoing service.

The double bind for young girls in a patriarchal system is that they are socialized to be both obedient and virtuous. Their obedience leads them to be potential victims while their virtue leads them to accept and carry the shame of their abuse. This is complicated by the fact that in patriarchal families, children are expected to share their parents' burdens and act in the service of their father (Gordon, 1986).

Social healing requires that children be protected from the abuses associated with ownership and subjugation. Society must become more sensitized to recognizing that children are abused because they are members of a weak and defenceless social strata. Change will not happen until society recognizes the independent rights of children and develops means of protecting and assuring those rights.

Examples of primary prevention include more credibility given to child testimony within the justice system and accommodation of the courts to meet the needs of children rather than faulting them for not meeting adult standards. Equal, if not more, consideration needs to be
given to the natural innocence of victimized children as to the unproven guilt of offenders. On the other hand, the emphasis on family reintegration following intrafamilial sexual abuse could be seen as harking back to a man's right within society to maintain control over his family. A more healthy and enlightened response is to strengthen the child and non-offending parent so that all family members have equal rights and ability in deciding the direction of their future relationships.

The funding and establishment of community efforts such as public education, child protection, and treatment programs for child sexual abuse reflect that society has begun to respond to the problem. More profound efforts are still required, however, to meet the challenge of attitudinal change. Healing requires that all minorities are recognized and protected as integral members of society. This implies the integration of women and men at all levels of social and economic life with recognition and protection given to the rights of children.

Sexual objectification.

One of the most obvious polarities existing in society is the differentiation between male and female with many social roles and behaviors considered gender
specific. Persons are also believed to have innate characteristics dependent on their gender.

For example, the concept of female attractiveness has been linked with intrigue and danger as reflected by the use of language. "Most of our words for feminine appeal, like glamorous, fascinating, spellbinding, enchanting, bewitching, enticing, and charming are derived from witchcraft. Others suggest enslavement or physical threat, as in alluring, enticing, captivating, enthralling, ravishing, devastating, and stunning" (Summit & Kryso, 1978, p.244).

On the other hand, language can be used to obscure the dynamics of child sexual abuse (G. Walker, 1984). For example, expressions such as "incestuous families" and "family violence" degenderize abuse and neuter who abuses whom and in what way. Some may feel the problem of child sexual abuse is an easier cause to promote when it is freed from "gender politics" and presented as a "human" concern. However, "reality can not be twisted to suit this particular ideological or political need" (Russell, 1984b, p.231).

Finkelhor (1982) outlines some of the socialized differences between men and women which predispose men to sexual abuse of children. Factors such as women learning
earlier to distinguish sex and affection, men seeing heterosexual success as part of their gender identity, men tending to isolate sexual activity from the context of the relationship, and men wanting younger and smaller sexual partners were discussed in Chapter Nine. Another interpretation is provided by Brian Taylor (1981) who suggests the fact that most abusers are male reflects the broader social license of women to express affection to children.

An example of the cultural double standard is that women are faulted for the offenses of men (Lawton-Speert & Wachtel, 1982). Most studies assume it is the mother’s role to provide sexual satisfaction to her mate and to shoulder the entire burden of child care (Wattenburg, 1985). This is an example of how sex-role stereotyping obscures responsibility and suggests that women are somehow obliged to ensure the satisfaction of men and the protection of children from men. The underlying myth that sexual desire is a valid excuse for assault is related to this concept of male/female roles. "The question of consent, even for adult women, much less for children, has been a recent phenomenon" (Mitchell, 1985, p.97).

Pornography is a form of child sexual abuse in that it portrays the sexual objectification or exploitation of
children. Children are victimized in that the producers and distributors of pornography exploit the innocence and availability of children. A second level of violation is using such material to entice or recruit further victims. "Perpetuating the sexual victimization of children is the most insidious purpose of child pornography" (Tyler & Stone, 1985, p.316).

