CHILD SEXUAL ABUSE: AN EXPLORATORY STUDY OF PROFESSIONALS' BELIEFS AND ATTITUDES

CYNTHIA J. HICKS

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By

© Cynthia J. Hicks, B.Sc., B.A., B.Ed.

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ABSTRACT

Child sexual abuse has become recognized as a serious problem in today's society. Increased awareness of abuse has led to a rise in the number of reported cases, which has put pressure on already overburdened child-serving agencies/professionals to not only respond effectively to current cases but also to find a way to prevent others from being subjected to such abuse. In an attempt to improve services to victims of abuse and to better utilize current services many communities have begun to focus efforts on developing a more coordinated agency response to the problem. Developing such a response is a very complicated process involving many factors.

This study is aimed at exploring one factor that may influence how well this coordinated interdisciplinary effort works: the presence or absence of shared or compatible philosophical beliefs about causes of sexual abuse and other attitudes and beliefs about the issue of child sexual abuse among the various individuals or agencies involved in responding to the problem. Exploratory interviews were conducted with fifteen individuals representing eight such agencies/professions: school, church, child welfare, police, courts, shelters, mental health, and medical health. Information from these interviews was utilized in conjunction with the current literature and research to construct a survey questionnaire that was distributed to 88 social workers, 100 police officers, and 235 school personnel. The interviews were also subjected to content analysis to provide information relevant to the research questions of the study.

The findings suggest that there is a diversity of beliefs about the causes of child sexual abuse among professionals and that many have formed eclectic views, drawing on

several of the major theoretical perspectives described in the literature. Police officers, social workers and school personnel, as well as males and females, appear to hold significantly different beliefs in many areas related to victims, perpetrators, treatment, and prevention that may cause conflict and misunderstanding in effecting a coordinated response to child sexual abuse. Differences in beliefs and attitudes may be reflected in the low level of satisfaction expressed regarding the response of particular agencies as well. A perceived lack of commitment among policy makers and those who control funding to initiating an effective interdisciplinary response to this problem is the attitude that seems to be creating the greatest amount of frustration and dissatisfaction among the professionals interviewed and surveyed.

Other results point to uncertainty or lack of knowledge concerning several causal and attitudinal components of child sexual abuse. There also appears to be some unfamiliarity with the roles and responsibilities and with the attitudes and beliefs of particular agencies, suggesting limited interaction among them.

These findings suggest that exploration and sharing of beliefs and attitudes among all parts of the system and at all levels of the hierarchy is a necessary process in the development of a truly effective interdisciplinary response to child sexual abuse.

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CHAPTER I - OVERVIEW OF STUDY

Background

In 1984 the report of the Badgley Committee, *Sexual Offenses Against Children* (1984), made it blatantly obvious that child sexual abuse is a problem of gigantic proportions in *every* part of Canada: Child sexual abuse is prevalent in all regions, in all socio-economic classes, in all races and among all religions. This conclusion was drawn from the results of a random National Population Survey conducted by the Badgley committee, which indicated that over half of the females and one third of the males surveyed had been victims of unwanted sexual acts during their lifetime, and that about four in five of these unwanted sexual acts had first been committed against these persons when they were children or youths. The term "unwanted sexual act" as used by Badgley included sexual exposure (19.7% of females; 8.9% of males), threatened sexual assault (10.5% of females; 5% of males), unwanted sexual activity, including kissing and fondling (23.5% of females; 12.5% of males), and attempted or actual anal or vaginal penetration (22.1% of females; 10.6% of males). These categories are not exclusive, meaning that victims could have experienced more than one type of abuse.

Bagley (1989) did an analysis of the results of the National Population Survey including only the last two categories: unwanted touching of sexual areas or attempted or achieved intercourse. This analysis revealed that 17.6% of females and 8.2% of males had experienced such abuse before their seventeenth birthday. According to the National Population Survey (Badgley, 1984), 99% of assailants were male: about one in four was a family member or a person in a position of trust, about half were friends or

acquaintances, and about one in six was a stranger. An Alberta study conducted by Stephens, Grinnell, Thomlison, and Krysik (1991) also found that 98% of perpetrators in reported cases were male, that 47% were individuals in the father role, and that 73% were either related to the victim by blood or legal ties. These Canadian figures are supported by similar research completed in the United States by Russell (1984) and Janus and Janus (1993). Other American studies, depending on their methodology and definition of sexual abuse, have found that between 6 and 62 percent of women and 3 to 9 percent of men were sexually abused as children (Finkelhor, 1989; 1986). Because the data on the prevalence of child sexual abuse are derived from retrospective studies or from documented reported cases the true incidence of child sexual abuse in this country is essentially unknown. However, all indications are that it is a widespread and deep-rooted problem.

One powerful indicator of just how widespread and deep-rooted child sexual abuse is in relation to other types of child mistreatment is found in the Statistics Canada figures released in May, 1991, revealing that one-half of violent crimes against children, other than homicide, were sexual assaults. Again, 98% of those accused of sexual assault against children were men and twice as many girls as boys were victims. Consistent with the Badgley Committee's and Stephens' et al (1991) findings on child sexual abuse in general, in 81% of the sexual assault cases in this report, the child knew the accused.

Another clue to the seriousness of this crime is revealed by statistics on violent crime collected from 13 police departments throughout Canada from 1988 to 1991. These

statistics reveal that "at least 40% of all *reported* [emphasis added] sexual assaults are on children 11 and younger, while another 40% are on young people aged 12 through 19." (p. 6). In 48% of those assaults the assailant was a family member, in 38% a casual acquaintance, and 8% a stranger (Begin, 1992).

As indicated, the above statistics represent only reported cases of child sexual abuse. Despite the fact that child sexual abuse is still vastly under-reported (as few as 2.5% of cases were reported in the Badgley study, depending on the nature of the abuse; and 5% and 12% of cases were reported in the Russell study and Janus Report, respectively), the number of cases reported in the last decade has steadily increased. For example, in Newfoundland for the year 1980-1981 only 18 cases of child sexual abuse were documented by Child Welfare, whereas in 1991-1992, 1407 cases were reported (Department of Social Services Statistics). As a result, and because of the efforts of community groups (Committee to Develop a Provincial Strategy Against Violence, 1993), child sexual abuse has moved into the realm of social and political concern in Newfoundland and the rest of Canada.

The Mount Cashel scandal in 1989 is perhaps the most prominent and dramatic event in Newfoundland that has contributed to the heightened public awareness and to an increased rate of reporting of child sexual abuse and to the fact that it is high on people's agenda in this province. The police in St. John's, Nfld had received reports of Christian Brothers physically and sexually abusing boys at the Mount Cashel Orphanage decades before any serious investigation was conducted and the perpetrators brought to justice in

1989. Reports of child sexual abuse received by Child Welfare almost doubled that year, from 694 cases in 1989-1990 to 1219 the following year. The extensive media coverage and ensuing investigations of the events surrounding the tragic abuse of boys at the Mount Cashel Orphanage shattered "the conspiracy of silence" surrounding the abuse of children in Newfoundland, and revealed that not only are children being sexually and physically abused by the people entrusted with caring for them but that the systems set up to protect children (social services, religious, police, and judicial) can fail miserably when those in charge misuse their political and cultural power to protect abusers rather than their victims. It is painfully obvious what happens when the administrative powers of protective systems collude with perpetrators of sexual abuse to cover up their crimes. The question now is whether these same systems can collaborate to protect the victims to the same degree.

The most prominent and dramatic event in my own life that contributed to my heightened awareness of child sexual abuse was going to work as a support counsellor in a shelter for homeless young women. Within a short time I became aware that more than three-quarters of those young women had been victims of child sexual abuse. Despite this, they were viewed by the general community and parts of the professional community as problem youth: runaway, delinquent, promiscuous, and so forth. The staff at the shelter had encounters with the families of these young women; with the Department of Social Services, with their schools, with the courts, and so on. There were individuals in all of these institutions who understood and supported the young women in their

struggles. But there were many more who did not. There was a high level of frustration among workers about the lack of awareness and about the attitudes and beliefs held about these young women and about the issue of child sexual abuse. It was my responsibility to know about this issue that was so pervasive among the young women at that shelter. It had been my responsibility to be aware of it five years earlier too, as a high school teacher in charge of nurturing and educating the children among whom sexual abuse is such a wide-spread problem. At that time, though, my level of "awareness" was limited to the brief exposure I had to the problem in a psychology course on adolescence. When I went to teach in my small home town, my beliefs were probably very similar to those held by most of the townspeople: That this kind of thing didn't happen in my little town; it only happened in large cities. If it did happen there, well, the perpetrators were men whom everybody knew were "different", "weird", or "strange". I knew nothing about the signs and indicators of child sexual abuse and probably would have been shocked to discover that any of my students were victims of such abuse. I know now that some of them were and there are still others that I wonder about, and whose behaviours I now see in a different light.

During the six months I worked at the shelter I read literature on child sexual abuse, discussed it with other counsellors with reference to the young women at the shelter and got to know the young women living there. I learned much in that time that makes me ashamed of my lack of awareness as a teacher. My responsibility does not end, though, with knowing more about the issue of child sexual abuse. I feel it is also my

responsibility to strive to help end this plague of our society. I hope that this research will contribute in some way. I hope that it will inspire others to educate themselves about the causes, the perpetrators and victims of such abuse. I hope adults will learn to recognize the signs of sexual abuse and that those still in denial will take off their blinders. For those individuals who feel that they have a high level of knowledge and awareness about this problem, I hope that they will explore and examine their own beliefs and attitudes about children and child sexual abuse and about the adults that perpetrate this crime, and that they will share their views so that we can all learn more about the causes and solutions, and move closer to finding the best response to this problem on both the personal and social level.

A major obstacle to addressing the problem of child sexual abuse is overcoming society's denial: denial of its existence and prevalence as well as denial as a defense by perpetrators. Child sexual abuse is a problem that can no longer be dealt with by assuming that it is something that happens somewhere else, to someone else, and that it is committed by "a dirty old man", and should be handled by "others". The problem is so extensive and deep-rooted in this Province (Newfoundland) that Mount Cashel is only the tip of the iceberg. In reality it is so pervasive that, though some children may be at a higher risk than others (Bagley, 1991), *any* child could be a victim, and their abusers live in our neighbourhoods, work with us, eat dinner with us; they are men we love and trust. The chilling fact is that the majority of child victims of sexual abuse are sexually exploited by a family member or by someone outside the family whom they know and

trust. As in the Mount Cashel case, most perpetrators of child sexual abuse are men. What Mount Cashel does not reveal, however, is that, according to current research, the majority of victims are female and that most offenses occur in the victim's home (73% in Stephens et al (1991) study). Child Welfare referrals in Newfoundland for the last five years (1987/88-1991/92) suggest that girls are nearly three times more likely (72%) to be victimized than boys (28%) (Department of Social Services). This is consistent with other Canadian and American research.

A disclosure of child sexual abuse requires the response of several child serving agents: the church and school may be involved in detection; if reported, child welfare personnel are mandated to inquire further; the criminal justice system responds to investigate criminal charges, and to prosecute and defend offenders; medical intervention will often be needed; and mental health workers may be involved to assess and treat victims, offenders, and their families. Lay counsellors, foster parents, and shelter workers may also be involved.

In fact, as the *Federal Response to Searching for Solutions* (1992) indicates, "Each and every Canadian and all sectors of our society have a role to play in putting a stop to child abuse." (p. 2). Thus, child serving agencies have a role to play not only in responding to allegations of child sexual abuse but in educating the rest of society about their role in stopping abuse. Before they can do this effectively they need to explore their own beliefs and attitudes about this problem; about its victims and its perpetrators. They need to explore the reasons they hold the beliefs they do: Are they based on experience?

Research? Ignorance? Child sexual abuse is so extensive and the "consequences for victims and society are so great that large scale attention must be given to this issue, using all possible political, economic, social, and moral will." (Hebert & Wyse, 1990, p. A95).

Statement of the Problem

Much of the literature and research concerning child sexual abuse advocate a collaborative interdisciplinary approach to responding to the problem of child sexual abuse (Attias & Goodwin, 1985; Bagley, 1986; Bander et al, 1982; Burgess & Groth, 1980; Driver, 1989; Eisenberg et al, 1987; Finkelhor, 1984a; Fontana, 1986; Frenken & Van Stolk, 1990; Furniss, 1991; Glaser & Frosh, 1988; Health and Welfare Canada, 1989; Haugaard & Reppucci, 1988; Justice & Justice, 1990; Martin, 1992; McGuire & Grant, 1991; O'Hagan, 1989; Saunders, 1988; Search, 1988; Trute, Adkins, & MacDonald, 1992; Wilk & McCarthy, 1986, etc.). Indeed, developing collaborative intervention models seems to be the trend (Anderson & Mayes, 1982; Baxter, 1986; Boushel & Noakes, 1988; Byles, 1985; Hunter, Yuille, & Harvey, 1990; Kilker, 1989; Kinnon, 1988; Rogers, 1990; Runtz & Corne, 1985; Scott, 1986). According to the training manual for Newfoundland and Labrador Child Welfare practitioners, "effective interdisciplinary co-operation and the timely exchange of information between the various professionals are essential at every stage of the intervention process." (Dickenson, 1989). O'Hagan (1989) and Glaser & Frosh (1988) suggest that such a coordinated approach be developed from a social work perspective with the social worker playing a central role. The major issue for most,

however, is that services be provided in a "coordinated, sensitive fashion" and that in order to do this "interprofessional cooperation is essential."(Rogers, 1990, p. 12). "Coordinated intervention is the ideal goal", according to Kinnon (1988), because it is known "to increase reporting and conviction rates, increase the effectiveness of treatment, and to decrease the trauma of disclosure for survivors." (p. 8).

On the other hand, lack of coordination of services leads to delays and misunderstandings in investigating and laying charges, requiring the victim of child sexual abuse to go through the process of being questioned/interviewed/examined again and again (Crewdson, 1988; Nevin & Roberts, 1990). Crewdson (1988) and Nevin and Roberts (190) report that "It is not unusual for sexual abuse victims to be interviewed dozens of times before the date for the first courtroom appearance finally arrives" (Crewdson, 1989, p. 187), so that "the journey through the criminal justice system can be an ordeal that matches, and sometimes even surpasses, the abuse itself."(p. 186).

This phenomenon likely occurs far too often if Trute, Adkins, & MacDonald (1992) and Gelles (1987) are accurate in their assertions that child protection services tend to operate in a fragmented manner, independent and distrustful of each other, both in diagnosing and treating cases of abuse. Cotter & Kuehnle (1991) also assert that "fragmented and ineffective intervention" continues despite legislation mandating improved coordination between disciplines and the strong public pressures to stop child sexual abuse.

It appears, though, that some progress is being made in developing an

interdisciplinary approach to child sexual abuse in Canada. The Federal Response to *Reaching for Solutions: Report of the Special Advisor on Child Sexual Abuse* (1990) claims that the Child Abuse Initiative and the first Family Violence Initiative carried out by the Federal Government has "fostered action by key professions and improved coordination among the criminal justice, health and social service systems." (p. 2). For example, protocols have been established in many areas policed by the RCMP that improve cooperation between agencies in investigating cases of child sexual abuse. The development of such protocols, according to Salter (1988), is one of the key first steps in developing a cooperative program. Health and Welfare Canada (1989) has attempted to provide consistent procedures for all agencies involved in working together in cases of child sexual abuse: *Child Sexual Abuse: Guidelines for Community Workers, Strengthening Community Response.* Bill C-15, which allows for a videotaped interview with the victim to be admissible as evidence, has improved the process of gathering evidence and laying charges (Rogers, 1990), which alleviates some of the tension between the criminal justice system and other agencies involved in protecting the child. It remains to be seen whether these changes will result in a larger proportion of perpetrators being charged or more cases being brought to trial. A recent Alberta study of 147 perpetrators found that only 37% of them were actually charged. Ninety percent of these perpetrators had a previous history of abuse (physical, sexual, or emotional) with a different victim. However, only 46% of these previous abusers were charged. Attitudes about the frequency of occurrence of the abuse and the type of abusive activity seemed to influence whether or not charges

were laid (Stephens et al. 1991). Thus, along with changes in laws and protocol, must come changes in attitudes.

Steps are also being taken in Newfoundland to coordinate a multi-disciplinary approach. In 1985, in response to requests from community groups recognizing the need for coordination in services to victims of child sexual abuse, the Community Services Council in St. John's, Newfoundland formed a committee (The Working Group on Child Sexual Abuse) to develop an action plan to improve the service system in that city. This Committee, in consultation and collaboration with a variety of community agencies, service providers, institutions, and government departments, examined the status of services and policies relating to child sexual abuse in St. John's. At that time they found "that the most important element lacking in how our community now responds to child sexual abuse is co-ordination of existing services and efforts by community agencies, youth serving groups, educators and government protection workers." (Scott, 1986, p. 4). This lack of coordination began at the disclosure of the crime and led to exacerbating the crisis by repeating interviews, procedures, and examination. The Working Group came to the conclusion that, "current agencies and services involved in responding to individual cases must be required to co-ordinate their initial assessments, investigations, and follow-up case management." (p. 28) and recommended that "appropriate measures be taken to develop coordinated response protocols among service providers who respond to reports of child sexual abuse."(p. 29). Similar recommendations were made regarding other aspects of the system (e.g. education and prevention efforts) (Scott, 1986). In January,

1987 five government departments signed a statement of cooperation in the field of sexual abuse (Working Group on Child Sexual Abuse, 1990).

Three years later, the Working Group on Child Sexual Abuse indicates in *A Guide to Services and Resources* (1990) that police and Child Welfare services now work together in investigating reports/suspicions of child sexual abuse. Morris (1992) indicated in a follow-up study of victims of child abuse that, from the perspective of the Newfoundland Child Protection Unit, there was a good working relationship between them and the police, between them and the Janeway Children's Hospital, and between them and most schools. The existence of several multi-disciplinary child protection teams and committees throughout the Province (e.g. the Janeway Child Protection Team, the Grand Falls Child Abuse Committee, and the Nain Child Welfare Committee) and efforts to develop a policy document which will become a protocol for a coordinated approach to child abuse and neglect (Working Group on Child Sexual Abuse, 1990) also suggest that efforts are being made to coordinate and manage an interdisciplinary response to child sexual abuse cases. Mental health agencies also appear to work closely with other agencies involved in their clients' cases. By 1992 there were indications that the Catholic Church may be ready to participate in an interdisciplinary response to cases involving child sexual abuse as well (*From Pain to Hope: Report from the Ad Hoc Committee on Child Sexual Abuse*, 1992; *Report of the Archdiocesan Implementation Committee*, 1992). In addition, a Multi-agency Committee on Sex Offenders has been organized in St. John's and is currently sponsoring a two year project to develop programs for offenders. The

project will also design interagency protocol for sharing information and design an integrated community based strategy for public education (Committee to Develop a Provincial Strategy Against Violence, 1993). Finally, the Department of Education has recently released a new policy on child abuse that includes suggestions for interagency coordination between the schools and other child serving agencies (Department of Education, 1993).

Despite such efforts, however, a consultation paper released by the Government of Newfoundland and Labrador in April, 1993 stresses that service delivery to victims of violence and abuse greatly needs more coordination among the various agencies and organizations. While it is recognized that professionals in these agencies have begun to talk more to each other and interagency protocols have been developed, the view expressed in this paper is that much more needs to be done to utilize "our scarce financial resources" more effectively and efficiently to create a "comprehensive client-centred approach" that "provides a better quality, more results oriented service to those seeking help."(Committee to Develop a Provincial Strategy Against Violence, 1993).

All of these agencies have the common goal of helping the child cope with the ordeal of child sexual abuse, so why, despite their efforts to do so, do they so often fail to cooperate? Of course there is no simple or easy answer to this question. The reasons are many and complex. But perhaps Finkelhor's (1983) suggestion that "serious philosophical difficulties" divide the professional communities over how sexual abuse cases should be handled sheds some light on one aspect of the problem. Such

philosophical differences can

> cause the organizations to work at cross purposes with one another. This can have severe consequences for the sexually abused child as well as his or her family, rendering treatment ineffective or, at times, even harmful. (Kays, 1990, p. 250)

Other studies (e.g. Craig, Erooga, Morrison, & Shearer, 1989; Kays, 1990; Kelly, 1990; MacFarlane & Bulkey, 1982; Pogge & Stone, 1990; and Saunders, 1988) also indicate that attitudes and philosophical beliefs about the factors contributing to child sexual abuse and treatment of victims are an important underlying factor in the pattern of interaction (isolated versus coordinated) of these agencies in their response to reports/allegations of abuse. Hechler (1988), however, is of the opinion that inexperience and lack of training is likely more responsible for the difference in approaches among agencies than are philosophical differences. It is my contention that the beliefs/attitudes an individual holds in relation to child sexual abuse are influenced and complicated by their training - or lack thereof, as well as by social/public attitudes, governmental/political issues, legal and professional issues, gender and power issues, and by their own personal experiences, feelings and reactions. These issues aside though, there is much disagreement in the literature and practice about theories of causation. The end result is that despite efforts to coordinate an interdisciplinary response, different viewpoints lead to different actions, which may lead to dispute and confusion. Trute et al (1992) point out that:

> It seems that a major element in the creation of such coordinated services is the presence of a shared ideology in which professionals hold in common some beliefs about (a) the factors that contribute to the basic causes of child sexual abuse, (b) how sexual abuse can impact on the well-being of the child (and the child's family), and (c) what might be done to reduce the negative consequences

> of the abusive situation. (p. 365)

Kays (1990) proposes that developing such a shared ideology or philosophy is one of the major tasks in the coordination process:

> They struggle with whether they will try and maintain the family, or only protect the victim; whether there is a difference between a violent and nonviolent offender; whether treatment can be forced. They develop outcome goals that give them hope that their needs can be met, and determine how they will cope with philosophical difference. (p. 256)

This view is echoed by Salter (1988): "For a program to be truly coordinated and effective, staff members must be working from common premises toward common goals."(p. 66). Yet,

> despite movement among the groups within the system to cooperate to minimize system-induced trauma for young vulnerable victims, there remains conflict within and between professionals on how best to proceed in child sexual abuse cases. (Saunders, 1988, p. 89)

Even the differences in the basic philosophies particular to agency role and structure may be inferred by victims, perpetrators and professionals as reflecting different, perhaps conflicting, attitudes and beliefs about child sexual abuse. For example, a father who sexually abused his child may be told by child protective workers that it is best that he admit to having abused the child and accept full responsibility; that the child is the victim. However, if this father is also involved with the justice system, he will likely be advised by his attorney to admit to nothing, and the argument for his defence may even be that it is he who is the victim (Vander Mey & Neff, 1986). How can such conflicts be resolved?

There is a belief by some that professional conflicts can be minimized when

underlying differences in perspective are surfaced and addressed directly, promoting increased understanding of the phenomenon of child sexual abuse for all (Kay, 1990). Such "understanding may help to bridge the gaps between the often different goals and concerns of each group," resulting in more effective services for victims and families (Haugaard & Reppucci, 1988, p. xii). Blagg (1989) cautions though that we must be careful that the aim of improving relationships between agencies does not become an end in itself. In other words, the success of multi-agency initiatives should not be judged on the basis of better relations between agencies/professionals but on whether or not services for victims and their families have improved as a result (Blagg, 1989).

Perhaps an even more important consideration, then, is the evidence found by Kelly (1990), Jackson & Nuttal (1993), Ringwalt & Earp (1988), and others which suggests that despite coordination of services, or lack thereof, professionals' attitudes regarding the impact of sexual abuse, attribution of responsibility, and treatment recommendations affect their responses to child victims of sexual abuse; which, in turn, affect the child's reaction to the abuse experience. For these reasons it is necessary that the attitudes of personnel involved in handling cases of child sexual abuse are explored and understood.

Purpose of the Study and Research Questions

The primary purpose of this study was to explore the perspectives of individuals working in the child care system and to investigate the extent to which the various helping

agents involved with child victims of sexual abuse share similar perspectives about child abuse. Such agents include those working in school, church, child welfare, and police systems, as well as counsellors, psychologists, lawyers, judges, doctors, and others. Specifically, in order to determine whether philosophical similarities exist, the study analyzed the beliefs these agents have about the causes of child sexual abuse and categorized these beliefs in terms of (1) individual pathology explanations, (2) sociological explanations, and (3) structural/political explanations. Subjects' attitudes about child sexual abuse (e.g. seriousness of problem, attribution of blame, most effective treatment, prevention) were also investigated, in order to find key areas of agreement and difference. A third component of this study elicits perspectives on the various children's services, including the roles of each agency; satisfaction with present roles of the subjects' agency and with the roles of other agencies; and satisfaction with protocol involving other agencies.

With this in mind, this study focused on obtaining answers to the following research questions:

1. To what extent do child-serving agents in St. John's, NF share common philosophical beliefs about:
   (a) the causes of child sexual abuse?
   (b) the victims of child sexual abuse?
   (c) the perpetrators of child sexual abuse?
   (d) the treatment of victims of child sexual abuse?

(c) the treatment/punishment of perpetrators of child sexual abuse?

2. To what extent are child serving agents clear about the role they play in stopping and ameliorating abuse?

3. To what extent are child serving agents satisfied with:

   (a) the current response to disclosures of child sexual abuse?

   (b) the role they play in stopping and ameliorating child sexual abuse?

4. To what extent are child care agencies responding to cases of sexual abuse in a cooperative, coordinated manner?

This research was conducted in two phases (Phase I - Exploratory Key Informant Interviews; Phase II - Questionnaire). During Phase I additional issues of interest arose that generated further questions. Thus, research questions were updated after Phase I (exploratory interviews) to include the following:

5. To what extent do child serving agents share common beliefs about:

   (a) non-offending mothers?

   (b) prevention of child sexual abuse?

   (c) the seriousness of child sexual abuse as a crime?

6. To what extent are child serving agents satisfied with the:

   (a) cooperation and coordination of the response to child sexual abuse cases?

   (b) attitudes and beliefs that other agencies/professionals hold regarding child sexual abuse?

7. To what extent do attitudes and beliefs affect interdisciplinary efforts?

Significance of the Study

This study is designed to examine child care professionals' theoretical views and attitudes about child sexual abuse as well as their level of satisfaction with the present response to child sexual abuse. It is recognized that if people do not share the same experiences they will not likely share the same beliefs and attitudes. Thus, what seems to be objective knowledge and reality to one individual/gender/agency is likely only one reality that co-exists with many others. A sharing of these realities is most likely to lead to a fuller understanding. The significance of this study is it's potential value for helping child centred agencies and institutions examine their own beliefs and attitudes, gain an understanding of the position of other professionals and agencies and identify areas of cooperation and conflict in working together, as it applies to effecting a response to the problem that is sensitive to the needs of victims. According to Saunders (1988), "An appreciation of similarities and differences among groups can prove instrumental in facilitating collaborative practice."(p. 84). It is hoped that this work will prove beneficial in helping individuals obtain further insight into their attitudes and beliefs and how their values influence and are influenced by the systems that intervene in sexual abuse cases, and perhaps function as a basis for establishing or modifying protocols between agencies that takes into account the necessary establishment of a mutual understanding and common philosophy regarding the causes, impact and treatment of child sexual abuse.

Although current policy and protocol may call for certain responses and prescribe certain roles, the fact that individuals may act in terms of their own attitudes and beliefs must also be considered in the functioning of an integrated interdisciplinary system. Through the process of exploring beliefs, attitudes and experiences regarding child sexual abuse and through sharing this information professionals and society in general stand a better chance of actually getting to the root of the problem and finding a solution that will end this pervasive social problem.

A decade ago professionals confronted with the issue of child sexual abuse were much like the blind men in the classic story about the elephant that invaded the Valley of the Blind. As happened in Newfoundland, a committee of blind men were commissioned to discover what this beast was. One man, standing at the animal's side, stated that, "the beast is broad and flat and furry." Another, who was studying the tail, insisted that, "it is skinny and slippery." Yet another argued that, "it is round and has a hole in it", upon studying the trunk. The point of the story, obviously, is that they are describing, from their various viewpoints, different aspects of the same thing. And though this elephant is a much less dangerous animal than the beast of child sexual abuse, it is my assertion that we do the same thing in attempting to describe and understand its nature. From our different vantage points we describe different aspects of a phenomenon too enormous to comprehend or encompass all at once. If we can learn to listen to one another, as did the Committee of the Blind, we may get a better picture of the whole monster called child sexual abuse and work together to plan the best way to respond to

it in terms of treatment and prevention.

Brief Overview of Methodology

Data for the study was collected in two phases. **Phase I** consisted of preliminary interviews with fifteen key informants from two categories: Administrative and Frontline workers. Two key informants (one administrator; one frontline worker) were selected from each of the following systems: school, church, child welfare, shelter, police, medical, mental health, and the court.[1] Interviews with the administrators were brief. The purpose of these interviews was to aid in making decisions regarding which systems to include in the second phase of the study.

Interviews with frontline workers were more extensive than those from the first category. The main reason for these interviews was to explore the perspectives of the various individuals interviewed and to explore areas that would be pertinent to the development of a survey questionnaire for Phase II of the study.

In **Phase II** of the study a survey questionnaire was developed and distributed to a sample of 418 subjects in St. John's, Newfoundland: 100 police officers, 83 social workers, and 235 school personnel.

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[1]One interview was conducted with the court system.

Scope and Limitations of the Study

This study deals with professional perspectives on many aspects of child sexual abuse. As with any study, there are limitations with the research. The research was directed at eight agencies/professions with specific focus given to child victims. A local sample was surveyed, all in St. John's, Newfoundland, which may limit the generalizability of these findings.

A major limitation is subject interpretation of questionnaire items. For example, Part C of the Front line Interview Schedule and Part C of the Questionnaire refers to "coordinated and cooperative responses" to child sexual abuse several times. Each respondent was left to interpret what such a response might entail. There is likely great diversity among respondents on this issue.

A primary disadvantage common to self-report surveys is that there can never be certainty as to whether the subjects' responses reflect their true attitudes. Under certain circumstances, for instance, if a belief that is felt to be "unacceptable" then an individual making the judgement may wish to disguise or fail to disclose his or her true attitudes.

Another limitation concerns the sample used. In the social services system all social workers in St. John's were surveyed while only some of the police and school personnel were asked to complete a questionnaire because of the large numbers in the latter two systems. As well, respondents who answered the questionnaire may differ significantly from non-respondents, thereby biasing the sample.

Definition of Terms

Child:

Refers to every human being below the age of sixteen years (as used in Section 49 of the Child Welfare Act in Newfoundland).

Child Sexual Abuse:

This study adopted the definition delineated by the Ontario Association of Professional Social Workers (1985):

"The use of a child for the sexual gratification of an adult, or the allowing of such use of a child by a parent, caretaker, or legal guardian. It includes any manual, oral, or genital sexual contact, or the use of an object for sexual penetration, or other explicitly sexual behaviour that an adult family member or caretaker imposes on a child by exploiting the child's vulnerability and powerlessness. It also includes exploitation of a child for pornographic purposes, including posing children for photographs, alone or with other children or adults, or animals, which are sexual or erotic in content, and/or making them available as prostitutes." (Ontario Association of Professional Social Workers, 1985)

The term child sexual abuse in this study includes both intrafamilial and extrafamilial abuse of children.

Interdisciplinary and Multidisciplinary

The research literature and those in the field use the terms interdisciplinary and multidisciplinary in a variety of ways and often use the two terms interchangeably.

In this study, Interdisciplinary was used to describe the process of interaction between agencies and professional groups. The term Multidisciplinary was used to describe the composition of a group which is includes professionals from more than one discipline.

CHAPTER II - LITERATURE REVIEW/THEORETICAL FRAMEWORK

Theoretical Issues and Concepts

Trute et al (1992) and O'Hagan (1989) recommend that developing a successful interdisciplinary approach to child sexual abuse requires a joint exploration of each agency's philosophy and policy regarding the prevention and treatment of child sexual abuse and the protection of victims. Before this step can be taken, each individual and agency involved must look at their own beliefs about what sexual abuse is and what its causes are, and at the attitudes towards victims and perpetrators of abuse that underlie their policies and practices.

Definition of Child Sexual Abuse

The problem of definition is of critical importance in all social issues, according to Haugaard and Reppucci (1988), "because often problem solutions are determined on the basis of problem definition."(p.14). Unfortunately, however, the term "sexual abuse" does not have a uniform definition. Definitions of what constitutes abuse and the sexual activities included in the definition vary from study to study. Many studies lack an explicitly stated definition entirely while others seem to accommodate their definition to fit their population sample. Of particular relevance to the focus of this study are further assertions made by Haugaard & Reppucci (1988) that:

> Not only do public and professional groups have differing definitions but mental health, legal, and social service professionals frequently differ among themselves; and differences exist within professional groups - for instance, mental health researchers commonly use different definitions when investigating the phenomenon. (p. 13)

> Each of these groups, as well as the general public may have quite different definitions of child sexual abuse, and this can lead to confusion in selecting treatment and making legal decisions about a particular case. (p. 24).
> How one defines child sexual abuse determines which children and children's families will be intervened with by legal and clinical agencies. Information about prevalence influences the extent of the effort that must be made to counteract any negative effects and suggests which children face the greatest risk of being abused. (p. xiv)
> If different professional groups do not have consensual definitions, they should become aware of their differences in order to coordinate their efforts and increase the probability of outcomes that are in the public interest. (p. 29)

Such statements can have chilling implications for victims of child sexual abuse in our society.

A vignette study by Atteberry-Bennett (1987; cited in Haugaard & Reppucci, 1988) involving legal professionals, protective service workers, probation and parole workers, mental health professionals, and a group of parents not in these professions indicated a significant difference between mental health and legal health professionals on their definitions of abuse. For instance, mental health professionals rated almost all vignettes as more abusive than legal professionals.

Despite the observations made above, there are some common areas of agreement in most current definitions of child sexual abuse. The majority focus on the exploitation of a child's innocence, trust, and obedience (Bagley, 1986; Glaser & Frosh, 1988; Milner & Blyth, 1989; Russell, 1984; etc.); but differ on issues such as the inclusion or exclusion of non-contact sexual acts (e.g. exposure); the inclusion or exclusion of peers as perpetrators; the age of the victim; whether or not consent can be given by the child; motivation of the perpetrator; and similarity or difference in intrafamilial and extrafamilial

abuse. These are some of the areas that lead to confusion in coordinating efforts to successfully combat the problem of child sexual abuse.

The following definitions of child sexual abuse indicate the position taken by Canadian federal government agencies and initiatives. Rogers (1990) defines sexual abuse as

> the misuse of power by someone who is in authority over a child for the purposes of exploiting a child for sexual gratification. It includes incest, sexual molestation, sexual assault and the exploitation of the child for pornography or prostitution. (p. 19)

Health and Welfare Canada (1989), in a review of the literature on family violence, provides a more specific definition:

> Sexual abuse is the use of a child for the sexual gratification of an adult, or the allowing of such use of a child by a parent, caretaker, or legal guardian. It includes any manual, oral, or genital sexual contact, or the use of an object for sexual penetration, or other explicitly sexual behaviour that an adult family member or caretaker imposes on a child by exploiting the child's vulnerability and powerlessness. It also includes exploitation of a child for pornographic purposes, including posing children for photographs, alone or with other children or adults, or animals, which are sexual or erotic in content, and/or making them available as child prostitutes. (Ontario Association of Professional Social Workers, 1985)

Based on the earlier observations cited from Haugaard & Reppucci (1988), the logical initial step to ameliorating interagency confusion seems to be to have all agencies adopt an agreed-on definition, such as those above, as the basis for handling particular cases and the whole issue in general. This is what Bagley & Thomlison (1991) had in mind when they suggested that each child protection system (medical, legal and child welfare) adopt the legal definition of sexual assault as specified in Bill C-15 and the Criminal Code. They thought this would help to attain some level of consistency and

facilitate collaboration both within and among these systems. In actuality there are now seventeen sexual offenses in the *Criminal Code* that could apply to child sexual abuse). However, finding a solution is not that simple. A look at just one of the factors that can vary in definitions, motivation of the perpetrator, illustrates the kind of debate that my arise around attempting to adopt a uniform definition. For instance, some agencies/professionals would have a problem with both definitions given above because of the words "sexual gratification". Runtz and Corne (1985) suggest that including these words is "both inaccurate and dangerous" because they suggest that the primary motive behind sexual abuse is sex. These authors are of the opinion (As is Sgroi, 1982; and others) that it is not sexual gratification, "but the desire to dominate and attain power that is the motivating factor behind sexual abuse." (Runtz & Corne, 1985, p. 25). Finkelhor (1984; 1987), however, thinks that, "sexual abuse is indeed very much about sex."(p. 6). His experience has been that, when they are interviewed about the abuse, sexual abusers report that being attracted to their victims' young bodies was a motivating factor. In Finkelhor's opinion, if they were simply motivated by power they would beat up or intimidate the children: If the abuser were expressing a need for affiliation, he would be satisfied with befriending the child. He adds: "I think what we need to say is that sexual abuse has both erotic and non-erotic components to it, and we need to understand both of them." (Finkelhor, 1987, p. 5). Campbell (1988) and Driver (1989) agree: "Sexual abuse is about sex. It is about gender and generations, desire and power," (Campbell, 1988, p. 66). "Those who molest children do so for many reasons, but the immediate and

primary goal is sex." (Driver, 1989). Viewed from this perspective, sexual abuse is not that different from other sexual behaviour:

> Even in sex between husbands and wives, there is always, some desire for a confirmation of your masculinity or femininity, a desire to feel powerful, a desire not to feel lonely or to feel wanted, and there are often times when many other less attractive kinds of non-sexual motivations come into play .... and it so happens that some of these non-sexual motivations are ones that make children of particular interest. (Finkelhor 1987, p.6)

Russell (1986) and Tzeng, Jackson and Karlson (1991) also believe that sexual gratification is a significant factor precipitating sexual abuse of children. La Fontaine (1990) takes this a step further: "If the urge to dominate and control is common to a wide range of sexual behaviour, as it indeed seems to be, then it is arguable that these elements are not merely additional motivations for a sexual act but intrinsic to it." (pp. 198-199).

The issue of sexual motivation has been used as a defence in court cases as well. Some offenders in Newfoundland have argued that there was no sexual intent or attempt at sexual gratification in their actions, and, as a result, were not convicted on charges laid. However, these rulings were later overturned in at least three cases by the Supreme Court of Canada on the grounds that lack of sexual motivation cannot be used to argue that abuse did not take place (Aylward, 1993, Oct 9; Anderson, 1992).

Thus it seems adopting an acceptable uniform definition by various agencies responding to the problem of child sexual abuse demands a careful and in-depth exploration of each agency's beliefs and attitudes about the nature of this problem.

While some struggle over the issue of trying to adopt a common definition of child sexual abuse Haugaard & Reppucci (1988) suggest that this is not the answer at all,

because the victims of child sexual abuse form such a heterogeneous group. Their reaction to the abuse situation may vary depending on such factors as relation to the abuser, severity of abuse and interpretation of the abuse situation. The best way to handle this heterogeneity, these authors say, is "to develop and use regularly a hierarchy of definitions and labels that becomes increasingly specific."(p. 371). O'Hagan (1989) had the same idea when she proposed a categorization system based on the type of abuse, the age and type of child involved, and the seriousness and difficulty of any particular case of abuse. It is my belief that whichever approach is taken requires some serious consideration of these underlying issues.

Causes of Child Sexual Abuse

I suggest that as a point of reference in analysing theories of causation and when developing new theories it is necessary to be aware of the factors that distinguish this type of child abuse from other types (e.g. physical abuse, neglect), as outlined by Craig et al (1989). One notable difference is that many more men than women become perpetrators of child sexual abuse (most studies suggest over 90% are men, e.g, Badgley, 1984; Finkelhor, 1984). Another difference, is that the child's word versus that of the abuser must be relied on more heavily when diagnosing sexual abuse than any other form of abuse. Third, victims of sexual abuse are placed under extreme pressure and/or threats to keep the abuse a secret. A fourth difference concerns the intense emotional reaction to sexual abuse: ".... many people, including professionals, still find discussion about

sexual abuse painful, and are liable therefore to minimize or even suppress its reality." As a result, "sexual abuse forces us to examine issues of gender, power, the place of children, and sexuality" to a much greater extent than do other forms of child abuse and requires different intervention techniques and treatment modalities.(Craig, et al, 1989, p. 60).

Much is yet to be learned about the etiology and dynamics of child sexual abuse and there is no one comprehensive theory to explain why it occurs. However, various theories and explanatory models have been constructed to attempt to explain its occurrence. Each has significant differences in their etiological accounts and strategies for addressing child sexual abuse issues. Theoretical explanations include, among others, the individual pathology explanations, sociological explanations, and structural/ political explanations (Craig et al., 1989; Finkelhor, 1984a, 1986; Glaser & Frosh, 1988; McLeod & Saraga, 1988; Mitchell, 1985; Salter, 1988; Vander Mey & Neff, 1986; Waldby et al., 1989). These represent three different foci for the explanation of abuse.

Individual Pathology Explanations

The individual pathology approaches focus on psychological disturbance or deviance to explain why child sexual abuse occurs. The psychological literature takes the offender's behaviour as its point of focus. The offender's behaviour is described as a reflection of lack of maternal bonding in childhood (Kempe & Kempe, 1984), "uncontrollable urges" (Schonberg, 1990), psychosis, immaturity, lack of conscience, low

intellect, intoxication, pedophilia (regressed versus fixated), "unresolved oedipal complex" (Li, West, & Woodhouse, 1990; Berlin & Krout, 1986; Waterman, 1986), and so forth. Some of the less common individual pathology approaches look for physiological or genetic explanations for child sexual abuse (Li et al, 1990).

The psychiatric literature, influenced largely by Freud's psychoanalytic theory, focuses on characteristics of the victim and the mother as the object of scrutiny in theoretical research, especially in father-daughter incest. Victims are described as being "seductive", as "willing temptresses", or as "willing partners" in the abuse; or they are thought to be lying or fantasizing (Glaser & Frosh, 1988; Li, et al, 1990; Mitchell, 1985; Rush, 1980; Schultz, 1973; Tzeng, Jackson, & Karlson, 1991). The latter explanation is rooted in Freud's psychoanalytic theory, in which he decided that the large number of women who reported sexual abuse by their fathers must have been fantasizing. There is still evidence of Freud's influence in current literature and practice. Schetsky & Green (1988) and Green (1991), for example, while stating that false allegations of sexual abuse are rare, assert that they do occur and may be the result of the child's fantasies or a desire for revenge or retaliation. A St. John's defence lawyer (1987) suggested that a 12 year old girl had fabricated her story about being sexually assaulted by her teacher (his client) to avoid being punished by him. He went on to say that, "It is difficult to believe that... any... teacher would have sexual designs on a child.... For what intention would someone have sexual designs on a child of tender years?" (*The Evening Telegram*, March, 1987). After the convictions of two priests in St. John's in 1989, a number of articles and letters

blaming victims appeared in the press (Archdiocese of St. John's, 1990).

Theories of seduction and active participation by the victim, while accepting that the abuse occurred, often remove all responsibility from the offender: "The majority of pedophiles are harmless individuals and their victims are usually known to be aggressive and seductive children." (Revitch and Weiss; 1962, cited in Glaser & Frosh, 1988). Doctor Benjamin Spock, America's foremost authority on child rearing, cautions boys who baby-sit that "a girl in the three-to-six-year-old period can become very seductive if, for instance, she gets excited in roughhousing." He continues that, "A youth with strong sexual feelings of his own may find it difficult to resist such disarming temptation to sex play, unless he's somewhat prepared." (cited in Rush, 1980). While such views of the child are less popular today, they are by no means absent (Glaser & Frosh, 1988), as indicated by the examples above. In another example, in 1989 a judge in British Columbia blamed a three year old child for exhibiting 'sexually aggressive' behaviour with the child's 33 year old male baby-sitter who had admitted to sexually molesting the child. The baby-sitter was given an 18 month probationary sentence (Kenna, November, 1989).

Maternal collusion is also viewed as a valid explanation of incestuous abuse by psychoanalytic theorists and by family dysfunction theorists (discussed in the section on sociological explanations). It entails blaming mothers for the sexual abuse of their children by the father. At best the mother is blamed for not protecting her child from abuse (Schonberg, 1990): An RCMP sergeant in the Atlantic provinces stated about incest

that, "The mother usually knows it's going on, but somehow can't cope." (Jones, 1984, p. 21). A paper prepared for a 1981 conference on child abuse in St. John's, Newfoundland described mothers of families in which incest occurred, as "quite disturbed" individuals who, "being a rejected child... failed to learn the mother role and that is to protect the child," (McCormack & Crawford, 1981). Psychoanalyst Steven Farmer, author of *Adult Children of Abusive Parents*, suggests that mothers in "incestuous families" are often in "passive agreement" with the "incestuous relationship." And that "at some level she knows what's going on but denies it." (1989, p. 28).

Another common belief, one that has leaked over into media portrayal of mothers is that mothers do not belief their children when they reveal that they are victims of sexual abuse by a family member. This view is often portrayed in movies about child sexual abuse (e.g. *Liar, Liar*, CBC). Contrary to this popular belief, Sirles & Franke (1989) found that the majority of mothers do believe their children. In *When Rabbit Howls*, by The Troops for Truddi Chase (1989), psychiatrist Robert A. Phillips portrays the mother as knowing about the abuse, and accuses her of turning her back on it and retaliating against the child. An even worse scenario is described by professionals who subscribe to the view that the mother orchestrates the whole abuse situation by depriving her husband of sex (Tzeng et al, 1991) and arranging for her daughter to take over her role as wife and lover. According to McCormack & Crawford (1981),

> In many cases, the mother sets up the father/daughter union, by being away from the home at critical times, refusing sex, and encouraging the daughter to be the 'little mother' in the home and 'look after' daddy. (p. 88)

She may do this by being "dependent and infantile" and unable to cope with her responsibilities as wife and mother (Mitchell, 1985). Faller (1986) gives a similar description of the mother's "role" in incestuous relationships. Mitchell (1985) summarizes the various rationales offered for this interpretation:

> She does this either because she identifies with her daughter and is acting out her own Oedipal wishes towards her father, or because she identifies with her husband and acts out her homosexual urges toward their daughter by pushing her husband to commit incest.(pp. 93-94).

Mental illness in the mother is also often used to argue that abuse did *not* occur, especially in cases where separation, divorce, and custody disputes are involved. The mother's accusations are described as delusional or the result of projecting her own sexual fantasies onto the husband and child (Green, 1991). In fact, a study by Ayoub, Grace, Paradise, and Newberger (1991) found that husbands accused of physical and sexual abuse of their children by mothers invariably used the argument that a psychiatric disturbance resulting from their own childhood abuse caused the wives to project accusations of abuse on them. When they don't label them as mentally ill, they accuse them of being vicious, false and vindictive for making such allegations (Caplan & Fassel, 1987). In any case, mothers are blamed instead of the abusing fathers. It seems no matter what mothers do they are blamed. They are either accused of not protecting their children, or attacked for attempting to protect them.

Until recently, most of the literature focused on individual pathology to explain child sexual abuse and to explain false allegations of abuse. This view is still quite popular today according to Tamarack (1986). And, indeed, I had no difficulty finding

examples of such views in the current literature and social practice. Mitchell (1985), MacLeod & Saraga (1988) and others indicate that such beliefs reflect the current prejudices in our society.

The emphasis in intervention and treatment for those operating from the individual pathology perspective - particularly the psychoanalytic approach - is on treating the individual for his or her "disease" or "illness" rather than on the family or society; this approach is often preoccupied with the unconscious in an attempt to promote self-understanding. Therapy is often reflective and is usually conducted with one client at a time in order to protect the client's "curative transference relationship with the analyst." (Vander Mey & Neff, 1986, p. 129). Other approaches include educating the perpetrator in an attempt to create empathy for the victim and help him understand how his behaviour impacts on the victim; social skills training, which attempts to teach the offender how to ask for attention and affection and handle rejection in appropriate ways; and programs that attempt to change and reduce deviant sexual arousal patterns, including behavioral (e.g. aversion therapy) and social learning methods, and biomedical procedures such as psychosurgery, castration, and chemotherapy (Li, et al, 1990; Vander Mey & Neff, 1986). When handled from this perspective sexual abuse cases tend to shift away from criminal charges to psychiatric treatment. The danger in this, according to Viinikka (1989), is that the needs of the offender (for treatment) may be set against the needs of the child (for protection).

There have been many criticisms of the individual pathology approaches. With

regard to perpetrator pathology, for instance, research indicates that perpetrators of child sexual abuse form an extremely heterogeneous group (Glaser & Frosh, 1988), and that "child sexual abuse is far too common to suggest that it is only 'disturbed' or pathological men who abuse." (Macleod & Saraga, 1988, p. 15). It is La Fontaine's (1990) experience that child sexual abuse perpetrators "are not obviously different from other people. The most striking characteristic of the parents of abused children who came to the therapy groups at the hospital was that they were so ordinary." (p. 102). Schonberg (1990) questions the validity of the influence of "uncontrollable urges" by pointing out that sexual abuse of children does not occur in public or at embarrassing moments (e.g. in front of a police officer).

Another criticism is that the psychopathology approaches do not explain why the vast majority of abusers are men. Part of this approach states that the abusers' own experiences of abuse as children have led to their present disturbance and is the reason they abuse. The author of a child sexual abuse training program for social workers in Newfoundland and Labrador is of the opinion that 70% of abusers were directly victimized as children, while another 10% observed the victimization of a sibling or parent (Dickinson, 1989). Since most victims are female this would suggest that most abusers should be *female*; when, in fact, the opposite is true. Such conclusions about psychopathology as those drawn by Dickinson are drawn from studies of convicted offenders who, according to Finkelhor (1984) and Driver & Droisen (1989), are probably not representative of all offenders, but form the most extreme group of offenders.

Finkelhor (1987), Driver and Droisen (1989), and McLeod and Saraga (1987) consider the belief that adults sexually abuse children because they were abused themselves as children to be one of the "new myths" about child sexual abuse; a dangerous misconception not really supported by research. There is a relationship between the two factors that may increase the risk of an abused child becoming an abuser but it does not mean that because one was abused as a child that one will become an abuser (Finkelhor, 1987).

The idea of the seductive or willing child is also criticized because it assumes that children can "consent" to sexual relations. As Ford (1982) says, "consent is a concept which applies only in the relationship of equals." Also, "consent" implies a knowledge of what is being consented to and of what the consequences will be. Children do not have such knowledge and thus cannot willingly tempt or seduce adults into sexual relations with them (Mitchell, 1985).

Criticism of beliefs about collusive mothers also abound because such beliefs seem to be based on the assumptions that women ought to be solely responsible for protecting their children from sexual abuse (Search, 1989), and that the father has the right to a regular sex life and to be "serviced in his own home", if not by the wife, then by the daughter (Mitchell, 1985, p. 94). Despite criticism of victim and maternal collusion beliefs, however, and in spite of the harsh recent criticism of psychoanalytic theory - from whence such views came - as more a quasi-religious cult than a body of proven scientific knowledge" (Li et al, 1990), such social prejudices about women and children are very

difficult to dispel. These beliefs have trickled over into and been kept alive by other etiological explanations of child sexual abuse, the most prominent being family systems explanations.

Sociological Explanations

Sociological explanations define child sexual abuse as a social problem rather than merely a matter of individual deviance. Despite continued wide acceptance of psychopathology beliefs family systems theory became the dominant theory in the 1960's and 1970's and continues to form the basis of much professional practice (e.g. child psychiatry, social work) (Haugaard & Reppucci, 1988; Li et al, 1990; MacLeod & Saraga, 1987, 1988). A national survey of professional practice in 1991 revealed that 49% of professionals considered Family Systems Theory their most important theoretical model (Conte, Fogarty, & Collins, 1991). More specifically, in reviewing the literature on the treatment of child sexual abuse, Waterman (1986b) concluded that "most writers espouse some sort of family systems approach to treatment planning." (p. 197). Barrett, Trepper, and Fish (1990) also identify family therapy as "one of the prime disciplines called on to treat incest families." (p. 152). And "because of the great professional prestige of the family therapists, many of their ideas [about child sexual abuse) have been incorporated into the protective services literature" as well (Vander Mey & Neff 1986, p. 131).

