CHILD SEXUAL ABUSE

The Search for Healing

CHRISTOPHER BAGLEY
AND
KATHLEEN KING

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KATHLEEN KING

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CONTENTS

TABLES

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ABOUT THE AUTHORS

Christopher Bagley studied in England and received a D.Phil. in social psychology from the University of Sussex before emigrating to Canada to take up the Senator Patrick Burns Chair of Child Welfare at the University of Calgary. He was part of a group which established an agency for counselling sexually abused children and their families in Calgary, using methods based on the humanistic model of therapy pioneered by Hank Giarretto. He also works with Native Bands in northern Alberta in programmes designed to prevent the removal of Native children from their families and to assist the return of Native children from the care of social services to their original families.

Kathleen King studied philosophy before undertaking social work training. She has extensive practice experience in Edmonton, Alberta, in the treatment and prevention of child sexual abuse, and has an M.S.W. degree from the University of Calgary. She now practises social work in rural Nova Scotia.

This book was completed while Chris Bagley held a visiting fellowship in the Department of Psychiatry at the University of Leeds, in 1987.

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Chapter One

THE MEANING OF SEXUAL ABUSE IN CHILDHOOD

> My natural love for beauty was checked by some ancestral dread. Yet this did not prevent me from feeling ecstasies and raptures spontaneously and intensely without any shame or the least sense of guilt, so long as they were disconnected with my own body. I thus detect another element in the shame which I had in being caught looking at myself in the glass in the hall. I must have been ashamed or afraid of my own body. Another memory, also of the hall, may help to explain this. There was a slab outside the dining room door…G.D. lifted me onto this, and as I sat there he began to explore my body. I can remember the feel of his hand going under my clothes; going firmly and steadily lower and lower. I remember how I hoped that he would stop; how I stiffened and wriggled as his hand approached my private parts. But it did not stop. I remember resenting, disliking it—what is the word for so dumb and mixed a feeling? It must have been strong, since I still recall it. This seems to show that a feeling about certain parts of the body; how they must not be touched; how it is wrong to allow them to be touched; must be instinctive. It proves that Virginia Stephen was not born on the 25th January 1882, but was born many thousands of years ago; and had from the very first to encounter instincts already acquired by thousands of ancestresses in the past.
>
> Virginia Woolf (1976)
> *Moments of being: autobiographical writings*

This book is a search for the meaning of sexual abuse in childhood, and an attempt to understand from a variety of clinical and research studies how the wounds inflicted on children by the

crime of sexual abuse can be healed, and how such abuse can be prevented. It will become clear to the reader that the available evidence suggests that the sexual abuse of children is not only disturbingly widespread but is also often harmful to the child victims. Our work in this field began in the 1960s, arising from an interest in sociological studies of the incest taboo and its transgressions (Bagley 1969). At that time we assumed, along with other researchers, that the interventions of a horrified society could do as much psychological harm to an innocent child in an incestuous relationship as could the sexual assault itself.

We were able at that time to begin a long-term follow-up study with some of our subjects, and were able to survey the adult lives of children who had been sexually abused within the context of the family (some ten years earlier), in comparison with children who had been removed from home because of physical abuse or neglect (Bagley and MacDonald 1984). This study has convinced us that sexual abuse itself (as opposed to any subsequent social interventions) is indeed grossly intrusive in the lives of children and is harmful to their normal psychological, emotional, and sexual development in ways which no just or humane society can tolerate.

The emotions and values of practitioners and researchers are of fundamental importance in social action, writing, and research in this most sensitive of areas. It behoves us, as potential experts in this area, to make our own position clear. Neither of us was abused in childhood, physically, emotionally, or sexually. Our childhoods, one in rural England, the other in rural Canada, were interesting, happy, and uneventful. We only came to an understanding of the widespread occurrence of the sexual exploitation of children, and the particular harm such abuse can do, through our practice as researchers and social workers. Never having experienced such abuse in a personal way, it was initially difficult for us to understand or empathize with victims and their emotional travail. In coming to terms with the reality of sexual abuse, we found the personal accounts written by women reviewing painful circumstances of abuse in childhood both moving and intellectually helpful.

We commend to our readers these personal accounts. They are stories of anguish, despair, courage, humour, hope, adventure, forgiveness, and rebirth. It was these brave writers who began publishing in the 1970s who first alerted the world to the real nature of the problem of the sexual abuse of children. The early

scholars—all women—deserve mention: Florence Rush, Judith Herman, Karen Meiselman, and Diana Russell, were among these intellectual pioneers. But it is above all to the non-clinical writers—Charlotte Vale Allen, Katherine Brady, Louise Armstrong, and others, including the women whose voices are recorded in the collections edited by Elizabeth Ward, Ellen Bass, and Louise Armstrong—who have changed our consciousness in the matter of child sexual abuse.

This book attempts to offer an intellectual understanding of the problem of child sexual abuse in many of its aspects. We overview this literature from the professional standpoint of social work, and from the value perspective of humanism. Our humanism is not entirely of the secular variety, and has its roots in the theology of the medieval schoolman, Duns the Scot, and in writers and philosophers as seemingly diverse as John Donne, St Vincent de Paul, the Quaker founders, William Blake, and Gerard Manley Hopkins. The thread which joins these writers is the joyful intuition that human beings have a spiritual essence which is constantly bubbling to the surface of life. The burden of the albatross is released through a simple act of grace. Though many perils in this life tempt and betray us, escape from the hosts of Gideon is ever possible. Everything that lives is holy, as William Blake said. Even material things, even a poplar tree, trembles with the essence of immanent beauty and goodness.

This intuition, this hypothesis about the conduct of living and of interpersonal relationships is tempered by the sombre realization that many humans fail to attend to the spirit within. It is a further tenet of our philosophical belief that human beings can be, must be, responsible for their own conduct and their own redemption. As Vincent de Paul said, even the slave, or the man in the deepest dungeon is responsible for his own sins, and his own redemption. The man who sexually abuses children, we can forgive, help and support: but he is always and ultimately responsible for his own rehabilitation and must accept responsibility for the harm he has imposed upon others.

Allied to these two principles—of innate goodness, and of ultimate personal responsibility—is our fundamental notion about the nature of children. They enter the world as pure, spiritual beings and are the source of salvation for each new generation. Denying or perverting the natural innocence and goodness of childhood is an action of the most tragic order. The person who abuses a child puts a millstone around his neck: but, in our

humanist philosophy, that millstone, like the albatross, can be shed by an act of will, by an act of redemption.

PERSONAL ACCOUNTS 1978 TO 1987

Each personal account has certain unique features, and each account has a different emphasis, a different tale to tell, a different way of retrieving dignity and a sense of personal well-being. Sometimes editors gather together accounts which are consistent with their own experience and philosophy. Louise Armstrong in 1978 edited *A speak-out on incest* which Susan Brownmiller described in a review as 'the first significant book on incest ever to appear in print'. We cannot quarrel with such a judgement: the sterile academic tomes published up to this time did nothing to understand or alleviate the plight of victims of child sexual abuse (sometimes described as incest when it takes place within a family context). Indeed, 1978 was a significant year for publications which guided our understanding of the real nature and widespread occurrence of child sexual abuse (Bagley 1985).

A Speak-Out on Incest—Louise Armstrong, 1978

This edited book contains twenty-six contributions by women who were sexually abused by a family member when they were children. The personal accounts are brave, calm, and written without self-pity. They are reflections of a mature understanding by women who have surmounted this childhood confusion about the way adults acted, and the nightmares and horror which the imposed sexual relationship often involved.

One of the ironies of this book is that it is written by psychological survivors—women who have been able to surmount the traumas imposed by the sexual assault of childhood and review this experience with constructive anger—without any 'therapy' from conventional helping professions.

> I kept the memory of these experiences inside for the first twenty years of my life. I prayed day and night that by the time I was a teenager the memory would have gone from me and I could finally have freedom through amnesia. But once a teenager, I realized I would have to live with the memory—it would never leave. I think I intuitively knew it

> was not a natural experience that had happened to me. And because such subjects were still in the closet in those days, there was nothing for me to read in order to get information. It was like invisible scars from a childhood disease.
>
> (Armstrong 1978:16)

Why is seduction and sexual assault in childhood so destructive of normal development? One of the purposes of the present book is to help the practitioner understand how and why the sexual abuse of children so often causes psychological damage. As Louise Armstrong says:

> Rape by a stranger is quick and brutal. It allows for a straightforward reaction—anger, hate. But the seduction or coercion of a child by a needed and trusted parent is far more complex. It is not amazing that some run away, that some turn to drugs, that some, having been called slut by their fathers, become promiscuous prostitutes. What is amazing is that many (no-one knows how many) do not.
>
> (Armstrong 1978:40)

The young victims coped in various ways—by passive submission, by running from home, by identifying with the sexual abuser, by a diffused or a focused hatred of self or others:

> And then he would do cunnilingus. I remember just sitting on the chair and watching his head between my legs, hating him. The hate, the hate was a living thing. I remember looking at his head and just wanting to take his hair and pull it out. At six years old…. And he would say, 'Look at your mother. She's had five children. What good is she to me? It's like sticking a sausage in a fireplace.' And tell me stories of how he had gone to bed with his sisters and their best friends and what they did, everything in detail. How did I cope? I compartmentalized it. I was able to son of put it away. I remember lying there, crying, when I was very small and saying to myself, 'Some day I'm going to grow up and some day I'm going to get away from here.' And I did. Starting at sixteen, I had three very early, very bad marriages. Because I simply was not capable of adult relationships, of a healthy relationship with a man…. I

> would become completely frigid. I would begin to act out all those angry things I had never been able to act out at the time.
>
> (Armstrong 1978:102–3)

This anguished account of both a childhood and early adulthood destroyed by sexual abuse, illustrates a number of features which have emerged in detailed studies of clinical populations. First of all, the motivation of the offender is often based on his memory of early experiences of sibling incest or of adolescent sexual experiences. He seems to be acting out this fixated memory, or seeks to recreate some of the circumstances of lost youth. This is a theme which frequently occurs, for example, in the novels of Vladimir Nabokov (Nabokov 1986).

A second clinical issue which this personal account illuminates is that of learned helplessness and impotent rage which becomes inner directed. This woman could only escape the sexual abuse by fleeing into another abusive or exploitative relationship, which became a series of relationships. What often happens is that a woman takes her children into new relationships, and her new partner may sexually exploit both her and her children. Sometimes the woman is aware of this, but is too defeated to intervene; often, however, she has no knowledge of the continued cycle of abuse. She has little ego strength herself, and her children have diminished or disrupted self-concept, because of the changes or upsets in their own lives. Often the sexual abuse of children takes place in such disrupted family circumstances. But such abuse can also occur in seemingly normal families, in which the father is a respectable professional, a religious man, and a community leader.

Another of the accounts told to Louise Armstrong illustrates the development of learned helplessness in a victim of childhood sexual abuse:

> And what these things did was they filled me with a deep, deep depression and disgust. Yet, there was something about my fantasies. It's always him. His bald head. Going down. You know? That association that I have—that I enjoy on a level—that I can't accept. Because then I experienced nothing but wanting to die…. See, there were two husbands. The two men in my life were both brutal. The first was the most brutal. The second one, the father of

> my fourth child, was not brutal to the kids. He was brutal to me…. Then I went with one other man because I still couldn't cope with kids. You wouldn't believe. There was no way of explaining my inability to cope. All they can do is blame me and hate me today…. I just mentally blocked everything out…. He only hit me twice. When he did, he went like this—and broke my eardrum. Second time, he went like this—and broke my nose. So I was in deathly fear of him…. And I was passive. Because, again, in my mother's home, the mother, whether she agrees or disagrees, must not disagree in front of the kids to her mate. I want to kill. I have feelings of rage inside. But as soon as it pertains to my own child, I go dead with feeling.
>
> (Armstrong 1978:124–7)

This woman makes it further clear in her account that she was unable to protect her son from sexual abuse, and that she had herself sexually abused younger children when she was a teenager. Later:

> Then my first really close girl friend, about seven years ago. She had a daughter. We lived together. We stayed together two years. I was cruel to that child, like those men had been to my kids…. I definitely got violent with her. I had urges—I mean not urges—but thoughts crossed my mind that I want to rip out her vagina, to destroy her. And I thought to myself, maybe the reasons for wanting to destroy a female body, a child female body, is because what my stepfather did to me shouldn't have happened. You shouldn't try to make an adult out of a little baby.
>
> (Armstrong 1978:128)

This woman further describes how she came home one day to find her boyfriend sexually molesting her 7-year-old child. She accepted the situation passively:

> I couldn't even get angry. Instead I felt subjugated. The same way with my stepfather. Like he had a right. But I don't feel logically that they have a right. But emotionally, I'm completely in their control.
>
> (Armstrong 1978:130)

It should be stressed that recent clinical studies (reviewed in a later chapter) have shown that the large majority of mothers in families where the sexual abuse of a child occurs had only vague clues that something was going wrong in the family, but when the daughter was able to reveal the abuse, the mother reacted with shock and horror, and usually supported the child through the crisis of revelation. The protection and support which mothers can offer is well illustrated in a number of the case studies included by Louise Armstrong.

Armstrong titles one of her case studies 'The pillar of the community'. This is written by David, who grew up in a prosperous and seemingly respectable rural household. His family were church-goers and engaged in voluntary social service. They took in foster children. Some of these children, like David and his sister, became victims of sexual abuse at the hands of David's father. David's mother was quite unaware of the abuse, which continued for many years.

> It was one of the times when my mom was out of the house. And my father had gone in to have intercourse with my sister, which he hadn't done before. He had done other things. But he had never attempted full intercourse with her. And she would not let him do that. And he got very angry with her. Called her a whore and a slut and so on and so forth. And I heard all this.
>
> I was extremely angry. And the next thing I remember he slammed off and went to the recreation room downstairs. Sara was just hysterical and beside herself and went to the bathroom and stayed there a long time. And then she came out. She was crying and all, so I went in to her and talked to her and she said she had gone to the medicine cabinet and taken aspirins—a whole bottle. So I went down to my dad and I started screaming at him and hollering at him. 'Look what you've done!' And with that he got up and left the house.
>
> He just stormed out of the house. So I took it upon myself to keep her on her feet and kept feeding her black coffee. At this point she was ten. I was fourteen.
>
> (Armstrong 1978:214)

After this incident, David finally told his mother about the abuse, which had been continuing for six years:

> I described that it had happened when she was out of the house, at class or at our P.T.A. or different times. 'Well, what did he do to you? And why didn't you tell me?' She was really hurt. I repeated that he told us that she'd skin us alive and that, you know—he'd said she would kill us and all this. She said, 'Do you really think I would have done that?' And I said no. 'Well, why didn't you tell me?'
>
> You know, sort of double bind. But after I told she was very protective. And—she lashed into him. She grew hysterical. Started yelling and screaming at him and he sat down and cried. And said he was really sorry. And that he knew it was wrong. And he couldn't help himself. But he also threatened me at that point, too. He said that if he ever got a hold of me, he was going to kill me. And I believed him.
>
> (Armstrong 1978:215–16)

The abuse was not reported to the authorities. None of the children received any therapy. The family remained silent but intact. Sara continued to engage in self-destructive behaviour. She writes:

> I felt rejected and depressed. I could never hurt anybody else and I guess that's another part of suppressing anger. I couldn't take my anger out on the people that really hurt me most. So instead I did bodily harm to myself. I've got scars all over my body, but my arms in particular from burning myself with an iron when I was mad. From just taking a knife when I was angry and slicing my finger or my hand. Because I was mad at somebody else and yet I couldn't do them any damage.
>
> (Armstrong 1978:221)

As a teenager Sara was confused in social relationships, and was marked down in high school as a potential victim. She was raped by three boys. In college her depression worsened, and she took several serious overdoses. After her father died, the self-destructive behaviour became worse. Sara deliberately wrecked her car, and was seriously injured. She took drugs, and eventually became an alcoholic. In her thirties, Sara eventually overcame her depression and stopped drinking. David had initially adjusted well, entering the gay scene while still in his teens. But it was

David who had the worst adjustment in the long run, and when both children were in their thirties it was David who was seriously suicidal.

This harrowing case history vividly illustrates a number of findings from clinical and epidemiological studies. First, children can be persuaded, cajoled, and threatened into accepting sexual abuse; women can be deceived about the reality that is happening; the traditional role of the father as imperious head of the household greatly assists the perverse exercise of power. Second, sexual abuse of children can occur in all kinds of families, including the seemingly upright, religious, and respectable ones; sexual abuse of children, even when revealed, is often not reported to any authorities; therapeutic help for children is either not available or is not offered. Third, sexual abuse in childhood can have profoundly negative influences on long-term adjustment. Last, appropriate therapy in adulthood is necessary to exorcize these psychological ghosts—and the therapy must focus not only on the current, presenting problem, but on the past memories of the sexual abuse too.

Father's Days—Katherine Brady, 1979

Katherine Brady's 'true story of incest' became a national bestseller in the United States. Brady's father was a seemingly upright man, a pillar of the local community. He was also authoritarian and dominating in personality (he was a senior guard at the local penitentiary). Yet beneath the bluff exterior, he was lonely and often tortured. Brady is humanistic and forgiving in this account of her father:

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

Katherine's older sister became pregnant, probably through contact with a neighbourhood boy. But she had also been sexually abused by her father. Ellen (her sister) told Katherine:

> I couldn't conceive that a man who locked up thieves and murderers could have done what he did. I kept thinking how dirty he made me feel…
>
> (Brady 1979:62)

After her pregnant sister left home, Katherine's father began having intercourse with her when she was 14; he had fondled Katherine sexually since she was 8 years old. The assaults were simultaneously both sexually stimulating and the cause of enormous guilt and shame. Katherine was afraid to tell her mother, to whom she was not close; she felt certain that she would be blamed and abandoned. Outwardly, Katherine maintained the façade of being a good daughter and a good scholar, a model citizen, just like her father:

> But beneath that façade, anger was shimmering. I felt she should protect me from my father, not push me at him…. But she neither saw nor intervened. And the rage continued to grow. By the time I reached high school, I had two absolutely separate personalities. The public one, exhibited to family and friends alike, was friendly, stable, honest, thoughtful, courteous, trustworthy, reliable, and cooperative. The private one was fearful, isolated, anxious and depressed.
>
> (Brady 1979:75)

Katherine 'the good' entered a conventional marriage which withered on the vine. She found emotional and intellectual support in a lesbian relationship, and with the support of a women's group, pressed a legal suit against her father.

The account has an ironic ending. Katherine's father, in court, accepted full responsibility for the incest. The judge accepted his testimony of stress in marriage, commended him for his honesty, and gave him a suspended sentence on condition that he entered counselling. After this, he appeared on national TV talk shows as 'the repentant father'.

Meanwhile, Katherine had a bitter court fight for the custody of her children, custody originally denied on the grounds of her lesbianism. It is likely, however, that Katherine's rejection of male sexuality was a direct result of her experience of the most brutal expressions of male aggression.

Despite all these tribulations, Katherine's personal account ends on a note of forgiveness and hope:

> I've learned a great deal by telling my story. I hope other incest victims may experience a similar journey of discovery by reading it. If nothing else, I would wish them to hear in this tale the two things I needed most, but had to wait years to hear: you are not alone and you are not to blame.
>
> (Brady 1979:253)

Katherine Brady's account of sexual assault, despite its ironic conclusions, almost certainly had a significant impact on the acceptance and understanding by American professionals and public alike of the extent and nature of the problem. It illustrates too the extremes of reaction to sexual abuse: Katherine became ultra-good and conformist as a mask of her inner turmoil, while her sister Ellen acted out in deviant manner almost immediately. But in the long run, both suffered great psychological pain. The study also illustrates another point made in the professional literature: offenders will deny their offence, or its harmfulness, and when finally confronted with reality will justify their actions in terms which minimize personal responsibility.

Charlotte Vale Allen's Personal Memoir, 1980

This was not Charlotte Vale Allen's first book; she wrote several books before and after this, and was a bestseller in the Canadian fiction list. This book is not fiction, however, but an autobiography of a childhood. At the age of 38 when she wrote *Daddy's girl* Charlotte still had nightmares about 'the man with knife'. Her domestic life involved an elaborate series of rituals to keep this shadowy figure at bay.

Charlotte was a lively, intense child with a high level of energy and intelligence. Her father, away at the war, missed out on the first four years of her childhood. Charlotte Vale Allen has a very clear visual memory, and the book, besides being an account of the struggle to survive many years of sexual abuse, is also an absorbing account of a Jewish girl growing up in Toronto in the 1940s and 50s:

> I was a city kid, with city games, accustomed to the crowds, the many different languages spoken on the streets, the noises, the sometime litter, the parades that periodically marched down Queen Street.
>
> (Allen 1980:23)

Charlotte's mother's family, settled Torontonians, were dull and conventional. But her father and his family, 'crazy Russians', were new arrivals. 'They were so wildly, madly alive that to be with them was as dizzying and thrilling as a ride on the roller coaster at Sunnyside Park. And as potentially dangerous.' Charlotte too had the Russian temperament and chafed against the dull restriction of her mother and older siblings. But closeness to her father had a terrible price. From the age of 7 until she was a teenager, Charlotte was systematically sexually assaulted by her father. She tried to tell her teacher about the assaults; no one understood, or would listen. Her mother began to work in the evenings. The assaults increased. How could Charlotte escape?

> You had to keep on and on, nights and mornings, day after day, forever. If I wanted it to end, I'd have to make it end, and the only way I could do that would be by killing myself. I thought more and more about that, but didn't want to do it. I wanted to believe something would happen to change things.
>
> (Allen 1980:82)

Charlotte was unable to tell her sisters about the abuse until she was an adult and the abuse had ended. Only then did Charlotte discover that one of her sisters had been raped during adolescence by a cousin, but was forced to silence by the threat of death.

> The irony and pain of it, and my own impotence left me speechless, shattered. All I could think and say was, 'If only somehow we could have told each other. Things might have been so different.' It seemed so monstrously unfair that she'd had to travel through so many years so terribly afraid—of men, of life, of herself, of so many things that for a time she drank heavily, and became repeatedly ill. She

> got almost cadaverously thin because she simply couldn't eat.
>
> (Allen 1980:84)

When Charlotte was an adult, she discovered also after her father had died, that he had sexually abused his granddaughter, a fact which only emerged when this girl in later years had a psychiatric breakdown.

Some important points emerge from this personal account, which underscore in a dramatic way, the findings of a number of clinical studies. First of all, child victims of sexual abuse are easily coerced into silence, through a combination of guilt, shame, and threats of various kinds. Second, sexual abuse destroys the spontaneity and freedom of childhood, and imposes a state of lonely terror upon the victim. Following this assault upon childhood itself, profound long-term psychological problems almost inevitably result.

The assailant (as clinical studies show) is often fixated in his behaviour, and will move from one victim to another. There is evidence in Vale Allen's book (from what her father had told her) that he had begun his pattern of offending in adolescence. Again, this supports a finding from a number of systematic studies.

Finally, Vale Allen's account makes, indirectly, an important feminist point. If women and girls have a stronger consciousness of the reality of sexual abuse, and are able to communicate with one another about the injustices perpetrated against women, then the kinds of abuse which Vale Allen and members of her family experienced might well have been prevented or stopped at an early stage.

Bass and Thornton, Personal Accounts of Survivors, 1983

In this book the editors bring together thirty-seven accounts by women recalling sexual abuse in their childhood. The assailants are fathers, brothers, stepfathers, cousins, teachers, caretakers, strangers—the whole range of older males who have access to female children. The message is a feminist one: one of the most fundamental and cruel ways in which men express power over women is in the sexual exploitation of powerless female children.

The women's writing, which includes a number of poems, is often intended to be therapeutic in its lyrical exorcism of the pain and humiliation which the abuse imposed.

The editors underline the rationale for a collection such as this:

> Statistics, for all the horror they imply, can be so vast that we shield ourselves from the individual lives they represent. We wanted to make the statistics real, to present the pain of the individual. At times, the enormity overwhelmed us. It is not easy to open oneself to the knowledge that millions of children are raped…. Behind each statistic, there is a child. She may be you. She may be your daughter. She may be your sister. She may be your friend. You cannot protect her until we can protect all children.
>
> (Bass and Thornton 1983:37–8)

The case of RC, included in the Bass and Thornton collection, illustrates graphically a point often made in the clinical literature, that sexual abuse can prepare a girl for further victimization—her helplessness and moral defeat, her confused explorations into the world of human relationships and sexuality brand her as an easy victim.

When RC was 4, her father began coming to her bed and forcing her to have oral sex with him. He continued to do this until she was 11 years old. Although RC repressed the knowledge of these nightly visits, her relationship to the world was fundamentally changed. RC lost the happiness and sparkle of childhood. As an adolescent, RC was everybody's lay, the girl you could rape without any fear of being reported. She married early, and was beaten and discarded by all the men she was involved with.

RC joined a women's group, and finally the whole revelation of the incest came flooding back to her:

> A woman was talking about her father. I don't remember now what she was saying, but anxiety permeated my stomach and chest. I curled up into a prenatal position…. All of a sudden, I knew. I felt like throwing up. I knew.
>
> (Bass and Thornton 1983)

Her mind is filled with images of the abuse:

> I see me, four years old. Thin, blondish hair. Little girl face. White pyjamas with little blue flowers. My father is crying and telling me to be good. He pulls down my pyjama

> bottoms and tries to put something too big inside my vagina. I think about shitting. How this is almost like shitting. Only it's not coming out of me and is not quite the right place. I am terrified that my father is crying. I won't mind the hurt if it will make him stop crying. The big thing won't go in, though, and he is still crying. He stops and tells me I must love him.
>
> (Bass and Thornton 1983)

These personal accounts underline a number of important findings in the professional literature. Fathers often emerge as crude, weak men, failures in other areas of life who impose their authority and their sexuality on children. Children had great difficulty in telling about the assaults for a variety of reasons—fear, loss of self-esteem, ignorance, and shame. These accounts also make clear that better education (including education and understanding from a feminist viewpoint) could help both women and children avoid and resist these sexual attacks.

Elizabeth Ward, Father-Daughter Rape, 1984

This book includes the personal accounts of nine Australian women who talk about sexual abuse by fathers or older brothers. Ward discusses these accounts in a theoretical overview, and the book ends with a 'Coda for Action'. This volume represents a nice balance of polemical accounts of personal pain, and policy proposals written from a feminist viewpoint:

> The incestuous family is a microcosmic paradigm of the rape ideology which operates in the macrocosm of society. In the incestuous family, we find the most powerless of females, a girl-child, has become the sexual possession of the father, the king in his castle lording it over his concubine.
>
> (Ward 1984:193)

Many of the assailants were in fact not biological fathers but stepfathers, underlining the finding of a number of epidemiological studies—sexual assault by biological fathers is relatively uncommon (being perpetrated by 1 or 2 per cent of all biological fathers); but sexual assault by stepfathers is rather common. Biological fathers may exercise power over their daughters in a tyrannical fashion, but they only atypically do so

in a directly sexual manner. It should be noted, however, that Judith Herman (1981a) in her book on incest, identifies a kind of quasisexual domination which fathers exercise. The 'princess' is her father's virgin idol, protected by him and 'given away' to an appropriate male at some later stage.

Quotations from one of the personal accounts, that of Lynette, about assault by her stepfather, illustrate many of the points brought out in clinical research studies:

> He'd touch me and kiss me in the shower—everywhere. I couldn't handle it—I didn't want him anywhere near me—but there was no getting away from it. That was when I first realized…my mother I just despised her because she wouldn't help me get out of it. Over the years I told her half a dozen times. I gave up in the end. I got to the stage where I knew I was wrong, and I knew I didn't want to do it, but there was nothing much I could do…
>
> (Ward 1984:68)

> And mum just kept at me, wanting to know why I didn't like him. But how do you tell her when she won't believe you? One night when I was thirteen, I was sort of half asleep (it was late) and I saw him in the doorway. I must have gone to sleep because the next thing I knew he was on top of me and mum was screaming… He tried to rape me that night, he really did. I still get nightmares about that now. That's the only time mum accepted it—but she blamed me!
>
> (Ward 1984:68)

> I don't know if you'd call it incest or molestation or what … it was the mental side…. It would happen every night for a few weeks, and then it wouldn't happen for a few weeks, and then he'd be there, standing over the bed with no clothes on, and it'd start again. When he stood there…. I still get nightmares over it…it's as if he sort of possessed me. Yes, that's it: I was sort of his, I was there for him. That's the way I feel. There was no way I could get out of it…. I'd just try and turn over, and…when I turned back, he'd still be there!
>
> (Ward 1984:68)

> Then he started telling me I was a bitch and a slut and a cheap tramp. When I left home, that was what I thought I was because I felt as though I'd let it all happen.
>
> (Ward 1984:70)

> I went to live in a hostel for young people: I grew up overnight there. The first time a guy touched me, I just freaked out: I couldn't stop screaming… I just felt so dirty, it was wrong—it was unbelievable, how I reacted.
>
> (Ward 1984:69)

Lynette's sister (who was probably also sexually abused by her stepfather) acted out sexually; but Lynette withdrew, and absorbed herself in school work, trying to disguise the tortured centre of self:

> The way you feel after that sort of thing has been done to you —you don't feel like a person, you feel like a thing… you feel like an object that they've done what they liked with, and that you haven't got any feelings. With me it's an emotional need more than a physical one…. I've got no sex drive at all. I guess it's because I've been given such a bad impression of sex. It takes away all dignity from your body, and from your soul. It is the ultimate invasion of privacy. There is nothing private left. Your whole body—all your feelings too—have been displayed against your will.
>
> (Ward 1984:72–3)

Once again, we see that sexual abuse can have different types of impact on victims, and probably reflects the pre-existing temperament of the victim. Nevertheless, the effects are frequently harmful, and interfere with the normal tasks of psychological development. The nightmares, terrors, and flashbacks which Lynette experienced are typical of victims, as is her feeling of depersonalization, powerlessness, and rejection of her physical self. Another common feature is her experience of double victimization—not only was Lynette victimized, she was blamed for causing the sexual abuse.

Sylvia Fraser, A Memoir of Incest and Healing, 1987

Of all the personal accounts of sexual abuse in childhood, Sylvia Fraser's book *My father's house: a memoir of incest and healing,* is the most remarkable. Between 1972 and 1980 Fraser published five novels in Canada, which achieved critical acclaim in North America. These books tremble with emotion: the violence and sexuality which permeate her works of fiction, occasionally thrust through the polished surface of the words, and the reader is fascinated and horrified. At the time she wrote these novels, Sylvia Fraser had no conscious recall of the way her father sexually abused her. Consciousness of the sexual abuse only emerged when Sylvia was well into her thirties, and it took several years of therapy before she was able to write an autobiography.

Sylvia Fraser grew up in the industrial city of Hamilton in Southern Ontario. The book is compelling on many different levels. Fraser, probably because of the therapy she received as an adult, has a particularly detailed memory of her entire childhood, from about the age of 3. The book, first of all, is a sparkling memory of an urban, Canadian childhood. But interspersed with these pleasant memories are long, italicized passages in which she finally recalls how her father sexually abused her from the age of 5 until her early teenage years.

Sylvia's father is an inspector in an automobile plant—he never drinks, and is a pillar of outward respectability. Every Sunday he takes his family to church, where he holds an important position. Sylvia listens in awe to the church sermons—the wicked Eve must go naked in the world:

> My daddy lies beside me in shorts and undershirt, smelling of talcum. He rubs against me, still hot and wet with his bath. My daddy breathes very loudly, the way he does when he snores, and his belly heaves like the sunfish I saw on the beach…something hard pushes up against me, then between my legs and under my belly. It bursts all over me in a sticky stream. I hold my breath, feeling sick like when you spin on a piano stool till the seat falls off. I hear God say: 'You've been dirty, go naked!' When I pull my daddy's pillow over my head I get feathers up my nose.
>
> (Fraser 1987:8)

This memory was recovered thirty years after the event. Sylvia survived psychologically by creating two halves of herself. The good part of her was conformist and scholarly: her bad half becomes submerged in her unconscious when terror overcomes her:

> Desperation makes me bold. At last I say the won't-love-me words: 'I'm going to tell my mommy on you!' My father replaces bribes with threats. 'If you do, you'll have to give me back all your toys.' I tot up my losses: my Blondie and Dagwood cutouts, my fairytale coloring book, my crayons. 'My mommy gave those things to me. They're mine.'
>
> 'I paid for them. Everything in this house belongs to me. If you don't behave, I've a good mind to throw them into the furnace.'
>
> I think of my beloved Teddy, his one good eye melting in the flames. 'I don't care! I don't care! I don't care!'
>
> 'Shut up! What will the neighbors think? If you don't shut up I'll… I'll…send you to the place where all bad children go. An orphanage where they lock up bad children whose parents don't want them anymore.'
>
> 'My mother won't let you!'
>
> 'Your mother will do what I say. Then you'll be spanked every night and get only bread and water.'
>
> '…I'll run away!'
>
> My father needs a permanent seal for my lips, one that will murder all defiance. 'If you say once more that you're going to tell, I'm sending that cat of yours to the pound for gassing!'
>
> The air swooshes out of me as if I have been punched. My heart is broken. My resistance is broken. Smoky's life is in my hands. This is no longer a game, however desperate. Our bargain is sealed in blood.
>
> (Fraser 1987:11–12)

At this point, Sylvia's knowledge of the abuse slides into a separate compartment of her mind. She was abused at least once a week for the next seven years. But after each abusive event, Sylvia immediately 'forgot' about the abuse and presented a normal face to the rest of the world. Yet, her 'bad' self kept pushing to the surface, and Sylvia became labelled as a difficult, resentful, ungrateful child:

> My other self is still wary, bitter, case-hardened, vengeful, frightened, furious, egocentric, inventive, and sly. She is not going to give up the bones and nettles of her autonomy without a stringent test. Before I am going to be allowed to love anyone, she is going to have to display her entire ragbag of hurts and furies.
>
> (Fraser 1987:113)

As an adolescent and adult, Sylvia experienced frequent bouts of depression and suicidal feelings. She experiences fearful dreams which feature monsters and devils. Relationships with men are difficult. She marries, and is divorced. Sylvia's monstrous dreams and fears continue. In one of her novels she features an incident of sexual abuse of a child. Still the personal truth of her own abuse is not revealed. Sylvia weeps 'old and desperate tears for reasons unknown to me'.

Then her father dies. 'When my father died, he came alive for me. A door had opened, like a hole cut in air. It yawned before me, offering release—from what to where?' Though Sylvia had a sense that something dreadful happened in her childhood, the exact cause of her profound disease was still not clear. She sought therapy, including both Freudian and Jungian analysis, as well as hypnotherapy. But still the secret evaded her. Sylvia's terrible dreams continue. No analyst can fathom them properly. But the content and focus of her dreams change and the focus intensifies, probably a reflection of her psychotherapy. She dreams she is in her father's house, and that Sylvia's dreadful death is impending:

> I now suspected I'd forgotten much that was vital about my earliest years. I also suspected something terribly wrong might have taken place, but I couldn't leap from suspicion to accusation, even in my own mind. I was never going to believe anything I dreamed to have literal truth, no matter how persuasive. My insight and intuition could only prepare me to remember. They were my detectives who could uncover clues, but who couldn't deliver a confession. That had to come from my other self. Yet, in getting rid of the gnarled tissue in my womb, I couldn't shake the disconcerting belief that I had aborted Satan's child.
>
> (Fraser 1987:217)

Soon after this dream, while fully awake, Sylvia has experienced spasms and involuntary convulsions:

> My shoulders scrunch up to my ears, my arms press against my sides with the wrists flung out like chicken wings, my head bends back so far I fear my neck will snap, my jaws open wider than possible and I start to gag and sob, unable to close my mouth…. These spasms do not feel random. They are the convulsions of a child being raped through the mouth.
>
> (Fraser 1987:220)

At this moment, she understands the horrible truth of her childhood. In the weeks that follow, Sylvia has a series of waking convulsions, each reliving a different episode of abuse.

The final chapter of this book is extraordinary, beautiful, and lyrical, like a soliloquy culminating an opera by Janacek.