Bagley (1984c) distinguishes the moralist, civil libertarian, feminist, and humanist responses to pornography. The moralist view sees any portrayal of sex outside of traditional roles as sinful. The civil liberties perspectives incorporates freedom of expression and anti-censorship concerns. The feminist view focuses on the portrayal of women as objects. The humanist perspective sees pornography as degrading to both men and women in that it presents them both in superficial and stereotypic ways. Social healing incorporates the humanistic interpretation outlined above.

Sexuality cannot be liberated as long as women and children define themselves vicariously through men (Person, 1980). Healing of society requires that both men and women are free to develop themselves unfettered by genderized stereotypes. Both would be encouraged to follow work and recreation activities which matched their
personal aptitudes and abilities rather than traditional roles. Sexual expression of both men and women would also be dependent on mutuality and freed from predetermined gender expectations.

**Violence.**

Violence is the compulsive repetition of the exercise of power (Miller, 1983). The power component is that violence is often used in response to disagreement or perceived lack of control. The writer identifies two different but related aspects of violence within society. One is the tendency of adults to perpetuate the violence experienced as children. The second is the tendency of society to promote identity through a process of stigmatization. They are alike in that both promote polarity, denial, and distance. The difference is that the first violates children by perpetuating their lack of power; the second violates children by objectifying them.

Alice Miller (1983) coins the concept of "poisonous pedagogy" to explain the tendency of parents to pass the cruelty of their own upbringing onto their children:

The scorn and abuse directed at the helpless child as well as the suppression of vitality, creativity, and feeling in the child and in oneself permeate so many areas of our life that we hardly notice it anymore. Almost everywhere we find the effort, marked by varying degrees of
intensity and by the use of various coercive measures, to rid ourselves as quickly as possible of the child within us - i.e., the weak, helpless, dependent creature - in order to become an independent, competent adult deserving of respect. When we reencounter this creature in our children, we persecute it with the same measures once used on ourselves. And this is what we are accustomed to call "child-rearing". (p.58)

The second manifestation of social violence is the process of stigmatization. "Society often finds it easier to locate evil in a few misfits who can then be properly punished and despised, because such a view does not require a change in the social system"; a more helpful perspective is to understand violent behavior as "embedded in the cultural and socio-economic context in which it occurs, rather than in ... the perpetrator" (Loewenstein, 1979, p.25).

The "maleness" of violence is a manifestation of our sex role heritage. The socialization of young boys is particularly harsh in that they are trained to dissociate from the "feminine" qualities of tenderness and compassion (Taubman, 1986). This presents a problem for offenders who are themselves victims of a violent, individualistic society which isolates individuals and fails to provide adequate support (Bagley, in press).

Healing of violence, for society as for an individual survivor, involves a process of acknowledging rather than
denying the historical reality, mourning the loss of what could have been, and moving ahead to learn new alternatives of attitudes and behaviors. The healing process as it applies to children and sexuality will be discussed in the following section.

C. Toward Healthy Childhood Sexuality

The question of child sexual health was raised in Chapter Three with health defined as the state of being sound in mind, body, and soul. Social healing implies that society must adopt values which support the expression of sexuality without ignorance, prejudice, guilt, or fear.

This is difficult when "sexuality is attended by more positive and negative emotions and by more psychologic conflicts than any other activity practised by men and women" (Blumberg, 1978). As well, a social taboo exists to keep sex hidden from children. This makes it difficult for parents to come to terms with their children's sexuality and to guide them to healthy expression (Burgess & Holmstrom, 1978b). A necessary prerequisite is that adults free themselves from the socializations of their own childhood and learn to accept their own sexuality.

"Human sexuality cannot be understood apart from the
culture in which it is carefully and pervasively shaped" (Loewenstein, 1978, p.107). Sexual role identity involves much more than biological reality. Factors of somatic, psychic, social, and cultural development must also be considered. Sexuality, whether in illness or in health, expresses itself as an integrated response of the above factors (Lieberman, 1979). The past section discussed how certain social values contribute to the continuation of child sexual abuse. Parents and educators need to take responsibility for not perpetuating attitudes which promote objectification and violence.