Adherents of family systems theory appear to reject psychoanalytic notions, stating that children do not lie and that the abuser is totally responsible for the abuse. However,

a closer look at this theory exposes a different scenario. Perhaps a more accurate perception of the responsibility attributed to the perpetrator is revealed in the following statement by a well known family therapist: "People always think of the father as an aggressive autocrat, but in many cases, he's like a child.... He has an adolescent romance with his daughter." (Henry Giaretto 1984, cited in Driver & Droisen, 1989). In actuality then, family systems theory views the sexual abuse as only a symptom of an underlying deeper "pathology" within the family system and therefore, the responsibility of all family members (Glaser & Frosh, 1988; James & Nasjleti, 1983; Waldby, 1989). The abuse is viewed as a family problem and the cause of the abuse may be explained as poor marital relationships, poor communication and weak generational boundaries in families. Some of those who are identified with this approach and who have completed research in this area include Cotter & Kuehnle (1991), Furniss (1991), James & Nasjleti (1983); Justice & Justice (1990), Kempe & Kempe (1984), McCarthy (1990), Meiselman (1990), Sabatino (1991), Schetky & Green (1988), and Waterman (1986).

Not surprisingly, the concept of maternal collusion is also given prominence in family systems perspectives in a manner similar to the individual pathology perspectives: "Mothers who do not fulfil their role as "emotional housekeepers" for the family are (covertly) held responsible... for their partners' sexual abuse of children."(Craig et al. 1989). James and Nasjleti (1983) believe that mothers are aware of the sexual abuse of their children and identify four main categories of mothers in "incestuous families": (1) the passive child-woman mother; (2) the intelligent, competent, distant mother; (3) the

rejecting, vindictive mother; and (4) the psychotic or severely retarded mother. Their analysis does not recognize the idea of an innocent mother. Furthermore, from this perspective, mothers are often seen as the "cornerstone" or "controlling force" in incestuous families, setting up and participating in the abuse on an "unconscious" or "preconscious" level (Forward & Buck, 1981, cited in Driver & Droisen, 1989; Gavey, Florence, Pezaro, & Tan 1990; Tzeng et al, 1991). Even a mother's illness or working outside the home are viewed as unconscious attempts to force her husband to turn to his daughter because the wife is unavailable. (Finkelhor 1984a; Glaser & Frosh, 1988; MacLeod & Saraga, 1988; Mitchell, 1985; Waterman, 1986). A recent qualitative study of mother blaming conducted by Carter (1990) concluded that "the feeling of 'being blamed' exemplified for [the mothers interviewed] the treatment they received after their children disclosed."(p. 80).

The therapeutic issue for family systems proponents is dysfunctional family relationships (e.g. cold, distant mother, infantile father, love-starved daughter) and treatment focuses on persuading all family members to accept equal responsibility for family problems and on restoring the husband-wife bond (McCarthy, 1990). The emphasis on re-aligning family roles concentrates on the roles of the mother and daughter (Waldby et al, 1989), and more emphasis is placed on 'normalizing' their relationship than on punishing or rehabilitating the father (O'Hagan, 1989). The sexual component of the abuse is often ignored because it is viewed as only a symptom of the deeper family problem. When it is explored, it is in the context of the mutual needs that are met for all

family members, and the issues of maternal collusion and victim complicity are addressed explicitly (Vander Mey & Neff, 1986; See also Constantine, 1982 and Aponte, 1982, cited in Vander Mey & Neff). The program developed by Hank Giaretto in San Jose. California - and adapted by Anderson and Mayes (1982) for treatment of family sexual abuse in Calgary - is based upon the family dysfunction model. However, this program employs other therapeutic methods in addition to family therapy.

Given the criticisms of the individual pathology approaches, it is not surprising that there is also criticism of the family systems approach to treating child sexual abuse. Even though they see value in this treatment approach, Craig et al (1989) have concerns about using whole family therapy too early in the treatment process because it "risks repeating the abusive dynamics of control, power and secrecy."(p. 76). They have even more reservations about using this approach as a means of reconstructing the family - as is often the case - because it has been their experience that the chance of safe reintegration of perpetrators with their families is very poor (Craig et al, 1989). Driver and Droisen (1989) are even more critical of this approach. They condemn the use of family therapy for the treatment of child sexual abuse as "hypocritical", as the following statement illustrates: "... to blame a woman who unknowingly remains with her husband while he molests her children and yet require her to stand by him, have sex with him, and allow him access to her children when this is sanctioned by professional 'guidance' is plainly illogical."(p. 49).

Other criticisms focus on theoretical aspects of the family systems perspective.

Like the individual pathology explanations, this approach fails to explain why it is men rather than women who respond to the dysfunction by sexually abusing their children. Another limitation is that it explains only one form of child sexual abuse: father-daughter incest. It does not explain abuse by siblings, uncles, grandfathers, and other forms of intrafamilial abuse (Finkelhor, 1984a).

A final criticism focuses on the lack of demonstrated success of using family therapy as a treatment approach for victims of child sexual abuse. According to Bagley (1991), as of 1989, there were no available evaluations of the success of the family systems therapy approach.

In another sociological explanation, Finkelhor (1984, 1986b) proposes a multifactor model to explain sexual abuse based on four underlying factors: **emotional congruence** (why relating sexually to a child is emotionally gratifying to an adult. e.g. sense of power and control); **sexual arousal to children** (e.g. theories about effect of childhood victimization, pornography); **blockage** of adult sources of gratification (e.g. marital problems, negative early sexual experiences); and **disinhibition** of common social constraints (includes theories of poor impulse control, alcohol/drug abuse, stress, and perceived condemnation).

Based on these factors Finkelhor theorizes that four preconditions must exist in order for sexual abuse to occur: The potential offender (1) needs to have some motivation or predisposition to abuse a child sexually (entails the factors of emotional congruence, sexual arousal to children and blockage); (2) has to overcome internal inhibitions against

acting on that motivation (entails disinhibition); (3) has to overcome external impediments to committing sexual abuse; and (4) has to undermine or overcome a child's possible resistance to the sexual abuse. All four of these preconditions must exist in order for the abuse to occur (Finkelhor, 1984a, 1986b). Finkelhor's model does not provide an etiological explanation of child sexual abuse, but provides a useful way to organize possible responses to the problem. For example, currently, most prevention efforts focus on the fourth precondition (the child's own ability to resist). Finkelhor believes a more effective prevention effort would focus on all four preconditions.

Social factors and socio-cultural approaches focus on social factors such as unemployment, poverty, overcrowding, alcoholism, discrimination, and isolation (geographical and social) to explain all abuse and violence in the family, including sexual abuse (MacLeod & Saraga, 1988; Tierney & Corwin, 1983). The problem with these approaches, however, is that they suggest that intrafamilial sexual abuse is restricted to poor working class and minority families. In fact it occurs in all social classes and races (Badgley, 1984; MacLeod & Saraga, 1988).

Structural/Political Interpretations

Feminist perspectives, developed largely from the rape crisis and shelter movements and through the exploration of the personal experiences of victims, have begun to cause a shift in traditional beliefs about the etiology of child sexual abuse. Feminists reject the view of mainstream professionals that women should be held

responsible for their partners' acts, because this belief is based on the sexist assumption that "it is the mother's role to provide sexual satisfaction and shoulder the entire burden of child care and nurturing." (Wattenburg, 1985, p. 208; Craig, Erooga, et al, 1989). Feminists also object to victims being held responsible for their abusers' acts. They do not believe that children have the knowledge necessary to be able to consent to sexual relations with adults or that children lie about being sexually abused. The view of incest as "just another symptom" of family dysfunction is also repudiated by feminists; not only because it removes responsibility from the perpetrator (by giving blame to the family system) and contributes to mother and victim-blaming but because it decriminalizes incest and presents it as just another mental health problem. The message sent to the survivor, the perpetrator, and to society is that it is more acceptable for a man to rape his daughter than any other woman (Barrett et al, 1990; Duggan, 1988; Gavey et al, 1990). Feminists also argue that child sexual abuse happens in normal families, not dysfunctional ones. Moreover the abuser is not deviant or pathological but 'normal' (MacLeod & Saraga, 1988). Thus, men are totally responsible for the abuse they inflict on children.

Such views have contributed to changes in the traditional handling of child sexual abuse cases so that believing the victims' story, supporting the victim, placing responsibility with the perpetrator, prosecuting the perpetrator, and creating awareness of the need for changes in laws and values has been given more emphasis (Finkelhor, 1984a, 1986; Rush, 1980; Russell, 1984; Sgroi, 1982). However, along with these positive changes has come a backlash. For example, Hart and Bartholomew, two attorneys, stated

in the Forward to Wakefield & Underwager's (1988) book, *Accusations of Child Sexual Abuse*, that "the most prevalent myth is that 'children don't lie.'" (p. xiii). They went on to say that false allegations of child sexual abuse are a serious problem. Apparently, three-fifths of the cases they have been involved in over a five year period resulted in a determination of no abuse. They have made the illogical leap that because abuse was not proven that abuse did not occur. They also indicated that others could plant the seed for a false allegation or distortion of the facts. "This experience may create confusion of fact and fantasy, elicit even greater incursions into the realm of fantasy, and train the child to please adults by giving them what they want."(p. xx). They report that custody cases and visitation disputes have a particularly high percentage of false allegations, ignoring the possibility that the discovery of child sexual abuse may have been the reason for such disputes. Wakefield and Underwager reiterated this position themselves a few pages later: "Like some adults, some children lie, exaggerate or fantasize. Some older children try to escape what is for them an unhappy home situation by claiming to be maltreated."(p. 10).

Feminist perspectives explain child sexual abuse in the context of a society structure that consists of class, gender, and race inequalities. Central to their explanation is the role of power - the power that men have over women and children. In contemporary society men as a class dominate women as a class and their gender power is supported by patriarchal dominance within social institutions (e.g,. health, legal, welfare, educational, economic, judicial, religious, and familial systems) and by male

socialization (Berrick & Gilbert, 1991; Birns & Meyer, 1993; Gavey et al, 1990; Keats, 1990; Waldby et al, 1989). "Males are socialized to sexualize power, intimacy and affection, and sometimes hatred and contempt.... [and] to take a 'predatory' approach to sexual gratification." (Tzeng et al, 1991, p. 156). Thus, patriarchy and male socialization sets the stage for the sexual assault of women and children:

> Men, in learning to become men, learn that they have the right to be sexually and emotionally serviced by women; they learn that their power can ensure that this happens, and that in order to feel like a man, they have to feel powerful. Within the family women are relatively powerless in relation to men, and children even more so. "Normal" families therefore offer the opportunity for men to sexually abuse children. (MacLeod & Saraga, 1987).

In patriarchal societies, women and children - daughters especially - are seen as private property. An indicator of this is that daughters are "given away" in marriage to other men, but sons are not. In fact, definitions of power are virtually synonymous with our society's definition of masculinity (Quina & Carlson, 1989): "Men do have sexual power over women, in addition to economic power, both being backed up by capitalism, law and the state."(Seidel, 1982, p. 142). An Ontario study on the experiences of non-offending mothers analyzed views held by key informants in child serving agencies/professions, Child Welfare records and mothers of victims descriptions of their own experiences, all of which pointed to "institutional complicity in defending male power in families."(Carter, 1990, p. 9). Child sexual abuse and other forms of violence against other vulnerable groups "exists and continues because of societal attitudes that tacitly condone the violence and sometimes even blames the victim" in the interest of preserving male patriarchal privileges (Committee to Develop a Provincial Strategy Against Violence, 1993).

> Our society has always endorsed violence (either explicitly or implicitly) and has always accepted women and children as appropriate targets for that violence. It is interesting to note that the problem of sexual abuse was only recognized in this province [Newfoundland] when the victims were male. Reporters giving background on child sexual abuse used to go back to Father Hickey; now they go back to Mount Cashel. The cases involving female survivors are rarely, if ever, mentioned. (Mercer, 1989, p. 6).

Thus, from the feminist perspective, child sexual abuse is not a pathology, but merely patriarchal authority taken to extremes (Search, 1988); an abuse of power that men (individually and collectively) could change if they wanted to (MacLeod & Saraga, 1988).

The view of perpetrators from this perspective is much less sympathetic than that of the individual pathology and family dysfunction perspectives. Abusers are seen as being very skilful manipulators of not only children, but of professionals as well (Driver, 1989):

> Too many who work with sex offenders are as yet unaware of their capacity to abuse the trust even of the professional and to dupe the therapist that one is 'cured' simply by making excuses ... or by parroting the therapist's analysis of one's problems in a flattering manner. "The molester knows that if he sings the right song and dances the right dance, he'll be out a lot quicker" [quoting Devenshire, 1985] .... Often they are either given 'social skills' training or psychotherapy. Both, if given alone, may be useless, or even dangerous .... They may give a man more seductive power to use against children [quoting Ray Wyre, 1986] (Driver, 1989, p. 48).

Ann Burgess, a criminologist who works with sexually abused children in Virginia, USA, has consistently noted a pattern of reactions or strategies that every child sexual abuser follows when he is exposed. Each strategy is an attempt to "throw the professionals off the scent and bring them into a position of supporting the offender, at the expense of the child." (Driver, 1989, p. 120):

1. The first strategy is denial. The offender will feign indignation or shock, or

claim that he has lost his memory, or been 'misunderstood'. These excuses can be utterly convincing and the offender is often knowingly or unknowingly aided in the cover-up by friends and associates.

2. If the offender is forced to admit the offence, he then shifts his tactics to the second strategy - minimization of the evidence. He will minimize the quantity and quality of the assault, trading on our alienated concern with externals - the fact that we will consider certain crimes against a child's body to be less serious than others, basing our judgement purely on anatomy.

3. Given that the child's witness of the assaults has been believed and that his own minimization has failed, the offender now turns to justification. He claims he loves the child or that he was acting under stress. He suggests that his wife would not sleep with him or that he was drunk. Ignorance of the girl's age is also put forward as a justification for abuse. All such excuses amount to victim-blame.

.... In most cases the accusations against the offender will already have failed or foundered before he has to resort to the fourth.

4. This is the 'sick' game. He will claim that he cannot control himself or that he is mentally ill. These are arguments that he is not morally responsible for his action. Pedophile manuals actually advocate them as a last-resort tactic, when all else has failed. At this point the professional may well be duped by the offender's obvious personal disorders, and let him off the hook for his offence. But one must ask oneself, if he is *compos mentis* enough to be so acutely aware of all his psychological problems, then why ever did he not go for help before? Why does his mental health become an important issue for him only when he is afraid of being imprisoned and thus denied access to children whom he was happy to assault before, regardless of his overwhelming mental suffering?

5. The 'sick' game combines effectively with the 'sympathy' game as an escape tactic. The offender's supporters emphasize what a respectable, stable pillar of the community he was, how he fought for his country, etc. The image of a model citizen suddenly having a tragic mental lapse is convincing to many. But for that very reason we must inform ourselves as to why some offenders ensure that they are well liked by their communities, and why they curry favour with the powerful in the first place. It helps them to prepare the ground for their offenses. Too many offenders have a Nice Guy face for us to ignore the phenomenon as accidental.

6. If he is still not believed or supported, the true nature of the offender finally emerges. He has nothing to gain by hiding it. Therefore, he is finally prepared to take the offensive against the professional. Attacks, harassment, threats and bribes are now used not only against the child and family, but also against the

> authorities. It is only at this point that the violence and selfishness at the heart of his crime are visible to all. And, sadly, few offenders are ever exposed at this level. For the vast majority, it would be true to say that the only people who really understand their brutality, their self-centredness, and their powers of manipulation are the children whom they have assaulted (Driver, 1989, p. 120).

In feminist practice "the first goal of intervention is to stop the abuse and to guarantee the safety, protection and treatment of the victim." (Birns & Meyer, 1993). The emphasis is on protecting and empowering both women and children to end and deal with the abuse. Driver (1989) believes that it is essential that therapeutic work with the child be done in the absence of the offender in order for the child to understand that she/he deserves respect in her own right. Children must feel safe in the knowledge that their therapist will never confer with or listen to their abusers so that they can be free to express every feeling towards the offender - including wish for revenge. Apparently, when this is allowed, anger tends to be the major emotion expressed (Driver, 1989).

Truesdell, McNeil, & Deschner wrote in 1986 that "Recent findings suggest that the mother is often the victim herself, a victim of wife abuse." (Cited in Schonberg, 1990). Schonberg (1990) describes mothers of victims of sexual abuse as secondary victims. As a result, the empowerment of women, particularly mothers, is considered essential in preventing and stopping child sexual abuse. Self-help groups for mothers and victims and for adult victims of child sexual abuse are an important component of feminist treatment approaches to provide emotional and moral support and to encourage independence and assertiveness and to emphasize that victims are not "mentally ill" (Runtz & Corne, 1985) and do not have to suffer lifelong devastation (Halliday, 1984).

Participants are not pressured to speak if they do not want to. Many feminists feel that psychoanalytic therapy is not helpful because it isolates the victim and focuses on her own guilt, feelings of inadequacy and emotional problems. Groups bring victims together and give them a common identity and a sense of mutual support (Driver, 1989).

Feminists' attempts at intervention and prevention, however, do not end with teaching children to protect themselves; society and individual perpetrators are targeted as well. Feminists assert that perpetrators need therapy to help them recognize that they made the choice to abuse children and to encourage them to take ownership of the problem and "to resolve the sexual and social problems to which he has subjected victims" (Vander Mey & Neff, 1987). According to Driver & Droisen (1989), "To effect genuine prevention, what we have to teach long-term is not so much how to say 'no' as how to accept it from others."(p. 52). Prevention programs should not only focus on children, but should challenge parental attitudes and behaviours as well (Lake, 1988). Efforts focus on attempts to change the way that masculinity and femininity are socially constructed, on the ways boys and girls are socialized to become men and women and on eradicating the patriarchal family and social structure and replacing it with a family and social structure that "nurtures a child's development of self-love and respect for others." (Birns & Meyer, 1993; Driver & Droisen, 1989). Examples of feminist action in this direction include developing and strengthening anti-sexist programs and sex education programs in school, changing laws and judicial attitudes and practices to end the inequalities of men and women in society and to lessen the dependence of women (MacLeod & Saraga,

1987).

Of the theories described above the feminist perspective seems to most adequately account for the fact that the vast majority of abusers are men and that most of their victims are female children. The abuse of boys is explained in the same way as that of girls, as an abuse of male adult power, and a betrayal of trust (Macleod & Saraga, 1988; Seidel, 1982). Some feminists believe that sex has nothing to do with child sexual abuse (e.g. Runtz & Corne, 1985), while others believe that sex is one of the primary motives (e.g. Driver, 1989; Search, 1988). I personally believe that sexual gratification is an important motivator in the sexual abuse of children although, as in other types of sexual behaviour, other important needs are being met as well; the needs met by the abuse of power being perhaps the most significant. Thus, males are socialized to believe that they must be powerful and in control and patriarchy allows men to abuse those less powerful to feel powerful and in control. However, men must have the desire to abuse a child sexually or have the belief that they have the right to take sexual gratification where ever they can get it in order for the freedom to do so to make any difference. In any case, I do not believe that the sexual issue is one of homosexuality, as the Mount Cashel problem was portrayed in the media and by commission counsel (Keats, 1990).

Although family dysfunction and psychological ideas still dominate professional practice, it is encouraging that there are individuals or groups of women within most agencies who base their practice on feminist beliefs (MacLeod & Saraga, 1987). That feminist approaches are becoming more mainstream is evident in Boushal & Noakes

(1988) description of the development of a feminist policy in a social services department, in O'Hara's (1988) feminist school policy, and in Barrett et al's (1990) "feminist-informed family therapy". In Canada, Rix Rogers' (1990) analysis of sexual abuse as the result of "patriarchal values that allow the more powerful to exploit the less powerful" and that has "placed men in the dominant role and women and children in a subordinate role" (p. 17) is probably reflective of views of the individuals and feminist groups he talked with during his research. Because this view is expressed in a federal report it has the potential to create an even greater shift in institutional and agency beliefs about the causes of child sexual abuse, and in turn, in the treatment and prevention practices of these agencies.

A criticism of the feminist approach is that it attempts to explain a complex problem by simplifying its cause to one or two factors. However, as one feminist points out, merely substituting one theory for another and refusing to evolve any further is not a practical solution to the problem of child sexual abuse. According to her, "feminism itself is useful only in so far as it is synthesized with other approaches to reflect the interests of the people whom it claims to represent." (Driver, 1989, p. 196). Others may be in agreement: Meiselman (1990) indicates that therapists who work with incest survivors tend to take an eclectic approach, utilizing elements from the feminist, psychoanalytical, humanistic/client centred, and cognitive/behavioral-rational emotive schools of therapy.

In any case, it is important to determine what individuals and agencies do believe about the causes of child sexual abuse. The reason for this is stated quite eloquently by

Sarah Nelson (1987). She outlines, from a feminist perspective, why it is essential to analyze and understand personal and agency perspectives regarding the prevention and treatment of sexual abuse:

> ... the first step in designing a programme among social work, medical, legal, and other agencies involves reaching a consensus on what incestuous abuse is about, and how it should be treated. That means agreeing a theory ... decisions on how you deal with each family member depend crucially on how you theorize about them. Is he/she mad, bad, sick or inadequate; blameless, collusive, or responsible for the whole thing? Are we looking at a family pathology, a Freudian spiders' web, a legacy of patriarchy?
>
> Theory decides whether you believe a runaway girl's story and whether or not you send her home. It shapes what you tell a tearful mother who arrives on your doorstep. Should she be more dutiful to her incestuous husband and give up her job and social life, or should she be less obedient and dutiful? It determines the policy you design for the offender: should he be imprisoned, removed from the home, psychoanalysed or helped to repair his marriage? It decides whether or not you intervene at all: is incest just a happy part of that culture, and best left alone?

Practice: Models and Strategies

Societal Roles and Responsibilities in Responding to Child Sexual Abuse

Dealing with the problem of child sexual abuse is one of the most complex and difficult problems facing child serving agents. The scope and complexity of the problem presents a challenge to society not only to respond to actual allegations or suspicions of abuse but also to make every effort possible to stop abuse from occurring in the first place. In order to accomplish either with any degree of success, all individuals and groups in our society must be willing to take their share of the responsibility for eradicating this problem. "To do justice to the problem of child sexual abuse broad-based

ownership is needed by all segments of society." say Hebert and Wyse (1990, p. A95). This means the problem has to be recognized as being true and valid even before victims speak out. It also means "taking responsibility for the problem, beginning with knowledge and understanding of the roots and dynamics of child sexual abuse." (p. A95).

When a case of child sexual abuse is disclosed several professionals may become involved: child protection workers, police, teachers or school counsellors, physicians, crown prosecutors, assessment psychologists or psychiatrists, child care personnel, family therapists, judges, and child advocates. Rather than attempt to make assumptions about the definite and specific roles that each of these agencies/groups (and others) should play, though some are obvious, I will attempt to identify the responsibilities that society is morally obligated to meet and give some indication about who may be mandated or expected to be involved in each aspect of the solution to the problem of child sexual abuse.

Awareness of the Sexual Abuse Problem

Child sexual abuse "persists in part because many persons, including health professionals, are unwilling to consider the reality" of such abuse (Riggs, 1982) and its meaning for victims (Bagley, 1991). Many people are uncomfortable discussing sexuality, and the sexual misuse of children is particularly unspeakable. As already discussed, others view sexual abuse in terms of "sick" or demented people who cannot distinguish fantasy from reality. Others believe it occurs only in isolated cities or that the perpetrator

is a sexual pervert. Or they believe that the victim seduced the parent/adult and he could not help himself. According to Riggs (1982), these are all myths and contribute to society's failure to recognize and successfully respond to child sexual abuse. Even worse they contribute to stigmatizing the victim as well as the perpetrator (Bagley, 1991). I believe all adults in society have a responsibility to be aware of the dynamics and nature of child sexual abuse and, if they work with children, to be familiar with their agency/organization's policy concerning disclosure; "Knowing what the procedure and policy is... can help prevent further stress on the child who is disclosing" (Halliday-Sumner, 1990a). Professionals/agencies who have special expertise in this area and the mass media also have a role to play in promoting awareness among people who may hold such myths and the responsibility to advocate for legislation on all levels for the detection, intervention, treatment and prevention of child sexual abuse. A group of sexual abuse victims discussing this issue all agreed that multiple-mass media awareness campaigns are essential to in order to "promote a more reality-oriented and accepting climate of public opinion, an environment in which children will be empowered to speak out if and when they are being mistreated." (Raychaba, 1991, p. 136). These young people also expressed the view that if we wish to take serious action against this problem public awareness campaigns have to take a "hard" approach focusing on the reality of this social issue. A "soft" approach will not be effective, in their view.

Individuals in authority in each social system/agency are obligated to provide training to ensure that the people working in that system, as well as lay persons and other

professionals, are made aware of the dynamics and seriousness of this problem and of appropriate responses to it. Yet a local study indicates that teachers in at least one Newfoundland school do not feel that they are getting such training, as indicated by the following views of the school's vice principal: "...when it comes to actual disclosures of child abuse, for example, its pretty frightening.... Really we are not trained or equipped to deal with these topics." (Power, 1993, p. 24). Furthermore, recent government cutbacks in funding for education make it likely that many teachers will remain untrained because the result has been fewer in-service opportunities in Newfoundland (Power, 1993). In order to successfully deal with child sexual abuse every individual has to get past the denial ("I can't believe he did that...") and helplessness ("I don't know anything about this; I can't do anything about it") to the stage where everyone is willing to take positive action to protect and nurture children. "We, as Canadians, have to admit *ownership* of child sexual abuse; otherwise, it simply *remains* a terrible crime committed by other people." (Raychaba, 1991, p. 135).

Observation and Detection

A first positive step professionals/adults can take is to become alert to the clues that would indicate sexual abuse and how to respond appropriately. Child victims of sexual abuse disclose an average of six to nine times before someone really hears (Halliday-Sumner, 1990a). The literature suggests that certain professionals have a particular obligation here (e.g., physicians, school nurses, teachers, shelter workers)

because they have wide exposure to children and, often, to their families as well (Brassard, Tyler, & Kehle, 1983; Romano, Casey, & Daro, 1990; Runtz & Corne, 1985). As a result they are potentially in strategic positions to observe the behaviours, reactions and physical condition of children on a regular basis and detect any changes that may indicate sexual abuse. Others may dispute this, arguing that teachers have too many responsibilities and roles to juggle now. However, they cannot deny that it is the role of teachers to identify children with learning problems; abused children are often part of this group (Westcott, 1992). Thus, even if teachers are only concerned with the education of children, they still need to be able to deal with issues that affect the learning of these children. According to Halliday-Sumner (1990a), teachers are often the people to whom children disclose. However, according to Lumsden (1991) and Haase & Kempe (1990) and Wagner (1987), a lack of knowledge and training, as discussed earlier, often prevents teachers and family physicians from recognizing sexual abuse because of the ambiguity of signs and symptoms that may indicate abuse.

Part of the problem with detecting child sexual abuse is that the indicators of such abuse may be indicative of problems other than sexual abuse. Halliday-Sumner (1990) attempts to resolve some of the uncertainty surrounding possible indicators in her article, "Sexual Abuse: The role of the teacher". Her article includes a list of possible indicators as well as the characteristics of normal sex play in children up to 10 years of age. The fear and uncertainty surrounding the recognition of signs of sexual abuse have not been lessened by the fact that teachers, school counsellors, administrators, and doctors in this

province are still not required to take even one course on the topic of child abuse. However, the School of Medicine at Memorial University insists that steps are being taken to rectify this situation in the training of doctors. One step being that first-year students are now given an introductory seminar on child abuse/family violence. The only other step being taken so far has been a compulsory one-day "teaching day" for all medical students on the subject of family violence. The individual that revealed this information hopes that this one-day session will continue to be introduced every couple of years, but there do not seem to be any guarantees. (Faculty Member, School of Medicine, MUN).

Reporting

Again, all adults are obligated, and mandated by law, to report suspicions or disclosures of child sexual abuse. Section 49 of the *Child Welfare Act* in Newfoundland states that

> Every person having information of the abandonment, desertion, physical ill-treatment or need for protection of a child shall report the information to the Director of Child Welfare or a social worker.
> Subsection (1) applies not withstanding that information is confidential or privileged, and no action lies against the informant unless the giving of the information is done maliciously or without reasonable and probable cause.

As already indicated, certain groups of professionals, by the nature of their job, may have greater exposure to the impact of child sexual abuse than others. These include medical, law enforcement, social service, mental health and education professionals/systems. These people have a particular responsibility to report suspicions of abuse. Professionals such as family physicians, pediatricians, teachers and day care

workers, being in strategic positions to detect sexual abuse, presumably have a special obligation to report. However, just as we cannot draw a foregone conclusion that professionals confronted with victims of sexual abuse will be able to identify them, nor can we assume that once suspicion is aroused that those suspicions will be reported to the appropriate authorities. Thirty-six percent of the professionals surveyed by Finkelhor (1984a) failed to report sexual abuse cases. Several factors contribute to decisions not to report, including lack of knowledge about how to identify or report cases, disagreement over the definition, confusion over what constitutes 'reasonable cause' of suspicion, fear of reprisal against the child, lack of faith in child protection intervention (Romano et al, 1990; Fontana, 1986; Gabarino, 1988; Haase & Kempe, 1990; Lumsden, 1991; Wagner, 1987). This last issue is complicated by the distancing of teachers from child protection agencies, accomplished by limiting the role they are required to play in surveillance of child protection areas (Tite, 1994). Other factors contributing to reporting decisions include the reporting philosophy of principals, emotional reactions (denial, fear), concerns about civil or criminal liability (Lumsden, 1991), beliefs that reporting will be harmful and/or that cases can be better handled privately (Wagner, 1987), concerns about effect on rapport with family, concern with interfering with family matters and fear of retaliation by parents (Berrick & Gilbert, 1991; Zellman, 1990). The Ontario Teacher's Federation suggested that reasons for not reporting may include not wanting to shatter their own illusions about "wise and loving" parents, personal child abuse experiences, dislike of the victim, and confusion about appropriate parenting behaviour (Csapo, 1988). Interpretation

of confidentiality rules may also influence decisions to report, especially in the case of priests and therapists (Wells, 1988).

Gabarino (1988) is of the opinion that education, training and legal sanctions are effective ways of dealing with fears about getting involved or tolerance beliefs about the lack of seriousness of the problem, including denial, but the solution to other reporting barriers is to improve child protection system response to reports of child abuse so that those who report will have some assurance that the child will be helped once a report is made.

Irrespective of barriers to reporting, part of the role of individuals who receive disclosures of abuse is to react sensitively, believe the child and let her or him know that she/he is believed, emphasize that the child is not at fault, and acknowledge that the child may have conflicting feelings about reporting. Promises should never be made by the adult that may not be able to be kept. As well, the child must be informed that others will have to be told in order to get help to stop the abuse from occurring. One should also explain to the child who these "others" are and what their roles are, as well as what will happen next. (Csapo, 1988; Halliday-Sumner, 1990a; Rosenzweig, 1984). In order to be able to do this it is necessary to be familiar with agency policy and procedures for reporting.

Investigation/Validation and Protection

In Newfoundland, two social agencies, the Department of Social Services and police departments, hold the mandate and responsibility to investigate reports of child sexual abuse. In St. John's, for example, this includes workers at the Child Protection Unit of Child Welfare (39 workers) and the Sexual Offence Unit of the Royal Newfoundland Constabulary (7 investigators and 1 sergeant). Social workers and police each have different purposes for investigating, however. Police officers are committed to the protection of human rights and to ensuring that society is protected and that justice is done. Thus, their purpose is to collect data to determine whether a crime has been committed. The purpose of the Child Welfare worker's investigation is to determine whether the child is in danger and whether formal action is warranted to protect the child from further abuse (Fontana, 1986; Kays, 1990; Martin, 1992; Pogge & Stone, 1990). Both require evidence of abuse, although to different standards of evidence (Glaser & Frosh, 1988). As well, when investigating incest cases the social worker may experience additional pressure from the conflict between protecting the child and maintaining the family unit (Haase & Kempe, 1990; Martin, 1992). In such cases, protection of the child involves decisions about removing the child or letting her/him remain in the home. Obviously, if the social worker has probable cause to believe that abuse occurred but police feel there is not enough evidence to warrant an arrest, the child may have to be removed, unless the perpetrator agrees to leave the home. If the police do arrest the perpetrator, the child still may not stay in the home. This will be determined by a

number of factors, perhaps most important of which is whether the mother is perceived as being in a position to be supportive of the child (Haase & Kempe, 1990).

Depending on the circumstances, other agencies and individuals may aid in the investigation. When concrete evidence is lacking child protection workers may turn to psychologists, psychiatrists or counsellors to help in determining whether an allegation is valid. These professionals can aid in determining validity by assessing the child's cognitive awareness and psychological status in terms of emotional stability (Choy, 1992).

The medical community also has an important role to play in investigation in the form of medical history evaluations and physical examinations, even though many cases of sexual abuse do not yield physical signs (70-75% of cases do not, according to Sgroi (1982)). The quality of evidence that arises from medical evaluation will depend on several factors. For example, the nature of the abuse and the period of delay between the last abusive incident and the examination. Sgroi (1982) asserts that a medical examination is essential regardless of when the last assault occurred or the nature of the suspected assault. In most cases, an accurate medical history may be the only way to obtain a true picture of the abuse (Collins, 1992). Collins suggests that the child's own pediatrician is usually the best person to help in eliciting an accurate history though trained nurses and social workers can obtain histories as well.

Providing evidence for the police investigation is not the only purpose of the medical investigation. The therapeutic aspect is just as important because many abused children have distorted beliefs about their bodies surrounding sexuality. They may need

to be reassured by a doctor that they are not permanently damaged (McGuire & Grant, 1991).

Obviously, investigating by all three groups requires considerable skill and knowledge not only about the nature and dynamics of sexual abuse and about the nature of child development, but also in terms of particular investigative and examining skills that take the special needs and conceptual views of children into account.

Assessment and Planning

During the course of the investigation professionals should be forming hypotheses about whether the victim or family will need treatment and if so, what should be the focus of that treatment, what would be the best treatment mode and how long will it be needed (Walker, Bonner, & Kaufman, 1988; Haugaard & Reppucci, 1988). The majority of victims of sexual abuse will require some form of treatment in order to repair the damage done by the abuse. However, Driver (1989) cautions that one should not automatically assume that children are permanently damaged by sexual abuse and Haugaard & Reppucci (1988) suggest that the commonly made assumption that all victims will benefit from treatment may be erroneous. On the other hand, one should never assume that a child does not need treatment simply because they do not display overt signs of distress (Vander Mey & Neff, 1986). Various factors need to be considered in determining treatment needs, such as the identity of the perpetrator, the amount and quality of support available to the victim from family and other sources, the presence/absence of physical coercion

during abuse, parental reaction to disclosure, prior mental health of the victim, the length of time over which abuse occurred, and the reasons the victim could not disclose (Cotter and Kuehnle, 1991; Haugaard & Reppucci, 1988). In any case, assessing the child's situation and developing an appropriate treatment plan is a highly specialized process.

Walker et al (1988) and Csapo (1988) recommend that in order to develop an effective treatment plan, or determine whether one is necessary, a comprehensive evaluation of the child's psychological, educational and social functioning is necessary. Glaser & Frosh (1988) suggest that this is the role of social workers. However, Kays (1990) thinks that the social worker, or any one agency, will not have the necessary expertise to perform all assessment and planning tasks. Thus, other professionals and agencies, such as psychologists and counsellors, may need to be involved. Csapo (1988) advocates the use of a list of tests, questionnaires, and so forth, to be administered to the child, parents, and other family members to make up a "multimodal battery" assessment of the consequences of sexual abuse on the child and family.

Treatment

Pogge and Stone (1990) define treatment as "the application of any set of techniques, efforts and skills directed at the improved functioning, enhanced quality of life and general emotional well-being of the patients."(p. 356). Though it is not clear from the available literature which therapeutic approach is best, effective treatment must involve a thorough understanding of the psychological devastation that can result from child

sexual abuse (Cotter and Kuehnle, 1991).

Ideally, treatment begins at disclosure in the form of crisis intervention. At that time professionals work to create an atmosphere of assurance and safety for the child. "*Safety* is crucial in treatment for victims of child sexual abuse", according to one group of young victims (Raychaba, 1991, p. 131). Victims will need to be made aware of what will happen following disclosure and will need continued reassurance at each step of the intervention and treatment process. Important aims of the treatment process should be to "create safety, security and the opportunity to build trust and a new sense of self." (Cotter and Kuehnle, 1991, p. 169).

Although treatment needs and concerns vary for each victim, some treatment issues to be addressed include guilt and responsibility feelings, anger, powerlessness, trust, mixed feelings about the perpetrator, the issue of secrecy, maladaptive behaviours, including sexualized behaviours, self-esteem, self-identity, body integrity and physical safety, ability to set limits, changes in living arrangements, criminal justice involvement, as well as the other developmental problems and issues common to children and adolescents (Cotter and Kuehnle, 1991; Haugaard & Reppucci, 1988; McGuire & Grant, 1991; Salter, 1988; Vander Mey & Neff, 1986; Walker et al, 1988). Having some control and power over their lives is an important issue for many victims. They need to have some say in the development of treatment plans and be allowed to decide when they are ready for treatment. They should not be forced, according to the group of victims that Raychaba (1991) wrote about. Treatment providers usually require specialized training so that in

addition to other concerns, they do not "restrict their focus of intervention exclusively to the sexual interactions and feelings related to sexual exploitation." (Cotter and Kuehnle, 1991, p. 170).

Mental health professionals (psychiatrists, psychologists, social workers, child counsellors, school counsellors, private therapists) are generally recognized as the treatment providers. Unfortunately, even with this diverse group of professionals, most communities lack suitable treatment resources for victims, perpetrators and other family members because of insufficient funding and inefficient use of existing resources (Kays, 1990). Mental health services for children and youth are particularly lacking in Canada (Working Group on Child Mental Health, 1990). Again, an appeal is often made to teachers and school counsellors to help rectify this situation. Westcott (1992) believes that educators should be involved in all aspects of child abuse - remediation, prevention and development - because it is their legal duty, their professional responsibility and their personal obligation in carrying out their work for children. According to him, "A concerted effort by schools to meet the developmental needs of victimized children can contribute significantly to their health and welfare." (p. 115).

Because of the wide range of treatment services often required by victims and their families, where possible, more than one agency will - or perhaps should - probably be involved in the treatment process. Child Welfare may be one of the service providers or may simply coordinate and monitor these services.

Treatment for the victim may vary depending on the effects of the abuse, the age

of the victim, the relationship to the perpetrator, and the nature of the abuse. It will also vary depending on the therapeutic models available and the philosophy of the service providers involved in the case. Treatment for the victim may include individual counselling, family counselling, play therapy, art therapy, group therapy, social skills training, and assertiveness training. Various treatment models for offenders also exist. McFarlane (1983; cited in Cotter and Kuehnle, 1991) breaks down the treatment methods in the following way: (1) 'talking therapies', which include supportive humanistic psychology, gestalt psychology, transactional analysis, and so on; (2) 'concrete therapies', like behaviour modification, sex therapy, and aversion therapy; (3) 'education', including sex education, parenting skills, and anger control: and (4) group therapy for victims, offenders, mothers, and other family members.

Treatment for victims and offenders alike suffer from lack of resources and expertise. An additional factor in decision-making regarding offender treatment programs is the conflict over the usefulness of offender treatment, especially when the offender is denying the abuse. This issue is complicated by the fact that few follow-up studies have been done to determine recidivism rates of offenders after treatment (Bagley, 1991). One must be cognizant of the fact that even though several treatment modes and models for victims and perpetrators have been developed and used regularly, very few have been evaluated empirically to determine their effectiveness (Bagley, 1991; Wagner, 1987; Williams & Hudson, 1991). One program that has been evaluated in Newfoundland is a group therapy program for victims of child sexual abuse (Taylor, 1989). The main

reason for the absence of program evaluation is that most programs are not structured in a way that can be easily evaluated. To remedy this problem, a federal study was conducted in Canada under Health and Welfare Canada to develop a program model that could be used to evaluate existing sexual abuse programs. The model was presented in a special issue of the *Journal of Child and Youth Care* in 1991 (Williams & Hudson, 1991).

Disposition of Criminal Charges

There is debate in the literature and among professionals about the efficacy of involving children in the court process. Many feel that this process is especially traumatic for children because of the nature of the court system and because of the mixed feelings that the victim may have about the perpetrator. Others believe that prosecution is an important step in the therapeutic process for the child and that the real challenge is to improve court proceedings so that the system and the professionals in it take account of the child's feelings (Driver and Droisen, 1989; Fontana, 1986; Harshbarger, 1990; Kays, 1990; Martin, 1992; Saunders, 1988; Wilk & McCarthy, 1986). One group of young sexual abuse victims expressed the opinion that they should not be the ones who have to deal with the stress and responsibility of having to decide whether or not charges should be laid in intrafamilial cases because it leads to further self-blame and victimization. Others should make these decisions (Raychaba, 1991). Complicating this issue are beliefs about the criminal aspects of abuse and whether or not perpetrators should be punished,

treated, or both. Concerns over the effectiveness of punishment without treatment and the use of the justice system to strengthen commitment to treatment as a way to avoid imprisonment are inherent in this debate (Fontana, 1986).

Obviously, the issues of punishment and prosecution become most important to a specific case when it is pursued through the court process. Though many cases do not go through this stage for many reasons (e.g., lack of evidence that will stand up in court; judgements about the victim's ability to testify, etc.), this is a very important role in the overall fight to deal with the social problem of child sexual abuse. Child sexual abuse is a serious crime and should be identified as such. Prosecution of perpetrators will help give that message as well as reinforce the position that sexual abuse will not be tolerated by society (Driver, 1989). According to Harshbarger (1990), all other efforts - treatment, prevention, education - will be ineffective responses to the problem "without the leverage of criminal prosecutions and sanctions" (p. 4). As well, many believe that prosecution is the only sure way to ensure that perpetrators get treatment. Perpetrators, many of whom deny the abuse, rarely enter into treatment voluntarily and the threat of incarceration may motivate them to do so (Driver, 1989; Kays, 1990; Vander Mey & Neff, 1986; Wagner, 1987). However, according to Cotter and Kuehnle (1990), issues of treatment and unsupervised contact with children are often avoided when determining case disposition, often because attorneys and judges do not have the required specialized training in the assessment, disposition, and supervision of cases. They suggest that judges make clear statements about what kind of treatment offenders are to receive and that there should be

a standard order stating that offenders have no unsupervised contact with any children.

Usually the Crown Attorney, along with the police, determines whether there is enough evidence to convict the perpetrator and thus whether the case should be pursued in court. To some degree, this decision is determined by how good a job investigative personnel have done. Crown attorneys are also the people who decide whether the victim is capable of testifying in court and who make recommendations about whether sentencing should be in the form of probation or jail time. "In this respect, prosecutors serve at least implicitly as public policy makers, who interpret or evaluate the law by deciding which crime problems to emphasize." (Mac Murray, 1991, p. 154). Judges play an important role here as well. A group of young sexual abuse victims in Canada expressed the view that, "If child sexual abuse is to be perceived and addressed as a serious social problem, the legal system must take the first step in the form of stronger sentencing." (Raychaba, 1991, p. 130).

If prosecution is going to take place it is essential that the child be prepared for the court process by acquainting him or her with the court surroundings, the roles of various court personnel, swearing an oath, and so on (McGuire & Grant, 1990). This may be done by the crown attorney, the child's counsellor, or by a social worker. It is also recommended that a child have a victims' advocate to follow her or him through the court process.

Monitoring and Follow-up

All agencies/professionals involved with a sexual abuse victim's case should also be involved in monitoring the child's progress throughout the process of case disposition and in providing support and understanding. Again, theoretically teachers and other school personnel may be in the best position to do this because they see the child daily (Haase & Kempe, 1990; McGuire & Grant, 1990). Halliday-Sumner (1990b) cautions that in an attempt to provide support to an abused child, teachers must be careful not to single them out for special attention because this makes them feel different and may invite ridicule and re-victimization from other students. Child Welfare is also responsible for monitoring the child's safety. If the child is receiving counselling, the mental health worker will also play an important role here. Shelter workers and foster parents are in a position to observe the child's progress and be alert to his or her needs if the child and perhaps other family members are staying at a shelter or foster home.

Probation officers, therapists, social workers, and so forth are also responsible for monitoring the perpetrator's contact with the victim to ensure that no unsupervised contact occurs and to take appropriate action if it does (Cotter and Kuehnle, 1991).

Prevention

In a sense, prevention of child sexual abuse encompasses, but is not limited to, all the areas discussed so far. Prevention can occur on three levels: primary, secondary and tertiary. On the primary level, efforts focus on preventing abuse from occurring at all by

providing programs to teach awareness and skills to children, parents and adults, to address a social structure that devalues children and to teach males non-exploitative ways of relating to females (Bagley, 1991). The aim of secondary prevention is early detection of, and intervention with, children who exhibit signs of being abused. Tertiary prevention requires treatment to reduce the effects of the abuse and to prevent further victimization of the victim. (Bagley, 1991; Berrick & Gilbert, 1991).

The secondary and tertiary levels have been discussed under other areas of responsibility, such as awareness of the problem, observation and detection, and treatment. Most of the literature on child sexual abuse focuses on interventions designed to help victims after abuse has been reported. Little research and policy deals with the issue of primary prevention (Bagley, 1991). The current major primary prevention effort is focused on teaching children how to protect themselves. Correspondingly, the school is increasingly being viewed as the appropriate place to implement personal safety programs for children (Trudell & Whatley, 1988). Numerous prevention programs have been developed and implemented in schools across Canada, though many schools still do not include such programs in their curricula. Well known programs include the *Feeling Yes, Feeling No* kit, the *C.A.R.E.* kit, and, in St, John's, the Janeway Children's Hospital's *Streetproofing* program, which is a one-day program. Though there is a lot of support for and belief in the efficacy of such programs, there are also many concerns expressed about their nature, effectiveness and function.

The first problem is that a number of people believe that information of this nature

should not be made available to young children. Some are uncomfortable with the sexual aspects, fearing that information about sexuality will destroy children's innocence or that their first exposure to discussion of sex will be in the negative context of abuse. Others are concerned that children provided with information about child sexual abuse will become fearful and anxious and afraid to trust any adults (Garneau, 1991; Haugaard & Reppucci, 1988; Tutty, 1990). Others think that this information should be taught by parents in the home rather than in the school (Tutty, 1991).

As a result of fears about exposing children to inappropriate sexual information, most prevention programs avoid the issue of sex and sexuality altogether. Children are told about "good" touches and "bad" touches and that people should not touch them in their "private parts" or areas covered by their bathing suits, but children often do not learn the names of these "areas" or the specifics about sexual abuse. Discussion of long-term abuse and abuse by parents is often ignored as well (Garneau, 1991; Haugaard & Reppucci, 1988). This then leads to the concern that children may have difficulty distinguishing between 'good' touches and 'bad' touches. The concern that arises here is that such programs my actually continue the practice of secrecy surrounding sexual issues. It could mean that children do not learn the vocabulary for telling when abuse has occurred. Children may also get the message from these programs that adults do not want to discuss intimate sexual activity and that sex of any kind is negative (Finkelhor, 1986b, 1984b).

These concerns aside, others object to the emphasis on child protection programs

because they feel that too much emphasis is being placed on the child for preventing abuse and that it is unjust to do so. In Melton's (1992) view, "it would be hard to imagine programs to prevent other crimes that could make victim responsibility such a key element and still be politically feasible." (p. 180). According to him, it is not only unfair to place the responsibility for preventing abuse on children, but it is also unrealistic. "One has to be careful when suggesting to a child that personal power exists when in fact it does not." (McGuire & Grant, 1991). "Telling children that they have control over their bodies makes them no more powerful."(Melton, 1992, p. 181). Driver (1989) adds that while it is currently necessary to teach kids to say "no" or to get help, "we should be accepting that abused children have all along been saying "no", whether in words or otherwise, and that many offenders are hardly likely to be intimidated by the mere verbalization of this refusal."(p. 52) Since adults are responsible for sexual abuse, prevention efforts and programs should start with the mind of the potential abuser, not the child (Bagley and Thomlison, 1991; Driver, 1989; Tutty, 1991). The opinion that child-focused prevention programs are over-emphasized is validated by Bagley (1991) and Ferguson & Mendelson (1991) who could not find any literature on the development of programs that focus on the perpetrator or potential perpetrator. Trute et al (1988) and Berrick & Gilbert (1991) are concerned that the emphasis placed on promoting the importance of child-focused programs may be detracting from pursuing other approaches to protecting children. There is currently some focus on adult responsibility, though not nearly enough, through parent awareness and parenting skills programs focused on

parents' behaviours and on teaching them to talk to their children about sexuality and sexual abuse. Proponents of this focus argue that what we need to teach as well is how to accept "no" as an answer from others (Driver, 1989, p. 52).

Apart from the issue of the injustice of focusing prevention efforts on children is the related argument that such a narrow focus constitutes a too simplistic approach to a complex social problem and that "prevention programs in every classroom in every school would not eliminate child sexual abuse." (Trute et al, 1988, p. 105). They can *help*, but they cannot solve the problem. A further concern is that victim-focused prevention programs may not only contribute to victim-blaming, but may reinforce children's tendency to blame themselves should they become a victim of sexual abuse (Trudell et al, 1988).

Those who support Finkelhor's four preconditions model (described above) advocate that prevention efforts should focus on factors related to the motivation to sexually abuse and factors related to the offender's internal inhibitors to abuse (Finkelhor, 1986b; Trudell et al, 1988; Walker et al, 1988). Such efforts, however, are hampered by limited knowledge on the etiology of sexual abuse. Some have recommended taking an approach similar to that taken to combat the problem of drunk driving: by using a media campaign to the convey the message that child sexual abuse is a crime, it is chronic unless one seeks help, it hurts children, and so forth, and by providing a number where individuals can get help (Walker et al, 1988).

Others believe that such a campaign would be ineffective because perpetrators

already know that what they are doing is wrong but do it anyway. These child advocates insist that intervention efforts should also focus on what it is about society that causes such a problem. Suggestions include teaching equality and respect for both sexes and destroying the old stereotypes of appropriate male and female behaviour, including sexual behaviour, in all social institutions. According to Power (1993) in order to promote equality and play a role in reducing male violence against women and children, "current school structures will obviously have to go." (p. 181). After studying this issue in a Catholic school in Newfoundland, Power reached the conclusion that pursuing gender equity "remains an elusive dream" in this school (p. 183). Other social changes that need to be made include banning child pornography, which Canada has now done, and teaching sex education as a regular course for all school children. This course in turn should be "situated within a comprehensive and mandatory health program which allows for the development of specific knowledge and skills about sexual abuse within the context of a normal, healthy development of the child. (Power, 1993, p. 168). Sex education should be integrated into other courses as well. "The most important aim of sex education is to share and make public knowledge, and to discourage any secretiveness or exploitation of privacy." (Driver, 1989, p. 53; McGuire & Grant, 1991; Tutty, 1991). Tutty's (1991) response to this debate is that arguing about the merits of adult protection versus child empowerment programs is counterproductive because both are necessary to prevent sexual abuse.

Another concern about current prevention efforts (namely, child focused programs)

is that many programs do not have the appropriate methodology to evaluate their impact. Attempts have been made recently, however, to evaluate many programs. An example is Hazzard, Webb, Kleemeier, Angert, & Pohl's (1991) evaluation and one year follow-up of the *Feeling Yes, Feeling No* curriculum. This study showed that prevention skills scores were maintained after a one-year period. However, it has not yet been determined whether children can apply such skills if a sexually threatening situation should arise or whether applying them would prevent sexual abuse from occurring (Berrick & Gilbert, 1991; Finkelhor & Strapko, 1992; Haugaard & Reppucci 1988).