Her mother, now 83, still lives in the same house where Sylvia was born, brought up, and brutalized. She tells her mother for the first time. Mutually, they review the past, and forgive the man who brutalized them both in different ways. Sylvia forgives her dead father in a way which addresses all the human qualities of this sad and lonely person:

> This I do know: my father was not a monster. His life was a bud that never opened, blighted by the first frost. His crime became his prison, his guilt his bars. He served his sentence as I have served mine, but his was for life, whereas I got off after forty-seven years for reasonably good behavior…. The force with which I came to hate my father was a measure of the love I and my other self once bore him. I know that now. Inarticulate with pain, my father expressed his love in a perverted way which was all he could manage. I know that now…. I forgive my father so I can forgive myself, so I can embrace with compassion that fierce and grieving child who held her tongue to save her cat…. I also forgive my father because I love him. That is the biggest shock of all. Not only that I once loved him but that I love him now.
>
> (Fraser 1987:241)

Sylvia Fraser's book is a remarkable memoir of incest and healing. From the pen of a professional writer, it is probably the

most densely-written account of the corruption and recovery of a human psyche that will ever be written. In a television interview following the publication of this book, Sylvia Fraser said that she had reached a point in her life where she no longer wished to write. The tortured unease which penetrated her earlier, successful novels had been purged. The urge to write was gone. She was at peace.

Sylvia Fraser's book *My father's house* illustrates a number of important points about incest victims which have emerged in the research literature. Although the complete 'splitting' of personality which she experienced probably occurs in only a small minority of victims, it is nevertheless a well-described phenomenon in the psychiatric literature. The existence of this compartmentalization of consciousness also has important implications for those studies which rely on adult recall of childhood events as a means of estimating the prevalence of child sexual abuse. It is distinctly possible that many women cannot recall childhood abuse because of this phenomenon of repression.

The personal account also indicates another research finding—that concealing painful memories does not guarantee good adjustment. Like Sylvia, victims of multiple personality suffer flashbacks, attacks of terror, grotesque and disturbing dreams, depression, and suicidal phases.

Sylvia's case also demonstrates the failure of conventionallybased therapies to approach the problem of the psychological aftermath of child sexual abuse. Indeed, Freudian therapy, with its assumption that recall of sexual contact in childhood with a parent is based on fantasy and wish-fulfilment, is counter-productive in therapy.

Another point which Sylvia Fraser's account brings out is that conventional morality (reflected in her father's respected position in his church) failed to inhibit the perpetrator of the abuse. Indeed, if child sexual abuse is to be prevented, a new morality has to be forged. The book illustrates too another finding from the research literature, that of revictimization. A lodger in Sylvia's house marked her down as an obvious victim, suspecting from her father's demeanour that she was being sexually abused. Men can tell these things; women, trusting or dominated, can rarely do so. Sylvia was marked down, and raped:

> Mr. Brown grabs me by the wrist. 'Don't try and fool me kid. I know what goes on in this house.'… My other self

whimpers rather than cries as Mr. Brown, trousers undone, rubs up against her, so roughly…

'What are you going to tell your old man?'

'Nothing.'

'You'd better not!'

Yanking his belt from his trousers, he lashes her across the leg…. 'You tell anyone, kid, and I'll kill you.'

(Fraser 1987:33)

CONCLUSIONS

We began this chapter with a quotation from the autobiography of the famous novelist Virginia Woolf. Woolf's intuitive reaction to the sexual assault on her is that there is a deep communality of women in the experience of sexual assault. Her existential outrage at the abuse is one shared by all women who have been abused in childhood. No woman suffers it gladly. For most, the memory of abuse is one of pain and self-disgust. Sexual abuse of children is often hidden, but it frequently brings in its train the disruption of childhood, the diminishment of adolescence, and the devastation of adult mental health.

How widespread is child sexual abuse? How can such abuse be prevented? How can victims be healed? How can aggressors be deterred and reformed? These are questions which will be addressed in the chapters that follow, in which we develop a humanistic, healing perspective of the problem. Child sexual abuse must be deterred and prevented. But in doing so, we must never lose sight of the fundamental needs of victims to recover self-esteem, and in this process understanding, sometimes being able to forgive, those who have abused them.

Chapter Two

HISTORICAL PERSPECTIVES

CHILD ABUSE AND SOCIAL CHANGE

The French social historian Jean-Claud Chesnais (1981) has charted the important changes in attitudes to children in western societies in the last hundred years, using demographic statistics, public health data, and crime reports. He shows that in a number of countries (particularly Southern Germany and France) high fertility combined with chronic poverty—the lot of many families—led to neglect, abandonment, and deliberate murder (infanticide) of large numbers of children. Those neglected frequently died.

Fathers had virtually absolute power in these poor families, and were the chief purveyors of abuse. In addition to physical abuse, fathers exercised sexual powers over all females in the family, including their own children. In such circumstances sexual abuse of children was so frequent as to be normative in some sectors of the population. As techniques of fertility control increased and poverty declined, the widespread physical abuse, neglect, and murder of children also declined. But the residual power of fathers remained and, Chesnais argues, so did the sexual power and control of these fathers. Sons (who eventually became fathers) were socialized in these norms of absolute power.

Social change in this area has been slow in coming. In Catholic cultures such as France and Southern Germany, sexual abuse of children is still not recognized as a problem. Only certain Protestant or secularized cultures (e.g., United States, England, Canada, Sweden, Norway, Netherlands, Northern Germany). have recently begun to recognize child sexual abuse as a moral, legal, and social problem. According to Chesnais's data, the sexual

abuse of children only entered the child abuse and criminal statistics of these countries in the 1970s. In some countries, such as France, this revolution has not yet begun. But according to the analysis presented by Chesnais, the problem in France is as serious as elsewhere. Only in North America (including Canada) have efforts at prevention and treatment of child sexual abuse made any kind of headway in understanding and perhaps reducing the problem (Bagley 1985).

THE HISTORY OF CHILDHOOD

Florence Rush (1980) is the first scholarly researcher to trace the antecedents of child sexual abuse and its continuing pervasiveness from a historical perspective. Her exposé places child sexual abuse firmly within a patriarchal system in which women and children are the property of their husbands or fathers. For example, under traditional Talmudic law a female child over three years of age could be betrothed by sexual intercourse with her father's permission. Intercourse with a child younger than three years was considered invalid—but not a crime. Rape was interpreted as a crime of theft against the father which could be legitimized through payment and marriage.

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

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

The Victorian age heralded the 'cult of the little girl', white slavery, and also was an age of commercial pornography involving young people. The idealization of the female child as trusting, pure, and capable of taming the savage man-beast has

been perpetuated through folklore to the present day—the maiden kisses the ugly frog who turns into a handsome prince. Rush cites Shirley Temple as a more recent example of the same ideology. 'These images are seductive and it is extremely difficult for a child (or woman) to resist the promise of reward for self-sacrifice to an old man' (Rush 1980:116).

Popular concern regarding child sexual abuse may be a sign that society is moving towards more protective and nurturing values. De Mause, for example, interprets the history of childhood as evolutionary: 'Good parenting is something that has been achieved only after centuries as generation after generation of parents tried to overcome the abuse of their own childhoods by reaching out to their children on more mature levels of relating' (De Mause 1975:85). It is indeed possible that abusive and healthy child-rearing practices have always coexisted in history (de Young 1982b).

HISTORY OF CHILD PROTECTION SERVICES

Children had little individual, social, or legal status prior to the twentieth century. They were largely seen as little adults and they expected to assume the roles society expected of them, performing the various tasks and servitudes required by community life. Much of western society had Roman common law as its socio-legal heritage in which personal relationships and custody rights were an extension of feudal property status, subject only to a weakly developed *parens patriae* principle. This doctrine of *parens patriae* derived from Roman law was incorporated as a legal principle which meant that the state was, in theory at least, the guardian of children in cases where parents were clearly unfit (Giovannoni and Becerra 1979).

Under Elizabethan poor law principles, for example, public provision for the poor included taking children into indenture and apprenticeship. This primary intervention was, however, based more on reducing threats to public order than on responding to the needs of children. Children so rescued became subject to the almost absolute authority of their guardian or employer.

However, beginning in the sixteenth century in England there was some legislative recognition of the need for the protection of children from sexual exploitation: 'A law was passed in 1548 protecting boys from sodomy, and in 1576, protecting girls under ten years of age from forcible rape' (Schultz 1982: 22). Offenders

were also protected, however, by the fact that rape of females over the age of ten years was merely a misdemeanour and proof of age was required before a felony could be proved (Rush 1980).

Nineteenth-century socialization was marked by a 'frenzied campaign against childhood masturbation' (De Mause 1975:87). Controls included sexual surgeries such as circumcision, clitorectomy, castration, and cauterization, as well as various constraints for children such as canvas splints, chastity belts, spiked cages, and special gloves (Armstrong 1983; Schultz 1982). It is curious that in such a repressive climate the sexual abuse of children went unnoticed or unchecked; unless of course we view these pseudo-medical interventions as themselves a form of sexual abuse.

Services for children in America evolved from three separate reform movements (Pfohl 1977). The first was the concept of preventive penology, based on the Elizabethan poor laws. This allowed houses of refuge to separate children of the poor from their parents, and reform schools were established to meet this need. These early reformatories were later expanded to include abused and delinquent juveniles when these children were also identified as requiring custodial care.

The second reform was the 'humane movement' which spread from Europe in the mid-nineteenth century. The American Society for the Prevention of Cruelty to Animals was formed in 1866, and was followed by the first American Society for the Prevention of Cruelty to Children in 1874. (These were the forerunners of the present American Humane Association.) The early children's societies reinforced the practice of removal of children from their parents or guardians in cases of physical cruelty. Other grounds for loss of parental custody, however, included 'endangering the morals' of children and 'exhibiting morally reprehensible behavior' (Giovannoni and Becerra 1979).

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

The third reform was through the juvenile court system which attempted to decriminalize juvenile proceedings and provide

treatment rather than punishment. Social workers of the later nineteenth century were concerned with the need to distinguish neglected and delinquent children from destitute children. Two major contributing factors in this movement were changes in ideology about child-rearing, and about poverty. 'The family' was seen as the best environment for children, while economic factors were given consideration over moral weakness as causes of poverty. Revision of the poor laws, culminating in the US Social Security Act of 1935, allowed poor families to remain intact while differential treatment was provided for abused or delinquent children (Giovannoni and Becerra 1979).

Although there is evidence that some authors had begun to document the serious abuses of children within families known to social agencies prior to the twentieth century (Lynch 1985; Masson 1985), it was much later that physical abuse was recognized as a widespread concern. The social changes sketched above marked a beginning of the awareness that physical cruelty could be curtailed and that treatment could be offered as an alternative to punishment for delinquent children. Sexual abuse of children, as a serious problem, received much less attention in professional literature.

PROFESSIONAL RESPONSES TO CHILD SEXUAL ABUSE

The psychoanalytical theories of Sigmund Freud, which dominated social casework in the early part of this century, gave new validity to ideas about subjective experience and sexual drives in the development of personality. It is ironic that Freud first revealed and then later denied the basic experience of so many of his female patients, namely that they had been subjected to unwanted sexual experiences in their early lives (Masson 1985; Peters 1976).

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

> All the singular conditions under which the ill-matched pair conduct their love-relations—on the one hand the adult, who cannot escape his share in the mutual dependence necessarily entailed by a sexual relationship, and who is yet armed with complete authority and the right to punish, and

> can exchange the one role for the other to the uninhibited satisfaction of his moods, and on the other hand the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility and exposed to every sort of disappointment, and whose performance of the sexual activities assigned to him is often interrupted by his imperfect control of his natural needs—all these grotesque and yet tragic incongruities reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail.
>
> (quoted in Masson 1985:283)

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

> Almost all my women patients told me they had been seduced by their father. I was driven to recognize in the end that these reports were untrue and so come to understand that hysterical symptoms are derived from phantasies and not from real occurrences. It was only later that I was able to recognize in this phantasy of being seduced by the father the expression of the typical Oedipus complex in women.
>
> (Masson 1985:199)

Freud was, ironically, deceived by his own unconscious, and served to perpetuate the myth that such happenings were rare. This ideology was to prevail for many more years before it was seriously challenged. Of particular note among early psychiatric literature is the often cited study of Drs Lauretta Bender and Abram Blau in 1937. This study was one of the first attempts to document the effects on children who had sexual experiences with adults, and as such is a common reference in subsequent reviews.

Over half of the 16 children studied were described as having dull, normal, or inferior intelligence, noted together with problems of developmental delay, prolonged infantile behaviour, and social handicaps. It would seem that such negative qualities

could be interpreted as contributing to increased vulnerability, or were symptomatic of previous abuse. However, another theme that has been frequently quoted in the literature as late as the 1980s, was that these 'unusually charming and attractive' children often initiated such activities, and were not harmed by them:

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

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

The early myths surrounding child sexual abuse were again reinforced by follow-up studies on the presumed effectiveness of the treatments afforded these children. Most of the children were found to have 'abandoned' their sexual behaviour when improved living opportunities were provided. This led the authors to conclude that childhood sexual disturbances were responsive to treatment and did not necessarily imply maladjustments in adult life (Bender and Grugett 1952). This interpretation suggested that the children were primarily responsible for their actions—even at the ages of 5 to 12 years. This commonly held view fails to take into account the responsibility of adults who introduced or exposed these children to sexual behaviours.

An interesting study by Linda Gordon (1986) reviews case records of Boston child protection agencies between 1880 and 1930. Of the family violence cases in the sample, 10 per cent contained incestuous episodes defined predominantly as sexual assault of girls by older male relatives. These cases only came to public attention, however, because of the girls' attempts to resist or escape the assault. But having left home they were thought to be in 'moral danger', and were often arrested or sent to institutions!

Alfred Kinsey and his associates found in 1953 (based on recall by large samples of adult subjects) that 1 out of 4 girls and

1 out of 10 boys had been sexually assaulted before the age of eighteen, and that 85 per cent of the offenders were known to their victims. Even more interesting is that this study was drawn from a young, white, predominantly middle-class, urban, educated population. The findings could have been used to dispel myths that such behaviour took place only among dull, extremely poor, or largely rural populations. However, the study had no more impact on the professional community than the original observations of Freud fifty years earlier.

Kinsey himself commented that: 'It is difficult to understand why a child, except for cultural conditioning, should be disturbed at having its genitalia touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sexual contacts', and suggested that more serious trauma was caused by the emotional reactions of adults to whom the child disclosed than by the sexual contact itself (Kinsey *et al.* 1953:121). Such a view dominated much professional thinking in the post-war period (Bagley 1969).

Another example of relatively recent bias in professional views is provided by Kaufman, Peck, and Tagiuri (1954) who argued that incest was the acting out of the Oedipal wish: 'The girls reacted to their mothers' unconscious desire to put them in the maternal role. They at the same time received gratification from the fathers as the parents who loved them in this pathologic way' (Kaufman *et al.* 1954:277). The girls reportedly showed guilt if the home was disrupted, but not over the sexual activities.

A review of earlier studies by Gagnon (1965) summarized two major themes of the literature, these being the allegedly minor effects of childhood sexual offences on adult adjustment; and the role of the child in initiating, maintaining, or concealing the offences.

It was against this ideological background that Kempe and his colleagues introduced the concept of the 'battered child syndrome' (Kempe *et al.* 1962) and established the medical profession as leaders in promoting legislative changes to combat child abuse. The movement received a strong lobby from the media, as well as from professional groups so that by 1966 all fifty American states had passed new legislation regulating child abuse (Pfohl 1977). Parallel developments occurred in Canada and the United Kingdom. This at least set the tone for recognition of sexual abuse of children when there was medical evidence of trauma.

A background to understanding 'sexual deviance' is provided by Gagnon and Simon (1967), who point out that deviant behaviour, defined as a violation of the collective norm, is determined by a complex interaction of legal sanctions, cultural values, and actual practice. An example of changing sexual mores is that premarital sex, masturbation, and oral-genital sex in their 1967 textbook are discussed as three main deviances. None of these behaviours is considered particularly deviant twenty years later, but rather they are seen as matters of personal taste or decision. It was only in the late 1970s that child sexual abuse was finally recognized as a widespread social problem, often grossly harmful to the victims.

SURVIVORS SPEAK OUT

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

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

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

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

> Society doesn't recognize that you can unknowingly marry a violent man. Your marriage can be declared null and void if you find your spouse had a contagious venereal disease at the time of the marriage. You are not protected by the law if you find out…that your spouse had a criminal record.
>
> (Pizzey 1974:38)

She also identified a high prevalence of incest and sexual abuse of children among physically abusive families.

Susan Brownmiller (1975) in her exposé of crimes against women provided a new interpretation of male-female socialization, sex, and power:

> Female fear of an open season of rape, and not a natural inclination toward monogamy, motherhood or love, was probably the single causative factor in the original subjugation of woman by man…. The historic price of woman's protection by man against man was the imposition of chastity and monogamy. A crime committed against her body became a crime against the male estate.
>
> (Brownmiller 1975:6–7)

Del Martin (1976) and Lenore Walker (1979) also identify assault of women and children as a widespread and highly under-reported problem and linked it to historical patterns of socialization:

> Men are seen as dominant (and thus strong, active, rational, authoritarian, aggressive, and stable), and women as dependent (and thus submissive, passive, and nonrational). But these role definitions are not natural to either sex.
>
> (Martin 1976:43)

> The women interviewed in my study all stated that their men felt it was their right to discipline them…. They were socialized to believe they must be doing something wrong if their men were constantly beating them.
>
> (Walker 1979:13)

Diana Russell and Nicole Van de Ven (1976) were editors of the First International Tribunal on Crimes Against Women. This meeting of over 2,000 women from forty countries was heralded as the birth of international feminism. Personal testimony was recorded on a full spectrum of crimes including persecution, economic oppression, rape, battery, torture, and objectification.

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

> As a kid I felt…. It was my fault. I was unclean. I was dirty. I was guilty. I didn't fit in. A sense of being tainted somehow. You're keeping so many secrets to yourself. So many skeletons in your closet. You hear other children saying my father this and my father that. But you're so guilt stricken and so guarded you can't say anything about your father.
>
> (Armstrong 1978:105)

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

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

Katherine Brady (1979) and Charlotte Vale Allen (1980) published personal memoirs poignantly describing their horror as little girls growing up with the experience of continuing sexual abuse by their fathers. The emotional complexities of these girls are explored as they attempt to carry on their lives and begin painful recoveries as adults. What is striking is that although

neither girl was vaginally penetrated (as required in the legal definition of incest), their difficulty in coping with the abuse was tremendous.

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

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

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

CONCLUSIONS

The history of childhood has revealed many and varied abuses, including the sexual exploitation of children and punishment of their supposed sexuality. Response to children as a special class began in western society in the late nineteenth century and evolved from preventive penology, the humane movement, and the development of juvenile courts, to a medical acknowledgement of child mistreatment, and a more defined and focused child protection movement. Recognition of child sexual

abuse, however, continued to receive sparse attention in professional literature in North America until the late 1970s, and only in the 1980s has the problem been recognized in Northern Europe.

Civil rights movements of the mid-century focused attention on oppressed and previously silent groups, including women and children. Consciousness raising by female authors exposed abuses suffered within intimate relationships. This opened the privacy of the family to public scrutiny and challenged the previously acknowledged sanctity of the family, and the almost unchallenged power of its male head. Child sexual abuse was revealed by a growing number of personal accounts as a pervasive phenomenon within families, providing the opportunity for those specially concerned with children to extend protection to this area. Attention and concern focused first on child victims of incest. However, as the dynamics of secrecy and seduction were explored, more and varied examples of the sexual exploitation of children became evident.

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

Chapter Three

DEFINITIONS AND ETHICS

> The most devastating result of the imposition of adult sexuality upon a child unable to determine the appropriateness of his or her response is the irretrievable loss of the child's inviolability and trust in the adults in his or her life.
>
> Sandra Butler (1985),
> *Conspiracy of silence: the trauma of incest*

RAISING THE QUESTION OF HEALTH

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

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

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

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

The literature on child sexual abuse tends to focus on aberrations without stating what the norms of sexual conduct for children, and in relation to children, might be. The following section outlines the range of deviations that have been identified. Child sexual abuse will be distinguished from incest; the spectrum of abusive activities will be presented; and child sexual abuse will be differentiated from rape and physical abuse.

Limitations of the Concept of Incest

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

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

1984). Under most Criminal Codes a charge of incest can be made only if heterosexual intercourse (involving vaginal penetration) has taken place. So far as criminal law is concerned, incest cannot occur between a father and his adopted daughter, or between a stepfather and stepdaughter. The ancient taboo on incest is based on ties of blood, not on the violation of trust or authority in close personal relationships. While there is good evidence from biological studies on potential impairments to offspring of incest (Bagley 1985), the major grounds for the taboo on incest are the disruption to the traditional kinship system that it would cause, including problems of socialization of children who were descended from related members of the same family (Bagley 1969; Meiselman 1978).

Other social justifications for the taboo on incest include the need to ensure that growing children look outside the nuclear family for marriage partners, and the encouragement of children to develop individual identities (Herman 1981a; Maisch 1973; Meiselman 1978; Rist 1979).

Although the forms vary, some form of incest prohibition exists within all societies. Judith Herman refers to this commonality as the mark of humanity:

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

Robin Fox, in a complementary view, suggests that human beings are 'naturally' non-incestuous and that the systems of incest avoidance reflect instead the human passion for rules, the evolution of the control of sex and aggression, and the power relationships between generations and sexes (Fox 1980:14).

Whatever meaning and peculiarities are accepted regarding the evolution of the incest taboo, the prohibitions do not address the discrepancy of behaviour between mothers and fathers towards their children, or the range of sexual activities other than

intercourse to which children may be subjected. A distinction is made by Bagley:

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

It is the intent of this book to understand child sexual abuse as a much more universal phenomenon than incest. Children in modern society are frequently exposed to a wide range of sexual exploitation by adults, both within and outside their families. Florence Rush (1980), in her historical overview of the sexual exploitation of children, argues that the frequency with which children were sexually abused at all times in human history (with the formal or informal approval of cultural norms) does not represent a violation of the incest taboo, even when a female child was sexually exploited by her father. What is critical in the formulation of the incest taboo is the possibility of fertility: the birth of a child with potentialities of handicap; and the possible chaos in family relationships with attendant problems of socialization of children of incest. In traditional cultures, a girl's menstruation is the occasion of ritual, exclusion, and separation—now the incest taboo becomes relevant. But in traditional cultures, and still in many industrialized countries (Chesnais 1981) fathers were able to sexually exploit their pre-pubertal children with relative impunity because of the power, control, and authority which they traditionally exercised over women in their family. Although through the *parens patriae* principle the state had ultimate control and authority over children, that power has always been exercised conservatively, giving parents huge latitude in choosing, if they wish, to exercise brutal and degrading power over their children.

The anthropologist Joseph Shepher (1983), writing from a biosocial point of view in explaining the incest taboo, assumes that culture is the species-specific adaptational mode of mankind. Despite their many variations, cultures operate under a rather limited set of biosocial or epigenetic principles, rooted in the biological needs and dispositions of men and women to survive

and pass on their genes, albeit wrapped within and protected by their culture. Culture thus represents the cumulative efforts of human beings to maximize adaptational capacity through maximizing what Shepher calls 'inclusive fitness', through mating with individuals 'related' by both genes and immediate culture. Mating with relatives is permitted to the degree that such mating enhances the 'fitness' of the culture, in biological or adaptational terms. Only mating with very close relatives would fail to do this.

The sexual use of children, according to Shepher's theory, is not a problem for any culture unless it results in pregnancies which diminish 'maximum inclusive fitness'. Sexual use of non-related children is acceptable (in epigenetic terms) provided such abuse does not interfere with socialization of females to engage in culturally appropriate sexual pairing. In this explanation of the cultural norms surrounding choice of sexual partners, it may even be functional (for males at least) if female children are used sexually, since it socializes them to accept the dominance, power, and sexual advances of males which are an integral part of a society maximizing 'inclusive fitness'.

This is a gloomy account of the development and maintenance of human culture, but one which fits with our knowledge of the exploitation of children in all cultures (Rush 1980). It is still the case in many parts of the world for female children to be married to older males once they reach puberty. Males who reach puberty are allowed sexual access, formally or informally, to prepubertal girls (or boys, in some cultures). There are echoes of this practice in some western cultures in the differential age of legally allowed marriage for males and females. For example, in Quebec in Canada, several 12-year-old females (but no males) enter marriage each year. This practice seems to pertain in traditional Catholic cultures (Chesnais 1981).

We argue that human cultures have to transcend, in a creative way, the injustice, exploitation, and inequalities of 'traditional' society and culture. Traditional cultures are often similar to modern, industrialized western societies in which children are still frequently abused, physically, sexually, and emotionally.

Our values in advocating for the task of reform are those of humanism (*both* religious and secular), which assumes that human beings can overcome primitive biological impulses and needs in creative and altruistic ways. It is an act of faith to assume that humankind can create a new era in which women,

men, and children are co-operative and nurturing rather than dominating and exploitative. Many of the social science studies reviewed in this book hopefully begin to lay the intellectual foundations for such change.

Spectrum of Child Sexual Abuse

Summit and Kryso (1978) have presented a ten-point spectrum for clinical analysis of child sexual abuse. Their categories include: (1) incidental sexual contact, which is accidental or unplanned; (2) ideological sexual contact, where the adult allows or encourages sexual exposure, sincerely believing it to be for the child's developmental benefit; (3) psychotic intrusion, where the adult suffers from reality confusion; (4) subcultural environment, where there are few cultural value contradictions; (5) true endogamous incest, where a father chooses to eroticize the relationship with his daughter; (6) misogynous incest, where the relationship is characterized by hatred or fear; (7) imperious sexual abuse, where men act out their authority; (8) paedophiliac abuse, where there is an erotic fascination with children; (9) child rape, where the abuser needs to feel power and is violent towards the child; and (10) perverse abuse, which is the most bizarre and destructive with emphasis on multiple partners and ritualistic torture. These categories are quite similar to those derived by Bagley (1969) from an empirical study of several hundred cases.

Kempe and Kempe, champions of the 'battered child syndrome', only briefly mentioned sexual abuse in their first book on child abuse (1978). They subsequently employed the definition of Schecter and Roberge (1976) that sexual abuse is 'the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give informed consent or that violate the social taboos of family roles' (Kempe and Kempe 1984:9). While the possibility of consensual sexual activity among children is not addressed, this definition is clear in suggesting that activities are abusive which do not consider the developmental needs of the child.

Categories of sexual abuse are listed by the Kempes (1984) as: (1) incest—sexual activity between family members; (2) paedophilia—the preference of an adult for prepubertal children as sex objects; (3) exhibitionism—the exposure of genitals by an adult male; (4) molestation—behaviours such as touching,

fondling, kissing, and masturbation; (5) sexual intercourse—including oral-genital, anal-genital, or penile-vaginal contact; (6) rape—sexual or attempted intercourse without consent of the victim; (7) sexual sadism—the infliction of bodily injury as a means of obtaining sexual excitement; (8) child pornography—the production and distribution of material involving minors in sexual acts; and (9) child prostitution—the involvement of children in sex acts for profit. These categories are obviously not mutually exclusive and illustrate the mix of activities to which children may be subjected.

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

Differences Between Rape and Physical Abuse

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

A similarity between physical and sexual abuse of children by adults is that both frequently extend over time, and indeed the same child may be both physically and sexually abused by the same or different perpetrators. However, they do not tend to occur simultaneously. In sexual abuse, the trauma is primarily psychological rather than physical; motivation of the perpetrator is more towards sexual and psychological gratification than physical harm; society is less overtly tolerant of sexual abuse than physical abuse; and pre-adolescents are most vulnerable to sexual abuse, while younger children and infants are more vulnerable to physical abuse (Finkelhor 1979a).

Sexual victimization of children is distinguished from rape, according to Finkelhor (1979a), by the profiles of victims and circumstances of the offence. While both are most frequently perpetrated by male offenders and cause varying degrees of

trauma, child victimization is directed towards male as well as female victims. Children are more often victimized by friends or family members than are rape victims; child victimization more often consists of repeated incidents; less physical force and violence are used; the specific sexual act is usually not intercourse; family members tend to be more emotionally involved in the aftermath; and social rather than legal agencies are more often involved (Finkelhor 1979a).

Since children are obviously vulnerable, because they are small, dependent, powerless, and defenceless, it is necessary to look at offenders rather than their victims for a more complete understanding of why abuse happens.

DIAGNOSTIC INTERPRETATIONS

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

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

Humanist Perspective

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

The humanistic literature on child sexual abuse, in keeping with this philosophy, shows a compassionate understanding of both the offender and the victim. Both are seen as reacting to

forces of socialization and personal crisis. Nicholas Groth, a pioneer of the humanistic approach in understanding offenders, described child sexual assault as equivalent to a symptom which 'serves to gratify a wish, to defend against anxiety, and to express an unresolved conflict' (Groth 1978a:11).

The most widely cited approach in this field (in North America at least) is the Child Sexual Abuse Treatment Program pioneered by Hank Giarretto in Santa Clara County, California. His model has become synonymous with humanistic treatment. The programme is restricted to treatment of incest, defined as 'sexual activity between parent and child or between siblings of a nuclear family' (Giarretto 1976:143). Although the programme is limited to family treatment, many of the concepts can be applied universally. The basic premise is that the offender must accept total and personal responsibility for his actions. The difference from more traditional approaches is that the offender is seen as requiring strong self-identity and self-esteem as prerequisites to rehabilitation and the acquisition of responsible social attitudes and actions. Part of Giarretto's programme, then, involves support for the development of self-esteem and identity development in both offenders and victims.

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

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

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

Feminist Perspective

Feminism is aptly described as 'the theory, cult, or practice of those who advocate such legal and social changes as will establish political, economic, and social equality of the sexes'

(Webster 1959). Feminism can be interpreted as a development of humanism in that it recognizes the same principles of full personal development. However, feminism tends to focus more specifically on defining and overcoming the various ways in which women have been oppressed, with emphasis on helping them regain a sense of power (Collins 1986).

The feminist literature on child sexual abuse tends to be polarized, drawing a strong distinction between the innocence of the female victim and the responsibility of the male offender. Various women writers were reacting to an established tradition of woman-blaming. For example, Kempe, a male physician (1978), in attempting to enlighten the pediatric community about child sexual abuse within families commented: 'Stories by mothers that they "could not be more surprised" can generally be discounted. We have simply not seen an innocent mother in cases of long-standing incest' (Kempe 1978:385). The following review illustrates the justified feminist reaction to such vicarious blaming of women for what is in essence a male crime.

Louise Armstrong, one of the first feminist authors to expose father-daughter sexual abuse, deliberately used the word 'diddling' to emphasize the gratuitous and unnecessary nature of that abuse:

> Repeated sexual abuse of a child by a needed and trusted parent or step-parent is the most purely gratuitous form of abuse there is. It requires thought. It does not arise out of anything as uncontrollable as rage…. It does not stem from physical addiction. Rather, it arises out of an assumed prerogative, super-structured with rationale, protected by traditions of silence, and, even more than in rape, an assurance of the object's continuing fear, shame, powerlessness, and, therefore, silent acquiescence.
>
> (Armstrong 1978:277)

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

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

Such assertions are necessary in order to counter early literature on sexual abuse which tended to blame the mothers for 'deserting' their husbands (Justice and Justice 1979), or the daughters for being 'seductive' (Bender and Blau 1937), with little fault directed towards the offending father.

Unfortunately, such stereotypes still abound, as evidenced by an article in *Health Digest,* a magazine of the Canadian Public Health Association. The article (Rodrigue 1987) asserts that:

> The mother is…a victim and a party to the incestuous drama: she is often a passive and submissive woman, very dependent on her husband…. Such a mother rejects her role and does not attempt to protect her child. Had she been made aware of the situation by her daughter, she would have scolded her and refused to believe her…. In some cases, she will ask her daughter to play the parts she gave up, in the home and with younger children.

This is specious and confused nonsense. In fact, these assertions are contradicted by recent studies of mothers in families where sexual abuse has taken place. We found, for example, in a study of forty-four mothers that only four had any knowledge that sexual abuse was taking place; but these four women were powerless to stop it (Bagley and Naspini 1987). We found no evidence of illness in mothers, and no evidence of role withdrawal or reversal. These women served their husbands faithfully and submissively in every way they could; but still these men sexually abused their daughters. When these girls were able to reveal the abuse, the large majority of mothers (38 out of the 40 who had no prior knowledge) acted with outrage and anger. With professional help they protected and supported their

children, and began a process of psychological development in which they recovered personal power and self-esteem.

Why is it that myths about the 'passive, colluding mother' prevail? This stereotype is part of an ideology which perpetuates male dominance. Some of the elements of this myth are:

> Child sexual abuse is rare;
> When it happens, little harm is done to the victim;
> Mothers are largely responsible, since they are sexually incapacitated or wilfully withdraw from their role as the provider of sexual and other services;
> It is inevitable that a man in such a situation must turn to his daughter—mothers in any case approve of this;
> Children often act seductively and initiate sexual relations with adults, which they enjoy;
> When children report sexual abuse to authorities they are usually lying;
> The intervention by welfare authorities, and not the abuse itself, causes psychological harm;
> The best method of coping with sexual abuse is to leave things alone—let sleeping dogs lie;
> In any case, sexual use of children (which is harmless, which mothers accept, and which children enjoy) is a feminist invention;
> Imprisoning offenders takes away the family breadwinner, and must be avoided at all costs.

Humanist and feminist approaches are united in a number of ways which represent a reaction to these myths and stereotypes: children are often harmed; mothers will defend and protect their daughters if sexual abuse is discovered; the process of intervention can be healing; integral in this process is that blame shall be fairly attributed, and the offender charged with a criminal offence; child sexual abuse is widespread; and children rarely lie about such abuse.

Definition Chosen

The humanistic model fits most closely with the concept of sexual health we developed earlier. Child sexual abuse is seen as any activity which diminishes or damages the budding sexual development of a child. The most comprehensive definition of

child sexual abuse, borrowed from Sandra Butler, is 'any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma' (Butler 1985:5).

This developmental model is chosen because it recognizes the wide range of abusive activities which follow a continuum rather than forming distinct categories. The resultant trauma may depend on the degree and duration of intrusion as well as the age and developmental level of the child to whom it occurs and the nature of relationship between the child and the offender. Patricia Mrazek (1983b) outlines a fourth factor that must be considered in a clinical definition, namely, the culture in which the abuse occurs. Nevertheless, we believe that although the prevalence and meaning of child sexual abuse may vary from culture to culture, the indignities and suffering imposed on women and children by men transcend cultural boundaries and are, in universal terms, wrong.

In summary, the key concepts in our definitions are embodied in the words 'imposed' and 'trauma' which mean that sexual activity is considered abusive when it is not wanted and when it causes harm.

EXPLORATION OF ETHICAL CONSIDERATIONS

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

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

child. The following section will discuss these issues and formulate an ethical position.

The Role of Taboo

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

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

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

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

Goodwin and DiVasto (1979) give the example of three different tribes where mothers routinely masturbate their nursing infants. Supposedly such children are not traumatized since they realize they have participated in culturally normative behaviour. Another culturally limited example is the circumcision rituals of both male and female children in some cultures. Although this involves varying degrees of physical pain and trauma, the suffering of these children is expected and accepted (by males at least) as part of a culturally appropriate socialization. However, anthropological studies usually describe the world from the point of view of male informants, and are written by men. The few anthropological studies about the world of women, written by a woman, are few.

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

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

Ethics Defined by Trauma

An important humanist value is respect and esteem for the integrity and intrinsic worth of other human beings. This means, by a process of deduction, that any activity is wrong by the degree that it harms or threatens to harm the lives of others. While children are not necessarily harmed by sexual contact with adults, available evidence confirms the possibility of a vast range of possible trauma. Since it is impossible to predict any particular outcome for a child when a sexual relationship is commenced, the simple probability or likelihood of harm resulting means that the sexual relationship of the adult with the child is *ipso facto* wrong.

Physical trauma resulting from child sexual abuse includes such possible physical effects as vulvar lacerations, genital lesions, syphilis and gonorrhea, gonococcal tonsillopharyngitis, and genital herpes infection (Blumberg 1978). Early onset of cervical cancer has also been identified as a possible result of infections which the prepubescent vagina is unable to neutralize (Densen-Gerber and Hutchinson 1979). Numerous physical trauma and infections can result from anal intercourse.