Children need to acquire a more healthy sexual awareness to develop fully as sexual beings (Jackson, 1982). The sexual experiences of young people reflect culturally dependent gender differences and hierarchy. For example, the transition to adult sexuality for girls requires little change. They are expected to maintain their innocence, attractiveness, and desire to please while not taking an active role. The achievement of sexual maturity for boys requires a much sharper break with childhood. They are expected to take initiative and control in a competitive social arena. "The facts that men learn to associate sex with power and develop the capacity to be aroused by childlike qualities create the
possibility that their sexual interests could be directed
towards children themselves" (Jackson, 1982, p.173).

Belief in male sexual prerogative has been one of the factors in the oppression of women and children. Touching and physical closeness have been undervalued in male socialization so that sexual intercourse becomes the primary expression for men seeking physical contact, love, or emotion. One author suggests, however, that such emphasis on sexual activity actually curtails the satisfaction of more basic emotional needs (Lindemann, 1983). A negative cycle is created similar to addiction whereby the chosen means of alleviating a need actually creates a greater need.

Children draw on sexual meanings to maintain gender segregation. This is particularly crucial at the time of adolescence when sexuality is assumed as a core of identity (Thorne & Luria, 1986). The social supports for gender segregation are lifelong. Children have the additional handicap that any explicit sexual activity is considered culturally deviant so that they have limited scope for experimenting with their own sexuality.

It is Jackson’s (1982) belief that enforcing sexual ignorance on children does more harm than good:

In attempting to protect children from sex we expose them to danger, in trying to preserve
their innocence we expose them to guilt. In keeping both sexes asexual, and then training them to become sexual in different ways, we perpetuate sexual inequality, exploitation and oppression. (p.180)

In this sense the development of healthy sexuality requires more than personal change. Parents can raise girls to be more independent and boys to be less aggressive, but both have the challenge of living in a society divided by gender and founded on competitive values. Political change is necessary to assure more healthy social reality for future generations.

Sexuality, like safety, is acquired through a developmental process (Comfort, 1985). Children need direction, opportunities for trial and error, limits, and guidelines. Part of this process is helping children feel good about themselves. Children who have had opportunities to be successful at work and play will feel more secure about themselves and their environment. Body exploration is part of normal development and children can tell the difference between touches that are caring and those that are exploitative (Anderson, 1979). Because children's rights have been historically denied, they need to be taught how to be assertive about their own boundaries and feelings.
D. Toward Social Healing

It is clear from the above discussions that society needs to move in a direction that is non-patriarchal, non-sexist, and non-violent. Change activity takes place along a continuum as does abusive activity. It is not enough that individuals begin to internalize new values and express them in their individual lives and relationships. Political changes are also required so that the whole process of socialization will shift.

Social change begins with awareness but it must also be embodied in practice and reflected in legal and economic realities. The first change needed is that of power imbalance. To be effective programs on sexual abuse must consciously embrace the issues of male power and sexual privilege and be directed toward the empowerment of women and children (Herman, 1981a).

However, the attitude of empowerment as opposed to control also has vast implications for social attitudes towards offenders. As long as offenders are blamed rather than held responsible, society will punish rather than rehabilitate. Only when society as a whole takes responsibility for its own abuses of power can individuals be helped to learn mutuality as an alternative method of relationship.
Another issue is that of sexism. One method suggested for reducing the difference in sex role orientation is to involve males more in child care. Herman (1981a) speculates that male dominance is perpetuated by the practice of women being the primary caretakers of young children:

In girls, the identification with the mother forms the basis for a secure sexual identity and for the development of the capacity to nurture. In boys, adult sexual identity is achieved only by repudiating the primary identification with the mother. In this process, all the qualities associated with mothering—tenderness, emotional responsiveness, and nurturance—are ruthlessly suppressed. The result is the formation of a male psychology in which sexual identity is forever open to question, dominance and sexuality are confused, and the capacity for caretaking is atrophied. Such a psychology makes it inevitable that some men will abuse children. (p.212)

If child care were shared by men and women, this basis for male dominance and female submission might be eliminated. Children of both sexes would have parent models who embodied autonomy, mututality, and nurturing abilities.