Berrick & Gilbert (1991) evaluated the components of many prevention programs and noted that the many abstract and multidimensional concepts used in such programs were beyond children's, especially young children's, cognitive and moral development levels. They assert that the focus on empowerment of children to prevent sexual abuse (which they attribute to the feminist movement) is ineffective for this reason, and suggest that efforts should be made to adapt the programs so that they are more readily understood by children. As an alternative to focused, short-term programs they suggest an approach in which adult responsibility for young children is emphasized (exercised through awareness of abuse indicators and appropriate response) and in which general communication skills are taught along with lessons about body awareness and secret touching as part of the ongoing process of education by classroom teachers.

Westcott (1992) contends that, "Through school-based prevention programs, educators can, in partnership with others in the community, contribute significantly to

reducing the risk of victimization for children and youth." (p. 105). However, Garneau (1991), a school principal, believes that child centred prevention programs cause more harm than good to the child and family and that they should be immediately suspended in all schools. The final word on this issue will be given to victims of child sexual abuse: "We feel that preventive education in schools is crucial and that programs such as the "Safe and Happy Personal Safety Kit" are essential.... Sex education in schools is also essential. It must begin in the earlier grades. The sooner the better." However, they also believe that prevention efforts should not stop there; but that parenting skills and the empowerment of women need to be taught on a much broader level to prevent adults from becoming abusers in the first place. (Raychaba, 1991, pp. 134-35).

Advocacy

In addition to advocating for improvements and legislation in responding to each of the responsibilities addressed above and for improved services for children in general, professionals involved with children and youth need to focus their efforts on improving children's rights and on changing negative views about children that exist in our society. An independent children's advocate can provide extra protection by evaluating the decision made by government agents (Child Welfare League of America/Canada, 1992).

As argued earlier, integration and coordination of efforts in each of these areas is seen by the various sources referred to as vital in order for measures to be effective. In most areas of responsibility more than one agency or group of professionals has a role to

play. Coordination increases the knowledge and skills that each has available, helps avoid duplication of efforts, ensures that some group or government department takes responsibility for coordinating and implementing necessary measures and services, and ensures that professionals are aware of the services available so that they can make appropriate referrals for victims of abuse, perpetrators and families.

Institutional Response to Child Sexual Abuse

Three types of laws address the problem of child sexual abuse in Canada: (1) Child Welfare laws, which mandates Child Welfare workers, as agents of the state, to intervene in families to investigate suspected cases of child sexual abuse; (2) civil laws, which mandate that citizens, especially professionals, are legally responsible to report cases of suspected child abuse to Child Welfare agencies; and (3) criminal laws, which can be used to charge perpetrators for a number of sexual offenses under the *Criminal Code of Canada* (Carter, 1990). If all of these laws were always followed, children would be better protected. But, not all known cases of sexual abuse are reported by professionals; of those reported, not all are investigated; and of those investigated, not all result in charges being laid. These phenomena reflect the beliefs and attitudes agencies and professionals have about children, child sexual abuse, families, prevention and intervention, and the function of various agencies.

A study by Mac Murray (1991) illustrates how agency beliefs and attitudes impact on practice. His study revealed that even establishing uniform policies and legislating

laws regarding child sexual abuse will not ensure consistent practice because beliefs and attitudes can lead to the implementation of these laws/policies in different ways. Mac Murray evaluated the ways in which district attorneys in North and South counties approached the implementation of the Chapter 288 legislation in Massachusetts. This law was legislated in 1983 and required an interface between the Department of Social Services and the jurisdictional district attorney's offices. In particular, the major requirements of the law were "(1) the mandatory referral of serious cases from DSS to the appropriate district attorney within five working days after investigation, and (2) the convening of a multidisciplinary team for each case." (p. 155) Mac Murray found that the district attorney office policies of the two counties were very similar. Both seek to treat child sexual abuse as criminal behaviour. Both approved of the Chapter 288 legislation and viewed it as an important move toward the public recognition of sexual abuse cases. As well, both offices had worked to improve liaison with DSS, and both had protocols or guidelines for systematic handling of cases. However, because the South County prosecutor distrusted diversion and treatment programs, he advocated full prosecution of charges through trial and tended to discourage diversion and plea bargaining. The North County attorney believed that "criminal prosecution may not always be in the child's best interest or that of any of the other parties involved in a case."(p. 160). As a result, he saw alternative dispositions and plea bargaining as appropriate options to going to trial. The beliefs of these two attorneys had a significant effect on case handling and outcomes. Because the South County prosecutor brought all

cases he handled to court, he had a higher standard of evidence for screening a case than the North County prosecutor. This led to more cases being rejected (40% versus 30% for the North County office). As well, because there were no alternatives given to full prosecution, the South County office had a higher rate of acquittal (20% versus 3% for North County office). This study suggests that individuals and professionals need to be aware of the impact that variations in beliefs and attitudes can have on the handling and outcome of cases of child sexual abuse and what this will mean for the victims of such abuse.

Attitudes and Beliefs about Children and Child Victims

In November 1989, Canada co-presented the *United Nations Convention on the Rights of Children.* Upon signing this agreement Canada and the other states were required to comply with the provisions and obligations the Convention contains. Through this Convention Canada has agreed, in Article 24, to recognize the right of the child to the:

> ... enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.... [and] that no child is deprived of his or her right to access to such health care services.

In order to ensure that this right is honoured, Canada has agreed, in Article 19, to:

> ... take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardians or any other person who has the care of the child.

Failing this, Canada is required, in Article 39, to:

> take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which *fosters the health, self-respect and dignity of the child* [emphasis added].

In carrying out this responsibility, Canada agrees to ensure that, in accordance with Article 3,

> In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative or legislative bodies, the best *interests of the child shall be a primary consideration* [emphasis added].

And Article 12,

> the child who is capable of forming his or her own views [be given] *the right to express those views freely in all matters affecting the child* [emphasis added], the views of the child being given due weight in accordance with the age and maturity of the child.

Although these are good intentions we must be aware of how our concept of what "victims" are and how they behave may complicate our reaction to any particular child and lead to some children not being treated with the dignity and respect that they deserve. This has particular relevance to the victims of child sexual abuse. Media coverage of the classically abused child contributes to the development of stereotypes about child victims: Images of "young children appearing with their faces hidden in a dreamlike vision from the world, or the toddler with that tell-tale expression of 'frozen watchfulness'" (Blagg, 1989, p. 16) elicit our sympathy for those lost, fearful victims. When victimologists discuss victims they describe them as passive, inert, completely "good" and "innocent".

However, these images of what victims should be are not necessarily typical of the

sexually abused child. Victimized children, children exposed to suffering and humiliation, especially within their families, feel angry, betrayed and wary. And these feelings quite often result in behaviours that adults view as "bad" and they may condemn not only the behaviour but the child as well. According to Blagg (1989), "The more victimized a child is, the worse, in adult terms, the child behaves."(p. 15) A recent study by Van Gijseghem & Gauthier (1994), for example, suggests that female adolescents with behaviour problems were more likely to have been victims of child sexual abuse than female adolescents without behavioral disorders.

Other victims, instead of exhibiting the stereotypical disengagement from the world and from adults, become over-engaged and attached. They don't seem much like victims. Many don't even seem like children because sexual abuse often destroys the developmental stage of childhood and forces unprepared children into the world of adult sexuality. In an attempt to adapt they act out sexualized behaviour and other behaviours that adults view as "dirty", "nasty", and "bad" and get punished and labelled by these adults because they are "difficult to live with". They are labelled as "sexually precocious", "disruptive", "promiscuous", "delinquent" and are sent off to reform schools and the like to be "straightened out". Such labels and actions serve "to place distance between ourselves and the suffering of child victims" (Blagg, 1989, p. 16), but it does nothing to ease their suffering or promote healing.

Thus, two idealized beliefs about children conflict with the result that the stereotype of the victimized child is overshadowed by the view of child as offender or

delinquent from whom society needs protection. When we see real, living victims we may fail to recognize the suffering because it is exhibited through behaviour that arouses disapproval and dislike. Until recently it has been the concern with controlling delinquents and other problem children which has dominated the political and policy agenda. "They" are the problem and it is "'them' and their behaviour that becomes the focus of intervention, rather than the deeper unhappiness of which this behaviour my be a presenting symptom."(p. 16). Current views that the Young Offenders Act in Canada is too lenient is again bringing this issue into the political arena and there are indications that this Act will again be toughened in the near future. On the other hand, the issue of appropriate treatment and rehabilitation is not even a part of the present Act (Prime Time Magazine, May 12, 1994).

This has tragic implications for the "problem" youth in our society, given the pain and trauma that often underlies their problems. Kelly-Garnett (1989) found that 99% of female adolescents incarcerated in a state institution for felony offenders had been sexually abused as children. Correlational studies show that 50% of the children in a reformatory in Maine and nearly all the children in a Chicago reformatory had been sexually molested prior to commitment. In addition, 70% of adolescent drug addicts and 52-75% of adolescent prostitutes have histories of being sexually abused. Up to 50% of children who run away from home have been sexually abused (Badgley, 1984; Brassard, Tyler, & Kehle, 1983; Csapo, 1988). Two studies showed a particularly high rate for female runaways, 73% and 83.9% (McGregor and Dutton, 1991). As High as these

figures seem, they reflect only the incidence of *sexual abuse* in "problem" youth. Other types of abuse (eg, physical, emotional) were not measured in these studies.

The emphasis on the problem behaviour of these youth can lead to blaming the victim for her or his behaviour and for the abuse itself. In some cases the child may not be considered to be a victim at all because his or her behaviour is interpreted as causing the abuse rather than being the result of abuse. For example, teenagers who are sexually active may be accused of seducing their abusers or of "giving the wrong signals". As a recent study shows, children may be blamed if they do not actively resist or if they encouraged the encounter (Broussard & Wagner, 1988). As long as children are viewed as "a problem in our society" it will be difficult for many to conceptualize the extent to which children and young people are being victimized in a society that promises to protect them. What is needed is more services for street youths, drug users, and so forth, that recognize the underlying problem rather than blaming these victims.

It is essential that we learn to take children and child victimization seriously. To do this we need to accept unconditionally and side with children and change the way we view them and the way we communicate with them. Instead of advising, interpreting and controlling, we need to listen, hear and validate their experiences. We must get rid of the stereotypes of deserving and undeserving victims and meet all victims on the level of their pain and understanding of the problem. This change has to be incorporated into our culture and socialization (Blagg, 1989; Wells, 1989, p. 45). Listening to and hearing the child requires recognition that a child is a person, not an object of concern (Search, 1988).

It also requires understanding the point of view of the child, putting ourselves in the child's place. Successful communication with children means being able to understand the powerlessness they feel, being able to empathize with their trauma, and being able to respect them as human beings (Wells, 1989). For many of us this means facing the scary task of confronting our own childhood experiences and getting in touch with our own child selves (Halliday-Sumner, 1990; Wells, 1989).

> By accepting and coming to terms with the trauma of our experiences, overshadowed by centuries of the misuse of children, we may be able to recognize that our importance as communicators with children is not based on the stuff of theory alone. Survivors of abuse who have been able to talk of their experience, and integrate it, see through the deception of theories that deny them the knowledge of their experience. Through the acknowledgement of their trauma they are empowering us as adults and children, so to speak (Wells, 1989, p. 48).

Professional skills and techniques are important and necessary in order to initiate an effective response to the problem of child sexual abuse. However, we must be aware of the dangerous potential for us to use our professional techniques to distance ourselves from the child victim and to "take over", further disempowering them, we need to put "the child itself and his or her definitions" at the centre of not only the treatment process but at the centre of the enquiry process as well. Sexual abuse "cannot be assessed scientifically but can only be verified through a close relationship with the child." (Blagg, 1989, p. 21).

Thus, it is essential that we keep in mind when designing multidisciplinary and interdisciplinary protocol that coordinating services and creating an interdisciplinary response to child sexual abuse is a waste of time if "we do not at the same time break

down the barriers between ourselves and children" by changing the way we view them and the way that we communicate with them (Blagg, 1989, p. 25).

Immediate and Long-term Effects of Child Sexual Abuse

The immediate physical effects of child sexual abuse may include sexually transmitted disease (in the mouth, vagina or anus), pregnancy, or injuries to the genital and rectal areas. Often, however, there are no physical signs. There is still some debate in the literature over the psychological impact of sexual abuse as exhibited by behavioral indicators. Some argue that effects are minimal, and have been greatly overstated (e.g., Henderson, 1983, cited in De Luca, 1992). Many others, however, believe that it is a very damaging experience for children and results in a variety of negative outcomes (e.g., Bagley, 1986; Finkelhor, 1984a; Glaser & Frosh, 1988; Haugaard & Reppucci, 1988; La Fontaine, 1990; Mandell & Damon, 1989; Mitchell, 1985; Runtz and Corne, 1985; Tamarack, 1986; Walker, Bonner, & Kaufman, 1988). According to La Fontaine (1990), "It is only in rare cases that it can be said not to damage the child in some way."(p. 83). Obviously, the effects are not the same for all children. They are individual and depend on a variety of factors:

- the nature/extent of the abuse,
- the frequency and duration of the abuse,
- the relationship between the victim and the offender,
- the age and developmental level of the child,

- the gender of the child and offender,

- the age difference between child and offender,

- the level of secrecy and dependency,

- the dynamics surrounding disclosure,

- the rewards/reinforcers offered to the child,

- physical sensations versus internal discomfort,

- degree of family/outside support (belief, safety, control),

- degree of responsibility experienced by the child,

- the child's previous background,

- the child's perception of what has happened (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Berliner & Ernest, 1984; Burgess, Groth, Holstrom & Sgroi, 1978; Cotter & Kuehnle, 1991; Haugaard & Reppucci, 1988; McGuire & Grant, 1991; Wachtel & Scott, 1991; Walker, Bonner, & Kaufman, 1988).

The fact is, children and adults can exhibit the entire gamut of behaviours in response to child sexual abuse, ranging from the negative to the "positive". Maladaptive responses may be internalized (e.g. depression, somatic complaints), externalized (e.g. anger, conduct disorders, inappropriate sexual behaviour); and/or cognitive (e.g. shame, helplessness, thought disorders).(Csapo, 1988). Some may not demonstrate any symptomatic behaviours but may still be traumatized by their experiences of abuse (Cotter and Kuehnle, 1991).

Effects on Children

Most victims of child sexual abuse were victimized by someone they know and trust. According to Cotter and Kuehnle (1991) and Finkelhor (1984), the major determinant in the degree of psychological trauma caused to the child is the destruction of trust, although this will vary among victims. The most common reactions reported by the authors cited in this section include shame and guilt; low self-esteem; fear of dark and strangers; delinquency; chronic pattern of inappropriate sexualized behaviour (which may lead to prostitution, teenage pregnancy, future victimization, perpetration by victims); severe testing of limits; poor concentration in school and failing grades (some also work hard to excel in school); sleep disturbances and nightmares; bedwetting; feelings of helplessness and inadequacy; depression and psychosomatic symptoms (e.g. asthma, eczema, abdominal pain, headaches); self-destructive and suicidal gestures, and self-mutilation; substance abuse; unsatisfactory peer relationships; pseudo-maturity; aggressiveness or sexual exploitation of others (due to lack of experience with adequate boundaries or to its us as a defence against helplessness or anger); distrust of adults; doubt, confusion, and worries about normal physiological changes in late latency/early adolescence; truancy; displacement phobias; fear of abandonment or banishment by mothers and society; failure to accomplish normal developmental tasks of childhood and adolescence; and lack of assertiveness (Bagley, 1986; Berliner & Ernest, 1984; Burgess et al, 1987; Cotter & Kuehnle, 1991; Finkelhor, 1984; Glaser & Frosh, 1988; Haugaard & Reppucci, 1988; La Fontaine, 1990; Mitchell, 1985; Wachtel & Scott, 1991). As

discussed previously, many of these reactions result in the victim being viewed as a problem child without insight into the many factors (only one of which is child sexual abuse) that can lead to such problem behaviour.

Effects in Adulthood

Studies show that adults (women are usually the subjects) who have been sexually abused as children are more than twice as likely as other adult women to have serious mental health problems (Bagley, 1991) and are more likely to suffer from sexual dysfunction (e.g., frigidity, sexual identity problems, vaginismus, flashbacks, fear of intimacy, sex guilt and sex anxiety), higher vulnerability to revictimization, depression, self-mutilation, suicide, substance abuse and addiction; anxiety, somatic complaints, sleep disturbances, anger, poor self-esteem, self-hatred; passivity/sense of powerlessness/helplessness, feelings of isolation and stigma, fear of others (particularly men) and interpersonal problems (such as distrust), tendencies to become involved with unworthy men, marital problems, lack of parenting skills; bitterness towards mothers, eating disorders/obesity, self-destructive behaviour; dissociation and multiple personality disorder (Beitchman et al, 1992; Finkelhor, 1984a; Glaser & Frosh, 1988; Herman, 1981; Russell, 1984; La Fontaine, 1990; The Troops for Truddi Chase, 1987; Walker et al, 1988).

In many cases these effects are not conclusively demonstrated by carefully conducted research, but data are accumulating suggesting their significance in the

emotional and social development of victims of child sexual abuse.

Beliefs, Attitudes, and Practices of Agencies/Professionals

Even though attitudes and beliefs can have a significant impact on planning interventions there have been relatively few studies of the philosophical beliefs and practices of the various child-serving agencies and professionals involved in child sexual abuse cases. The results of the studies presented below provide the basis for much of what is known about the perspectives of professionals in this area. Attempts to compare the results of these studies are quite limited because this line of research appears to be quite new, and few studies have been done, with practically no studies replicating earlier work. As well, each study focuses on a different group or groups of professionals, uses different methods of investigation and focuses on attitudes dealing with different aspects of abuse. These limitations make comparison of studies difficult and may be misleading.

One of the earliest studies attempted to assess the attitudes and opinions of child psychiatrists (LaBarbera, Martin, and Dozier, 1980). This study, conducted at a time when some researchers were arguing that many molested girls showed no ill effects, indicated that this group of professionals considered incest psychologically harmful in almost all cases. However, there was little agreement about the nature of short-term effects. Thus, even though intervention was recommended, the type of intervention varied within this sample of child psychiatrists. Interestingly, the psychiatrists in this study viewed the disruptive effects of concerned agencies as fairly harmless.

Research on attitudes and beliefs involving other professionals has focused on the attribution of blame in incest cases rather than views about effects on the victim. A series of studies using the Jackson Incest Blame Scale (JIBS), an adaptation of the Attribution of Rape Blame Scale (Jackson & Sandberg, 1985), found that attorneys and judges (Jackson & Sandberg, 1985), mental health professionals (Jackson & Fischer, 1982, cited in Jackson & Sandberg, 1985), and university students (Jackson & Ferguson, 1983; cited in Jackson & Sandberg, 1985) all attributed most blame to the offender, followed by situational and societal blame, with the victim being blamed least. That attitudes do affect practice was indicated by the finding that attorneys and judges imposed/desired stricter sentences as agreement of offender blame increased.

The psychologists in Wagner, Aucoin and Johnson's (1993) vignette study also attributed most of the blame for abuse situations to the perpetrator. However, the amount of responsibility attributed to the child, though low overall, was influenced by the perpetrator's sex, the child's age, and the child's response, with more responsibility being attributed to older (15 years old versus 11 years old) child victims who were encouraging the perpetrator's actions.

Saunders (1987) also looked at offender culpability and victim culpability, along with other factors, in his study of police officers. Overall, the results of this study indicated that police officers believe children are not responsible for the abuse. However 16% of the sample indicated that children do invite victimization and may play a collaborative role in their abuse. This study also yielded evidence that police officers see

children as credible and that about half of them thought abusers were "sick" while the other half thought they were not. The attorneys and judges in Jackson and Sandberg's (1985) study also tended to believe that offenders have deviant personality characteristics that drive them to incest.

Social workers were the subjects of Ringwalt and Earp's (1988) study of the attribution of responsibility for incest. This study involved vignettes and focused on father, mother, and victim blame. Data on situational and societal blame were not collected. Again, as in the Jackson studies, victim blame was a factor even though perpetrators were assigned the most blame. Mothers were also attributed blame. An earlier survey of 200 child protection workers (Deitz & Craft, 1980) found that even though 80% of them believed that mothers were also victims of the father's abuse, 87% believed that the mother gives at least her unconscious consent to the incestuous relationship, and 65% believed that she is fully as responsible for the relationship as the father. As with the attorneys (Jackson & Sandberg, 1985), the attribution of responsibility affected how social workers responded to ameliorate the abuse situation. The finding that victim blame and mother blame factors do in fact exist among social workers, police officers, attorneys, judges, and mental health workers is important and has significant implications for the treatment of victims, families, and offenders.

Collings and Payne (1991) distinguished between 'causal' and 'moral' responsibility attributed to the victim in surveying 480 psychology students. They found that even though 47.7% attributed some causal responsibility to victims, only 14.6%

attributed some moral responsibility to the victim. In this study the victims' behavioral response in the context of abuse and the victims' age appeared to affect attribution of victim responsibility.

Another meaningful finding to come out of these studies and which became a pervading theme in comparative studies of professional attitudes and beliefs was that a significant gender difference existed in views about child sexual abuse. In the studies by Jackson and his associates, it was found that males blamed victims more than females while females ascribed more blame to the offender than did males.

Conte, Fogarty, and Collins (1991) in a survey of 276 professionals focused their attention on a wider range of attitudes and knowledge about etiology and treatment of sexual abuse, paying little attention to blame factors. Some of the significant findings of this study include the finding that 40% of professionals believe that child sexual abusers have a "typical psychological profile" even though the empirical literature fails to identify such a profile. Half of the respondents indicated a belief that sexual offenders are either "regressed or fixated" pedophiles. Sixty-five percent of respondents believe that almost all abusers were abused themselves as children; fifty-nine percent believe that mothers of incest victims should apologize to their daughters for failing to protect them; sixty-eight percent believe incest is a problem with origins in family relationships; and 27% believe that incest is a problem with origins in the individual psychopathology of mothers, daughters, and fathers.

Comparison of Professional Beliefs and Attitudes

Despite the emphasis on a multidisciplinary coordination of response to child sexual abuse and the importance given to the role philosophical beliefs and attitudes play in successfully establishing such a response, there are few studies that systematically compare the views of various professionals.

Finkelhor's (1984a) study of 790 professionals (from social work, psychology, medicine, law, education, nursing, and law enforcement) attending conferences and meetings on child sexual abuse found that much disagreement exists among professionals regarding how child sexual abuse cases should be handled. His analysis showed that the agency individuals worked for was a more powerful predictor of attitudes and behaviour than their professional affiliation. Workers from different agencies showed distinctly different patterns and different preferences in the interventions they chose, especially with regard to whether or not charges should be laid, whether or not the perpetrator should be removed from the home and whether or not the family should be kept together. These preferences seemed to be influenced by whether child sexual abuse was seen as a crime or illness, or a form of family dysfunction. Finkelhor suggests that the lack of consensus on goals may make it difficult to develop uniform interagency procedures for dealing with child sexual abuse.

Conversely, Attias and Goodwin (1985), using a vignette questionnaire, found no significant differences among the responses of 108 psychiatrists, psychologists, pediatricians, and family counsellors. However, as seen in some of the studies of single

professions above, significant differences were found in male and female respondents. Women tended to view incest as a more serious and prevalent problem and were more likely to recommend referral to child protective services and a physical examination. As well, more men underestimated the frequency of father-daughter incest and overestimated the percentage of children who report fantasies rather than real occurrences of incest. Of particular importance was the number of subjects who overestimated the percentage of children who are recounting fantasy when they disclose incest. Psychiatrists overestimated more frequently (a function of gender rather than profession, as indicated). Forty percent of psychiatrists, most of whom were male, estimated that 25% or more of children's accusations are fantasies. Moreover, if a child retracted her allegations, more than half the psychiatrists and less than one third of the other disciplines would choose not to refer the family to child protective services. More than half of the subjects surveyed viewed families in which incest occurred as dysfunctional and socially isolated with marital problems, while twenty-nine percent thought that such abuse occurred in "normal", typical families.

Jackson and Nuttal (1993) surveyed a similar group of professionals: clinical social workers, pediatricians, psychiatrists, and psychologists. The larger sample (656 subjects) suggests a greater reliability in results. A great deal of variability of responses resulted from this sample, indicating huge differences of opinion among clinicians about how to handle disclosures of child sexual abuse. For each vignette (total of 16) clinician credibility ratings ranged from being very certain that sexual abuse had occurred to being

very certain that sexual abuse had not occurred. Several factors affected this variability including discipline and theoretical orientation. Social workers were more likely to view allegations of sexual abuse as credible than their colleagues from other disciplines. Subjects with a family systems orientation were also more credulous. As in the Attias and Goodwin (1985) study, gender was a significant variable: Females rated the vignettes as more credible than did males.

Eisenberg, Owens, and Dewey's (1987) survey of health visitors, nurses, and medical students also revealed important information about the attitudes of health professionals. These professionals gave more significance to cases involving intercourse and felt these cases caused more harm and should result in more punitive treatment. Health visitors and nurses tended to recommend family therapy. Attitudes were found to vary based on gender and experience in the field.

Significant differences were also found in the attitudes of 132 child welfare workers, police officers, district attorneys, public defenders, and judges in Saunders' (1988) study regarding victim credibility, victim culpability, offender culpability and crime and punishment. Statistically significant differences were found among the groups regarding the credibility of the victim, with district attorneys finding them most credible, followed by social workers. Public defenders found children least credible. No attempt was made in this study to determine which groups were statistically different from each other (i.e., no t-test analyses were carried out). There were no significant differences among the groups regarding victim and offender culpability. Most tended to hold the

offender responsible and not blame the victim. Most also viewed sexual abuse as a serious crime. Yet there was a significant difference found on the punishment scale: Public defenders were least likely to recommend punishment, with social workers only a little more likely to do so. Police officers were the most punitive-oriented, followed by judges.

Victim credibility was also the focus of Kendall-Tackett's (1991) study, along with the issue of false allegations. The mental health and law enforcement professionals in her sample perceived children as rarely making false allegations about abuse. Although there was no difference between the two professions' perceptions of false allegations of children under 10 years old, they appeared to be differentially affected by the 10-12 year olds. Mental health professionals reported a significantly higher percentage of false allegations in this age group than did law enforcement professionals. Consistent with other studies, women reported a smaller percentage of false allegations than men.

Wilk and McCarthy (1986), in a rural study of the attitudes of police officers, protective service workers, and mental health workers also found differences among professional groups. However, unlike Saunders (1988), they carried out t-tests to determine which groups were significantly different from each other. They found that police officers more frequently favoured arrest of the father, and, sometimes, the mother and tended to recommend court intervention and incarceration more often than mental health workers and child protective workers. While police officers tended to view perpetrators as criminals, child welfare workers and mental health professionals viewed

them as mentally ill. Police officers were less likely to allow the child to remain in the home, while child welfare and mental health workers tended to believe the child should remain in the home. Mental health workers tended to fall between the other two groups. They did not focus on punitive measures as much as the police officers, but were less likely than child welfare workers to recommend mental health solutions alone. Consistent with these finding, Craft and Clarkson (1985) found that social workers recommended court action less frequently than attorneys.

Similarly, Kelly (1990) found that police officers recommend more severe punishment than do nurses or child protective workers. More severe punishment was recommended by all groups when physical force was used and/or when the victim was female.

Kelly (1990) also solicited views related to attribution of responsibility. Although the offender was held mainly responsible for the abuse, only 12% of subjects held him/her entirely responsible for the abuse. Eighty-four percent of subjects assigned some responsibility to the mother (mean of 18.7% of responsibility). A small proportion of responsibility (mean = 3.7%) was also attributed to the child by 20% of the subjects. Society was attributed 6.1% of responsibility. Police officers tended to attribute more responsibility to the offender than child protective workers and nurses. Nurses attributed more responsibility to mothers than did the other two groups. Child protective workers and nurses assigned more responsibility to society than did police officers. As well, teachers were found to attribute more blame to victims than did social workers in a study

by Johnson, Owens, Dewey, and Eisenberg (1990).

A more recent questionnaire study of 101 mental health professionals conducted by Reidy and Hochstadt (1993) also found that most subjects attributed the majority of the blame to the father. The mother was assigned about 10% of the blame and the daughter was not blamed at all. Psychologists and psychiatrists tended to blame situational factors more than social workers and counsellors. Gender differences were noted in this study as well.

Trute, Atkins, and MacDonald (1992) surveyed the philosophical beliefs of police, child welfare workers, and community mental health staff in a rural community in Canada. They developed a 14-item scale measuring three factors: severity and seriousness, treatment versus punishment, and perpetrator identity. The "severity and seriousness" factor measured the extent to which child serving agencies viewed child sexual abuse to be a serious social problem. Their results suggest that child welfare workers viewed child sexual abuse as being more extensive and having a more serious impact on the victim than did police officers. However, this difference lost its significance when adjustments were made for gender.

The "treatment versus punishment" factor measured beliefs regarding the most effective intervention to ameliorate and reduce child sexual abuse. Police officers tended to focus more on punishment and saw treatment as less effective, whereas child welfare workers and mental health workers gave more importance to treatment.

The "perpetrator identity" factor measured beliefs about whether child sexual abuse

is rare and caused by deviant individuals. Child welfare workers were more likely than police to indicate that child abuse occurs in many different types of families and that perpetrators make up a heterogeneous group.

This study, like many described above, found gender to be an important indicator of attitude toward child sexual abuse. Women were more likely to see treatment as an effective deterrent, and more likely to see perpetrators and families as being not significantly different from the general population.

The results of this study suggested that even though the differences described were statistically significant, there was an overall similarity of views about the widespread occurrence of child sexual abuse, about the serious effects this has on children and their families, and that more subtle intrusions on a child (such as pornography or acts of fondling) constitute sexual abuse. The greatest disparity in views pertains to the punishment versus treatment issue. The differences in beliefs about what should be done about perpetrators may cause conflict between professionals investigating child sexual abuse cases.

In conclusion, it seems rather obvious that attitudes and beliefs held by various child serving professionals do impact on their response to allegations of abuse, to its victims, and to its perpetrators. This in turn may lead to disagreement and conflict regarding the best approach to prevention, treatment and so on, so that a truly coordinated interdisciplinary response remains an elusive dream, a fantasy that remains just that unless each individual and each social group can explore the nature and origins of their own

beliefs and share them openly and honestly with all other social groups involved in an interdisciplinary response to child sexual abuse.

CHAPTER III - METHODOLOGY

Introduction

The major focus of this study was on the perspectives and beliefs held by various child-serving agents regarding the problem of child sexual abuse. This chapter provides a description of the two phases used in the study to gather information relevant to the research questions. In Phase I interviews were conducted with 15 key informants. Eight of these interviews were designed to solicit information about each of the research questions as well as generate information and ideas to aid in further specifying the design of Phase II, the survey questionnaire. The other seven interviews conducted during Phase I were utilized mainly as a source of background information about agency policies and as a guide to aid in deciding which agencies/organizations to include in the survey portion (Phase II) of the study.

I chose a combination of qualitative and quantitative methodology for this study because I believe that utilizing both approaches gives a broader picture of the phenomenon being studied. My belief was informed by a number of researchers who contend that using a combination of qualitative and quantitative methodology is superior to using only one of these (Reichardt & Cook, 1979; cited in Borg & Gall, 1989). Different researchers approach the issue of research methodology from varying perspectives, but offer essentially the same advice. For instance, while Jayaratne (1980; cited in Driscoll and McFarland, 1989) asserts that "every quantitative research project should include some qualitative data"(p. 154), feminist researcher, Kersti Yllo (1988)

suggests that qualitative data be supported by quantitative data:

> We learned a great deal through our qualitative approach, but I would not want to be limited to qualitative methods. Our exploratory research generated questions that cannot be answered through further qualitative research." (p. 35).

In essence, "each method can be greatly strengthened by appealing to the unique qualities of the other method." (Sciber, 1982, p. 178). Shipman's reasoning for not limiting one's methodology was perhaps the most convincing: He believes that when only one method is used to collect data, the result is, "a one-dimensional snap-shot of a very wide and deep social scene." (p. 147; cited in Borg and Gall, 1989). Utilizing a triangulation of methods, on the other hand, as feminist researcher Tomm (1989) suggested, allows the researcher to explore wide behaviour patterns while increasing the likelihood that data reflects the circumstances of the subjects' lived experience. According to this view, qualitative research enables us to better understand our quantitative respondent data by allowing us to locate action and experience in its context. It not only helps researchers understand their respondents better, but helps others who read the research publications gain a better understanding of quantitative data (Jayaratne, 1980; cited in Driscoll & McFarland, 1989). Various researchers cited by Burgess (1982; 1984) have also recommended using multiple methods as a way of assessing the validity of social research.

The assertions about the benefits of combined methodology discussed above led me to conclude that in order to interpret accurately and insightfully the results of a study of this nature, it was essential to hear about the personal experiences that informed the

attitudes and beliefs of child serving agents. As a result I decided to interview various individuals about their beliefs and experiences. I believe this has made a difference in how I came to view and approach the issue of attitudes and beliefs about child sexual abuse and about interdisciplinary response. However, with a limited number of interviews and a large number of agencies it was difficult to determine whether or not philosophical differences among individuals were due to individual or agency differences. The inclusion of a survey questionnaire provided quantitative data to further substantiate this question. As well, because key informants were selected on the basis of their expertise in the area of child sexual abuse in most cases, they may have been non-typical subjects. Thus it was desirable to check findings using other methods. The survey questionnaire was used to evaluate a more representative sample (Borg & Gall, 1989). As Borg and Gall (1989) promised, "The use of triangulation [more than one method] help[ed] to demonstrate validity and open[ed] up new perspectives about the topic under investigation." (p.397).

Seiber (1982) describes several practical benefits that can be gained by using a combination of survey and field research. Many of these were particularly relevant to this study. For example, the field work (Key Informant Interviews) contributed to the survey design by bringing information and categories to light of which I was not previously aware. In terms of survey data collection, the field research contributed to the development of the survey instrument through pre-testing; it provided a means of gaining familiarity with the survey population, which, I believe, resulted in a "more sophisticated

questionnaire" that was "administered more smoothly"; and it was a means of gaining legitimation for the survey from the appropriate authorities. The qualitative fieldwork in this study also contributed to survey analysis by verifying survey findings, especially findings that were surprising, by providing a means of interpretation of statistical relationships, and by clarifying ambiguous responses to a questionnaire. In turn, the survey data contributed to the field work by verifying field interpretations and by shedding new light on inexplicable or misinterpreted field data (Seiber, 1982).

Subjects and Procedures

Data for the study were collected in two phases. **Phase I** was carried out in the Summer and Fall of 1993 and consisted of preliminary interviews with fifteen key informants. **Phase II** involved the development, pretesting and distribution of a survey questionnaire. Questionnaires were distributed in the Spring and Fall of 1994. Table 3-1 outlines the procedure followed in this study.

Phase I: Exploratory Key Informant Interviews

Subjects (Key Informants)

Respondents for Phase I were volunteers who I contacted by telephone, most of whom were selected from names suggested by members of the Working Group on Child Sexual Abuse.[1] I selected 15 individuals (10 women and 5 men) from the following social systems in St. John's, Newfoundland: School, church, child welfare, shelter, police,

[1] I interviewed two members of the Working Group prior to conducting other interviews.

TABLE 3-1: Procedures and Subjects

	PHASE I	PHASE I	PHASE II	PHASE II
	K-I INTERVIEWS (Administrative)	K-I INTERVIEWS (Front-line)	Contact Regarding Survey Distribution	SURVEY DISTRIBUTION
PURPOSE	Utilized mainly to: -elicit background information about agency role and policy. -enquire about procedures regarding permission to survey. -obtain an impression about willingness to complete questionnaires.	Utilized mainly to: -explore perspectives related to child sexual abuse. -explore areas pertinent to the development of the survey instrument in Phase II.		
AGENCY		AGENCY		
Police:	Yes	Yes	Letter to Chief of Police and subsequent meetings with the sergeant assigned.	100 distributed among 4 sections (platoons) by contact sergeant.
School	Yes	Yes	Telephone contact with assistant superintendents, followed by letter and description of my proposal. Telephone contact with principals of randomly selected schools.	235 distributed to 10 randomly selected schools via the principal or guidance counsellor.
Dept. Soc Services	Yes	Yes	Telephone contact and subsequent meeting with Director of research. Signing of memorandum of agreement. Contacted general managers of each regional office	83 distributed to all social workers working with children and families in the St. John's region.
Shelter	Yes	Yes		
Mental Health	Yes	Yes		
Medical	Yes	Yes		
Church	Yes	Yes		
Court	No	Yes		
TOTALS:	7	8		418

medical, mental health, and the court.[2] Two key informants were interviewed from each of these eight systems.[3] They were chosen from two particular groups of experts:

(1) Individuals in a supervisory position who could articulate the "official" policy position of the agency/institution in which they work (one from each system); and

(2) individuals who work in the "front lines", who are involved in implementing policies on a daily basis, and who have special knowledge and experience in dealing with women and children's issues, especially relating to child sexual abuse (one from each system).

An administrative key informant interview and a front-line key informant interview was conducted to represent each of the eight systems listed above.[4] The seven key informants in supervisory positions gave background information for conducting Phase II of the study. The eight front-line key informants gave detailed information about their attitudes and beliefs about child sexual abuse which was utilized to develop the survey instrument for Phase II of the study and to interpret the results of that survey.

Key informants ranged in age from the twenties to the sixties. Some demographic data was not available for most of the administrative key informants (see Table 3-2), but all who did supply this information had been involved in at least one case of child sexual

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[2]Rural subjects were not included because restrictions on the researcher prevented the interviewing of individuals working in rural areas.

[3]Only one interview was conducted with the court system.

[4]An administrative interview was not conducted with this court system.

abuse, although some not in their present job. Two-thirds of the front line key informants had experience with 10 or more cases. Key informants from the school had the least experience. All front-line key informants had worked with the agency being represented for more than two years, ranging up to more than 20 years experience. One front-line worker had recently changed agencies, but was still working in the same field. That key informant's responses during the interview were based on experiences in the previous agency.

The individuals contacted for an interview were very willing to meet to talk about the issue of child sexual abuse, despite their busy schedules. Many indicated that this is such an important issue that we must make the time to discuss and research it. No key informant refused to be interviewed, although two administrators contacted suggested that I interview someone else in the organization with more expertise in the area of child sexual abuse. One of these did agree to a brief interview once I explained the nature of the information that was required from him. The other was not interviewed. Another administrator felt that it would be more appropriate for me to talk to someone else in that system but was very willing to give information, nevertheless. While most were as willing to meet as the front-line workers, administrators were more likely to ask, "Why do you want to talk to me? I don't know anything about this." (Response by two male administrators).

All 15 key informants received a verbal explanation and description of the study, as outlined in the consent forms (see Appendix A). The eight front-line key informants

Table 3-2: Characteristics of Key Informants

Characteristic	Administrative Key Informants n	Frontline Key Informants n
Gender:		
Male	3	2
Female	4	6
Age:		
20-29	3	1
30-39	1	3
40-49		3
50-65	1	1
65+		
Work Experience in Present Agency		
2 years		
2-5 years	1	2
5-10		3
10-20	1	1
20+	1	2
Experience with Sexual Abuse		
No experience		
One case		
Less than 5	1	1
5-10 cases	1	1
More than 10	1	6

signed consent forms agreeing to the audio taping of the interviews. Six administrative informants signed consents to allow me to take notes. Another administrator was interviewed by telephone and gave verbal permission. Interviews with administrative personnel ranged from 20-30 minutes. The interviews with front-line workers averaged about one hour. All eight of the front line interviews were taped, transcribed in full and subjected to content analysis to capture the essence of common themes.

Interview Design

I designed the interview schedules for this study based on a review of the literature and research in the area of child sexual abuse. Interviews with the first category of informants (administrative) were brief. The purpose of these interviews was not to explore issues related to the research questions. Rather these interviews entailed explaining the rationale for the project, soliciting background information about agency/organization role and policy, and enquiring about procedures necessary to obtain permission to involve agency personnel in Phase II of the study and, where appropriate, enquiring about willingness of individuals in each system to fill out questionnaires. The complete interview schedule is included in Appendix A.

Interviews with the second category of key informants (front-line) were more extensive than those with administrative key informants and comprise much of the data relevant to answering the research questions. The main reason for the second group of interviews was to explore the perspectives of the various individuals interviewed and to

explore areas that would be pertinent to the development of a survey questionnaire for Phase II of the study. Questions in Interview Schedule 2 focused on three areas: (a) the philosophical beliefs; (b) agency policy and procedure regarding child sexual abuse; and (c) interdisciplinary protocol and procedure. In addition to general questions asked of all eight key front-line informants, three or four agency-specific questions were asked. See Appendix A for complete interview schedule.

Presentation of Key Informant Data

The data from the in-depth interviews with the eight front-line key informants were transcribed and are presented through extensive use of quotes. Their words and meanings were interpreted and categorized to reflect theoretical orientations related to child sexual abuse. Key informants were each designated a number (from KI-1 to KI-8) in order to ensure anonymity. This designation is used consistently throughout the text and appendices. As data from the seven administrative interviews were used mainly as background information, this information is not presented except in the analysis of professionals' knowledge about roles and policy. As well, in rare cases, administrative informants made comments related to issues other than role and policy. If their comments were particularly relevant they were included and distinguished from the other key informant responses. Care must be taken in interpreting key informant data because the very qualities that make them key informants (their skills and expertise) also may make them non-typical. They were not randomly selected but were referred and selected, in

most cases, because of their special knowledge and skills.

The purpose of Phase I was to solicit background information about agency role and policy (Administrative Key Informants) and to explore underlying themes related to professionals' knowledge, beliefs and attitudes about child sexual abuse and about professional response to the problem (Front-line Key Informants). This information generated further research questions, aided in the development of a survey questionnaire, and influenced the selection of a survey population for the second phase of this study.

Phase II: Questionnaire Administration and Data Collection

Subjects

In Phase II of the study I developed a survey questionnaire (See Appendix A) and distributed it to a number of subjects in St. John's, Newfoundland. A representative sample from each of the eight systems represented in the preliminary interviews would have been ideal. However, since a minimum of 50 completed questionnaires were desired from each group, several basic principles were used to determine which groups to include in this phase of the study. These included:

(1). The number of people available within each system.

(2). Access to individuals.

(3). General perceived willingness of individuals to fill out questionnaires.

(4). Interviewees' perceived importance of the group in an interdisciplinary approach to dealing with the child sexual abuse problem.

There was an insufficient number of individuals working with children in the shelter and mental health fields (excluding school guidance counsellors) to achieve the desired sample size. As a result, even though both groups, especially mental health professionals, were viewed as important components of an integrated response to child sexual abuse, neither of those two groups were included in the survey sample. The responses of key informants indicated that the church is not closely involved in the majority of reported cases of child sexual abuse, and although it would have been interesting to explore the reasons behind this more fully, a decision was made not to include this group in the study, mainly because the anticipated response to being asked to complete a questionnaire was less than desirable. Medical personnel were not included because similar tendencies were indicated. Since the police and Department of Social Services are required to be involved in responding to reports of sexual abuse and because indications were that a sufficient number of these individuals were available to participate in a survey study a decision was made to include them. Another factor influencing this decision was that the Royal Newfoundland Constabulary (RNC) and Department of Social Services (DOSS) have a memorandum of understanding to coordinate their response to such reports. This left the school and the court. There was a sufficient number of subjects in both groups. However, indications were that school personnel would be more accessible and that many school personnel would be willing to fill out questionnaires. The final deciding factor that led to including the schools rather than the courts was my own special interest in this group, as a former teacher, especially since I had gleaned from the literature the

impression that teachers were supposed to be in a unique position to detect and respond to evidence of child sexual abuse.

Accordingly the subjects for Phase II reflect:

(1) The full population of social workers in the St. John's region who work with children and families. Most work with the Children's Protection Unit of the Department of Social Services (DOSS). Questionnaires were delivered to 83 social workers. The response rate was 34%, providing 28 questionnaires for analysis.

(2) A sample of Royal Newfoundland Constabulary (RNC) police officers. Questionnaires were delivered to 100 police officers. Eighty were distributed among four sections or platoons (20 to each). Five were sent to the Traffic Division and 15 to the Criminal Investigation Division. The response rate was 38%, resulting in 38 completed questionnaires for analysis.

(3) A sample of school personnel from the St. John's Roman Catholic and Avalon Consolidated School Boards. Schools were selected randomly and, depending on suggestions of principals, either approximately half or all teachers in those schools were surveyed. Eighty-seven questionnaires were distributed among a number of schools selected from the Avalon Consolidated School Board. Forty individuals (48%) responded. The response rate for schools ranged from 12.5% to 100%. One hundred and forty-eight questionnaires were delivered to schools in the Roman Catholic School Board for St. John's. The return rate was 22.9% (34

individuals responded). Overall questionnaires were delivered to 235 teachers from 10 schools. In total, the response rate from schools was 31.5%, yielding 74 questionnaires for analysis.

Demographic data on the social workers, police officers and school personnel are presented in Table 3-3.

Procedure

Once the three target groups were selected, the RNC, DOSS and the Avalon Consolidated and St. John's Roman Catholic school boards were contacted in the manner suggested by administrative key informants (i.e. by telephone and/or letter); (See Appendix A for letters). Within a few days a sergeant contacted me indicating that the RNC would be very willing to contribute to my research. The approach taken in surveying RNC officers was for the contact person to distribute the 100 questionnaires among the various sections via the staff sergeant of each platoon. I picked up the completed questionnaires three weeks later and made a follow-up call a week after that. No additional questionnaires were returned.

Obtaining permission to conduct the survey within the Department of Social Services took several weeks, during which arrangements were made to draw up a memorandum of agreement (See Appendix A). Once permission was obtained, the general manager of each regional office in St. John's was contacted and the questionnaires distributed. Two follow-up calls were made. No additional questionnaires were returned.

TABLE 3-3:
Characteristics of Survey Respondents

CHARACTERISTIC	Police		Social Work		School		Total	
	n	%	n	%	n	%	n	%
GENDER:								
Female	2	5.4	24	88.9	56	75.7	82	59.4
Male	35	94.6	3	11.1	18	24.3	56	40.6
Total	37	100.0	27	100.0	74	100.0	138	100.0
Missing	1		1		0		2	
AGE:								
20-29	12	32.4	16	59.3	9	12.2	37	26.8
30-39	22	59.5	7	25.9	26	35.1	55	39.9
40-49	3	8.1	3	11.1	34	45.9	40	29.0
50-65	0	0.0	1	3.7	5	6.8	6	4.3
Total	37	100.0	27	100.0	74	100.0	138	100.8
Missing	1		1		0		2	
WORK EXPERIENCE:								
<2 Years	0	0.0	4	14.8	3	4.1	7	5.1
2-5 Years	3	8.1	13	48.1	14	19.2	30	21.9
5-10 Yrs	13	35.1	7	25.9	11	15.1	31	22.6
10-20 Yrs	19	51.4	2	7.4	25	34.2	46	33.6
20-30+ Yrs	2	5.3	1	3.7	20	27.4	23	16.8
Total	37	100.0	27	100.0	73	100.0	137	100.0
Missing	1		1		1		3	
EXPERIENCE WITH SEXUAL ABUSE CASES:								
No experience	12	34.3	4	14.3	42	65.6	58	45.7
Yes, not specified								
One case	1	2.9	1	3.6	3	4.7	5	3.9
Fewer than five	4	11.4	4	14.3	14	21.9	22	17.3
5 to 10 cases	7	20.0	5	17.9	1	1.6	13	10.2
More than 10	11	31.4	14	50.0	4	6.3	29	22.8
Total	35	100.0	28	100.0	64	100.0	127	100.0
Not Applicable	0		0		8		8	
Missing	3		0		2		5	

Subsequent to making the decision to include teachers and other school personnel in the study, a labour dispute in that system made it necessary to wait until September of 1994 to survey this sample population. At that time a number of schools were randomly selected. The Roman Catholic and Avalon Consolidated school boards were then contacted and permission was obtained to distribute the questionnaires. In the case of the Roman Catholic School Board, permission was conditional on changes to Section C of the questionnaire (See Appendix A).

Once permission was received, the principals of the various schools were contacted by telephone and arrangements made to have them distribute questionnaires to their staff. The number of questionnaires brought to each school depended on how many the principals suggested I bring in. Some suggested bringing in enough for half of their staff members to complete, while others said they could give a copy to all staff members in the school. Questionnaires were distributed along with a letter to each principal or guidance counsellor (depending on whether the principal had agreed to distribute them or assigned this task to the guidance counsellor), and picked them up two to three weeks later.

Questionnaire Design.

The survey questionnaire instrument (see Appendix A), which I designed for this study focused on four key areas: (a) philosophical beliefs regarding the causes of abuse, e.g. individual pathology causes, sociological causes, structural/political causes; (b)

attitudes and beliefs, regarding the seriousness of the problem, attribution of blame, most effective treatment, prevention; (c) agency roles, including satisfaction with roles of their own and other agencies/organizations and satisfaction with interagency protocol; and (d) demographic information, e.g. age, gender. The questionnaire was developed from the information obtained from the preliminary front-line key informant interviews and from a review of the related literature and research in the area of child sexual abuse.

Section A of the questionnaire consisted primarily of items related to theoretical beliefs about the causes (individual pathology, sociological, structural/political) of child sexual abuse. A general item about etiological beliefs was presented along with two vignettes that elicited information about etiological beliefs and attitudes based on reactions to hypothetical situations. Statements about etiological beliefs associated with these vignettes were drawn from the literature and key informant data to represent typical views of various theoretical perspectives. Also included in this section was an item on specific treatment options for the two vignettes and an item on blame attribution as applied to the same two fictional cases. The items related to treatment were asked here because key informants indicated that treatment recommendations should be specialized to each individual case. The item regarding responsibility attribution was used to explicitly measure responses about blame attribution in an attempt to gather further information about a statement made by a key informant that there are "still some who blame the victim." Respondents were asked to assign a percentage of responsibility to the perpetrator, mother, child, society and to other factors. The responses to hypothetical

situations were compared with general beliefs about victims, perpetrators, responsibility, and so forth. The general item on etiology was a ranking scale which asked respondents to rank a list of theoretical causes based on the importance they accord to them as a cause of child sexual abuse. Respondents were asked to rank only the causes they thought were important and were given the option of listing other causes. Other items asked respondents to check off a list of options or indicate their position on a five point Likert scale: 1) Strongly Agree, 2) Agree with Reservation, 3) Not Sure, 4) Disagree with Reservation and 5) Strongly Disagree.

Section B contained items concerning attitudes and beliefs about the severity of the problem, victims, perpetrators, non-offending parents, blame, and beliefs about how the problem should be handled (prevention, protection, and treatment). The items in Section B all required responses to a five point Likert scale as described above.

The literature on child sexual abuse states that it is unusual to find a coordinated multidisciplinary response to allegations of such abuse. Yet several systems have a role to play when abuse is reported. Section C was designed to evaluate the coordination of response efforts in St. John's by looking at satisfaction with current response. This section focuses on perspectives regarding agency/individual roles and satisfaction with training, roles, and interdisciplinary protocol, and so forth. A brief vignette was included to determine what interventions respondents would take in a hypothetical situation. In addition, since key informants tended to refer to coordination in specific case terms, questions were asked about the most recent child sexual abuse case that respondents were

involved in (except in the questionnaire completed by Roman Catholic School Board personnel, see Appendix A). Respondents having no experience with child sexual abuse cases were to omit this portion of Section C. These items were designed to elicit information regarding present interdisciplinary efforts in the St. John's area. Items related to current practice included a list of agencies to choose from. Satisfaction items contained a five point scale: 1) Very Satisfied, 2) Satisfied, 3) Not Sure, 4) Dissatisfied, and 5) Very Dissatisfied.

The last part of the questionnaire, Section D, solicited demographic information about variables that may impact on other factors measured in the study. These included age, gender, work experience, and contact with child sexual abuse cases. Respondents were requested to circle the category that best described them. Again, the item inquiring about experience with child sexual abuse cases was modified in the version distributed to the Roman Catholic School Board, as they had requested. These respondents were asked whether they had experience with cases of sexual abuse, but, unlike the other respondents, were not required to specify the amount of experience they had.

Pretest.