Psychological effects are more numerous and often have long-term repercussions. Symptoms and behaviour manifested by victimized children include depression, guilt, poor self-esteem, and feelings of inferiority (de Young 1982b; Herman 1981a; Justice and Justice 1979; Meiselman 1978), plus increased

suicide attempts and self-destructive behaviour (Bagley and Ramsay 1986; Briere and Runtz 1986).

The social costs of child sexual abuse must also be considered. Studies have shown a high correlation between child sexual abuse and interpersonal problems, delinquency, and substance abuse (Herman 1981a) as well as adult psychiatric illnesses of various kinds (Meiselman 1978). Childhood sexual exploitation has also been shown to be an antecedent to prostitution (Bagley and Young 1987; Silbert and Pines 1983).

Ethics based on an understanding of trauma are reinforced by such studies, which confirm a wide range of immediate and long-term disruptions of individual functioning, interpersonal relationships, and social behaviour. Any activity which has the potential of causing so much damage to another human being must be prevented or curtailed by legal and social remedies. While we must try and understand and accept the motivations of offenders, it is also essential (as Giarretto (1982) argues) that police and prosecutors should always investigate reported cases, and initiate court procedures where there is sufficient evidence. Ideally (as in the Santa Clara County model) both defence counsel and judges would co-operate in giving the offender a sentence of brief imprisonment or probation, which facilitate both his own and his victim's rehabilitation. Long or punitive sentences should only be imposed when it is clear that possibilities for reform are limited, when violence has been used (as in the violent rape of a child), and when the individual offends again.

The Issue of Consent

An important value is that of consent. 'For true consent to occur, two conditions must prevail. A person must know what it is that he or she is consenting to, and a person must be free to say yes or no' (Finkelhor 1979b). Children cannot give informed consent to sex with adults because they lack the information about the full social and biological meanings of sexuality. Part of the process of socialization for children is for them to gradually assume responsibility for their own decisions and actions with the guidance of those to whom their care is entrusted.

This is related to the issue of a right relationship which implies that, 'It is the responsibility of the person with the greater power and authority to avoid misusing the power to take advantage of the vulnerability of the less powerful person' (Fortune 1983:82).

This rule governs professional and parental relationships and means, among other things, that adults have no right to have their sexual needs met at the expense of children.

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

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

Fortune's (1983) multi-dimensional interpretation of sexual violence fits equally well for child sexual abuse and adds a further dimension for consideration. Within this model, sexual abuse is seen as an offence against the victim in that 'It denies and violates the personhood of the victim'; an offence against self, in that it is 'A destruction of relationship with another and a distortion of one's own sexuality'; an offence against the community in that it creates 'A hostile, alien environment which diminishes the possibility of meaningful relationships'; and an offence against God in that 'It is a violation of God's most sacred creation, a human being' (Fortune 1983:85–6).

This adds the concept of spirituality to ethics, the idea that persons are responsible not only to each other as individuals and as a society, but as well to another level of being, whether this is seen as God, or as a life force, a Being or a Spirit. This idea of a respect for life goes beyond social and professional roles and calls for an experience of healing which encompasses mind, body, and spirit.

CONCLUSIONS

The question of child sexual abuse has been discussed in the context of the largely undefined ideal of child sexual health. It is not enough to define abuse as mistreatment and injury. It is that,

surely, but it is also an impediment to optimal growth and development.

The question of how to define sexual abuse has been raised. Meanings of incest have been discussed but found to be fraught with biological and legal complications. It is felt the term 'incest' is best restricted to anthropological interpretations of the taboo surrounding prohibitions of sexual relations between adults closely related by blood. A more general term free of these connotations is required to express the range of sexual activities to which children are subjected. The spectra of such activities have been presented, in the definitions of recent authors. Child sexual abuse is also differentiated from rape and physical abuse.

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

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

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

Chapter Four

STATISTICAL DIMENSIONS

The intent of this chapter is to illustrate the prevalence of child sexual abuse which is indicated by recent population surveys. Characteristics of victims and offenders that can be derived from these studies are also identified.

SETTING THE STAGE

Most of the early literature regarding the sexual abuse of children was based on clinical samples; that is, persons were studied who had already been identified as having problems of some kind (e.g., Meiselman 1978). While this information is useful and necessary within a treatment perspective, it is generally agreed that those cases which reach official attention are only the 'tip of the iceberg', visible evidence of a hidden and potentially more frightening reality. A more fundamental question is to what extent sexual abuse occurs, undetected or unreported, in the larger population.

'Public and professional acknowledgement that significant numbers of children are sexually abused by their relatives and caretakers did not really begin to emerge until the mid-70s' (Sgroi 1982b:1). As more and more survivors in North America chose to reveal their histories, a fuller understanding of their trauma was identified and disseminated by public media. Validation by other survivors gave strength to self-help groups, and in addition professional groups began to hear and believe that child sexual abuse was a serious and widespread phenomenon. These changes occurred in England about four years after the development of a new consciousness of the problem in Canada and the United States. But it became clear that no particular culture was immune, and the problem in Britain was as serious as

elsewhere (Ward 1984). This shift of public and professional attitudes led to a greater accumulation of clinical and general population studies, although the latter are still relatively rare.

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

Even Kinsey (1953), who revolutionized his own times by openly discussing sexuality, discounted the relevance if not the statistic of the high percentage of persons who reported histories of childhood sexual encounters. It is interesting that his figures of 'one out of four girls and one out of ten boys' were later resurrected and are now quoted extensively in reports and workshops.

One of the first authors on the topic within social work circles was De Francis (1969) of the American Humane Association who published a study of 1,100 known cases of child sexual abuse in New York City. At the time he estimated a national occurrence of 100,000 cases annually. Limited though this study was, it marked the first serious involvement of child protection agencies, distinguished child sexual abuse from physical abuse, and was one of the first attempts to estimate occurrence at a national level. De Francis also revealed that 75 per cent of the offenders were known to the children they assaulted.

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

Surprising results were revealed in a reader survey undertaken by *Cosmopolitan* magazine (Wolfe 1981) which asked readers about their sexual experiences. Eleven per cent of the 106,000 women who responded reported they had experienced unwanted

sexual contact with a relative as a child, and that those experiences were often traumatic. While this figure could not necessarily be considered representative of the population, it certainly indicated the widespread nature of the problem.

The primary factors which determine the outcome of any study of the prevalence of child sexual abuse are the definition of abuse, the questions and the way they are presented, and the population studied. For example, intrafamilial abuse tends to be reported more to child protection agencies, while abuse by strangers tends to be reported more to legal authorities (Canada 1984). The prevalence studies which are discussed below are all attempts to sample the general population.

RECENT PREVALENCE STUDIES

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

A number of recent studies will be reviewed which represent major attempts to sample non-clinical populations, and illustrate how different methodologies, definitions, and cultures influence results.

Finkelhor (1979a)—New England Students

David Finkelhor's 1979a study of college students has received widespread publicity because it was the first detailed study in this area, using a careful methodology, linked to comprehensive theoretical interpretations. The population surveyed were college students in social science classes in six New England universities and colleges. The participation rate was 92 per cent in a sample of 796 students, 530 female and 266 male. The disproportionate number of females was treated as an advantage in that more reports of victimization were anticipated from this group.

Limitations of the sample included the fact that 75 per cent were 21 years of age or younger so that the survey reflected a

relatively limited segment of the general population. It could also be argued that persons whose social functioning had been seriously affected by childhood sexual abuse would probably not be numbered amongst college students.

Participants were asked to complete a questionnaire which contained questions about childhood, incestuous, and coercive sexual experiences. Sexual abuse was defined as a sexual experience between a child and an older person, or one with a person of similar age that involved force or threat. Sexual experiences included a range of behaviours from intercourse and attempted or simulated intercourse to fondling, exhibitionism, sexual touching, and overt sexual overtures. Three categories of older partners were considered: those legally defined as adults, adolescents at least 5 years older than victimized children, and adults at least 10 years older than victimized adolescents.

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

Russell (1983)—San Francisco Women

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

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

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

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

and the latter as

> any kind of exploitive sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old.
>
> (Russell 1983:135)

With both categories of sexual abuse combined, 38 per cent of the women reported at least one experience of sexual abuse before the age of 18 years, with 29 per cent reporting such an experience before the age of 14.

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

> When applying these broad definitions…that include experiences with exhibitionists as well as other unwanted non-contact sexual experiences, 54 per cent (504) of the 930 women reported at least one experience of intrafamilial and/or extrafamilial sexual abuse before they reached 18 years of age, and 48 per cent (450) reported at least one such experience before 14 years of age.
>
> (Russell 1983:138)

The narrower definition (excluding threats and exhibitionism) will be retained for uses of comparison in this chapter.

Kercher and McShane (1984)—Texas Study

Glen Kercher and Marilyn McShane (1984) attempted a representative survey of the adult population in Texas by drawing a systematic random sample of persons holding a valid Texas

driver's licence. Questionnaires were mailed to each of the 2,000 names drawn. The return rate was 53 per cent, with responses completed by 593 female and 461 males.

The definition of abuse used by the authors was:

> Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may be committed by a person under the age of 18 when that person is significantly older than the victim or when the perpetrator is in the position of power or control over another child.
>
> (Kercher and McShane 1984:497)

In addition, sexual abuse was said to include pornography, rape, molestation, incest, and prostitution.

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

These may be conservative figures as another 7 per cent did not answer the question about sexual victimization. Other reasons mentioned by the authors for the relatively low rates are the biases inherent in driver's licence files, general difficulty in dealing with sex-related issues by mail, and the rather lengthy survey booklet used.

Finkelhor (1984a)—Boston Parents

A further study was conducted by David Finkelhor (1984a) in the spring of 1981 in the Boston metropolitan area. This study examined public attitudes, whether the parent population knew of children who had been sexually abused, and whether the adults themselves had been abused as children. Parents were chosen from an area probability sample and screened for the presence of children between the ages of 6 and 14. A response rate of 74 per cent resulted in 521 interviews from a possible 700. The parent sex ratio was somewhat skewed, with 187 men and 334 women. This was due to the predominance in the sample of single-parent families headed by women. The parents had a combined total of 1,428 children.

Twelve per cent (15 per cent of the women and 6 per cent of the men) reported having been sexually abused in childhood.

These figures are somewhat lower than Finkelhor's earlier student sample. The reason may be that in the Boston survey, respondents were asked generally if any sexual things were done to them and if they considered the experience to have amounted to sexual abuse. Only those experiences so considered were reported as sexual abuse, whereas the earlier study had used more general criteria, and respondents had not been asked for a subjective judgement.

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

Canada (1984)—Canadian National Survey

The National Population Survey, commissioned by the Committee on Sexual Offences Against Children and Youth, undertook a representative sample of Canadians living in all regions of the country. The survey took place in January and February of 1983. An 88 per cent compliance rate resulted in 1,833 responses for analysis. Interviewers from Canadian Gallup Poll personally delivered the questionnaires and waited for them to be completed, but were not allowed to discuss the contents with the respondents. The figures below are based on further analysis of these data by Bagley (1988a).

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

> Has anyone ever touched the sex parts of your body when you didn't want this?
>
> Has anyone ever tried to have sex with you when you didn't want this, or sexually attacked you?
>
> (Canada 1984:179)

Respondents were asked to judge which actions were unwanted rather than which were abusive. The advantage of this wording was that abuse was defined by the subjective trauma of the respondent rather than by arbitrary criteria set by other researchers.

The results indicated that 17.6 per cent of females and 8.2 per cent of males in the total population had been the victims of serious, unwanted sexual assault (at least the touching of unclothed breasts, buttocks, penis, or vagina) prior to the victim's seventeenth birthday.

Sorrenti-Little and Associates (1984)—Canadian Students

Sorrenti-Little, Bagley, and Robertson (1984) replicated Finkelhor's (1979a) American study with 568 students at the University of Calgary in Western Canada, including 406 women and 164 men. About 18 per cent of the age group 18 to 24 are enrolled in university education in Western Canada.

Rather than using Finkelhor's definition in interpreting these results, the researchers used an 'operational definition' which involved identifying as potentially abusive only those assaults which had a sequel in young adulthood, reduced self-esteem (below the fiftieth percentile) in combination with a subjective assessment of any trauma experienced by the respondent. These operational criteria resulted in the following definition of serious sexual abuse in childhood: someone achieving a sexual relationship with the subject by force, or threat, or seniority (being at least three years older) involving handling or interference with the child's unclothed genitals, or attempted or achieved intercourse. According to these definitions, 19.6 per cent of females in this college sample, and 8.5 per cent of males, were the subject of sexual assault by the time they were 17.

We found (as had Finkelhor 1979a) that subjects often recalled sexual encounters in childhood which could not be classified as abusive: no force or threat was involved, the partner was usually close in age, no subjective trauma was associated with the relationship, and there was no correlation with self-concept levels as a young adult. The one exception was in the case of males who reported more than one such voluntary relationship—they tended to have better self-concept than average. No less than 74 per cent of males and 63 per cent of females reported such a voluntary sexual relationship up to the age of 7. Two-thirds of these events occurred before the age of 13, and often involved mutual display and touching of close-in-age peers and siblings.

These results alert us to the fact that children do have curiosity about sexual feelings and relationships. Yet we have available remarkably little research on this from mainstream psychology

and sociology. Only those writing in the Freudian school have offered any speculation and some research about children's developing sexuality (e.g., Lehrer 1984). Research has, however, usually concentrated on children's knowledge of reproduction in a broad, cognitive sense (e.g., Goldman and Goldman 1982), or on problems surrounding teenage sexuality (e.g., Meikle, Peitchinis, and Pearce 1985).

We know virtually nothing from children themselves of how they feel about sexual relationships in childhood, although the adult recall studies do indicate that consensual relationships between children are frequent, and non-traumatic. The essence here seems to be the voluntariness of the act—it is rare or seemingly impossible for a child to have a voluntary sexual relationship with an adult (Finkelhor 1979b). The research studies (based on adult recall) are clear, however, that a sexual relationship forced on a child may for a significant minority, involve long-term trauma and harm. This is clear, for example, from our follow-up study from childhood to the adult years of children removed from home because of sexual abuse, physical abuse, or general family breakdown (Bagley and MacDonald 1984). This English study showed that mental health outcomes were significantly poorer for those who had experienced sexual abuse by an adult, in comparison with those females who were removed because of marital breakdown or parental death, and where no abuse occurred.

Wyatt (1985)—Afro and White American Women

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

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

perpetrator was five years older, or if the experience was unwanted.

Findings were that 62 per cent of the women reported at least one incident of sexual abuse (in this broad definition) prior to age 18. A slight ethnic difference of 57 per cent for Afro women and 67 per cent for white women was not statistically significant. Neither were ethnic differences regarding the categories of non-contact and contact abuse. Forty per cent of Afro and 51 per cent white women experienced contact abuse (actual touching) of some kind.

Baker and Duncan (1985)—British Study

Anthony Baker and Sylvia Duncan (1985) conducted the first national prevalence study of child sexual abuse in Britain. A compliance rate of 87 per cent resulted in a randomly drawn sample of 969 men and 1,050 women aged 15 and over. Interviews were conducted in respondents' homes in the context of a more general attitude survey. The following definition of child sexual abuse was printed on a card and presented to each respondent, who was asked if they had ever had such an experience:

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

Ten per cent of those interviewed (12 per cent of females and 8 per cent of males) reported they had been sexually assaulted before the age of 16. Another 13 per cent declined to answer. It must be noted that the cut-off age of 15 years for childhood experience is younger in this study than in all but one of the others reviewed. It must also be noted that respondents were not questioned further if they replied negatively or refused to answer. This is strikingly different from the North American surveys which have approached the topic using a variety of different methodologies.

Fromuth (1986)—Female College Students

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

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

Bagley and Ramsay (1986)—Community Mental Health Study

This study arises from a study of mental health and experience of suicidal behaviour in self and others in 692 adults randomly sampled from the population of Calgary, a west Canadian city with a population of 650,000. The telephone directory (in the city in which 98 per cent of residents have a telephone) was used as the sampling frame (Ramsay and Bagley 1986). Questions about sexual abuse were not asked in the initial inquiry, but all women in the study who were available (387 in number) were interviewed a year later. Subjects repeated the socio-demographic and psychological test measures, and at the end of the questionnaire subjects were asked:

> When you were a child (up to the age of 16) did you experience a serious sexual assault by an older person? (Sexual abuse involves at least someone fondling your genital area under clothing, but over or under panties, by someone at least three years older, or by someone of any age using force or threat to achieve this end.)

Three-quarters of subjects (75.6 per cent) reported no sexual abuse in response to this question; 2.6 per cent answered 'Yes', but declined to give further details; and 21.7 per cent said they had been sexually abused, and gave further details. All of those

who declined to give further details were aged over 50, indicating a reluctance among some older people to talk about sexual abuse. We have used a working figure of 22 per cent as the prevalence of childhood sexual abuse in this study, excluding the subjects who gave no further details. It should be mentioned that the rate in women under 40 was 28 per cent compared with 18 per cent in those over 40 (making a combined rate of 22 per cent). It is possible that this significant difference reflects the reluctance of older people to talk about sexual abuse issues, rather than a real difference in prevalence. Or it could be that the prevalence of child sexual abuse actually is increasing in real terms, and does not reflect rates of reporting (Russell 1986).

Bagley and Young (1988)—Mothers of Young Children

A subsequent study in Calgary (with fieldwork in 1986–7) studied 632 women who had a child born in the first half of 1980. Mothers were randomly selected from community health clinic records, and systematically followed up several times. The original sample contained 1,000 women, but only 632 of the original subjects were retained in the study at the time their children were 6. Sample loss was mainly due to subjects moving out of the area. While most questions focused on child development issues (the original purpose of the study), mothers completed a range of mental health measures, and in the last phase of the study responded to questions about unwanted sexual acts in childhood. The item format was identical to that employed in the national Canadian study (Canada 1984; Bagley 1988a), and questions were asked about unwanted sexual touching, and attempted or achieved intercourse up to age 17.

This definition (different from the one used in the previous Calgary study) gave a prevalence figure of 24 per cent. This rate is somewhat less than that found in the community mental health study (28 per cent in women under 40), but the discrepancy is not significantly different.

Summary

A number of prevalence studies carried out since 1979 have been reviewed. The samples include over 9,000 persons from three different countries. These studies can be summarized:

(1) Nineteen per cent of female and 9 per cent of male college students reported having been sexually assaulted as children (aged 16 or less) by an older partner. The majority of respondents were 21 years of age or younger (Finkelhor 1979a).

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

(3) Eleven per cent of female and 3 per cent of male Texas residents reported having been sexually abused as children (age not specified) in a mailed survey (Kercher andMcShane 1984).

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

(5) Eighteen per cent of female and 8 per cent of male Canadians in a national survey reported having been the victims of 'unwanted sexual acts' (involving physical contact) before the age of 17 (Bagley 1988a).

(6) Twenty per cent of females and 9 per cent of males in a population of students in Western Canada reported a sexual relationship in childhood (usually involving force or threat, or a significantly older partner) which had a sequel in poorer self-esteem as a young adult (Sorrenti-Little *et al.* 1984). These events occurred up to their eighteenth birthday.

(7) Forty-five per cent of Los Angeles women reported at least one instance of sexual abuse experience before age 18. There was no significant difference between Afro and white respondents (Wyatt 1985).

(8) Twelve per cent of female and 8 per cent of male residents of Britain reported having been sexually abused before the

age of 16 (Baker and Duncan 1985). This represents the youngest cut-off age of the surveys presented.

(9) Twenty-two per cent of female college students in the Eastern United States reported at least one sexually abusive experience as a child aged 16 or younger (Fromuth 1986).

(10) Twenty-two per cent of women of all ages in a community mental health study in Calgary, Western Canada, reported serious sexual abuse up to their seventeenth birthday (Bagley and Ramsay 1986).

(11) Twenty-four per cent of women aged 22 to 36 in a survey of 632 mothers with young children reported sexual abuse involving at least contact with their (the mothers') genital area, before age 17 (Bagley and Young 1988).

According to these studies, the chances of a male being sexually assaulted before age 17 are from about 6 to 9 per cent, with a figure of 8 per cent before age 16 in the British survey.

In interpreting these figures, which present both similar and differing estimates of the amounts of sexual abuse, we should note first that ecological differences may exist: the higher rates apparently emerging in California may represent higher rates in that State, while the somewhat lower rates in, for example, the British study could mean that rates are actually lower in that country. But the differences could also be due to the different methodologies employed (Peters, Wyatt, and Finkelhor 1986).

Another caution should be noted. For a variety of reasons, these figures may well be underestimates. First of all, there is clinical evidence (Bagley 1985) that some child victims react to their abuse by repression, depersonalization, or the development of an alternative personality (Fraser 1987). These are unconscious devices which may protect the ego, but they do mean that some victims of childhood abuse will not, as adults, report that abuse because they simply cannot recall it. Second, some victims (particularly older people) may be reluctant to talk about sexual matters and will not reveal earlier sexual abuse. Third, the studies reviewed have accessed only geographically stable or well-educated people. But we know from other studies that sexual abuse in childhood is often associated with school drop-out, and other disorganized and deviant behaviours. Surveys of stable

populations will miss the drifters, the street people, and the prison and mental hospital populations. Yet these groups almost certainly contain a disproportionate number of child abuse victims.

Differing methodologies—different ways of defining sexual abuse, different forms of interview, and differences in sampling technique—can also account for the varying results. Despite all of these difficulties, the studies reviewed lead to the following generalization:

Serious sexual abuse in childhood (up to age 16 or 17) involving unwanted or coerced sexual contact occurs in at least 15 per cent of females in the populations surveyed, and in at least 5 per cent of males. Because of various methodological factors, these are likely to be the most conservative or minimum estimates.

There is another, equally serious aspect to this problem. Since sexual assault of children can range in time from a single experience on one day, to many events occurring over a period of years, many children will be former victims, but will still be suffering the psychological legacy of that abuse. At any point in time (according to our estimates in the Calgary survey), at least 30 per cent of the female child and youth population (and about half that proportion in males) will be current or former victims of child sexual abuse. Since about a quarter of all sexual abuse victims carry a legacy of long-term psychological harm from their abuse (Bagley and Ramsay 1986), these are serious figures indeed.

VICTIM PROFILES

This section will review the ages at which a child is most likely to be victimized, and what will most likely be the nature of the assault. These details are reported in some, but not all of the studies cited above.

Finkelhor (1979a) found the average age of victims to be 10.2 for girls and 11.2 for boys, with the most vulnerable age for both being 10–12 years. Of the children who reported having had experience with older partners, 47 per cent of the girls and 41 per cent of the boys were in that age range. The next most vulnerable age for girls was 7–9 (23 per cent) with 13–16 for boys (32 per cent). Girls rated their experiences more negatively than boys (66 per cent compared with 38 per cent). Finkelhor found that touching and fondling were the most common sexual activities.

Fifty-five per cent of the children reported having force or threats used against them.

In Finkelhor's second study (1984a) the parents reporting on their own experiences had been abused most frequently between the ages 7–12 (65 per cent). The children they knew as victims of assault came from the same age group (44 per cent) but with a surprising number (37 per cent) below that age. The parents reported touching and fondling as the most frequent activities (26 per cent and 27 per cent) when they had been abused. Exhibition and sexual requests, however, were reported as common (26 per cent and 28 per cent) for the children whom they knew to be abused.

The Canadian national survey (Canada 1984) found that girls were at most danger of being victims of exposure at ages 7–11, of being touched at ages 12–15, of being assaulted at ages 14–15, and of being threatened at ages 14–17. Boys were in most danger of being seriously assaulted at ages 12–17.

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

Baker and Duncan (1985) used only two age categories, 10 or below and 11 or above. They found that the average age of victimization for girls was 10.7 years, with 54 per cent of abuse being reported in the older age range. The average age for boys was 12 years, with 73 per cent of the abuse occurring in the older age group.

In the first of the Calgary studies, based on a sample of 568 students (Sorrenti-Little *et al.* 1984), 40 per cent of assaults on females first occurred when the victim was aged 6 to 12, and 52 per cent occurring after this age. A few assaults took place before age 6, but it is important to note that recall of very early assaults may be poor—yet, like other trauma occurring in the infant years, the effects could be negative and long lasting. Males in this study reported most assaults occurring between the ages of 12 and 16. It should be borne in mind in this and in other studies, 'age at assault' is the age at first assault. A number of studies have shown that child victims are often abused by different figures at various times, presumably because of their vulnerability and victim status (Finkelhor 1979b; Russell 1983; Bagley and Ramsay 1986).

In the two Calgary community studies of women (Bagley and Ramsay 1986; Bagley and Young 1988) results were similar enough for us to be able to combine data for the 1,007 women. It was found that 9 per cent of victims were first assaulted up to age 5; 32 per cent between ages 6 and 9; 40 per cent between ages 10 and 13; and 19 per cent after age 13. The peak age for second and third assaults (by a different person) was in the age range 10 to 13. Nine per cent of the total sample had been victims of different assailants, at different points in time.

What summary can be made from this material? It would certainly appear that children of both sexes are at risk at all ages of their childhood. Because the studies used different groupings for analysis, direct comparisons are difficult. Pre-adolescence appears to be the developmental period during which children are at the highest risk for sexual abuse, with 10 to 11 years the average age for girls of first victimization, with boys being victimized on average a year later. Touching and fondling appear to be the most common forms of abuse.

OFFENDER PROFILES

Who are the offenders and what is their likely relationship to their victim? In the words of Sandra Butler, 'sexual abuse has a gender and it is male' (Butler 1985:211).

Finkelhor (1979b) found 94 per cent of the abusers of girls and 84 per cent of the abusers of boys were men. Russell (1983) found 96 per cent male offenders in both intrafamilial and extrafamilial abuse. Canada (1984) found 98 per cent of the suspected offenders against females were male, while 83 per cent of offenders against male children were male. Wyatt found that '97% of the incidents reported by Afro-American women and 100% of the incidents reported by their white peers involved abuse by male perpetrators' (Wyatt 1985:516). Kercher and McShane (1984), Finkelhor (1984a), and Baker and Duncan (1985) did not specify percentages although they refer to the perpetrators as male. In the Calgary studies, offenders against female children were male in 98 per cent of cases.

Finkelhor (1979b) found 24 per cent of the offenders were strangers while 76 per cent were known to the child. Six per cent of the assailants were parent figures, 37 per cent 'other relatives', and 33 per cent were friends or acquaintances. Included in the

relatives were siblings for 15 per cent of the girls and 10 per cent of the boys.

Russell's (1983) analysis found that only 15 per cent of extrafamilial perpetrators were strangers while 42 per cent were acquaintances, and 41 per cent were more intimate family friends. The number of perpetrators exceeds the number of women reporting abuse (186 intrafamilial offences on 152 women and 461 extrafamilial offences on 357 women). This indicates that many women were abused by more than one person, approximately 60 per cent of the time extrafamilially and 20 per cent of the time intrafamilially. This may mean that having been victimized increases one's vulnerability, or that certain conditions predispose some women to continued assaults.

Russell's later work (1984 and 1986) provides evidence that having a stepfather increases a woman's risk of being sexually assaulted six-fold. She found that 17 per cent of women who had a stepfather were abused by him, compared with 2 per cent who were abused by their natural fathers. She also found that abuse by stepfathers involved more serious violations.

Finkelhor (1984a) found 8 per cent parent figures, 24 per cent relatives, 35 per cent acquaintances, and 33 per cent strangers among perpetrators in parent self-reports, with 2 per cent parent figures, 8 per cent relatives, 45 per cent acquaintances, and 45 per cent strangers among the reports on behalf of a child. He also found a variance in the ages of the perpetrators. While the majority (79 per cent) were over 21 in the parent self-reports, 50 per cent were under 21 in the child reports. This seems to indicate that parents are simply less aware of the younger perpetrators.

The Canadian study (1984) used slightly different categories of relationship. This national Canadian study of the offender population revealed the following profiles: 10 per cent at the hands of a family member (parents, siblings, grandparents); 8 per cent by other blood relatives; 3 per cent by those in a guardianship position; 3 per cent by other family members (including step, foster, and common law relationships); 48 per cent by friends and acquaintances; and 9 per cent by other persons known to the victim.

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

Baker and Duncan (1985) in their British study found that 51 per cent of abuse was by strangers, 35 per cent was extrafamilial,

and 14 per cent was intrafamilial. This varied for males and females, with boys experiencing 43 per cent abuse by strangers, 44 per cent extrafamilial, and 13 per cent intrafamilial, while girls experienced 56 per cent abuse by strangers, 30 per cent extrafamilial, and 14 per cent intrafamilial.

The results of the three Calgary studies (Sorrenti-Little *et al.* 1984; Bagley and Ramsay 1986; Bagley and Young 1988) are close enough for data on female victims to be combined: 12 per cent of assailants were strangers; 38 per cent were dates or acquaintances; 2 per cent were authority figures (teacher or a minister); 8 per cent were stepfathers or other unrelated male friends of the mother resident in her home; 1 per cent were biological fathers; 10 per cent were siblings; and the remainder (some 35 per cent) were 'other relatives'—mainly uncles, or cousins.

These studies underline the fact that teenage girls are at risk from predatory males in both their peer and acquaintance groups. Sometimes this took the form of 'date rape', but also includes situations in which the teenage girl was sexually attacked by a group of teenage boys. Less than 5 per cent of any of the assaults recalled were reported to authorities at the time, a finding which parallels a number of other studies (Finkelhor 1979a and 1984b; Bagley 1985; Russell 1986).

In our own work, we have found that in at least half of the situations in which the victim revealed the assault to a relevant person (teacher, parent, social worker, police) effective action to help the victim, prevent further assault, or heal the psychological wounds, was not taken. In some cases intervention actually made the victim's adjustment worse, and led to revictimization. The following example from our community studies illustrates this. A 12-year-old who complained to a teacher about sexual abuse by her stepfather was removed and placed in a foster home. She was offered no therapy or help which focused on the sexual abuse. She was sexually abused again by an older foster brother, and ran from the house. On the streets she was soon absorbed into a network of drug dealing and using, and eventually into teenage prostitution where the cycles of sexual abuse continued (Bagley and Young 1987).

The data on sexual abuse of boys in our Calgary work (Sorrenti-Little *et al.* 1984) indicate that they were significantly more likely (in 59 per cent of cases) to be assaulted by strangers, authority figures, or non-related acquaintances. We found too that

85 per cent of offenders against males were also males. The majority of the female assailants described by the male respondents were adolescent females who experimented sexually with a younger child whom they were baby sitting. We know from another study (Bagley and Dann 1987) that girls who engage in this kind of behaviour are very likely to have been sexually abused themselves, and are acting out or elaborating aspects of their own abuse.

In summary, the findings confirm that perpetrators are predominantly male, with statistics ranging from 94 per cent to 100 per cent for offenders against female victims. A slightly lower figure of around 85 per cent was noted for offenders with male victims.

A summary of relationship of victim to offender is presented in Table 4.2. The chances of an assailant being a stranger range from 11 per cent to 51 per cent. The chances of an offender being intrafamilial range from 10 per cent to 43 per cent, with father figures identified as 2 per cent to 8 per cent within that category. The chances of an offender being known and extrafamilial range from 33 per cent to 49 per cent. It must be stressed that these figures represent the percentages within the offender population, not the degree of risk these categories represent for the general population.

CONCLUSIONS

The figures represented in this chapter emphasize that the sexual abuse of children is a widespread social phenomenon. Prevalence rates reported by these population surveys confirm that many children, up to one in four girls and one in ten boys, have been subjected to serious forms of sexual abuse. The majority of assailants are known to their victims, and the majority of assaults involve the misuse of authority inherent in age differences and family relationships. The actual incidence of father-daughter 'incest' is low, supporting the study of Parker and Parker (1986) which showed that close biological relationship within the framework of shared parenting inhibits sexual aggression against children. However, the presence of a biologically unrelated adult male, such as a stepfather in the child's household, puts her at considerable risk; as many as one in four stepfathers may sexually abuse the female children to whom they have access.

Table 4.1 Comparison of prevalence across eleven studies

Study	*Definition of childhood*	*Females abused* (%)	*Males abused* (%)
Finkelhor (1979a)	16 & under	19.2	8.6
Russell (1983)	under 18	38	—
Kercher & McShane (1984)	?	11	3
Finkelhor (1984a)	16 & under	15	6
Canada (1984)	under 18	18	8
Sorrenti-Little *et al.* (1984)	under 18	—	—
Wyatt (1985)	under 18	40	—
Baker & Duncan (1985)	under 16	12	8
Fromuth (1986)	16 & under	22	—
Bagley & Ramsay (1986)	16 & over	22	—
Bagley & Young (1988)	under 18	24	—

While some of these children also show up in clinical and victim statistics, it is still not clear why some are more traumatically affected than others. These questions will be addressed in following chapters which discuss issues of intervention.

Table 4.2 Comparison of offender-victim relationships for women across five studies

Study	*Stranger (%)*	*Acquaintance (%)*	*Family (%)*
Finkelhor (1979a)	24	33	43
Russell (1983)	11	60	29
Finkelhor			
(1984a) Parents	33	35	32
(1984a) Children	45	45	10
Canada (1984)	15	50	35
Baker & Duncan (1985)	51	35	14
Calgary Studies			
Bagley & Young (1988)	12	38	50

Notes

1. Finkelhor's (1979a) families include:
   6% parents
   10–15% siblings.
2. Russell's (1983) families include:
   6.8% fathers
   7.4% uncles
   4.3% cousins
   4.0% brothers.
3. Finkelhor's (1984a) families include:
   8% and 2% parent
   figures respectively.
4. Bagley and Young's (1988) combined sample of families includes:
   1.7% biological fathers
   7.6% stepfathers/cohabitees
   9.9% siblings
   35% other relatives.

Chapter Five

A COMMUNITY MODEL

> To criticize and find remedies for one part of the system while ignoring the others is an unfulfilling exercise in futility, besides being a waste of money and effort.
>
> Vincent Fontana (1984),
>
> 'When systems fail: protecting the victim of child sexual abuse'

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

The need for early identification and comprehensive services is paramount (Shamroy 1980; Topper 1979). Community agencies of control and change in the health care, social service, and legal systems must intervene co-operatively to ensure a society nurturing of and safe for children. The three primary types of intervention on behalf of protection of children are: (1) protection of children—traditionally administered by social services, (2) change treatment—traditionally the realm of therapy, and (3) punishment—traditionally administered by the police (Porter 1984). Each of these components will be discussed with focus on their contribution to an interdisciplinary model.

PROTECTION OF THE CHILD

Case Management Tasks

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

Sgroi (1982b:96) defines the ten essential tasks in case management of child sexual abuse as: reporting, investigation, validation, child-protection assessment, initial management planning, diagnostic assessment, developing a problem list, formulating a treatment plan, treatment intervention, and monitoring and reassessment.

Although Sgroi feels it is essential for statutory protection of the child, she also acknowledges that, 'In the absence of adequate preparation, it is totally unrealistic to expect the average police officer, child-protection services worker, counselor, or therapist to be able to work effectively with child sexual abuse cases' (Sgroi 1982b:384). In other words, all workers involved with the victim of child sexual abuse need to be well trained, and also need to have an agreed-upon protocol of action and co-operation.

Validation

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

Justice and Justice (1979) identify such cues as frequent bouts of depression; diminished or chronically low self-esteem; genital infections and irritation; and behavioural cues such as enuresis, soiling, hyperactivity, sleep disturbance, fears, phobias, eating

disorders, compulsive behaviour, learning problems, compulsive masturbation, precocious sex play, excessive curiosity about sexual matters, and separation anxiety involving a non-abusing parent. While these problems and signs are no guarantee that sexual abuse has taken place, they should alert the worker to the possibility of disruptions in the child's family and abuse of the child—emotional, physical, or sexual.

Health care professionals are frequent partners in child protection work. A specific allegation may be made which requires medical investigation, or medical assistance may be requested for validation of an alleged abuse. On the other hand, health care professionals may request the co-operation of social workers when sexual abuse is uncovered as a possible underlying cause of other symptoms (Thomas and Rogers 1981).

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

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

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

Corroboration

Corroboration refers to evidence that may be required for court purposes. One limitation of the child protection system is that it has virtually no control over alleged offenders in Canada, Britain, or North America. Laws governing the protection of children, such as the Children Act in Britain, and the various Provincial and State laws in Canada and the USA allow social workers to intervene and remove a child from a family when they suspect that there is 'good cause' to believe that the child is being seriously neglected or abused. Such laws rarely give social workers or family courts any power in relation to alleged offenders. This results in the ironic situation that it is victims rather than abusers who are often removed, even when the child is firmly attached to the non-offending adults and siblings in the household. The irony is compounded when, as often happens, the child is placed in a holding shelter in the company of children on remand for juvenile offences. Child protection workers and clinicians must also, despite the constraints of the system under which they work, co-operate closely with police and legal authorities by providing evidence and expert opinion.