Child pornography is recognized as another contributing factor to the sexual abuse of children. Research has demonstrated a connection between exposure to violent pornography and violent behavior (Russell, 1986). Speculation is that child pornography may create the desire to abuse children in some viewers and reduce the
internal or social inhibitions of others. It is not enough that consumers are sensitized to possible dangers. Legal sanctions prohibiting the production and distribution of child pornography are required for the full protection of children in society.

Elimination of violence is another goal of social healing. "The media, educational system, and other social institutions legitimate violence as a problem-solving method and encourage competitiveness and physical dominance as opposed to cooperation and egalitarian values" (Dietz & Craft, 1980, p.608). This is also related to the issue of power in that offenders receive a double message if they are treated violently after disclosure.

Violence is ultimately related to the dynamics of power and control. Societies, like people, who are secure in their own development and at peace with themselves have no need to assert themselves through violence. Alice Miller (1983) summarizes the redeeming value of nurturing instead of control:

Those who actually had the privilege of growing up in an empathic environment (which is extremely rare, for until recently it was not generally known how much a child can suffer), or who later create an inner empathic object, are more likely to be open to the suffering of others, or at least will not deny its existence. This is a necessary precondition if old wounds
are to heal instead of merely being covered up with the help of the next generation. (p.63)

Social healing depends on society not denying or minimizing the effects of sexual abuse on children. Those who have never been victimized know about nurturing relationships. They and those who have been healed have an obligation to reach out to others who are not so fortunate. At the same time those who recognize the negative effects of their socialization have an obligation to seek and find new alternatives. Society needs to affirm the components of socialization which are nurturing and build on those which need to be.

E. Summary and Conclusions

This chapter outlines the need for healing at the level of society. Three levels of prevention are reviewed with eradication of root causes considered primary, awareness and reduction of prevalence considered secondary, and rehabilitation considered tertiary. The need for individual intervention was reviewed first, followed by the larger concerns of community education and changes in social values. This progression from a micro to a macro orientation parallels the development in previous chapters from individual healing to social change.
Three socialization issues are targeted for change within primary prevention. Although they are recognized as interactive, the dynamics of power imbalance, sexual objectification, and violence are identified as components contributing to child sexual abuse. Power imbalance includes the male domination characteristic of patriarchy and the general subjugation of children's rights within society. Sexual objectification includes the use of language to obscure the gender realities of abuse as well as sex role stereotypes for boys and girls. Pornography is included as an example of sexual objectification. Violence is seen as the compulsive repetition of the exercise of power. Adults tend to repeat the violence experienced by themselves as children by perpetuating childhood as a social strata without power. Violence is also extended to children by the social tendency to promote identity through the stigmatization of others.

Healthy sexuality in childhood requires that a child learn to accept and express his or her sexuality without ignorance, guilt or fear. Both boys and girls need to acquire awareness of their developing sexuality free from the restrictions of genderized roles. The same applies to their capacity for autonomy and nurturance.

Society needs to move in a non-patriarchal,
non-sexist, and non-violent direction to promote healing. Programs for the prevention of child sexual abuse must address the issue of empowerment for those who have been victimized. This includes holding offenders responsible in ways that are non-stigmatizing so that they too are empowered to become responsible citizens. Increased involvement of males in child care is seen as one means of reducing sexism. Legal changes to curtail child pornography are also necessary for the further protection of children from sexual abuse. Elimination of violence in the media and at all levels of society is also a component of social healing.