Prior to surveying the target population, the questionnaire instrument was pre-tested by two classes of graduate students at Memorial University of Newfoundland. The students were representative of two of the target population groups, school personnel and social workers. They were asked to complete the questionnaire and make

recommendations for improving the instrument as a whole. Based on their suggestions revisions were made to improve clarity of potentially confusing and/or ambiguous items. Vignette A and Vignette B in Section A in particular had caused some agitation about expectations. As a result an introductory statement was placed at the beginning of Section A to assure participants that their choice was not an indication about whether or not they should take the allegation seriously but about what they suspected most likely to be the case.

Several other items were revised in Section A and C and two items added to Section B as an attempt to ameliorate concerns about researcher bias and to make choosing a response less difficult. An item was also omitted in Section C as several participants interpreted it as being very similar to another item and, thus, redundant.

Variables

The variables used in the survey portion of this study were derived from a review of the literature and analysis of key informant responses, and include theoretical beliefs about etiology, attitudes, satisfaction, and demographic information. The theoretical beliefs variables included the following:

(1) Variables that solicited information about reasons for deciding that abuse probably did not occur in each of the two fictional vignettes. The checklists were to be completed only if they believed abuse had probably not occurred.

(2) Nineteen single statement variables related to etiological beliefs about two fictional abuse cases (nine for Vignette A and 10 for Vignette B), to be completed by respondents who believed that abuse probably did occur in each vignette.

(3) Variables that measured overall theoretical perspectives about the etiology of child sexual abuse. All respondents were asked to rank only those causes that they thought were important causes of child sexual abuse. They were asked to chose the SEVEN top causes and rank them, with "1" indicating the most important and "7" indicating the seventh most important cause.

Values for the causal variables were later grouped in an attempt to obtain information about respondents theoretical perspective. The perspectives were categorized to form the following variables: Feminist, Family Systems, Social Factors, Individual Pathology, Cycle of Abuse, and Abuse of Power.

Attitudes and beliefs about child sexual abuse were also based on a review of the literature and the key informant data, and were measured by several variables. Because Key Informant data indicated that treatment recommendations would often be dependent on the abuse situation, an item was included in Section A and measured as the following variables:

(4) Treatment recommendations for Vignette A and treatment recommendations for Vignette B.

As blame attribution also seemed to be linked to specific situations the following variables measured where blame was attributed in the two vignettes:

(5) Percentage of responsibility given to the perpetrator in Vignette A and in Vignette B.

(6) Percentage of responsibility given to the child's biological father in Vignette B.

(7) Percentage of responsibility given to the non-offending parent in Vignette A and in Vignette B.

(8) Percentage of responsibility given to the victim in Vignette A and in Vignette B.

(9) Percentage of responsibility given to society in Vignette A and in Vignette B.

(10) Percentage of responsibility given to other sources in Vignette A and in Vignette B.

The 30 items in Section B were divided into eleven groups; each reflecting an attitude or belief that individuals may hold about some aspect of this problem. These include the following:

(1) Views about the seriousness of the problem.

(2) Attitudes towards victim precipitation/culpability.

(3) Attitudes about victim credibility. Victim credibility was examined in a scale containing five statements. The reliability coefficient alpha for the

entire scale was .69. When statement number 4 was removed (trustworthy evidence in court) the internal consistency improved to .75.

(4) Attitudes about perpetrator responsibility.

(5) Attitudes toward non-offending parent in incest cases.

(6) Beliefs about the effect on victims.

(7) Beliefs about general treatment of children.

(8) Beliefs about treatment of perpetrator.

(9) Beliefs about the criminal nature of child sexual abuse.

(10) Beliefs about prevention.

(11) Beliefs about the sex of victims and sex of offenders.

Variables related to the degree to which agencies/professionals interact to coordinate intervention efforts were measured in Section C and include the following:

(1) Variables reflecting intervention recommendations that subjects would make for the individuals in a fictional vignette.

(2) Variables that reveal who reports child sexual abuse incidents.

(3) Variables indicating which agencies become involved in cases.

(4) Variables measuring the outcomes of most child sexual abuse cases. The twenty item checklist was grouped into seven outcome variables.

Variables in (2), (3) and (4) above were applied to the most recent case of child sexual abuse that subjects were involved with.

Other variables measured in Section C focused on respondents' satisfaction with:

(5) the outcome of the specific case they described,

(6) their role in responding to child sexual abuse,

(7) their agency's response to the problem,

(8) the outcome of interventions in most cases,

(9) the attitudes and beliefs of various agencies,

(10) coordination efforts of various agencies,

(11) treatment programs,

(12) prevention efforts, and

(13) coordination of prevention efforts.

The last part of the questionnaire, Section D, measured demographic variables that could impact on attitudes and beliefs. Respondents were asked to indicate

(1) their approximate age,

(2) the number of years they had worked with their present agency/organization,

(3) the amount of experience they have had with child sexual abuse cases (Roman Catholic School Board respondents were asked to respond (a) yes or (b) no to this item, at the request of school board personnel),

(4) their gender as male or female, and

(5) their job position or profession.

The Research Model

Based on the available research and literature on child sexual abuse, the present study has attempted to explore the perspectives of professionals working with this immense social problem. In particular, the study has focused on the philosophical beliefs and attitudes that professionals have with regard to causes, victims, perpetrators, treatment issues and professional/system response.

This research design is predicated on a number of underlying principles: That background factors such as professional or agency affiliation affect beliefs and attitudes; that beliefs and attitudes affect behaviours; and that professional affiliation, causal beliefs, attitudes, and behavioral response all affect satisfaction with behavioral response. Based on a review of the literature the premise has been taken that the behaviours affected include the patterns of communication and cooperation with other agencies/professions that respond to the problem of child sexual abuse and the quality of response these professionals give to victims of child sexual abuse. Although the literature indicates such a relationship, it is necessary to examine the strength of the relationships between variables in this study. The diagram below illustrates this conceptualization.

The major hypotheses arising out of these underlying assumptions include the following:

1. There will be a relationship between professional/agency affiliation (and other demographic factors) and causal or etiological beliefs.
2. There will be a relationship between demographic factors, causal beliefs, and

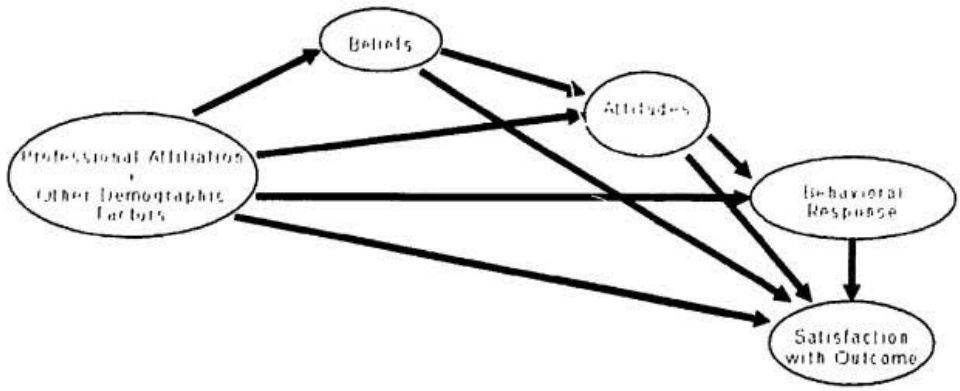

Figure 1: Research Model

attitudes.

3. There will be a relationship between demographic factors, causal beliefs, attitudes, and behavioral response.

4. There will be a relationship between demographic factors, causal beliefs, attitudes, behavioral response and satisfaction with behavioral response.

The perceived relationship between philosophical beliefs and attitudes and patterns of interagency cooperation was explored during **Phase I** of the study (preliminary interviews) and was tested empirically in **Phase II** through questionnaire results. The variables listed earlier were selected to represent each component of the model. For example, in addition to the professional/agency affiliation, the demographic variables, age, sex, years working at present agency, and experience with child sexual abuse cases were selected as independent variables to represent the first part of the model. The causal

beliefs component of the model are represented by the causal variables, along with independent causal statements applied to two vignettes. The variables selected to represent attitudes and beliefs include the variables that measure the degree to which subjects view child sexual abuse to be a serious social problem; the amount of responsibility or culpability placed on the victim for having precipitated the abuse; how credible child victims are viewed to be; the amount of responsibility given to the perpetrator; whether maternal collusion is a significant factor influencing professional response; beliefs about the criminal nature of child sexual abuse; views about how seriously children are affected by child sexual abuse; views about successful treatment for perpetrators; and preferred prevention approaches.

The behavioral response component of the research model was represented by the nine treatment variables for Vignette A and the nine treatment variables for Vignette B, which specify the preferred treatment approaches of each agency, and by the variables that identify which agencies take a child-centred approach; variables that indicate what interventions each agency would take in a specific case; variables that describe the outcome of the respondents' most recent case; variables that indicate the number of agencies involved in a specific case, and the variables that specify how many of these responded in a coordinated manner.

The last part of the model, satisfaction, was measured by several variables: A variable indicating the level of satisfaction with the individual roles that respondents play in responding to the problem of child sexual abuse; a variable measuring satisfaction with

current response to child sexual abuse cases; a variable measuring satisfaction with the outcome of most cases; several variables measuring the level of satisfaction with attitudes and beliefs and with interdisciplinary efforts; and variables measuring satisfaction with treatment efforts, prevention efforts, and coordination of prevention efforts.

Since several independent variables have been measured that do not appear to relate directly to the research questions, it is necessary to explain the inclusion of each of these variables. The demographic variable indicating respondents' profession is used to determine whether this variable impacts on philosophical beliefs about the causes of child sexual abuse, its victims, treatment, and so on. As indicated in Chapter II, such differences may exist. However, differences in these factors can also be influenced by such variables as age, sex and experience with victims and/or perpetrators of child sexual abuse. Child sexual abuse is a problem that has only recently been recognized as serious and prevalent, and theories about the etiology of the problem are evolving. Thus, depending on where training initiatives are coming from, younger professionals may exhibit beliefs consistent with more recent theories (eg. feminist theories), while older professionals may have beliefs that are consistent with older theories.

The gender variable was included because the literature suggests that more women than men were sexually abused as children. It could be argued then, that women would have a greater understanding of the dynamics of the problem and will be sympathetic to victims' views. As well, women are frequently victims of male violence in general and can thus identify with the victim role. Finally, the structural/political theories are mainly

representative of "feminist" views and thus *may* be more popular with female professionals than with male professionals.

If agency affiliation influences a professional's beliefs about child sexual abuse, it could be argued that the longer an individual works for that agency the more 'agency views' will be incorporated into their own conceptualizations about the problem. Information was collected on the amount of experience respondents have with cases of child sexual abuse because those who have had more opportunity to witness the consequences of sexual abuse may have different beliefs about prevalence, victims, and so forth, than those who have formed their beliefs on a more abstract basis. In order to determine the effect of respondent profession on beliefs and attitudes it is necessary to control for the effect of these other demographic variables.

The inclusion of so many variables related to causal beliefs needs to be explained as well. These variables were designed to represent the major theories on etiology. Each of these theories has several beliefs associated with it; as represented by the nine items in AI(b) and ten items in AII(b) of the questionnaire. Item analyses by the researcher and project supervisor of these seventeen items revealed that statements chosen to represent each theoretical perspective were not discrete enough to allow quantitative analysis of various statement groups (eg. family systems perspective, individual pathology perspective). Thus, each of the seventeen statements was analyzed as an individual variable in order to determine whether there was a statistically significant difference between the beliefs of police, school and social work respondents. The independent

causal variables were then included in an attempt to determine whether there was a statistical agency difference in overall etiological beliefs about child sexual abuse. These variables were grouped based on their association with a major theoretical perspective. Respondents ranking or exclusion of each was organized to reveal their major theoretical orientation. The major theoretical perspectives discussed in the literature include individual pathology, sociological, and structural/political perspectives. However, the individual pathology perspectives fall into three main categories. Two focus on the pathology of the perpetrator: The cycle of violence views were separated from the other perpetrator pathology views because data from key informant interviews suggested that these views may not be consistent with each other, and if analyzed together would not give a true picture of individual pathology beliefs. The third individual pathology perspective focuses on victim and non-offending parent (usually the mother) characteristics as precipitating abuse. Again, these beliefs may or may not be consistent with the first categories.

Sociological perspectives are not necessarily complementary either. Two popular views have been chosen as a focus here based on preliminary interview data: Views pertaining to family systems and to social factors as causal agents. The first focuses on dysfunction with the family system as the cause of the occurrence of child sexual abuse, whereas the second highlights the influence of factors that are most often characteristic of lower socioeconomic class families or individuals.

There are variations in structural/political beliefs as well. Some proponents of

such views believe sex has nothing to do with the abuse; that it is simply an abuse of power to fulfil the need to feel powerful. Other view both the abuse of the power of patriarchy and male socialization (including sexual socialization) as both being necessary for abuse to occur.

It is hypothesized that causal beliefs variables affect other attitudes and beliefs about child sexual abuse. For example, individuals/agencies that have theoretical beliefs that child sexual abuse is caused by a "sickness" or "illness" will have different attitudes about perpetrators and/or victims than those who believe that it is normal adult men who abuse, which would then have implications for the their beliefs about prevention, treatment, punishment, and so on. Beliefs about the causes of child sexual abuse and attitudes and beliefs about victims and perpetrators, it is hypothesized, will influence ideas and decisions made about appropriate treatment for victims and perpetrators, as well as beliefs about the direction or focus prevention efforts should take. Such beliefs and attitudes will, in turn, affect reactions to victims and perpetrators and influence recommendations made for intervention and treatment. If conflicts exist in these areas between agencies, the nature and quality of the interdisciplinary response may be affected, as may be indicated by respondents satisfaction with case outcomes, attitudes and beliefs of other agencies, cooperation and coordination of efforts, treatment programs, prevention efforts and coordination of prevention efforts.

Generalizability

Since this study involved only subjects working in St. John's, NF. I make no attempt to generalize the findings to a wider population.

The Analysis

This study has attempted to identify the perspectives held by child serving agents regarding child sexual abuse, as well as what factors influence such perspectives and how their perspectives affect their response to the problem of child sexual abuse. In order to accomplish this, several techniques were employed. Both qualitative (from key informant interviews) and quantitative (from the survey questionnaire) data were generated for analysis.

Qualitative data were subjected to content analysis based on particular categories of beliefs and attitudes in search for recurring themes.

For quantitative data, chi-square and analysis of variance analysis comparisons were made between the police, school and Social Services systems to determine whether these groups differed significantly on the variables tested above. That is, the philosophical or etiological beliefs (individual pathology, sociological and structural/ political perspectives) and attitudes and beliefs (regarding seriousness of the problem, attribution of blame, treatment and prevention) of each. Chi-square and analysis of variance statistics were also computed for the other independent variables, gender, age, work experience, and sexual abuse experience. Where there were significant differences

these variables were controlled to determine the effect of profession. A significance level of .05 was used to determine whether a statistically significant difference existed (Borg & Gall, 1989). For significant F's post hoc t-tests were used to test the statistical significance of differences between particular group means.

In terms of the attitudinal component of the study, each construct, which was representative of a particular attitude relative to child sexual abuse, was subjected to principal component analysis and the alpha reliabilities were measured.

In an attempt to show the relationship between the demographic factors, causal beliefs, attitudes, behavioral response and satisfaction, a series of regression equations was estimated. These include:

$$X_2 = a_1 + b_{21}X_1 + e_1$$

$$X_3 = A_2 + b_{31}X_1 + b_{32}X_2 + e_2$$

$$X_4 + a_3 + b_{41}X_1 + b_{43}X_3 + e_3$$

$$X_5 = a_4 + b_{51}X_1 + b_{52}X_2 + b_{53}X_3 + b_{54}X_4 = e_4$$

Descriptive statistics such as frequencies, means, standard deviations, and correlations are also presented.

CHAPTER IV - RESULTS

Introduction

The rationale for this study is based on two premises: (1) Understanding the differences in attitudes and philosophical beliefs about child sexual abuse is an important underlying factor in developing a successful interdisciplinary response to the problem; and (2) the attitudes and beliefs of professionals affect how they respond to victims and perpetrators. Their reactions can have a significant impact on how well victims deal with the trauma of child sexual abuse. As indicated previously, I developed the framework for this study around the assumption that agency/professional affiliation influences philosophical beliefs, which in turn affect attitudes and beliefs, and finally, attitudes and beliefs affect behavioral responses. In order to validate the study and the research questions explored, I derived the following hypotheses to test the relationship between demographic factors, theoretical beliefs, attitudes and behavioral response:

1. Demographic factors, agency/professional affiliation, age, sex, years working, or experience with cases of child sexual abuse will influence respondents' theoretical beliefs about the causes of child sexual abuse.

2. Demographic factors and theoretical beliefs about the causes of child sexual abuse will influence respondents' attitudes about (a) the seriousness of the child sexual abuse problem, (b) the effect on the victim, (c) the credibility of victims. (d) victim responsibility, (e) perpetrator responsibility, and (f) the role of the non-offending parent in the dynamics of incest.

3. Demographic factors, etiological beliefs and attitudes regarding child sexual abuse will influence respondents' views about the most appropriate treatment for victims and offenders and the level of coordination within the child care system.

4. Demographic factors, etiological beliefs, attitudes, and behavioral responses will influence respondents' satisfaction with their role, the response to the problem of child sexual abuse and the level of coordination and cooperation within the child care system.

These hypotheses were tested during the questionnaire phase of the study, as there were too many relevant variables and too few subjects to do this during the exploratory interview stage.

The approach taken by this researcher in reporting and analysing the results of the study was to attempt to provide answers to the research questions. Key informant data and questionnaire data were reported in each section and compared where possible. Analysis of interview data focused only on the eight in-depth interviews with front-line personnel. In the analysis of interview data, the agency/organization that the individual works for was not identified in order to protect the anonymity of the individuals involved. Agencies/organizations were identified in the analysis of questionnaire data as anonymity is protected by the larger number of respondents.

The validity of the assumptions underlying the framework of this study were reported by describing the relevant results from the questionnaire survey in terms of the four hypotheses arising out of these assumptions.

Causes of Child Sexual Abuse

> Some kind of mental illness.... Probably a person who has been sexually abused as a child themselves.... emotional difficulty stemming from their childhood.... Of course then, you have the whole issue of ... low self-esteem and need for power. (KI-7)

Several theories were put forth by key informants to explain the etiology of child sexual abuse. They include explanations involving abuse of power/trust, in some cases gender related; cycle of abuse; perpetrator pathology; family dysfunction; and social factors. Similar beliefs were expressed by survey respondents. This was true both in responses to specific vignette cases (See Table 4-1 and Table 4-2) and in ranking of general possible causes of child sexual abuse (See Table 4-3). For both groups of respondents the categories above were not necessarily exclusive. That is, most key informants and survey respondents expressed beliefs representing more than one of these theoretical perspectives. In essence, a combination of causes were commonly cited, with the following remark representing the broader categories: "... desperation... economics... low levels of education... the media... low self-esteem and it's a power thing.... very difficult family situation.... possibly the sexual abuse arose out of them." (KI-5). Despite the variation, however, some beliefs were more prevalent and were given more importance than others.

Power, or the abuse of power, was cited most often by key informants as a causal factor in child sexual abuse and was most frequently cited as the *primary* cause. For

TABLE 4-1:
Professionals' Responses to Statements About Causes of Sexual Abuse in Vignette A.

CAUSAL STATEMENTS (n = 132)	Agree		Disagree		Don't know		Mean	SD
	n	%	n	%	n	%		
Genna's father must be a very sick man.	77	58.8	35	26.7	19	14.5	2.5	1.3
If the abuse occurred, Genna's father is a pedophile.	47	36.5	37	28.7	45	34.9	2.9	1.2
Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	33	25.8	77	60.1	18	14.1	3.7	1.4
The dynamics of the family system are responsible for the sexual abuse, rather than any one family member.	28	21.2	81	61.3	23	17.4	3.1	1.2
The father abused Genna because men are socialized to find small, powerless females attractive.	16	12.1	105	79.5	11	8.3	4.2	1.1
Poverty probably played a role in causing the father to abuse Genna.	15	11.4	98	74.2	19	14.4	4.2	1.1
The father sexually abused her because he was unable to resist her sexual advances.	5	3.9	118	90.1	8	6.1	4.7	.9
Genna's provocative behaviour caused her to be abused.	4	3.0	124	94.0	4	3.0	4.8	.7

[a]Average responses reported: 1= strongly agree to 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree. Mean is based on uncollapsed category.

TABLE 4-2:
Professionals' Responses to Statements About Causes of Sexual Abuse in Vignette B.

CAUSAL STATEMENTS (n = 56)	Agree		Disagree		Don't Know		Mean	SD
	n	%	n	%	n	%		
The step-father's abuse of Paula is an attempt to dominate and control her.	34	61.8	13	23.6	8	14.5	2.5	1.4
The sexual abuse of Paula is the result of a patriarchal society that gives men the power to dominate women and children.	31	56.4	20	36.4	4	7.3	2.8	1.4
The step-father was probably abused himself as a child.	31	55.4	4	7.1	21	37.5	2.3	.9
The sexual abuse in this family is a symptom of some deeper dysfunction within the family system.	22	39.3	11	19.6	22	39.3	2.7	1.2
Psychiatric testing of the step-father will probably reveal some kind of mental illness or other psychological disturbance.	20	35.7	24	42.9	12	21.4	3.4	1.3
Since the step-father appears to be a user of alcoho' :he sexual abuse of Paula was likely caused by a drinking problem.	12	21.5	37	66.1	7	12.5	3.8	1.2
The stress on the step-father to prove himself as a lawyer probably led to the abuse.	3	5.4	48	85.7	5	8.9	4.4	1.0
If Paula's mother had not been away from home so much the abuse probably would not have occurred.	2	3.6	43	76.8	11	19.6	4.4	1.0
The step-father probably began to molest Paula because his wife did not want to have sex with him.	1	1.8	47	76.8	12	21.4	4.2	.9

[a]Average responses reported: 1= strongly agree to 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree.

TABLE 4-3:
Percentage, by Gender and Profession, Ranking Causes of Child Sexual Abuse:

CAUSAL FACTOR	Percentage Ranking Item						Average
	Female	Male	Police	Soc.Wk	School	Total	Rank*
Abuser was abused as a child	84.6	84.3	82.4	76.0	88.7	84.6	3.6
Abuse of power/trust	76.9	68.6	73.5	92.0	67.6	73.8	4.4
Pedophilia	57.7	72.7	82.4	56.0	57.7	63.8	4.9
Family dysfunction	52.6	43.1	35.3	68.0	49.3	49.2	5 7
Pornography	50.0	39.2	50.0	40.0	45.1	45 4	6.6
Stress, alcohol, and/or poverty	48.7	33.3	23.5	52.0	49.3	43 1	6.3
Society's treatment of women and children as objects	48.7	21.6	23.5	56.0	38 0	37.7	6 6
Male Socialization	21.8	9.8	8.8	40.0	12.7	36.2	7.3
Expression of power, intimacy and affection through sex	37.2	27.5	17.6	40.0	39.4	33.8	6.6
Lack of social skills in the abuser	14.4	15.7	14.7	20.0	12.7	33.1	7.5
Lack of conscience	32.1	35.3	32.4	20.0	38.0	26.2	7.0
Social or Geographical isolation	19.2	27.5	26.5	44.0	14.1	23 1	7 4
Lack of education or low intelligence	11.5	37 3	41.2	16 0	14 1	16.9	7 4
Poor marital relationships	12.8	17 6	17.6	12.0	14 1	14 6	7 7
Mental illness in the abuser	26.9	51.0	64.7	0.0	35 2	14.6	6.5
Divorce/family reconstruction	7.7	17.6	20.6	4 0	9.9	11.5	7.6
Patriarchy	12.8	5.9	8.8	12.0	9.9	10.0	7.7
Mother fails to protect child	9.0	9.8	11.8	20.0	4.2	9.2	7.2
Inability to distinguish between sexual & nonsexual forms of affection	10.3	5.9	0.0	12.0	11.3	8.5	7.7
Enforced celibacy	6.4	7.8	2.9	0.0	11.3	6.9	7.8
Homosexuality	5.1	9.8	14.7	0.0	5 6	6.9	7 8
Irresistible urges in the abuser	24.4	29.4	35.3	4 0	29.6	3.8	7 1
Child fantasies	2.6	55.9	8.8	8.0	0.0	3 8	7 8
Mother encourages child to become the "little mother" in the family	3.8	2.0	2.9	4 0	2.8	2.4	7 9
Mother withholds sex	0.0	5.9	0.0	0.0	4.2	2.3	7.9
Mental illness in the mother	2.6	0.0	0.0	0.0	2.8	1 5	6.5
Child is provocative or is willing to participate	0.0	2.6	0.0	0.0	1.4	0.8	8.0

[a]Average rank is based on the mean of scores: 1= Most important to 7= Seventh most important, including 8= Not Ranked.

example, one explained that, "Basically, to me, it's a misuse of power.... that feeling of manipulation and control that they have over them" and that although sexual gratification is part of the attraction, the feeling of power and control is the major reason abusers manipulate children (KI-2). Another indicated that, "mostly, I think, it's power, and the fact that they have been able to get away with it."(KI-4). This individual also indicated, as did others, that many perpetrators of abuse have been abused themselves in some way.

Other key informants thought cycle of abuse was the primary cause of child sexual abuse, though this belief was not expressed as often as beliefs about the abuse of power. Among survey respondents, however, the cycle of abuse explanation was selected most frequently (See Table 4-3) and was also most frequently cited as the *primary* or number one cause (25.0%). Only a few respondents elaborated on their choice of cycle of abuse. The following comment by a school survey respondent is typical of those who did have more to add:

> Genna's dad possibly was a victim of child sexual abuse and/or his own father could have been a pedophile attracted to young girls (he learnt along the way this behaviour was acceptable within the family).

However, as with key informants, abuse of power/trust was also chosen by a large percentage of survey respondents and was also often identified as the primary cause (15.7%). As one social work survey respondent put it, "Genna's father was a power hungry man!" Other causal explanations often pinpointed by survey respondents include pedophilia and family dysfunction. Again, these were often identified as the primary or most

influential cause of child sexual abuse (pedophilia: 19.3%; family dysfunction: 10.7%). These last two explanations were present among key informant beliefs as well, but were rarely given primary importance.

The comments of one key informant who expressed a belief that cycle of abuse was the primary cause of child sexual abuse, gives some insight into the rationale behind this perspective. This key informant explained that many perpetrators are people who have been abused themselves and, as a result, have not learned appropriate boundaries for interacting with other individuals. They simply repeat the behaviour that they have learned. This lack of socialization around appropriate boundaries can then be aggravated by socioeconomic factors, poverty, stress and so on, often leading to abuse of a child. This individual also saw pedophilia and psychiatric disturbance as causal factors in some abusers. Others agreed: "In most cases there has been a history of something with them [the perpetrator]; some kind of dysfunction."(KI-3). Society was also seen as playing a role by this survey respondent for not taking a stronger stand against it. The fact that mostly males abuse was attributed, again, to power and control issues and to females being born and raised as "people's property, almost."(KI-3). About a third of survey respondents expressed beliefs related to the role of males and females in society as well but only a minute number attributed primary significance to these factors.

A gender breakdown of the general causal statements in the survey data reveals that both males and females chose "Cycle of abuse" most often as being among the important explanations for the occurrence of child sexual abuse (See Table 4-3). Women also

frequently selected "abuse of power/trust" pedophilia, family dysfunction, pornography, society's treatment of women and children as sex objects, and stress/alcohol or poverty. Men frequently chose "pedophilia", abuse of power/trust and mental illness in the abuser. The causal factors that males rated most often as the *primary or number one* causal explanation of child sexual abuse were pedophilia (21.4%) and cycle of abuse (19.6%). Abuse of power/trust (12.5%), mental illness in the abuser (12.5%), and family dysfunction (8.9%) were also often targeted as the number one cause. The causal factor most often rated as the *primary* cause of child sexual abuse by females was cycle of abuse (29.3%), followed by abuse of power/trust (18.3%), pedophilia (17.1%), family dysfunction (12.2%) and expression of power, intimacy, and affection through sex (7.3%). The only statistically significant differences in the beliefs above, however, are that significantly more men than women thought mental illness in the abuser (51% versus 26.9%[1]) played a role and significantly more women than men were inclined to believe that society's treatment of women and children as sex objects (males, 21.6%; females, 48.7%[2]) was an influential factor. The only other significant gender differences on the ranking of general causal statements were that men were significantly more likely than women to select lack of education/low intelligence (37.3% versus 11.5%[3]) and mother withholding sex (5.9% versus 0.0%[4]) as important causes. Thus, there are similarities between male and female

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[1] $\chi^2(1, \underline{N} = 129) = 7.7, p < .001$

[2] $\chi^2(1, \underline{N} = 129) = 9.6, p < .01$

[3] $\chi^2(1, \underline{N} = 129) = 12.0, p < .001$

[4] $\chi^2(1, \underline{N} = 129) = 4.7, p < .05$

beliefs, but there are also significant differences.

Females responding to Vignette B were twice as likely (65.8%) as males (37.5%) to think that patriarchy was a significant cause. In responding to Vignette A females were significantly more likely to assign some causal responsibility to the mother in this case independent of professional affiliation.[5] Survey respondent age and experience with cases of child sexual abuse did not significantly affect responses to causal statements related to Vignette A. Work experience was significantly related to whether or not survey respondents thought the family dynamics were responsible for the situation in the vignette. Survey respondents with the least work experience (< 2 years) and those with more than 10 years experience were significantly less likely than respondents with 2-10 years experience to agree that the family dynamics was a causal agent in this vignette.[6]

The similarities and differences discussed above for male and female beliefs appear to exist for professional groups as well. Though the order of frequency and order of importance may vary, cycle of abuse, abuse of power/trust, and pedophilia explanations always appear among the five most frequently cited causes. Among police officers pedophilia and cycle of abuse were most frequently selected. Pedophilia was identified as the primary cause by 23.7% and cycle of abuse by 15.8%. Abuse of power/trust, mental illness in the abuser, and pornography were also frequently selected causes. Social workers most commonly chose abuse of power/trust, cycle of abuse, society's treatment of women

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[5] ($p < .05$)

[6] $X^2(16, \underline{N} = 129) = 38.0, p < .005$

and children as sex objects, pedophilia, and stress/alcohol/ or poverty. Twenty-nine percent of them chose abuse of power/trust and 17.9% chose cycle of abuse as the primary cause of child sexual abuse. School survey respondents ranked the following most often: cycle of abuse, abuse of power/trust, pedophilia, family dysfunction, and stress/alcohol/ or poverty. Cycle of abuse was chosen as the primary cause of child sexual by 32.4% of school survey respondents, while pedophilia was chosen as the primary cause by 17.6%.

A chi-square analysis of police, social workers, and school personnel revealed that though there was correspondence among the three groups on the causes ranked most often, significant differences exist in several areas (See Table 4-4). Significantly more police officers than social workers and school personnel ranked pedophilia and lack of education/intellect as causes of child sexual abuse. However, these differences were not significant after controlling for gender. In Vignette A, however, school personnel were most likely to agree with pedophilia as a cause of the abuse in the vignette, significantly more often than social workers, though almost half responded, "Don't know" to this item (See Table 4-5). School personnel were also significantly more likely than police to assign some responsibility to the mother as a cause than were police.[7] After controlling for gender, however, professional differences remained significant only for males' beliefs about pedophilia.[8]

Very few or none of the social workers ranked mental illness or irresistible urges

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[7] χ^2 (10, N= 136) = 22.0, p< .01

[8] χ^2 (8, N = 50) = 17.7, p< .05

in the abuser as general causes of abuse, while a significant number of police and school survey respondents ranked these items (See Table 4-4). The difference remained significant after controlling for gender. Corresponding to these findings, all three groups differed significantly in their responses to sickness being a cause in Vignette A, with social workers agreeing least often and school personnel agreeing most often (See Table 4-5). School personnel and police officers did not always agree with the "sickness" explanation, however and offered alternative explanations. One police survey respondent commented that abusers are not sick but "perverted". A school survey respondent suggested that the father in Vignette A may have been drinking - not sick. After controlling for gender, differences between professions remained significant only for females.[9]

Table 4-4 shows that significantly more social workers and school personnel ranked stress, alcohol, and/or poverty as general causes, yet, in Vignette B no social workers indicated that alcohol or stress were causal factors (See Table 4-5). Most (94.5%) disagreed that alcohol could be a cause. One said that, "the alcohol may be an inhibitor but certainly not a cause." A school survey respondent indicated that alcohol use did not cause the abuse, "perhaps, so much as intensified". In the same vignette most social workers said they did not know if stress could be a causal factor. On the other hand, most police and school personnel disagreed that stress could be a causal factor in Vignette B,[10] but were significantly more likely than social workers to think that alcohol could have some

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[9] $p < .001$

[10] χ^2 (8, N = 136) = 18.1, $p < .05$

TABLE 4-4:
Percentage of Each Professional Group Ranking Causes and Average Rankings: 1= Most Important to 7= Seventh most Important; 8= Not Ranked.

CAUSAL FACTOR	Percentage rating this item			Chi-	Average ranking			Chi-
	Police	SocWrk	School	Square	Police	SocWrk	School	Square
Pedophilia	82.4	56.0	57.7	*6.9	4.1	5.3	5.2	17.7
Family dysfunction	35.3	68.0	49.3	*6.2	6.4	5.4	5.5	19.8
Stress, alcohol, and/or poverty	23.5	52.0	49.3	*7.2	7.1	5.9	6.1	16.7
Society's treatment of women and children as objects	23.5	56.0	38.0	*6.5	7.3	5.8	6.6	18.1
Male socialization	8.8	40.0	12.7	**12.0	7.5	6.4	7.6	*27.4
Social or geographical isolation	26.5	44.0	14.1	**9.6	7.1	6.6	7.5	18.3
Lack of education or low intelligence	41.2	16.0	14.1	**10.5	7.0	7.4	7.5	*22.5
Mental illness in the abuser	64.7	0.0	35.2	***26.2	4.9	8.0	6.7	***52.0
Mother fails to protect child	11.8	20.0	4.2	*5.8	7.8	7.5	7.9	12.4
Irresistible urges in the abuser	35.3	4.0	29.6	*8.2	6.7	8.0	4.5	18.3
Child fantasies	8.8	8.0	0.0	*6.3	7.5	7.8	8.0	**17.1

* p< .05 ** p< .01 *** p< .001 **** p~ 0

TABLE 4-5:
Percentage of Professionals in Agreement[a] with Statements about Causes of Sexual Abuse in the Vignettes.

CAUSAL STATEMENTS	AGREE			DISAGREE			DON'T KNOW			Significant Chi-Square Profession	Significant Chi-Square Gender
	Pol.	SocW.	Sch	Pol.	SocW.	Sch.	Pol.	SocW.	Sch.		
VIGNETTE A: Genna's father must be a very sick man.	56.7	25 9	73 1	24.3	51.8	17.9	18.9	22.2	9.0	**22.5	
If the abuse occurred, Genna's father is a pedophile.	31.5	29.6	41.8	45.7	44.4	13.5	22.9	25.9	44.8	**25.5	
Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	18.9	22 2	31 3	78.4	66.6	46.9	2.7	11.1	21.9	**22.0	*13.6
VIGNETTE B: The step-father's abuse of Paula is an attempt to dominate and control her.	61.5	55 5	66 6	7.7	38.9	20.9	30.8	5.6	12.5	**25.4	
The sexual abuse of Paula is the result of a patriarchal society that gives men the power to dominate women and children.	46.2	53 0	64 0	53.9	35.2	28.0	0.0	11.8	8.0		*13 2
The step-father was probably abused himself as a child	38 5	44 4	72 0	7.7	11.1	4.0	53.8	44.4	24.0	*18.9	
The sexual abuse in this family is a symptom of some deeper dysfunction within the family system.	48 5	33 3	44.0	15.4	16.7	24.0	46.2	50.0	28.0		
Psychiatric testing of the step-father will probably reveal some kind of mental illness or other psychological disturbance.	38.5	22 2	44 0	30.8	66.6	32.0	30.8	11.1	24.0	*21.7	
Since the step-father appears to be a user of alcohol, the sexual abuse of Paula was likely caused by a drinking problem.	46.2	0 0	24 0	53.9	94.5	52.0	0.0	5.6	24.0	***37.6	**16 4
The stress on the step-father to prove himself as a lawyer probably led to the abuse	7.7	0 0	8 0	92.4	11.1	80.0	0.0	88.9	12.0	*18 1	
If Paula's mother had not been away from home so much the abuse probably would not have occurred.	7.7	0 0	4 0	69.3	88.9	72.0	23.1	11.1	24.0	*21.7	*11 1
The step-father probably began to molest Paula because his wife did not want to have sex with him	0.0	0 0	4 0	69.3	72.2	84.0	30.8	27.8	12.0	*18.2	*10 7

[a]Pol = Police (n=38), SocW = Social Workers (n=28), Sch = School personnel (n=74)

* p< 05 ** p< 01 *** p< .001

causal influence[11] (See Table 4-5). One school survey respondent suggested drinking as an alternative to the sickness explanation in Vignette A. Males (37.5%) were significantly more likely than females (15.4%) to blame alcohol in Vignette B, but after controlling for gender, professional group differences remained only for females.[12] As well, older survey respondents were significantly more likely than younger respondents to think that stress might be a causal agent.[13] The difference in ranking of general causes related to stress, alcohol, and/or poverty was not significant after controlling for gender.

Correlation coefficients were computed to determine the relationship between causal statements referring to specific vignettes and general selected causes of child sexual abuse. In most cases, alcohol and stress related variables excepted, the correlations were significant, suggesting a correspondence between general professed beliefs and specific application of beliefs. However, analysis of individual groups reveal some interesting contrasts between survey respondents expressed general beliefs and their responses to specific fictional cases. For instance, although, as Table 4-4 shows, at least three quarters of police officers, social workers, and school personnel ranked previous abuse as being a cause of sexual abuse, Table 4-5 reveals that police officers and social workers were significantly less likely than school personnel (72.0%) to agree with a specific statement

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[11] χ^2 (10, $\underline{N}$ = 136) = 37.6, $p < .001$

[12] χ^2(3, $\underline{N}$ = 39), $p < .05$

[13] χ^2(9, $\underline{N}$ = 55) = 26.2, $p < .01$

(Vignette B) suggesting that previous abuse had been a factor.

Even though police officers ranked pedophilia as a cause of child sexual abuse significantly more often than social workers and school personnel (See Table 4-4), school personnel were significantly more likely to express a belief that Genna's father was a pedophile (Vignette A) than were police or social workers See Table 4-5).

Table 4-4 shows that only about a quarter of police officers cited stress/alcohol/poverty as being responsible for child sexual abuse, while half of social workers and school personnel did so. However, in Vignette B almost half of police officers cited alcohol (46.2%) as responsible, while none of the social workers and only a quarter of school personnel pointed to alcohol as a causal factor in the vignette. Police officers and school personnel were significantly more likely (though only a small proportion did) to cite stress as being responsible than social workers.

With regard to other general beliefs, significantly more social workers than police or school survey respondents ranked family dysfunction, society's treatment of women and children as sex objects, male socialization, social or geographical isolation, and mother's failure to protect the child as being among the seven most important causes of child sexual abuse (See Table 4-4). Further analysis, controlling for gender, revealed that these difference between professional groups was linked to gender. The differences remained significant only for females. Other professional differences were linked to gender as well. For instance, significant professional group differences exist for females, but not for males, on whether or not homosexuality and abuse of power/trust were rated as causes.

On the other hand, there were significant professional group differences among males, but not females, on whether or not they ranked the mother's withholding sex, expression of power, intimacy, and affection through sex, and inability to distinguish between sexual and nonsexual forms of affection.

In addition to prevalent views, there was some uncertainty among key informants about what causes child sexual abuse. In some cases, uncertainty was expressed along with tentative views that it is a sickness and a problem involving attraction to children, and in some cases, possibly homosexuality. This uncertainty was not limited to individual personal experience. For example, it was suggested that our knowledge of the phenomenon is such at this time that no one really knows what causes the problem:

> Every fact situation is quite different and the kinds of people who abuse are quite variable. We have some people who abuse because statistically they identify as pedophile. [But] why does an otherwise active heterosexual male also engage in sexual contact with a four year old? I don't know the answer to that. I don't think any of us do at this stage in time. But there certainly don't appear to be any one or two causes. (KI-8)

Survey respondents also expressed a significant amount of uncertainty, particularly in their responses to statements concerning cycle of abuse, pedophilia, and family dysfunction in the fictional cases presented in Vignette A and Vignette B (See Table 4-1, Table 4-2, Table 4-5). Interestingly, these were the same statements that were selected most often as important general explanations of child sexual abuse (See Table 4-3). With regard to family dysfunction, for example, a third to a half said they did not know if this was a factor in Vignette B.

Chi-Square analysis of data for Vignette B revealed significant differences among professionals concerning the amount of uncertainty they experience (See Table 4-5). Significantly more police survey respondents were uncertain about whether the abuse in Vignette B was an attempt to dominate Paula. Controlling for gender revealed that the effect of profession on this belief remained significant only for males.[14] Police and social workers were significantly more likely than school personnel to be uncertain about whether or not the mother refusing to have sex with the father might have been a factor. A quarter of police and school personnel were uncertain about whether the mother's being away from home a lot could have been a factor, though very few indicated that it might be. Furthermore, males (75.0%) were significantly more uncertain about whether this could have been a factor than were females (20.5%). About half of police and social workers were uncertain about whether the father might have been abused himself as a child, while school survey respondents were significantly more certain that he was. As well, beliefs about the mental illness of Paula's father differed significantly based on age[15] and sexual abuse experience.[16] These uncertainties are undoubtedly affected by the limited information available in the vignette and may be more a reflection of training that encourages one to be fully informed before making a decision, but may also reflect areas where additional training is needed. One social worker commented, in reference to

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[14] χ^2 (8, $\underline{N}$ = 16) = 19.3, $p < .05$

[15] χ^2(12, $\underline{N}$ = 129) = 35.3, $p < .001$

[16] χ_2(16, $\underline{N}$ = 129) = 38.8, $p < .01$

the case in Vignette A, "Every situation like this is an individual one. A thorough evaluation has to be carried out before reaching conclusions as to why the abuse occurred." Another suggested that the child's behaviors "are indicators of some trauma, without more information some of these questions cannot be answered." Others commented that not enough information was given to form an opinion about some items. Although most survey respondents were able to rank general causes, one school survey respondent made the following comment:

> Sorry, I am unable to rank. I do not believe that homosexuality causes child sexual abuse. However, a stressed out homosexual who is living in enforced celibacy with access to children, etc., etc. begins to paint a picture. All these factors may have varying impacts in varying combinations.

Another school survey respondent suggested that the possible causes listed were "all equally important as far as I knew."

After controlling for the effect of gender and experience with sexual abuse cases, the nature of the gender distribution for the police (mostly male) and social work (mostly female) samples meant that chi-square values could not be computed for many of the subpopulations. However, for those that were computed, the data suggests that professional differences remained among females who had little or no experience with child sexual abuse cases, while the professional difference could remain significant for males at any level of experience. Upon controlling for age as well, however, professional group differences remained significant for older males with no experience with sexual abuse and older females with experience with more than 10 cases of child sexual abuse. After controlling for work experience, in addition to the variables above, significance

tended to remain for older males and females, with no sexual abuse experience, and more than 5 years of work experience at their present agency/organization.

Several theories attempt to explain the causes of child sexual abuse in our society. In order to determine the impact of these theories on beliefs, twenty-seven general statements about the causes of child sexual abuse were grouped according to the major theory(s) with which it is associated (there are some overlaps). The average ratings reveal that there is not always a correlation among the items in each group, indicating that perhaps parts of different theoretical perspectives are being adopted without embracing the whole theory, as was the case with key informant data (See Table 4-6). For example, "abuse of power" is given a much higher rating than any other item representing the structural political theory.

The means for each of these theories indicate that the cycle of abuse perspective is rated most highly overall. When each group is looked at individually only social workers rate another theory just as highly (structural/political). Freudian beliefs were given the least importance of all the theories by all groups. There was a significant difference among groups in beliefs associated with two theoretical perspectives. Significantly more social workers rated structural/political (feminist) beliefs as more important than police or school personnel. There was a significant difference in the beliefs related to individual pathology for all groups, with police giving more importance than school and social workers and school giving more importance than social workers to this theory (See Table 4-6). Significant differences were observed between males and

TABLE 4-6:
Average Ratings for Causal Factors and Associated Theory by Profession.

THEORETICAL PERSPECTIVE			AVERAGE RATING Police	Soc. Wrk	School
STRUCTURAL/POLITICAL (FEMINISM):					
Abuse of power/trust			4.6	2.9	4.8
Male socialization			7.5	6.4	7.6
Patriarchy			7.5	7.7	7.8
Society's treatment of women and children as sex objects			7.3	5.8	6.6
Expression of power, intimacy and affection through sex			7.6	6.2	6.4
F= 9.4; df= 2,129; p< .001	**Total Sample Mean: 6.6**	**MEAN**	7.0	5.8	6.7
FAMILY SYSTEMS:					
Family Dysfunction			6.4	5.4	5.5
Mother withholds sex			8.0	8.0	7.8
Mother fails to protect the child			7.8	7.5	7.9
Mother encourages the child to become the "little mother."			7.9	7.9	7.9
Divorce/family reconstruction.			7.3	7.9	7.6
Poor marital relationships.			7.5	7.8	7.7
F= .21; df= 2,129; p>.05	**Total Sample Mean: 7.4**	**MEAN**	7.5	7.4	7.4
SOCIAL FACTORS:					
Stress/alcohol &/or poverty			7.1	5.9	6.1
Pornography			6.3	6.9	6.6
Social/geographic isolation			7.1	6.6	7.5
Lack of education/intellect			7.0	7.4	7.5
F= .63; df= 2,129; p>.05	**Total Sample Mean: 6.9**	**MEAN**	6.8	6.7	6.9
INDIVIDUAL PATHOLOGY:					
Child is provocative/willing			8.0	8.0	8.0
Enforced celibacy			7.9	8.0	7.7
Mental illness			4.9	8.0	6.7
Lack of social skills			7.4	7.5	7.5
Lack of conscience			6.9	7.4	6.8
Irresistible urges			6.7	8.0	7.0
Child fantasies			7.5	7.8	8.0
Mental illness in the mother			8.0	8.0	7.9
Pedophilia			4.1	5.3	5.2
Homosexuality			7.5	8.0	7.8
F= 13.9; df=2,129; p< .001	**Total Sample Mean: 7.2**	**MEAN**	6.9	7.6	7.3
FREUDIAN:					
Child is provocative/willing			8.0	8.0	8.0
Child fantasies			6.7	7.8	8.0
Mental illness in the mother			8.0	8.0	7.9
Mother withholds sex			8.0	8.0	7.8
Mother encourages the child to become the "little mother."			7.9	7.9	7.9
F= 1.2; df= 2,129; p>.05	**Total Sample Mean: 7.9**	**MEAN**	7.9	7.9	8.0
CYCLE OF ABUSE:					
Abuser was abused as a child			3.5	4.2	3.4
Inability to distinguish between sexual and nonsexual forms of affection.			8.0	7.6	7.6
F= .83; df= 2,129; p>.05	**Total Sample Mean: 5.6**	**MEAN**	5.8	5.9	5.5

females for the same two theories, with females rating feminist beliefs as more important than males,[17] and males rating individual pathology beliefs[18] as more important. Professional differences remained significant after controlling for gender.

In summary, even though professionals hold a large variety of causal explanations for child sexual abuse, some views are very prevalent while others are rare. Abuse of power, cycle of abuse, pedophilia, and family dysfunction beliefs are among the more widely accepted explanations, while explanations involving, for example, mental illness in the mother or the victim's willingness to participate are pointed to infrequently, though such beliefs do exist. In fact, every item on a list of twenty-seven suggested causes was selected as among the seven most important causes of child sexual abuse by at least one survey respondent and others not on the list were suggested. For example, low self-esteem, lack of self-discipline/control, and media coverage. In short, there is evidence of philosophical beliefs tied to several etiological theories. For example, the individual pathology perspectives (mental illness, dysfunction, sickness, "emotional difficulty... stemming from childhood", psychiatric disturbance, pedophilia); the sociological perspectives, including family systems ("very difficult family situation") and social factors ("economic", "poverty", education"); and the structural political perspective ("misuse of power", "society plays a role", "females... peoples' property"). Many survey respondents appear to hold beliefs drawn from more than one of those categories. However, overall,

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[17] $F = 9.1$, $df = 1,129$, $p < .01$

[18] $F = 10.7$; $df = 1,129$; $p < .01$

females tended to assign more importance to structural/political causal beliefs than did males, while males rated individual pathology beliefs as more important. Social workers ranked structural/political beliefs more frequently than did police or school personnel. Police gave significantly more importance to individual pathology perspectives (especially pedophilia) than did social workers and school personnel.

Victims

> KI-8: We've gone from the extreme of professionals who absolutely refuse to believe or accept that children were being abused, to professionals at the other end who have, and do - and I've been in circumstances where they have made statements that children do not lie about child abuse. And you set yourself up to be taken down if you approach any issue where it's an absolute acceptance of one side or the other. Neither one is real. And you have to maintain a degree of objectivity and balance in order to do your job.... of course kids lie.

Information related to professionals' beliefs about the victims of child sexual abuse fall into three categories: (a) victim characteristics, (b) victim credibility, and (c) victim responsibility.

The professionals interviewed in Phase I (key informants) were asked how they would describe most victims. Key informants responses were one of two types, (a) responses describing the victims after abuse had occurred and (b) responses describing the kind of children who become victims. Common to the latter view was the issue of lack of emotional nurturing and low self-esteem. However, there were some differences

in their views:

> I: How would you describe most victims of child sexual abuse?
>
> KI-2: Most victims are passive. Most of them are purposely picked to be victims because they are subdued, they are quiet, they long for attention.... victims very generally are people who have very low levels of self-esteem and this kind of attention is better than none.
>
> KI-1: ... very often children who are vulnerable for one reason or another. They are already vulnerable by virtue of their age and status in society so they are certainly potential victims of abuse of power in many contexts, not just the sexual context. Children who are living in environments where there isn't a great deal in the way of nurturing, emotional nurturing, will often be easy targets because they're very responsive to kindly overtures.
>
> KI-5: I don't know if there is a certain type of personality or something that attracts that; if there is a certain softness in some young boys that might bring that kind of thing on them. Because other kids, other boys lived in the same situation and nobody ever went near them.... But then also, I think that some children that are in family situations that are not ideal; that are not fostering their self-esteem - I think self-esteem has so much to do with an awful lot - that probably they might fall prey to that kind of thing.

Those who described victims after abuse had occurred spoke of the victims' reactions and the impact the abuse has on them. One indicated that profound distrust was the most damaging characteristic. But the general view was that victims could exhibit a wide range of behaviours; that "reactions to a very large extent are very individual specific."(KI-8).

> KI-3: ... lots of characteristics.... I've worked with some kids who are really, really withdrawn, just sort of sad looking, very quiet.... immune to pain.... And I've seen other children who, no boundaries, absolutely none,... they're very touchy kids... sexual comments. Other kids are quite aggressive.... They act out and hit out.

They indicated that there is a general tendency for victims to blame themselves and feel guilty for the abuse, but otherwise there is no typical reaction. One survey respondent, however, thought that Genna's reaction in Vignette A was not typical: "In my experience, little girls who have been abused are afraid of men, not friendly to them." Hopefully her

perspective will not limit her ability to detect symptoms of abuse in a child or inhibit her ability to accept that abuse has occurred in cases where the child does not openly express fear of her abuser. There was some agreement that victims' reactions are affected by the responses people make to them and the amount of support they receive when they disclose abuse. According to one, older children are "often very angry and afraid and upset" but smaller children "are more upset with their parents' upset than with what's happened, unless there's been violence involved."(KI-4).