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

It is equally inappropriate to rely on physical findings for validation or corroboration (Sgroi, Porter, and Blick 1982). Thorough medical examinations can be helpful in that for example an enlarged vaginal opening is frequently correlated with sexual abuse (Cantwell 1983), and a colposcope can be used to detect microscopic scratches or tears (Woodling and Heger 1986). However, lack of medical evidence is not sufficient reason to discount alleged sexual abuse. And the converse is true, because there is considerable variation in the physiology of children's genitalia. The conclusions of a group of American paediatricians are worth quoting:

> Experience with more than 375 cases of possible sexual abuse has taught us that much work still needs to be done in understanding normal prepubertal female anatomy and

> interpreting findings in sexual abuse cases…. The hymen, contrary to common notion, is often a slack, thick, folded, stretchable tissue which may persist after digital or penile penetration. Findings secondary to sexual abuse are often subtle. Acute tears or bruising are rare because force is seldom a part of the sexual acts committed against a child…. An 'intact' hymen does not preclude vaginal penetration. Lack of physical evidence never rules out abuse because many sexual acts leave no physical findings.
>
> (Herman-Giddens and Frothingham 1987:203)

We would add that the prevalence studies reviewed in the previous chapter show that in the majority of cases recalled by adults (few of which were reported to any authority), full vaginal or anal penetration occurred in less than 10 per cent of cases. Yet the 'lesser' forms of assault were often deeply traumatic or disturbing to the child victims.

Strategies of corroboration include statements made by the child victim to parents or relatives; use of play with pictures, stories, and dolls; sexual knowledge inappropriate to the child's age or developmental status; and inappropriate sexual behaviour ranging from masturbation and seduction to aggressiveness with other children (Faller 1984). In addition, statements made to investigating workers (social worker, psychologist, nurse, or doctor) soon after the alleged offence can be audio-taped or video-taped and are now admissible in court in many jurisdictions (Dawson 1987). There is controversy about whether children aged less than 6 can or should testify in court (Yates 1987)—there are problems in their ability to reconstruct events, and the court experience may be traumatic for them. However, older children can testify in court in ways which do justice to the truth, and which are also non-traumatic, and even helpful to victims.

Legal changes in Canada, similar to those in the United States, now allow video-taped evidence in criminal trials involving child sexual abuse, as well as 'hearsay' evidence—testimony from someone the child talked to soon after the assault (Dawson 1987).

Goodwin (1982) emphasizes age differentials in the child's verbalization about the assault in relation to developmental stages. For example, the infant-to-child aged 4 will be clinging and fearful and cannot be expected to make any definitive statement other than about 'hurting'; the child aged 4 to 6 often exhibits symptoms of neglect or abandonment, and is inclined to

make cryptic statements about the assault or the relationship with the assailant; the latency age child will often present with somatic complaints or school problems, and be very graphic; adolescents typically present with behavioural problems and tend to blame themselves, while their fears can sometimes cause them to discount the seriousness of the complaints.

Adams-Tucker (1985), in a study of twenty-seven children referred for psychiatric evaluation, found similar age differences in the way the assault was reported. Denial and sexualization were the most common defence mechanisms of school-age children, while acting out and internalization of pain were more common among female adolescents.

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

While children will fail to report sexual abuse or will be inhibited from reporting it, or may actually withdraw true allegations for a variety of reasons including fear of the abuser, the possibility of false accusations has to be considered (Faller 1984). In this respect Mary de Young (1986) has produced an extremely useful conceptual model for judging the truthfulness of young children's allegations of sexual abuse. One related problem is the fact that children under 7 have no clear cognitive or conceptual model for knowing that what an adult is doing to them is sexual abuse, even though the child is very confused and distressed by the assault (Hollinger 1987). Children may delay reporting of the abuse for a variety of reasons, not least because of their psychological domination by the abuser. However, when the child is able to report abuse, this remains the single most important factor in deciding that abuse has taken place. While physical examination of the child, and observation of play using anatomically correct dolls, can provide useful corroborative evidence, it is the testimony of the child that abuse has taken place which is the fundamental factor in deciding whether to prosecute an offender.

Some younger children can give clear and unambiguous testimony (Yates 1987), but generally in our experience children

under the age of 7 should not be involved as witnesses in court proceedings. De Young (1986) points out a number of psychological reasons involving the child why this should be so. However, it should be noted that Hollinger (1987) presents a detailed account of successful prosecution of a couple operating a day care centre who abused many pre-school children in their care: the evidence of at least a dozen children about abuse was, despite differences in detail, sufficiently corroborative that it allowed the overall picture of abuse to emerge. The discretion of the court in allowing the 'hearsay' testimony of someone the child has talked to about the assault, allowing video-taped or audio-taped interviews with the child to be introduced, and separating the child from the alleged offender during court hearings can mean that many under-7s may be able to testify in court (Gothard 1986; Yates 1987).

Additional strain is placed on the child victim when the perpetrator denies guilt, and his counsel claims in cross-examination that the child is lying. During such time the child needs careful therapeutic support which reduces the child's personal anguish without distorting or influencing the child's memory of events (Jaffe, Wilson, and Sas 1987).

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

THERAPEUTIC INTERVENTIONS

Needs of the Victim, Family, and Offender

Society must care for the needs of all people, meeting these needs non-judgementally, viewing even the most heinous offenders as evolving human beings deserving of our consideration and attention (Giarretto, Giarretto, and Sgroi 1978). The most striking example of the humanistic model of practice comes from the

work of Nicholas Groth (1987), the American psychologist who works with convicted offenders serving long sentences. Groth demonstrates that even the child rapist and murderer, who because of the length of sentence will likely die in prison, is capable of psychological development in which he understands the nature of his offence and his motivations, and from that point on accepts his incarceration with an almost spiritual calm. Though Groth's model is based overtly in secular humanism, we are impressed with its similarity to the work of St Vincent de Paul with prisoners—helping individuals to accept responsibility for their sins as an essential precursor for spiritual growth.

The child, family, and offender will all have unique and sometimes seemingly contradictory needs following a disclosure of child sexual assault.

The primary focus is the child-victim who needs a guarantee of protection, and assurance that he or she is believed, cared about, and supported (Spencer 1978). The possibility of additional physical abuse must not be overlooked. For example, in one study of eighty sexually abused children, 67 per cent had also suffered physical abuse (de Young 1982b). Sgroi (1978) adds that while the insertion of foreign bodies is a recognized variant of child abuse, any genito-urinary or rectal insertion under some pseudo-medical guise may also be a sexual assault. Spanking and beating of children may also have a sexual element or motivation.

Family members often need support in understanding practical ways of being most helpful to the victimized child. The sexual assault may be experienced as a crisis for the family as well as the child, and all members may require help with functional disruptions and the possibility of court procedures (Burgess, Holmstrom, and McCausland 1978). If the offender was a father figure in the home, separation from the child is an important component of the treatment programme. If the aggressor does not agree to leave the home, the family may be forced to relocate.

Another important consideration is that the allegation or disclosure of child sexual abuse often triggers a profound crisis for adult members of the family who were themselves abused as children (MacFarlane and Korbin 1983).

The offender needs assurance that he will be treated with compassion within a legal system in which the option of treatment is available. Such reassurance may work to reduce his denial. If the offender can be encouraged to co-operate with the legal system, the child is spared the further trauma of the court

process. However, the limitations of treatment must also be appreciated. While all persons deserve compassion, the risk to society of severely sadistic and anti-social offenders must be weighed against the qualified effectiveness of any treatment programme, and often such treatment is only appropriate after the offender has been incarcerated.

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

It is equally important in confronting an offender that clinicians operate from a strong basis of moral, structural, and clinical authority. It is unlikely that an extreme abuse of power will respond to non-authoritative intervention (Groth 1982).

Trauma of Disclosure

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

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

> One notable feature when the silence is broken is the characteristic of the unresolved issue phenomenon. The incident has been encapsulated within the psychic structure for so long that when the person finally discloses the secret, the emotional affect can be quite strong.
>
> (Burgess and Holmstrom 1975:561)

The act of disclosure demands new coping strategies from both the victim and family members. This can be particularly disruptive when the sexual abuse has happened within the family

and over a period of time. 'Disclosure disrupts whatever fragile equilibrium has been maintained, jeopardizes the functioning of all family members, increases the likelihood of violent and desperate behaviour, and places everyone, but particularly the daughter, at risk for retaliation' (Herman 1981a:131).

Dualistic Model

The dualistic model of crisis intervention plus advocacy outlined by Holmes (1981), is appropriate for child sexual abuse interventions. Crisis interventions are appropriate at the stage of revelation in that they can reduce the impact of trauma, help the victim regain control, and strengthen future coping mechanisms. It is also important, in parallel, to work with individual families to ensure that social systems become more responsive to their needs, and also to help society become less tolerant of the abuse within its midst while at the same time accepting the needs of both offenders and victims. This model of social work in the health field is well elaborated by Carel Germain (1984).

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

Our approach adopts the humanist position that a person cannot become an effective clinician without attending to self-realization. This self-development includes striving for social conditions that foster the same conditions of self-realization in others (Giarretto 1981). The basic humanist philosophy is that the strongest human drive is for feelings of self-worth with regard to relationships with others. To work effectively with sexual abuse offenders, one must accept that the same is true and possible for them.

DEALING WITH THE OFFENDER

Need for Ethical Clarity

The ethical clarity we advocate is based on the premise that child sexual abuse is morally wrong, that the offender must bear both moral and legal responsibility for the act, and that treatment is not a substitute for responsibility (Berliner 1985). While opinions on detail will vary among professionals and the general population, an effective community programme cannot be achieved until there is at least a working agreement regarding these issues.

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

An opinion contrary to our proposed ethical statement is offered by Borgman, who in a study of victims felt the sexual assaults had not been 'consciously intended' in many cases (1984:182). These included activities resulting from corporal punishment of teenage girls, sexual contacts which occurred only when the offenders were inebriated, activities that occurred when men had been having sex with adults and turned to children who happened to be present, and prostitution arranged by the girls' mothers. The author suggests that such acts are not fully intentional, and often 'the offender' escapes the consequences of marginally criminal behaviour. We would reject such a view, however, arguing instead that in all cases involving the sexual exploitation of minors, adults have a large measure of both free will and moral responsibility for their actions.

The criminal code reflects the formal mores of the community, but popular sentiment regarding deterrence, rehabilitation, and punishment will usually determine actual enforcement practices. The challenge for legislation is to match sanctions with community standards. If the courts are too lenient, offenders are not deterred and citizens may resort to private vengeance; if they

are too harsh, citizens may be unwilling to aid prosecution (Taylor 1981).

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

On the other hand there will always be cases that defy legal containment. As Taubman points out: 'If public agencies abandon the family when it becomes clear that a legally provable case cannot be made, their actions become part of the problem' (Taubman 1984).

Adaptation of Police and Court Systems

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

It is important that investigations and interviews be adjusted to the developmental level of the child involved (Graves and Sgroi 1984). It is even more important that the police work to build cases which do not require testimony of the child (Frost and Seng 1986). Cases are more likely to go to court when victims are over seven years of age. Younger victims are often not considered credible witnesses; older children may be wrongly suspected of complicity (Finkelhor 1983).

The challenge for the court system is to become more flexible in meeting the needs of younger children. Jones and Krugman (1986) document how legal procedures were adapted to accommodate a three-year-old victim-witness. The major

adaptation was that the treating psychiatrist also acted as court interviewer. This allowed the psychiatrist to communicate at the child's development level, as well as being available to quickly identify and attend to any signs of distress.

Sgroi (1982b) quotes Nova Scotia and Israel as examples of jurisdictions where child evidence can be given by proxy, a practice now incorporated in all Canadian provinces (Dawson 1987). De Francis (1969) warns, however, that this could violate the basic rights of the alleged offender to face the accuser, cross-examine, exclude hearsay evidence, and enjoy equal protection under the law. A balance must be achieved whereby traditional legal rights are incorporated within procedures more responsive to the developmental needs of children. The new Federal law in Canada based on the recommendations of the Justice Committee report (Dawson 1987) attempts to do this—but it may be open to a variety of appeals, challenges, and varying interpretations in different geographical areas.

PROMOTION OF SOCIAL CHANGE

Children at Risk

Finkelhor (1980a) in his study of college students identified the following risk factors for child sexual abuse of females: a low socio-economic status; a socially isolated or rural background; stepfather families (this was the strongest risk factor in that a girl living with a stepfather had a 1 in 4 chance of being sexually abused by him); having lived at one time apart from her mother; mother with substantially less education than father; and mother punitive about sexual matters. These factors were noted to have an additive effect in that over 50 per cent of girls with four or more of these factors had suffered sexual victimization as a child.

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

It is not typical for sexual abuse to occur independently of other aspects of family dysfunction. It occurs with greater frequency in homes disrupted by parental absence or separation, or in those in which standards of parental care are punitive,

confused, and rejecting. Sandra Butler (1985:214) emphasized that the 'good' child—the one who is quiet and conformist—is often more vulnerable. Poor self-esteem in the child contributes to her inability to resist abuse, and her lack of confidence about reporting (Bagley and Ramsay 1986). In this and other research we found that two factors recalled by adult women were strongly associated with sexual abuse in childhood. The first was a harsh, authoritarian psychological climate (sometimes accompanied by excessive physical punishment) which required the child to be obedient to adult needs and wishes. The second was long-term separation from a biological parent (usually father), sometimes (but not always) followed by the introduction of unrelated males into the household. Both authoritarianism and parental separation resulted in lowered self-esteem for the child, and she was rarely able to avoid the sexual approaches of the adults, which merely acted to reinforce her feelings of personal worthlessness. In such households girls were also at risk for sexual victimization by more than one adult (Bagley and Young 1988).

There are many suggestions in the literature of ways to improve services for victimized children. The need for more comprehensive legislation and more consistent statistics has been outlined by Bagley (1986)—some of these changes have recently become law in Canada (Dawson 1987). A practical suggestion for providing non-threatening information and initial help to child and adolescent victims is the use of recorded telephone messages with provision for personal back-up and face-to-face interviews if the caller wishes either alternative (Thomas and Johnson 1979). There is still a dearth of special help-lines for sexual abuse victims, and one excuse offered by professionals is that if everyone who was being abused sought help, the system would be overwhelmed with cases!

Education of the Public

Finkelhor (1984a) has identified a number of 'vulnerability factors' for sexual assault in childhood. These include the possibilities that the child is emotionally deprived, socially isolated, acquainted with the adult, fond of the adult, vulnerable to incentives, helpless and powerless, ignorant, sexually repressed and curious, and ultimately coerced. These concepts need to be incorporated into safety education for children as well as into information programmes alerting parents to the

possibilities of child sexual abuse. A variety of films and videos have been made for this purpose and are available in Canada and North America as a whole (Byers 1986). In Calgary, for example, films, drama, and informational programmes are regularly shown in schools, and each presentation results in further disclosures by children. Since 1980 the number of cases of child sexual abuse reported to authorities has increased by some 50 per cent a year. The reported rate in 1987 is ten times the rate reported in 1980. Yet workers are still seeing only the tip of the iceberg of actual cases which we know to exist, based on the estimates from adult recall studies (Bagley and Young 1988).

The credibility and vulnerability of children are themes which need constant reiteration. These premises have never been firmly established and a movement is arising to challenge them further. Some individuals in North America who feel they have been wronged by child protection agencies or the courts are forming VOCAL groups (Victims Of Child Abuse Legislation) to protest against the right of society to intervene for protection of children (Conte 1986; Summit 1987b). While some grievances may be legitimate, the danger of such groups is that they perpetuate the myth that children's stories are often not credible.

However, the converse is true: children rarely produce accounts of abuse which really has occurred. The large majority of victims are never able to reveal the abuse: they have been trained, coerced, or cajoled by their abuser into deceiving the world. They must never reveal the abuse to anyone, and they must lie if abuse is suspected. The penalties for telling the truth are awesome, and involve considerable psychological costs for the child. This is why children with low self-esteem (which often preceded the abuse, and is further diminished by the sexual abuse) are rarely able to report. Children who are sexually abused are not only often terrified, they frequently feel considerable guilt about participation and having to deceive their mothers. The ego of the sexually abused child is fragile: it is not difficult to force or pressure the abuse victim to retract his or her statement. If children lie about sexual abuse it is in the statements that they have *not* been sexually abused.

We have some insight into this process from the accounts which 'adult survivors' of sexual abuse have given in a number of studies (Bagley and Young 1988). Some adults, recalling their childhood, tell harrowing tales of the disbelief of adults when the child summons up the courage to reveal abuse.

Another problem which children have in giving accounts of child sexual abuse relates to the mind's attempts to control psychological pain by pushing the events of consciousness into another realm of the mind, even to the extent that the personality becomes split into two halves, or into many parts (Fraser 1987). For others, the mind simply suppresses a clear memory of the events. Consider, for example, the following personal account revealed in the Canadian national population survey (Canada 1984):

> Even though I am no longer a child or a youth (I am 40), I would like to report sexual abuse as a child. The first rape occurred when I think I was approximately 18 months old. I was too little to speak and tell my mother. A second rape occurred when I was between two and three. From three to age seven, I was raped routinely, especially in the summer when I could not be kept in the house. The rapist was my father.
>
> Until age 36, I had no recollection of my childhood. Growing up on a farm, I had assumed until then it had been a happy one. I knew my father as a good man, religious, and a leader in our small community.
>
> When he died, freeing within me the terror and the rage against him, I started experiencing serious problems towards men. If any man showed any interest, I would 'freeze up', be paralyzed inside, and unable to move or speak.
>
> (Canada 1984:163)

This personal account illustrates too the problems which adult recall studies of child sexual abuse can face. An unknown number of actual victims will deny that they were sexually abused in childhood because they have no clear memory of the abuse.

When children do report sexual abuse, they usually have to give accounts of the abuse to more than one person—a social worker, a police person, a prosecutor, and a clinician. Before a case ever comes to court, the child's story will be carefully listened to and evaluated, and his or her ability to testify assessed (Jaffe, Wilson, and Sass 1987). Only the most consistent and plausible accounts will survive this long and sometimes harrowing process. Kathleen Faller (1984) has usefully

summarized the evidence on the veracity of children's accounts of sexual abuse. The lynch-pin of procedure has to be the child's personal account. That account can be strengthened or corroborated by other data, such as evidence from a medical examination; some specific behavioural indicators (such as sudden regressions in behaviour, withdrawal, fear, loss of self-esteem, decline in school work, night terrors, depression); the child's general sexual knowledge and behaviour (sexually abused children often have precocious sexual knowledge, and may engage in sex play with other children); and the child's play with anatomically correct dolls and drawings of genitalia (Yates, Beutler, and Crago 1985).

None of these can substitute for a child's personal account, and great caution should be exercised (by social workers in deciding whether to remove a child from a family, or by police in deciding whether to recommend prosecution) if the child does not give a plausible or coherent account of sexual abuse. Medical evidence, for example, can be supportive but not conclusive: many sexually abused children show no medical signs of such abuse, while others will show anatomical signs or changes of the genitalia which did not result from sexual abuse *per se* (Enos, Conrath, and Byer 1986).

A particularly difficult problem which has emerged in recent years concerns allegations of sexual abuse of very young children in child custody disputes. The possibility of malicious or mistaken allegations by a parent has to be considered. Such allegations could effectively prevent the other parent (usually the father) having any visitation rights. Courts (in Canada and the United States) have in the past often allowed fathers access, tending to allow access even when mothers have been certain that the child has been abused. In one case in our knowledge, it was subsequently found that the 3-year-old had a sexually transmitted disease, which was traced to the father. But corroborating evidence is not usually as clear cut as this. Our own solution is to use the 'whistle' technique—giving the child standard preventive education to alert them to the possibility of child sexual abuse; and warning the adults involved that any sexual assault against the child will likely be detected, and prosecution would follow. The social worker as a 'moral policeman' has a legitimate role in the field of child sexual abuse! There are good grounds for supposing that many potential child abusers (but not the most

fixated paedophiles) can be deterred by moral admonition and the potential for discovery.

Education of Professionals

The proportionately greater risk of suicide among survivors adds to the urgency of early identification and treatment by human service professionals (Briere and Runtz 1986).

The need for a co-operative model is stressed by Anderson and Shafer (1979). It is critical that agencies avoid mixed messages to their clients and to each other. Recognition of the different roles of mandated agencies is important for casework management (Sgroi 1982b). It is essential that each programme addresses the complexities of system and agency interplay, rivalry, and conflict (Bander, Fein, and Bishop 1982; Zefran, Riley *et al*. 1982).

Porter (1984) suggests time frames for the initial stages of intervention: (1) suspicion and disclosure—the first twenty-four hours, (2) preliminary investigation—one to three days, and (3) long-term management—up to twenty-one days or longer. A multi-disciplinary approach is required with the different professionals knowing their specific roles and tasks at each stage.

Any complete family violence and child protection programme must include prevention, identification, intervention, referral, and follow-up. Accountability and quality assurance are also essential components of any child protection programme. Multi-disciplinary systems rely on clear organizational lines and well-defined roles and responsibilities. An example of all these components working well together is the US Navy Family Advocacy programme for offenders of family child sexual abuse. The programme is based on the assumption that it is more cost effective to deter or rehabilitate most offenders than to dismiss or incarcerate them, and the programme is designed so that families receive quality service with a philosophically and legally consistent response between posting locations (Rosswork 1985).

Each professional discipline as well as each integrated programme has its own unique perspective and strengths. Professionals need to stimulate discussion to reduce their differences and maximize understanding (Wilk and McCarthy 1986). Further discussion of improved services, prevention, and social change are presented in an appendix to this chapter, and Chapters 10 and 11.

CONCLUSIONS

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

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

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

The need for ethical clarity is paramount in dealing with offenders. The sexual abuse of children must be seen primarily as a criminal offence, with treatment offered as a complement to punishment rather than as a substitute for it. If the offender is punished without treatment, he will continue to be a risk to society. However, the denial and secrecy involved in child sexual abuse are such that without strong external motivation such as legal coercion, many offenders would simply avoid treatment.

The responsibility of legislation is to hold the offender accountable while providing treatment options. The challenge for community agencies is to develop a model of working together so that each has a complementary and non-conflicting role. This is best achieved by focus on the victimized child. Children's

accounts of sexual abuse may be confused, but children rarely lie about such abuse.

Prevention programmes are an important part of advocacy. A three-pronged approach is needed: education programmes about children's rights and safety are important to sensitize the public; identification of risk factors for children can allow preventative work in strengthening families; and finally, professional education and dialogue are necessary to improve common understanding and interdisciplinary co-operation.

APPENDIX: COMMUNITY DEVELOPMENT: CANADIAN AND BRITISH CASE STUDIES

Canada

The first case study illustrates a significant social change movement which took place in Canada between 1981 and 1987 initiated by a Liberal government, continued after some hesitation by a Conservative administration, and supported at the local level by Conservative administrations of various colours, including the far right (in British Columbia) and the moderate right (in Alberta). It should be said that only the provincial government of British Columbia represents an ideology which has much resemblance to that initiated by the Thatcher governments in the United Kingdom. The federal Conservative administration in Canada has many features in common with the mainstream tenets of social democracy, and resembles in its ideology many of the features of British Conservative administrations of the early 1970s.

A major step was taken in Canada in the setting up of a major Committee of Inquiry into Sexual Offences Against Children and Youth, sponsored jointly by the federal Departments of Health and Welfare, and Justice. This report carried out several major research surveys and heard evidence across the country from a variety of witnesses, individuals, political pressure groups, and professional bodies and agencies. This process of evidence-taking is important, since it raises both consciousness and expectations in those elaborating and articulating their views. Often too these groups initiate their own programmes without waiting for federal initiative. The report which finally emerged (Canada 1984) was a massive, two-volume report, 1,300 pages long and containing fifty-one major recommendations for reform of social and legal

services for assisting and protecting sexually abused children, reforming the law, and improving the handling of offenders. The report (under the Chairmanship of Dr Robin Badgley) in terms of its strong research base, its thoroughness, the lucidity and breadth of its proposals, and above all in its wholly child-centred approach, is a unique document and the most important government report on the problem of child sexual abuse to appear in any country.

It was abundantly clear that the problem of child sexual abuse was widespread, and often very harmful in its effects. But there was little purposeful or co-ordinated activity by police, social work, and health care systems to protect victims, and the laws supposedly protecting children from sexual assault often had the opposite effect. For example, it emerged that a man could require his daughter to have oral sex with him with legal impunity, provided that she was aged 12 or more, that full intercourse did not take place (in which case a charge could be laid under the statute against incest), and provided that the girl was 'not of previously chaste character' (Bagley 1986). The legal status of 'not of previously chaste character' also meant that police were powerless, or unwilling, to intervene to protect juvenile prostitutes from adult male customers (although the girls were frequently fined for soliciting).

Another important feature of the national Canadian Committee was its moral integrity and purpose in condemning laws and policies which failed to protect child victims. Nowhere is this better illustrated than in the section on juvenile prostitution. The Committee's conclusions are based on an empirical study of juvenile prostitutes across major Canadian cities and are worth quoting at length, since they illustrate the outrage this Committee felt, and the kind of impact it had in many quarters in Canada:

> In the Committee's judgement, the relationship between young prostitutes and pimps encompasses one of the most severe forms of abuse of children and youths, sexual or otherwise, that currently occurs in Canadian society. The relationship is based on two forms of ruthless exploitation: psychological and economic. The pimp exploits and cultivates the prostitute's vulnerability—her low self-esteem, her feelings of helplessness, her loneliness on the street and her need for love and protection. These weaknesses are the fetters with which the pimp binds the

> girl to him and keeps her on the street. Economically, pimps exploit prostitutes by drawing them into a form of virtual slave labour, or at least into a relationship in which one party, the pimp, provides a service whose value is vastly outweighed by the amount which the other party, the prostitute, is required to pay for it. The cost to the prostitute of working for a pimp goes far beyond the earnings that she gives him; it amounts to the girl's forfeiture of her future. Opportunities to obtain a better education, to become free of drugs and alcohol addiction, to sort out emotional problems, to return to a normal lifestyle and to enter into healthy, caring relationships, are seriously jeopardized or permanently destroyed. The relationships between juvenile prostitutes and pimps are parasitic and life-destroying. In the Committee's judgement, it must be viewed as a problem of the utmost gravity. It must be stopped.
>
> (Canada 1984:1061)

Among the local initiatives which emerged at about the same time as the federal government commissioned its committee of inquiry was the formation of a group of professionals (psychiatrists, lawyers, social workers, psychologists, paediatricians, child care workers and nurses, and others) into the Calgary Society for the Prevention of Child Sexual Abuse. While the work of this committee is not unique—it was paralleled in a number of centres across Canada—it does illustrate how the initiative for change arose at a grassroots, community level amongst concerned professionals and lay people. Similar initiatives in British Columbia and in other parts of Canada and the USA have been described by MacLeod and Wachtel (1984).

In Calgary (a Western Canadian city with a population of 650,000) the Society for the Prevention of Child Sexual Abuse ('the Society') argued to the provincial government that the problem was both serious and unrecognized. The government responded by giving the Society a substantial grant to undertake research on needs and resources, and responses in other countries, particularly in the United States. As a result of this research, a comprehensive report was made, recommending that a number of parallel programmes should be set in place, including a specialized, multi-disciplinary core team to deal comprehensively with child sexual abuse, education, and training for professionals, and for members of the community (including children); self-help

programmes of various kinds should be encouraged, supported, and funded; independent agencies should also be encouraged and supported; and the network of assessment, referral, treatment, training, education, and community awareness projects should be integrated by a specialized co-ordinator.

These recommendations have by and large been accepted by Alberta Social Services. The approach is both integrative and pluralist, in the sense that agencies with different treatment philosophies have been funded (or are paid on a fee-for-service basis); but the work of the various agencies is co-ordinated by a key team in the government social service agency. This special team in the Calgary region includes a specialist co-ordinator and six workers specializing in child sexual abuse, who act in close co-operation with a specialized child abuse unit in the local police force. Professionals in Alberta are bound by the Child Welfare Act to report to the director of child welfare any 'reasonable suspicion' of child abuse. The child protection team is obliged to investigate such a report, and co-ordinate inquiries with police specializing in child abuse cases. Usually the police professional and the social worker co-ordinate their inquiries, agreeing on whom to interview, and what evidence to collect.

It is public policy to prosecute all alleged offenders whenever sufficient evidence can be obtained. Judges and public prosecutors are involved in the professional consultation groups, and usually a first-time offender will get a lenient or suspended sentence, provided that he co-operates with the treatment and restitution process. The dominant model in the city is the humanistic model of treatment, adapted from the California model to suit local circumstances (Anderson and Mayes 1982). However, some diverse approaches (including traditional family therapy) are also funded. Medical and other assessments are often carried out by the specialized child abuse team at Alberta Children's Hospital. Co-operation in processing cases between social services, hospital, and police appears to be working well. It happened in the past that victims dropped through the net (Bagley 1984), but this seems to be happening less often now.

While this system of service delivery seems to have many advantages in meeting the needs of victims, there are still many problems to be overcome. Because of the continuing success of presentations to schools and community groups, new referrals are increasing by at least 50 per cent a year. This means that agencies and their funding resources have to run just to keep still. Any

cutback in funding would have disastrous results. There is no cheap or easy way of treating a child who has suffered severe psychological damage after several years of sexual abuse within her family. All cases that are detected have to be investigated and treated.

There are problems with this delivery system too. It is still usual practice to remove victims from home, rather than any alleged offender—a situation similar to that of 'battered women' who have to leave home to escape battering. Kids too still often suffer a double victimization, being taken from home while the man who assaulted them stays put. A proper legal framework which would enable the child to remain with her mother while the alleged offender is removed, still has to be established. Another big gap in service delivery relates to services to offenders; often they are not treated, or treated inadequately. Programmes addressed to adolescents who engage in sexual assault are virtually non-existent. Another problem is the failure of conventional mental health services to address the treatment needs of adult survivors of sexual assault. Finally, we know from adult recall studies what the prevalence of child sexual abuse in Calgary is likely to be (Bagley and Ramsay 1986), and we are aware that less than 20 per cent of child victims of severe sexual abuse ever come to the attention of authorities. There is much work yet to be done.

Parallel initiatives at the federal level have facilitated the work of various community and local groups. The federal government has largely accepted the recommendations of the Canada (1984) report, and an extensive programme of legal reform aimed at protecting child victims was passed in 1987 (Dawson 1987). These innovations allowed changes to the rules for giving evidence, so that a child's uncorroborated testimony, as well as video-taped testimony, may be accepted by the court. A large amount of money has been allocated for 'demonstration projects' by local community groups, and a parallel commitment has been made to public awareness and education programmes aimed at helping prevent child sexual abuse. How successful these various programmes and changes will be in the long run is a matter for evaluation, but we can say that Canada is doing more than most western countries to understand and diminish the problem of child sexual abuse.

Nevertheless, it is only very recently that an adequate model has developed in Canada for co-operation between social workers

and police in processing reported cases of child sexual abuse. The legacy of an older policy is well illustrated by a case in Toronto (in December 1987) in which prosecutors decided not to proceed with charges against a couple whom a social service agency had described as 'depraved' and who had engaged in sexual abuse and torture of their three children, a boy and two girls, now aged between 8 and 13. They had been in care for three years, following removal from a home in which they were subjected to every kind of sexual abuse, including buggery and bestiality, various acts of degradation, and being kept in a darkened room for long periods. The only possibility of gaining a prosecution was for the children to give evidence in court. The prosecutor withdrew charges after being assured by psychiatrists and social workers that the children were too psychologically damaged to testify.

When the children were removed to a place of safety three years earlier, a protocol of co-operation between police and social workers had not been worked out. Police were not called in until much later, and the opportunity to collect valuable evidence had been lost. Video-tapes recorded at the time of initial intervention, and recording of affidavits by social and child care workers to whom the children confided would most likely have led to a conviction without the need for the children to go to court. But the vital opportunities were lost.

England

The dangers and difficulties of an uncoordinated protection system have been dramatically illustrated by the revelations which emerged from the Cleveland child abuse inquiry in England (Davenport 1987). Following complaints by a local politician that children were being removed from their parents in growing numbers because of alleged sexual abuse, a judicial inquiry was set up by the national government. The increase in referrals to the local social services department followed the appointment of a new consultant paediatrician to the main hospital in Middlesbrough, an industrial city in the district of Cleveland, North Yorkshire.

This extraordinary chain of events began in Leeds, a university city in West Yorkshire. Because of the initiative of an individual paediatrician, a well-developed system for recognizing, referring, and treating victims of all types of child abuse had been

developed (Buchanan 1986). The Leeds Child Abuse team which emerged was based in the local university hospital, and consisted of two community paediatricians, a psychiatrist, psychologist, and social workers. This team had developed a well-researched system for the medical and psychological investigation of child sexual abuse cases (Hobbs and Wynne 1987).

When a paediatrician attached to this team, and trained in the successful methods developed over a number of years in Leeds began to apply these measures in Middlesbrough, she discovered prima facie evidence of recent sexual abuse in a significant number of cases. She carried out specialized physical examinations only on children who were thought to be physically abused, or who following admission to hospital displayed behavioural symptoms consistent with a history of sexual abuse. In the course of a year the doctor in question, Dr Marietta Higgs, referred about 140 children to social services, and after further investigation the majority of these children were removed to a place of safety.

These referrals, however, placed the social work system under great strain, since all available child care spaces were soon used up. What was happening was little co-operation or co-ordination between the various professionals and agencies concerned on what to do. Police often failed to co-operate with social services (in most parts of England sexual offenders against children are not prosecuted). The police maintain their own network of specialist medical advisors, and these doctors (who had no specialist interest in children) were often defensive about and critical of the work of paediatricians—although co-operation appears to be slowly improving (Roberts 1987; Seton 1987). A judicial inquiry was set up because the system for protecting children was in chaos and disarray, and no clear policies appeared to exist for ensuring that the welfare of children was protected as they moved through the system. Probably too much reliance was based by social services on some aspects of medical evidence, and some children who were clearly not sexually abused were retained in the system far too long (*TheTimes,* 1987–8). Case work with parents of protected children was minimal.

The irony of the report of the Cleveland Inquiry (Butler-Sloss 1988) is that we know from other studies of the prevalence of child sexual abuse that social services were seeing only a small proportion of all cases of child sexual abuse. There is a great need for better training, and for better co-ordination of the

activity of social workers in child sexual abuse cases. The work of Maureen Stone (1988) in East Sussex has shown that this can be done in England—in the north (Hobbs and Wynne 1987); in the midlands (Seton 1987); and in the south (Stone 1988). They demonstrates a system in flux, in a state of dialectic from which a better, more humane, more child-centred, more co-ordinated system will hopefully emerge. Again, the Canadian and British social policy comparisons are instructive.

Chapter Six

TRAUMA TO THE CHILD VICTIM

> There seemed to be a memory deeper than the usual one, a memory in the tissues and cells of the body on which we tattoo certain scenes which give a shape to one' s soul and life habits. It was in this way she remembered most vividly that as a child a man had tortured her; still she could not help feeling tortured or interpreting the world today as it had appeared to her then in the light of her misunderstanding of people's motives…it was his behaviour which she did not understand as a child which destroyed her faith in life and in love.
>
> Anais Nin (1979),
> *Winter of artifice and house of incest*

VICTIMOLOGY

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

Patterns of typical victim behaviour have been identified which are common to victims across different kinds of disaster. These kinds of reactions among victims of childhood sexual abuse attest to the traumatic impact of the experience as well as explaining some of the behaviours which are the immediate sequel. The components of victimization which are relevant are universal rejection, victim-precipitation, learned helplessness, attribution

and locus of control, disaster syndrome, traumatic infantilism, and traumatic bonding.