Social healing is the culmination of individual and community programs. It is the achievement and expression of social values which promote mutuality, respect, and optimal development for all members of society. Child sexual abuse is prevented at this ideal level because children's rights deserve special protection and all persons are encouraged to develop themselves in the context of caring relationships.
CHAPTER ELEVEN: IMPLICATIONS FOR SOCIAL WORK PRACTICE

Social work is a profession committed to the goal of effecting social changes in society and the ways in which individuals develop within their society for the benefit of both. Advancement toward this purpose is achieved through the complementarity of social reform and therapeutic approaches premised in the belief that social conditions of humanity can be bettered.

Preamble to Canadian Association of Social Workers Code of Ethics (1983)

Social work is recognized as a profession that seeks social change by addressing the problems of individuals, their environment, and the interface between the two. The ideas developed in preceding chapters were that child sexual abuse is a pervasive phenomenon; children are frequently traumatized by their victimization; healing services can be effectively offered to survivors, offenders, and family members; and yet individual healing is only one part of the solution. Social attitudes and values must also be changed to prevent further victimization of children. This final chapter will summarize the role of social work in the healing of both individuals and society, identify areas where continued research is needed, and make recommendations for a more integrated and responsive practice.
A. Interface of Social Work and Healing

The nature of social work intervention is based on developmental principles rather than social control. Three different specializations will be highlighted to illustrate that social work mandate encompasses the full spectrum of intervention from individual treatment to social change. Clinical practice, child advocacy, and social development each provide unique but complementary aspects of healing.

Clinical practice.

This area of social work specializes in individual healing. While work may occur in group or family formats, the focus is on empowering each person to become a more healthy individual and more nurturing of both self and others. The treatment issues and principles developed in Chapters Seven to Nine are not exclusive to social work and can be adapted to any clinical programs dealing with the survivors or offenders of child sexual abuse.

Within clinical practice, a history of sexual abuse must be considered as part of routine assessment, particularly when working with young people from high risk populations (Herman & Hirschman, 1981). Clinicians need to prepare themselves to explore this possibility and to
work with the ambivalence of clients around disclosure and resolution, particularly when childhood victimization may be masked by a myriad of other problems or even lost to conscious memory. "Treatment for other disorders is unlikely to be successful until the child sexual abuse experience is identified and open to treatment" (Bagley & Ramsay, 1986).

**Child advocacy.**

An underlying problem is society's ambiguity about the worth of children (Bagley, in press). A comprehensive philosophy of childhood is required, incorporating the belief that children have intrinsic worth as human beings and the right to have their developmental needs nurtured and protected.

Services for children need to address the totality of their needs, from nutrition and health care to intellectual stimulation and emotional security. Child advocacy includes concern and action about a range of issues such as support for families, day care services, educational programs, playground safety, and recreational opportunities as well as basic emotional and financial securities. This list is not meant to be exhaustive but to illustrate the many levels at which the needs of
children are overlooked.

The prevention of child sexual abuse is an important focus within child advocacy concerns. Included are educational programs designed to teach children personal safety, awareness programs to sensitize parents to the possibilities of abuse, and professional development programs to improve services offered by the range of helping agencies. For example, the justice system is often more interested in prosecuting young prostitutes than their adult customers (Conte, 1986). This somehow perpetuates that the young people are at fault while denying that without the adult participation, there would be no exploitation.

Child advocacy means acting on behalf of children who may not yet be developmentally capable of articulating their own needs or whose needs may not be recognized as legitimate by adult society. This includes institutionalized children such as the mentally retarded and physically handicapped (Shore, 1983). It is extremely important to remember that young children do not ask for help; they must be recognized and referred (Calica, 1986; Summit, 1987a, 1987b). Similarly, we cannot wait until children ask the right questions before providing sex education and assertiveness training (Gochros, 1982).
Social development.

Clinical practice and child advocacy both point to the need for social development or political change. Political, in this sense, means change in the public domain as well as the personal; it means changes in the values that shape culture and society.