Comments made by survey respondents revealed that though they recognized that the behaviors exhibited by the children described in the vignettes may indicate that abuse had occurred (e.g. "Genna's actions are a sign that she is being abused or is aware of someone else being abuse.") some also cautioned that displaying such behavior did not prove that sexual abuse had occurred. One social worker's reaction was,

> There could be long term reasons as to why she is acting this way. The family unit (original) could have displayed serious problems for years prior to the parents' separation and the child may be reacting. She may feel unwanted in the new family unit and she may be rebelling as a result, she may not be used to rules and organization.

Others expressed this belief that the symptoms described "can be symptoms of abuse but symptomatic of other things as well."

Interestingly, in their descriptions of victims not one of the key informants commented on their gender, despite a widely accepted belief in child abuse research and literature that the majority of victims are female. The survey data offers one possible explanation for this omission. Responses indicated that most survey respondents believe that male children are as likely to be sexually abused as female children (88.6%). Chi-

square analysis suggests that this belief is fairly consistent across the three professions and across gender.

Victim credibility may be an issue of contention between those who respond to cases of child sexual abuse. Key informants seemed to be divided into two camps on this issue. Several commented that when an allegation of abuse is made by a child, the child is always believed. As one said, "I just automatically accept it."(KI-3). However, others indicated that they do not automatically accept what the child says as true. For example, "I'm not a person who always believes the child. I do think there are cases that, for some reason or other, children fantasize, or whatever, not most of the time, but I do think that can happen." (KI-5). One indicated that though they occasionally get false allegations, "the percentage is so small that it's almost negligible....most kids tell the truth about this. I mean, most kids lie to get out of trouble, not to get into it." This key informant sees those who do lie about abuse as doing it to get out of trouble: "generally it happens with thirteen, fourteen, fifteen year old girls who have consented to sex with their boyfriends and then their period is late and then they panic and they've got to come up with a story for mom or dad." (KI-2). The school key informant indicated that,

> Its a real concern for me that there are children out there that are saying they are abused when they're not...It has put on some male teachers a big burden...and it has changed...the nature of the teacher's relationships, especially with a male teacher and a female girl, especially when you're talking about older kids.

It seems male teachers are particularly fearful of being falsely accused by adolescent girls. Such fears are probably fuelled by beliefs similar to that expressed by the administrative school key informant: "Teenage girls easily get infatuated with their teachers, and when

they are rejected they often retaliate and try to get even by accusing the teacher of some sexual advances."

The issue of victim credibility was examined further in the survey using a likert scale containing five items (See Table 4-7). While survey respondents in the study, collectively, find children more credible than not (the mean scale score for all survey respondents was 13.0), statistically significant differences in victim credibility were found among the groups surveyed.[19] An examination of means on the credibility scale revealed that social workers find children significantly more credible (X= 11.2) than police (X= 13.5) and school personnel (X= 13.3) and that females (X= 12.2) find children significantly more credible than males (X= 14.2).[20] Chi-square analysis of the scale items presented in Table 4-7 indicate that professionals differed significantly in their beliefs about the possibility of false accusations from both younger children and adolescents and on whether or not children should always be believed when they report being abused. However, they tended to believe that adolescents make such allegations more often than younger children. Many indicated as well that a child's knowledge of explicit sexual activities did not necessarily indicate abuse, suggesting that children with such knowledge "may have exposure to pornographic material", or, as one police officer remarked, "the information may have been obtained through 'leading questions'." Social workers gave significantly more credibility to the victim in each of these areas than did

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[19] $F = 3.7$, $df = 2,133$, $p < .05$

[20] $F = 9.3$, $df = 1,131$, $p < .005$.

TABLE 4-7:
Percentage in Agreement with Beliefs about Victim Credibility by Gender and Profession.
1= SA; 2= A; 3= DK; 4= D; 5= SD

VICTIM CREDIBILITY BELIEF	FEMALE			MALE			Chi-Square (Gender)	POLICE			SOCIAL WORK			SCHOOL			TOTAL			Chi-Square (Prof.)
	n	%	X	n	%	X		n	%	X[a]	n	%	X	n	%	X	n	%	X	
A child who reports sexual abuse should always be believed even if there appears to be no evidence of abuse.	56	68.3	2.2	28	50.0	2.9	**15.2	23	60.5	2.7	24	85.7	2.0	39	52.7	2.6	86	61.5	2.5	*18.3
Children rarely make false accusations of sexual abuse.	57	69.5	2.3	29	51.8	2.8	**12.8	22	57.9	2.6	26	92.8	1.9	40	54.1	2.6	88	62.8	2.5	**20.5
Children cannot describe sexual activities in graphic detail without having been abused.	52	63.4	2.4	28	50.0	2.9	*10.8	21	55.3	2.8	19	67.9	2.4	40	54.0	2.7	80	57.2	2.6	7.2
Children, especially young children, are usually unable to supply trust-worthy evidence in court.[b]	11	13.9	3.6	9	16.7	3.8	4.3	3	7.9	4.0	5	19.2	3.7	12	16.9	3.5	20	14.8	3.7	11.7
Adolescents rarely make false accusations of sexual abuse.	31	38.8	2.9	14	25.9	3.4	*10.2	10	27.0	3.4	17	60.7	2.5	20	28.1	3.1	47	34.5	3.1	**19.3

* $p < .05$ ** $p < .01$

[a] Strongly Agree and Agree were collapsed into one category of agree. Mean is based on uncollapsed category.

[b] Scores on this item were reversed before computing scale score.

police or school personnel and females gave significantly more credibility to victims than did their male counterparts. After controlling for gender, however, none of the professional group differences described remained significant. On the credibility scale significant differences existed between groups with various amounts of experience with cases of child sexual abuse,[21] independent of gender and profession. However, the relationship was not consistent. That is, having more experience or less experience was not consistent with giving more or less credibility to victims.

The findings for the survey data regarding differences in credibility based on victim age were corroborated by the responses to specific fictional cases (See Table 4-8). Survey respondents were much more likely to believe that abuse had occurred in Vignette A (94.2%), involving a young child, than in Vignette B (38.8%), involving an adolescent. The most common explanation suggested for the situation described in Vignette B was that Paula was lying (1) so she could live with her father, (2) to get even for her new curfew, and/or (3) to get attention. Several survey respondents suggested that Paula's problems and her allegations probably result from feelings of anger and resentment about her parents' divorce and her mother's subsequent remarriage. They suggested that perhaps Paula saw the abuse allegations as a way of removing the step-father from their lives and possibly having her parents reunite. Others suggested that Paula made the accusations because she has problems not arising from sexual abuse: "psychological problems", "abuse of drugs, alcohol", "too much freedom from her real parents", "jealous of her mother's

[21] $F = 2.5$, $df = 4,120$, $p < .05$

happiness", "jealous of the step-father". "She appears very confused and may choose to say the abuse occurred without thinking of consequences", observed a school survey respondent. One police officer who did suspect that Paula had been abused implied this as well: "I would also consider the possibility of her allegations being untrue or distorted given the benefits she could attain if her allegations are believed." A few suggested that she may have fantasized the abuse. Others were even less sympathetic towards Paula. One school survey respondent indicated that "she may be trying to manipulate adults to be able to do her own thing." Another expressed the opinion that "Kids do lie. Especially when they are used to getting their own way." Paula was "probably sexually active with some guys she does drugs with", said another. Yet another, "Though I can see the bias in my own reaction, my honest first reaction is that Paula is a trouble-maker, is streetwise, and knows what strings to pull to get what she needs or wants." However, though a large proportion of professionals thought Paula was likely lying about having been abused and many disagreed with the statement that children never make false allegations and, thus, should always be believed when they make such allegations, it is encouraging that among the actual cases of child sexual abuse they described it was rarely concluded that the child was lying (1.6%). Less encouraging, however, was that a third of these actual cases were not taken to court because there was not enough evidence to support the allegations. The issue of evidence came up in the vignette responses as well. Several survey respondents indicated that there was not enough information given for them to ascertain whether or not abuse had occurred in Vignette B, though few made such

TABLE 4-8:
Percentage of Subjects Indicating Abuse and No Abuse in Vignette A and Vignette B by Gender and Profession.

	TOTAL			POLICE			SOCIAL WORK			SCHOOL		
	Female n %	Male n %		Female n %	Male n %	Total n %	Female n %	Male n %	Total n %	Female n %	Male n %	Total n %
VIGNETTE A:												
YES	76 95.0	51 92.7		2 100.0	34 97.1	37 97.4	23 95.8	3 100.0	27 96.4	51 94.4	14 82.4	65 91.5
NO	4 5.0	4 7.3		0 0.0	1 2.9	1 2.6	1 4.2	0 0.0	1 3.6	3 5.6	3 17.6	6 8.5
Total						38			28			71
Missing						0			0			3
VIGNETTE B:												
YES	36 43.9	15 27.3		0 0.0	12 35.3	12 32.4	15 68.2	1 33.3	17 65.4	21 39.6	2 11.1	23 32.4
NO	41 53.2	40 72.7		2 100.0	22 64.7	25 67.6	7 31.8	2 66.7	9 34.6	32 60.4	16 88.9	48 67.6
Total						37			26			71
Missing						1			2			3

Chi-square (Gender) Vignette A = .30, p> .05
Vignette B = 5.1, p< .05

Chi-square (Profession) Vignette A = 1.9, p> .05
Vignette B = 9.6, p< .01

comments about Vignette A. Those who were unsure indicated that they would "definitely investigate" or do an assessment because "the child should always be taken seriously"; "you can't take a chance" as it is "very possible" that the abuse may have occurred.

For Vignette A there were no significant professional or gender differences in response to whether or not abuse had probably occurred. However, a chi-square analysis revealed a significant gender difference in responses to Vignette B with females almost twice as likely as males to indicate that abuse had occurred. There was a significant professional difference in response as well, with social workers twice as likely as police and school personnel to indicate that they thought abuse had likely occurred. Differences remained significant after controlling for gender. The data suggest that causal beliefs may influence beliefs about the occurrence of abuse in the second vignette. Fifty-four percent of survey respondents choosing pedophilia and 48% of those choosing abuse of power as the primary cause of child sexual abuse indicated that Paula was likely abused, while only 20% of survey respondents choosing family dysfunction and 30% of those choosing cycle of abuse as the primary cause believed that she was probably abused. The findings from the vignettes, then, suggest that the biggest area of contention about the believability of victims is with adolescent victims rather than child victims in general.

Significant differences existed based on the amount of experience survey respondents had with child sexual abuse cases, with those with more experience more

likely to believe that the abuse had occurred than those with less experience.[22] Eighty-five percent of those with no experience said abuse probably did not occur in Vignette B versus 25% of those who had experience with more than 10 cases. Differences remained after controlling for gender, but upon controlling for gender and profession significant differences remained only for male police and female school personnel. Significant differences also existed based on work experience, but, in contrast to experience with sexual abuse cases, the longer one had been working at one's current agency, the more likely one was to believe that abuse had not occurred in Vignette B.[23] Twenty-nine percent of individuals with less than 2 years work experience indicated that abuse probably did not occur whereas 75% of those with 10 to 20 years work experience and 68% of those with more than 20 years work experience thought abuse probably had not occurred.

Another area of disagreement that impacts on the credibility of adolescents is whether or not they are capable of consenting to sex with an adult. Social workers were significantly less likely to think that an adolescent could give such consent while police officers were most likely to think they could.[24] After controlling for gender, professional differences remained significant for males[25] but not for females. None of the differences in the remaining demographic variables (age, gender, experience with sexual abuse, work

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[22] $\chi^2(4, \underline{N} = 123) = 30.5, p \sim 0$

[23] $\chi^2(4, \underline{N} = 131) = 9.9, p < .05$

[24] $\chi^2 = 15.5$; df= 8,135; $p < .05$

[25] $\chi^2(8, \underline{N} = 54) = 33.6, p = .00005$

experience) were significant for this variable.

In terms of the percentage of professionals who attributed some responsibility to the child for the situations described in the vignettes and the amount of responsibility assigned to the victim, again, for Vignette A, there were no significant professional or gender differences and the overall percentage assigning blame (6.9%) and the average blame assigned (1.3%) were very low (See Table 4-9). As one police officer commented, "At an age of four years I find it difficult to be able to place any blame on Genna."

The percentage of survey respondents assigning some responsibility to the child in Vignette B was much higher than for Vignette A (See Table 4-9). Police and school personnel were significantly more likely to blame the adolescent child than were social workers and males were more likely than females to do so. After controlling for gender, professional differences remained only for females.[26] Gender differences remained significant independent of profession.[27] There were very significant differences between groups having various amounts of experience with child sexual abuse cases, with those with the most experience significantly less likely to assign responsibility to the victim in Vignette B than those with little or no experience.[28] These differences remained significant after controlling for gender.[29]

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[26] $\chi^2(2, \underline{N} = 58) = 6.0, p < .05$

[27] $p < .05$

[28] $\chi^2(4, \underline{N} = 92) = 28.7, p = .00001$

[29] $p < .01$

TABLE 4-9:
Percentage of Professionals Attributing some Responsibility to the child in Vignette A and Vignette B.

	Percentage of Subjects Attributing some Responsibility to the Victim.[a]												Average Amount of Responsibility Attributed to the Child.[b]					
	Total		Police		Social Work		School		Male		Female		Total	Police	Social Work	School	Male	Female
	n	%	n	%	n	%	n	%	n	%	n	%	Perc.	Perc.	Perc.	Perc.	Perc.	Perc.
Vignette A	9	6.9	3	9.1	1	3.8	5	7.0	6	11.8	3	3.8	1.3	.5	.6	2.0	1.2	1.5
Vignette B	50	50.0	15	55.6	4	20.0	31	58.5	28	68.3	22	37.9	22.3	31.7	6.3	23.5	34.5	14.0

[a] Chi-square (Profession)
Vignette A: $\chi^2(2, \underline{N} = 130) = .62$, $p > .05$
Vignette B: $\chi^2(2, \underline{N} = 100) = 9.1$, $p < .05$

Chi-square (Gender)
Vignette A: $\chi^2(1, \underline{N} = 129) = 3.0$, $p > .05$
Vignette B: $\chi^2(1, \underline{N} = 99) = 8.9$, $p < .005$

[b] F (Profession)
Vignette A: $F(2, 136) = .92$
Vignette B: $F(2, 136) = 5.1$, $p < .01$

F (Gender)
Vignette A: $F(1, 134) = .3$
Vignette B: $F(1, 134) = 5.3$, $p < .05$

Differences in work experience were also significant for Vignette B,[30] with survey respondents who had more than 10 years working experience being more likely to assign some responsibility than respondents with little work experience. Age differences were not significant for either vignette.

The average amount of responsibility assigned to the child was significantly higher for Vignette B (22.3%) than for Vignette A. Again, for Vignette B the difference was significant for gender, professional group, and sexual abuse experience[31] based on one way analysis of variance. Males assigned more than twice as much blame to Paula as did females; police and school personnel assigned significantly more blame than did social workers (See Table 4-9); and individuals who had been involved in one case or less assigned significantly more blame than those with more experience. After controlling for gender professional group differences were no longer significant but differences in sexual abuse experience remained significant. Further analysis revealed that the reason for the higher percentage of responsibility attributed to the victim in Vignette B was that more survey respondents believed that Paula was probably not abused, whereas more believed that Genna likely was abused. Survey respondents assigned significantly more blame when they thought that the adolescent victim was lying about the abuse allegations (43.3% versus 0.3% when they thought Paula had been abused). One school survey respondent attributed responsibility for the situation, "not for suspected abuse but for contributing to

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[30] $\chi^2(4, \underline{N} = 98) = 9.5, p < .05$

[31] $F = 6.9$, df= 4,91, $p = .0001$

the degeneration of the family." When Paula was believed to have been abused there were no significant gender or professional differences in the amount of responsibility attributed to her for the abuse situation.

In summary, it seems despite research evidence to the contrary, professionals in this study believe that victim gender is not a significant factor determining which children will be sexually abused. If key informant data is reflective of general views, they are more inclined to believe that victim characteristics such as low self-esteem and a need for nurturing may be more significant determinants or predictors of possible victimization. Generally professionals believe children when they make allegations of abuse but they are more cautious about accepting the word of an adolescent than that of younger children. Many expressed a need to investigate further before making up their minds about adolescents. Their hesitation seems to be based on a general belief that children - adolescents in particular - do lie, though not often, about sexual abuse for various reasons. When the child is believed to be lying a significant proportion of the blame for the situation is placed with her/him, but when the allegations are accepted the victim is generally seen as not being responsible. There were significant gender and professional differences regarding credibility issues, though some of this appears to be mediated by experience with cases of child sexual abuse. Social workers appear to give more credibility to child victims than do police or school survey respondents and females tended to find children more credible than do males. These factors were mediated by the survey respondents' experience with cases of child sexual abuse: Those with more

experience tended to be more likely to believe that children would not make such allegations if they were not true.

Perpetrators

> It would be, I think, almost impossible for us to give a description of perpetrators. Our experience is that they come from all walks of life and all kinds of associations and all kinds of practices. The majority of them are rarely individuals who you would look at and say, "Yeah, that doesn't surprise me about him." The reality is that most people we find who are charged with offending against children are the last people you would suspect (KI-8).

Data regarding professionals' beliefs and attitudes about the perpetrators of child sexual abuse can be divided into three categories: (1) general identifying characteristics, (2) specific characteristics, and (3) attribution of responsibility. Many of the individuals interviewed during Phase I of the study expressed a belief similar to that quoted above. That is, that child sexual abusers can be practically anybody and there are no characteristics that easily identify them. As one individual put it, "I've seen some people who would be considered very righteous and upstanding in the community; and I've seen weasels; and everything in between." (KI-4). This belief does not appear to be held by everyone, though, if the following response of one school survey respondent to the situation described in Vignette B is indicative:

> The fact that the step-father is a professional - lawyer - makes some of these questions difficult - because of his obvious education and understanding of laws and morally correct behavior.

The idea that abusers could be anyone was tested in the survey by asking survey respondents' opinion regarding the possibility that there could be child sexual abusers working in their agency/field. Two thirds of survey respondents agreed with this

statement. However, police officers were significantly less likely to believe that their co-workers could be child sex offenders than were social workers and school survey respondents (See Table 4-10). Beliefs about this issue were consistent across survey respondents' age, gender, case experience with sexual abuse, and work experience.

Although many professionals working with cases of abuse believe that abusers can be anyone from any walk of life they did attempt to identify some characteristics that seem to be common to many perpetrators. For instance, all individuals interviewed during Phase I said that most sexual abusers of children are people known to the children, very often a family member. The following quotes express the views of the entire group:

> I: How would you describe most perpetrators?
>
> KI-2: Most of the abuse happens at the hand of a relative or baby-sitter, or neighbour, but most of it is at the hand of a relative. And it's because they have the opportunity.
>
> KI-4: Someone known to the child.... older sisters' boyfriends, common law parents, boarders, ... outside... teachers, taxi drivers.... fair amount of abuse by parents.

One school survey respondent, though, seemed to express some reluctance to accept that the father could have been the abuser of the little girl in Vignette A: "She could be abused but not necessarily by her father. Her behavior is unusual but could be T.V., porn books, etc." This individual also indicated that she could not respond to items about perpetrators for this vignette because "there is no proof about the father".

Most of the individuals interviewed said that more males than females sexually abuse children. The survey results, however, indicated that a fairly large proportion of survey respondents believe that females are as likely to be perpetrators as males (See Table 4-11). Over half of males agreed with this statement, whereas less than a quarter

TABLE 4-10:
Percentage of Each Profession Agreeing with Statements about Child Sexual Abuse Perpetrators

STATEMENTS ABOUT PERPETRATORS	POLICE (n=38)			SOC. WORK (n=28)			SCHOOL (n=74)			TOTAL (n= 140)			Chi-Square (df=8)
	n	%	X[a]	n	%	X	n	%	X	n	%	X	
There are probably individuals working in your agency/field who are child sexual abusers.	21	55.2	2.1	21	75.0	2.0	54	72.9	2.1	96	68.6	2.1	**20.3
Perpetrators of child sexual abuse generally have more than one victim.	30	78.9	1.9	26	92.9	1.6	48	64.8	2.1	104	74.3	2.0	14.9
Most sexual abusers believe they are entitled to sexually abuse children.	17	44.7	2.7	12	42.8	2.8	25	34.3	2.8	54	38.8	2.8	5.6
Females are just as likely to be sexual abuse offenders as males.	25	65.8	2.5	11	39.3	3.0	14	19.4	3.6	50	36.2	3.2	***28.3

** $p < .01$ *** $p < .001$

[a]Average responses reported: 1= strongly agree and 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree. Mean is based on uncollapsed category

of female survey respondents did so, a significant difference. Police officers were significantly more likely to agree with this statement than social workers and school personnel (See Table 4-10). Upon controlling for gender, however, differences remained significant only for females.[32] There were no significant differences based on survey respondent age, work experience, or case experience with sexual abuse.

In addition to these general characteristics professionals revealed various beliefs about the nature of child sexual abusers. As expected, given the data on their beliefs about causes of child sexual abuse, these descriptions reflect beliefs based on a combination of theoretical perspectives. The most commonly expressed beliefs were that child sexual abusers were probably victims of such abuse themselves, were pedophiles, were psychologically or emotionally disturbed, and/or were abusers of power. Much of this information has been presented in the section describing causes and is summarized in Table 4-12. However, some additional comments are revealing. For instance, though very few professionals characterized perpetrators as homosexual there were some conflicting views. One key informant suggested that "homosexuality seems a big part of at least what was involved with the church", and a police officer in the survey commented that, "In relation to homosexuality, it seems from my experience that homosexuality is a very attraction based relationship and as these people lose their attractiveness they prey on more vulnerable persons, leading them to children, etc. (It is not discrimination)." On the other hand, another key informant cautioned that sexual abuse of children should not

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[32] $F = 15.8$; $df = 8$; $p < .05$

TABLE 4-11:
Professionals Responses to Statements about Child Sexual Abuse Perpetrators by Gender (Females: n=82; Males: n=56)

STATEMENTS ABOUT PERPETRATORS	AGREE		DISAGREE		NEITHER		MEAN[a] (SD)		Chi-Square
	F	M	F	M	F	M	F	M	
There are probably individuals working in your agency/field who are child sexual abusers.	72.0	64.3	9.3	7.2	20.7	28.6	2.0 (1.0)	2.1 (1.0)	1.2
Perpetrators of child sexual abuse generally have more than one victim.	73.2	76.8	4.9	7.2	22.0	16.1	1.9 (.9)	2.0 (1.0)	1.1
Most sexual abusers believe they are entitled to sexually abuse children.	43.9	32.7	17.1	25.5	39.0	41.8	2.6 (1.1)	2.9 (1.0)	5.4
Females are just as likely to be sexual abuse offenders as males.	23.5	54.5	61.7	40.0	14.8	5.5	3.5 (1.3)	2.8 (1.4)	**15.1

[a]Average responses reported: 1= strongly agree and 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree. Mean is based on uncollapsed category

**p<.005

TABLE 4-12:
Percentage of Professionals Agreeing with Beliefs about Offender Responsibility in the Vignettes.

BELIEF	POLICE			SOCIAL WORK			SCHOOL			Chi-Square
	n	%	X	n	%	X	n	%	X	
The father sexually abused her because he was unable to resist her sexual advances (Vignette A).	2	5.6	4.4	0	0.0	5.0	3	4.4	4.7	17.3
Irresistible urges	12	35.3	4.4	1	4.0	7.0	21	29.6	4.5	*8.2
The dynamics of the family system are responsible for the sexual abuse, rather than any one family member (Vignette A).	6	16.2	3.9	5	18.5	3.7	17	25.0	3.6	4.5
If abuse occurred, Genna's father is a pedophile (Vignette A)	11	31.5	3.2	8	29.6	3.3	28	41.8	2.6	**25.5
Pedophilia	28	82.4	3.3	14	56.0	3.2	41	57.7	3.1	*6.9
Genna's father must be a very sick man. (Vignette A)	21	56.7	2.5	7	25.9	3.4	49	73.1	2.1	**22.5
Mental illness	22	64.7	3.2	0	0.0	0.0	25	35.2	4.3	***26.2
Psychiatric testing of the step-father will probably reveal some kind of mental illness or other psychological disturbance. (Vignette B)	5	38.5	3.1	4	22.2	3.9	11	44.0	3.1	*21.7
The stress on the step-father to prove himself as a lawyer probably led to the abuse. (Vignette B)	1	7.7	4.2	0	0.0	4.6	2	8.0	4.3	*18.1
Since the step-father appears to be a user of alcohol, the sexual abuse of Paula was likely caused by a drinking problem. (Vignette B)	6	46.2	3.1	0	0.0	4.6	6	24.0	3.6	***37.6
Stress/Alcohol/Poverty	8	23.5	4.0	13	52.0	3.9	35	49.3	4.1	*7.2
The step-father was probably abused himself as a child. (Vignette B)	5	38.5	2.7	8	44.4	2.6	18	72.0	2.0	*18.9
Cycle of abuse	28	82.4	2.6	19	76.0	2.9	63	88.7	3.8	2.5
Enforced celibacy	1	2.9	3.0	0	0.0	0.0	8	11.3	5.0	4.8
Lack of education/intellect	14	41.2	5.5	4	16.0	4.5	10	14.4	4.6	**10.5
Lack of social skills	5	14.7	4.2	5	20.0	5.6	9	12.7	3.9	0.8
Lack of conscience	11	32.4	4.6	5	20.0	5.2	27	38.0	5.0	2.7
homosexuality	5	14.7	4.6	0	0.0	-	4	5.6	4.8	5.2

* $p < .05$ ** $p < .01$ *** $p < .001$

be confused with sexuality, referring to assumptions about homosexuality.

The results of both the interview data and the survey data indicate that there may be some conflicting beliefs and attitudes regarding how professionals feel about child sexual abusers and whether or not they believe that perpetrators sexually abuse children with explicit deliberateness. Comments that describe perpetrators as "domineering type of people", "a power hungry man", or "perverted", suggest that some professionals have little sympathy for the abuser. One police officer in the survey expressed his feelings very clearly: "I believe that men who abuse children are very perverted, not sick. They are well aware of their actions but are too selfish about their own sexuality to care about hurting another even if it is only a child." One school survey respondent who believed male socialization may contribute to child sexual abuse nevertheless had little sympathy for abusers:

> Maybe society encourages men to find the "waif-like" Kate Moss types sexy and appealing. However, it is up to the individual to act upon these feelings! If the child was being sexually overt, she was taught and because of her age, cannot differentiate between appropriate and inappropriate behaviour.

Professionals who believe that abusers were likely abused themselves as children were less critical of the perpetrator and his actions. One key informant explained that as a result of their own abuse abusers often lack knowledge about appropriate boundaries between adults and children and do not have parenting skills and, thus, may "inadvertently" abuse their own children when they become adults. A school survey respondent echoed this belief: "Genna's dad possibly was a victim of child sexual abuse and/or his own father could have been a pedophile attracted to young girls (he learned

along the way this behavior was acceptable within family.)" Such beliefs led some survey respondents to attribute some responsibility for the abuse situation to the "father's family of origin". A social worker from the survey suggested that some offenders with a mental delay may not be able to distinguish between sexual and nonsexual forms of affection because they have had no "'appropriate' sexuality counselling."

Emotional difficulties were often cited as common characteristics of abusers by those interviewed: "problem in their ability and their skills relating to adults"(KI-2); "a lot of emotional needs that are unmet"(KI-3); "low self-esteem"(KI-5) "they're very insecure"(KI-3). Some key informants suggested that many perpetrators do not think they are doing anything wrong. One attempted to explain this in the context that subconsciously abusers may feel they have a right to abuse others because they were abused themselves. Such beliefs imply understanding of the abuser's behavior. Approximately 40% of survey respondents agreed with this concept of perpetrator behavior (See Table 4-11). For instance, one school survey respondent explained that the step-father described in Vignette B abused the adolescent because he "did not have highly enough developed abilities to cope with the desire to perform inappropriate actions - i.e. lack of own self esteem/self confidence/self knowledge." Another school survey respondent, though, was sceptical of the idea of "irresistible urges", suggesting that the abuser only thinks his urges are uncontrollable. The data suggest that there were no significant gender or professional differences with regards to this belief.

When characteristics related to social factors, such as poverty, poor education, and

alcohol abuse, were used to describe perpetrators some cautioned that "that's not to say that sexual abuse is exclusive to the lower socioeconomic groups."(KI-1). Those expressing these views were often sympathetic towards the perpetrator as well. "I cannot blame society outright even though I believe the step father to be a 'victim' (and I use the term extremely loosely) of his upbringing AND his inability, in spite of being an adult to cope with his problems." Others emphasized that even though society is a factor influencing the abuser's behavior, the abuser "must be held accountable for his actions." Society was given a mean of 5.3% and 4.9%, respectively for the situations described in Vignette A and Vignette B.

An analysis of the amount of responsibility attributed to the individuals accused of child sexual abuse in Vignette A (83.5%) and Vignette B (51.8%) indicate that no matter how understanding they were of the perpetrators' actions, the majority of survey respondents assigned most of the responsibility to the perpetrator, though only 29.2% and 18.0%, respectively, of the subjects held the offender entirely responsible. When the survey respondents who thought abuse did not likely occur in Vignette B were omitted the average responsibility attributed to the perpetrator increased to 86.3% and 35.4% of survey respondents assigned complete responsibility to the abuser.

In Vignette A police assigned significantly more blame to the perpetrator (91.5%) than did school survey respondents (78.2%).[33] Upon controlling for gender this

[33]F= 7.0, df= 2,129, p< .01

difference remained significant only for males.[34] In Vignette B, on the other hand, social workers assigned significantly more responsibility to the perpetrator (78.4%) than did police (47.1%) and school (44.1%) survey respondents.[35] Females assigned significantly more responsibility (60.3%) to the perpetrator in Vignette B than did males (38.5%).[36] Professional differences remained significant only for females after controlling for gender.[37] As well, individuals with experience with cases of child sexual abuse assigned significantly more responsibility to the perpetrator in Vignette B than those with less experience.[38] Those with no such experience attributed a mean of 28.1% of the responsibility to the perpetrator, whereas those with experience with more than 10 cases attributed 85.8% of the total responsibility to the perpetrator. This difference remained significant after controlling for gender. However, the lower percentage of blame assigned by police and school survey respondents and by respondents with no case experience with child sexual abuse is largely a factor of a significantly greater likelihood that they thought abuse did not occur. For those who believed that abuse had occurred in this vignette there were no significant professional, gender, or case experience differences in the amount of responsibility attributed to the perpetrator.

The significant differences between professionals based on work experience were

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[34]F=11.9; df= 2,50; p< .001

[35]F= 6.8, df= 2, 99, p< .01

[36]F= 8.4, df= 1,98, p< .005

[37]F= 4.7; df= 2,57; p< .05

[38]F= 13.7; df= 4,87; p~ 0

also related to beliefs about the occurrence of abuse in Vignette B. For the entire sample, those who had worked longer at an agency tended to assign less responsibility than those who had worked at their agency for a shorter period of time. For example, those who had worked at the agency for less than two years attributed 91.2% of the blame to the perpetrator, yet those with more than 10 years experience attributed an average of only 40% of the blame to the perpetrator. However, for those who believed Paula had been abused there were no significant work related differences in the amount of responsibility attributed to the perpetrator. Differences among various age groups were not consistently related to more or less responsibility being attributed to the perpetrator, although there were significant differences between some groups.

An analysis of the amount of responsibility attributed to perpetrators in Vignette A and Vignette B and their agreement or disagreement with statements that characterize abusers reveal that beliefs related to these statements did not significantly affect the amount of responsibility attributed to the abuser if respondents believed abuse had occurred. For both vignettes, though, individuals agreeing with family systems beliefs attributed slightly less responsibility to the perpetrator (79.4% and 80.0%, respectively) than those disagreeing with such beliefs (87.8 and 89.0%, respectively). Survey respondents who did not think that the abuser was mentally ill attributed slightly more responsibility (90.3%) than those who thought he was (82.0%). As well, the few individuals who agreed with the statement that the perpetrator was unable to resist the child's advances attributed slightly less responsibility (72%) than those who disagreed

with this statement (86.6%).

Thus, again, even though some of the key informants share some beliefs about perpetrators and for the most part hold him responsible for the abuse, there is considerable variability in their views which could have implications for collaborative recommendations for treatment and/or punishment.

Non-Offending Mothers

> The mom should have been more observant and recognized the inappropriate behavior prior to someone outside the home noticing it. I do not believe she caused the problem but could have helped prevent further occurrences. (Comment made by police officer responding to the survey)

The major theme emerging from the data concerning the role of non-offending mothers is that though they are not often blamed for *causing* abuse when a father figure sexually abuses a child, they are still sometimes accused of knowing the abuse was going on and blamed for failing to protect the child.

The view among key informants was that though "things are getting better than they used to be" there is still some mother-blaming occurring among professionals who respond to cases of child sexual abuse. One commented that, "I have seen some blame being placed on the mother. Maybe not so much blame, but her role in it....You know, not being able to protect the child, for whatever reason." (KI-3). Key informants expressed concern as well about the lack of sensitivity among professionals to the mother's situation and to women's needs in cases of incest. This lack of sensitivity may lead some professionals to be careless about the way they talk to mothers, possibly

leading them to think, "'Oh, she is blaming me.' Sometimes its just in the wording. People are not careful sometimes in the way they ask questions." (KI-3).

The survey data indicate that very few professionals see a mother's withholding sex or being away from home as contributing to the occurrence of abuse. A few indicated that the mothers' failure to protect the child could be a causal factor, with more yet believing that this failure to protect the child made her partly responsible for the abuse (See Table 4-13, 14). Interestingly, given a fictional situation (Vignette A), females were significantly more likely than males to attribute responsibility to the mother for not protecting the child (Table 4-14). As well, school survey respondents were significantly more likely than police or social work survey respondents to attribute responsibility for this reason. Significantly more social workers than police or school survey respondents indicated a belief that mothers should apologize to their children for not protecting them, while equal percentages of males and females agreed with this belief. However, the professional differences were no longer significant once the effect of gender was controlled.

When asked specifically to give a percentage to the amount of responsibility the mother has for the abuse situations in Vignette A and Vignette B there were no significant chi-square differences in the percentage of each profession or of males and females who assigned some blame to the mother in either vignette. Overall, 62.3% assigned her some portion of responsibility in Vignette A and 70.0% did so in Vignette B. The average amount of blamed assigned was 10.2% for the first vignette and 12.3% for the second.

TABLE 4-13:
Percentage of Survey respondents for Each Profession Agreeing with Statements about Attitudes and Beliefs About Non-Offending Mothers in Vignettes A and B and in General.

ATTITUDE OR BELIEF	χ^2 or F (Prof.)	POLICE n	POLICE %	SOC. WORK n	SOC. WORK %	SCHOOL n	SCHOOL %
VIGNETTE A:							
Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	**20.3	7	18.9	6	22.2	20	31.3
Percentage of subjects attributing some responsibility to Genna's mother.	.2	19	57.6	18	69.2	44	62.0
Average percentage of responsibility assigned to Genna's mother.	F= *3.5		5.5		8.6		12.9
VIGNETTE B:	8.4	0	0.0	0	0.0	1	4.0
The step-father probably began to molest Paula because his wife did not want to have sex with him.							
If Paula's mother had not been away from home so much the abuse probably would not have occurred.	10.8	4	30.8	0	0.0	1	4.0
Percentage of respondents attributing some responsibility to Paula's mother.	.2	18	66.7	14	70.0	38	71.7
Average percentage of responsibility assigned to Paula's mother.	F= 1.7		9.4		10.4		14.5
GENERAL:	2.5		0				
Mother withholds sex.							
Mother fails to protect the child.	12.4		4				
Mother encourages child to become the "little mother."	5.2		1				
Mental illness in the mother.	1.7		0				
Mothers of victims of child sexual abuse are often victims of wife abuse and thus are secondary victims.	*17.9	26	68.4	15	53.6	45	61.7
Most mothers of incest victims knew the abuse was going on.	10.4	19	50.0	12	42.9	24	32.9
Incest victims' mothers should apologize to their children for failing to protect them from the abuse.	*16.3	17	44.7	20	71.4	25	37.5

* $p < .05$ ** $p < .01$

TABLE 4-14:
Percentage of Survey respondents Agreeing with Statements Related to Attitudes and Beliefs about Non-Offending Mothers in Vignettes A and B and in General. Percentage in Agreement by Gender.*

ATTITUDE OR BELIEF	AGREE		DISAGREE		NEITHER		MEAN* (SD)		Chi-Square (df= 4)
	F	M	F	M	F	M	F	M	
VIGNETTE A:									
Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	29.3	19.6	50.7	74.5	20.0	5.9	3.4 (1.3)	4.1 (1.4)	**13.4
Percentage of responsibility attributed to Genna's mother.	65.4	58.8							.6
VIGNETTE B:									
The step-father probably began to molest Paula because his wife did not want to have sex with him.	2.6	0.0	76.9	75.1	20.5	25.0	4.4 (.9)	3.9 (.8)	6.0
If Paula's mother had not been away from home so much the abuse probably would not have occurred.	2.6	6.3	76.9	75.1	20.5	18.8	4.3 (.9)	3.9 (1.1)	6.6
Percentage attributing some responsibility to Paula's mother.	69.0	73.2							.2
GENERAL:									
Mothers of victims of child sexual abuse are often victims of wife abuse and thus are secondary victims.	62.2	60.0	11.0	16.3	26.8	23.6	2.3 (.9)	2.3 (1.1)	1.8
Most mothers of incest victims knew the abuse was going on.	34.1	47.3	23.2	16.3	42.7	36.4	2.8 (1.1)	2.6 (1.0)	2.6
Incest victims' mothers should apologize to their children for failing to protect them from the abuse.	45.7	45.5	22.2	29.1	32.1	25.5	2.6 (1.2)	2.7 (1.3)	1.3

*Average responses reported: 1= strongly agree and 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree. mean is based on uncollapsed category.

** p< .01

One way analysis of variance reveal no significant gender differences in the average amount of responsibility attributed to the mother in either vignette. School survey respondents, however, attributed significantly more responsibility to the mother in Vignette A than did police officers (12.9% versus 5.5%). Individuals with no experience with cases of child sexual abuse assigned significantly more responsibility to the mother than those with experience with more than one case.[39] When individuals who indicated that abuse probably did not occur in the vignettes were removed from the analysis the percentages assigning blame were 61.0% for Vignette A and 54.2% for Vignette B, and the average amount of blame assigned was 9.1% and 5.7%, respectively. The percentage of responsibility assigned ranged from none to 70% in the first vignette and from none to 25% in the second vignette.

Perhaps mothers are held partly responsible because many professionals (one third to one half in this study) believe that most mothers of incest victims know that the abuse is going on (Table 4-13). As one school survey respondent put it, "It's hard to imagine that a mother would not eventually know." The percentage of survey respondents indicating this belief seemed to be consistent across professions and gender. However, Table 4-15 suggests that significant shifts seem to occur in professionals' beliefs concerning this issue as their experience with cases of child sexual abuse increases. More than half of those with little or no experience expressed uncertainty about this statement, while very few of those who had experience with more than 10 cases did so. However,

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[39] $F = 6.5$, $df = 91,4)$, $p < .001$

Table 4-15:
Professionals' Beliefs About Mothers' Knowledge of Incest Based on Experience with Cases of Child Sexual Abuse.

Number of Cases Professionals have been Involved With	Agree		Don't Know		Disagree	
	n	%	n	%	n	%
No Experience (n= 57)	19	33.3	31	54.4	7	12.3
One Case (n= 5)	1	20.0	4	40.0	0	0.0
Less than 5 cases (n= 22)	10	45.5	10	45.5	2	9.1
5 to 10 cases (n= 13)	6	46.2	3	23.1	4	30.8
More than 10 cases (n= 29)	16	55.2	2	6.9	11	37.9

χ^2 (Case Experience) = 33.8, df= 16, $p < .01$

the effect of experience seems to be to change the "Don't Knows" into expressing some opinion, rather than to influence whether or not professionals come to agree or disagree with this statement.

Complicating the issue of beliefs about the mother knowing about incest and assigning responsibility was the finding that more than half of all survey respondents and more than half of all professions and both genders were inclined to agree with the statement that mothers are often secondary victims in families where incest occurs. Seventy one percent of survey respondents who believe mothers usually know also indicated a belief that the mother is often a victim as well. One school survey respondent commented that, "they are victims even if not abused as they are often tacitly accused of not preventing it", indicating that if they are not victims of their husbands they become victims of the system was the abuse is disclosed. Police officers and school personnel were significantly more likely to agree with this statement than were social workers (Table 4-13). School personnel were also significantly more likely to respond "Don't Know" to this item. These differences were no longer significant after controlling for gender. Individuals who had worked at their agency/organization for more than 2 years were significantly more likely than those with less than 2 years working to be uncertain about the mother as victim.[40] Whether or not survey respondents viewed mothers as secondary victims or not did not seem to have much impact on the amount of responsibility attributed to her.

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[40] $\chi^2(16, \underline{N} = 101) = 26.3, p < .05$

In summary, though key informants indicate the situation is improving, a large percentage of professionals still assign some portion of responsibility to the mother for their children's abuse and many still accuse them of knowing the abuse was going on; and may blame them for not stopping it. Female survey respondents were significantly more likely than males to believe that the mother is partly responsible for the abuse in Vignette A. There were no other significant gender differences, but once professional differences were analyzed controlling for gender the professional differences did not remain significant. When profession alone was considered, school survey respondents were more likely to say that the mother is partly responsible for the abuse in Vignette A and assigned a higher proportion of the blame to her. Social workers were less likely than police and school survey respondents to indicate a belief that mothers are often secondary victims in sexual abuse situations and more likely to believe that mothers of sexually abused children should apologize to them for not having protected them from the abuse.

Treatment

Treatment of Victims

Two major themes emerged from the data regarding the necessary elements of treatment for victims of child sexual abuse: (1) A child-centred approach, and (2) an individualized approach to treatment plan. All individuals interviewed during Phase I emphasized the importance of treatment. The victims' right to choose what process to follow was an important aspect of treatment for some key informants: One proposed that

victims "should have more say in what happens to them and be given permission to make decisions.... Everything should be explained to them and they should have choices" (KI-2). Another advised that "we have to look at it from the child's point of view and not necessarily from the point of view of the agencies involved." (KI-4). Yet another key informant was careful to stress that "I think it is really inappropriate to sit kids down and...really force the issue. That is why entrance into very focused abuse groups, I think, should only be seen as one option in a range of treatment options for a child and family."(KI-1). A chi-square analysis of the survey data suggest that some professionals are more likely than others to agree with the views expressed by key informants (See Table 4-16). For example, social workers were significantly more likely than police or school survey respondents to believe that children should have more control over and more say about what happens when abuse is disclosed and that victims who seem reluctant to deal with the abuse issues should not be pressured to do so. However, more than a third of school survey respondents expressed uncertainty about whether or not children need more control, suggesting a lack of knowledge about treatment issues. Survey respondent comments regarding particular treatment selections suggest that at least some of them take a child centred approach: A police survey respondent recommended "Whatever treatment victim is comfortable with", and a social work survey respondent advised that family therapy, including the offender, might be appropriate "when child is ready" and "if child wants this". There were no significant gender, case experience, work experience, or age differences regarding these issues. Upon controlling for gender

TABLE 4-16:
Percentage of Child Care Agents Agreeing with Statements about Treatment of Victims

STATEMENTS ABOUT TREATMENT OF VICTIMS	POLICE (n=38)			SOC. WRK (n=28)			SCHOOL (n=74)			Chi-Square (df= 8)
	n	%	X[a]	n	%	X	n	%	X	
Victims of child sexual abuse will never, even with treatment, fully recover from the trauma of child sexual abuse. They will be scarred for life.	16	42.1	2.8	11	39.3	3.2	44	59.5	2.3	*15.9
Children should have more control over and more say about what happens when abuse is disclosed.	21	55.2	2.7	23	82.1	2.1	33	45.9	2.6	**22.1
If victims are reluctant to talk about the abuse in therapy, they should be strongly encouraged to "deal with the issues."	24	63.2	2.3	7	25.0	3.4	38	52.0	2.5	**23.8
Most child sexual abuse does not affect the child's personality development, particularly if the abuse is nonviolent.	3	7.9	4.6	3	10.7	4.5	4	5.4	4.6	4.8
It is not the sexual abuse that causes problems for an abused child but the reaction of parents and others upon disclosure.	11	28.9	3.7	12	44.4	3.0	15	20.5	3.8	**21.7

* $p < .05$ ** $p < .01$

[a]Average responses reported: 1= strongly agree and 5= strongly disagree. Strongly agree and agree were collapsed into one category of agree, and strongly disagree and disagree were collapsed into one category of disagree. mean is based on uncollapsed category.

professional differences remained significant only for females.[41]

Some key informants also stressed the importance of "normalizing" the abuse experience for the child and the potential for recovery:

> I think it is incredibly important to label the potential for health for children and families.... to give people messages that they can survive and be healthy people; not just survive and carry their victim status with them as their badge.

This view is significant given that a large proportion of professionals surveyed believe that victims would never recover from the trauma of child sexual abuse (See Table 4-16). School survey respondents were significantly more likely than police and social workers to believe this. One comment in particular by a school survey respondent was disturbing: "I'd like to add that from my experiences with these victims, they seem to sabotage every chance or opportunity for happiness or success in their own lives." Differences were not significant after controlling for gender. Age, work experience, case experience and gender differences were not significant independent of profession, suggesting that this belief may not be responsive to these variables. The finding that half of professionals indicate a belief that victims will never recover from child sexual abuse while the other half are unsure or disagree has significant implications for a comprehensive approach to promoting the child's recovery.

The split in beliefs about the above issue has implications for a related theme as well. That is, the belief that a very important element in how well a child handles the abuse is the reaction she gets from parents and professionals when she discloses sexual

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[41] $\chi^2(8, \underline{N} = 82) = 16.7, p < .05$

abuse and the support she subsequently receives: "A lot of times it's not the actual abuse that... causes the most problem for the child, it's the reaction when the child talks about it."(KI-3). Among survey respondents, social workers were significantly more likely than police and school survey respondents to take this view of problems related to abuse (See Table 4-16). A few survey respondents commented that both the abuse and adults' reactions affect the child's adjustment. One social worker remarked that, "The sexual abuse certainly causes problems but recovery and moving beyond the victim role largely depends upon the reaction of others during disclosure." Upon controlling for gender differences remained significant only for males.[42] Again, case experience and age differences were not significant, but differences in work experience were significant.[43] Survey respondents with less than two years work experience and those with more than 10 were significantly less likely to agree with the above statement about treatment than those with between 2 and 10 years experience.

Most of the individuals interviewed in Phase I talked about the issues above without referring to specific treatment modalities or goals. One key informant suggested a range of treatment options, from "having a very supportive family" to psychotherapy and drug therapy, depending on the level of abuse and stuff."(KI-7). From this key informant's experience, many children find group programs (e.g. at the Janeway) very therapeutic, so she recommends such treatment to clients. Individual counselling may also

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[42] $\chi^2(8, \underline{N} = 55) = 25.1, p < .002$

[43] $\chi^2(16, \underline{N} = 135) = 30.0, p < .05$

be recommended by this key informant. One recommended the Thomas Anderson Centre or the Janeway and another suggested that the victim and perpetrator both be given counselling to help the perpetrator admit his guilt and help the victim understand that what he did is a sickness. This key informant's opinion was that the perpetrator and victim should then be brought together so that the perpetrator can ask for forgiveness and the victim give it. This "seems to be the most healthy solution to it all", according to this key informant, "the victims can't be healed as long as they're harbouring resentment and seeking revenge."(KI-6). Apart from these recommendations most individuals interviewed indicated that treatment would differ for different victims, depending on the relationship between the victim and offender, as well as other factors, and talked in terms of general, long-term goals such as "helping family work things out and possibly stay together". Survey respondents made similar comments. One social worker advised that, "Different therapies depend on frequency of abuse, willingness of family for counselling, etc." For example, comments about family therapy including the offender revealed that the recommendation of this therapy could be subject to certain conditions. The opinion of one social worker was that this could be an option for the family in Vignette A (Genna), "If family decides to stay together and father has accepted responsibility and is receiving help." Other social work and school survey respondents expressed these sentiments as well. However, a different opinion was expressed about Genna's family by the following school survey respondent: "I do not see a rebuilding, patching of the original family as a desired option. There has been a significant betrayal of trust." Such differences of

opinion need to be addressed and the underlying philosophies analyzed in order to determine appropriate treatment plans.

Because of the expressed importance of individualizing programs by professionals in Phase I, during Phase II survey respondents were asked to select treatment recommendations for specific fictional vignettes describing cases of child sexual abuse. Table 4-17 shows the treatment recommendations made by all survey respondents for the victims in Vignette A and Vignette B. The most frequently recommended treatments for both vignettes were individual and group therapy. Despite this, however, survey respondents reported that in actual cases of child sexual abuse only 19.7% of victims received group counselling and 55.8% received individual counselling. Eight percent received family counselling excluding the offender and 1.6% received family counselling including the offender.

An examination of the figures in Table 4-17 reveals that there are prominent differences in the percentage of survey respondents who recommended group therapy and self help for the victims in the two vignettes. These two treatment modes were recommended more often for Paula (Vignette A) than for Genna (Vignette B). A gender breakdown revealed that these differences existed for women's treatment recommendations, but not for the recommendations made by men (See Table 4-18). A breakdown of the professional groups indicated that school survey respondents differed noticeably in their treatment recommendations for the two vignettes on the two treatment modes listed above. Social workers recommended group therapy more often for Paula

than for Genna, while police officers recommended group therapy more often for Genna than for Paula.

Table 4-18 reveals that there are additional significant differences between treatment recommendations made by male and female survey respondents. In Vignette A women were significantly more likely to recommend family therapy including the offender than were males, both alone and in conjunction with family therapy that excluded the offender. Social workers were twice as likely as police to recommend family therapy that included the offender. As well, a third of police officers and a quarter of school survey respondents recommended family therapy excluding the offender while no social workers social workers did so.[44] For the victim in Vignette B women were significantly more likely than men to recommend group therapy and social skills training. Social workers (94.1%) and school personnel (89.7%) recommended group therapy significantly more often than police officers (33.3%).[45] Males were equally likely to recommend family therapy, excluding the offender, for both victims, but were much less likely to recommend including the offender, when prescribing family therapy for Paula (6.3%) than when prescribing it for Genna (30.8%).

There is some evidence that etiological beliefs may affect treatment recommendations as well. For example, there were some noticeable differences in the percentage of survey respondents recommending family therapy in Vignette A and

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[44] χ^2 (14, $\underline{N}$ = 132) = 27.5, $p < .05$

[45] χ^2 (2, $\underline{N}$ = 53) = 23.9, $p < .001$

TABLE 4-17:
Treatment Recommendations made for Victims in Vignette A and Vignette B

Treatment Recommendation For Victim	Percentage of Professionals Recommending this Treatment			
	Vig. A (n=132)		Vig. B (n=59)	
	n	%	n	%
Group therapy	63	47.7	46	78.0
Individual therapy	110	83.3	50	84.8
Mother-daughter counselling Alone	32	24.2	12	20.3
Along with other dyad combinations[a]	21	15.9	21	35.6
Father-daughter counselling Alone	4	3.0	0	0.0
Along with other dyad combinations[a]	21	15.9	19	32.2
Step-father-daughter counselling Alone	N/A		2	3.4
Along with other dyad combinations[a]	N/A		11	22.1
Family therapy - including offender	50	37.9	16	27.2
Family therapy - excluding offender	29	22.0	17	28.8
Both	23	17.4	8	13.6
Self-help group	47	35.6	33	55.9
Social Skills training	49	37.1	17	28.8

[a]These three categories overlap.

TABLE 4-18:
'Treatment Recommendations made for Victims in Vignette A and Vignette B by Gender of Respondent.