Universal Rejection

Alexandra Symonds (1979) describes the universal reaction of the animal kingdom and humans to reject an injured or sick member: 'This need to blame and reject the victim is so universal that it extends to the medical and mental health fields' (Symonds 1979:163). Exposure to the victim can make unharmed members feel vulnerable, through a primitive fear of contamination. Blaming the victim satisfies a need of the blamer to dissociate from responsibility and the possibility of a similar fate. In counter to this primitive but often found reaction, understanding the factors leading to a child's forced participation in a sexual relationship with an adult is an important part of understanding the child's innocence (Gruber 1981).

The silence of professionals, encountered by Sandra Butler (1985) in her research on victims, may have represented a similar kind of dissociation. Newberger and Newberger (1984) have argued, from their practice data, that often both perpetrators and victims are processed harshly by 'the system'. Many professionals have, in the past, reacted to the perceived 'uncleanliness' of both victim and perpetrator by various kinds of rejection and institutionalization. The rejection, in Newberger's analysis, seemed to be greater in the case of already marginal ethnic and social class groups. Such actions are the province of 'professionals' who have failed to come to terms with their value biases, and their feelings and antipathies with regard to sexual issues.

Victim-precipitation

The concept of 'victim-precipitation' proposes that victims somehow 'cause' their own assault by lack of precaution, or by unintentionally or otherwise provoking their abuser. For example, victim-blame models of rape attempt to identify characteristics of victims in comparison to successful resisters (Rabkin 1979). This is in contrast to the victim-perpetrator model which sees the young child as a helpless victim of an aggressive adult (Rosenfeld 1979). Rosenfeld argues that the victim-perpetrator model is too simplistic for many situations of sexual abuse within

the family—for example, when force is not used and the victim has an interactive or dynamic relationship with the offender.

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

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

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

Learned Helplessness

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

By analogy, when children are operating from positions of passivity and helplessness, their subjective perception becomes a reality and their behaviours are determined by this belief. Feelings of helplessness are also carried from one aversive situation to another so that the child's task becomes survival rather than escape (Browne 1980). This could explain why children often remain passive participants for so long, and also indicates the possibility that other family members, who are

unable to come to the child's defence, may experience similar helplessness.

Attribution and Locus of Control

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

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

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

> I learned very young that if I were to survive whole in this family I could not be angry. So I certainly couldn't be angry at my father's sexual advances because that would surely have caused me to be dead—at least in my child mind. Likewise, all strong emotions were not allowed.
>
> I remember being about four years old and standing in front of the house, just before I was going to go in from playing, and I decided that the only way I was going to make it with my crazy parents was to shut myself off. I don't know if I thought about it in those terms, but I felt they were just too crazy, just too sick, just too unable to relate to me in a helpful manner. So I had to preserve myself by locking it up.
>
> (Butler 1978:50)

Disaster Syndrome

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

Following impact, the victim characteristically experiences shock, denial, and disbelief. This may be accompanied by feelings of helplessness and self-blame in the face of natural disasters as well as criminal acts, and abuse against the person. During this second phase the victim is particularly vulnerable, so may minimize the personal damage or threat. It is during this time, which Martin Symonds previously identified as a state of terror, that a condition he calls 'traumatic psychological infantilism' occurs (Symonds 1978:218). This is a reaction during which the victim is reduced to a reversion to the coping mechanisms of early childhood, and becomes obediently compliant. This would explain the increased vulnerability of sexually abused children to continued abuse in the early years of the abuse, and their increased guilt in retrospect.

Whether the third phase is characterized by passivity and depression or recovery depends on whether the victim has been overwhelmed by the threat of danger, or has the opportunity to reintegrate her ego or self-identity. Feelings of self-blame may be increased by remembrance of previous compliance, with the victim retreating into a state of silence and shame which becomes a permanent personality trait, difficult to remove except by therapy. These reactions can all be part of a chronic or long-lasting post-sexual assault trauma, the extent and duration depending on the degree of violence and terror experienced.

Traumatic Bonding

The final component of victimology we note is that of traumatic bonding, described by Don Dutton and Susan Painter (1982). This refers to the development of strong emotional attachment under conditions of intermittent maltreatment. Experiments with dogs showed that those who were treated intermittently with indulgence and punishment showed higher degrees of bonding

than dogs who had been consistently either indulged, punished, or isolated.

The prerequisites of this kind of bonding are first, a power imbalance so that a cycle of dependency is established and second, periodicity of abuse so that times between are characterized by normal or pleasant behaviour. This explains the strong attachments many abused children have for their parents (Kempe and Kempe 1978) and the tendency of many sexual abuse victims to deny their own hurt in sympathetic understanding of their abuser. 'Feeling "guilty" about punishing your oppressor is a classic response of oppressed peoples, particularly females, whose oppression is based in putting others before themselves' (Ward 1984:145).

Relation to Child Sexual Abuse

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

SYMPTOMS OF SEXUAL ABUSE

Definition of Symptoms

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

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

> It has been my experience that a therapist makes much more therapeutic progress if he or she tries to understand a patient's sexual problems as a result of sexual abuse by adults. I do not interpret the seductive behavior of a so-called hysterical patient as an expression of her sexual desires but as an unconscious message concerning an event she has completely forgotten, which can be approached only by way of this re-enactment. I believe that in her active role the patient will repeatedly demonstrate that which once—or more than once—happened to her but which she cannot remember because it was too traumatic to retain on a conscious level without the aid of an empathic support figure. Instead, she reenacts the unconscious childhood trauma that caused her illness.
>
> (Miller 1986:121)

> An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time. In a supportive environment the wound can become visible and finally heal completely.
>
> (Miller 1986:182)

An understanding of symptomatic behaviour as the expression of unresolved trauma provides a necessary background for discussion of specific post-sexual assault syndromes.

Rape Trauma Syndrome

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

Reorganization is a long-term process often characterized by increased motor activity (moving, travel, changing phone number, seeking out support persons), nightmares, and phobic

reactions such as fear of indoors, fear of outdoors, fear of being alone, fear of crowds, and fear of people behind them, depending on the circumstances of their attack. Sexual fears associated with flashbacks are also a common reaction.

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

Accommodation Syndrome

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

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

Children are normally expected to show obedience and affection to adults, especially those in positions of authority, so that the child is at a power disadvantage from the beginning and will typically cope silently. A natural reaction is to develop survival skills which embody a sense of power and personal control. Such an alternative involves the abused child in believing that he or she somehow caused their own pain.

The above reactions often result in a delayed or unconvincing disclosure. Summit (1983) convincingly describes the double bind in which children are too often caught. If they are to survive by acting out their anger in various delinquent activities, they are discredited for causing further problems. On the other hand, if they had attempted to hide their pain and shame under a serene or

perfect exterior, they are equally discredited for complaining to authorities when they were not seemingly affected. Once again, pressure is frequently put on the child to assume responsibility for the situation and a fabricated 'retraction' carries more credibility than the original disclosure.

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

Clinical Predictors

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

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

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

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

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

Other syndromes and groupings of symptoms associated with sexual abuse are 'borderline states' which sometimes resemble psychosis, and are sometimes wrongly diagnosed as schizophrenia, and the multiple personality phenomenon (Briere 1984). In addition, gross and chronic diminishment of self-esteem is often a specific outcome of sexual abuse in childhood, and this makes individuals vulnerable in later years to stressful events, which in turn lead to the onset of severe depression (Bagley and Young 1988).

Eating and body image disorders have been linked to a history of sexual abuse. These disorders may have a specific link to the abuse—distorting one's body image by excessive eating or dieting can be a way of denying sexuality or avoiding sexual contact. Some eating disorders are a direct reflection of being forced to engage in oral sex; other disorders such as bulimia, with its binge eating and self-induced vomiting, may have important symbolic links to acts of sexual abuse and the ritual self-punishments which can stem from these events (Bagley 1985a).

EFFECTS OF CHILDHOOD SEXUAL ABUSE

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

Factors Affecting Trauma

Burgess and Holmstrom (1975, 1978a, 1978b) devised three diagnostic categories associated with sexual assault at any age. These are: rape trauma, accessory-to-sex, and sex-stress. Rape trauma has already been discussed. The accessory-to-sex syndrome occurs when the victim is pressured into sexual activities, and an adverse emotional reaction stems from the pressure and tension of the secret. Sex-stress results from a consensual situation that the younger person afterwards regrets, and feels considerable guilt over.

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

The reactions of parents and family, the reaction of professionals, and the type of treatments, if any, that are offered, are also factors that can contribute to trauma. A one-time incident which may be experienced as unpleasant may have negative effects which can be exacerbated by the horror of family or professionals (Sanford 1980).

Finkelhor and Browne (1985) provide a model of factors affecting trauma based on the subjective reactions of the victim, rather than on external criteria. The four factors identified are traumatic sexualization, betrayal, powerlessness, and stigmatization.

Traumatic sexualization refers to the 'process in which a child's sexuality (including both sexual feelings and attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse' (Finkelhor and Browne 1985:532). Children so traumatized may cope by becoming promiscuous or developing an aversion to sex. Each type of reaction represents a failure to develop normal sexual relationships.

Betrayal is the dynamic in which 'children discover that someone on whom they were vitally dependent has caused them harm' (Finkelhor and Browne 1985:531). This has a sequel in an impaired ability to trust other people in many subsequent situations, especially those involving interpersonal relationships.

Powerlessness is the dynamic process in which 'the child's will, desires, and sense of efficacy are continually contravened' (Finkelhor and Browne 1985:532). Repeated invasion of the child's territory and body space reinforce his or her self-perception as a victim. Prolonged assaults may lead to a permanent sense of powerlessness in the victim, and an inability to avoid further victimization, be it sexual, social, or economic.

Stigmatization refers to the process by which negative connotations, such as badness, shame, and guilt, 'are communicated to the child around the experience and then become incorporated into the child's self-image' (Finkelhor and Browne 1985:532). 'Keeping the secret of having been a victim of sexual abuse may increase the sense of stigma, since it reinforces the sense of being different' (Finkelhor and Browne 1985:533).

Continuum of Abuse

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

Sgroi (1982b) describes sexual activity between an adult and a child often progressing through the following spectrum of behaviours ranging from exposure to the child, through fondling and kissing the child's naked body, to various forms of penetration:

> The typical scenario is a progression from less intimate types of sexual activity (such as exposure and self-masturbation) to actual body contact (such as fondling), and then to some form of penetration. Oral penetration may be expected to occur early in this progression, which is often

> followed by digital penetration of the anus or vagina. Ejaculation by a male perpetrator, sometimes against the child's body can occur at any time in this progression.
>
> (Sgroi 1982b:12)

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

Short- and Medium-term Effects

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

The possible effects of child sexual abuse are multi-faceted. Categories include physical (somatic complaints); psychological (impairment or distortion of emotions; affect and motivation); cognitive (memory loss); and social (impaired relationships and continued victimization due to confusion about intimacy and abuse).

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

Sexual abuse of children has also been found to be associated with delinquency, acting out behaviour, depression, self-mutilation, chemical dependency, and eating disorders. As immediate or longer-term sequels of child abuse, other authors identify low self-esteem, guilt, depression, alienation, distrust, self-destructive behaviours, and a desperate and often ineffective search for nurturing (Bagley 1985).

Jones, Gruber, and Timbers (1981) found a 50 per cent incidence of previous sexual victimization among delinquents, while Silbert and Pines (1981) and Bagley and Young (1987) found a 70 per cent incidence of prior victimization among prostitutes. McCormack, Janus, and Burgess (1986) reported that 38 per cent of male and 73 per cent of female runaway adolescents reported previous sexual abuse. Mary de Young (1982b) found that effects during or immediately following sexual abuse included isolation in the family, behavioural acting out, sexual victimization by others, and a variety of psychological disturbances and physical complaints.

Revictimization of abused children is a common theme in the literature (Adams-Tucker 1981; De Jong, Hervada, and Emmett 1983; Russell 1986). Mary de Young (1984) cites counterphobic behaviour as a possible cause. Young children have few resources for dealing with their acute anxiety following an assault and may develop phobic reactions. The counterphobic response is described as one 'in which the children unconsciously attempted to gain mastery over their phobias by engaging in the very behavior that caused them anxiety in the first place' (1984:338). This understanding is critical because it explains why some children may be molested more than once, and why some may also attempt to act out their abuse by repeating it with other (usually younger) children. This could explain the fact that about 30 per cent of males who sexually abuse children are themselves juveniles. The majority of these juveniles have been sexually abused themselves. These adolescent perpetrators often go on, as adults, to continue this pattern of abusive behaviour which, when fixated, is described as paedophilia (Bagley and Dann 1987).

An alternative explanation for the further victimization of sexually abused children is that adults involved with the child, knowing that he or she is already a victim, take the opportunity to exploit a vulnerable individual (Bagley and Ramsay 1986). Another possibility is that the isolation of some children, their poor self-esteem, and lack of the ability or opportunity to approach adults for help, make such children particularly vulnerable to sexual assault by more than one individual.

Long-term Effects

Long-term effects are based on reactions which emerged in childhood, and continue to mar adult adjustment.

Mrazek and Mrazek (1981) provide an overview of possible long-term effects. These too are listed in the Appendix. The following review will focus on other authors and more recent studies. Among her adult patients who were child sexual assault victims, Karen Meiselman (1978) found the most striking sequels to abuse were frequently occurring sexual problems, including frigidity, promiscuity, confusion about sexual orientation, and sexual masochism.

Goodwin, McCarthy, and DiVasto (1981) note that inhibitions about tenderness resulting from child sexual abuse can profoundly and negatively influence later decisions about marriage and children. Long-range effects described by de Young (1982b) include a variety of psychological and sexual problems, vulnerability to further victimization, and repeated unwanted pregnancies.

Halliday (1985) identifies migraine headaches, back problems, stomach problems, infections (27 per cent of her sample had hysterectomies because of infections), anorexia, obesity, asthma (especially among male victims of oral sex), epilepsy, multiple personality, addictions, severe depression, self-mutilation, and increased acceptance of pain, as long-term sequels. She found that male victims tend to be more aggressive or externalizing of their distress, while females tend to be more internalizing and self-destructive.

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

Dissociation and Multiple Personalities

Multiple personality has been identified as a form of dissociation and survival in cases of extreme abuse (Jones 1986). John Bowlby (1979) suggests that the normal development of cognitive processes in children excludes much of the information received after unconsciously assessing and evaluating its relevance. The need of children to be desired and loved can similarly lead them to shut off feelings and memory they or their

parents do not wish them to have. Given this understanding, we can recognize how some children can suppress, or rigidly compartmentalize deeply negative emotional experiences. Sometimes this can result in the development of a separate, or indeed, a 'multiple personality'.

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

> Normal at birth, the doctor speculated Sybil had fought back until she was about two and a half, by which time the fight had been literally beaten out of her. She had sought rescue from without until, finally recognizing that this rescue would be denied, she resorted to finding rescue from within. First there was the rescue of creating a pretend world, inhabited by a loving mother of fantasy, but, the doctor hypothesized, being a multiple personality was the ultimate rescue. By dividing into different selves, defenses against not only an intolerable but also a dangerous reality, Sybil had found a *modus operandi* for survival. Grave as her illness was, it had originated as a protective device.
>
> (Schreiber 1973:207)

THE EXTENT OF TRAUMA IN SEXUAL ABUSE VICTIMS

We have identified a range of negative outcomes which can be associated with child sexual abuse. But how prevalent are these outcomes? And do the severe, long-term effects involve a significant proportion of adult survivors? We need epidemiological research rather than small-scale clinical studies to answer these questions. Unfortunately, most of the large-scale studies of prevalence cited in a previous chapter did not extend their questioning to clinical or mental health variables. Yet these are vitally important studies, and because of the dearth of work of this kind, we will review and summarize here our own studies in this area, which were carried out in Canada and Britain (Bagley

and MacDonald 1984; Sorrenti-Little, Bagley, and Robertson 1984; Bagley and Ramsay 1986; Bagley and Young 1987, 1988).

The first study was designed to establish adult sequels of child sexual abuse by means of a long-term follow-up study into adulthood of sixty-four children who had been removed from their families by social workers in the late 1960s because of physical abuse; because of sexual abuse (by a father or stepfather); because of general family breakdown involving physical and perhaps emotional neglect, but with no evidence of abuse *per se;* or because of a combination of these factors. The children, all female, were aged on average 12 years when they were separated from parents. Originally ninety-five children were identified, and sixty-four were successfully followed up when they were an average 21 years old. The subjects were equally divided between those who had been sexually abused, physically abused and neglected. A quarter of the subjects in the sexual abuse group had also been physically abused. The adult survivors were compared with a 'normal' group who had grown up in similar circumstances (in slum areas of South London) but who had never been separated from parents.

As young adults, the subjects completed a variety of standardized measures of psychological and social adjustment. Contrary to our original expectation (Bagley 1969) that it was separation from parents rather than the sexual abuse itself which would cause long-term harm, the data showed that the sexually abused children (none of whom had any treatment or counselling related to the abuse experience) had significantly poorer mental health outcomes than any of the other groups. Nearly 70 per cent of the sexual abuse victims had mental health profiles within the abnormal range (with problems sufficiently serious that they warranted psychiatric treatment), compared with one-third of the physically abused and separated children, 20 per cent of the neglected and separated, and 8 per cent of the normal controls. One of the sexually abused women was a long-stay mental patient, and was too ill to be interviewed; and two of the sexually abused women (none in any other group) could not be interviewed as they were in prison—one for the manslaughter of a pimp. Five of the sexual abuse victims, and only one of the remaining subjects had made a serious suicide attempt.

Complex statistical analysis (multiple regression) suggested that the association between poor mental health and sexual abuse was most likely a causal one. Outcomes were worst in women who

had been physically as well as sexually abused, and where the abuse had continued over a long period of time, culminating in regular intercourse with the child (Bagley and MacDonald 1984).

In a Calgary study, we have undertaken a replication of American work with students (Finkelhor 1979a) and added two measures of self-esteem (Coopersmith) and self-concept (Tennessee) to the questions about childhood sexual abuse asked of 1,085 Calgary students (404 female and 681 male) aged 18 to 37. Nineteen per cent of females, and about half that proportion in males, had experienced serious sexual abuse up to the age of 16. Twenty per cent of females with prior sexual abuse had very poor self-esteem and disorganized self-concept, compared with 6 per cent of the non-abused—a highly significant difference. Significant differences also occurred in males (the sexually abused having poorer self-concept), but these were not so marked. Abuse of both males and females was overwhelmingly at the hands of males, so the abuse of boys was usually homosexual in nature. Boys who had been sexually abused and who as young adults were currently practising homosexuals, had rather poor self-concept in comparison with all other groups, except those who were currently homosexual but who had never been sexually abused as children. It looks as though sexual abuse of boys acts for some as a kind of recruitment process into adult homosexuality: it is the conflicts surrounding the homosexual role rather than the childhood abuse *per se* which diminishes self-esteem and self-concept.

In females, however, it appears that the effects of sexual abuse in childhood are more deep-seated, more complex, and more profound.

The third study we carried out was a community mental health study, based on a random sample of adults in Calgary, a Canadian city with a population of 650,000. The first phase of the study asked 672 men and women about suicidal ideas and behaviour in their lifetime. Subjects also completed a number of standardized mental health measures (Ramsay and Bagley 1986). A year later the 372 women in this study were reinterviewed, and the same mental health measures were administered, plus some new standardized psychological tests, and questions were asked about abuse in childhood—physical, sexual and emotional. As we reported in an earlier chapter, 22 per cent of the 372 women reported a serious event of sexual abuse, defined as at least the unwanted touching of the child's genital area, ranging to the

grossest forms of abuse. A quarter of the abuse victims in this random sample had been sexually abused on separate occasions by different assailants.

Comparison of the eighty-two women reporting sexual abuse in childhood (up to age 16) with the 285 reporting no such abuse, indicated many significant differences. The abuse survivors were twice as likely to have serious psychological problems (depression, anxiety, or severe neurosis) as the comparison subjects. Eighteen per cent of the abuse victims, compared with 9 per cent of the other women, had clinical profiles indicating the presence of major chronic psychiatric illness or disability. Five per cent of the abuse victims had made a suicide attempt in the previous six months, compared with none of the controls. Nineteen per cent of the former abuse victims had devastated or very low self-esteem, compared with 5 per cent of controls. Seven per cent of abuse victims, and none of the controls, had psychiatric treatment in the past year for psychosis (the most serious type of mental illness). No less than 34 per cent of former abuse victims had received psychiatric treatment of some kind for psychosis, depression, anxiety, obsessional neurosis, or other psychological conditions in the previous year, compared with only 4 per cent of controls. Not a single one of the eighty-two sexual abuse victims in this survey had received any therapy which focused specifically on the abuse experience and its psychological aftermath. Yet, there are good grounds for supposing that these assaults in childhood have an important causal link with the later problems of adjustment—a possibility discussed in the next section.

A further Calgary study of child sexual abuse was undertaken in the context of a child development study of a cohort of a random sample of 620 children born in 1980, and followed up in 1983 and 1986. Mothers of these children completed a number of measures of psychological adjustment, as well as measures of abuse in their own childhood, and separation from their parents. We found that 24 per cent of these young women (all were under 40 when interviewed) reported serious sexual abuse in childhood. Fifty-six per cent of the former sexual abuse victims displayed signs of moderate or severe depression, compared with only 11 per cent of those without a history of abuse. However, these symptoms of depression appeared to reflect a combination of sexual and physical abuse, as well as emotional neglect.

The final Calgary study involved a detailed inquiry of forty-five women aged 18 to 26, who had recently left prostitution (Bagley and Young 1987). Control subjects for these women were obtained from the community mental health survey outlined above. We found that many of the prostitutes had experienced multiple abuse while growing up: two-thirds experienced significant physical abuse, and an overlapping two-thirds were victims of emotional abuse and neglect. Nearly three-quarters (73.3 per cent) had experienced serious sexual abuse by the age of 16, prior to entering prostitution. All had experienced at least one type of abuse, physical, emotional, or sexual. Twenty-nine per cent of control subjects had experienced sexual abuse, and 35 per cent had also been victims of at least one of these kinds of abuse.

A second comparison was made of the thirty-three former prostitutes who reported sexual abuse, together with all of the sexually abused women in the relevant age group from the community sample. This comparison showed that the ex-prostitutes had experienced much more severe forms of sexual abuse. The abuse began earlier in their lives, more often involved one or more close biological relatives, went on longer, and was more likely to involve the grossest forms of sexual exploitation. A quarter of the ex-prostitutes reporting sexual abuse, and none of the sexually abused controls had been involved in sado-masochistic activities and/or posing for pornographic pictures or movies prior to entry into prostitution.

Mental health outcomes for the entire group of ex-prostitutes were much worse: 27 per cent had made a suicide attempt or bid by age 21 (9 per cent in the controls); 71 per cent had currently 'devastated' self-esteem; and 80 per cent were still showing signs of clinical depression or anxiety (20 per cent in controls).

CAUSAL PATTERNS

We have to be cautious in inferring a causal link between sexual abuse in childhood and the increased prevalence of poor mental health in adult survivors of abuse.

In the case of the ex-prostitutes, for example, the many hazards of street life (often involving drug use, rape, and physical beatings) may have been responsible for the poor adjustment these women manifest as adults. A detailed inquiry into the lives and developmental circumstances of these women had convinced

us, however, that for the majority of these ex-prostitutes sexual and physical abuse in the home was responsible for them running from home (75 per cent had left home permanently by age 16). On the street they were rapidly drawn into drug and prostitution sub-cultures. Regression analysis (a statistical technique which calculates the individual contribution which different antecedent variables make to outcome measures) gave a clear indication that early sexual abuse in the ex-prostitutes remained linked, in statistical terms, to the very poor mental health outcomes even when the experience of prostitution was taken into account. Sexual abuse remained a strong predictor of poor mental health even when the independent influences of physical abuse, emotional abuse, and separation from a parent were taken into account.

Although sexual abuse can take place in 'normal' families—where the abusing father appears to be a normal upstanding, god-fearing man and a pillar of his community (e.g., Fraser 1987)—sexual abuse is more likely to take place in family settings in which the biological father is replaced by a stepfather or cohabitee, or in which a parent has a drinking or mental health problem, or where the child is subjected to vacillating emotional support, or to authoritarian control or rejection—or a combination of these circumstances. Often a lonely and depressed child, with self-esteem diminished by family disruption or malfunction, is then subjected to sexual assaults which she is unable to resist or report because of her sense of powerlessness at the outset. Her already low sense of self-esteem is further diminished by the assaults.

This is the picture which has emerged in a number of studies (Finkelhor 1979a, 1984; Russell 1986; Bagley and Ramsay 1986). Once identified within her family circle as a victim, the child is often subjected to further sexual assaults by other family members, or family 'friends'.

We also tried to trace patterns of cause by case study analysis, and multiple regression analysis of our data on abuse survivors, and control subjects (Bagley and MacDonald 1984; Bagley and Ramsay 1986; Bagley and Young 1987, 1988). The regression analyses show that despite being often linked to one another in a child's development, sexual abuse, physical and emotional abuse, and parental separation all make independent, statistically significant contributions in understanding outcome in terms of poor mental health.

Case study analysis, based on extended interviews with twenty sexual abuse survivors, contacted through the community mental health study (Bagley and Ramsay 1986) indicates a complex patterning of cases with different patterns of sequence and cause. Table 6.1 (see p. 128) indicates the various patterns. Since we interviewed in depth less than a third of seriously abused victims in this series, we can say that it is likely that other types of complex patterning exist. These results remind us that in therapy with survivors we have to address a range of complex developmental issues and traumas.

Table 6.2 (see p. 129) shows another type of complex patterning of antecedents of depression in the longitudinal sample of young mothers (Bagley and Young 1988). In this table, data are presented on ninety-eight women with a history of sexual abuse. The model we explored suggested that vulnerable women with diminished self-esteem based on childhood disruptions (parental loss, sexual and other abuse) would be more at risk following significant social stressors, and in the absence of social support, to develop depressive illness. This model is derived from the work of George Brown (1986). The model is strongly supported by our data. All of the women who experienced sexual abuse, with or without accompanying loss of a parent and/or physical or emotional abuse, and who experienced recent stress in the absence of social support, experienced the onset of symptoms of moderate or severe depression. These findings suggest that although women may experience some specific symptom patterns (e.g., multiple personality, memory loss, eating disorder, borderline psychosis) as a result of sexual abuse in childhood, they are also likely to be vulnerable to develop the more typical patterns of prevalent mental disorder, such as depression and anxiety.

CONCLUSIONS

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

Symptomatic behaviour is seen as a survival strategy, either communicating the pain of the child to those who would hear the

message, or helping the child cope with a deeply embedded pain. Specific patterns of behaviour that have been identified are the rape trauma syndrome, the accommodation syndrome, and the specific syndrome cluster of child sexual abuse. Understanding of these syndromes helps both the clinician and client anticipate the range of possible reactions.

The effects of child sexual abuse have in addition been documented as pervasive and numerous. There are several classifications of the factors affecting the degree of trauma. From an objective point of view, these include the child's age, developmental status, relationship to offender, frequency and duration of abuse to the child and other family members, types of threats used, reactions of family and professionals following disclosure, and type of treatment received. Traumatic sexualization, and feelings of betrayal, powerlessness, and stigmatization have been described. The effects of child sexual abuse are differentiated between short-, medium-, and long-term—the second pertaining to childhood and the last carrying over to adulthood. Within these two time frames, disruptions occur in psychological functioning, sexual adjustment, and interpersonal adjustment. Dissociation, borderline psychosis, and multiple personality are seen as two of the more extreme survival symptoms. However, abuse survivors are also vulnerable to stressors in later life which, in the absence of social support or therapeutic help, may result in the development of severe depression, anxiety states, and suicidal behaviour.

Epidemiological work suggests that a fifth to a quarter of child sexual abuse victims have chronic and often severe mental health problems which are caused directly or indirectly by sexual abuse and associated family disruptions, including physical and emotional abuse, and loss or departure of a parent. When these various other factors are taken into account, studies show that the significant and almost certainly causal link between childhood sexual abuse and later mental health problems, remains. Given our 'minimum estimate' of a rate of childhood sexual abuse of 20 per cent in women, and an estimate that a quarter of victims have long-term problems of mental health and severely diminished self-esteem, we estimate that about 5 per cent of all women in Britain, Canada, and the United States have chronically impaired adult adjustment because of sexual abuse in childhood.

Table 6.1 Patterns of sequence of parental separation, parental punitiveness and sexual abuse in childhood in twenty subjects

Pattern 1:	Separation from a parent before age 5, followed by unhappiness and emotional neglect of child, followed by sexual assault two to five years later by stepfather or male relative (5 cases).
Pattern 2:	Emotionally cold and punitive household in which child thought they did not count much, followed by sexual assault one to three years after fifth birthday by a relative or family friend (4 cases).
Pattern 3:	Emotionally cold and punitive household, with frequent quarrelling between parents; eventual departure of one parent contributed further to child's diminished self-esteem; subsequent sexual assault (one to seven years later) by stepfather, father, or male relative (3 cases).
Pattern 5:	Sexual assault by father (for which child was blamed) precipitated marital breakup; child subsequently sexually abused by stepfather or male relative (2 cases).
Pattern 6:	Emotionally cold and punitive household; little communication between parents; child sexually assaulted by a stranger at age 11; felt too ashamed to inform a parent (1 case).
Pattern 7:	Child placed with foster parents at age 5, following removal from home because of physical abuse; sexually abused by foster father over several years (1 case).

Data from a study by Bagley and Ramsay (1986).

Table 6.2 Depression (in 1986–7) by combinations of childhood abuse and loss; stress (1986–7) and social support (in 1983) within 98 subjects reporting childhood sexual abuse

Combination	*N*	*Depressed %*
Physical or emotional abuse or loss; stress; no social support	25	100
Physical or emotional abuse or loss; stress; social support	12	58.3
Physical or emotional abuse or loss; no stress; social support	12	41.7
Physical or emotional abuse or loss; no stress; social support	8	50
No physical or emotional abuse or loss; stress; no social support	10	100
No physical or emotional abuse or loss; stress; social support	11	54.5
No physical or emotional abuse or loss; no stress; social support	12	25
No physical or emotional abuse or loss; no stress; no social support	8	37.5

Note

All subjects reported sexual abuse in childhood, and had self-esteem in 1983 below the median for the survey group. 'Loss' refers to permanent separation from a parent before age 16. 'Stress' refers to external stressors, defined by Ramsay and Bagley (1986); 'social support' indicates at least a moderately close, supportive relationship with spouse or partner, and at least one reasonably close friend or confidant outside the family. 'Depression' indicates a score of 21 or more on Radloff's (1977) scale. Eta, measuring variation of depression scores across categories, 0.429, p. less than 0.001.

APPENDIX

EFFECTS OF CHILD SEXUAL ABUSE

Mrazek and Mrazek (1981:242–3) provide an overview of the effects of child sexual abuse documented in studies to that time. The information from their tables is reproduced below, but the items have been regrouped.

Possible Short-term Effects

Problems in Sexual Adjustment

Preoccupation with sexual matters,
Premature development of adolescent interests,
Despair regarding inability to control sexual urges,
Promiscuity,
Molestation of younger children,
Increased or public masturbation,
Sudden rush into heterosexual activities,
Venereal disease,
Pregnancy,
Prostitution.

Interpersonal Relationships

Bewilderment concerning social relations,
Frightened by contacts with adults,
Running away from home,
Hostile interactions with older women,
Increased affection seeking from adults,
Homicidal ideas and fantasies.

Education Problems

Learning difficulties,
Truancy,
Sudden disruptive behaviour,
Depressed withdrawal from usual activities,
Collapse of self-esteem.

Other Psychological Symptoms

Personal guilt or shame, 'Infantile stage' prolonged or

reverted to,
Tendency to withdraw from activities of normal childhood,
Obesity,
Anxiety states and acute anxiety neuroses,
Somatic symptoms,
Behaviour problems and delinquency,
Suicidal ideation,
Nervous symptoms, fits and epileptic seizures,
Sleep problems including nightmares,
Impulsive self-damaging behaviour,
Depression,
Anorexia,
Bulimia.

Review of Possible Long-term Effects

Problems in Sexual Adjustment

Sexual dysfunction including frigidity,
Promiscuity,
Impulses to brutally sexually assault a child,
Aversion to sexual activity,
Unsatisfactory sexual relationships,
Many unwanted pregnancies,
Prostitution,
Having incestuous relationships,
Sexual molestation of child.

Interpersonal Problems

Conflict with or fear of husband or sex partner,
Conflict with parents or in-laws,
Social isolation and difficulty in establishing close human relationships.

Other Psychological Symptoms

Low self-esteem and long-lasting sense of helplessness,
Somatic symptoms,
Obesity,
Masochism,
Neurosis,
Personality disorder,
Chronic depression,

Non-integrated identity,
Psychosis/schizophrenia,
Suicidal ideation and attempts,
Murder or interpersonal violence,
Eating and body image disorders.

Chapter Seven

HEALING OF THE CHILD SURVIVOR

> Healing, and the belief we can heal ourselves, and the decisions to move toward healing are all radical acts which transform us in and of themselves…because by the process of caring for ourselves, we become more and more ourselves.
>
> Susan Griffin (1979),
> *Rape: the power of consciousness*

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

TREATMENT IMPLICATIONS

Goals of Therapy

Giarretto (1976) identifies the four goals of therapy for child sexual abuse victims as emotional catharsis, confrontation, self-identification, and self-management. Each of these will be briefly explained.

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

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

Self-identification is the process of becoming aware of all components of one's individual personality. This is a necessary condition for the development of an adequate self-concept, for only that which is known, mastered, controlled, and integrated can be valued and esteemed.

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

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

Six considerations for the treatment of child sexual abuse victims are advanced by Dawson (1983). These are: (1) reduction of guilt about participation, reporting, family disruption, and the past experience of pleasure and anger; (2) reduction of fears regarding further abuse, permanent damage, and the legal process; (3) resolution of ambivalent feelings through identifying and understanding the difference between feelings and actions, and accepting this ambivalence as normal; (4) improvement of self-esteem; (5) improvement of assertive skills; and (6) teaching of appropriate sexuality.

Another helpful frame of reference for healing is provided by Faria and Belohlavek (1984) who outline the goals of therapy in

practical terms. These are to help the client: (1) establish commitment for involvement; (2) identify old patterns which interfere with present relationships; (3) grow in self-control; (4) build self-esteem and confidence about survival; (5) encourage constructive expression of anger; (6) identify and gain control over self-destructive and self-defeating behaviour; (7) network with other support systems to develop meaningful relationships; and (8) increase self-esteem through improving body image and understanding human sexual response.

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

Treatment of Male Victims

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

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

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

This qualification must be kept in mind for the duration of this chapter. The word ‘children’ is used to encompass both boys and

girls. However, most of the studies have worked with predominantly female populations, with few attempts made to distinguish differences in trauma or treatment between boys and girls. A notable exception is the approach to therapeutic group work outlined by Forward and Buck (1978).

TREATMENT OF SPECIFIC TRAUMAS

The categories of sexual abuse trauma and treatment have been described in different ways. Courtois and Watts (1982) cluster them as social; psychological; physical; sexual; family relations; self-esteem; relations with men; and relations with women. Lee and Rosenthal (1983) use the more general areas of affective; cognitive; and operational, with the different ways of developing empathy, restructuring cognition and affect, and acquiring new problem-solving skills in each area.

The following section uses slightly different categories (which we have developed in our own work), and will discuss treatment concepts appropriate to each. Relationship healing will be discussed first. It is in relationships that children learn or lose their self-esteem; emotional integration depends on the development of a set of trusting relationships. Only after these are developed is a child free to develop his or her sexual response. Dissociation and self-destructive behaviour will be discussed as separate categories.

Relationship Healing

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

Summit and Kryso (1978) argue that the children abused within their family often experience three levels of betrayal—by their father from whom there is no escape, by their mother from whom there is often a lack of immediate understanding, and by

helping institutions which punish instead of protect. It is important that the therapeutic milieu not betray the child further. Responses to the child must be made as honestly as possible, with no false promises attached.

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

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

Emotional Healing

Porter, Blick, and Sgroi (1982) elaborate many feelings typical of the abused child and suggest treatment responses appropriate to each. We follow this model in the following paragraphs.

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

Guilt is often very diffuse. The child may feel guilty about the abuse itself, guilty about disclosure, and guilty about any resultant family disruptions. It is important to convey to the child that he or she was not responsible for the initiation of the abuse. With older children, it may be important to identify those elements of behaviour for which they were responsible, and separate these from the abusive act. For example, a child who stayed out past curfew or went to a forbidden party will have to accept responsibility for those actions, but not for assault which happened as a result.