A helpful perspective for understanding the context of political change is presented by Valentich and Gripton (1984). They suggest that political position is dependent on ideology. Ideology is defined as "a set of ideas and values that provide an integrated and comprehensive view of the world and human nature" (p.449). The differences between conservative, liberal, and radical ideologies are identified for the sake of illustration. Each political stance has its own impact on the development of social service programs and the possibility of social change.

Following this analysis, a conservative ideology maintains traditional values such as family unity and a male-dominated political and economic system. Such an ideology would tend to see child sexual abuse within a systems perspective, with emphasis on the child's role in his or her own abuse. Service to the child would include crisis counselling and therapy to strengthen the family
A liberal ideology leans more towards individual freedom and opportunity; it challenges traditional gender-role stereotypes and promotes full recognition of women's rights in society. Such an ideology would see child sexual abuse in light of gender socialization and social inequality. Services would include both direct treatment and public education programs. Both child and offender are seen as equally victimized by their specific socializations. Educational activities would include professional in-service and multi-disciplinary planning to improve the awareness and responsiveness of all community programs.

A radical ideology, supported by some feminist groups, calls for social action as an end to patriarchy and the oppression of women and children. Child sexual abuse is seen as another expression of women and children's lack of political and economic power. Service would be directed toward consciousness raising by helping women realize their oppression and organizing them to political action. Individual work is seen as a catalyst to social change as the economic and political structures are the true targets of intervention.
It is evident from the concepts developed that changes of a radical nature are a necessary part of social healing. There will be individual casualties who need treatment as long as the causes of child sexual abuse remain. Part of the ongoing social work response is continued attention to all levels of the healing process.

B. Identification of Research Needs

A number of research needs were identified in earlier chapters. Effective management of treatment agencies will always depend on the collection and utilization of comparative information (MacLeod & Wachtel, 1984; Turney & Corwin, 1983). The focus on individual healing raised issues around diagnostic assessment, the difference between abuse and trauma, and the effectiveness of treatment modalities. Larger questions to be addressed include the causality and effects of socialization.

Early authors identified the need for more empirical studies to clarify diagnostic evaluation (Johnston, 1979). Studies are still required to separate the effects of child sexual abuse from those of family background (Brown, 1979; Framuth, 1986) and from other traumas such as physical abuse or extreme neglect which may be happening simultaneously (P. Mrazek, 1983).
Little is known about the etiology of erotic desires and fantasies (Conte, 1982). Attempts are needed to distinguish individual characteristics from personal history and family structures for both offenders and victims (Giles-Sims and Finkelhor, 1984). For example, it is known that the majority of offenders were abused as children; yet not everyone abused as a child becomes an offender. Identification of the dynamics which make the difference would allow earlier screening and intervention with high-risk families. More information is also needed about the adaptations in later life of adolescent perpetrators (D. Mrazek, 1983).

Similarly, not all children who are abused are traumatized. The psychodynamic consequences of unresolved sexual incidents have a variety of implications for adult identification and the development of sexuality (Burgess & Holmstrom, 1975). More needs to be known about the developmental process, for example, how an early assault shapes the formation of adult personality (Herman, 1981a) and whether particular types of victimization lead to specific kinds of problems (Painter, 1986).

The skills and strengths of victimized children whose lives were not negatively affected need to be identified (de Young, 1981). As well, comparative exposure to risk
Factors by victims and non-victims within the same sample will help identify factors of vulnerability (Jones, Gruber, & Timbers, 1981).

More needs to be known about which factors determine whether a young victim will be symptomatic and what the long term effects will be (Mian, Wehrspann, Klajner-Diamond, LeBaron & Winder, 1986). More specific information is needed about the predictors of self-destructive behavior as a survival response (Lindberg & Distad, 1985b) and the relationship between sexual abuse and running away (McCormack et al, 1986).

Methods of crisis resolution need to be identified which are most appropriate for each developmental stage (Elwell, 1979). Testing the effectiveness of treatment modalities is an integral part of any clinical program. Single-subject designs are suggested by Conte (1984a). The advantage of this type of evaluation is that the need for a control group is eliminated. Care must also be taken to ensure that treatment outcomes are not altered by research observations (Coulter, Runyan, Everson, Edelshon, & King, 1985).