Treatment Recommendation For Victim	Chi-Square	Female n	Female %	Male n	Male %
VIGNETTE A		(n = 78)		(n = 52)	
Group therapy	.4	39	50.0	23	44.2
Individual therapy	2.2	70	89.5	40	76.9
Mother-daughter counselling	1.6	17	21.8	14	26.9
Father-daughter counselling	1.6	3	3.8	1	1.9
Both	1.6	16	20.6	6	11.5
Family therapy - including offender	*16.7	33	42.3	16	30.8
Family therapy - excluding offender	*16.7	17	20.5	16	30.8
Both	*16.7	17	20.5	6	11.5
Self-help group	.2	29	37.2	17	32.7
Social Skills training	2.0	31	39.7	17	32.7
VIGNETTE B:		(n = 42)		(n = 16)	
Group therapy	****16.3	39	92.9	7	43.8
Individual therapy	.8	35	83.3	14	87.5
Mother-daughter counselling Alone	5.9	8	19.0	4	25.0
Along with other dyad combinations*	5.9	17	40.5	3	18.8
Father-daughter counselling Alone	5.9	0	0.0	0	0.0
Along with other dyad combinations*	5.9	16	38.1	2	12.5
Step-father-daughter counselling Alone	5.9	2	4.8	0	0.0
Along with other dyad combinations*	5.9	10	23.9	1	6.3
Family therapy - including offender	12.8	15	35.7	1	6.3
Family therapy - excluding offender	12.8	11	26.2	5	31.3
Both	12.8	7	16.6	1	6.3
Self-help group	.34	23	54.8	10	62.5
Social Skills training	**6.9	15	35.7	2	12.5

*These three categories overlap.

Vignette B on the depending on whether they cited family dysfunction (93.3% and 73.4%, respectively), cycle of abuse (78.8%; 60.7%), abuse of power (90%; 50%), or pedophilia (63%; 40.7%) as the primary cause of child sexual abuse. The percentage of survey respondents recommending family therapy including the offender for Vignette B ranged from 33.4% for those choosing cycle of abuse to 80% for those choosing family dysfunction as primary causes.[46]

A recurring complaint among the individuals interviewed in Phase I was that there are not enough services for children, thus limiting choices when selecting treatment options. Survey results also revealed a low level of satisfaction with currently available treatment programs, with only 20.8% of all survey respondents expressing satisfaction and 38.4% expressing dissatisfaction. Typical comments made by social workers were that there is "little available" and "waiting lists [are] way too long." A significant 40.8% indicated they were not sure whether they were satisfied or not. The data suggests that lack of familiarity with cases of sexual abuse and treatment programs accounts for the large number of professionals being unsure about their level of satisfaction. Significant differences existed between groups with various amounts of experience,[47] but once the individuals who were unsure were removed from the analysis the differences were no longer significant. Over half of those with no case experience were uncertain, whereas less than 10% of those with some experience expressed uncertainty. As well, social

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[46]The significance of these differences was not tested statistically.

[47]$\chi^2(16, \underline{N} = 120) = 36.3, p < .005$

workers were significantly less likely to report being sure than the other two groups (17.9% versus 37.1% and 52.2%) suggesting that lack of information about treatment programs and outcomes may be a factor. Further analysis revealed that most of the variance for case experience and uncertainty about treatment programs was attributable to female school survey respondents.[48] One teacher commented, for instance, that she "suspect[s] they are lacking", indicating that she does not really know. Much of the remainder was attributable to male police officers with 5 to 20 years of work experience.[49]

Once survey respondents who were unsure about satisfaction with treatment were removed from the analysis gender and professional differences in satisfaction remained. Females indicated being dissatisfied significantly more often than males (83.0% versus 36.7%)[50] and social workers (78.3%) and school survey respondents (75.0%) reported being dissatisfied significantly more often than police (36.4%).[51] Upon controlling for gender, however, professional differences were no longer significant. There are significant differences in level of satisfaction and work experience with more work experience being linked with more satisfaction. For example, no survey respondents who had been working for less than two years at their agency were satisfied with treatment programs, whereas 61.5% of those with more than 20 years experience reported being

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[48] $\chi^2(9, \underline{N} = 42) = 44.7,\ p \sim 0$

[49] $\chi^2(9, \underline{N} = 11) = 18.0,\ p < .05$

[50] $\chi^2(1, \underline{N} = 77) = 17.2,\ p < .00003$

[51] $\chi^2(2, \underline{N} = 77) = 11.1,\ p < .005$

satisfied.

In summary, many professionals believe that treatment recommendations for victims of child sexual abuse should be individualized to meet the needs of the victim(s) and their families. However, gender and professional factors seemed to have a greater influence on treatment recommendations than did case characteristics. For most of the issues examined, social workers beliefs differed significantly from those of police and school survey respondents. These differences were strongly linked to gender in many cases. In addition, school respondents expressed significantly more uncertainty in this area than did social workers and police officers, suggesting that they have less knowledge regarding treatment matters than the other two groups of professionals surveyed. When selecting treatment options for fictional cases most professional differences seem to revolve around the appropriateness of family therapy, group therapy, social skills training and self help groups for a particular case. Also commonly expressed as important elements in treatment, especially by social workers, was that child victims should have more control over and more say in what happens in the treatment process and that adults need to respond in an appropriate manner to disclosures of abuse in order to ensure that no further damage is inflicted on the victims. Again, though, there were some significant differences of opinion on these issues that may need to be addressed by professionals responding to cases of child sexual abuse.

Treatment of Perpetrators

The main theme that emerged from the data regarding beliefs about how perpetrators of child sexual abuse should be dealt with was that they should be punished, but they should also be treated. What we've been doing for offenders, professionals said, has not been working. Jail is not enough; they need treatment too. Other trends revolve around beliefs about (1) the individualization of treatment/punishment programs, (2) the effectiveness of treatment, and (3) perpetrator denial.

The individuals interviewed during Phase I expressed strong support for treatment despite some concerns about the effectiveness of current treatment programs. As was the case with victims, the general feeling was that services for offenders are lacking and that we should be spending money to improve such services because, as one key informant put it, "the life of the perpetrator is as valuable as the life of the child." (KI-1). There was equally strong support for punishment, with key informants believing stricter punishment is necessary in order to impress upon society and individual perpetrators that this is a very serious crime:

> I think, you know, that society has to let those people know that that's not going to be tolerated and it needs to be punished. But I don't think it stops there. Its one thing to put them away and let them out. They haven't learned anything other than they feel awful bad while they're in there. Some people might benefit from it in that they have a lot of time to think and go over, but it doesn't address the roots of the behavior and you need to do that through some kind of therapy (KI-7)

> ...right now a person can spend more time in jail for killing a moose out of season, or were they poaching something, or catching codfish. They can get more for that than for abusing a child. I think we have to weigh that very heavily, you know, where our priorities are. (KI-2).

A few of the individuals interviewed during Phase I recommended jail as appropriate

punishment, but most did not refer specifically to incarceration. It is not clear whether they assumed incarceration would be the punishment or if they had other forms of punishment in mind. At least one felt that being incarcerated in a regular jail was not really the answer. This key informant recommended that there be a place set up specifically for sex offenders and "instead of getting three years in jail, they get three years in there." (KI-3). Those suggesting that punishment be decreased were rare, and even then it was in the context of sacrificing punishment in favor of treatment:

> ... maybe a shorter sentence for the perpetrator, but with the obligation to take counselling and to attend programs, rather than just incarceration. If there's somebody that is a threat to society, by all means. but if this is a person who has really been ostensively [sic] a good person; raising a family, providing for them, but then it's discovered that he has been having this waywardness whereby he's abused children....
> ... if half the time that he was in, or even all the time he was in there he was doing programs, fine.... But at least if they can't get the programs in there, give them half the term in there and the other half to really do programs. (KI-6)

Table 4-19 indicates that survey respondents hold similar views about treatment and punishment of child sex offenders. Incarceration and treatment were recommended by more than two-thirds of survey respondents, either alone or in combination with other treatment/punishment in fictional cases. Yet, in actual cases of abuse described by the survey respondents approximately 73% were incarcerated while only 37% received treatment. In support of their recommendations for vignettes most survey respondents expressed general beliefs that abuse should always be reported, that every child sex offender should be prosecuted and imprisoned to deter others from such crimes, and that current sentences are too lenient. Police were significantly more likely than social workers or school personnel to agree with imprisonment and significantly less likely to

TABLE 4-19:
Punishment/Treatment Recommendations for Perpetrators in Vignette A and Vignette B and Percentage of Subjects Agreeing with General Statements Related to Punishment/Treatment.

TREATMENT VERSUS PUNISHMENT	TOTAL n	%	POLICE n	%	SOC WRK n	%	SCHOOL n	%
VIGNETTE A:	(n= 132)		(n= 37)		(n= 27)		(n= 68)	
Incarceration	16	12.1	4	10.8	2	7.4	10	14.7
Probation	4	3.0	1	2.7	0	0.0	3	4.4
Court-ordered Treatment	17	12.9	1	2.7	5	18.5	11	16.2
No Court Action	1	0.8	0	0.0	0	0.0	1	1.5
Incarceration + Probation	0	0.0	0	0.0	0	0.0	0	0.0
Incarceration + Court-Ordered Treatment	41	31.1	11	29.7	8	29.6	22	32.4
Probation + Court-Ordered Treatment	8	6.1	0	0.0	0	0.0	8	11.8
Incarc. + Prob. + C-O Treatment	33	25.0	19	51.4	8	29.6	6	8.8
No Punishment or Treatment Recommended	11	8.3	0	0.0	4	14.8	7	10.3
VIGNETTE B:	(n= 60)		(n= 13)		(n= 18)		(n= 29)	
Incarceration	8	13.3	2	15.4	2	11.1	4	13.8
Probation	2	3.3	1	7.7	0	0.0	1	3.4
Court-Ordered Treatment	4	6.7	0	0.0	2	11.1	2	6.9
No Court Action	0	0.0	0	0.0	0	0.0	0	0.0
Incarceration + Probation	2	3.2	1	7.7	0	0.0	1	3.4
Incarceration + Court-Ordered Treatment	17	28.3	0	0.0	7	38.9	10	34.5
Probation + Court-Ordered Treatment	4	6.7	0	0.0	0	0.0	4	13.8
Incarc. + Prob. + Court-Ordered Treatment	15	25.0	7	18.4	5	27.8	3	10.3
No Punishment or Treatment Recommended	6	10.0	1	2.6	2	11.1	3	10.3
GENERAL:	(n= 140)		(n= 38)		(n= 28)		(n= 74)	
Prosecution of parent abusers should be avoided if the child can be adequately protected without it.*	13	9.3	3	7.9	6	22.2	9	12.3
Every child sex offender should be imprisoned for some period of time to deter others from these crimes.*	18	13.0	34	89.5	18	64.3	45	63.4
Sentences for child sexual abuse offenders are too lenient.	97	70.8	33	86.8	27	96.4	58	79.5
Not all cases of child sexual abuse need to be reported to the police.	125	84.9	1	2.6	6	21.4	6	8.2

Vignette A χ^2 (Profession) = 39.9, df= 16, p< .001; Vignette B χ^2 (Profession) = 24.9, df= 18, p> .05
χ^2 (Gender) = 10.4, df= 8, p> .05; χ^2 (Gender) = 14.3, df= 9, p> .05

*χ^2 (Profession) p< .05

agree with the statement that prosecution be avoided if it is not needed to protect the child. As well, police survey respondents suggested a combination of incarceration/probation/court-ordered treatment for the perpetrator in Vignette A significantly more often than did school personnel and social workers. Social workers and school personnel were significantly more likely to recommend court-ordered treatment alone for the perpetrator in this vignette. There were no significant differences for gender, age, number of years worked, or case experience for any of these variables. Recommendations for punishment versus treatment in Vignette B did not differ significantly for any particular group of survey respondents.

A look at specific treatment recommendations for the offender, however, indicate that there are significant differences here (See Table 4-20). A chi square analysis revealed that for the perpetrator in Vignette A social workers and school personnel recommended family therapy significantly more often than did police officers. However, this difference was no longer significant after controlling for gender. School personnel and police officers were significantly more likely to recommend self-help groups and parenting/social skills training than were social workers. Differences remained significant only for female survey respondents after controlling for gender.[52] Survey respondents who had experience with five to ten cases of sexual abuse were significantly less likely than others to recommend parenting/social skills training.[53] As well, males (59.6%)

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[52] $\chi^2(4, \underline{N}\ 78) = 13.1, p < .05$ and $\chi^2(6, \underline{N} = 78) = 19.1, p < .005$, respectively

[53] $\chi^2(12, \underline{N} = 127) = 22, p < .05$

TABLE 4-20:
Percentage by Profession Choosing a Particular Treatment Modality for Perpetrators in Vignette A and Vignette B

	Chi-Square		Police		Soc Wk		School	
TREATMENT MODALITY	Prof.	Gender	n	%	n	%	n	%
VIGNETTE A:			(n= 37)		(n= 27)		(n= 68)	
Group Therapy	7.4		21	56.8	16	59.3	45	66 2
Individual Therapy	3.9		25	67.6	23	85.2	49	72.1
Marital Therapy	[b]27.5	*	15	40.5	12	44.4	26	38.1
Father-Daughter Counselling	4.0		5	13.5	6	22.2	16	23.5
Family Therapy	*27.5	*	15	40.5	20	74.1	38	65.7
Self Help Group	*12.3		13	35.1	3	11.1	33	48.5
Behaviour Modification	.2		21	56.7	11	40.7	31	47.0
Aversion Therapy	13.5	*	2	13.5	3	11.1	19	28.0
Sex Therapy	13.5	*	18	48.6	8	29.6	32	47.1
Sex Education	13.5	*	8	21.6	4	14.8	19	28.0
Parenting/Social Skills Training[a]	**19.1		20	55.6	7	26.9	34	51.5
Anger Management	.2		6	16.2	4	14.8	15	22.0
VIGNETTE B:			(n= 12)		(n= 18)		(n 29)	
Group Therapy	2 6		6	50 0	14	77 8	19	65 5
Individual Therapy	***20.0	**	5	41.7	15	83 3	24	82.8
Marital Therapy	19.3		3	25.0	6	33.3	10	34.4
Father-daughter Counselling	8.9		0	0.0	1	22.2	9	31.0
Family Therapy	19.3		0	0.0	10	55.6	14	48.2
Self Help Group	4.7		1	8.3	3	16.7	9	31.0
Behaviour Modification	8.2		5	41.7	10	55.6	13	44.8
Aversion Therapy	8.8		3	25.0	3	16.7	8	27.5
Sex Therapy	8.8		3	25.0	6	33.3	12	41.0
Sex Education	8.8		3	25.0	2	11.1	8	27.5
Parenting/Social Skills Training	12.4		3	25.0	4	15.4	13	17.8
Anger Management	8.2		0	0.0	2	11.2	9	31.0

*p< .05 **p< .01 ***p< .001

* Police (n= 36); Social Work (n= 26); School (n=66)

[b]Marital therapy and family therapy were analyzed within the same variable. However, a look at the results reveal that most of the variance for those two treatment modes is attributable to differences in recommendations for family therapy.

recommended sex therapy more often for Paula's abuser than did females (35.8%) while older survey respondents were more likely to recommend some combination of sex education, sex therapy, and aversion therapy for the perpetrator in Vignette A than were younger respondents.[54]

In Vignette B individual therapy was recommended for the perpetrator significantly less often by police officers than by social workers and school personnel. As well, males (56.3%) recommended this treatment significantly less often than females (81.0%), and survey respondents between the ages of 30 to 39 were significantly less likely to recommend it than other respondents.[55] Upon controlling for gender the professional differences were no longer significant.

As was the case with their views concerning appropriate treatment for victims of abuse, the individuals interviewed during Phase I tended to think that treatment and punishment recommendations for perpetrators would depend upon the nature of each case. One suggested that treatment may not be suitable for some and recommended sentences would depend on the circumstances. Several survey respondents made comments to this effect as well in their responses to whether or not incarceration and/or probation would be appropriate or whether or not the abuser should be prosecuted at all. They indicated generally that punishment and treatment would depend on the "type and seriousness of abuse". An examination of the figures for general punishment/treatment (Table 4-19)

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[54] $\chi^2(21, \underline{N} = 130) = 39.3, p < .01$

[55] $\chi^2(6, \underline{N} = 58) = 12.6, p < .05$

reveals no outstanding differences in recommendations for perpetrator A and perpetrator B. There were no striking differences in specific treatment recommendations either for the total sample. However, police survey respondents recommended several modes of treatment more often for the perpetrator in Vignette A than for the perpetrator in Vignette B. There were a couple of noticeable differences in social work and school recommendations for the two perpetrators as well.

Key informants expressed a variety of views about the effectiveness of current treatment programs, ranging from, "we do a very poor job of working with perpetrators, by and large" (KI-1), and "treatment doesn't seem to really work with offenders unless it's long, long term and very intense, and right now we don't have anything that meets the bill"(KI-2) to "from what I understand, they're quite successful" (referring to offender group programs run by Emmanuel House) (KI-7). As indicated above, many felt that programs for perpetrators could be more effective if they were individualized to meet the needs of the individual. Yet some also believed that even with treatment we could "never consider them cured" and that a large number of perpetrators cannot and should not be trusted again.

Further complicating the issue of treatment effectiveness is the perpetrator's willingness to accept treatment. Key informants were divided on this issue as well. Some thought that, "most of them deny right up to the end."(KI-2), while others believed that a great deal of them do admit it and that "a lot of them would love to have the opportunity to live their life again so they would never do anything of that nature."(KI-6).

Regardless of which view professionals expressed regarding perpetrator willingness to admit their crime, there was a generalized belief that the offender cannot be helped unless he admits to the abuse. Similar results were found for survey respondents. Eighty-eight percent indicated that they believed therapy could not be successful if the abuser is in denial. Chi-square analysis revealed that there were no significant professional, gender, case experience, work experience or age differences in responses to this variable.

In summary, there appears to be a widespread belief among key informants and survey respondents that perpetrators of child sexual abuse should be punished for their crimes, but that they should also be treated, even though current treatment programs are not particularly effective, especially when the perpetrator is in denial. They also believed that specific treatment and punishment recommendations would depend on the nature and severity of the abuse, along with other circumstances. Despite this, however, few significant differences emerged from survey data in relation to their recommendations for the perpetrators in fictional vignettes. The most obvious difference was that police officers tended to emphasize punishment more frequently (Table 4-19) and recommend specific treatment modes less frequently (Table 4-20) than either social workers or school survey respondents.

Awareness and Prevention

Awareness of Abuse as a Serious Social Problem

As described in the section on punishment for offenders, key informants and survey respondents view child se. ual abuse as a serious crime that should be punished. As seen earlier, very few survey respondents believed that prosecution should be avoided or that some cases of abuse need not be reported. However, there seem to be intervening factors that determine whether prosecution is a suitable intervention:

> There are some cases that never get far enough that charges even get laid because determinations are made very early in the process that, for whatever number of reasons, there is no point, or it's not in the child's best interest to take this matter to court. In cases that pass the first hurdle and actually charges get laid, the numbers of them that end up going through court would actually be fairly significantly high and we would put far more through court at that stage than we would actually pull. But that's ignoring the number that didn't get to the stage where charges were actually laid. (KI-8)

Lack of evidence is perhaps the most common reason why charges may not be laid and the perpetrator not prosecuted. The social work key informant asserted that, "When [the police] do an investigation and lay a charge, they have to be pretty confident that when this goes to court there is going to be a case and there is going to be enough evidence to present to the court." This was reiterated by the police administrative key informant. This informant indicated that another reason that charges may not be laid is that the child's story has too many inconsistencies:

> We may interview the child on one occasion and she will tell one story. Perhaps when we interview her again she may tell a different story, one that is inconsistent with the first. On a third occasion she may tell yet another story. Plus, she may have told parents, guidance counsellors, and so on, different stories. Then you don't have anything to go on. It might not be that the child was not abused, just that she's traumatized and not a strong witness. It's not her fault. But this kind of case will not get anywhere in court. Her testimony will be picked apart.

Survey respondents' views corresponded with key informants' in that they

indicated widespread agreement that this is one of the most serious issues affecting children's safety today and that sentences for abusers are too lenient (See Table 4-21). The only significant difference among professionals was that survey respondents over age 50 were less likely than younger respondents to agree that child sexual abuse is one of society's most serious problems.[56] With regard to related issues, police officers were significantly more likely than school or social work respondents to indicate uncertainty (39.5%) about whether or not there could be child sexual abusers working in their agency. As well, individuals with no experience with cases of child sexual abuse were significantly more likely to respond "Not Sure" to the statement that perpetrators typically have more than one victim. This uncertainty decreased and agreement increased progressively as case experience increased. There were no significant gender differences on any of these issues.

Promoting Awareness

There was a high level of agreement among key informants and survey respondents that broader community education is needed on the dynamics of child sexual abuse. At present DOSS, the RNC, and the shelters seem to be playing the largest role in training and promoting awareness of the dynamics of child sexual abuse within their own and among other agencies. The police key informant describes having received "a tremendous amount of training in this area" and is really impressed with the new training

[56] $\chi^2(3, \underline{N} = 135) = 12.4, p < .01$.

TABLE 4-21:
Percentage of Professionals Agreeing with Statements About Child Sexual Abuse as a Serious Social Problem.

BELIEF ABOUT PROBLEM	POLICE		SOCIAL WORK		SCHOOL		Chi-Square (Prof.) (df= 8)
	n	%	n	%	n	%	
Child sexual abuse is one of the most serious issues affecting children's safety in society today.	38	100.0	25	92.9	67	90.6	7.7
There are probably individuals working in your agency/field who are child sexual abusers.	21	55.2	21	75.0	54	72.9	**20.3
Perpetrators of child sexual abuse generally have more than one victim.	30	78.9	26	92.9	48	64.8	14.9
Sentences for child sexual abuse offenders are too lenient.	33	86.8	27	96.4	58	79.5	8.9
Not All cases of child sexual abuse need to be reported to the police.	1	2.6	6	21.4	6	8.2	9.6
Prosecution of a parent abuser should be avoided if the child can be adequately protected without it.	3	7.9	6	22.1	9	12.3	*18.2
Every child sex offender should be imprisoned for some period of time to deter others from these crimes.	34	89.5	18	64.3	45	63.4	*16.5

* p< .05 **p< .01

package that they have developed for the training of police officers and social workers. Apparently, this package has now been given to Memorial University for accreditation. The police are also involved in a series of seminars using this training package that will be offered provincially and will include crown attorneys and medical people in addition to police officers and social workers. The social work key informant also indicated that the RNC are doing a lot in the way of training. However, another key informant believes that police officers need better training, particularly in the area of investigating children.

In addition to training their own personnel, individuals from these agencies go out into the community upon request to do presentations (e.g. schools, medical school, groups such as Pathfinders, and Girl Guides). The key informant for each of these agencies indicated that they do a fair amount in this area but each would like to see their agencies do more. The police key informant would like more done in the way of public education with adults rather than focusing mainly on children. The social work key informant would like to have a public relations person in her agency to handle this aspect of responding to the problem. The school key informant indicated that the schools do quite a bit to promote awareness among children through family living and education in sexuality and sexual abuse, starting with the primary grades. However, some other key informants were under the impression that many schools do not address these issues until family living is introduced in Grade 9. Whatever the case, there are indications that some school personnel are uncomfortable with this particular role: "a lot of teachers are not

comfortable talking about certain things, especially in relation to one's sexuality." For this reason, the school key informant would like to see professionals come into the schools more often to talk with students.

Though some agencies/organizations have a greater role than others in promoting awareness and prevention of child sexual abuse, most key informants believed that they and their agency/organization had some role to play in this area. It is likely that their beliefs about the seriousness of this problem and how deep-rooted they think it is will influence how they approach prevention strategies.

Prevention

> Changing sexist attitudes are important but I don't know if they'll affect sexual abuse - Hopefully it will. (School survey respondent).

As suggested above, many key informants felt that more could be done in the area of prevention. There was a general feeling, for instance, that the church and school system could play a larger role in promoting awareness as a preventive measure and that they should be more open about the problem. As one said,

> the churches have to take the responsibility in saying, "we won't tolerate this any more; it's not appropriate; we won't condone it" and they will do everything they can to support agencies who are doing something about it, because a lot of people look to their church as an example to follow, and to be a role model sort of thing. And if the churches were giving permission to people to talk about it - if the minister did a sermon on it one Sunday morning in church.... because that's what is going to decrease the problem: to talk about it. And they never have, and the churches have been one of the biggest offenders there, that you didn't talk about this kind of stuff. Nobody did. But the church has to play a lead role in changing that.

While acknowledging, along with other key informants, that the schools have a large role to play in prevention in terms of teaching kids basic messages about appropriate and

inappropriate touching and developing self-esteem, one key informant felt that prevention efforts are currently too focused on children and that adults need to take more responsibility for preventing child sexual abuse. This key informant proposed that adults can begin to take more responsibility by taking "ownership of the problem" and "creating a whole mind set; a climate that children are not there to be abused by other people." (KI-2). Among survey respondents, social workers were significantly more likely than school or police respondents to believe that too much responsibility for prevention is being placed on children.[57] When the neutral category was removed from analysis, females were significantly more likely than males to believe that this is the case.

Most survey respondents were not satisfied with current prevention efforts or with the interprofessional coordination of such efforts. It is significant that a third of respondents responded "Don't Know" when asked about current prevention efforts (See Table 4-19), yet were much less likely to respond in a neutral manner to most *general* statements about prevention (See Table 4-22). This suggests that uncertain responses to items about current programs may be related more to lack of knowledge about current prevention efforts than to lack of knowledge about what is necessary in order for prevention to be effective. As one school respondent remarked, referring to current prevention programs, "I don't know enough about this."

There was a high level of agreement among and across the three professions surveyed that changing sexist attitudes is an important aspect of prevention of child sexual

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[57] $\chi^2(2, \underline{N} = 101) = 9.3, p < .01$ without the neutral category.

abuse. Male survey respondents were significantly more likely than females to indicate a neutral (i.e. "Not Sure") response to this statement. Police officers were significantly less likely than social workers and school survey respondents to indicate a belief that effective prevention requires radical changes to our social structure (See Table 4-22), but were significantly more likely to indicate a "Not Sure" response. The difference remained significant only for female survey respondents upon controlling for gender.[58] As well, overall, female survey respondents were significantly more likely than males to think that changing our social structure is necessary. However, again, this significance disappeared once the neutral category was removed, indicating that males were significantly more likely to respond "Not Sure" to these items. Finally, individuals who had been working at their current agency more than two years were significantly more likely to believe that prevention requires radical changes to our social structure than those who had worked at their present agency less than two years.[59]

In summary, though DOSS, the RNC, the shelters, and, in some cases, the schools, are doing quite a bit to promote awareness of the dynamics and seriousness of child sexual abuse and are focusing efforts on prevention, there is a general belief that more needs to be done, particularly by the schools and churches. Most professionals think that one aspect of prevention is prosecution and appropriate punishment of perpetrators.

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[58]Females: $\chi^2(6, \underline{N} = 82) = 15.5, p < .05$; Males: Not significant.

[59]$\chi^2(12, \underline{N} = 136) = 29.9, p < .005$ when neutral category included
$\chi^2(8, \underline{N} = 109) = 19.3, p < .05$ when neutral category excluded

TABLE 4-22:
Percentage Agreeing with Statements about Prevention of Child Sexual Abuse by Profession and Gender.

VIEW/BELIEF	Male		Female		Chi-Sq Gender (df=4)	Police		Social Work		School		Chi-Sq Prof (df= 8)
	n	%	n	%		n	%	n	%	n	%	
Broader community education is needed on child sexual abuse.	55	98.2	78	95.1	*9.9	38	100.0	27	96.4	70	94.6	10.0
Too much responsibility is being placed on children for prevention of child sexual abuse.	23	41.1	44	53.7	7.6[a]	13	34.2	22	78.5	32	43.2	*18.4
Education programs that focus on changing sexist attitudes should be an important component of attempts to prevent sexual abuse.	43	78.2	70	86.4	*8.1	28	73.6	26	92.9	61	84.7	11.9
In order to prevent child sexual abuse radical changes need to be made to our social structure.	33	60.0	62	75.6	*10.2	19	50.0	25	89.2	52	71.2	**19.1

[a]When neutral category removed, $\chi^2(1, N = 99) = 4.3$, $p < .05$

* $p < .05$ **$p < .005$

However, the reality of the justice system sometimes makes this impossible. In terms of the specific requirements of effective prevention males and police officers indicated more uncertainty about whether such measures as changing sexist attitudes or completely changing our social structure would successfully prevent children from being abused.

Role Knowledge and Professional Satisfaction

Roles: Knowledge

The data related to professionals' knowledge about their role in responding to child sexual abuse consists of (1) general information from key informants and administrative key informants, and (2) specific responses to a vignette situation from survey respondents. The two types of data were compared on a limited level to obtain more information on police, social work, and school role awareness. Indications are that many professionals are clear about their role in responding to the problem of child sexual abuse.

Key informants were asked:

> In which of the following areas does your agency and yourself have responsibilities regarding the problem of child sexual abuse?
>
> (a) Promoting awareness of the abuse problem
> (b) Observation and detection
> (c) Reporting and referrals
> (d) Investigation
> (e) Treatment, counselling, and follow-up
> (f) Prevention
> (g) Other

For the most part key informants seemed to be very clear about their roles and their responses were consistent with statements made by administrative personnel about the roles of their particular agency/organization. Certainly, all were aware of their legal

responsibility to report suspicions of child sexual abuse. Some reported that their obligation was to report directly to police, while others said that they were supposed to report to the Department of Social Services. One is required to report to a higher official within their organization, who would then report to police. Social workers and police are supposed to report to each other.

Most felt that they had a role to play in prevention and in promoting awareness of the abuse problem. Some were more specific in their descriptions of how they did this than were others. Several indicated that they go out into the community to educate particular groups when invited, and gave examples of how they have been doing this. Many key informants described in detail the procedures they follow when they receive a report or a disclosure of child sexual abuse.

Information about the knowledge that survey respondents have about their role in responding to child sexual abuse was obtained by asking respondents what actions they would take given the following situation:

> Vignette: A mother from a middle-class family comes to the office where you work and says that she believes her daughter is being sexually molested by her step-father. The woman is convinced that this is happening, and does not know what to do.

Responses to this vignette were compared to the roles described by administrative and front-line key informants for their particular agency. However, it must be noted that the comparison between the two types of data is very limited and must be interpreted with caution because some survey respondents may not have been sure what role they were supposed to take in responding. School survey respondents seemed to be most confused

by this issue, making comments such as, "What role am I supposed to be playing here?" and, "I am assuming I am in the role of a social worker as I answer this." On the other hand, not all social work survey respondents seemed to have taken the role of a social worker. One suggested, for instance, that she would encourage the mother to report the situation to DOSS.

Most survey school respondents (88.9%), indicated that they would report the fictional allegation to DOSS (See Table 4-23). Several pointed specifically to the Children's Protection Unit or Child Welfare, which is consistent with the *Provincial Child Abuse Policy and Guidelines* (Dept. of Education, 1993). One survey respondent indicated that after reporting to DOSS she would leave it up to them to follow through. A significant number (41.7%) indicated that they would also report to the police. The school key informant was also under the impression that teachers were required to report to the police though nothing in their policy suggests this. As well, a quarter of respondents said they would interview the child even though the guidelines specifically say not to (Dept. of Education, 1993). Generally, though, school respondents were most likely to report to DOSS and were significantly less likely to take many of the other actions listed than were police and social workers. However, they were significantly more likely to suggest psychological examinations than were social workers, though less likely to do so than police officers.

According to the Administrative key informant for DOSS, the DOSS policy on child abuse is not a public document and is continuously under revision. Thus, no direct

TABLE 4-23:
Percentage of Professionals Indicating That They Would likely take Various Interventions Given a Fictional Case of Suspected Child Sexual Abuse.

INTERVENTION	POLICE		SOCIAL WORK		SCHOOL		Chi-Square
	n	%	n	%	n	%	
Interview the mother	36	94.7	23	82.1	33	45.8	***30.6
Report to Department of Social Services	37	97.4	22	78.6	64	88.9	5.9
Interview the child	35	92.1	19	67.9	19	26.4	****46.3
Visit the home	26	68.4	14	50.0	12	16.7	****30.6
Report to police	31	81.6	16	57.1	30	41.7	***16.1
Interview the family	18	47.4	9	32.1	8	11.1	***18.1
Interview the step-father	29	76.3	7	25.0	15	20.8	****35.0
Suggest a physical examination	33	86.8	17	60.7	30	41.7	***20.9
Suggest a child psychological examination	25	65.8	5	17.9	27	37.5	***16.2
Suggest a psychological exam for the step-father	14	36.8	2	7.1	12	16.7	**10.0
Suggest a family psychological exam	12	31.6	2	7.1	8	11.1	**9.8
Encourage the parent to press criminal charges	24	63.2	6	21.4	15	20.8	***22.3
Try to get the step-father removed from the family	24	63.2	13	46.4	17	23.6	***17.1
Try to get the child removed from the family	10	25.3	2	7.1	6	8.3	*8.2
Other	4	10.5	5	17.9	3	4.2	5.0

* p< .05 ** p< .01 *** p< .001 ****p~0

comparison could be made. Both the social work administrative key informant and the social work key informant indicated that all cases of sexual abuse received by DOSS are reported to the police. However, only a little more than half (57.1%) indicated that they would take this action for the situation described in the vignette. One commented that she would first "investigate to see if any evidence to take to police." Another indicated that if the child interview caused suspicion she would report the situation to the police.

The social work key informant indicated that the first step taken when an allegation of abuse is received is to do a risk assessment in order to determine the safety needs of the child. An important part of this assessment is collecting information about family history. Many social work survey respondents indicated that they would interview the mother (82.1%) and child (67.9%). However, fewer indicated that they would visit the home (50%) or interview family members (32.1%) or the step-father (25%). One survey respondent pointed out that interviewing the step-father was a police role, but another indicated that if the child interview caused suspicion she would likely interview the step-father. Several others indicated that they would take actions such as attempting to have the step-father removed from the home or suggesting psychological examinations "only if interview with child indicates abuse" and that they would attempt to get the child removed only "if step-father isn't removed." The social work key informant also indicated that the child was removed only if the abuser was not removed from the home or if it was believed that the child could not be protected adequately in the home.

Both the police administrative and police key informants informed me that the

primary role of the police is investigation and protection of society. They would "interview child, perpetrator, take statements from other people." High percentages of police respondents said they would interview the mother (94.7%), the child (92.1%), and the step-father (76.3%) and suggest a physical examination (86.8%), which is consistent with their investigative role. Two-thirds would try to get the step-father removed from the home, which is consistent with the protective role. One indicated that he would press charges if the victim was comfortable with this. Again, some indicated that taking such actions as having the perpetrator removed from the home and encouraging the laying of charges would depend on the results of the investigation. Each of the actions listed in Table 4-23 were chosen more often by police respondents than by social work and school respondents.

Roles: Satisfaction

> Professionally, I would like to be more accessible to my clients. Personally, I've been working with child sexual abuse [for several years]... and I've found that I've been able to support families well, just not enough. The bit of support that I can give, I think I do a good job.... We all have a certain standard that we would like to be able to do. But... realistically, the system doesn't allow for it.(KI-7)

Among key informants role satisfaction ranged from "I think we do a really good job in this area in particular."(KI-2) to "more satisfied than I used to be... but always feel I could do better", and "I do too much from what one person can do, but I keep doing it because there's nobody else doing it." The satisfaction level of many was linked to and limited by time and resources as well as by the limitations placed on one's role by other

agencies. One commented that "once I'm told the situation then I deal with it. But... you can't deal with the... situation if you don't know anything about it."(KI-5).

> KI-8: Satisfied with the role, yes; satisfied that we have sufficient time to perform our role adequately, no. We're badly over-stressed in terms of the demands on our time and our ability to do our job.... if I'm asked whether on a case by case basis I think I do a good job on every file, the answer is no. I know I don't.... We don't have the ability within the resources that we've got to do the kind of job that every kid deserves to have done when there is a complaint of abuse made.

A little more than half of survey respondents expressed satisfaction with their own role in responding to child sexual abuse (See Table 4-24). However, only 7% reported being dissatisfied. The remainder responded "Don't Know". Chi-square analysis indicated that school survey respondents were significantly more likely than police and social workers to respond "Don't Know" to this issue. Such a response seemed to be largely a function of experience with cases of child sexual abuse[60] and profession together, perhaps because school professionals have significantly less experience with cases of child sexual abuse than social workers and police officers. Individuals with experience with one case or less were significantly more uncertain than those with more experience. However, there are indications that dissatisfaction among school survey respondents is related to the limitations placed on their role as well:

> I feel that the role of the school is limited, and there is a sense that we don't know what is going on as a case progresses. When a young child discloses to us (teachers) our role is not to explore but simply report to Social Services and drop the issue. The only problem is, the child discloses to a teacher who he/she trusts - and yet we are not in a position to "get involved". How do you tell a 7 or 10 year old, "I'm sorry that your neighbour is doing that. I'll find someone to help you. But we won't talk about it any more"? I understand why this is my role - but in a practical sense it can be difficult.(School Survey Respondent)

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[60] $\chi^2(12, N = 119) = 32, p < .005$

TABLE 4-24:
Survey respondents' Satisfaction with the Current Response to Child Sexual Abuse.
1= VS; 2= S; 3= DK; 4= D; 5= VD

SATISFACTION WITH RESPONSE	Satisfied n	Satisfied %	Don't Know n	Don't Know %	Dissatisfied n	Dissatisfied %	Mean[a]	SD
Satisfaction with own role in responding to the problem of child sexual abuse.	72	56.3	47	36.7	9	7.0	2.4	.80
Satisfaction with outcome of last case involved with.[b]	24	42.9	10	17.9	22	39.3	3.0	1.15
Satisfaction with agency response.[b]	84	63.6	32	24.2	16	12.2	2.3	.93
Satisfaction with outcome of most cases.[b]	44	33.1	41	30.8	48	36.1	3.1	.98
Satisfaction with current treatment programs.	27	20.8	53	40.8	50	38.4	3.3	.94
Satisfaction with current prevention programs/efforts.	30	22.9	42	32.1	59	45.1	3.3	.95
Satisfaction with coordination of prevention efforts.	41	31.5	42	32.3	47	36.2	3.1	.96

[a]The categories Satisfied and Very Satisfied were collapsed into one category of Satisfied. The categories Dissatisfied and Very Dissatisfied were collapsed into one category of Dissatisfied. Mean is based on uncollapsed category.

[b]Information available only for subjects who reported being involved with a case of child sexual abuse (Police: n=19; Social Workers: n= 21; School: n=16).

Satisfaction with Current Response

> I think I would feel fairly comfortable in saying without exception that in this country, much less in this province, nowhere are we appropriately resourced or sufficiently resourced to deliver the kind of service that children have the right to expect if they have to come into a system such as this.... A lot kids are still not getting an adequate response in the system; a lot of families are still not getting an adequate response within the system. (KI-8)

The general feeling among key informants with regard to the current response to child sexual abuse is that although things are much better now than they were a few years ago, we still have a long way to go in providing a satisfactory response to the problem of child sexual abuse. In essence, sometimes professionals do a good job of responding and sometimes they don't. Generally, any dissatisfaction with one's own agency response was related to manpower shortages and lack of resources. The structure of the Department of Social Services and the high turnover rate of social workers was an area of dissatisfaction for the social work key informant, but again this was seen as being connected to and aggravated by high caseload and poor working conditions (i.e. lack of manpower and resources).

The survey data suggest that respondents' satisfaction with their own agency's response is quite high for police and social workers. The significantly lower satisfaction level of school personnel was largely due to the fact that significantly more of those individuals responded "Don't Know" to this item (See Table 4-25). As well, women were significantly more likely to respond "Don't Know" than men (See Table 4-26). The only significant effect after neutral respondents were removed from analysis was that survey respondents having experience with more than 10 cases were significantly less satisfied

with the response of their agency/organization than those with less experience.[61] The significance remained after controlling for gender.[62] Despite the high level of satisfaction with their own role and their agency's response to the problem of child sexual abuse, fewer than half of professionals were satisfied with the outcome of their last case. This low level of satisfaction was consistent across profession, gender, experience, and age. With the outcome of cases in general, school survey respondents were significantly less satisfied than police and social workers. Significant differences were indicated on the basis of case experience as well.[63] This significance remained for females after controlling for gender[64] but lost significance once those responding "Don't Know" were removed from the analysis. A large proportion of those with little experience (45.3%) choose this response. However, lack of experience may not have been the only factor contributing to a "Don't Know" response. As one school survey respondent commented, "I never hear the outcomes."

The issue of money and economics is seen as key to the quality of the system's response to the problem of child sexual abuse. Some saw this as a problem in the top levels of government: "need more commitment to the problem in higher levels" (KI-2); "Not just lip service"(KI-1); "It's just a big money factory and what matters is dollars and

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[61] $\chi^2(4, \underline{N} = 90) = 12.0, p < .05$

[62] Females: $\chi^2(12, \underline{N} = 67) = 33.1, p < .001$; Males: $\chi^2(12, \underline{N} 52) = 27.2, p < .01$.

[63] $\chi^2(12, \underline{N} = 120) = 42.1, p < .001$.

[64] $\chi^2(12, \underline{N} = 69) = 24.9, p < .05$.

TABLE 4-25:
Percentage of Professionals who are Satisfied with the Current Response to Child Sexual Abuse.
1= VS; 2= S; 3= DK; 4= D; 5= VD

SATISFACTION WITH RESPONSE	Police n	%	X[a]	Soc. Work n	%	X	School n	%	X	Chi-Sq. (df= 8)
Satisfaction with own role in responding to the problem of child sexual abuse.	23	71.9	2.1	19	67.9	2.4	30	44.1	2.5	**20.1
Satisfaction with outcome of last case involved with.[b]	9	47.3	2.8	9	42.9	3.2	6	37.5	2.9	12.1
Satisfaction with agency response.[b]	30	85.7	1.8	21	75.0	2.3	33	47.8	2.6	****44.1
Satisfaction with outcome of most cases.[b]	20	58.8	2.7	11	39.3	3.2	13	18.3	3.2	***28.1
Satisfaction with current treatment programs.	14	40.0	2.9	5	17.9	3.7	8	11.9	3.3	***27.6
Satisfaction with current prevention programs/efforts.	17	48.6	2.9	4	14.3	3.7	9	13.2	3.4	**22.2
Satisfaction with coordination of prevention efforts.	22	62.9	2.6	5	17.9	3.5	14	20.9	3.2	***31.0

[a]The categories Very Satisfied and Satisfied were collapsed into one category of Satisfied.

**p< .01 ***p< .001 ****p~ 0
[b]Information available only for subjects who reported being involved with a case of child sexual abuse (Police: n=19; Social Workers: n= 21; School: n=16).

TABLE 4-26:
Percentage of Male and Female Survey Respondents who are Satisfied[a] With the Current Response to Child Sexual Abuse.

SATISFACTION WITH RESPONSE	Female n	Female %	Male n	Male %	Chi-Square
Satisfaction with own role in responding to the problem of child sexual abuse.	41	53.2	31	62.0	4.2
Satisfaction with outcome of last case involved with.	14	40.0	10	47.6	1.4
Satisfaction with agency response.	45	58.4	38	70.4	**18.4
Satisfaction with outcome of most cases.	19	24.1	24	45.3	8.55
Satisfaction with current treatment programs.	8	10.7	19	35.2	***23.2
Satisfaction with current prevention programs/efforts.	10	13.2	20	37.0	**13.3
Satisfaction with coordination of prevention efforts.	17	22.7	24	44.4	*11.5

[a]The categories Satisfied and Very Satisfied were collapsed into one category of agree. Mean is based on uncollapsed category.

* $p < .05$ **$p < .01$ ***$p < .001$

cents, not the lives of the individuals involved"(KI-7) and "we should be spending the money"(KI-1). Others saw it as a product of a bad economy, with no one really being to blame: "There's all kinds of political will to do it; but political will doesn't translate into dollars in pocket and it doesn't translate into an available competent resource base either."(KI-8).

The problems with money/economics translates into a problem of resources and, of course, resources affect how well professionals are able to respond. All of the key informants felt that there were not enough services out there for victims and many of them felt that more attention should be paid to the needs of offenders as well. Survey respondents also expressed a very low level of satisfaction with current treatment and prevention programs, although police officers were significantly more satisfied than social workers and school personnel (See Table 4-25) and males were significantly more satisfied than females (See Table 4-26). Professional differences remained significant only for females' satisfaction with current treatment programs after controlling for gender.[65] The significance of differences in satisfaction with treatment between professionals with various amounts of case experience was due to the large proportion of survey respondents with little experience indicating lack of knowledge in this area.[66]

Key informants admit that resources were put into place in the last few years to meet the needs of individuals and families involved in abusive situations. "What we've

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[65] $\chi^2(6, \underline{N} = 75) = 13.4, p < .05$.

[66] $\chi^2(16, \underline{N} = 120) = 36.3, p < .005$.

also seen, however, is an incredible increase in the numbers of reported cases.... the resources... have become so overwhelmed by the demands that they can't possibly meet the need."(KI-8). However, the ability to respond effectively to the problem of child sexual abuse depends on many factors, limited resources being only one. Another issue is the newness of this issue as a recognized social problem: "We are still in the early stages of trying to figure out what it is that we are dealing with here and how to handle what we're dealing with."(KI-8).

Many felt that even with the resources we do have, things could be improved if we paid more attention to the victims. As discussed in the section on Victims, the general feeling was that the victims "should have more say in what happens to them."(KI-2). Although things are getting better, the whole process is still seen as being more disruptive for victims and their families than it needs to be. Lack of sensitivity to kids needs is seen as a factor contributing to this problem for several key informants. This was particularly true for the court system: "The courts are there to provide justice, supposedly, and they don't because they don't understand children." (KI-4). The length of time it takes for the court system to process cases was also viewed by many key informants as contributing to unnecessary disruption, as was the lack of continuity in the Department of Social Services. A comment by one school survey respondent suggests that there are other areas of difficulty in interacting with DOSS: This respondent said she would

> report [suspicions/allegations] to guidance counsellor. Many may state that they would report it to S. Services. I have had to report such a case that was terribly handled by S. Services - so much so that I had to take action re: lack of confidentiality. Needless to say I have learned my lesson.

Lack of awareness of the roles of other agencies and of what other agencies were doing is also a significant problem for several key informants. Many made comments similar to the following:

> One of the problems is that a police officer doesn't understand what a doctor does; the doctor doesn't understand the social worker; the social worker doesn't understand the police officer; nobody understands the judges; the crown prosecutors have their own agendas; and so on. (KI-4)

One key informant suggested that, "there should be some kind of central kind of manual or repository of information on what government agencies and on what private agencies are doing. What they're all about and what they're doing, and what their approach is." (KI-2). Another recommended that all the individuals who are being trained in these areas (e.g. social work, medicine, law) should receive training in just what it is other professionals do.

In terms of people's willingness to get involved, survey respondents indicated that usually individuals want to do everything they can to help. There were exceptions to this tendency, however, as discussed in the next section.

Satisfaction with Attitudes and Beliefs

In discussing their satisfaction with the attitudes and beliefs of professionals key informants made a distinction between attitudes that are encountered fairly often on an agency/organization basis and those encountered, more rarely, on an individual basis which were not necessarily related to any particular agency.

Generally, the attitudes that key informants most often expressed having problems

with on an agency basis were (1) fear of getting involved (or reluctance to do so) and (2) lack of sensitivity to victims' needs. They indicated that both attitudes stem largely from lack of knowledge and lack of awareness of the dynamics of child sexual abuse. Specifically, key informants indicated that many teachers are afraid to talk about the issue because they are uncomfortable with it. Doctors and some police officers were also seen as generally not wanting to get involved. It was suggested that many are reluctant to get involved in child sexual abuse cases because they don't have time for it while others feel like they don't know enough about the issue to be able to handle it appropriately.

Most key informants thought that lawyers, judges, and doctors need more awareness of the dynamics of this problem and more training in sensitive management of cases.

> ... we get to talk to the medical school too. And it's scary sometimes when you go in there and talk about child sexual abuse and they ask questions like a high school student. They don't know. And how did they ever get through medical school this far without knowing about it?... if we didn't go in and do these talks, would they ever know? (KI-3)

A school survey respondent also stressed that the "Justice system needs to be educated as to the dynamics." For the most part the courts are reported as approaching this problem from an adult perspective rather than a child-centred perspective. They fail to take into consideration the developmental stage of the child and the way the child interprets everything that is happening to him or her.

As indicated in the section above, the issue of secrecy and silencing of discussion around sexuality were viewed to be a problem with the church and school system in particular. For example, one key informant told of an incident where her son brought a

book to school for his teacher to read. The book was on inappropriate touching. The teacher would not read the book because she felt it was not an appropriate book for school. One key informant who is involved in educating particular groups on family violence and sexual assault, reports that they don't get invited to some schools to talk about these issues, particularly Catholic schools. When they do get invited, they have to be very careful about what they say. Another key informant stated that, as a group, the churches are "very archaic in their outlook.... They don't want to talk about sexuality, or abuse or anything else."(KI-4). It is important to note, however, that despite problems with the school and church systems overall, many felt that not all exhibited attitudes such as those discussed above. As one school survey respondent remarked, we "cannot label [them] all together."

Key informants and survey respondents both indicated that though there seem to be problems with particular agencies, it is difficult to make all encompassing statements about any agency or organization because there have been a broad range of experiences with all groups. A social work survey respondent summed this view up as follows: "All these are very dependent on particular agencies. E.g. some medical communities are very good, others are very poor."

Key informants cautioned that increasing awareness can have negative consequences as well if it is not handled appropriately. For instance, instead of dispelling fears, the fear can take on a different form. Apparently some professionals and other individuals have developed a sort of hyper-awareness to the problem, so that they over-

react and are over cautious in their communications and interactions with children.

Other attitudes and beliefs that key informants found disturbing were encountered on an individual-basis and were not related specifically to any particular agency. Some of the problematic attitudes cited include the following: "There is still a group who feel that the victim is the guilty one. I still hear people saying, 'Well that three year old is awful provocative.'"(KI-4). "The old myth that it doesn't happen in those families or those groups of people. It only happens in the lower, the poorer groups."(KI-3). The belief that kids never lie is problematic for some because it is based on a faulty premise. Other problematic attitudes/beliefs were related to the nature intervention should take:

> You have to be careful though, about who is providing the aftercare, because people with funny opinions sometimes arise... some situations that I know of where the well meaning [professional] has done, what I think, is some long-term harm to the child and to the other parent, the mother usually. (KI-4).

> There are a lot of people, professionals, who take the stand that it's important that people stay together.... Helping the family stay together is not always in the best interests of the child.... have very serious questions about whether or not we're doing anybody any service by automatically assuming that it's best these families work things out and stay together. (KI-8)

An even more individualized complaint, and perhaps the most disturbing, was the suggestion that there are people in the system who are incapable of understanding and appreciating the seriousness and nature of this problem, no matter how much training they receive:

> You can't train people to be situationally appropriate around children. You can't train people to be sensitive. I mean it doesn't matter how much training you give, but an asshole is still going to be an asshole at the end of the day, you know. You can't train that out of him.

Survey respondents were not asked to indicate specific attitudes or beliefs that they were satisfied or dissatisfied with. They were asked to simply indicate whether or not

they were satisfied with the attitudes and beliefs of several agencies/organizations (See Table 4-27). Overall a large proportion of respondents indicated a neutral response to each of the agencies/organizations listed (i.e. "Don't Know"). Once those individuals were removed from the analysis, respondents expressed the greatest amount of satisfaction with the attitudes and beliefs of shelters, medical health, and mental health (over 90%), and the greatest dissatisfaction with churches (71.7%) and the Provincial Government (70.9%).

Results suggest that females are most satisfied with the beliefs and attitudes of shelters while males are most satisfied with the beliefs and attitudes of the police and Department of Social Services. In all cases except mental health, shelters and provincial government, females responded "Don't Know" more often than males to this question. Chi-square analysis revealed that males and females differed significantly in their satisfaction with the attitudes of police, prosecuting attorneys and judges (See Table 4-28). In each case, females were less likely to indicate satisfaction, but twice as likely to respond "Don't Know". Once the latter category was removed from the analysis, females were still significantly less satisfied than males with the attitudes of police officers and judges.[67]

Police survey respondents reported being most satisfied with their own and the

[67]Police officers: $\chi^2(3, \underline{N} = 101) = 18.9, p < .001$; Judges: $\chi^2(3, \underline{N} = 86) = 14.1, p < .01$.