Fears are also pervasive. Children need assistance in identifying their fears, and encouragement in expressing feelings about them. Safety mechanisms which can allay these fears need

to be identified and utilized so that the child feels more in control.

Chronic depression, which is sometimes profound, is often associated with post-sexual assault trauma. Careful use of medications for severe episodes of depression can be helpful as a complement to other therapy for adult survivors.

Low self-esteem is often reflected in poor social skills. Children need to be believed and supported as they learn to feel better about themselves. They also need skill training and modelling for healthy and age-appropriate communication and social skills. Sanford, writing about therapy, observes that 'feeling good about yourself is the most important feeling in the world' (1980:13). All children need to believe they are lovable and worthwhile.

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

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

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

The treatment needs of children which need to be addressed by therapists can be summarized as the need to address their traumatic penetration (physical and psychological); the threat to their sense of individual being; the psychological neglect and emotional abuse they have experienced; their sense of exploitation at having been used; and the need to foster the growth adaptation of their survival tactics (Jones 1986).

Sexual Healing

Sexuality is a primary mode of individuation for the human person. All people are socialized to relate to each other as male or

female, quite apart from whatever sexual activities they choose. Freely chosen sexual expression is integrally related to emotional health.

Karen Meiselman (1978) notes the high frequency of sexual problems among child sexual abuse survivors whom she treated for other psychological problems. These included frigidity, promiscuity, confusion about sexual orientation, and sexual masochism.

The drift theory of Vitaliano, James, and Boyer (1981) can help explain this phenomenon. This can be summarized briefly as the movement towards deeper integration of badness. Primary deviance involves acting out behaviour that can be normalized. Secondary deviance, on the other hand, happens when the person's identity becomes organized around the acts of deviance. The labelling process, whereby the child, adolescent, or young adult assumes the negative associations of the behaviour, must be overcome in order to restore a feeling of self-confidence.

Many children who have been sexually abused have difficulty distinguishing sex and affection. They may attempt to sexualize the therapy relationship in an attempt to test their beliefs (Courtois and Watts 1982). Acknowledgement of these feelings, boundary setting, and the establishment of warm but non-sexual relationships with members of the opposite sex are important roles for the clinician at this point.

Dissociation

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

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

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

The essence of treatment is to teach the client to reach and accept the child inside, allow expression of childhood experiences, and provide assurance of present safety. Sometimes prolonged therapy, including hypnotherapy, may be necessary to enable this to happen (Fraser 1987).

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

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

(2) The decision to seek help is surrounded by additional anxiety, since the adult is cautious about acceptance by the therapist, and by a therapeutic group.

(3) Anxiety increases after several sessions as childhood terror begins to surface. These symptoms need to be normalized so that they are not seen as a result of group participation.

(4) The decision to continue weighs present anguish against the disruptions caused by unresolved memories of the assault.

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

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

(7) Breaking down further blocks to adequate recall involves becoming more organized about reconstruction of the memories. The initial recollections are often more emotional than accurate, and a clear, cognitive sequence needs to be established.

(8) Integration of memories with present adult motivation and behaviour is a continual process of recovering the memory, working through it, and coping with it.

(9) Resolution concerns the final stage of giving up the victim label and making free decisions about present life style.

An excellent example of these stages, achieved through a process of self-analysis and individual therapy, is provided by Sylvia Fraser (1987) in her autobiographical account of healing and survival following incest.

Self-destructive Behaviour

Goodwin (1981) warns the practitioner to be alert to the possibility of suicidal behaviour. Attempts were made in over 5 per cent of the survivors she treated. Mothers of sexual abuse victims may also experience suicidal crises when their daughter reveals the abuse (Bagley and Naspini 1987).

Reasons for self-injurious behaviour are advanced by de Young (1982a). She bases her hypotheses on a study of forty-five female victims of paternal incest of whom twenty-six had engaged in self-injurious acts. Reasons include: (1) primitive thinking, such as the girl believing the injury would somehow prevent further abuse; (2) self-punishment due to introjection of hostility or feeling of betrayal by her body; and (3) ego reintegration, whereby the injurious act releases the person from a depersonalized state of dissociation, decreases tension, and restores the ego defences.

Briere and Runtz (1986) studied 195 women seeking help from a community health centre and found that former sexual abuse victims were more than twice as likely to have attempted suicide than non-abused clients. Factors of impaired self-esteem and self-blame; powerlessness including vulnerability to depression; interpersonal dysfunction; and attempts to escape the abuse seemed to be important antecedents of self-destruction in this series. Bagley and Young (1988) suggest that adult survivors bring greatly increased psychological vulnerability into their adult lives (based on greatly diminished self-esteem) and thus become much more vulnerable to current stressors, which in turn lead to increased rates of depression and self-destructive ideas and behaviour.

TREATMENT METHODS

There is a relative paucity of information on specific treatment methods for child and adolescent victims. Much has been written about early identification and the need for innovative community programmes, yet very little is available to the clinician who wants to work directly with victimized children. When sexual abuse happens within a family, traditional family therapy is of limited value, and can sometimes be counterproductive (family treatment is discussed more fully in Chapter 8). The present section seeks to review treatment methods available specifically for children and adolescents.

Individual Work with Children and Adolescents

Basic clinical principles prevail, as with any client. It is important that children and their responses not be stereotyped, on stylized or wrongly interpreted experiences. Rather, they need to be listened to as individuals with unique and highly personal experiences. It is also important for the clinician to maintain a balance between (a) feeling the child is 'special' and so needs to be referred elsewhere; and (b) focusing on the sexual abuse to the neglect of other concerns.

Traditional counselling or therapy is contraindicated for a number of reasons. 'Because of its confidential nature, the (traditional) therapy relationship does not lend itself to a full resolution of the issue of secrecy' (Herman and Hirschman 1977:755). Whatever transpires in sessions is still a secret

between the child and therapist, and not tested in the real world. Beverly James (1987) emphasizes, however, that the child's caregivers (but not an offending parent) be involved as part of the treatment team. This helps to overcome the negative dynamic of something secret happening to the child, and can help the development of healthy relationships.

David Mrazek (1980) suggests that a child psychiatrist can help provide an understanding of the psychological impact of the sexual abuse experience on the child and family. Yet, the approaches he suggests deal as much with the family as the child. These include assessment of the developmental needs of the child, deciding whether factors which allowed the assault situation are still present, and if so, what are the parents' motivation and capacity to change. These evaluations are important in helping plan the child's treatment. It is important, of course, that any offender in the child's family should be removed from the household (as a voluntary act, or by legal compulsion) by this stage.

Any work with children involves play, for it is in play that children combine the concrete and symbolic experience of the world. Therapists must be open to the meanings of symbols used by the child (Naitove 1982).

Art work can also be a wealth of information from children. Drawings, paintings, and sculptures can be used imaginatively in a free-association type of process or subjected to more objective analysis. For example, impulse control and the quality of repression were found to be significant factors that could be measured in drawings (Yates, Beutler, and Crago 1985).

Anatomically correct dolls are another tool which can be used to help children demonstrate what they cannot describe verbally. There is some controversy, however, over whether such dolls could inappropriately stimulate children (James 1987). More work is required to establish normative data based on large samples, in order to compare the reactions of abused and non-abused children to the dolls (White, Strom, Santilli, and Halpin 1986).

Group Work with Children and Adolescents

Work with children in groups has a number of important advantages, in addition to the obvious one of making a scarce therapist available to more clients. First, it provides the peer

normalization that is particularly crucial for older children. Groups allow them to experience a reduction in isolation and to receive direct support and encouragement from each other.

Cognitive restructuring can also be part of the group process. This is based on the premise that beliefs have a significant influence on feelings and actions (Jehu, Klassen, and Gazan 1986). Examples of unhealthy beliefs include dichotomous thinking, over-generalizing, and mislabelling.

Delson and Clark (1981) emphasize the needs of girls to experience their bodies on many levels and suggest movement and body exercises be incorporated into group experiences. Blick and Procter (1982) see the main issues for initial group therapy as ventilation of anger, resocialization, preparation for court, and sexual education.

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

Group work can be particularly appropriate for adolescents, for whom peer communication and support are very important (Zingaro 1987). Forward and Buck (1978) provide useful examples in their handbook for guiding therapists in this field. The encouraging thing about their approach is that it can be used by dedicated people with some background in the helping professions: one does not need to be an M.D. or a Ph.D. psychologist to undertake such therapy.

Finally, it is important to remember that some deeply traumatized adolescents may not be ready to enter group therapy immediately, and need individual counselling to give them sufficient ego strength and reduction of anxiety before they can take full advantage of interaction with other young survivors. But once established, this peer support network can be very powerful, and an essential prerequisite to successful family reintegration (Anderson and Mayes 1982).

Play Therapy with Children

Play therapy is usually individual in nature, since the sexually abused child, more often than other children suffering various kinds of trauma, has difficulties in verbalizing aspects of the trauma (Mann and McDermott 1983). Thus play therapy is particularly appropriate. Such therapy is described in detail by a number of writers (Jernberg 1983; Porter, Blick, and Sgroi 1982; Schaefer and O'Connor 1983), and its proponents claim it is the treatment of choice for victims of sexual abuse, aged less than 7 (James and Nasjleti 1983; Waterman 1986). Art work is another method of utilizing an abused child's natural activities for a therapeutic purpose (Yates, Beutler, and Crago 1985; Naitove 1982).

Adults Molested as Children

The growing demand for treatment by adults who were molested as children confirms the sad reality that the needs of many children were not met at the time of their abuse (Daugherty 1984). It is not the intention of this chapter to explore in detail the treatments available for adult survivors. However, this is a significant population which warrants attention and innovative techniques of therapy.

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

Specific techniques for group work include structured interviews, writing exercises, journal keeping, guided imagery, and 'divorce', involving a symbolic representation of the perpetrator (Courtois and Watts 1982; Faria and Belohlavek 1984).

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

Another important option for survivors is the development of self-help groups (Halliday 1985). Such groups can enhance feelings of safety, and encourage the use of personal power.

Disclosure within the group will often parallel how the person as a child handled the initial assault. For example, adult survivors will often experience fear of how others will react, and may be able to minimize their own pain in anticipation. All groups go through stages of an initial sense of belonging, power, and control over feelings, fear of consequences of change, grief over loss of what was and what could have been, and finally, the transition to continued intimacy.

THERAPIES: AN OVERVIEW

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

Psychoanalysis

It is, of course, most unfair to attempt to describe or criticize psychoanalysis in a few paragraphs. It has been referred to as a method of psychotherapy as well as a theory of personality (Hall 1979). Sigmund Freud is considered the father of psychoanalysis with his theories of the dynamic forces that make up the human personality. Freud was one of the first theorists to explore the unconscious depths of the mind, and to explain the development of personality through the complex interactions of unconscious forces and the demands of social morality. Through these complex, dynamic interactions, the ego, the ongoing, acting, integrating core of the self, attempts to master the darker forces, conflicts and drives of the unconscious, and to hold these powerful but often atavistic drives in leash, while satisfying the demands of higher morality. This is not an easy task, and human beings often achieve ego-integration in various forms of 'fixated identity', including the denigration of others, and sometimes the denigration of the self (Bagley, Verma, Mallick, and Young 1979).

Psychoanalytical theory tends to deal with unresolved intrapsychic conflicts, and has been used (to the outrage of many modern therapists) to suggest that the sexually abused child and her mother may actually allow or even encourage the sexual

relationship with an adult because of their own unresolved Oedipal wishes:

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

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

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

The lack of culpability of the adult male in this 'family romance' is implicit, and sometimes explicit in such writing. Studies such as the one cited, allege that the mothers in such families withdrew sexually from their husbands, and often put the daughter in such a position where sexual contact with her father seemed inevitable. An example given is of a woman who worked a night shift, which was interpreted as an unconscious permission for a man to sexually abuse his daughter!

The right of the woman to her own sexual identity was a non-issue for these earlier writers. A later critic noted that none of the studies addressed the issue of why women might want to avoid sexual activity with their husbands (Lindemann 1983).

On the other hand, it is possible that family members may develop sexual feeling or affection for each other because of the

intensity of their interactions. Pincus and Dare explain this through a Freudian model:

> It is…inevitable that incestuous fantasies are part of the secret life of every family. For children to develop into healthy, loving, and sexual adults, these fantasies are necessary, but their overt expression has to be controlled by the parents.
>
> (Pincus and Dare 1978:82)

> In infancy and early childhood, close physical bonds of love with parents are vitally important, but we need to recognize that the child's healthy development involves growing free of these bonds. If the difficulty in attaining this freedom, both for the children and for the parents, can be acknowledged, then their secret longings can be more clearly understood, and the acting out of incestuous fantasies stemming from the infant's earliest feelings is much less likely to occur.
>
> (Pincus and Dare 1978:88)

The points above are well taken. However, it has been amply demonstrated that the acting out is never on the initiative of the child, since children possess neither the structural power nor the independent volition to do so. The trauma of child sexual abuse is, in Freudian terms, that the child experiences stimulation for which he or she is developmentally unprepared, and which may flood the consciousness with feelings of sexual and emotional confusion, which bring in their wake a profound neurosis (Freud 1981). The disastrous psychological consequences of allowing incestuous fantasies to become reality are amply demonstrated in the elaborated case histories presented by Wilhelm Stekel (1926).

There are, of course, several systems of psychotherapy which derive from the original insights and intuitions of Freud: the names of Adler, Jung, Fromm, and Erikson all spring to mind. All of these writers, although owing an intellectual debt to Freud, have abandoned Freud's pan-sexualism—the idea that sexual motivations underlie every human action—and have replaced such ideas with notions of a psyche which develops and changes in a more dynamic interaction with the contemporary world. Alfred Adler has taken this idea furthest in arguing that the fundamental motivation of human beings is to achieve power and

mastery in their social world, and to be esteemed in the exercise of that mastery (Becker 1971).

Adler's analysis of human motivation is helpful in understanding why men have for long exercised arbitrary and self-indulgent power (including sexual power) over women and children. This approach also gives us clues to an important need in victims—to recover a sense of personal esteem, power, and control over the events of their lives. Modern psychoanalytic researchers (Kohut 1977; Firestone 1987), stemming from a greatly modified Freudian position, also put great stress on restoring self-esteem, damaged by distorted family interactions. We have attempted to utilize the insights and methods of Hans Kohut and Robert Firestone in group therapy with adult survivors of child sexual abuse (Bagley and Young 1988).

Although Freudian psychoanalysis, and its naive adoption by the 'helping professions' of social work and psychiatry, has undoubtedly impaired the proper recognition and treatment of sexual abuse victims, one important idea of Freud is clearly of relevance in understanding and treating the aftermath of such abuse. Freud's understanding and insights concerning the unconscious aspects of the mind seem to us to be vitally important in understanding why some sexual abuse victims are able to repress memories of abuse and push them into an 'unconscious' part of the mind, which nevertheless disturbs and torments the victim with disturbed dreams and nightmares, sudden flashbacks, anxiety and panic attacks, chronic fears and obsessions, and unexplained bouts of depression. Conventional therapy such as behaviour modification or psychotropic drugs are unlikely to be anything but temporary ameliorants of these conditions. But, as Pincus and Dare (1978) have shown, quite brief psychotherapy focusing on the potentiality of unconscious motivations can be dramatically successful in helping individuals to both understand and heal their often distorted relationships with other people, including family members.

In conclusion, although the traditional psychoanalytic approach has rightly been criticized (e.g., by Rush 1980) for the unjust blaming of both mothers and victims, nevertheless it has led to some important and significant developments, particularly in the work of those who have modified Freudian theory. These developments have indeed added to our therapeutic understanding of child sexual abuse.

Family Systems Therapy

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

Family systems therapy assumes participation of all members of the family in child sexual abuse, and so looks for motivation and sometimes for responsibility in each. The focus is on family dynamics rather than sexual behaviours, with the intent to distribute responsibility and to place guilt in perspective (Machotka, Pittman, and Flomenhaft 1967). Another author in this tradition suggests that the father is often unjustly given 'the label of tyrant' to explain away involvement of other members (Walters 1975). This alerts us to the fact that the family systems approach often embodies some of the worst faults of the older school of psychoanalysis in seeing the adult male aggressor as only partially, or sometimes not at all, at fault; sometimes family systems theory attributes a major share of responsibility to mother and daughter in collusion (Larson and Maddock 1985).

Jorne (1979), typical of many family system theorists, suggests that the 'symptom' of incest (sexual abuse within the family) be treated as any other stress problem. The danger in such an approach is that it often profoundly underestimates the negative impact of such abuse on the child. Sometimes family therapists will decline to separate the victim and the offender. Instead, both have to face one another in the 'blameless' encounter of a family therapy group. The danger of such an approach, in our judgement and experience, is that it fails to address the profound harm and injustice which can be done to the child victim. If victim or perpetrator are not separated from the domestic situation, re-abuse can, and does occur. For many family therapists the major problem is not the abuse *per se,* which is simply a symptom of the main problem—disordered interaction and emotional patterns within the family.

Within the modality of family therapy, team interventions are said to be useful in changing the balance of power in a so-called

'abusive family' (Bander, Fein, and Bishop 1982). This assumes that the person doing the abusing has too much power, which may well be true, but also presumes the responsibility and ability of other family members to hold the abuse in check. While this may be a useful intervention, it is misplaced if it holds all family members liable.

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

Humanist Therapy

Humanist theory has already been introduced in Chapter 3. Humanism is fundamentally concerned with the value of life and what it means to be human. Humanistic psychology developed in reaction to psychoanalysis and behaviourism, seeking a more holistic understanding of personality and social adjustment. Each person is seen as striving for growth and development, having responsibility for their own actions, attempting to master stresses which threaten their strivings towards growth and development.

An optimistic view is maintained by humanist theory, namely that persons are in essence free and autonomous and will, given reasonable conditions of choice, prefer altruistic solutions to human problems. Feeling good about oneself is essentially the same as feeling good about the welfare of others. A good self-concept is an essential prerequisite to accepting and helping others (Bagley *et al* 1979). Hank Giarretto, leading pioneer of the humanistic model for treating sexually abused children and their families, has written:

> The self is a unique entity which is more than the changing functions of mind, body, and spirit. A strong sense of self-identity must be internalized by an individual before [they] can experience self-esteem.
>
> (Giarretto 1976:154)

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

Two major criticisms of the humanist approach are that it cannot operate without a humanistic society, which does not exist except at a very local level (Anderson and Mayes 1982); and that it is too occupied with self-awareness and self-actualization while ignoring major structural issues of social inequality (Butler 1986).

The focus on personal development, while valuable from an individual point of view, does not address the right of society for protection from certain offenders. Nor does it question the structure of society or provide an orientation to prevention. The political reality of the social forces which shape our lives needs to be recognized so that social changes can be integrated with personal changes. This presents a challenge to those committed to humanistic development, and in our judgement the model can best be used in collaboration with an ecological model such as that for social work practice developed by Germain and Gitterman (1981). This model sees the client in humanistic terms, but as crucially modifying and modified by significant individuals and institutions in the broader social environment. The humanistic model has been adapted, with some success, to suit the local conditions which prevail in a Canadian city (Anderson and Mayes 1982), and it may be that each community needs to adapt the humanistic model (developed by Giarretto in San Jose, California) to local conditions.

Feminist Therapy

Feminist theory has also been introduced in a previous chapter. 'A feminist approach to the process of sexual assault resolution combines therapeutic intervention skills with the underlying knowledge that sexual assault, harassment, and exploitation affect all women in our society and are extensions of sexism' (Yassen and Glass 1984:253).

The feminist analysis encompasses all existing theories and examines them in the context of gender relations (Herman

1981b). Patriarchy and male socialization are seen not only as the prime cause of child sexual abuse, but also as causes of the oppression of women in general:

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

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

Recovery of mental health in abuse victims includes the component of consciousness raising. The intent is to move from private healing to public impact, and the goal is to increase public awareness so that women's and children's rights to safety and freedom from assault are seen as the responsibility of the entire community (Herman 1981b).

A major criticism of feminist theory and therapy is that it fails to clarify at what point the victimized male child becomes the adult male offender. Men are not given the same opportunity as women in this model, of responding to change in the forces of socialization. Boys too are sexually victimized by adult males, an issue which the feminist approach largely ignores.

Another challenge for feminism is to overcome that degree of mother-daughter estrangement that occurs when there has been abuse within the family (Herman and Hirschman 1977). While daughters may learn to understand the forces that victimized both them and their mothers, there is still too often an anger and resentment rather than a reaching out in mutual compassion, and an establishment of unity of suffering and unity of purpose. It is interesting to note that the modified humanistic model developed by Carolyn Anderson and Peggy Mayes (1982) incorporates many of the most positive aspects of feminist theory, including the reconciliation and mutual support of mothers and daughters.

Feminist therapy has been particularly successful, in our experience, in offering group treatment for adult survivors. Many survivors have been through a variety of conventional treatment systems, none of which have addressed their needs adequately nor offered any therapeutic resolution. Meiselman (in writing about the treatment of adult survivors) is quite emphatic that a value statement is one of the underlying principles for group therapy:

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

Forseth and Brown (1981) in another important statement of universal principle within a feminist framework, stress the need for clinicians to become skilled through diverse modalities, including individual, group, marital, and family therapy methods, all used with a focus on the needs of the abuse victim, but with a parallel, humanistic concern for others involved. In addition, therapists in this area must have a skilled understanding of the issues outlined earlier in this chapter on specific goals of therapy in relation to the particular needs of sexually abused children, and the need to address and treat the specific trauma imposed on child victims and adult survivors.

CONCLUSIONS

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

Healing is the process of learning to enjoy living with oneself in the world. 'Effective coping with victimization requires not only coming to terms with a world in which bad experiences happen to oneself, but also restoring a damaged self-image'

(Russell 1986:166). Transformation is a process of becoming conscious of and accepting inner strengths (Leonard 1982).

The goals of therapy are to help survivors express acceptance of a full range of emotional responses, put the abusive experience into a historical and emotional perspective, and empower the former victims to rebuild their own self-esteem and confidence. 'Once the experience is given language—language to name it as an assault and to hold the perpetrator responsible—the first irrevocable steps towards healing have begun' (Butler 1985:209).

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

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

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

Finally, a review of four major therapeutic approaches illustrates how different orientations treat the phenomenon of child sexual abuse. Psychoanalysis contributes an understanding of intrapsychic dynamics, but in its Freudian version has often overlooked the very real helplessness of the child. Family systems theory explains how persons interact with each other within a complex and sometimes pathological system, but this approach risks further victimization of the child by assigning mutual responsibility to all family members. Humanist theory

looks at the growth potential of all persons, including both victim and offender, but often overlooks the social realities of inequality which perpetuate victimization. Feminist theory incorporates clinical intervention with political advocacy to increase the power of women and children in society. A criticism is that it ignores some important aspects of the therapeutic situation, including the needs of male victims.

Despite problems in a number of approaches to healing, it is clear that without intervention, many of those who are wounded remain helpless or turn to aggression, or self-destruction. Healing involves reconciling the helplessness and vulnerability of childhood with choosing a path of survival and personal control in adult life.

The next chapter will look at the impact of child sexual abuse on all family members, with suggested treatment responses.

Chapter Eight

HEALING THE FAMILY

> To assign to each family member a role in causing the incestuous assault is to imply that whatever happens to women and children in our homes can be traced back to something that is our fault. The promise held out to us… is that once we figure out as mothers and children what we have done wrong, our victimization will stop.
>
> Sandra Butler (1985),
> *Conspiracy of silence: the trauma of incest*

SEXUAL ABUSE OF DAUGHTERS BY FATHERS

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

The statistics outlined in Chapter 4 suggest that biological fathers make up only some 2 per cent of all offenders. The following sections must be read with that qualification in mind. Although there may well be overlaps between the dynamics of abuse within families and outside of families, this cannot be assumed. Sometimes the role of stepfathers is, in dynamic and

structural terms, similar to that of biological fathers, but again, this may not always be the case.

Early Theories

Maisch (1973) argued that incest was not the cause but a symptom of family disruption. He felt the discovery and punishment of the offence was more dangerous than the activity itself in that more stress was added to an already disturbed family. This thesis was originally held by Bagley (1969), but was abandoned in the light of data from a longitudinal study, which showed that sexual abuse was often very harmful to long-term psychological development, independently of intervention by authorities (Bagley and MacDonald 1984).

Browning and Boatman (1977) reported an excessively high degree of alcoholism in sexually abusive fathers, with a corresponding degree of depression in mothers. They suggested that the fathers' tendency to violent behaviour contributed to their wives' passivity. Justice and Justice (1979) identified the correlates of incest as role confusion in the family, poor parenting skills, and social isolation. They also reported that parents in families in which paternal incest occurred had higher stress levels than non-abusive families.

Sexual abuse of a daughter by her father can be both a response to family stress and the cause of more stress to all concerned. This has been well summarized in the findings of Meiselman (1978), whose position is that, in an absolute sense, the effects of incest cannot be separated from family pathology. A similar interpretation is offered by Cohen:

> The dynamics of the classic incestuous family indicate that all family members are emotionally deprived, that the sexually taboo relationship is a manifestation of the basic need for warmth and nurturance, and provides a defence against possible family breakup.
>
> (Cohen 1983:161)

Incest has also been described as a collective pathology of the family (Jorne 1979), a developmental failure (Gaddini 1983), and the father's narcissistic reaction to his own fears of abandonment (Hirsch 1986). In these models the child, and usually the mother,

are innocent in instigating the abuse, but have to share in the pathological misery which the father imposes on his family.

Herman and Hirschman (1977, 1981) developed the theory that incestuous behaviour springs from the socialization of men to be served, and of women to serve them. The result is that many fathers are unable to assume a nurturing role when mothers are not available:

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

The view that the sexual exploitation of his children by a biological father is based on traditional patriarchy and male dominance is clearly different from the view that fathers who perpetrate incest are motivated by personal inadequacy, personality disorder, and psychological illness. But the two theories maybe compatible. Chesnais (1981) and Rush (1980) have argued from historical data that fathers in patriarchal societies (including North America and Northern Europe until quite recently) have treated children as property, and often abused them sexually prior to the onset of puberty. Once a girl entered her fertile years, however, the strict taboos against incest became operative. Child sexual abuse which begins and ends before a child's menarche is rarely, in a legal or sociological sense, incest.

Only weak or pathological fathers would continue such abuse past a child's puberty, formally committing the crime of incest. Today, weak or inadequate males may exert authority only against the very weak and defenceless—their children. In any case, 'normative', well-controlled, and well-concealed child sexual abuse may well not have come to the notice of the authorities—only the most obviously pathological fathers may

have been discovered—so clinical studies (e.g., Maisch 1973) have probably been used on highly biased samples.

Special Concerns of Step-families

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

> Any kind of exploitive sexual contact or attempted contact that occurred between relatives, no matter how distant the relationship, before the victim turned eighteen years old. Experiences involving sexual contact with a relative that were wanted and with a peer were regarded as nonexploitive and hence nonabusive.
>
> (Russell 1986:41)

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

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

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

First, what predisposes a person to want to sexually abuse a child? Second, what undermines his or her internal inhibitions against acting out this desire? Third, what undermines the social inhibitions against sexually abusing a child? And fourth, what undermines the child's ability to avoid or resist such sexual abuse? Since this fourth question suggests that the child can avoid or resist the sexual abuse if his or her capacity is not

undermined, it will be rephrased as follows: What increases the child's vulnerability to sexual abuse? (Russell 1986:256).

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

The second question, regarding internal inhibitions, is answered three ways. Stepfathers may not feel as bound by the incest taboo because there is no blood relationship to their daughters; the bonding between the two may also be weaker if the stepfather did not share the daughter's early years; and there may be a smaller age disparity between stepfathers and daughters.

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

Russell offers several suggestions on the question concerning the vulnerability of step-daughters. The incest taboo may be weaker from the daughter's perspective, who may not feel the same sense of betrayal if approached by a stepfather. A stepdaughter may also be more vulnerable because of separation from her biological father, previous victimization, and family dynamics in which the daughter is competing (or is forced to compete) with her mother for the stepfather's attentions.

The dynamics identified by Russell (1986) are compatible with results from an earlier study of Giles-Sims and Finkelhor (1984) who, in officially reported cases, found that stepfathers constituted a third of all fathers who were perpetrators of child physical abuse. Some of the theories offered to explain these findings also apply to child sexual abuse. For example, stress is often an antecedent of abuse, and step-families experience the added stress of two family systems coming together. As well, people with problems in impulse control, alcoholism, and self-esteem are more likely to have difficulties in marriage and, therefore, more apt to be in a position to marry again. It is also possible that some 'fixated' paedophiles (as defined by Groth

1978b) may actually seek out and marry women with children, simply to get sexual access to these children.

FAMILY RECONSTRUCTION MODEL

Family reconstruction is one possible response by social service agencies to child sexual abuse within the family. On the face of things, effective reconstitution of the family could be cost effective both socially and financially, with the costs of support treatment offset by the costs of foster care for the child, incarceration for the offenders, and financial assistance for the mother if she is not able to support her family (Tyler and Brassard 1984). However, great care must be exercised in such programmes to ensure both that abuse does not recur, and that the victim is fully healed.

Meiselman (1978) offers several reasons why incestuous families do not fare well with the traditional type of family therapy: the offender is often uncooperative, sexual problems that exist between the parents are not appropriate for discussion involving the children, the victimized child experiences increased guilt as a result of the sharing of responsibility, and different crisis interventions are required for the different family members. These problems are overcome by a reconstructive model in which the members are dealt with individually first, and marital issues are handled by the parents alone. The family is brought together in therapy, and later as a family unit only if both parents are prepared to assume responsibility and show appropriate support to their child, and of course, if the mother as the non-offending parent wants this, and child victims clearly want this too. Not surprisingly, however, the discovery of child sexual abuse within the family is a crisis which often precipitates divorce between parents. According to a number of clinical studies, at least a half of families in which abuse is discovered experience divorce of the parents within two years of that crisis.

Philosophy of Treatment

The programme pioneered by Henry Giarretto for the treatment of incestuous families was based on the growth model of humanistic psychology and conjoint family therapy developed by Virginia Satir (1967). It was clear that conjoint family therapy was usually inadequate in cases of child abuse, and certainly could not be

applied during early stages of crisis. The family was frequently so tragmented following disclosure, that each person needed individual support before they could even decide what they wanted to do in terms of family structure (Giarretto 1976).

The methodology of reconstruction includes counselling at the progressive levels of all of the individuals involved; and then counselling in pairs: mother-daughter, marital (if the parents have the potential to stay together), and father-daughter; and then the family itself (Giarretto 1976, 1981, 1982). After individuals have been stabilized by individual counselling (which can take several months), dyadic counselling can begin. At this stage, too, individuals can join guided self-help groups with peers—victim groups, mothers groups, fathers groups (Anderson and Mayes 1982). This treatment model is described in detail in the Appendix to this chapter.

Empowering the non-offending spouse is the foundation of reconstruction work. This corresponds with Sandra Butler's (1985) warning that the increasing focus on reunifying families after a sexual assault could, if not undertaken within a feminist framework, further trap the mother and children into yet another closed system with the offender. Care must be taken to strengthen both women and children within the family. The possibility that the mother herself is a past victim must also be considered.

Other workers have developed therapeutic principles for the treatment of father-daughter abuse which fit within the Giarretto model. Herman, (1981a) for example, outlines three essential objectives in treatment of families in which a child has been sexually victimized by an adult member. These are: (1) to restrict and control the power of the father; (2) to reinforce and foster the power of the mother; and (3) to restore the mother-daughter relationship.

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

Kathleen Faller (1981) presents a four-part model for dealing with families in which incest has occurred. Determining factors for treatment and prognosis include whether the mother was

collusive or independent, and whether the father was mentally ill. It is important in Faller's model of treatment that the therapist should not end up in a power struggle with the father for control of the family. This can be averted by individual alliances with the mother and with the victim that are established before the family is brought together.

It must also be emphasized that the professional components of a successful child sexual abuse treatment programme include all the officially responsible members of the community—police, social workers, mental health workers, physicians, probation officers, defence and prosecuting counsel, judges, and rehabilitation officers (Giarretto 1982). Co-operation of the offender cannot be assumed without at least the real possibility of criminal prosecution (Hoorwitz 1982).

The integrated programme can be summarized as encompassing four stages (Hoorwitz 1983). The first is to clarify professional roles to ensure protection of the child. This may include such seemingly extreme measures as foster placement, impending prosecution or court orders outlining or forbidding access by an alleged abuser, and supervision of family visits. The second stage is to attend to the individual needs of all the family members. The third is to strengthen the mother-daughter relationship, and the marital bond if the couple so chooses. Bringing the father together with his daughter and the whole family is reserved for the fourth stage, at which time such dynamics as role boundaries, communication, sex education, external resources, and self-esteem are also addressed.

Another essential component of the original humanistic treatment model is the formation of self-help groups, which have become known as Parents United, and Daughters and Sons United (Giarretto 1976). As well as providing self-help and support, these organizations give group members an opportunity to be a strong voice in the community, advocating change in co-ordination of services, and improvements in quality of service.

Contraindications to Family Reconstruction

The paradox is noted by Armstrong (1983) that substantial attempts are often made to keep abusive and incestuous families together, when divorce is generally accepted as part of normal life, and would be a more realistic option for such families. This is one of the basic dilemmas confronting professionals offering

treatment for the non-offending partner of an abusive parent. 'Domestic violence is unique among criminal behaviour in that the victim is not only likely to feel love for the offender but also is often aware of the offender's personal torment and suffering' (Taubman 1986).

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

The reconstruction model does not apply to intrafamilial offenders who are not part of the nuclear family, such as grandfathers or uncles (Goodwin, Cormier, and Owen 1983). Treatment of men who are not suitable for family reconstruction work, and those who abuse outside of their family, will be discussed in Chapter 9.

TREATMENT NEEDS OF MOTHERS

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

Mothers have not received support in the early literature. Louise Armstrong, in reflecting on this situation, expresses her sympathy for the mother's confusion:

> An open declaration of expectations must be made to women. What will gain a mother praise and support from society and the law, should her husband prove to be unsocialized or unsocializable; should he abuse her or abuse their children? What do we expect? That she leave? That she stay? That she go into therapy? That she kill him? (If the law will not help her, if she is outside its borders—is it

> legitimate to condemn her for what she does to help herself or her children?)
>
> (Armstrong 1983:202)

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

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

The complexity of this dilemma is clarified by understanding that people often tend to marry spouses with different but often complementary needs and problems (Satir 1967; Pincus and Dare 1978). Both spouses may project concerns to distract themselves from their own pain: at the same time both need to prevent abandonment by the other partner, and settle into an uneasy equilibrium, waiting for the other to change (Taylor 1984). Because the mother is often a victim of wife abuse, or of previous sexual abuse, the continuation of her learned victimized behaviour is an important consideration in understanding her inability to protect her own children (Truesdell, McNeil, and Deschner 1986). For example, a woman who feels helpless and unworthy is inclined to marry a man who also has damaged self-esteem (Satir 1967). Her sense of helplessness is increased by his abusive acts, while his acting out may be aggravated by her continuing passivity.

We undertook a study of thirty-eight mothers in families referred for counselling following the revelation of the sexual abuse of a child by his father or stepfather (Bagley and Naspini 1987). First of all we found, without exception, that the revelation was a deeply traumatic event in the lives of these women, and was reflected in various kinds of mental health crisis including severe depression, acts of deliberate self-harm, and acute anxiety attacks. It was crucial in therapy to offer mothers maximum support, both to restore some level of mental health, and to enable them to offer support to their children—and especially to the abuse victim.

We could find little evidence, from the personal accounts of these women, of withdrawal from the usual roles of marriage: they simply soldiered on, serving their husbands sexually and in various nurturing ways, in the typical manner of subordinated women. Five of the thirty-eight knew about the sexual abuse of the daughter, but were powerless in various ways to prevent it. Another twelve mothers had picked up ambiguous clues and messages. These messages included pleas by their daughters not to be left alone with their father—something the mothers interpreted as normal signs of adolescent rebellion. Often the seemingly inexplicable disturbed and acting out behaviour of the child-victim was attributed to some innate tendency to badness. Mothers were shocked and grief-ridden when they understood why the child had been so angry. One of the salutary lessons of child sexual abuse which this study reinforced is that child victims can be coerced, deceived, and threatened into accepting sexual abuse by a family member, and will not betray this secret, however terrible—or rather because the secret is so terrible.