The relative effectiveness of treatment programs for male and female children needs to be differentiated (Pierce & Pierce, 1985b). As well, research is required
to determine the effectiveness of groups in comparison with individual treatment (Chandler, 1982) and which modalities suit which types of children (D. Jones, 1986).

Moving beyond individual healing (tertiary prevention) to the education of society (secondary prevention) raises new questions which can also be addressed by research. A major question is regarding the incidence of child sexual abuse: Is this an increasing social phenomenon or not?

The question has been addressed by two major authors. Badgley (1984) found the amount of sexual assault in childhood reported by adults did not vary significantly with the age of the person reporting. On the other hand, Russell (1986) compared reported incidents over ten year intervals and found a significant increase in both intrafamilial and extrafamilial abuse: "Both incestuous abuse before eighteen and extrafamilial child sexual abuse before fourteen have quadrupled between the early 1900s and 1973" (p.81). Clearly, more studies are required to confirm these figures and determine regional and cultural differences.

Russell's (1986) findings regarding the increased vulnerability of step children indicate the need for more work in this area. More information is required about the
numbers of accessible children and their ages in relation to biologic versus step father abuse (Phelan, 1986).

More also needs to be known about the effectiveness of preventative teachings (Conte, Rosen, Saperstein, & Shermack, 1985). Effectiveness includes which types of learning will help the child recognize, resist, or report in a practical situation, and how long concepts are retained (Meikle, Peitchinis & Pearce, 1985; Swan, Press & Briggs, 1985).

At the level of social healing, or primary prevention, more needs to be known about the social causes of stress as factors which contribute to abusive socialization (Gelles, 1973). How children are affected by the exposure to and participation in pornography is another unresolved issue (Pierce, 1984).

Above all, more needs to be known about the nature and consequences of any kind of childhood sexual experience. Studies of abuse may in fact contribute to the pathology by overlooking the affirmation and celebration of health. "We know more about rape than we do about rapture" (Finkelhor, 1980b, p.192). Society must not loose sight of child sexual health.
C. Summary of Theses Presented

Because healing implies restoration, it is important to formulate the healthy ideal toward which movement is directed. All of the discussion about healing has followed from this premise.

The history of child sexual abuse indicates this is not a new phenomenon but one that has been manifest in many different ways in different cultures over time. Services specifically for children, however, have a relatively short history and within that tradition, recognition of the trauma caused by child sexual abuse is even more recent. Much of present awareness can be credited to the consciousness raising movements of women's groups who exposed the violence suffered by women and children within their homes.

Child sexual abuse is defined as any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma (Butler, 1985). The key concepts are that the activity is imposed and that it caused harm. Ethical questions about a child's participation or the extent of trauma must be considered in the context of nurturance toward optimal health.

A survey of prevalence studies confirms that child sexual abuse is a pervasive social phenomenon, with up to
one in two females and one in three males having experienced part of the continuum of abuse. The development of a community model serves to introduce the many components of healing which are outlined in more detail.

Trauma to children is described in the context of victimology to help explain the dynamics by which they become entrapped by abusive activities. The possible effects of being traumatized are varied and can impact all emotional and relationship aspects of a survivor's life. Each aspect of damage needs to be addressed as part of healing so that survivors are free to make new choices about their life, relationships, and sexuality.

Healing for survivors is essentially a process of empowering them to identify, express, and accept the full range of feelings they experienced as a result of their abuse. The abusive history can then be put in perspective as tragic and/or unfortunate but over. Clinicians can facilitate the release of restrictive feelings such as anger, guilt, and fear by non-judgmental caring and acceptance. Survivors may need to relearn developmental tasks such as trust and self-respect within a safe therapeutic environment. Skills of discernment and assertiveness also need to be developed to enable
survivors to have more control over their own lives and decisions.