TABLE 4-27:
Professionals' Satisfaction with the Beliefs and Attitudes held by Various Agencies that may be Involved in Cases of Child Sexual Abuse, by Gender. 1= V; 2= S; 3= DK: 4= D: 5= VD

Agency/ Profession	SATISFIED			DISSATISFIED			DON'T KNOW			MEAN[b]			Chi-Square (df=4)
	Fem	Male	Tot.	Fem	Male	Tot.	Fem	Male	Tot.	F	M	Tot.	
Department of Social Services	64.9	84.6	73.1	13.0	5.8	10.0	22.1	9.6	16.9	2.4	2.0	2.2	9.2
shelters	75.0	69.2	72.9	4.0	5.8	4.7	21.1	25.0	22.5	2.1	2.2	2.2	2.4
police	54.7	86.5	68.0	18.6	1.9	11.7	26.7	11.5	20.3	2.6	1.8	2.3	***23.7
medical community	60.5	71.7	65.4	6.5	3.8	5.3	32.9	24.5	29.2	2.4	2.2	2.4	3.8
schools	61.5	71.7	65.2	19.2	11.3	15.9	19.2	17.0	18.9	2.5	2.3	2.5	2.1
mental health agencies	65.3	60.4	63.6	6.7	3.8	5.4	28.0	35.8	31.0	2.3	2.3	2.3	2.0
prosecuting attorney	32.9	64.2	45.4	22.3	15.1	19.2	44.7	20.8	35.4	2.9	2.4	2.7	**14.2
judges	15.8	50.9	30.0	42.1	28.3	36.1	42.1	20.8	33.8	3.4	2.9	3.2	***21.0
defence attorney	15.8	30.2	21.5	39.5	34.0	36.9	44.7	35.8	41.5	3.3	3.2	3.3	8.4
churches	13.2	30.8	20.2	55.2	44.2	51.2	31.6	25.0	28.7	3.6	3.3	3.5	7.1
Provincial government (policymakers)	19.5	15.1	17.6	44.2	41.5	42.7	36.4	43.4	39.7	3.5	3.4	3.4	3.9

[a]Number of females =82; Number of males = 56
[b]Average responses reported: 1= very satisfied and 5 = very dissatisfied. Very satisfied and satisfied were collapsed into one category of satisfied, and very dissatisfied and dissatisfied were collapsed into one category of dissatisfied. Mean is based on uncollapsed category.
**p< .01 ***p< .001

TABLE 4-28:
Percentage of Professionals who are Satisfied with the Beliefs and Attitudes held by Various Agencies that may be Involved in Cases of Child Sexual Abuse. 1= V; 2= S; 3= DK; 4= D; 5= VD

Agency/ Professional Group	POLICE			SOCIAL WORK			SCHOOL			TOTAL			Chi-Square (df=8)
	n	%	X	n	%	X	n	%	X*	n	%	X	
Schools	26	76.5	2.3	13	46.4	2.9	47	67.1	2.3	86	65.2	2.5	13.1
Churches	9	26.5	3.3	5	17.9	3.7	12	17.9	3.4	26	20.2	3.5	6.8
Medical Community	28	82.4	2.1	20	71.4	2.4	37	54.4	2.5	85	65.4	2.4	*18.2
Mental Health Community	20	58.8	2.4	24	88.9	2.0	38	55.9	2.4	82	63.6	2.3	11.7
Police	33	100.0	1.6	19	70.4	2.4	35	51.5	2.6	87	68.0	2.3	***37.7
Department of Social Services	32	97.0	1.8	24	85.7	2.0	39	56.5	2.6	95	73.1	2.2	***29.3
Prosecuting Attorney	26	76.5	2.3	13	46.4	2.9	20	29.4	2.8	59	45.4	2.7	****39.1
Defence Attorney	11	32.4	3.3	6	21.4	3.5	11	16.2	3.2	28	21.5	3.3	****29.0
Judges	19	55.9	2.9	6	21.4	3.5	14	20.6	3.1	39	30.0	3.2	****31.7
Shelters	22	66.7	2.3	22	78.6	2.1	50	73.5	2.1	94	72.9	2.2	6.1
Provincial Government (policymakers)	4	11.8	3.5	8	28.6	3.5	11	15.9	3.3	23	17.6	3.4	11.5

*Very Satisfied and Satisfied were collapsed into one category or satisfied. Mean is based on uncollapsed category.

* p< .05; ** p< .01; ***p< .001; ****p~ 0

Department of Social Services' (DOSS) attitudes and beliefs; social workers with the attitudes and beliefs of the mental health community and DOSS; and schools with the attitudes and beliefs of shelters and schools (see Table 4-28). School survey respondents were significantly less knowledgeable (i.e. "Don't Know") than social workers and police about the attitudes and beliefs of defence attorneys, the medical community, DOSS, and the police. As well, school and social work survey respondents knew significantly less than police about the attitudes of attorneys and judges. When all neutral respondents were removed from the analysis, the only significant professional difference was that school survey respondents were significantly less satisfied with the attitudes and beliefs of the police and DOSS[68] than police and social workers were with their own and each other's attitudes and beliefs. Once the neutral category was removed, the rate of satisfaction was high (70% or more) for all agencies except churches, provincial government, defence attorneys, and judges (less than 50%).

Satisfaction with Cooperation and Coordination of Response

In order to test the assumption that coordination of services exists in the child-serving community survey respondents were asked to indicate the agencies/ professionals involved in the most recent case they had responded to and the agencies which coordinated and cooperated with them. Overall an average of 3.6 agencies/professions were involved in these cases. The police and DOSS were involved in most cases and the

[68]Police: $\chi^2(6, \underline{N} = 102) = 18.2, p < .01$; DOSS: $\chi^2(6, \underline{N} = 108) = 13.3, p < .05$.

schools, medical community, and courts were involved in about half of them. Others were involved much less frequently.

In general the opinions expressed regarding cooperation and coordination of response (often referred to by key informants as "networking" or "case conferencing") reflect various levels of satisfaction. Those expressing dissatisfaction cited various problems in interacting with other agencies: (1) lack of resources, (2) confusion around confidentiality issues., (3) lack of information regarding the roles and responsibilities of each agency/profession, and (4) lack of commitment at the higher levels of the response system (i.e. government)

Where there has been a deliberate effort to establish a formal liaison between two or more agencies/professions whereby they can cooperate and coordinate their efforts key informants seemed satisfied with the outcome. For example, the police and social work key informants indicated that the Royal Newfoundland Constabulary and Department of Social Services (DOSS) have a memorandum of understanding to do joint interviewing in child abuse cases. Initially all cases received by DOSS are reported to the police and vice versa. Depending on the nature of the referral, a joint interview may be done right away or a child protection worker may interview the child first to determine whether there are grounds for an investigation with the police. In the second case, the information gathered is presented to the police and they make a decision as to whether or not they should investigate it. If they are going to investigate, then a joint interview is done. If not, Child Welfare then pursues the problem. Both of these key informants were satisfied

that this process works effectively although sometimes limited by police manpower shortages.

The Child Protection Unit (CPU) of Child Welfare and one of the shelters have a liaison committee to enhance coordination of child abuse cases. As well, Child Welfare has a full-time liaison person working with the Child Protection Team at the Janeway Children's Hospital. The Janeway Child Protection Team also works with the Department of Social Services on joint education and awareness for other agencies in the community. These relationships reportedly work out quite well.

Apart from these specific links between agencies key informants expressed views in terms of coordination within the whole child-care system. One indicated that "the agencies... do work together. They may not all come together in the one room, but they do work together....The whole community shares information. "(KI-7). According to this key informant case conferencing works

> far better than any other ad hoc kind of way of gathering information....information sharing is very good. It lays everything on the table. This one knows what that one is doing. You set up a case plan and each person, I guess, has their own little task in that case plan.

Others, however, suggested that there is some sharing of information but not enough and that sometimes case conferencing "works well and sometimes not."(KI-1). Those who believe that it does not work sometimes suggested that often it is because confidentiality issues lead to uncertainty about what information should be shared at case conferences. The school key informant in particular expressed general dissatisfaction with DOSS concerning willingness to share information, though encounters with some social workers

were positive in this regard. Also, there was general agreement that lack of information regarding the roles and responsibilities of each agency results in confusion around case management:

> I'd like to see a little more networking between agencies, and we've meshed well with Social Services, but there are other agencies out there who should really know what is happening in the community and that we should be involved with....and there has been a fair bit of that, but I would like to see more getting together with all these agencies, everybody understanding everybody else's role, what it is we really do and how we really feel about the issue, and just trying to focus a bit more on consistent approaches....Right now we are kind of in the dark sometimes about what the other person's position is. (KI-2).

The following quote is representative of the least positive responses: "Networking. We all want to do it and we all strive to do it, and some of the other agencies say that as well. But we're not doing it. We're not doing it productively."(KI-3).

For those expressing dissatisfaction with coordination and cooperation the general feeling was that the resources are just not there to initiate an effective interdisciplinary response. One expressed exasperation with the emphasis on coordinating and cooperating at the expense of the basic issue of delivery:

> KI-8: You know, people get too focused on getting coordinated and don't pay enough attention to delivery. We all know what we need to do to be coordinated.... We've all got protocols, inter-agency protocols, now. But they're not worth the paper they're written on if we don't have the resources to act in accordance with the protocols, and the reality is, we don't have those resources....In order to do it on a case by case basis you have got to be extremely well resourced. And we're not.
>
> And a lot of kids are still not getting an adequate response within the system....But coordination is not going to solve the problem. We all recognize that we gotta be coordinated, we gotta work together, it's better for the kids if we do that. But if the child care worker or the police officer can't find me because I'm over..., then coordination is not worth the paper it's written on. Coordination presupposes an ability to deliver the coordinated service. And that's where, to me, we need to be coming from right now, is "How do we deliver? What resources do we have to have in place? Where are we falling short?.... It's silly for us to be saying, "Well, if we get better coordinated, we'll do a better job".... We can coordinate all we want, but if we don't have a body there, or if we've got a body there and she's got 150 cases and she can only cope with 50, she can't deliver.

There was a feeling of helplessness among some key informants who explained that the commitment and willingness to improve delivery along with coordination is there at the front-line level but not at the higher levels: "There needs to be more commitment from higher level sources" (KI-2). Essentially,

> Coordination has to come from the top levels of government departments in order to be effective. For years these departments have been giving lip service to multidisciplinary responding but nothing is being done. Committees are set up at lower management levels which have no real power to endorse the necessary activities. Endorsement for change has to come from the very top levels of politics. As long as this is not a priority for them, nothing will happen.

One key informant believes that this commitment will come because eventually the front-line workers - the people who appreciate the seriousness of this issue - will move up through the system and into positions where they can do something about the issues that are currently interfering with an effective response to child sexual abuse and other abuse issues. Insight into how things might change when this happens is offered by the following key informant:

> I would like to see an interdisciplinary government agency which would take from Health, Education, Justice, Social Services... and have an independent set up, probably with its own deputy minister and infrastructure, ... so that you don't have the police officer answering to Justice and the social worker talking to his or her minister.... Because everybody has their own little agendas. (KI-4)

Survey respondents were asked to rank their level of satisfaction with a number of agencies/professionals that could become involved in a case of child sexual abuse. Frequency analysis revealed that half or more of survey respondents indicated that they did not know if they were satisfied or not (i.e. "Don't Know") with the coordinating efforts of churches, prosecuting attorneys, defence attorneys, judges and the provincial government. (See Table 4-29). Half or more of school respondents responded "Don't

Know" to all agencies except schools and DOSS. Some of this was due to the fact that some respondents had no case experience with child sexual abuse, but, as well, those who did have experience seemed less likely to know about the activities of these particular agencies. For each of these organizations, except the Provincial Government, females were significantly more likely than males (Table 4-29) and school survey respondents were significantly more likely than police or social work survey respondents (Table 4-30) to respond "Don't Know" when asked to indicate their satisfaction level.

Once the neutral responses were removed from the analysis high levels of satisfaction with coordination/cooperation were reported for all agencies/organizations except churches, the Provincial Government, defense attorneys, and judges. The only significant difference between professionals was that police officers were significantly more satisfied with the cooperation and coordination efforts of DOSS than were school survey respondents.[69] As well, males were significantly more satisfied than females with the coordination of response of churches, the medical community, the police, and DOSS.[70]

Do attitudes and beliefs affect interdisciplinary efforts? According to the comments of one key informant, when respondents get together to discuss case management, ideas about what should be done to deal with the problem of child sexual

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[69] $\chi^2(6, \underline{N} = 99) = 13.4, p < .05$.

[70] Church: $\chi^2 3, \underline{N} = 56) = 8.0, p < .05$; Medical community: $\chi^2(2, \underline{N} = 79) = 11.0, p < .01$; Police: $\chi^2(3, \underline{N} = 91) = 9.0, p < .05$; DOSS: $\chi^2(3, \underline{N} = 98) = 8,2, p < .05$.

TABLE 4-29:
Satisfaction with the Cooperation and Coordination of the Efforts of Various Agencies that may be Involved in Cases of Child Sexual Abuse. Percentage According to Gender[a]

Agency/ Profession	SATISFIED			DISSATISFIED			DON'T KNOW			MEAN[b] (SD)			Chi Square (df=4)
	Fem	Male	Tot.	Fem	Male	Tot.	Fem	Male	Tot.	F	M	T	
schools	63.2	59.6	61.2	19.7	9.6	15.5	17.1	30.8	23.3	2.6 (.9)	2.5 (.9)	2.5 (.9)	7.9
churches	5.3	21.6	11.7	34.2	29.4	32.8	60.5	49.0	55.5	3.4 (.8)	3.2 (1.0)	3.3 (.9)	*9.9
medical community	52.0	65.4	57.8	8.0	0.0	4.7	40.0	34.6	37.5	2.5 (.7)	2.2 (.7)	2.4 (.7)	*11.6
mental health agencies	56.0	57.7	57.0	8.0	0.0	4.7	36.0	42.3	38.3	2.5 (.7)	2.3 (.6)	2.4 (.7)	7.8
police	52.0	78.8	63.3	13.3	1.9	8.6	34.7	19.2	28.1	2.6 (.8)	2.1 (.7)	2.4 (.8)	*12.8
Department of Social Services	58.1	80.8	67.7	14.9	3.8	10.2	27.0	15.4	22.0	2.5 (.8)	2.1 (.7)	2.3 (.8)	*10.7
prosecuting attorney	20.3	61.5	37.0	14.9	11.5	13.4	64.9	26.9	49.6	2.9 (.7)	2.5 (.9)	2.7 (.8)	***23.6
defence attorney	6.8	23.1	13.4	25.7	30.7	27.6	67.6	46.2	59.1	3.3 (.7)	3.2 (.9)	3.2 (.8)	*9.2
judges	13.5	44.2	26.0	27.0	25.0	26.0	59.5	30.8	48.0	3.2 (.8)	2.8 (1.0)	3.1 (.9)	**17.1
shelters	51.4	51.9	52.0	10.8	3.8	7.9	37.8	44.2	40.2	2.5 (.8)	2.4 (.7)	2.5 (.8)	2.2
provincial government (policymakers)	13.5	17.3	15.0	32.5	44.6	33.1	54.1	48.1	52.0	3.3 (.9)	3.2 (.9)	3.3 (.9)	1.8

[a]Number of females =82; Number of males = 56

[b]Average responses reported: 1= very satisfied and 5 = very dissatisfied. Very satisfied and satisfied were collapsed into one category of satisfied, and very dissatisfied and dissatisfied were collapsed into one category of dissatisfied. Mean is based on uncollapsed category.

TABLE 4-30:
Percentage of Professionals who are Satisfied with the Cooperation and Coordination of the Efforts of Various Agencies that may be Involved in Cases of Child Sexual Abuse.
1= V; 2= S; 3= DK; 4= D; 5= VD

Agency/ Organization	POLICE			SOC. WORK			SCHOOL			TOTAL			Chi-Square Value
	n	%	X	n	%	X	n	%	X	n	%	x	
Schools	24	70.6	2.3	17	60.7	2.5	38	56.7	2.6	79	61.2	2.5	9.4
Churches	9	26.5	3.1	3	10.7	3.3	3	4.5	3.4	15	11.7	3.3	*16.3
Medical Community	26	76.5	2.1	19	67.9	2.4	29	43.9	2.6	74	57.8	2.4	**17.1
Mental Health Community	24	70.6	2.2	24	85.7	2.1	23	37.9	2.7	73	57.0	2.4	**23.8
Police	34	100.0	1.8	23	82.1	2.2	24	36.4	2.7	81	63.3	2.4	***48.9
Department of Social Services	34	100.0	1.8	21	77.8	2.3	31	47.0	2.7	86	67.7	2.3	***35.5
Prosecuting Attorneys	27	79.4	2.3	10	35.7	2.9	10	15.4	2.9	47	37.0	2.7	***59.6
Defence Attorneys	9	26.5	3.3	4	14.3	3.5	4	6.2	3.1	17	13.4	3.2	***30.1
Judges	21	61.8	2.7	6	21.4	3.4	6	9.2	3.1	33	26.0	3.1	***60.6
Shelters	19	55.9	2.4	16	57.1	2.6	31	47.7	2.5	66	52.0	2.5	*14.3
provincial government (policymakers)	7	20.6	3.4	7	25.2	3.3	5	7.7	3.3	19	15.0	3.3	14.9

[a]Average responses reported: 1= very satisfied and 5 = very dissatisfied. Very satisfied and satisfied were collapsed into one category of satisfied, and very dissatisfied and dissatisfied were collapsed into one category of dissatisfied. Mean is based on uncollapsed category.

abuse are not always congruent:

> Some of the problem is that not everyone agrees on the mode that you are going to take. Sometimes there's disagreement around case plan.... But generally... we're able to work those kind of things out. (KI-7)

Another indicated that the number one problem in interacting with other agencies/organizations is lack of awareness of the dynamics of child sexual abuse. However, this problem was not generally encountered with front-line workers:

> Where I find the most problem there is with people who are not front line or the public in general who- like, there was a lot of criticism of the young boys at Mount Cashel, you know, why did they stay there? Why didn't they just tell somebody? And that kind of thing. Why did they keep going back? and blah, blah, blah. Yeah, people don't really have a good sense of why victims keep getting victimized. They think that they should tell right away, and, I find most of that attitude comes out of inexperience or just, you know, ignorance. (KI-2).

Another key informant feels shut out by other professionals when the issue of forgiveness is introduced as a necessary part of treatment and healing for the victim and for the perpetrator. This key informant feels that others think he is taking up for the perpetrator, but the issue for this key informant is that, in his opinion, you can't cure one part of the problem and ignore the others and he feels that this is a necessary component of dealing with the problem.

The evidence suggests that at least some professionals are aware of philosophical differences and attitudes between agencies as well as individuals. It seems that some of these difficulties are able to be worked out, whereas others result in frustration. Whether or not this has a big impact on interdisciplinary efforts is unclear, although there was a significant correlation between survey respondents' satisfaction with the attitudes/beliefs of each agency and their satisfaction with the coordination/cooperation of that agency (See

Table 4-31). However, there were many other significant correlations as well.

In summary, most professionals seem to be clear about their role in reporting child sexual abuse and indicate responses consistent with their agency/organization policy. For those individuals who had experience with child sexual abuse cases, satisfaction with role varies and is influenced by such factors as lack of resources and lack of time, as well as restrictions imposed by other agencies/organizations. In general there was a high level of satisfaction with the response of one's own agency to cases of child sexual abuse among survey respondents, though less so among key informants. The level of satisfaction with case outcomes, and availability of treatment and prevention programs, however, was low for both groups of subjects. Key informants indicated that though things are improving there are still attitudes and beliefs among some professionals that are unsatisfactory. Most of these are related to lack of awareness of the dynamics of child sexual abuse and lack of knowledge about the nature of childhood. Survey respondents were most satisfied with the attitudes and beliefs of shelters, the medical community and the mental health community and were least satisfied with churches and the Provincial Government. Females were significantly less satisfied than males with the attitudes of the police and judges and school survey respondents were significantly less satisfied than police or social workers with the attitudes and beliefs of DOSS and the police. Satisfaction with the coordination and cooperation of agencies/organizations responding to child sexual abuse varied among key informants but was fairly high among survey respondents, with the exception of satisfaction with churches, the Provincial Government,

TABLE 4-31:
Correlation of Satisfaction with Attitudes/Beliefs of Various Agencies with Satisfaction with the Cooperation and Coordination of their Response to the Problem of Child Sexual Abuse

	SATISFACTION WITH COORDINATION AND COOPERATION										
Satisfaction with Attitudes/ Beliefs	Schools	Church	Medical	Mental	Police	DOSS	Prosec	Defense	Judge	Shelter	Govt.
Schools	**.27	***.30	.11	.12	.14	.10	.10	*.20	.16	**.24	.13
Churches	*.21	***.62	.01	.10	.15	-.01	.09	*.19	.17	.09	**.22
Medical Community	**.28	.13	***.44	***.41	***.36	***.33	.15	.09	**.23	**.38	.05
Mental Health	.12	.09	***.39	***.58	***.37	***.32	.12	.02	.15	.17	.15
Police	**.28	**.25	***.34	***.50	***.73	***.50	***.37	.14	***.30	.13	*.18
DOSS	***.31	**.26	***.40	***.56	***.54	***.58	***.28	.05	***.32	**.27	***.30
Prosecuting Attorney	.12	.10	***.31	***.35	***.31	***.29	***.73	***.28	***.44	***.30	**.23
Defence Attorney	-.04	.17	-.04	.14	.08	-.01	**.23	***.67	***.40	.01	*.22
Judges	.14	***.30	.13	**.23	**.27	.13	***.35	***.33	***.71	.13	***.37
Shelters	.09	.03	***.32	**.23	.14	.11	.17	.05	.13	***.57	-.02
Provincial Government (policymakers)	.08	***.28	-.04	.15	.12	.10	-.02	*.21	.15	.14	***.63

*p< .05 **p< .01 ***p< .001

Correlations between the satisfaction with the attitudes/beliefs of an agency with the satisfaction with the coordination/cooperation of that agency are recorded in bold.

defense attorneys and judges. There are significant correlations between survey respondent satisfaction with attitudes and beliefs and satisfaction with coordination and cooperation of each agency/organization. However, it is not entirely clear whether or not attitudes and beliefs affect interdisciplinary response.

CHAPTER V - SUMMARY, IMPLICATIONS, AND SUGGESTIONS FOR FURTHER RESEARCH

The results of this study suggest that St. John's police, social work and school professionals share many beliefs about child sexual abuse, but differ significantly on many beliefs as well. In addition to professional differences, gender and experience with cases of child sexual abuse were associated with differences in many beliefs and attitudes. These findings are consistent with other studies of various professional groups (e.g. Jackson & Nuttal, 1993; Saunders, 1988; Trute et al, 1992; Wilk & McCarthy, 1986). In this chapter I provide a summary of the main findings from the study, a discussion of its theoretical and practical implications, and some suggestions for further research.

Summary of Main Findings

(i) Professionals believe many factors cause child sexual abuse and express some uncertainty about what the cause(s) might be in particular cases.

Responses to causal items indicate that although particular theoretical perspectives predominate among professionals, they seem to have drawn their etiological beliefs from a number of theories (e.g. individual pathology, family systems, social factors, structural/political), embracing parts of these perspectives but not accepting all aspects of any one theory. For example, in drawing from structural/political (or feminist) theory, abuse of power/trust was pinpointed by three quarters of survey respondents, but only one

tenth indicated that "patriarchy" could be a causal factor. Abuse of power, cycle of abuse, pedophilia, and family dysfunction were most frequently cited as causes and were most often given *primary* causal importance. Many other causes were indicated as well, some more frequently than others. All professions and both genders pointed most frequently to the causes listed above. However, overall, females tended to assign more importance to structural/political causal beliefs than did males, while males rated individual pathology beliefs as more important. Social workers ranked structural/political beliefs more frequently than did police or school personnel. Police gave significantly more importance to individual pathology perspectives (especially pedophilia) than did social workers and school personnel.

Professionals' stated beliefs did not always correspond with their specific applications of these beliefs. For example, though police selected pedophilia as a general causal factor significantly more often than school personnel, school personnel pointed to pedophilia as a cause in Vignette A more often than did police, suggesting that other factors affect the application of beliefs. As well, although cycle of abuse, pedophilia, and family dysfunction were commonly selected as *general* explanations of abuse, in fictional cases professionals often expressed uncertainty about suggesting that these factors might have been the cause(s). One possible explanation for this is that very little specific information was provided about these cases. Several of the professional differences were strongly linked to gender.

Though, in general, Freudian beliefs are given the least importance of all theories

by all groups responses to the vignette cases suggest that there is some ambivalence about such beliefs. For example, a quarter of police and school personnel expressed uncertainty about whether or not the mother's being away from home might have been a factor in the abuse situation. This was largely gender related, with significantly more males (75%) than females (20.5%) indicating they were uncertain about this issue. The wording of the statement in the questionnaire makes it unclear whether this uncertainty was related to the significance of this as a causal factor or whether "opportunity to abuse" was the issue.

(ii) Professionals' response appear to be influenced by victim age, gender and behavioral characteristics. Conflicting views exist about whether or not children lie about abuse.

Key informants indicated that there is no "typical" reaction to being sexually abused. Victims may be very withdrawn, very outgoing, aggressive, or sexually promiscuous. This view of victims is supported by the literature (Bagley, 1986; Finkelhor, 1984; Mitchel, 1985). Though any child can become a victim of sexual abuse, Child Welfare referrals in Newfoundland for the last five years (1987/88-1992/93) suggest that girls (72% of referrals) are more likely to be victimized than boys (28%) (DOSS). These figures are consistent with other Canadian and American research. However, professionals in St. John's seem to believe that male children are as likely to become victims of sexual abuse as female children. If key informant data are reflective of general views, professionals are more inclined to believe that victim characteristics such as low self-esteem and a need for nurturing may be more significant determinants or predictors

of possible victimization than gender.

Victim credibility seems to be an issue of contention between some professionals who respond to cases of child sexual abuse. Professionals seem to be divided on this issue. Some indicated that they always believed the child because children do not lie about abuse, while others indicated that children sometimes do lie about abuse. The data suggests that though, overall, professionals find children more credible than not, social workers find them more credible than do police and school professionals and females find them significantly more credible than do males. This is consistent with other research (e.g. Jackson & Nuttal, 1993; Kendall-Tackett, 1991). As Kendall-Tackett (1991) found, the results of this study suggest that the victim's age appears to influence readiness to accept an allegation of abuse. Though most professionals tend to believe younger children they seem to be much more cautious about accepting the word of an adolescent. Many indicated that sometimes adolescents do lie about abuse in order to get attention, get their own way, get revenge, and so on. Members of the Working Group on Child Sexual Abuse[71] had suggested that differences in philosophy existed regarding younger and older children.

Factors other than the age of the victim may have influenced beliefs regarding the vignettes, as well. It is possible that the portrayal of the adolescent in Vignette B as a "problem" child (i.e. promiscuous, runaway, drug/alcohol user, thief) may have led

[71]An interview was conducted with two members of this group prior to conducting the current study.

professionals to believe that this child was not a victim. Such a conclusion is likely if professionals have a view of victims as totally "innocent" and "good" and if they do not have an understanding of the ways that abuse can affect a child's behavior (Blagg, 1989; Wells, 1989). Whatever the reasons, females were almost twice as likely as males to indicate that the adolescent had probably been abused and social workers were twice as likely as police and school professionals to indicate such a belief. As well, experience with child sexual abuse increased the likelihood that the adolescent in Vignette B was believed. In contrast, the longer one had been working at their particular agency/organization the less likely one was to indicate a belief that abuse had likely occurred. When the child is believed to be lying a significant proportion of the blame for the situation was placed with her, but when the allegations were accepted the victim was generally viewed as not being responsible. Many expressed a need to investigate further before they could make a decision about the occurrence of abuse in the vignettes, especially the vignette involving the adolescent.

(iii) Professionals believe that perpetrators can be anyone and hold them responsible, but theoretical perspective influences descriptions of "typical" characteristics and views of perpetrators.

Perpetrators of child sexual abuse can be anyone, from any region, race, sex, socioeconomic class, profession, personality type, etc. This was a commonly held belief but was by no means universal. For example, police officers were significantly less likely

than social workers and school professionals to believe that there could be child sex offenders working in their agency. Males were significantly more likely than females to believe that females were as likely to be perpetrators as males, despite evidence in the literature and research to the contrary (Badgley, 1984; Begin, 1992; Stephens et al., 1991).

Many professionals described perpetrators as having emotional difficulties, such as low self-esteem, feelings of insecurity/inadequacy, lack of skills in relating to adults. Driver & Droisen (1989) dismiss such characteristics, along with views about confusing affection with sex, alcoholism, etc., as being myths. One key informant suggested that most abusers regret their actions. However Driver & Droisen (1989) suggest that, "He does not. He regrets his arrest." (p. 120). Professionals who have etiological beliefs primarily related to abuse of power and male domination tend to hold less sympathetic views of perpetrators than those who hold cycle of abuse, or other individual pathology, etiological beliefs. However, the amount of empathy and understanding one had for the perpetrator did not significantly influence the amount of responsibility attributed, though there were some trends. Once professionals decided abuse had occurred, most held the abuser mainly responsible. Other researchers have found similar results regarding perpetrator responsibility (e.g. Jackson & Sandberg, 1985; Kelly, 1990; Reidy & Hochstadt, 1993; Ringwalt & Earp, 1988; Saunders, 1988).

(iv) Some professionals still attribute some responsibility to non-offending mothers for not protecting the child.

According to the professionals interviewed for this study there is less mother-blaming among professionals now than there was in the past, but it still exists. Non-offending mothers of incest victims are not often blamed for causing the abuse but they are still sometimes accused of knowing the abuse was going on and blamed for failing to protect the child. Interestingly, given a fictional situation (Vignette A), females were significantly more likely than males to attribute responsibility to the mother for not protecting the child. The overall average percentage of blame assigned was less than 10% but more than half of professionals assigned some portion of responsibility and the proportion ranged from none to 70%. Kelly (1990) and Reidy and Hochstadt (1993) found similar levels of responsibility attributed to mothers among the professionals they studied. In this study, school respondents assigned more than the other two professions as did professionals with little or no case experience with child sexual abuse.

Many believe the mother knows the abuse is going on. The majority who do believe this, however, also believe that many mothers are also victimized by the perpetrator. Recent findings suggest that this is often the case (Schonberg, 1990). More than half of professionals believe this, but social workers were less likely than police or school professionals to hold this belief and were more likely to believe that mothers of sexually abused children should apologize to them for not having protected them from the abuse. Whether or not the mother was viewed as a victim did not seem to greatly affect

the amount of responsibility attributed to her. The persistence of mother-blaming despite recognition of her powerlessness is viewed by psychologist Gerrilyn Smith as part of society's punitive attitude toward women: "Society has an expectation that women ought to be able to protect their children from sexual abuse - something that the combined efforts of the courts, the police, the law, social services and the medical profession cannot do - and then blames mothers when they can't." (Search, 1988, p. 89).

(v) Professionals agree that treatment services are lacking for victims and offenders, but there is less agreement concerning treatment plans for vignette cases.

Professionals believe that perpetrators of child sexual abuse should be punished for their crimes. Consistent with the findings of Wilk & McCarthy (1986) and Kelly (1990), police were more likely to recommend court involvement and imprisonment than social workers and school personnel. However, three-quarters of professionals recommended that the perpetrators also have treatment available to them. They suggested that treatment be court-ordered because of the frequent reluctance to admit to abusing and reluctance to agree to treatment. On the other hand, many professionals, especially social workers, suggested that victims be given more control over treatment decisions and that treatment be more child-centred. The general view of professionals was that ideally treatment plans for both victims and perpetrators should be individualized to fit the nature of each case. Their treatment recommendations for vignette cases provided some evidence, though not much, to support this assertion. Gender and professional factors

seemed to have a greater influence on treatment recommendations than did case characteristics. For the most part, the views of social workers were significantly different from those of police and school respondents. These differences were strongly linked to gender. Whatever the case, the reality is that treatment resources are *very* limited and often clients do not get the treatment they need. In addition, current treatment plans for perpetrators are viewed as largely ineffective. The general feeling is that the effects of child sexual abuse are serious enough to warrant giving priority to improving treatment resources.

Driver (1989) cautioned that one should not automatically assume that children are permanently damaged by sexual abuse. However, half of professionals surveyed believe that victims will never recover from such abuse. This has significant implications for any comprehensive approach to promoting the child's recovery, especially since almost half of social workers and a quarter of police and school personnel also believe that the potential for recovery depends on the reaction of others during disclosure. Experienced professionals were more likely to believe this than were those with little or no experience.

(vi) Many professionals seem to lack knowledge about current prevention efforts but believe that everyone has a role to play in the prevention of this serious social problem.

Generally, professionals asserted that everyone has to play a role in preventing child sexual abuse but at the same time indicated lack of knowledge about and

dissatisfaction with current prevention efforts. As the research suggests (Melton, 1992; McGuire & Grant, 1991), most of the responsibility for effective prevention seems to be still placed mainly on children rather than adults or society as a whole, though some professionals in this study would like to see this change. Monkman (1988) contends that, "If the Canadian state commits itself to addressing the problems of sexual abuse in childhood, it must also commit itself to the empowerment of women, and to the deconstruction of gender roles on which our social institutions are founded." (p. 58). Male professionals and police officers indicated more uncertainty than other professionals about whether such measures as changing sexist attitudes or completely changing our social structure would successfully prevent children from being abused, though large percentages of other professionals believed that these changes were necessary in order for prevention to be effective. The responses of the latter suggest that prevention beliefs for these individuals may be linked to feminist theory (Driver & Droisen, 1989; MacLeod & Saraga, 1987).

(vii) Professionals are dissatisfied with the attitudes/beliefs of particular individuals and agencies but are most dissatisfied with the uncooperative attitude at the top of the hierarchy.

Professionals expressed some dissatisfaction with particular aspects of the response and coordination of response to child sexual abuse, such as unwillingness to be open about sexuality issues, fear of getting involved, lack of sensitivity to victims needs, and

lack of information regarding the roles and responsibilities of other agencies/professions. Overall, professionals were least satisfied with the response of churches, the courts and the Provincial Government.

Though professionals indicated that particular attitudes and beliefs sometimes made coordination difficult, their overall level of satisfaction with their own role, professional attitudes and beliefs, coordination, etc. seems to be influenced mostly by their perception of the level of commitment at the top levels of government to initiating an effective coordinated response to the problem. Their views were reiterated by members of the Working Group on Child Sexual Abuse. According to them, though an Interdepartmental Committee has been set up each government department continues to cling to their own areas of power and funding and, in effect, do nothing to improve the service to victims of abuse. Finkelhor's (1983) suggestion that "serious philosophical difficulties" divide the professional communities over how sexual abuse cases should be handled seems befitting of the disparity between the beliefs of the Provincial Government and front-line service providers. While government is stressing that professionals need to do much more to "utilize our scarce financial resources" to provide a better quality service (Commission to Develop a Provincial Strategy Against Violence, 1993), many professionals are saying we can plan to coordinate all we like, but if government departments do not cooperate to allocate funding and resources it is not going to happen. "We have the professional knowledge to make progress in this field. What is now needed is the political will of legislators in support of progress." (Bagley and Thomlison, 1991, p.7).

Implications for Theory and Practice

In theoretical terms, the results of this study underline the necessity of focusing on developing a comprehensive theory that explains how professionals learn and develop their own set of knowledge about the nature of child sexual abuse, and how they use that knowledge to define their own role and proceed with their own professional work. Professionals appear to have drawn their beliefs from a number of existing theoretical perspectives and seem to have developed their own eclectic views. There are many similarities but differences as well, along with much uncertainty regarding some areas. Further exploration of existing theoretical beliefs, their origin (e.g. experience, training, media), the underlying rationales, and the influence of other factors such as gender, views of children, views of child victims, could contribute to the development of a comprehensive theoretical foundation based on intense evaluation of the ideas and experiences of many professionals. Such a foundation is essential to developing more effective approaches to treatment, promoting awareness and prevention and to forming more accurate perceptions of perpetrators, victims, and mothers.

This study suggests that a search for practical solutions to initiating an effective response to the problem of child sexual abuse must begin with professionals' evaluation of their own etiological beliefs, the reasons they hold such beliefs, how these beliefs are applied in actual cases, and how they influence their beliefs about victims and perpetrators, treatment and prevention. They also need to be cognizant of the ways that others may interpret their reactions and be sensitive to the impact misinterpretation may

have on victims and non-offending mothers. These issues need to be addressed in training and in coordinating services, but require extensive internal soul searching on an individual basis as well.

In practical terms, although a number of training initiatives exist in the St. John's area there is widespread agreement that more is needed. Findings in this study suggest a need for further training in several areas. In addition to focusing on etiology and appropriate response, training programs need to address such concerns as lack of sensitivity to victims of abuse, fear of getting involved, inaccurate beliefs, uncertainty regarding certain issues, and lack of knowledge about current prevention efforts (despite the finding that most professionals feel they should be involved). As well, in promoting awareness of the dynamics of child sexual abuse, attention needs to be focused on how professionals actually apply theoretical information in real life situations. Professionals should not only be given information, they should be given a chance to learn to apply the information through role playing and case studies and to develop insight into how professional and gender issues come into play in their reactions and decision-making. Practical training should involve the various professionals who ought to be involved in the response to a particular case. As well the effects of training could be enhanced and broadened by making information (e.g. research findings) more readily available to the public. This may also contribute to a willingness to accept responsibility for ameliorating and eradicating child sexual abuse.

Professionals are generally dissatisfied with current prevention efforts and believe

that everyone has some role to play in prevention. Many seem unaware of how they can play a role or where they should start. At present, efforts focus mostly on children, with some schools playing large roles and some doing very little. Although a great deal of effort needs to be put into developing effective prevention measures, one way that all professionals can contribute to ameliorating and eradicating child sexual abuse is by promoting an atmosphere of openness and willingness to discuss sexuality issues, including sexual abuse, and by creating a "climate that children are not there to be abused by other people". These suggestions are consistent with suggestions made by experts such as Bagley & Thomlison (1991), Driver (1989), and Tutty (1991): Since adults are responsible for sexual abuse, prevention efforts and programs should start with adults.

Even though the RNC, Child Welfare, and school systems have specific units or groups of personnel who are trained to handle reports of child sexual abuse (e.g. the RNC Sexual Assault Unit, the DOSS Child Protection Unit, and guidance counsellors), the contact all individuals in these systems have with children and families requires that *all* members of these systems need to be aware of, be able to detect, and be able to appropriately respond to incidents of abuse that have not yet been reported to the appropriate personnel in each system. In order for a true interdisciplinary response to occur that is most beneficial to the victims/families the initial response of all professionals must be consistent with and compatible with the philosophy and procedures of specific units set up especially to handle cases of child sexual abuse.

The literature suggests that teachers are in a unique position to promote awareness

and implement prevention programs, as well as to detect abuse and monitor children's progress in dealing with abuse situations. However, of the three groups included in this study, school respondents appeared to be the least involved in training initiatives and they often appeared to be isolated from other professions in intervention. If teachers are going to play a significant role in this area they should be trained and linked with child protection services. They should also be involved in discussion of service integration.

Consistent interdisciplinary training can not only help coordinate beliefs but can create an awareness of the roles and responsibilities of other agencies and professionals, along with an understanding of actions that seem unnecessary or counterproductive to individuals in other professions. Memorial University can do much to promote such a multi-disciplinary understanding in the helping community. It is a relatively small university so it should be possible to coordinate training efforts so that a program is offered that educates each discipline on the roles and responsibilities of others and offers opportunities for these groups to get together and talk through issues. Another alternative is to create multidisciplinary training academies for the training of individuals in the helping community. Training should then be mandatory and consistent.

The issues that require attention in interdisciplinary training also have to be addressed in the coordinating of services. The various theories and perspectives differ in their etiological explanations and ways of addressing the problem, which means that various professionals will still vary in the beliefs they form. However, the common goal of all theories and all professionals/adults should be to work toward the best interest of

the child. With this goal they can concentrate on reaching a common understanding of the overall problem, finding common or compatible philosophies and reaching agreement about the roles of the various professionals. Such a framework is necessary to a successful interagency response (Kays, 1990).

The key to a true interdisciplinary response to the problem is a coordinated approach to promoting awareness of the problem, of society's unwillingness to tolerate such behavior, and ensuring that people are aware of their responsibility to be prepared to respond appropriately to suspicions and reports of child sexual abuse in order that they do not further victimize or traumatize the child. I suggest that many adults in our society are not aware of this responsibility. A media campaign appealing to the need for adults to be able to respond responsibly may influence all adults to take steps to learn more about this problem.

Media messages on the total responsibility of the perpetrator and the inappropriateness of blaming the victim and/or mother may influence public/agency attitudes as well, further contributing to an interdisciplinary response to the problem. If there is any truth to the belief that the reactions of adults to the child's disclosure greatly impacts on the level of traumatization and emotional difficulties the child subsequently has, an appropriate response on the part of all adults may decrease the need for therapy and the length of therapy when it is needed. This would take some pressure off treatment providers and would be part of an interdisciplinary response to the treatment needs of the child.

The other side of the issue is, of course, as is already happening, that increased awareness and heightened sense of public responsibility to detect and report leads to increased reporting and increased demand on already overloaded services. Thus, government policy makers and funding providers cannot fully fulfil their responsibility to deal with this problem through promoting awareness unless they are equally willing to commit to providing adequate services to help the victims of this atrocious crime. If the higher levels of the government hierarchy believe that coordination of resources is so essential they must begin by sharing and coordinating at that level rather than clinging to their own areas of power and funding.

Perhaps, as one professional in this study suggested, an appropriate solution to coordinating response from the top is to set up a separate department that deals with children that would encompass the components of the other departments - Health, Education, Justice, and Social Services - that are necessary to serve the needs of children. Another possibility is for Social Services to set up a separate agency for family and child services that would include on-site mental health, medical, law enforcement and legal services. An effective interdisciplinary response must be well thought out on all levels and from all angles; not just on the level of integrated response to particular cases.

Suggestions for Further Research

This study looked at the beliefs, attitudes and satisfaction of police officers, social workers, and school personnel. Other professionals were involved only in the interview

stage. Further research should look at the beliefs and attitudes of other professional populations that are involved in the response to child sexual abuse. For example, the mental health community, the medical community, the church and the courts. Exploration of the views of those who have the power to change the way the system responds (e.g. policy makers and individuals at the top of the hierarchy on school boards, churches, DOSS, etc.) would be useful as well.

Future research replicating this study might attempt to obtain a more gender-representative sample. Most of the police respondents in this study were male while most social workers were female. Though the school population was more evenly distributed, the overall sample distribution made it difficult to separate the effect of gender and profession. For instance, there were indications that professional influence on attitudes may be different for male and female professionals, but the small number of female police officers and male social workers limited analysis of this influence.

One limitation of the vignettes used in this study is that they evoked the response that there was not enough evidence to decide whether or not abuse had occurred. One RNC officer contacted me with this concern. He wanted to make it clear that a response of "not enough evidence to decide" would not be misinterpreted to mean that police officers do not have a good attitude about this issue. He feels they are very committed to responding to the problem. Future research should attempt to resolve the agitation that

responding to this item sometimes caused. As well, emphasis should be placed on finding out how lack of evidence affects initial response to disclosures of abuse.

The results of this study suggest that professionals have drawn etiological beliefs and other beliefs about child sexual abuse from a number of theoretical perspectives. How do professionals develop their theories about child sexual abuse? From training? Experience? Media? This study underscores the need for more extensive, in-depth research into the causes of child sexual abuse.

A more detailed analysis of the rationales underlying causal beliefs about child sexual abuse is necessary. For example, if professionals believe that family dysfunction caused a child to be abused, how did this cause it? How do they determine that family dynamics were responsible? If a family has problems do they assume that this caused the abuse or do they consider the possibility that the abuser set up a family situation that would give him the opportunity to abuse? Causal studies need to look at cases and conclusions professionals have drawn from these cases.

It is especially necessary to look at causal beliefs that influence our views of perpetrators and the validity of those views considering the perceived ineffectiveness of treatment models for offenders. Professionals in the study indicated a belief that previous abuse is the most frequent cause. Dickenson (1989) states in the training manual for

social workers that 70% of abusers were victimized themselves and another 10% witnessed abuse of family members. According to Finkelhor (1987), such figures are drawn from studies of convicted offenders who are an extreme group and not representative of most offenders. Finkelhor (1987), Driver and Droisen (1989) and McLeod and Saraga (1987) consider the belief that adults sexually abuse because they were abused themselves as children to be one of the "new myths" about child sexual abuse; a dangerous misconception not really supported by research. There is a relationship between the two factors that may increase the risk of an abused child becoming an abuser but it does not mean that because one was abused as a child that one will become an abuser (Finkelhor, 1987). Since this is such a prevalent belief among professionals in St. John's it requires further research.

Another important area to explore in further research is whether or not treatment providers share the beliefs and treatment recommendations made by professionals in this study, especially the recommendations for family therapy. In recommending treatment for vignette cases approximately half recommended family therapy that included the offender. This percentage corresponds with the proportion of professionals who indicated that family dysfunction was a causal factor in child sexual abuse. One suggested that this type of therapy was appropriate if the family planned to stay together and the perpetrator had taken responsibility for the abuse. There are many concerns expressed in the literature about including the perpetrator in family therapy, especially if the aim is to

reintegrate the perpetrator. One concern is that using whole family therapy too soon "risks repeating the abusive dynamics of control, power and secrecy" (Craig et al, 1989, p.76). Other concerns are related to recidivism rates. Craig et al (1989) contend that the chance of safe reintegration of perpetrators with their families is very poor. Furthermore, Viinikka (Cited in Driver & Droisen, 1989) asserts that, "a number of recent surveys over five and ten years have found virtually identical rates of re-offending in both treated and untreated groups of offenders." (p. 152). According to Dreiblott and others, statements by sex offenders about re-offending are not reliable, though it is "easy to be misled by their law-abiding and cooperative stance." (Cited in Driver & Droisen, 1989, p. 153). Driver (1989) warns that, "Family therapy sacrifices the child's need for a sense of safety and self-worth....her sense of powerlessness is reinforced. The child is made to relive her incest in a way that does not heal but merely silences." (p.111). This certainly does not fulfil the requirements for treatment recommended by Cotter and Kuehnle (1991): That important aims of the treatment process should be to "create safety, security and the opportunity to build trust and a new sense of self." (p. 169). How do treatment providers feel about this issue?

In this study data related to recent cases of child sexual abuse revealed that only 18.2% of cases involved mental health and 29.5% involved a psychiatrist. Sixty-three percent involved neither of these, though 56% of the victims received group and/or individual treatment. Further research that determines what agencies/organizations are

carrying out assessment and treatment responsibilities when mental health/psychiatrists are not involved would be valuable.

Professional affiliation, gender, and sexual abuse experience were found to be related to the beliefs, attitudes, and behaviours of professionals in this study. Further research should focus on how training, personal life philosophies, philosophies about the nature of children and the nature of child victims, and beliefs about sexuality affect beliefs about and responses to child sexual abuse. How do these other philosophies affect how etiological theory translates into practice?

What factors lead to the formation of inaccurate beliefs such as the belief that women are as likely as males to be perpetrators and boys are likely as girls to be victims? Do such beliefs arise out of ignorance, misinformation, media attention to high profile cases?

What factors contribute to undecidedness or uncertainty? Lack of training? Lack of willingness to commit to (get involved with) this issue?

How effective are current training efforts in this province? How are they being evaluated? How are professional and gender differences affected by training?

There was a belief among the professionals studied that broader community education is needed and that all professionals have a role to play in prevention of child sexual abuse. If everyone is going to become involved in prevention in this community a detailed study is needed of the views professionals hold concerning what constitutes effective prevention. Do beliefs correspond or are they contradictory? Who do professionals believe should plan and develop prevention efforts? What populations do they believe should be targeted? And how?

Further research is essential regarding beliefs and attitudes about adolescent victims. What leads professionals to doubt the allegations of some adolescents? Does the identity of the alleged perpetrator influence whether or not the adolescent is believed? Is there a relationship between "problem" adolescents and credibility when they make allegations of sexual abuse? Is credibility influenced by knowledge and insight into the dynamics underlying behavior problems?

What rationales underlie conflicting beliefs such as children do/do not lie about child sexual abuse?

Subsequent studies should focus on awareness of the dynamics of child sexual abuse and sensitivity to victims. Such studies should especially include the organizations/ professions where these problems were an issue in St. John's, Newfoundland.

Further research is needed to clarify beliefs about the role of non-offending mothers in incest cases, especially with regard to issues where there is a high level of undecidedness. For example, why did so many professionals indicate that they were unsure about whether or not the mother's being away from home could have been a factor in the abuse of her child? Were their responses influenced by uncertainty about whether this factor could be related to etiology or opportunity or was it related to an unwillingness to express "unpopular" views?

Many professionals believe that most mothers know about the sexual abuse of their children by paternal figures. Fictional portrayals (e.g. movie, novels) of familial child sexual abuse consistently present this message as well. However, there seems to be little systematic evaluation of the accuracy of this prevalent belief through valid research methods. How many mothers actually do know about the sexual abuse of their children?

This study continues the process of understanding child sexual abuse and the role of the beliefs and attitudes among some service providers and raises new questions about exploring ways that professionals develop their own particular set of beliefs and how they apply them when responding to the prevention and treatment needs of victims and perpetrators of child sexual abuse. Such exploration and sharing of the perspectives of professionals in all parts of the child care system and at all levels of the hierarchy is a necessary process in the development of a truly effective interdisciplinary response to

child sexual abuse.

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APPENDIX A

INTERVIEW AND SURVEY INSTRUMENTS

Informed Consent - Interview 1 (Administrative personnel)

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with cases of child sexual abuse. Exploratory information in this area may aid relevant agencies in developing a coordinated multidisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education.

I would greatly appreciate your assistance in this research in the form of a brief interview (15 to 20 minutes). All results will be confidential and results of the study will be reported on a group basis only. With your permission I would like to take notes. You are free to decline answering any question you wish and you may withdraw from the study at any time.
If you have any questions or concerns please do not hesitate to contact me. Thank you for your consideration of this request.

Cynthia Hicks

(709) 579-3108

I _____ (interviewee) hereby give my permission to be interviewed in a study of the perspectives of agencies/professions that respond to allegations of child sexual abuse. I understand that participation is entirely voluntary and I may withdraw from the study at any time. All information is strictly confidential and no individual will be identified.

_____ _____

Date Signature

Informed Consent - Interview 2 (Field Experts)

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with child sexual abuse cases. Exploratory information in this area may aid relevant agencies in developing a coordinated multidisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education.

Your assistance in this research would be greatly appreciated. I request an interview (around 60 minutes) to explore your perspectives about child sexual abuse as a preliminary to developing a questionnaire for sampling on a wider scale. With your permission the interview will be recorded and transcribed for data analysis purposes. Tapes will be destroyed upon completion of the study. However, if you do not wish to be taped, I will take notes of our discussion; again, with your permission. All results will be confidential and the results of the study will be reported on a group basis only. You are free to decline answering any question you wish and you may withdraw from the study at any time.

If you have any questions or concerns please do not hesitate to contact me. I realize this interview requires a substantial amount of your time and thank you for participating.

Cynthia Hicks

(709) 579-3108

I _____ (interviewee) hereby give my permission to be interviewed in a study of the perspectives of agencies/professions that respond to allegations of child sexual abuse. I understand that participation is entirely voluntary and I may withdraw from the study at any time. All information is strictly confidential and no individual will be identified.

_____ _____

Date Signature

Interview Schedule 1 (Administrative personnel)

1. What does your agency do?

2. What is your role in responding to child sexual abuse allegations?

3. What is your policy on child sexual abuse?

4. How many people work with your agency?

5. Could you recommend someone in your agency who works on a regular basis with children for a more in-depth interview?

6. Do you think the people in your agency would be willing to fill out a questionnaire about child sexual abuse?

7. What procedure do I follow to obtain permission from your agency/ organization to administer questionnaires to the personnel at your agency?