In the Calgary study (in which over half of the mothers were treated by the agency whose practice is outlined in the Appendix to this chapter), we found that the mothers were not a typical segment of the population. First of all, their average age at marriage was much lower than that in control subjects, drawn from a community mental health sample (Bagley and Ramsay 1986). The majority of mothers of abuse victims were married by their eighteenth birthday—three had married at 14, and eight married at age 15 or 16. Often these early marriages were attempts to escape from homes riven by discord and abuse. It is also possible that their husbands (on an average ten years older) were men with a sexual interest in young girls which they transferred, in time, to their daughters.

We found that just over half of the mothers of abuse victims had experienced serious sexual abuse within their family, compared with 18 per cent of controls in comparable periods of family life. The questions must be asked: Why didn't these mothers suspect the possibility of the sexual abuse of their daughters, when many had experienced such abuse in their own childhood? The extended accounts of the mothers suggest an attempt to escape their abusing homes by entering idealistically into new relationships which they assumed must inevitably be better.

A combination of naive optimism and continued powerlessness and subordination to male dominance had resulted in an emotional and cognitive framework which made it very difficult for them to understand what might be going on. The revelation of the abuse caused their fragile world to collapse. In many ways the therapy of the sexually abused child involves a double task: supporting both mother and daughter, first individually, and then in dyadic therapy.

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

Treatment needs of the mother in therapy are often similar to those of the child (Sgroi and Dana 1982; Myer 1985). Impaired self-image can be repaired through teaching women to recognize and respond to their own nurturance needs. Denial can be confronted as they learn to ventilate conflicting motivations and loyalties. Focus on universalizations can help shape reasonable expectations of their husbands and children. Practice in limit-setting is required to overcome failures in establishing and enforcing limits. Anger needs to be recognized and validated, with appropriate outlets found. Impaired communication can be improved through role-playing.

Hospitalization is also recognized as necessary for some extremely distressed women who are not able to deal with victimization of their children (De Jong 1986).

TREATMENT NEEDS OF SIBLINGS

The primary consideration for siblings is the possibility that other children in the family have also been abused or are at risk of future victimization. Assessment of this possibility is a necessary part of any investigation following disclosure of child sexual abuse.

Reactions of Non-victimized Siblings

Attention must be given to the needs of children within the family who may not have been sexually victimized, but who suffered the consequences of disordered family dynamics before and after revelation. An example is the resentment of a young boy who was physically abused, but was not receiving the same sympathetic attention as his sister who was 'only' touched sexually (James 1987).

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

The results for other siblings can be numerous. Rivalry and jealousy may result from all children in the family craving love and attention, and not realizing the price of special favours. Collusion may result when other children are socialized to be the next victim; or they may experience a combination of guilt and gratitude that they were not chosen. A climate of premature sexual stimulation within the family may result in the children being more susceptible to victimization by older persons outside the immediate family.

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

> The incestuous family…is a closed and generally pathological system, constantly draining more and more energy from the individuals who comprise the family and offering little that is positive in return. At the same time the

> individual family member's dependence on this pathological system is enormous and the difficulty in extricating himself or herself and maintaining a healthy independent existence is equally great. These families and their members develop few skills for coping with the outside world that are effective or adequate to meet the complex demands of daily living.
>
> (Sgroi, Blick, and Porter 1982:32)

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

Sexual Abuse among Siblings

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

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

A further study by Sorrenti-Little, Bagley, and Robertson (1984) found that three aspects of sexual activity among peers affected adult self-concept. The greater the age difference, the more 'advanced' the contacts, and the more threats and force that were used, the worse was the prognosis in terms of self-concept.

While mutual exploration among siblings close in age may be considered natural or developmentally appropriate, this is certainly different from sadistic or exploitative sexual activities forced on a young child by a much older sibling.

Russell's (1986) study sheds more light on sibling sexual activity. Two per cent of her sample of women reported at least one abusive experience with a brother before age 18. It is important to remember that wanted or neutral experiences were excluded by definition from this study. The average age of the brothers was 17.8 years, compared with the sisters' 10.7 years. This is an age disparity of more than seven years, quite above the five-year period used by most researchers to differentiate peer from abusive experiences (Finkelhor 1984a). Russell adds:

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

CONCLUSIONS

This chapter has examined issues of treatment for the families of sexually abused children.

The first consideration was abuse within the family, of daughters by biological fathers. This form of abuse has been in the forefront of sexual abuse awareness and the development of treatment programmes. It is important to remember, however, that this represents only about 2 per cent of all child sexual abuse. Professional understanding and response must not be restricted by assuming that father-daughter assault is the main or most serious type of abuse.

Within the area of abuse by fathers, special concerns over step-families are noted. Women with a stepfather carry at least a one in seven (14 per cent) risk of abuse by the stepfather; but the risk in relation to biological fathers is about 2 per cent. The greatly elevated risk of abuse by stepfathers is related to many factors, including the active seeking out of women with children by such men, a weaker taboo and less bonding to the child, smaller age discrepancy, and the complex dynamics between mothers and daughters within a step-family.

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

The role of mothers has been stigmatized, in that they are often unjustly blamed for allowing the abuse of their children. The primary treatment issues are their own previous victimization, chronic powerlessness, and the mental health crises evoked by revelation. Other treatment needs are much the same as those previously discussed for the child. These include such problems as impaired ability to trust, damaged self-esteem, denial, anger, lack of assertiveness and social resources, and poor social skills.

There are two major treatment issues for siblings over and above their own risk for victimization. The family dynamics which fostered the sexual victimization of one child can have damaging effects on the adjustment of other siblings, even if they were not abused themselves. Another major concern is the continuation of learned sexually abusive behaviour among siblings. Mutual exploration among children close in age is frequent, and is not developmentally inappropriate: however, there is also a range of more coercive activities by older children forced upon young siblings which must be considered abusive.

In summary, the treatment of child sexual abuse includes being able to respond to a variety of needs in parents and siblings. A more general overview of offenders and treatment considerations will follow in Chapter 9.

APPENDIX TREATING FAMILY SEXUAL ABUSE WITH A HUMANISTIC MODEL

Adapted from C.Anderson and P.Mayes (1982) with permission of the authors, and editors of the *Journal of Child Care*.

Family Treatment Plan

The focus of this treatment programme is not only on the child but in the context of her entire family. Effective treatment of the child is extremely difficult if it cannot be done in conjunction with the other family members. Although we use the family as a backdrop for the overall treatment approach, we begin the therapy process by conducting individual treatment of the family members. Intra-family sexual abuse is a devastating problem for a family to face. By the time family pathology reaches the extent wherein sexual abuse would occur and be disclosed, the family is too severely fragmented to benefit from conjoint family therapy.

The goal of individual treatment is to develop sufficient self-awareness on the part of each family member in order that each may recognize their individual potential. Each person must see themselves as an individual with the accompanying rights and responsibilities to make decisions for themselves. This is accomplished in the context of a strong therapeutic relationship.

The Victim

In our treatment of the victim we emphasize certain key themes as follows:

(1) Validation of the child's experience and resulting feelings. It is important that we convey the message to the child that we do believe what she is saying regarding the sexual abuse. We explain to the child that other children have had similar experiences and that they are not weird or different because of it. Typically, these children believe that they are the only ones that this has ever happened to. The children are terribly confused because they feel hatred and love towards the same person. These feelings need to be normalized by the therapist

(2) Alleviation of guilt feelings. The feeling of responsibility and accompanying guilt are characteristic of these children. Inevitably, they hold themselves responsible for the occurrence of the sexual abuse. Their guilt is intensified upon the disclosure of the activity and the ensuing family disruption.

(3) Exploration of the child's feelings towards individual family members. The child typically has mixed feelings towards her mother and siblings whom she may believe to have known about the sexual abuse. Regardless of whether or not the mother was aware of the sexual abuse, the child usually believes that her mother should have been able to protect her.

(4) Exploration of the child's perception of feelings of other family members towards her. Often the child believes that other family members do not love her any more, and/or are angry about the disclosure of the sexual abuse.

Although our goal remains to increase self-awareness and self-esteem of each individual, before they can even begin to concentrate on this, it is necessary to deal with the current fears and feelings.

The Mother

Traditionally, the mother has been the most forgotten one in the treatment process, when in reality she holds the key role. From the outset, the mother is encouraged to support her children and have the father leave home. This is done while providing her with the assurance that family reconstruction is a future possibility. The main issues that we cover in individual counselling with the mothers include:

(1) Providing a clear outline of the treatment process and approximate time line.

(2) Allowing for the ventilation and validation of feelings. Normalization of ambivalent feelings the mother may feel towards both her husband and her daughter. The mother is placed in the unfortunate position of having to support one of the people she loves while at the same time withdrawing that support from another. She typically vacillates back and forth and requires encouragement to realize that only through the initial support of her daughter can she hope to regain any semblance of a happy family life.

(3) Alleviation of guilt feelings. If the mother has been unaware of the sexual abuse, she is typically very remorseful and self-blaming. She begins to recall what she now sees as clues her daughter may have presented to her over the years, and wonders how she could have been so blind.

(4) Reassurance that the child will not necessarily be irreparably scarred for life as a result of this experience.

(5) Reinforcement of the adult male's responsibility for the occurrence of the sexual abuse.

(6) Exploration of the mother's own childhood experience. It is important to take a social history from the mother. In so doing, it may be found that as a child she was herself sexually or emotionally abused. This has implications for her present situation, in that frequently it helps her to gain some awareness and understanding of her present feelings and behaviour patterns, both towards her daughter and in her marriage.

(7) Provision of emotional support and guidance in coping with the many new life tasks she finds herself facing. We must remember that the mother is suddenly faced with many new responsibilities which she may or may not be equipped to handle at the time. These new responsibilities include financially supporting her children and maintaining her household, applying for public assistance, seeking legal advice, parenting her children, and facing life as a single person.

Siblings

It is common that the non-abused siblings in these families are neglected by professionals. These children are very aware that something traumatic has happened within the family, and need to be encouraged to express their fears and ask questions about the situation. Many times the siblings are not aware of the details of the situation, and may misdirect the responsibility for what has occurred onto someone other than the father.

The Father

With regard to the perpetrator, six points should be emphasized:

(1) Immediately the offender's first concern is the legal action against him. Until he is assured of some support throughout the entire process, and given some concrete sequence of events regarding court and the treatment process, it is difficult to engage him in a therapeutic relationship.

(2) Acceptance of responsibility for the sexual abuse. Many times the offender will deny or rationalize the occurrence of the sexual activity with his child. The goal of an effective treatment plan is that the father accept and own the total responsibility of the sexual abuse.

(3) It is our experience that, at least initially, the focus of individual sessions needs to be on the offender himself, rather than on the act he has committed. It is necessary that he come to view the therapist as one who is accepting of him as a person, although not of his behaviour. He must feel that the counsellor is concerned about him as an individual before he will be able to trust enough to share and explore his situation.

(4) Examination of the personal history of the offender generally leads to a realization that connections may be made between roles and attitudes learned as a child, and the situation he is in at present. Very often the insecurity and confusion over his maleness, experienced as a child, extends to the offender's adult life. He often lacks the social and relationships skills that would enable him to function as a mature adult. It is important that the offender become aware of these connections and begin to develop these skills.

(5) In order to learn social and relationship skills, the offender must begin to be aware of himself and the impact he has on others. With this awareness comes the acceptance of responsibility for his own actions. He learns that he alone is

responsible for his actions, and that as a result, he may shape his own environment.

(6) Once the offender has reached this level of awareness, he is able to acknowledge and own the total responsibility of the sexual abuse. When he is able to do this, it is time to begin sessions with the offender and each of the other members of the family. The offender must face each member individually in a counselling session and claim responsibility for his actions, and apologize to them.

Dyadic Counselling

A second step in rebuilding the family involves the resolution of the conflict between family members. Dyadic counselling has been found to be most effective in accomplishing this end. Counselling of the various dyads may occur in any order, depending on the individual family circumstances. It has been our experience that successful reconstruction of any family unit is dependent upon the various dyads being able to air their concerns to one another.

Mother-victim

Through individual counselling, each of these individuals identifies certain feelings regarding the other. They each have their own fears of what the other is thinking about them, in addition to questions they would like to ask, but are afraid to do so on their own. It is important that the mother be brought to the point where she can meet with the daughter and provide her with the reassurance that the responsibility for the sexual abuse lies clearly with the father. The mother must convey the message to the child that the disclosure of the sexual abuse is a good thing, and again that the child is not to blame for that either. If the child thinks that the mother knew, or should have known about the abuse, she needs to have the opportunity to tell her mother that, and hear her mother's response. Essentially, the mother must acknowledge her role as parent and protector to her child, and apologize for her inability to effectively carry it out in past circumstances.

Father-victim

It has been our experience that the child who is able to hear her father accept and own the total responsibility of the incest, is able to deal much more easily with the fact that it happened. In the session between father and child, the offender must face the child and apologize for his behaviour. The child is encouraged to ask any questions she may have of the offender, and he is supported to answer honestly. The father is also encouraged to explain to the daughter how he felt during the abuse and upon disclosure. Of course, the therapist is aware of what type of exchange will occur in order that the meeting may be mutually beneficial to the child and offender. The case example which follows may serve to explain.

In a meeting between a father and his 13-year-old daughter who had been molested for six years, the father was able to apologize to his child. He told her that the sexual abuse was totally his responsibility, and that even if she had wanted to stop it, she couldn't have. He further stated that when he found out that she had told someone, he certainly had been frightened, but that more than that, he had felt relieved. The child had many questions such as 'do you hate me?', and 'can you ever love me again?' Her father reassured her that he never stopped loving her and that he wondered if she could still love him! He told her that he was proud of her for being able to tell someone who could help her when he was not able to do it.

In this example, it is evident that the father holds the key to the release of much of the child's guilt, and that this type of confrontation can be most therapeutic.

Marital Couple

Marital counselling is a necessary prerequisite to family counselling. Individually, the husband and wife are encouraged to identify critical issues that must be dealt with if the marriage is to continue. It is at this point that the couple is able to realistically discuss their situation and make the decision as to whether or not they wish total reconstruction of the family to occur. If reconstruction of the family is the choice they make, it is imperative that they be clear on their rules as husband and wife to each other, in addition to their roles as parents and protectors of their children.

Family Counselling

The success of our programme is not oriented to the total reconstruction of the family unit, but rather to the healthy functioning of whatever segment of the family chooses to remain together. Prior to the father moving back into the family home, we feel that it is necessary for the family to be brought together in a therapy situation. The abuse must be openly acknowledged and discussed. Emphasis is placed on the changes that have occurred in the family to ensure that the abuse will not be repeated. It is the father's place to reassure the family that the abuse will not recur. The therapist leads the family in a discussion of what the implications of the father's return are likely to be for each of the family members. Of course, the full impact of this event will not be realized until it actually occurs. However, it is important that the family be made aware that this will involve some adjustment for each of them. They need to know that family therapy will continue until the family restabilizes.

Self-help and Group Component

In addition to the community co-ordination and reconstructive family therapy, a third vital aspect to the treatment programme is that performed by the self-help and therapy groups, Parents United and Daughters and Sons United.

While trained therapists may assist these families through the process of restructuring their lives and offering support through the maze of various agencies' involvement, it is the self-help group that is able to offer the strongest emotional support.

Intrafamily child sexual abuse is viewed with great revulsion by the general public and much of the professional community. It follows from this that the stigma that attaches itself to the family members is pervasive and serves to further isolate them. We must remember that this client population suffers from very loose self-concepts to begin with, and further degradation serves only to intensify the problems. Through the development of our self-help network we are able to place new family members in touch with others who have endured a similar crisis and managed to come through it. The emotional support derived from this has proven to be invaluable. The clients are able to see for themselves that they are in fact not some type of freaks because of the occurrence of

sexual abuse in their families. They are also provided with some much-needed hope for the future in a much more real sense than a therapist can provide on her own.

Parents United and Daughters and Sons United were developed to meet the needs of these families for validation and support through the crisis of disclosure of the sexual abuse, as well as through the extended treatment process. The groups are comprised of both parents in the adult group plus a therapist. In this type of group, it is mandatory that a counsellor be a part of the group in order that some measure of control be available. The reason for this is that a number of offenders have been ordered to attend, and it is the treatment programme's responsibility to ensure that the groups remain credible and effective. This is not to say that the parents cannot have some hand in determining the direction of their groups. Daughters and Sons United is similar to the Parents United groups. Daughters and Sons United accepts both victims and siblings into their membership. The groups provide an atmosphere in which the children may exchange and test out their feelings, beliefs, and ideas while receiving support to do so. The counsellor plays a more directive role in these groups.

The self-help groups provide a vehicle through which the members are able to have an impact on their environment. As the clients proceed through the individual and group treatment process, they reach a point where they may wish to contribute something to the community. This may take the form of public education with regards to the problem of sexual abuse of children in the home.

Conclusion

The programme suggested here stresses a positive approach to the problem of healing the family, with an emphasis on rehabilitation and family reconstruction. This is in contrast to the traditional punitive approach used with the offender, leaving the individual family members in a state of disruption. All of the resources presently involved with the sexually abusive family have a crucial role to play. It is imperative, however, that these agencies be aware of their respective roles and be willing to carry them out in conjunction with the others. We must ensure that the agencies are not working at cross-purposes and making the 'helping

process' as traumatic for the victim and her family as the sexual abuse itself.

The treatment programme is based on the assumption that the average within-family offender has committed the sexual abuse in part because of his possession of an extremely negative self-concept. He has usually not had the ability to meet his own needs in a positive way, and has reacted by sexually abusing his child, which further intensifies his guilt feelings and serves to confirm the low opinion he holds of himself. The humanistic approach assumes that each individual has a natural inclination towards growth. It is when this growth process is stunted or blocked that there is a resulting decrease in self-esteem and evidence of psychological pathology. We assume that human beings are capable and predisposed to growth and positive change. They can be guided in a manner which will increase their self-awareness and self-esteem, thereby increasing their ability to manage their own behaviour in a positive way.

Chapter Nine

HEALING OF OFFENDERS

> Many a man commits a reprehensible action, who is at bottom an honourable man, because man seldom acts upon natural impulse, but from some secret passion of the moment which lies hidden and concealed within the narrowest folds of his heart.
>
> Napoleon I (1858),
> *Correspondence and maxims*

> The sexual abuse of children is a crime, first and foremost. Treatment can and should begin after that recognition and an appropriate legal response has been made.
>
> Sandra Butler (1985),
> *Conspiracy of silence: the trauma of incest*

Treatment of offenders is recognized as one of the most crucial issues in the prevention of child sexual abuse at the individual level. However, this is a very new and experimental field. It is beyond the scope of this chapter to review all of the beginning clinical efforts in this area. Rather, we will attempt to review the types of offenders, theories of aetiology, and their implications for treatment.

TYPES OF OFFENDERS

Early Theories

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

Bagley (1969) was one of the earliest authors to offer a categorization of incest offenders. His study of 1,025 cases from a variety of sources, including published data, uncovered 425 offenders with sufficient data for comparison. The typology of incest developed included functional (marriage of a close relative to prevent division of property); disorganized (total role chaos and normative confusion in a family); pathologic (one parent psychotic); fixated (the father attracted to the child because of experiences in his own childhood); and psychopathic (a father without any apparent moral scruple, who exploits his child regardless of consequences). It was emphasized that treatment and prevention must take into account these various types.

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

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

Molester/Rapist Typology

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

Fixation refers to an arrested development.

> A fixated child offender is a person who has, from adolescence, been sexually attracted primarily or exclusively to significantly younger people, and this attraction has persisted throughout his life, regardless of what other sexual experiences he has had.
>
> (Groth 1978b:6)

Fixated offenders are characterized by persistent interest and compulsive behaviour, with offences often preplanned. Male (same sex) victims are the prime targets (Groth, Hobson, and Gray 1982). Treatment of these offenders is difficult as they are fixated at an earlier developmental stage, and have limited experience of successful sociosexual peer relationships.

Regression refers to a retreat from a stage of relative maturity:

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

Regressed offenders are generally reacting to stress, including the stress of self-imposed alcoholism: their offences are initially impulsive, and females are the primary targets (Groth 1987). Most are amenable to treatment programmes, and the goal of such therapy is to restore a level of healthy functioning.

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

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

Anger rapists are described as using more force than necessary to overpower the victim. The offender's mood is one of anger and depression, with victim selection determined by availability (Groth 1978a, 1987).

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

Sadistic rapists are those for whom aggression and physical force have been eroticized. If power has been eroticized, the child or young person is subjected to ritualistic acts and bondage; if anger is eroticized, the young person is subjected to both torture and sexual abuse. Assaults are calculated and preplanned, with the offender's mood one of excitement and dissociation. Victims are usually strangers.

It is important to remember that these distinctions, while useful, are not mutually exclusive, and also identify, in typological terms, only a minority of severe sexual assaults on children. Groth's typology is based on the study of offenders after conviction, but we know from other sources (e.g., Canada 1984) that the large majority of sexual assaults on children and young people are never reported to any authority.

It may well be that only the severest of rapes are reported, and only the most persistent or compulsive of offenders are caught. It remains distinctly possible that many rapes of children are casual expressions of sexual dominance and power, without any clearly underlying psychopathology or deeply rooted motivation other than the simple expression of male dominance. Often sexual and power motivations are intertwined—especially in a prevalent type of rape, the sexual assault by teenage boys of teenage girls. These assaults may be perpetrated by a single individual (including the category of 'date rape'), or by groups of youths who pick off an isolated or vulnerable female (Bagley 1988a). These data come from victim reports, not from studies of incarcerated offenders.

The Gender Component

Diana Russell (1984b) brings together several factors to explain the gender gap among perpetrators, namely, why the large majority (some 90 per cent) are male. Her arguments can be summarized in the following points.

(1) 'Women are socialized to prefer partners who are older, larger, and more powerful than themselves'; while men 'are socialized to prefer partners who are younger, smaller, innocent, vulnerable, and powerless' (1984b: 229) This increases children's attractiveness to men and decreases it for women.

(2) Males 'are not only expected to take the initiative, but also to overcome resistance' regarding sexual relationships (1984b:229). Women are conditioned to be more passive, and sexual abuse is unlikely to be initiated by children.

(3) 'Men appear to be more promiscuous than women' (1984b:229). This may be related to biological factors. Whatever the reason, the choice of multiple partners is more likely to include under-age partners.

(4) 'Men seem able to be aroused more easily by sexual stimuli divorced from any relationship context…. Women, on the other hand, rely more on a totality of cues, including the nature of the relationship with the sexual partner' (Russell

1984b:229). Women are also much more likely to have a relationship with children which precludes sexual arousal.

(5) 'Men appear to sexualize the expression of emotions more than women do' (1984b:230). Women seem better able to express affection and intimacy in ways that do not involve sex.

(6) 'Having sexual opportunities seems more important to the maintenance of self-esteem in men' (1984b:230). Women look to other ways to enhance their self-esteem.

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

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

(9) 'Sexual contact with children may be more condoned by the male subculture' (1984b:230). This is reflected by the historical evidence presented in Chapter 2.

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

Female Offenders

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

A complete psychological profile of female offenders is unavailable. From the limited information available, adult female offenders are believed to have the following characteristics in

common: 'A spousal relationship that is absent or emotionally empty; extremely possessive and overprotective attitudes toward child victims; alcohol used as a crutch and as a disinhibitor to the expression of sexual feelings' (James and Nasjleti 1983:23). The sexual activities may have both a masturbatory and a masochistic quality (Forward and Buck 1978; James and Nasjleti 1983). There is also some clinical evidence that women who engage in 'Munchausen syndrome by proxy', which involves the engineering of symptoms of disease (e.g., smothering, poisoning, causing diarrhoea), may themselves have experienced physical and sexual abuse in childhood (Meadow 1977; Hobbs 1987).

Russell (1986) found in further work with a general population sample that only 1 per cent of the women interviewed reported sexual abuse by a female. From a review of other studies, she concludes, 'Only about 5 per cent of all sexual abuse of girls and about 20 per cent of all sexual abuse by boys is perpetrated by older females' (Russell 1986:308).

The national Canadian survey of adults recalling incidents of sexual abuse in childhood found that 14 per cent of assaults on males were by females, while only 3 per cent of assaults on females were by individuals of the same sex (Bagley 1985). The most typical situation of female-male assault appears to be that perpetrated by an adolescent female, herself the victim of sexual assault by an older male, who engages in sexual play and experimentation with children whom she is babysitting.

Juvenile Offenders

Sexual offences by children often need to be seen as a symptom of emotional disturbance (Groth, Burgess, and Holmstrom 1978). Juvenile offenders present a special concern for treatment programmes as they are often both victim and offender. Even when psychopathology is not the principal factor in sexual assault by an adolescent, this is still a crucial time for intervention, for therapeutic and educational purposes. Intervention with adolescent sexual offenders is much more likely to be successful than with older individuals, and can prevent the development of fixated, paedophile behaviour (Stenson and Anderson 1987).

Molestation of younger children has often been found as an indication of a child's own sexual victimization. Three dynamics may account for this behaviour: (1) it is a way of channelling aggression and turning anger at one's own victimization into

power; (2) it provides a means of creating mastery over remembered events; (3) it is a means of validating heterosexuality, particularly for a young boy who was abused by a male (James and Nasjleti 1983).

The high incidence of untreated sexual victimization in the histories of adult offenders suggests that lack of treatment may be related to their later abusive behaviour (Ryan 1986). Treatment of young offenders, up to and including adolescence, is crucial in breaking the cycle of abuse, because permanent adult preferences have not yet been formed (Stenson and Anderson 1987).

There is a continuum of sexual behaviour among children, some of which may be exploratory and developmentally appropriate. It is important, however, that the context of all publicly observed or complained-of sexual behaviour be considered, for it may be masking trauma on the part of the young offender.

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

Young sexual offenders are children in need of treatment and protection. The good news is that childhood or adolescence is a more opportune time for therapeutic change than later adulthood, when fixated, paedophile behaviour is difficult or impossible to treat.

The importance of intervening at this time is underlined by a study of residents in treatment centres in Calgary for severely disturbed adolescents (Bagley and Dann 1987). These adolescents were admitted for severe acting out behaviour (including delinquency, fire-setting, attempted murder) as well as a history of serious acts of self-injury. We surveyed the records of over

600 adolescents admitted to two centres between 1978 and 1987, and identified sixty-one males who had engaged in serious sexual assaults. Such assaultive behaviour was never the main reason for admission, however, and often information about the sexual assault was buried in the notes. In not a single case had treatment specific to the disturbed sexual behaviour been offered, and those recording the fact of sexual assault by the youth often treated it as a mild deviation which the young person would grow out of!

Yet a statistical analysis indicated a different picture. A comparison with sixty-one age-matched, same-sex controls showed clearly that sexual assault belonged to a spectrum of behaviour which included depression, diminished self-esteem, suicidal behaviour, and fire-setting. The sexually assaultive youths were much less likely to externalize their problems in the form of violent delinquency, in the form of robbery and theft, than were controls. The sexually assaultive youths were lonely, depressed, and isolated: their fire-setting most often involved the homes, in which they had frequently been abused, sexually, physically, and emotionally.

We described the sexually assaultive youths as coming from 'hot house families'—still intact, but in which one or both parents had problems of alcoholism or mental illness. Fifty-five per cent of the youths who had engaged in sexual assault (including the rape of much younger children) had themselves been the victims of sexual assault, in their homes or in the community, almost always by an adult male.

Most tragically, none of these youths received treatment which addressed their distorted sexual motivation. But we now know that at least one of these youths, now a young adult, has engaged in sexual assaults against several male and female children. We emphasize once again that adolescence may be the only time for many individuals when intervention and treatment can prevent the cycle of sexual abuse.

AETIOLOGY OF OFFENCES

Preconditions

Russell (1984b) attempts to explain the preponderance of males in sexual offenders in terms of socialization; others have argued for a central role for lack of inhibitors in sexual behaviour (Frude

1982). These theories are integrated by Finkelhor who outlines four preconditions that must be met before sexual abuse actually occurs:

(1) A potential offender needs to have some motivation to abuse a child sexually.

(2) The potential offender has to overcome internal inhibitions against acting on that motivation.

(3) The potential offender has to overcome external impediments to committing sexual abuse.

(4) The potential offender (or some other factor) has to undermine or overcome a child's possible resistance to the sexual abuse.

(Finkelhor 1984a:54)

In other words, the potential offender needs to have initial sexual interest in children, and has to overcome factors of conscience in yielding to such temptation. External controls and inhibitions concerning sexual contact with children also need to be weak. Finally, children actually have to be available, and the potential offender has to find some way (temporarily at least) of overcoming a child's resistance to such an approach. This model has important implications for prevention strategies, which must have multiple focuses: preventing circumstances which motivate men to want sex with children; stressing in various moral suasions that such behaviour is wrong; ensuring that penalties for abuse are likely to be direct and deterrent; and giving children a cognitive and emotional base which can help them recognize and report sexual abuse when older people attempt this.

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

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

Socialization Theory

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

> These men are victims, not only of their particular parents, school systems and economic circumstances, but of something more pervasive than the sum of all these things. They are the victims of male-defined standards of appropriate behavior that leave little room for the acknowledgment of deeply felt and repressed needs for love, acceptance, nurturing and warmth; victims of not being permitted to feel and express the full range of human feelings and of not being taught to understand the strength in admitting weakness; victims of not being able to open their arms or hearts to others, never having experienced arms in which they were encircled and made to feel safe.
>
> (Butler 1985:76–7)

The humanistic approach to child sexual abuse assumes that both men and women can learn new values and behaviours, based on mutual support, new insights, and new understanding.

Social Deviance Theory

Dreiblatt (1985) presents three alternative or complementary models for understanding child sexual abuse: family dysfunction, power, and learned sexual deviance. The family dysfunction

model, which assumes sexual abuse is caused and sustained by family dynamics, may be relevant in understanding motivations towards sexual assault both within the family, and beyond. The power model, which assumes sexual assault is an expression of a power motive, may apply to many types of sexual assault, both within and outside the family. This drive towards sexual power and dominance may be derived from both pathological motivation, and from traditional male socialization.

The sexual deviance model developed by Dreiblatt (1985) provides a useful basis for understanding deviant sexual behaviour as a learned phenomenon. The model suggests that an offender may develop, for a variety of reasons, a behaviour pattern which is acted out through sexual assault. The behaviour can be reinforced by such dynamics as a sexual release, excitement, or a sense of power. This is followed by a refractive stage where the offender feels guilty or fearful, which in turn is followed by repression. This period of denial must not be confused with a change in orientation. The offender then experiences renewed temptation, the offence is repeated, and the cycle is repeated. Treatment addressing the sexual deviance model requires attention to the original vulnerability, as well as to the process of denial.

Addiction Theory

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

(1) Preoccupation—the trance or mood wherein the addict's mind is completely engrossed with thoughts of sex. This mental state creates an obsessive search for sexual stimulation.

(2) Ritualization—the addict's own special routine which leads up to the sexual behaviour. The ritual intensifies the preoccupation, adding arousal and excitement.

(3) Compulsive sexual behaviour—the actual sex act, which is the end goal of the preoccupation and ritualization. Sexual addicts are unable to control or stop this behaviour.

(4) Despair—the feeling of utter hopelessness addicts have about their behaviour and their powerlessness.

(Carnes 1983:9).

Carnes (1983) indicates that there are three levels of addicted sexual behaviour. Level one behaviours are generally tolerated by the public, but can be devastating when indulged in by the addict compulsively or publicly. Examples are masturbation, promiscuous heterosexual and homosexual relationships, use of pornography, and resort to prostitution. Level two behaviours have the consequences of someone being victimized, and usually involve legal sanctions. Examples are exhibitionism, voyeurism, indecent phone calls, and indecent sexual suggestions or touching. Level three behaviours represent profound violations of cultural boundaries. Examples are rape, incest, and child molesting.

Often in sexual addiction, there is progression through the levels of activity, as well as massive denial (Blanchard 1985a). A negative spiral of behaviour is created encompassing or reflecting an early psychosexual trauma, early compulsive behaviours, and the inability to experience lasting pleasure or satisfaction in a sexual act or relationship. Often the early trauma initiating the sexual addiction or paraphilia was a sexual trauma of some kind (including sexual assault) incurred in the individual's own childhood.

Although Freud has been criticized for his failure to recognize the prevalence of child sexual abuse within the family (suggesting, rather, that children's accounts reflected fantasy rather than reality), it is also clear that in his writing on sexuality, edited by Richards (Freud 1977), he frequently treated a 'perversion of the sexual instinct', namely paedophilia, a neurotic fixation having its origins in infantile sexual conflicts and attachments (Freud 1977:60). He also recognized that fathers would sexually assault daughters where cultural norms forbidding this were weak (1977:208). Based on both Freudian and behaviourist theory, the fetishistic attachment to a child as a

sexual object requires treatment which is similar in many cases of paraphilia (Money 1987).

Developmental Theory

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

Freeman-Longo (1986) observes from his work with offenders that the majority were sexually abused as children, but very few overcame their own victimization. While most still harbour the negative feelings experienced as a child, they are unable to link their feelings at having been abused to the harm which their abusive actions cause. They lack empathy and tend to focus on the positive aspects of their own abuse, while repressing the traumatic aspects.

Nicholas Groth (1987) summarizes two major sets of risk factors in the aetiology of sexual offending. The first is the presence of biological flaws such as genetic or hormonal defects. Other researchers have also found significant patterns of hormonal and neuropsychological impairment in sexual deviants (Hucker, Langevin, Wortzman, Bain, Handy, and Chambers 1986).

The second major factor is developmental trauma owing to a history of childhood sexual abuse in the offender. All offenders studied by Groth over a ten-year period, have displayed one or both of those factors, with a history of sexual abuse considered to be aetiologically significant in up to 80 per cent of adult offenders and 100 per cent of juvenile offenders (Groth 1987).

A third factor, which is not mutually exclusive to the other two aetiological factors, is a sexually repressive upbringing. The awakening of sexual urges at puberty can be a very troublesome time if all sexual activity is considered impure and evil (Groth 1987). Finkelhor (1979a) also showed that a sexually repressive household (perhaps inhibiting the use of masturbation or external sexual contact) was a significant risk factor in sexual abuse within the family.

Identifying and Deterring Potential Offenders

Ideally, we should be able to identify potential sexual offenders against children, and offer them help and sympathy, as well as social control which would inhibit any indulgence of their neurosis, fantasy, lust, sexual or power drive. Ronald Langevin of the Clarke Institute for Psychiatry in Toronto has devised a lengthy Sexual Preferences Schedule which could assist in this task (Langevin 1985). Included in this measure is a sub-scale designed to elicit the expression of sexual preference for children, or under-age individuals. We have data on this scale for 714 male Canadian students: 4.4 per cent of subjects expressed a clear preference for under-age individuals as sexual objects.

However, useful as these data are in giving us some idea of the number of 'fixated' paedophiles there might be in the population, the price we had to pay in return for honesty in completing the questionnaire was complete anonymity: we have no way of knowing who these individuals are, and no way of reaching and helping them.

Our data also support another of Langevin's (1985) findings: a sexual interest or preference for children by no means precludes other forms of sexual interest. Langevin and his colleagues have shown that it is not easy to identify paedophiles by developmental characteristics: some (at least half) were themselves sexually abused as children—but many were not. Conversely, only a minority of male sexual abuse victims develop into adult offenders; a significant minority of paedophiles have neurological or hormonal abnormalities—but most do not, and a majority of those (for example) with temporal lobe disorders have no abnormal sexual motivation; some paedophiles can be identified by means of abnormal scores on personality tests—but most cannot; some paedophiles respond in a clearly defined way to sexual stimuli involving children—but many do not; and most paedophiles can present themselves as well-adjusted, heterosexual adults.

To complicate matters further, 'chemical castration' for persistent paedophile offenders is often unsuccessful: motivation for offending seems to be predominantly psychological, rather than hormonal. But even this psychological motivation is elusive. In our Calgary research with adult students, we found a statistical link between a sexual preference for children, and elevated scores on the neuroticism and psychoticism scores in the Eysenck

Personality Inventory. Yet, the large majority of individuals with high P and N scores expressed no such sexual interest; and some 40 per cent of individuals expressing a sexual interest in children had profiles in the normal range on the psychological tests used.