Treatment for family members includes dealing with the dynamics of intrafamilial abuse, non-offending parents, non-abused siblings, and sexual abuse among siblings. Healing within the family involves a similar process of dealing with feelings and enabling family members to respond to each other more directly and supportively.

Healing of offenders appears more complex as it includes dynamics of addiction, developmental trauma, socialization, and possible biological flaws. These components must all be assessed. Evidence indicates that few offenders voluntarily seek or complete treatment so that effective programs need to work in conjunction with legal authorities. As well, healing of offenders is a process of control rather than cure. They must be empowered to accept responsibility for their own behavior as there are no recognized cures for deviant sexual orientations.

Sexual deviance is defined by culture and change is also needed at this level. Primary prevention of child sexual abuse is possible only through eradication of the root causes. Three components of socialization that
support the deviance of child sexual abuse are power imbalance, sexual objectification, and violence. While a society based on complete respect and mutuality is recognized as an ideal, this is the model of health toward which political change must focus.

The principles of healing encompass all disciplines. Final recommendations will be made within the mandate of social work.

D. Recommendations and Conclusions.

The special orientation of social work provides a unique opportunity to contribute to social healing.

Social work - because of its contact with cases involving the sexual abuse of children and because of its experience in viewing problems as based in the person and in the environment - is in an ideal position to contribute to professional understanding of sexual abuse and of how best to resolve its aftermath. (Conte, 1984b, p.262)

The skills required by social work practitioners to deal with child sexual abuse are not new. What is required is a new sensitivity to the pervasiveness of the problem, to the dynamics of secrecy and socialization, and to the extent of associated trauma. The following recommendations are made in the context of social work practice, although it is understood that many of the implications are inter-disciplinary.
(1) Social work must commit itself to accessing and understanding new information about child sexual abuse. This presentation has attempted to provide the background and emerging trends of current literature, recognizing that because of the information explosion no such review can claim to be complete. It is important, however, to maintain an overall perspective so that new information can be placed in context. Several bibliographies have been compiled to assist readers in search of more specific information (Bagley, 1983a, 1983b, 1985; Dabney, 1983; P. Mrazek, 1983a; Ryan, 1986; Schultz, 1979).

(2) Social work must undertake to provide training, education, and effective supervision to its members regarding the treatment of child sexual abuse (Bergart, 1986). It is important that helpers have sufficient knowledge and skills to be empowered themselves to help those who have been victimized.

(3) Social work must expand its knowledge and skill base sufficiently to provide meaningful and effective advocacy within society (Holmes, 1981). This means clinical intervention skills must be matched with basic knowledge such as civil rights and the interaction of other social systems. Individual freedoms must always be weighed against the actual or potential oppression of
other members of society (Valentich & Berry, 1987).

(4) Social work must take particular responsibility for the protection of children. "We must continue to learn, and to teach, openness to children and sympathetic belief in them" (Butler, 1982, p. 108).

(5) Social work must commit itself to continued research at all levels of causality and treatment, many of which were outlined above. This includes a commitment to act upon recommendations already made, such as those contained in the Badgley Report (Bagley, 1984a, 1986).

(6) Social work must make a strong commitment to all levels of prevention. "The need to effectively treat the hideous results of child sexual abuse is matched only by the need to prevent it" (Nanaimo, 1984, p. 85). This includes the advocacy of political changes if they are needed for the prevention of further abuse to children.

It is important that all persons, lay and professional alike, be sensitized to the trauma of child sexual abuse and motivated to take action toward healing. The words of Kahlil Gibran were used in introduction as a reminder that society is the steward rather than owner of its children. Another of his thoughts, on good and evil, will be used in conclusion:
You are good when you walk to your goal firmly and with bold steps.
Yet you are not evil when you go thither limping.
Even those who limp go not backward.
But you who are strong and swift, see that you do not limp before the lame, deeming it kindness. (1885, p.65)
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