8. I would prefer to hand deliver the questionnaires to each agency. Would it be possible to have you or one of your colleagues distribute and collect the questionnaires in your agency?

Interview Schedule 2 (Field Experts)

I. Philosophical Beliefs

1. What comes to mind when I mention the term "child sexual abuse"?

   - How would you define it?

   - What kind of image arises in your mind?

2. I have a list of behaviors that some people view as sexual abuse. **[Give List of Behaviors to interviewee and ask to check behaviors that think are sexual abuse. Interviewee may add other behaviors on the back of the sheet. Explain that an envelope is provided to ensure anonymity]**

3. Several behaviors on the list involve parent and child. The literature describes other types as well, such as abuse with strangers. Which type, in your opinion, is most common?

4. What, in your opinion, are the one or two most significant causes of child sexual abuse in our society?

5. How would you describe most perpetrators of child sexual abuse?

6. How would you describe most victims of child sexual abuse?

7. In responding to child sexual abuse allegations, which of the following would you consider to be the most important? Why? Which would rate second and third? Why?

   a) Protecting the child

   b) Helping the family work things out and stay together

   c) Accepting and validating the child's report

   d) Determining whether the allegations are true

   e) Maintaining some sense of safety and stability for the child

   f) Obtaining evidence for prosecution

   g) Obtaining treatment for the child

8. What should be done about child sexual abuse cases in terms of treatment and punishment?

- What kind of treatment do you advocate for the victim? (family therapy, psychotherapy, play therapy, etc.)
- Should the offender be treated or punished? or both?
- What kind of treatment/punishment should they receive?

II. Policy and Procedure

1. In which of the following areas does your agency yourself have responsibilities regarding child sexual abuse:

a) Promoting awareness of the abuse problem
b) Observation and detection
c) Reporting and referrals
d) Investigation
e) Treatment, counselling and follow-up
f) Prevention
g) Other

2. What can you tell me about your agency's policy on child sexual abuse?

- How is child sexual abuse defined by the policy?
- What philosophical beliefs underlie the policy?

[Communicate to interviewee that following questions are specifically about his/her agency and his/her specific roles]

[Insert questions specific to each agency/organization. If **school** use Insert 1; if **medical** use Insert 2; if **church** use Insert 3; if **mental health** use Insert 4; if **shelter** use Insert 5; if **police** use Insert 6; if **Child Welfare** use Insert 7; and if **court** use **Insert 8.]**

3. Are you satisfied with your role in responding to child sexual abuse?

- Why or why not?

4. Are you satisfied with your agency's role(s) in handling child sexual abuse cases?

- Should your agency play a greater role or lesser role?
- Why or why not?

III. Interdisciplinary Protocol and Procedure

1. Some agencies in St. John's support a multidisciplinary response to child sexual abuse. Does your agency have an interdisciplinary protocol to follow when child sexual abuse is suspected or reported?

[If NO, Go to #2]

- If yes, what agencies/professions are included?
- Do you find this procedure is compatible with the work of your agency?
- In your opinion, does following this protocol usually result in effective handling of the case?

2. How do the individuals in your agency interact with other professionals in child sexual abuse cases?

- Does your agency work to develop cooperative relationships with other agencies?
- Are there areas in which you work well together in coordinating a response?
- Are there any overlaps in roles/responsibilities or conflicting issues that impede a coordinated response?
- Do these other agencies fulfill the roles and responsibilities expected of them?

3. When interacting with other agencies, what causes the greatest problem(s)?

a) Confidentiality rules.

b) Lack of sensitivity to victims needs.

c) Lack of awareness of the dynamics of child sexual abuse.

d) Unwillingness to cooperate or share information. [Related to confidentiality or control issues?]

e) Others too busy - cannot connect.

f) Other. Please specify.

- Which agency/organization is most difficult to work with?
- Which is least cooperative?
- Overall experience good or bad?

[If issues in questions 4 and 5 addressed in previous questions GO TO 6]

4. Have you come across any attitudes or beliefs about child sexual abuse in your own or other agencies/professions that bother you?

- What beliefs and attitudes held by others are most frustrating to you?

5. According to the literature, victims and perpetrators of sexual abuse may be treated differently based on such factors as their socioeconomic status, sex, race, criminal record and personality. Do any of these factors play a role in your agency's and others response to victims and their families?

6. What should be the role(s) and responsibilities - if any - of each of the following agencies/organizations in handling cases of child sexual abuse?

- Schools
- Church
- Social Services

- Police
- Mental health workers (eg, counsellors, psychologists)
- Medical health (eg. pediatricians, nurses)
- Shelters
- Courts (eg. Crown prosecutors, judges)

7. How can the efforts of these agencies be better coordinated to prevent additional trauma to the abused child? Do you see any of these playing a central coordinating role?

IV. Questions Specific to each Agency

Insert 1: School Interview

1. Most of the literature on child abuse suggests that teachers and other school personnel are in a unique position for early detection and prevention of child abuse. What is your opinion of this position as it applies to child sexual abuse in particular?

- Do you think the schools have an important role to play in the prevention of child sexual abuse?

2. What would determine whether or not you report suspicions of sexual abuse?

- What factors lead you to make a report?
- What factors lead you to not make a report?

3. To whom would you report your suspicions? Principal? Social Services? Police? Other?

4. If the suspected abuser is a member of the child's family, does this bring different factors and issues into play than when the abuser is a non-family member?

Insert 2: Medical Interview

1. What problems and issues arise for you in deciding whether or not to report suspicions of child sexual abuse?

2. In terms of physical evidence, how certain can you be that the signs indicate sexual abuse? Can you be more certain of some signs and symptoms than others?

3. If no physical evidence is found, but you still suspect sexual abuse what would you be likely to do?

Insert 3: Church Interview

1. Do you think the church's view of child sexual abuse differs from those of secular child serving agencies?

   - In what way?

2. Have the incidents of child sexual abuse involving the clergy influenced how you handle suspicions or reports of child sexual abuse?

   - How have such incidents affected the relationship between the church and other child serving agents?

3. What values need to be taken into account when deciding whether a case of abuse should be reported to other authorities or handled by the church itself?

4. What information does the church give its parishioners about the problem of child sexual abuse?

   - Have their been any other attempts at providing pastoral care in this area?

Insert 4: Mental Health Interview

1. In assessing a child referred to you for suspicion of sexual abuse, how certain can you be that abuse has occurred?

2. Is your assessment usually accepted by the Criminal Justice System and Child Welfare? the family?

3. What should be the goals of treatment for victims of sexual abuse? For perpetrators?

4. Do you see Child Welfare and criminal justice system involvement as a help or interference with your treatment of the child?

Insert 5: Shelter Interview

1. Some of the literature on child sexual abuse focuses on attributing responsibility for the abuse to mothers or to the victim herself. Do you find there is much mother-blaming or victim-blaming within the various agencies involved in handling child sexual abuse cases?
2. Individuals working in this area usually operate from a feminist perspective. Is this accurate in your case? In your experience, how prevalent is the feminist perspective in the systems that respond to child sexual abuse in St. John's?
3. Is "professionalism" an issue when shelter workers interact with other agencies? (i.e. are shelter workers seen as being a member of the professional community, with, for example, expert knowledge and respect for client confidentiality)
4. What generally happens when you or someone else in your agency suspects or receives a report of abuse?
   - What problems have to be dealt with and what decisions have to be made?
   - What factors affect the decisions made?

Insert 6: Police Interview

1. In your experience, do cases of child sexual abuse that are reported to Child Welfare usually get reported to the Constabulary?
2. When reports of sexual abuse are received, how often are arrests made? Do many cases go to trial? Why or why not? If the perpetrator is not arrested, who is usually removed from the home? What factors influence this decision?
3. In cases of child sexual abuse the literature suggests two things

need to be done: (1) investigating the crime and (2) handling the child in a manner that is therapeutic rather than traumatic. Do these roles conflict? Are both jobs possible for you in your role?

Insert 7: Child Welfare Interview

1. The increasing number of reports of child sexual abuse places a heavy burden on limited agency staff. How does your agency determine which cases to investigate first and which not to investigate at all?
2. Are the police involved in every case? At what point are they brought into the investigation?
3. In joint interviews with the police, who is the primary interviewer? Are both parties usually satisfied with this arrangement?
4. To whom are victims and perpetrators referred for treatment? Why this particular group? What do you understand their treatment goals to be?

Insert 8: Court Interview

1. There is some debate in the literature about whether involvement of the criminal justice system in child sexual abuse is a traumatic or positive experience for the child. What is your opinion regarding this issue?
2. Do the way other agencies/professions handle sexual abuse cases interfere with your ability to build a good case?
3. Which types of cases would you be reluctant to undertake to prosecute? What factors determine whether you push for a court trial or decide to plea bargain?

List of Behaviors

[] a strange man exposes his genitals to a child

[] a child's uncle gives her candy for a kiss on the lips

[] a father bathes with his four year old daughter

[] a child and parent engage in intercourse

[] a parent allows a child to watch pornographic movies

[] a grandfather pats his teenage granddaughter on the bottom

[] a four year old child forces a crayon into the anus of another four year old child

[] two children masturbate each other

[] a parent takes pictures of a child posing in the nude

[] a father joins his 14 year old daughter in the shower or bath

[] an adult persuades two children to masturbate each other

[] a parent fondles the child's genitals

[] the parents have intercourse in front of the child

[] a parent masturbates in front of the child

[] a parent forces a child to undress in the presence of other adults

[] a parent allows a child to look at Playboy and other pornographic magazines

[] a parent has the child perform oral sex on him/her

[] a parent has the child pose for seductive pictures or commercials

[] an uncle teasingly fondles an adolescent girls breasts

[] an adult makes lewd comments about the child's body

[] an adult describes to a child the sexual experiences he/she had with adults as a child

[] a parent kisses a five year old on the lips

[] a parent kisses a fifteen year old on the lips

[] an uncle kisses a five year old on the lips

MEMORANDUM OF AGREEMENT

BETWEEN: CYNTHIA JANNIS HICKS
11A RANKIN STREET
ST. JOHN'S, NEWFOUNDLAND
A1C 4W7

AND: PROVINCIAL DEPARTMENT OF SOCIAL SERVICES
NEWFOUNDLAND AND LABRADOR
P.O. BOX 8700
ST. JOHN'S, NEWFOUNDLAND
A1B 4J6

RE: COMPARATIVE STUDY OF THE PERSPECTIVES OF PROFESSIONALS WHO RESPOND TO ALLEGATIONS OF CHILD SEXUAL ABUSE

This memorandum confirms that CYNTHIA JANNIS HICKS will be providing research services through the period commencing MAY 1, 1994 up to the time required for the completion of a research project for the Educational Psychology Programme of CYNTHIA JANNIS HICKS.

GENERAL AND SUPPLEMENTARY CONDITIONS:

1. All information provided by the Department of Social Services to CYNTHIA JANNIS HICKS or any information or other matter that may come to or be acquired by CYNTHIA JANNIS HICKS in the performance of her research services relating to the affairs of the Department of Social Services or its clients shall not be publicly disclosed by CYNTHIA JANNIS HICKS without the prior written permission of the Department of Social Services.

2. Without restricting the generality of 1.,

   (i) If requested by the Department of Social Services, CYNTHIA JANNIS HICKS will swear an Oath Of Office, utilizing a form devised by the Government of Newfoundland and Labrador.

   (ii) If requested by the Department, CYNTHIA JANNIS HICKS will provide to the Department of Social Services a Certificate of Conduct from the police office.

   (iii) With respect to any participation by clients in this study, it is understood that their participation will be entirely voluntary and Informed Consent Forms must be obtained from each client, prior to any contact of the client by Ms. HICKS. The Development of Informed Consent Forms is the responsibility of Ms. HICKS.

(iv) CYNTHIA JANNIS HICKS agrees not to disclose the identity of clients of the Department of Social Services. Without limitation of the generality of the foregoing, CYNTHIA JANNIS HICKS agrees not to identify Clients of the Department in

- Symposiums
- Workshops, Conferences
- Publications, Articles, Papers and Reviews
- Thesis

3. CYNTHIA JANNIS HICKS will provide to the Department of Social Services a copy of her thesis and will return to the Department copies of all materials compiled during her research as it may relate to specific clients or generated as a result of her research.

Witness

CYNTHIA JANNIS HICKS

DATE: June 2nd, 1994

Witness

ON BEHALF OF
THE DEPARTMENT OF
SOCIAL SERVICES,
NEWFOUNDLAND AND
LABRADOR

DATE:

The Avalon Consolidated School Board
P.O. BOX 1980, ST. JOHN'S, NEWFOUNDLAND A1C 5R5
TELEPHONE (709) 754-0710 FAX (709) 754-0122

September 14, 1994

Ms. Cynthia Hicks
11A Rankin Street
St. John's, NF
A1C 4W7

Dear Ms. Hicks:

Thank you for a description of your proposal and questionnaire relating to your exploration of the perspectives (attitude, beliefs) that various professionals have about the issue of child sexual abuse (eg. causes, perpetrators).

You are granted permission to approach the school principals, who you have identified, for the purpose of setting up the conditions under which the questionnaire is to be administered.

Please respect the wishes of the principals regarding the administering of the questionnaire.

Every success in your study.

Yours truly,

-

Fred Rowe
Assistant Superintendent

cc S. Crocker, Principal, Bishops Feild
G. Mayo, Principal, Macpherson Junior High
M.L. Green, Principal, Harrington Primary
A. Martin, Principal, Morris Academy
E. Hiscock, Principal, St. Mary's Elementary
R. Chaytor, Principal, Cowan Heights
M. Moores, Principal, Bishop Abraham Elementary
F. Tulk, Principal, I.J. Samson Junior High

TELEPHONE (709) 753-8530 FAX (709) 753-840

Roman Catholic School Board for St. John's

BELVEDERE
67 BONAVENTURE AVENUE
ST. JOHN'S, NEWFOUNDLAND
A1C 3Z4

October 31, 1994

Ms. Cynthia Hicks
11A Rankin Street
St. John's
Newfoundland
A1C 4W7

Dear Ms. Hicks:

Permission is granted for you to conduct research for your thesis in this district. Thank you for your understanding in redesigning your questionnaire to ensure confidentiality of all concerned.

Best wishes for success in your work.

Yours truly,

David E. Locke
Assistant Superintendent
Curriculum

/mstc

c.c. Principals

Letter of Introduction

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with cases of child sexual abuse. Exploratory information in this area may aid relevant agencies in developing a coordinated interdisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education. Mr. Fred Rowe, Avalon Consolidated School Board, has also granted permission for this study to be conducted with in your school.

I am particularly interested in obtaining your responses because your experience in responding to child protection problems will provide valuable information contributing to an improved understanding of the problem of child sexual abuse for all agencies and individuals involved.

I request that you assert your belief in the importance of research on child sexual abuse by completing the following form by **October 10, 1994** and returning it to your principal in the envelope provided. All results are confidential and results of the study will be reported on a group basis only. Please fill in the form as completely as possible; however, you are free to decline answering any question you wish. Completion time for other individuals ranged from **20 to 40 minutes.** If you feel you cannot spend that much time completing the form, I would appreciate it if you would complete as many items as you can. Thank you for your assistance in this research.

If you have any questions or concerns please do not hesitate to contact me at 579-3108.

Sincerely,

Cynthia Hicks

Letter of Introduction

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with cases of child sexual abuse. Exploratory information in this area may aid relevant agencies in developing a coordinated interdisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education. The Department of Social Services has also granted permission for this study to be conducted with Child Welfare and social workers (See attached memorandum of agreement).

I am particularly interested in obtaining your responses because your experience in responding to child protection problems will provide valuable information contributing to an improved understanding of the problem of child sexual abuse for all agencies and individuals involved.

I request that you assert your belief in the importance of research on child sexual abuse by completing the following form by **July 10, 1994** and returning it to your district manager in the envelope provided. All results are confidential and results of the study will be reported on a group basis only. Please fill in the form as completely as possible; however, you are free to decline answering any question you wish. Completion time for other individuals ranged from **20 to 40 minutes.** If you feel you cannot spend that much time completing the form, I would appreciate it if you would complete as many items as you can. Thank you for your assistance in this research.

If you have any questions or concerns please do not hesitate to contact me at 579-3108.
Sincerely,

Cynthia Hicks

Letter of Introduction

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with cases of child sexual abuse. Exploratory information in this area may aid relevant agencies in developing a coordinated interdisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education.

I am particularly interested in obtaining your responses because your experience in responding to child protection problems will provide valuable information contributing to an improved understanding of the problem of child sexual abuse for all agencies and individuals involved.

I request that you assert your belief in the importance of research on child sexual abuse by completing the following form by **May 30, 1994** and returning it to your Staff Sergeant in the envelope provided. All results are confidential and results of the study will be reported on a group basis only. Please fill in the form as completely as possible; however, you are free to decline answering any question you wish. Completion time for other individuals ranged from **20 to 40 minutes**. If you feel you cannot spend that much time completing the form, I would appreciate it if you would complete as many items as you can. Thank you for your assistance in this research.

If you have any questions or concerns please do not hesitate to contact me at 579-3108.

Sincerely,

Cynthia Hicks

SECTION A

I realize that the situations described in Vignette A and Vignette B do not contain enough concrete evidence for you to make a definite statement about whether or not sexual abuse occurred and that you may feel obligated to pursue the matter despite your own suspicions about the situation. However, apart from this issue, please indicate which possibility you think is most likely in each case.

Vignette A

Genna is a four year old girl with blonde hair and blue eyes. She is mature for her age and is very friendly and outgoing, especially towards men and boys. She often kisses them on the lips, attempts to touch their genitals, and moves her bottom around when she sits in their lap. A neighbor was concerned about this behavior and called Child Welfare. An investigation was conducted and through the use of anatomically correct dolls Genna indicated that her daddy had had sexual contact with her on a number of occasions. Genna's mother works full-time as a waitress and her father is a seasonal worker. He is currently unemployed. Genna's parents denied any sexual abuse by the father.

I. Do you suspect that Genna was sexually abused by her father or not abused? **CIRCLE ONE.**

1. Suspect she probably WAS abused ▬▬ *(GO TO I(b), PAGE 2)* ➡
2. Suspect she probably WAS NOT abused *(GO TO I(a), BELOW)*

⬇

I(a) Indicate all reasons why you suspect the abuse probably did not occur.

1. The actions simulated by Genna with the dolls may simply describe her own behavior with her father, and not any abuse by the father.
2. Genna may be lying to get out of trouble for her seductive behavior.
3. Genna may be trying to please the interviewer.
4. Children often behave in seductive ways. It does not mean they have been abused.
5. Genna could be acting out her sexual fantasies about her father.
6. Other. _____

_____

_____

GO TO I(d), PAGE 3

I(b) **If you suspect that Genna was abused by her father, read each statement and circle one number that represents your particular point of view.**

1 = Strongly Agree
2 = Agree with Reservation
3 = Not Sure
4 = Disagree with Reservation
5 = Strongly Disagree

1.	Genna's provocative behavior caused her to be abused.	1 2 3 4 5
2.	The father sexually abused her because he was unable to resist her sexual advances.	1 2 3 4 5
3.	Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	1 2 3 4 5
4.	If the abuse occurred, Genna's father is a pedophile.	1 2 3 4 5
5.	The father abused Genna because men are socialized to find small, powerless females attractive.	1 2 3 4 5
6.	Genna's father must be a very sick man.	1 2 3 4 5
7.	The dynamics of the family system are responsible for the sexual abuse, rather than any one family member.	1 2 3 4 5
8.	Poverty probably played a role in causing the father to abuse Genna.	1 2 3 4 5
9.	Other. _____	

I(c) If you suspect Genna was abused, indicate the kind of treatment, if any, that you think should be offered to this family.
Check all that you think would form <u>an effective treatment plan for THIS family.</u>

1._____ Group therapy - victim
2._____ Group therapy - offender
3._____ Group therapy - mother
4._____ Individual therapy - offender
5._____ Individual therapy - victim
6._____ Marital therapy
7._____ Mother-daughter counselling
8._____ Father-daughter counselling
9._____ Family therapy - including offender
10._____ Family therapy - excluding offender
11._____ Self-help group for victim
12._____ Self-help group for mother
13._____ Self-help group for father
14._____ Behavior modification for offender
15._____ Aversion therapy for offender
16._____ Sex therapy for offender
17._____ Sex education for offender
18._____ Parenting skills for mother and father
19._____ Social skills training for offender
20._____ Social skills training for victim
21._____ Anger control management for offender
22._____ Incarceration of offender
23._____ Probation for offender
24._____ Court-ordered treatment for offender
25._____ No court action
26._____ Other, _____

I(d) Give a percentage to the following in terms of the amount of responsibility they should be given for the occurrence of the situation described in vignette A.

_____% Father
_____% Mother
_____% Genna
_____% Society
_____% Other _____

TOTAL= 100%

Vignette B

Paula is a 15 year old girl who has recently run away from home. According to her parents and teachers, she is always getting in trouble, is abusing drugs and alcohol (which she steals from her step-father), "runs around with a hard crowd", and is sexually promiscuous. As a result her parents, the mother a college instructor and the step-father a lawyer, have given her a curfew of 9:30 p.m.

After running away, Paula went to her biological father's house and said that her step-father had been sexually abusing her since she was eleven. She wants to live with her biological father. Her biological father reported the allegation to Child Welfare. He also wants Paula to live with him. Paula's step-father denied that the abuse had occurred and said Paula was trying to get revenge for the new limitations put on her activities.

(II) Do you suspect that Paula was sexually abused by her step-father or not abused? CIRCLE ONE .

1. Suspect she probably **WAS** abused ▬▬ *(GO TO II(b), PAGE 5)* ➡

2. Suspect she probably **WAS NOT** abused *(GO TO II(a), BELOW)*

⬇

II(a) Circle all reasons why you suspect Paula was not abused.

1. She is probably lying about the abuse so that she can live with her father.
2. She may be lying to get even with her parents for the 9:30 p.m. curfew.
3. She could be lying to get attention.
4. She may have come to believe her own fantasies about her step-father.
5. There may have been a sexual relationship between them but since it went on for four years, Paula probably consented to the sexual activity.
6. Other. _____

_____

_____

GO TO II(d), PAGE 6

II(b) If you suspect that Paula was sexually abused by her step-father, read each statement and circle one number that represents your particular point of view.

1 = Strongly Agree
2 = Agree with Reservation
3 = Not Sure
4 = Disagree with Reservation
5 = Strongly Disagree

1.	The sexual abuse in this family is a symptom of some deeper dysfunction within the family system.	1 2 3 4 5
2.	The step-father probably began to molest Paula because his wife did not want to have sex with him.	1 2 3 4 5
3.	If Paula's mother hadn't been away from home so much the abuse probably would not have occurred.	1 2 3 4 5
4.	Psychiatric testing of the step-father will probably reveal some kind of mental illness or other psychological disturbance.	1 2 3 4 5
5.	The stress on the step-father to prove himself as a lawyer probably led to the abuse.	1 2 3 4 5
6.	The step-father's abuse of Paula is an attempt to dominate and control her.	1 2 3 4 5
7.	The sexual abuse of Paula is the result of a patriarchal society that gives men the power to dominate women and children.	1 2 3 4 5
8.	Since the step-father appears to be a user of alcohol, the sexual abuse of Paula was likely caused by a drinking problem.	1 2 3 4 5
9.	The step-father was probably abused himself as a child.	1 2 3 4 5
10.	Other. _____	

II(c) If you suspect Paula was abused, indicate the kind of treatment, if any, that you think should be offered to this family.
Check all that you think would form <u>an effective treatment plan for THIS family.</u>

1._____ Group therapy - victim
2._____ Group therapy - offender
3._____ Group therapy - mother
4._____ Group therapy - biological father
5._____ Individual therapy - offender
6._____ Individual therapy - victim
7._____ Marital therapy
8._____ Mother-daughter counselling
9._____ Father-daughter counselling
10._____ Stepfather-daughter counselling
11._____ Family therapy - including offender
12._____ Family therapy - excluding offender
13._____ Self-help group for victim
14._____ Self-help group for mother
15._____ Self-help group for biological father
16._____ Behavior modification for offender
17._____ Aversion therapy for offender
18._____ Sex therapy for offender
19._____ Sex education for offender
20._____ Parenting skills for the step-father
21._____ Social skills training for offender
22._____ Social skills training for victim
23._____ Anger control management for offender
24._____ Incarceration of offender
25._____ Probation for offender
26._____ Court-ordered treatment for offender
27._____ No court action
28._____ Other. _____

II(d) Give a percentage to each of the following in terms of the amount of responsibility they should be given for the occurrence of the situation described above.

_____% Step-father
_____% Mother
_____% Biological father
_____% Paula
_____% Society
_____% Other. _____

TOTAL= 100%

III. A lot of different assumptions have been made in the literature about the causes of child sexual abuse. What do you consider to be important causes of child sexual abuse?

Rank the SEVEN (7) most important causes; the most important cause being number 1 and the least important of the seven being ranked 7.

You may find it easier to rank important causes by first crossing out those you consider not to be causes

Rank <u>ONLY</u> those causes that <u>YOU</u> <u>consider</u> <u>important</u>.

_____ Family dysfunction
_____ Child is provocative or is willing to participate
_____ Stress, alcohol, and/or poverty
_____ Pornography
_____ Abuse of power/trust
_____ Mother withholds sex
_____ Abuser was abused as a child
_____ Enforced Celibacy
_____ Social or geographical isolation
_____ Lack of education or low intelligence
_____ Male socialization
_____ Mental illness in the abuser
_____ Lack of social skills in the abuser
_____ Lack of conscience
_____ Irresistible urges in the abuser
_____ Child fantasies
_____ Mother fails to protect child
_____ Mother encourages child to become the "little mother" in the family
_____ Mental illness in the mother
_____ Patriarchy
_____ Divorce/family reconstruction
_____ Poor marital relationships
_____ Society's treatment of women and children as objects
_____ Pedophilia
_____ Homosexuality
_____ Expression of power, intimacy and affection through sex
_____ Inability to distinguish between sexual and nonsexual forms of affection
_____ Other. _____

SECTION B

For each statement below, please CIRCLE ONE number that represents you particular point of view.

1 = Strongly Agree 2 = Agree with Reservation 3 = Not Sure 4 = Disagree with Reservation 5 = Strongly Disagree

1.	Child sexual abuse is one of the most serious issues affecting children's safety in society today.	1	2	3	4	5
2.	Most child sexual abuse does not affect the child's personality development, particularly if the abuse is nonviolent.	1	2	3	4	5
3.	A child who reports sexual abuse should always be believed even if there appears to be no evidence of abuse.	1	2	3	4	5
4.	A child is not capable of 'consenting' to sex with an adult.	1	2	3	4	5
5.	Male children are as likely to be sexually abused as female children.	1	2	3	4	5
6.	Children rarely make false accusations of sexual abuse.	1	2	3	4	5
7.	Broader community education is needed on child sexual abuse.	1	2	3	4	5
8.	Not all cases of child sexual abuse need to be reported to the police.	1	2	3	4	5
9.	There are probably individuals working in your agency/field who are child sexual abusers.	1	2	3	4	5
10.	Perpetrators of child sexual abuse generally have more than one victim.	1	2	3	4	5
11.	Children cannot describe sexual activities in graphic detail without having been abused.	1	2	3	4	5
12.	Victims of child sexual abuse will never, even with treatment, fully recover from the trauma of child sexual abuse. They will be scarred for life.	1	2	3	4	5
13.	Too much responsibility is being placed on children for prevention of child sexual abuse.	1	2	3	4	5

14.	An adolescent is not capable of "consenting" to sex with an adult.	1	2	3	4	5
15.	Most sexual abusers believe they are entitled to sexually abuse children.	1	2	3	4	5
16.	Children, especially young children, are usually unable to supply trust-worthy evidence in court.	1	2	3	4	5
17.	Education programs that focus on changing sexist attitudes should be an important component of attempts to prevent sexual abuse.	1	2	3	4	5
18.	Children should have more control over and more say about what happens when abuse is disclosed.	1	2	3	4	5
19.	If victims are reluctant to talk about the abuse in therapy, they should be strongly encouraged to "deal with the issues."	1	2	3	4	5
20.	Adolescents rarely make false accusations of sexual abuse.	1	2	3	4	5
21.	Sentences for child sexual abuse offenders are too lenient.	1	2	3	4	5
22.	Mothers of victims of child sexual abuse are often victims of wife abuse and thus are secondary victims.	1	2	3	4	5
23.	Most mothers of incest victims knew the abuse was going on.	1	2	3	4	5
24.	Incest victims' mothers should apologize to their children for failing to protect them from the abuse.	1	2	3	4	5
25.	In order to prevent child sexual abuse radical changes need to be made to our social structure.	1	2	3	4	5
26.	It is not the sexual abuse that causes problems for an abused child but the reaction of parents and others upon disclosure.	1	2	3	4	5
27.	Successful psychological therapy cannot be conducted with a sexual abuser as long as he continues to deny that he has a problem.	1	2	3	4	5
28.	Prosecution of a parent abuser should be avoided if the child can be adequately protected without it.	1	2	3	4	5
29.	Every child sex offender should be imprisoned for some period of time to deter others from these crimes.	1	2	3	4	5
30.	Females are just as likely to be sexual abuse offenders as males.	1	2	3	4	5

SECTION C

I. Vignette: A mother from a middle-class family comes to the office where you work and says that she believes her daughter is being sexually molested by her step-father. The woman is convinced that this is happening, and does not know what to do.

CHECK ALL OR ANY of the following interventions you would most likely take in this case.

1. _____ Interview the mother
2. _____ Report to Department of Social Services
3. _____ Interview the child
4. _____ Visit the home
5. _____ Report to police
6. _____ Interview the family
7. _____ Interview the step-father
8. _____ Suggest a physical examination
9. _____ Suggest a child psychological examination
10. _____ Suggest a psychological exam for the step-father
11. _____ Suggest a family psychological exam
12. _____ Encourage the parent to press criminal charges
13. _____ Try to get the step-father removed from the family
14. _____ Try to get the child removed from the family
15. _____ Other _____.

II. Have you ever been involved with a case of child sexual abuse?

Circle **ONE** only

No ▬▬ GO TO QUESTION III, PAGE 12 ➡

Yes ▬▬┐
▼

The following questions refer to the **MOST RECENT CASE** of child sexual abuse you have been involved with.

1.) Who (if anyone) reported the last case you were involved in?

1.____ parent
2.____ school
3.____ neighbor
4.____ physician
5.____ nurse
6.____ victim
7.____ offender
8.____ mental health agency
9.____ church
10.____ women's shelter
11.____ police
12.____ Department of Social Services
13.____ lawyer
14.____ other. _____

2.) Indicate all agencies/professionals involved in the case.

1.____ No other agency
2.____ police
3.____ mental health
4.____ physician
5.____ shelter
6.____ church
7.____ psychiatrist
8.____ Department of Social Services
9.____ court
10.____ school
11.____ other. _____

3.) Which of the agencies involved with the case, if any, cooperated and coordinated their efforts with yours and other agencies?

1.____ No other agency
2.____ police
3.____ mental health
4.____ physician
5.____ shelter
6.____ church
7.____ psychiatrist
8.____ Department of Social Services
9.____ court
10.____ school
11.____ other. _____

4.) What was the outcome of the case? **INDICATE ALL** outcomes or decisions.

____ The child was removed from the home temporarily.
____ The perpetrator was removed from the home.
____ It turned out that the child was lying about the abuse.
____ There was not enough evidence to bring the case to court.
____ Perpetrator was charged.
____ Perpetrator was convicted.
____ Perpetrator was imprisoned.
____ Accused was found not guilty
____ Perpetrator was placed on probation.
____ Perpetrator was mandated to receive treatment.
____ Perpetrator agreed to treatment as an alternative to prosecution.
____ The child was placed in foster care.
____ Both child and offender remained in the home.
____ The child received group counselling.
____ Child received individual counselling.
____ All family members received group or individual counselling.
____ The family received family counselling, without the offender.
____ The family received family counselling, with the offender.
____ Don't know what happened
____ Other. _____.

5. How satisfied were you with the outcomes? **1 2 3 4 5**

1 = Very Satisfied 2 = Satisfied 3 = Not Sure 4 = Dissatisfied 5 = Very Dissatisfied

III. Rate your level of satisfaction regarding the following issues.

1 = Very Satisfied 2 = Satisfied 3 = Don't Know 4 = Dissatisfied 5 = Very Dissatisfied

6.	Your own role in handling child sexual abuse cases.	1	2	3	4	5
7.	Your agency's response to child sexual abuse cases.	1	2	3	4	5
8.	The outcome of interventions in <u>most</u> child sexual abuse cases.	1	2	3	4	5
9.	The <u>attitudes and beliefs</u> about child sexual abuse that are held by people in (a) schools	1	2	3	4	5
	(b) churches	1	2	3	4	5
	(c) medical community	1	2	3	4	5
	(d) mental health agencies	1	2	3	4	5
	(e) police	1	2	3	4	5
	(f) Department of Social Services	1	2	3	4	5
	(g) prosecuting attorney	1	2	3	4	5
	(h) defence attorney	1	2	3	4	5
	(i) judges	1	2	3	4	5
	(j) shelters	1	2	3	4	5
	(k) provincial government (policymakers)	1	2	3	4	5

1 = Very Satisfied 2 = Satisfied 3 = Don't Know 4 = Dissatisfied 5 = Very Dissatisfied

10.	Coordination of intervention efforts with other agencies/professions.					
	(a) schools	1	2	3	4	5
	(b) churches	1	2	3	4	5
	(c) medical community	1	2	3	4	5
	(d) mental health agencies	1	2	3	4	5
	(e) police	1	2	3	4	5
	(f) Department of Social Services	1	2	3	4	5
	(g) prosecuting attorney	1	2	3	4	5
	(h) defence attorney	1	2	3	4	5
	(i) judges	1	2	3	4	5
	(j) shelters	1	2	3	4	5
	(k) provincial government	1	2	3	4	5
11.	How satisfied are you with the effectiveness of currently available treatment programs?	1	2	3	4	5
12.	How satisfied are you with currently available prevention programs/efforts?	1	2	3	4	5
13.	How satisfied are you with the coordination of prevention and awareness efforts among various agencies?	1	2	3	4	5

SECTION D

Please circle the number that best describes you for each question below

1. Please indicate your gender:
   (1) Female
   (2) Male

2. In which of the following age categories do you presently fall?
   (1) 20-29
   (2) 30-39
   (3) 40-49
   (4) 50-65
   (5) 65+

3. How many years have you worked with your present agency?
   (1) < 2 years
   (2) 2 - 5
   (3) 5 - 10
   (4) 10 - 20
   (5) 20 - 30+

4. How much experience do you have with victims of child sexual abuse?
   (1) No experience
   (2) One case
   (3) Less than five
   (4) 5 - 10
   (5) More than 10

5. Indicate your job title: _____

Thank-you for participating in this study.

Letter of Introduction

I am a graduate student in the Educational Psychology Programme, Faculty of Education, at Memorial University. I am currently conducting a thesis study investigating the attitudes and beliefs of the various professionals involved with cases of child sexual abuse. Exploratory information in this area may aid relevant agencies in developing a coordinated interdisciplinary approach to child sexual abuse that is based on an understanding of the position of each agency and knowledge of areas that should be incorporated into interdisciplinary training. This study has received the approval of the Faculty of Education's Ethics Review Committee and is being supervised by Dr. Rosonna Tite in the Faculty of Education. Mr. David Locke, Assistant Superintendant, Roman Catholic School Board, has also granted permission for this study to be conducted with in your school.

I am particularly interested in obtaining your responses because your experience in responding to child protection problems will provide valuable information contributing to an improved understanding of the problem of child sexual abuse for all agencies and individuals involved.

I request that you assert your belief in the importance of research on child sexual abuse by completing the following form by **November 24, 1994** and returning it to your principal in the envelope provided. All results are confidential and results of the study will be reported on a group basis only. Please fill in the form as completely as possible; however, you are free to decline answering any question you wish. Completion time for other individuals ranged from **20 to 40 minutes**. If you feel you cannot spend that much time completing the form, I would appreciate it if you would complete as many items as you can. Thank you for your assistance in this research.

If you have any questions or concerns please do not hesitate to contact me at 579-3108.

Sincerely,

Cynthia Hicks

SECTION A

I realize that the situations described in Vignette A and Vignette B do not contain enough concrete evidence for you to make a definite statement about whether or not sexual abuse occurred and that you may feel obligated to pursue the matter despite your own suspicions about the situation. However, apart from this issue, please indicate which possibility you think is most likely in each case.

Vignette A

Genna is a four year old girl with blonde hair and blue eyes. She is mature for her age and is very friendly and outgoing, especially towards men and boys. She often kisses them on the lips, attempts to touch their genitals, and moves her bottom around when she sits in their lap. A neighbor was concerned about this behavior and called Child Welfare. An investigation was conducted and through the use of anatomically correct dolls Genna indicated that her daddy had had sexual contact with her on a number of occasions. Genna's mother works full-time as a waitress and her father is a seasonal worker. He is currently unemployed. Genna's parents denied any sexual abuse by the father.

I. Do you suspect that Genna was sexually abused by her father or not abused? **CIRCLE ONE.**

1. Suspect she probably WAS abused ▬▬ *(GO TO I(b), PAGE 2)* ➡
2. Suspect she probably WAS NOT abused *(GO TO I(a), BELOW)*

⬇

I(a) **Indicate all reasons why you suspect the abuse probably did not occur.**

1. The actions simulated by Genna with the dolls may simply describe her own behavior with her father, and not any abuse by the father.
2. Genna may be lying to get out of trouble for her seductive behavior.
3. Genna may be trying to please the interviewer.
4. Children often behave in seductive ways. It does not mean they have been abused.
5. Genna could be acting out her sexual fantasies about her father.
6. Other. _____

_____

_____

GO TO I(d), PAGE 3

I(b) If you suspect that Genna was abused by her father, read each statement and circle one number that represents your particular point of view.

1 = Strongly Agree
2 = Agree with Reservation
3 = Not Sure
4 = Disagree with Reservation
5 = Strongly Disagree

1.	Genna's provocative behavior caused her to be abused.	1 2 3 4 5
2.	The father sexually abused her because he was unable to resist her sexual advances.	1 2 3 4 5
3.	Genna's mother is partly responsible for the abuse because she failed to protect her daughter.	1 2 3 4 5
4.	If the abuse occurred, Genna's father is a pedophile.	1 2 3 4 5
5.	The father abused Genna because men are socialized to find small, powerless females attractive.	1 2 3 4 5
6.	Genna's father must be a very sick man.	1 2 3 4 5
7.	The dynamics of the family system are responsible for the sexual abuse, rather than any one family member.	1 2 3 4 5
8.	Poverty probably played a role in causing the father to abuse Genna.	1 2 3 4 5
9.	Other. _____	

I(c) If you suspect Genna was abused, indicate the kind of treatment, if any, that you think should be offered to this family.
Check all that you think would form <u>an effective treatment plan for THIS family.</u>

1._____ Group therapy - victim
2._____ Group therapy - offender
3._____ Group therapy - mother
4._____ Individual therapy - offender
5._____ Individual therapy - victim
6._____ Marital therapy
7._____ Mother-daughter counselling
8._____ Father-daughter counselling
9._____ Family therapy - including offender
10._____ Family therapy - excluding offender
11._____ Self-help group for victim
12._____ Self-help group for mother
13._____ Self-help group for father
14._____ Behavior modification for offender
15._____ Aversion therapy for offender
16._____ Sex therapy for offender
17._____ Sex education for offender
18._____ Parenting skills for mother and father
19._____ Social skills training for offender
20._____ Social skills training for victim
21._____ Anger control management for offender
22._____ Incarceration of offender
23._____ Probation for offender
24._____ Court-ordered treatment for offender
25._____ No court action
26._____ Other. _____

I(d) Give a percentage to the following in terms of the amount of responsibility they should be given for the occurrence of the situation described in vignette A.

_____% Father
_____% Mother
_____% Genna
_____% Society
_____% Other _____

TOTAL= 100%

Vignette B

*P*aula is a 15 year old girl who has recently run away from home. According to her parents and teachers, she is always getting in trouble, is abusing drugs and alcohol (which she steals from her step-father), "runs around with a hard crowd", and is sexually promiscuous. As a result her parents, the mother a college instructor and the step-father a lawyer, have given her a curfew of 9:30 p.m.

*A*fter running away, Paula went to her biological father's house and said that her step-father had been sexually abusing her since she was eleven. She wants to live with her biological father. Her biological father reported the allegation to Child Welfare. He also wants Paula to live with him. Paula's step-father denied that the abuse had occurred and said Paula was trying to get revenge for the new limitations put on her activities.

(II) Do you suspect that Paula was sexually abused by her step-father or not abused? CIRCLE ONE.

1. Suspect she probably **WAS** abused ▬▬ *(GO TO II(b), PAGE 5)* ➡

2. Suspect she probably **WAS NOT** abused *(GO TO II(a), BELOW)*

⬇

II(a) Circle all reasons why you suspect Paula was not abused.

1. She is probably lying about the abuse so that she can live with her father.
2. She may be lying to get even with her parents for the 9:30 p.m. curfew.
3. She could be lying to get attention.
4. She may have come to believe her own fantasies about her step-father.
5. There may have been a sexual relationship between them but since it went on for four years, Paula probably consented to the sexual activity.
6. Other. _____

_____

_____

GO TO II(d), PAGE 6

II(b) If you suspect that Paula was sexually abused by her step-father, read each statement and circle one number that represents your particular point of view.

1 = Strongly Agree
2 = Agree with Reservation
3 = Not Sure
4 = Disagree with Reservation
5 = Strongly Disagree

1.	The sexual abuse in this family is a symptom of some deeper dysfunction within the family system.	1 2 3 4 5
2.	The step-father probably began to molest Paula because his wife did not want to have sex with him.	1 2 3 4 5
3.	If Paula's mother hadn't been away from home so much the abuse probably would not have occurred.	1 2 3 4 5
4.	Psychiatric testing of the step-father will probably reveal some kind of mental illness or other psychological disturbance.	1 2 3 4 5
5.	The stress on the step-father to prove himself as a lawyer probably led to the abuse.	1 2 3 4 5
6.	The step-father's abuse of Paula is an attempt to dominate and control her.	1 2 3 4 5
7.	The sexual abuse of Paula is the result of a patriarchal society that gives men the power to dominate women and children.	1 2 3 4 5
8.	Since the step-father appears to be a user of alcohol, the sexual abuse of Paula was likely caused by a drinking problem.	1 2 3 4 5
9.	The step-father was probably abused himself as a child.	1 2 3 4 5
10.	Other. _____	

II(c) If you suspect Paula was abused, indicate the kind of treatment, if any, that you think should be offered to this family.
Check all that you think would form <u>an effective treatment plan for THIS family.</u>

1._____ Group therapy - victim
2._____ Group therapy - offender
3._____ Group therapy - mother
4._____ Group therapy - biological father
5._____ Individual therapy - offender
6._____ Individual therapy - victim
7._____ Marital therapy
8._____ Mother-daughter counselling
9._____ Father-daughter counselling
10._____ Stepfather-daughter counselling
11._____ Family therapy - including offender
12._____ Family therapy - excluding offender
13._____ Self-help group for victim
14._____ Self-help group for mother
15._____ Self-help group for biological father
16._____ Behavior modification for offender
17._____ Aversion therapy for offender
18._____ Sex therapy for offender
19._____ Sex education for offender
20._____ Parenting skills for the step-father
21._____ Social skills training for offender
22._____ Social skills training for victim
23._____ Anger control management for offender
24._____ Incarceration of offender
25._____ Probation for offender
26._____ Court-ordered treatment for offender
27._____ No court action
28._____ Other. _____

II(d) Give a percentage to each of the following in terms of the amount of responsibility they should be given for the occurrence of the situation described above.

_____% Step-father
_____% Mother
_____% Biological father
_____% Paula
_____% Society
_____% Other. _____

TOTAL= 100%

III. A lot of different assumptions have been made in the literature about the causes of child sexual abuse. What do you consider to be important causes of child sexual abuse?

Rank the SEVEN (7) most important causes; the most important cause being number 1 and the least important of the seven being ranked 7.

You may find it easier to rank important causes by first crossing out those you consider not to be causes

Rank <u>ONLY</u> those causes that <u>YOU</u> <u>consider</u> <u>important</u>.

_____ Family dysfunction
_____ Child is provocative or is willing to participate
_____ Stress, alcohol, and/or poverty
_____ Pornography
_____ Abuse of power/trust
_____ Mother withholds sex
_____ Abuser was abused as a child
_____ Enforced Celibacy
_____ Social or geographical isolation
_____ Lack of education or low intelligence
_____ Male socialization
_____ Mental illness in the abuser
_____ Lack of social skills in the abuser
_____ Lack of conscience
_____ Irresistible urges in the abuser
_____ Child fantasies
_____ Mother fails to protect child
_____ Mother encourages child to become the "little mother" in the family
_____ Mental illness in the mother
_____ Patriarchy
_____ Divorce/family reconstruction
_____ Poor marital relationships
_____ Society's treatment of women and children as objects
_____ Pedophilia
_____ Homosexuality
_____ Expression of power, intimacy and affection through sex
_____ Inability to distinguish between sexual and nonsexual forms of affection
_____ Other. _____
_____
_____
_____
_____

SECTION B

For each statement below, please CIRCLE ONE number that represents you particular point of view.

1 = Strongly Agree 2 = Agree with Reservation 3 = Not Sure 4 = Disagree with Reservation 5 = Strongly Disagree

1.	Child sexual abuse is one of the most serious issues affecting children's safety in society today.	1	2	3	4	5
2.	Most child sexual abuse does not affect the child's personality development, particularly if the abuse is nonviolent.	1	2	3	4	5
3.	A child who reports sexual abuse should always be believed even if there appears to be no evidence of abuse.	1	2	3	4	5
4.	A child is not capable of 'consenting' to sex with an adult.	1	2	3	4	5
5.	Male children are as likely to be sexually abused as female children.	1	2	3	4	5
6.	Children rarely make false accusations of sexual abuse.	1	2	3	4	5
7.	Broader community education is needed on child sexual abuse.	1	2	3	4	5
8.	Not all cases of child sexual abuse need to be reported to the police.	1	2	3	4	5
9.	There are probably individuals working in your agency/field who are child sexual abusers.	1	2	3	4	5
10.	Perpetrators of child sexual abuse generally have more than one victim.	1	2	3	4	5
11.	Children cannot describe sexual activities in graphic detail without having been abused.	1	2	3	4	5
12.	Victims of child sexual abuse will never, even with treatment, fully recover from the trauma of child sexual abuse. They will be scarred for life.	1	2	3	4	5
13.	Too much responsibility is being placed on children for prevention of child sexual abuse.	1	2	3	4	5

14.	An adolescent is not capable of "consenting" to sex with an adult.	1	2	3	4	5
15.	Most sexual abusers believe they are entitled to sexually abuse children.	1	2	3	4	5
16.	Children, especially young children, are usually unable to supply trust-worthy evidence in court.	1	2	3	4	5
17.	Education programs that focus on changing sexist attitudes should be an important component of attempts to prevent sexual abuse.	1	2	3	4	5
18.	Children should have more control over and more say about what happens when abuse is disclosed.	1	2	3	4	5
19.	If victims are reluctant to talk about the abuse in therapy, they should be strongly encouraged to "deal with the issues."	1	2	3	4	5
20.	Adolescents rarely make false accusations of sexual abuse.	1	2	3	4	5
21.	Sentences for child sexual abuse offenders are too lenient.	1	2	3	4	5
22.	Mothers of victims of child sexual abuse are often victims of wife abuse and thus are secondary victims.	1	2	3	4	5
23.	Most mothers of incest victims knew the abuse was going on.	1	2	3	4	5
24.	Incest victims' mothers should apologize to their children for failing to protect them from the abuse.	1	2	3	4	5
25.	In order to prevent child sexual abuse radical changes need to be made to our social structure.	1	2	3	4	5
26.	It is not the sexual abuse that causes problems for an abused child but the reaction of parents and others upon disclosure.	1	2	3	4	5
27.	Successful psychological therapy cannot be conducted with a sexual abuser as long as he continues to deny that he has a problem.	1	2	3	4	5
28.	Prosecution of a parent abuser should be avoided if the child can be adequately protected without it.	1	2	3	4	5
29.	Every child sex offender should be imprisoned for some period of time to deter others from these crimes.	1	2	3	4	5
30.	Females are just as likely to be sexual abuse offenders as males.	1	2	3	4	5

SECTION C

I. Vignette: A mother from a middle-class family comes to the office where you work and says that she believes her daughter is being sexually molested by her step-father. The woman is convinced that this is happening, and does not know what to do.

CHECK ALL OR ANY of the following interventions you would most likely take in this case.

1. _____ Interview the mother
2. _____ Report to Department of Social Services
3. _____ Interview the child
4. _____ Visit the home
5. _____ Report to police
6. _____ Interview the family
7. _____ Interview the step-father
8. _____ Suggest a physical examination
9. _____ Suggest a child psychological examination
10. _____ Suggest a psychological exam for the step-father
11. _____ Suggest a family psychological exam
12. _____ Encourage the parent to press criminal charges
13. _____ Try to get the step-father removed from the family
14. _____ Try to get the child removed from the family
15. _____ Other _____.

II. Rate your level of satisfaction regarding the following issues.

1 = Very Satisfied 2 = Satisfied 3 = Don't Know 4 = Dissatisfied 5 = Very Dissatisfied

6.	Your own role in handling child sexual abuse cases.	1	2	3	4	5
7.	Your agency's response to child sexual abuse cases.	1	2	3	4	5
8.	The outcome of interventions in <u>most</u> child sexual abuse cases.	1	2	3	4	5

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1 = Very Satisfied 2 = Satisfied 3 = Don't Know 4 = Dissatisfied 5 = Very Dissatisfied

9.	The attitudes and beliefs about child sexual abuse that are held by people in					
	(a) schools	1	2	3	4	5
	(b) churches	1	2	3	4	5
	(c) medical community	1	2	3	4	5
	(d) mental health agencies	1	2	3	4	5
	(e) police	1	2	3	4	5
	(f) Department of Social Services	1	2	3	4	5
	(g) prosecuting attorney	1	2	3	4	5
	(h) defence attorney	1	2	3	4	5
	(i) judges	1	2	3	4	5
	(j) shelters	1	2	3	4	5
	(k) provincial government (policymakers)	1	2	3	4	5
10.	Coordination of intervention efforts with other agencies/professions.					
	(a) schools	1	2	3	4	5
	(b) churches	1	2	3	4	5
	(c) medical community	1	2	3	4	5
	(d) mental health agencies	1	2	3	4	5
	(e) police	1	2	3	4	5
	(f) Department of Social Services	1	2	3	4	5
	(g) prosecuting attorney	1	2	3	4	5
	(h) defence attorney	1	2	3	4	5
	(i) judges	1	2	3	4	5
	(j) shelters	1	2	3	4	5
	(k) provincial government	1	2	3	4	5

1 = Very Satisfied 2 = Satisfied 3 = Don't Know 4 = Dissatisfied 5 = Very Dissatisfied

11.	How satisfied are you with the effectiveness of currently available treatment programs?	1	2	3	4	5
12.	How satisfied are you with currently available prevention programs/efforts?	1	2	3	4	5
13.	How satisfied are you with the coordination of prevention and awareness efforts among various agencies?	1	2	3	4	5

SECTION D

Please circle the number that best describes you for each question below

1. Please indicate your gender:
   (1) Female
   (2) Male

2. In which of the following **age** categories do you presently fall?
   (1) 20-29
   (2) 30-39
   (3) 40-49
   (4) 50-65
   (5) 65+

3. How many years have you worked with your present agency?
   (1) < 2 years
   (2) 2 - 5
   (3) 5 - 10
   (4) 10 - 20
   (5) 20 - 30+

4. Have you ever been involved in responding to cases of child sexual abuse?
   (1) No
   (2) Yes

5. Indicate your job title: _____

Thank-you for participating in this study.