What this adds up to is that our state of knowledge of the motivation of individuals with a sexual interest in children is still very elementary. While, for example, a distinction has been made between regressed and fixated offenders, this is by no means the only classification possible. Regressed and fixated groups could also overlap: it might be that individuals regress from normal social and sexual roles, and because of a newfound sexual interest and comfort in the sexual company of children, become fixated in this mode.

Nothing in this research leads us to alter our opinion that the legal authorities should be involved in every case of child sexual abuse, and a prosecution brought wherever the evidence justifies this. While co-operation with therapists and child protection authorities should count towards a light or suspended sentence, the real threat of punitive retribution may well act as a deterrent for those tempted to become sexually involved with children. For those whose offending is repeated, obsessive, compulsive and seemingly uncontrollable or untreatable, there seems little alternative to a lengthy period of preventive custody.

TREATMENT IMPLICATIONS

It is important to incorporate treatment programmes wherever offenders are identified. If they go through the judicial system enduring only the punishment of custody, they will probably return to society unchanged, at least in terms of internal motivation. If they are systematically stigmatized and rendered helpless, this may lead to even greater insensitivity or aggression. Nor is it enough to prepare society to be vigilant. Attempts must be made to curtail the motivation of the offenders themselves.

The ‘dangerousness’ or risk of an offender to society is a composite of many factors (MacDonald 1981). Groth (1978a) lists the areas to be assessed as impulse control, tolerance for frustration, emotional stability, contact with reality, interpersonal relations, self-awareness and self-image, and adaptive strengths.

The importance of these functional skills is underlined by the consideration that one’s sexuality is almost always discovered rather than chosen. Groth (1987) emphasizes that a person’s

sexuality is different from many other aspects of their personality and character. While their sexual preference usually is not volitional, how they choose to express and act upon it is. Sexuality is arrived at through the complex interaction of biology, genetics, and early experiences. Everyone does not arrive by the same route or at the same end, although everyone has a responsibility to contain their own sexuality within the mores of the society in which they live. However, the challenge to an offender to accept responsibility for handling deviant drives becomes an empty statement if society does not provide suitable support and treatment programmes (Groth 1987).

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

Similar concepts are reinforced by Herman (1981a), who sees the components of treatment as teaching offenders: (a) the distinction between sexual impulses and the desire for tenderness and affection; and (b) a rudimentary awareness of the effects of their behaviour on other people. She emphasizes that freedom from alcohol addiction be a precondition for participation in a treatment programme, and that offenders can never be considered absolutely cured.

TREATMENT METHODOLOGIES

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

Behavioural Models

This approach is concerned with changing the behavioural manifestation of sexual preference. Behavioural principles include four major objectives: (1) rewarding 'normal' adult sexual relationships; (2) improvement of sexual functioning

within adult sexual relationships; (3) increased self-control over sexual behaviour; and (4) adjustment to innate sexual preference (Yaffe 1981). Techniques aimed specifically at sexual arousal include aversion, systematic desensitization, and biofeedback.

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

The use of fantasy training can be a successful part of the treatment process. Sexual offenders are often unable to make constructive use of their fantasy functions, and can be taught this process to help reduce identified behaviours (Matek 1986). An example is to have the offender include a police intervention in a fantasy scene of child seduction.

Technology measuring erectile responses to various sexual stimuli can be useful in terms of both assessment and confrontation. For example, Marshall, Barberee, and Christophe (1986) report that several molesters, who denied having offended against children or having used coercion, admitted their guilt after being shown their results which confirmed significant arousal to those stimuli.

'Chemical castration' is another method available for use in extreme situations. Anti-androgen drugs reduce the availability of circulating testosterone, which in turn reduces sex drive, decreases the ability to sustain an erection, and reduces sperm production. Because these medications are still at an experimental stage, there are not yet established protocols for measuring change. The medication must be used voluntarily with careful follow-up, but the success of this method is by no means assured (Frost and Seng 1986).

Addiction Model

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

Principles of counselling the sexually addicted offender have been established by Games (1983) and Blanchard (1985b). The starting point of therapy, as with any addiction, is a point of 'drying out', or in this case, celibacy. The focus of therapy is to bolster the offenders' fragile self-esteem, improving their ability to delay gratification, teaching new coping skills, exposing the process of using pleasure to reduce pain, and assisting in recovery from early life traumas which often began the whole process. The recovery process is maintained and strengthened through group work, as with the Alcoholics Anonymous model. The group provides a sense of connectedness, concrete acceptance and support, motivation through seeing others change, and a forum for issues of trust and the confrontation of denial.

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

Developmental Model

The developmental model responds to the idea that the sexual offender has been the subject of developmental delay or distorted development of emotion, motivation, and control—most probably because of childhood trauma which may or may not have included sexual abuse. This model can be applied in association with either the behavioural or the addiction approach to treatment (Carnes 1983).

A developmental assessment includes many of the same questions used to trace patterns of social deviance or addictive behaviour. Developmental skills and learnings need to be assessed; repressed emotions need to be brought to the surface and explored; and early sexual traumas and identifications must be recognized, as well as choices resulting from those experiences. The offender's self-esteem and confidence must be restored

within the context of a relationship which can sensitize him to the needs and feelings of others, along with increased self-awareness.

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

CONCLUSIONS

Early theorists tended to categorize offenders according to family dynamics. This is consistent with the first wave of awareness which focused on intrafamilial abuse, particularly of daughters by fathers. The recent typologies developed by Nicholas Groth are, however, much more useful from a treatment perspective and in understanding the spectrum of sexual offenders.

Child sexual abuse can be categorized first as molestation or rape. Molestation is the crime of offenders who seek an emotional relationship with the child and want to believe that the child enjoys the sexual touching or the progressive sexual activities. There are at least two types of molesters, including the fixated, and the regressed. Fixated molesters are those with arrested sexual development who seek sexual outlets which are usually focused on children. Regressed molesters are those who have achieved a level of adult functioning, but under severe interpersonal stress seek out a child partner whom they see as a pseudo-adult.

A third, and potentially more prevalent type, is the power molester—the adult who uses children sexually, simply because they are both powerless and available, and are an adjunct rather than an alternative to the adult's sexual expression. In our search for clinical insight into adult sexual interest in children, we should not lose sight of the historical perspective: sexual abuse of children has, for most of history, not been an expression of individual pathology, but simply a reflection of the maintenance of power and control by men over the lives of women and children.

Rape is the crime of those whose assault is characterized by violence, hostility, or dominance. There are at least three types of rapists. Anger rapists act out their aggression and hostility in a sexual way. Power rapists act out their need for control and

acceptance. Sadistic rapists are those for whom either anger or power have become eroticized and are part of the sexual excitement.

The sexual abuse of children is predominantly (in some 90 per cent of cases) a male offence. Several factors contribute to this predisposition. These include the socialization of men to prefer partners who are younger, smaller, and more vulnerable; a tendency of men to take the initiative in sexual relationships; a tendency to be more promiscuous; a tendency to be more easily aroused by stimuli outside of a relationship context; a tendency to sexualize the expression of their emotions; a tendency to use sexual opportunities to maintain self-esteem; a tendency to have less sensitivity to the needs of young children; a tendency to empathize less with the impact of victimization; and a tendency to be more accepting of child sexual abuse within their own subculture.

Juvenile offenders are a group giving grounds for special concern, since they represent the beginning of the abusive cycle in that they are often acting out their own victimization experiences. The treatment of these young people is very important because their adult sexual preferences may not yet be formed. Values and behaviour that can still be modified in childhood or adolescence will be much more difficult to change in adulthood.

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

Methods of treatment chosen will depend on the type of offender and the model of aetiology which seems to explain the behaviour best. The primary goal of treatment is for offenders to accept responsibility for controlling their own behaviour. It is recognized that there is no real cure for some types of sexual deviance, just as there is no cure for many addictions. Rather, new skills can be taught to overcome old stressors, self-esteem strengthened, and social supports improved. Individuals, while

not completely cured, can be given a new range of alternatives for coping with and enjoying life.

Chapter Ten

HEALING OF SOCIETY

> We need to broaden the sphere of morality to take into consideration all practices which involve a lack of respect for persons: systems of race, class, age and gender—in short, all inequalities and aggressions. A moral society would be a just system which eliminated inequality while acknowledging and catering for difference and variety. If moral debate is reduced to sexual matters, then all other inequalities are bound to be obscured by insistent screams of shock and horror—by exaggeration and distortion. As long as that process continues, children will be exploited sexually, racially, through their poverty, or simply because they are children.
>
> Judith Ennew (1986),
> *The sexual exploitation of children*

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

LEVELS OF PREVENTION

Three levels of prevention are identified (Bagley and Thurston 1988). These are: (1) primary—aiming to address the root causes

and cultural values involved in an identified problem; (2) secondary—aiming to reduce the harm caused by the problem within the status quo, using conventional treatment models; and (3) tertiary—which intervenes only after the fact and is basically rehabilitative, preventing, for example, cycles of abuse between generations. These levels of prevention will be reviewed in reverse order, moving from the individual treatment philosophies presented in preceding chapters, to the more difficult challenge of social change.

This movement in focus can also be described as a movement from micro to macro orientation. Individual treatment programmes are the building blocks of a comprehensive and multi-disciplinary model, necessary, but not sufficient conditions: each contributes to the larger programme, but also depends on the work of the other disciplines for improved effectiveness. Similarly, community programmes depend on social acceptance, but also shape and change social awareness.

Tertiary Prevention—Rehabilitation

The treatment programmes presented in Chapters 7 to 9 were a review of what could be called secondary and tertiary prevention at a micro level. This type of healing recognizes the vast numbers of wounded persons who never received help in childhood, and the need to restore them as adults to a more functional and integrated level of health. Individual healing embodies the humanistic principles of respect for and development of human potential, and contributes to prevention by helping people become healthier or more responsible members of society. The humanist builds on an established body of knowledge in social psychology in assuming that improved self-concept, and the ability to empathize with others and fill personal needs in non-exploitative ways, go hand in hand (Bagley *et al.* 1979).

This is a particularly relevant principle when considering the intergenerational aspects of child sexual abuse. Studies have indicated that the reactions of many sexually abused children are to a large degree dependent on gender differences. Victimized girls are more likely to internalize their own trauma, engage in depressed, self-defeating and self-destructive behaviours, and acquire partners who perpetuate their abuse. Victimized boys, on the other hand, are more likely to act out their trauma and dissociate from their own pain by imposing it on others. Healing

of both male and female children will help break these generational cycles by giving them new alternatives for their own life and role in society.

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

Secondary Prevention

Secondary prevention involves healing at both the individual and the community level, and can be accomplished by many different means. Education and improved community awareness for earlier identification, immediate help for those who report single incidents of abuse, comprehensive community programmes, and legal change have all been mentioned as ways of meeting the challenge (Canada 1984).

This kind of prevention makes good financial sense, in terms of costs and benefits. The costs for services such as child protection, prosecution, incarceration, and treatment can be avoided through secondary prevention. The resources saved could be applied to more general services such as family life education, screening and support for high-risk families (Gentry 1978).

Servicing highly disturbed children in residential facilities is an extremely expensive and uncertain endeavour. Preventing the child sexual abuse which underlies a significant proportion of this disturbed behaviour can be highly cost effective in the long-term, although expensive in the short-term. Unfortunately, however, finite social service budgets are usually fully stretched coping with the phenomenal increase in reporting rates of child sexual abuse, which in most areas are increasing at between 50 and 100 per cent a year, and mean that treatment budgets usually fall significantly below current needs. Funding is inadequate for secondary prevention, let alone for primary prevention. Clearly, some fundamental value changes concerning the worth of children and the damaging nature of sexual abuse need to take place in society, before budgetary resources can be reallocated.

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

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

Education of professionals is another major thrust of secondary prevention, in helping front-line workers to act in a speedy, effective, humanistic, and co-ordinated fashion when child sexual abuse is suspected or reported. Studies of attitudes indicate there is much work to be done before the common understanding referred to in Chapter 5 is achieved (Stone 1988). For example, one study of professionals found those with more clinical experience tended to view child sexual abuse as less damaging to survivors (LaBarbera, Martin, and Dozier 1980). While this is contrary to what would have been expected, this finding may reflect a symptom of helplessness or desensitization among professionals as a result of non-existent or ineffective treatment programmes. Another study found that psychiatrists were the

professional group most likely to consider children's accusations as fantasies (Attias and Goodwin 1985).

A comprehensive approach is necessary which includes public education, professional training, institutional changes, and media sensitization (Cohn 1986). Education needs to extend to children, parents, and high-risk offender groups. Healing at the community level needs to incorporate power, understanding, and compassion in social service professionals. Concern needs to extend beyond those who have already been victimized, in reaching all potential offenders. The final level of prevention and healing requires change of cultural values surrounding children in order to eliminate the need for community programmes such as those described above.

Primary Prevention—Social Change

The primary level of prevention takes a broader political view in that it strives to eliminate the root causes of child sexual abuse. Taubman (1984) identified a number of factors that contribute to the sexual victimization of children. These include cultural values concerning sexual exploitation, and the continued exercise of power and dominance by males. Taubman argues that these implicit value supports for the continued sexual exploitation of children have to be considered with the more general categories of power imbalance and objectification of human beings in modern society, with the widespread tolerance of violence as an additional contributing factor.

Primary prevention challenges the conventional foundations of values and behaviour. Pioneering change is difficult, since society is built on habit and tradition. Particular vision and commitment are required to move from an accumulated heritage along an uncharted path. Yet, healing is possible only when society with some degree of consensus is able to look back as a collective entity at its own development in a self-critical manner, acknowledge rather than deny its own liabilities, and overcome its limitations by determining new directions to incorporate chosen values. Such a statement of purpose may seem hopelessly idealistic. Yet, for the writers viewing the world from a Canadian vantage, radical change of a humanistic kind within the context of a society espousing broadly liberal values, seems entirely possible. We have argued, for example, that Canada's enlightened policy with regard to multiculturalism and the

absence of marked racism in many areas could provide a valuable model for other countries (Bagley 1986).

Ultimately, the major change required is a personal one, at the level of social identity and the process of defining ourselves through our differences rather than our commonality. The community has, however, to be grounded in the principles of pluralism in which certain fundamental values are shared, but in which the uniqueness and autonomy of individuals and cultural groups is recognized and supported. We need to be analytic about personal motives, experiences, and values, and empathic and tolerant about the motivations of others. The political approach which this implies is necessarily one of pluralism, both social and interpersonal. The essence of pluralism is agreement on the structural regulation of interpersonal conduct, particularly by legal mechanisms. We have significant confidence in the law as a regulator of human conduct in interpersonal relations, including the conduct of adults in the care of children.

Children have been isolated from full recognition as persons by subtle variations of the process of mindless collectivism, and the absence of a structure in which the individual nature of human beings can be expressed, tolerated, and protected. Ways in which conventional socialization supports this failure to recognize the needs and rights of children, and how this contributes to child sexual abuse, are discussed below.

SOCIALIZATION ISSUES

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

Social life is a cultural achievement, with social order created and maintained through symbolic learning, with each person motivated to participate by the human need of respect from others (Harré 1979). Yet, part of that symbolic interaction is the ritual stigmatization of groups and individuals by others within society. Power imbalance based on economic exploitation, sexual objectification, and oppressive violence are all expressions of this

process of symbiotic, socialized modes of exploitation and control. All of these modes of control prevent the full development of individuals in society: these issues of individual rights must be addressed to ensure social healing at a macro level.

Power imbalance contributes to child sexual abuse in that children are victimized as members of a defenceless and vulnerable stratum. Sexual objectification, which includes stereotyping and pornography, curtails the development of both boys and girls as full persons. Violence, which involves a wide range of insensitive and abusive responses to child sexuality, destroys the trust and self-esteem of developing children (Wells 1979). Sexual objectification and violence are both expressions of power imbalance. Similarly, violence can include sexual degradation and stigmatization, and sexuality can be used as an expression of both power and violence.

Power Imbalance

The power imbalance exposed and challenged by feminist thinkers is patriarchy (Gordon 1986), and is quite simply a social system ruled and ordered by males, as the heads of family and of government. Characteristics relevant to the sexual exploitation of children include the legal tradition of women and children as property, the marriage contract whereby women and children become legal dependants, and the social endorsement of continued economic subordination of women and children to male wage earners for the purpose of ongoing service.

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

Social healing requires that children be protected from the abuses associated with ownership and subjugation. Society must become more sensitized in recognizing that children are abused because they are members of a weak and defenceless social group. Fundamental change will not happen until society recognizes the independent rights of children and develops means of protecting and assuring those rights. We elaborate this point later in this chapter.

Examples of secondary prevention (rapid and effective intervention on behalf of victims) include the credibility given to child testimony within the legal system and accommodation of the courts to meet the needs of children, rather than faulting them for not meeting adult standards in presenting evidence. Consideration needs to be given to the natural innocence of victimized children, balanced against the unproven guilt of offenders. On the other hand, the emphasis on traditional family therapy following the revelation of intrafamilial sexual abuse can, if naively applied, simply defer to a man's right to maintain control over his family, and can fail to protect a child from further abuse. A more healthy and enlightened response is to strengthen the child and non-offending parent before considering reintegration, and any kind of systemic family therapy.

The funding and establishment of community efforts such as public education, child protection, and treatment programmes for child sexual abuse, reflect the important reality that society has begun to respond to the problem. More profound efforts are still required, however, to meet the challenge of improved funding, more focused and integrated approaches, and above all, attitudinal change. Healing requires that all minorities (including children) are recognized and protected as integral members of society. This implies the integration of women and men at all levels of social and economic life in a pluralistic social structure, with special recognition and protection given to the rights of children.

Sexual Objectification

One of the most obvious polarities existing in society is the differentiation between male and female, with many social roles and behaviours assumed to be both unequal in status, and gender specific. Persons are also frequently believed to have innate characteristics dependent on their gender.

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

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

Finkelhor (1982) identifies some of the socialized differences between men and women which predispose men to sexual abuse of children. Factors such as men often failing to distinguish between sexual approach and affection; men seeing heterosexual success as part of their gender identity; men tending to isolate sexual activity from the context of a relationship; and men wanting younger and smaller sexual partners—are all part of the cultural package surrounding maleness. A rather similar interpretation is offered by Brian Taylor (1981) who suggests the fact that most abusers are male because of the broader social licence of women to express affection to children independently of any sexual context. In other words, because of the manner in which most men are socialized, they have difficulty in relating to children in non-sexual ways, whenever they become physically close with children. There is a welcome exception: men who share the child caring roles of women become more like women in their attitudes to children, and are much less likely to sexually abuse young children (Parker and Parker 1986).

An example of the cultural double standard is the likelihood that women are faulted for the offences of men (Lawton-Speert and Wachtel 1982). Many studies have assumed that it is the mother's role to provide sexual satisfaction to her mate and to shoulder the entire burden of child care, and that deviation from these roles somehow justifies sexual exploitation of children by the adult male who is no longer properly 'served' by his wife (Wattenberg 1985). This is an example of how sex-role stereotyping obscures responsibility, suggesting that women are somehow obliged to ensure the satisfaction of men, as well as the protection of children. The underlying myth that sexual desire is a valid excuse for assault is related to this concept of male/female roles. 'The question of consent, even for adult women, much less for children, has been a recent phenomenon' (Mitchell 1985:97).

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

We have distinguished moralist, civil libertarian, feminist, and humanist responses to pornography (Bagley 1984c). The moralist view sees any portrayal of sex outside of traditional roles as sinful. The civil liberties perspective incorporates freedom of expression and anti-censorship concerns. The feminist view focuses on the portrayal of women as objects. The humanist perspective sees pornography as degrading to both men and women in that it presents them both in superficial, sex-degraded and stereotypic ways. Social healing incorporates this humanistic critique of all pornography. Crude and exploitative depictions of the sexuality of men, women, and children are unacceptable to a civilized society because they denigrate an aspect of human relationship which in truth should be characterized by caring, restraint, and spiritual expression.

Violence

Violence is the compulsive repetition of attempts to exercise power by the use of physical or emotional force. We can identify two different but related aspects of violence within family and society. The first is the tendency of adults to perpetuate the violence they experienced as children; the second is the tendency of society to restrict or define certain forms of identity through stigmatization. They are alike in that both promote polarity, denial, and distance between human beings. The difference is that the first tendency violates children by perpetuating their lack of power; the second violates children by objectifying them.

Alice Miller coins the concept of 'poisonous pedagogy' to explain the tendency of parents to pass the cruelty of their own upbringing on to their children:

> The scorn and abuse directed at the helpless child as well as the suppression of vitality, creativity, and feeling in the child and in oneself permeate so many areas of our life that

> we hardly notice it anymore. Almost everywhere we find the effort marked by varying degrees of intensity and by the use of various coercive measures, to rid ourselves as quickly as possible of the child within us—i.e., the weak, helpless, dependent creature—in order to become an independent, competent adult deserving of respect. When we re-encounter this creative in our children, we persecute it with the same measures once used on ourselves. And this is what we are accustomed to call 'child-rearing'.
>
> (Alice Miller 1983:58)

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

Stigmatization has, unfortunately, often been the frequent reaction of authorities when faced with the revelation of sexual abuse. Eli Newberger (1983) has chronicled such reaction in medical staff in the United States. In such stigmatized reaction both the abuser and his victim are processed harshly, and the child as well as the adult is rejected as if the sexual contact had tainted both. Moreover, such rejection is more likely when the victim is poor, black, or both.

One of the most extreme examples of rejection occurs when the victim is put in holding or detention facilities, along with juvenile delinquents and young prostitutes, by 'protection' workers. An extreme example of this occurred in 1982 when a 13-year-old girl was committed to prison by a Californian judge when she broke down in court and refused to testify against her father, accused of sexual assault. She was brought back to court a week later from women's prison manacled hand and foot (as was customary for prisoners in transit), but again could not 'purge her contempt'.

The 'maleness' of violence is a manifestation of our sex role heritage. The socialization of young boys is often particularly inappropriate in that they are trained to dissociate themselves (by adult and peer culture) from the 'feminine' qualities of tenderness and compassion (Taubman 1986). This presents a problem for offenders who are themselves victims of a violent, individualistic

society which isolates individuals and inhibits their propensity to share intimate problems, or to seek help.

Healing of violence, for society as for an individual survivor, involves a process of mourning the loss of what we could have been, and moving ahead to learn new, alternative attitudes and behaviours. The healing process, as it applies to attitudes to children and sexuality, must be a consideration of particular importance.

TOWARDS HEALTHY CHILDHOOD SEXUALITY

Social healing as we outlined in Chapter 3, implies that society must adopt values which support the expression of sexuality by all its members without ignorance, prejudice, guilt, or fear. Children have the need, and the correlative right, to have their curious questions about sex answered with warmth, respect and intelligence by adults and older children. Children have the right to the comfort, care, and personal hygiene of their genitals; a parent has the duty to support a child in this. Private masturbation by a child is not wrong: again, a parent should support and guide children in this—not in the techniques of genital play (this will come naturally enough!), but in the protocol of self-care as a private matter.

We know from adult recall studies (Finkelhor 1979a; Sorrenti-Little *et al.* 1984) that the majority of children will at some time engage in sex play and exploration. Provided that this display and exploration is voluntary and between close-in-age peers or siblings, the evidence suggests that it is entirely consonant with the development of a healthy sexual identity (Sorrenti-Little *et al.* 1984).

Adults and older children have a duty not to use or exploit children (or younger children) sexually in any way. This etiquette of respect for the sexuality and sexual needs of others is a most important goal for socialization, and is also linked to socialization for the etiquette of relationships between the sexes. Sexism and sexual exploitation are attitudes and behaviours learned in childhood. In childhood, too, we may learn to respect the status and sexuality of others.

An important message to adults which should emerge from such child-centred socialization is that for adults to be involved in deliberate sexual stimulation or exploitation of a child could be psychologically disastrous for a child, and is absolutely inimical

to the goals of child-centred socialization, of optimizing healthy growth, self-development and understanding, and mastery of the environment. The message we must give to adults with a sexual interest in children is this:

> If you really 'love' children, you will respect their integrity, their needs, their difficulty in making informed choices, and their acute vulnerability—by having no sexual contact with children at all. If you genuinely love and care about children, you will never become sexually involved with a child.

The expression of healthy sexual feelings in a child is difficult when 'sexuality is attended by both strong positive and negative emotions, and by more potential psychological conflicts than any other activity practised by men and women' (Blumberg 1978). As well, a social taboo exists to keep sex hidden from children. This makes it difficult for parents to come to terms with their children's sexuality and to guide them to healthy expression (Burgess and Holmstrom 1978b). A necessary but difficult prerequisite is that adults should free themselves from the negative and confused socializations of their own childhood, and learn to accept their own sexuality. This is a crucially important task for professionals who work with abused children.

Children need to acquire a more healthy sexual awareness of themselves and others in order to develop fully as sexual beings (Jackson 1982). The sexual experiences of young people reflect culturally dependent gender differences and hierarchy. For example, the transition to adult sexuality for girls conventionally requires little role change. They are expected to maintain their innocence, attractiveness, and desire to please adults. The achievement of sexual maturity for boys requires a much sharper break with childhood. They are expected to take initiative and control in a competitive social arena. 'The facts that men learn to associate sex with power and develop the capacity to be aroused by child-like qualities create the possibility that the sexual interests of adolescents could be directed towards children themselves' (Jackson 1982:173).

Belief in male sexual prerogative has been one of the factors in the oppression of women and children. Non-sexual touching and physical closeness have been undervalued in male socialization so that sexual touching and holding, and intercourse itself

become the primary expression of men seeking physical contact, love, or emotion. One author suggests, however, that such emphasis on sexual activity actually curtails the satisfaction of more basic emotional needs (Lindemann 1983).

Children absorb sexual meanings from adult media and older peer messages in maintaining gender segregation and stereotypes. This is particularly crucial at the time of adolescence when sexuality is assumed as a part of the core of identity (Thorne and Luria 1986). The social supports for gender segregation and stereotyping are lifelong. Children have the additional handicap that any explicit sexual activity (such as that between peers) is considered culturally deviant, so that children have limited scope for developing norms or etiquette associated with their own sexuality. In fact, the natural altruism of children can create its own protocols of humanity and tenderness. Laurie Lee's account of a Somerset childhood is pleasantly reminiscent, in this respect, of the Oxfordshire childhood of one of us! Laurie Lee gives a charming picture of the mutual sexual exploration between pre-pubertal children:

> They received me naturally, the boys and girls of my age, and together we entered the tricky wood. Daylight and an easy lack of shame illuminated our actions. Banks and brakes were our tiring houses, and curiosity our first concern. We were awkward, convulsed, but never surreptitious, being protected by our long knowledge of each other. And we were all of that green age which could do no wrong, so unformed as yet and coldly innocent, we did little more than mimic the realities.
>
> (Lee 1962:206)

It is Jackson's argument that enforcing sexual ignorance on children does more harm than good:

> In attempting to protect children from sex we expose them to danger, in trying to preserve their innocence we expose them to guilt. In keeping both sexes asexual, and then training them to become sexual in different ways, we perpetuate inequality, exploitation and oppression.
>
> (Jackson 1982:180)

In this sense the development of healthy sexuality requires more than personal change. Parents can raise girls to be more independent and boys to be less aggressive, but both have the challenge of living in a society divided by gender and founded on competitive values. Political change is necessary to assure more healthy social reality for future generations. In this respect the findings and recommendations of the 1984 National Commission on Sexual Offences Against Children initiated by the Canadian Departments of Health and Justice (Canada 1984) are important. Time and again, in the numerous case histories collected by this Commission, the adults recalling sexual abuse in childhood said that they had been puzzled and confused by the sexual advances of adults because they had no clear understanding of what sexual assault was, and what adults were allowed to do or not to do to them, in relation to their bodies.

The Canadian Committee recommended, on the basis of this evidence that:

> …the Office of the Commissioner which we recommend be established have as one of its principal responsibilities, in cooperation with the provinces and non-governmental agencies, the development, coordination and implementation of a continuing program of public education and health promotion focussing on the prevention of sexual offences and the protection of young children, youths and adults who are victims.
>
> (Canada 1984:193)

The Committee advocates that children and young people be given both the knowledge to understand the nature of sexual abuse, and the support and self-confidence to report such abuse when it occurs, in the knowledge that an adequate network of helping agencies exist. The struggle to achieve this at a local level in many Canadian communities is part of the dialectic of change, an essential component of the healing process at the community level.

Knowledge and feeling about sexuality is acquired through a developmental process (Comfort 1985). Children need direction, opportunities for trial and error, limits, and guidelines. Part of this process involves helping children feel good about themselves in many different spheres. Children who have had opportunities to be successful at work and play will feel more secure about

themselves and their environment, and can accept and distinguish 'good touching'. Body exploration is part of normal development and children can, with sympathetic help and education, soon tell the difference between touches that are caring and those that are exploitative (Anderson 1979). Because children's rights have traditionally been ignored, children need to be taught how to be assertive about their own necessary boundaries, and feelings about sexuality. Adults should build, in non-intrusive ways, on the child's natural tenderness, creativity, and altruism with regard to sexuality and other matters.

TOWARDS SOCIAL HEALING

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

Social change begins with awareness, but it must also be embodied in practice and reflected in legal and economic realities as well as in interpersonal values. The first change needed is that of remedying power imbalance. To be effective, programmes on sexual abuse must consciously embrace the issues of male power and sexual privilege and be directed towards the empowerment of women and children (Herman 198la).

However, the attitude of empowerment as opposed to awareness also has large implications for social attitudes towards offenders. As long as offenders are blamed rather than held responsible, society will punish rather than rehabilitate. Only when society as a whole takes responsibility for its own abuses of power can individuals be helped to learn mutuality as an alternative method of relationship.

Another issue is that of sexism. One method suggested for reducing the difference in sex role, power and role differentiation is to involve males more in child care. Herman speculates that male dominance is perpetuated by the practice of women being the primary caretakers of young children:

> In girls, the identification with the mother forms the basis for a secure sexual identity and for the development of the capacity to nurture. In boys, adult sexual identity is achieved only by repudiating the primary identification with the mother. In this process, all the qualities associated with mothering—tenderness, emotional responsiveness, and nurturance—are ruthlessly suppressed. The result is the formation of a male psychology in which sexual identity is forever open to question, dominance and sexuality are confused, and the capacity for caretaking is atrophied. Such a psychology makes it inevitable that some men will abuse children.
>
> (Herman 1981a:212)

If child care were shared more equally by men and women, this basis for male dominance and female submission would be eroded. Children of both sexes would have parent models who embody autonomy, mutuality, and nurturing abilities. Direct evidence that the engagement of fathers in basic child care roles with infants (feeding, changing of infants, etc.) reduces the amount of sexual abuse comes from a study by Parker and Parker (1986). Men who learn the techniques of non-sexual intimacy with children (i.e., who learn to be more like women in their child care roles) are statistically very unlikely to develop any sexual interest in children.

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

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

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

> Those who actually had the privilege of growing up in an empathic environment (which is extremely rare, for until recently it was not generally known how much a child can suffer), or who later create an inner empathic object, are more likely to be open to the suffering of others, or at least will not deny its existence. This is a necessary precondition if old wounds are to heal instead of merely being covered up with the help of the next generation.
>
> (Miller 1983:63)

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

VIOLENCE AND CHILD ABUSE

Child sexual abuse is a sub-set of the general category of child abuse. While sexual abuse is the most harmful of all the types of abuse (excluding categories in which the physical abuse actually kills a child), it is, paradoxically, easier to ultimately prevent. We can say to society with some certainty that the sexual use of children by adults is absolutely wrong—a moral and a legal crime which we should prevent on many levels. The problem in regard to physical abuse of children is, unfortunately, more complex. Society tolerates a great deal of physical violence at many levels, including violence against children. Adults and teachers are allowed to use violence and pain as instruments of control and socialization of children. This paradox is highlighted by a recent Canadian case: a man was prosecuted for fondling his 11-year-old stepdaughter's buttocks over her nightdress. However, if he had beaten the child on her buttocks over her nightdress twenty

or thirty times, causing intense pain but using a method which did not leave overnight bruising or scars, the law would have no grounds for intervening, providing that the man claimed that such beating was necessary to discipline a wayward child.

It is our contention that if society is to heal itself in the matter of child sexual abuse, it must heal itself also in the matter of physical and emotional abuse of children. Ironically, the current social movement towards treating child victims of sexual abuse, and preventing such abuse, seems to have drained resources and political energy from programmes which traditionally addressed the issue of physical abuse. Social workers are now often occupied with sexual abuse cases when previously they would have spent their time with physical abuse. Yet, there is no evidence that physical abuse of children has decreased. It is our contention, however, that the movement for wholeness in childhood, the press for conditions of health, physical, moral, and spiritual for children must be one enterprise, a whole, a seamless coat. Yet, intervention procedures for physically abused children are still haphazard and inefficient.

Why, as Barbara Chisholm (1980) asks of Canada and elsewhere, are standards and definitions of child physical and emotional abuse so vague? Why are reporting systems and procedures for dealing with such abuse so inconsistent? Why is child abuse so often ignored and unreported? Why are public standards of what constitutes child abuse so vague? And why is professional action often so unprofessional, uncoordinated, and weak? One of the reasons, as Chisholm points out, is that society itself not only tolerates, but sometimes actually encourages child abuse in the form of physical punishment of children.

'What kind of society permits child abuse?' James Garbarino (1980) asks rhetorically. The answer seems to be that the general values of North American society permit a considerable amount of child abuse simply by allowing levels of violence of all kinds. This seems inevitable, suggests Garbarino, in highly individualistic societies in which, for example, the right to arm oneself against potential attacks by one's neighbours is claimed as a constitutional right. In such a society, gross or publicly disturbing acts of violence against children are attributed to defective parents, while lesser degrees of violence are either tolerated or actually commended as a reflection of parental authority and concern. But such a view, in Garbarino's model, is 'inconsistent, unfeasible and contradictory'. Abusing families are

themselves victims of a violent, individualistic society which isolates individuals and fails to supply adequate social supports and social controls which could inhibit the abuse of children.

North American society blames defective parents for child abuse when, in truth, it should blame itself. Only in a society such as Sweden, in which societal values inhibit the physical abuse and punishment of children, can the individual pathology of parents be clearly identified as a cause of child maltreatment (Tietjen 1980). As David Gill (1984) has said, child maltreatment and child welfare are ideological rather than simply structural or interpersonal issues. Violence in family and public life is an American value: 'Genuine child welfare cannot be attained through professional, technical, and administrative processes alone, but requires consistent political practice toward comprehensive relations and personal lifestyles and values' (Gill 1984:307).

Edfeldt (1979), in her review of violence towards children in many different cultures, has shown that levels of such violence vary greatly between one country and another. Why this is so is not clear; but one thing is certain, violence begets violence—children subjected to excessive physical punishment tend to repeat such a pattern in their own adulthood. There is no evidence that violence towards children is an effective means of discipline. Rather, children subjected to physical punishment become more aggressive. Edfeldt concludes that:

> The graver the violence used in general practice, the more violent are the forms of corporal punishment which, not only teachers and parents, but also children, tend to accept from their concept of violence towards children. The same seems to apply more or less to psychological punishment as well…there is nothing in our material that refutes our initial hypothesis that all kinds of physical punishment, from the slightest shove to cruel child battering, are behaviours belonging to one and the same behavioural continuum…nor is there anything that refutes our derived hypothesis that the only way to tackle the social problem of child battering successfully is to criminalize the lower part of this violence-towards-children continuum.
>
> (Edfeldt 1979:63–4)

What Edfeldt is concluding from her extensive material is that a society which tolerates the physical punishment of children in family and school holds fundamentally ambiguous values about violence towards children in general. Physical abuse of children can only be successfully tackled if it is addressed at all levels, including the tolerance of some societies such as Britain, USA, and Canada, for a whole range of violent activities including the physical punishment of children by parents and teachers. So long as such 'minor' physical abuse is both widespread and legal, attempts to eliminate the more serious types of abuse are likely to founder.

The general violence of North America is reflected in high rates of homicide, not only of adults, but of children as well. This is shown clearly in the comparative study of twenty-three developed countries by Christoffel and Liv (1983). Three per cent of male children under five in the United States die as officially-recorded victims of deliberate or negligent violence, a higher proportion than in any other developed country. Within the international statistics, the US homicide rate of male infants was exceptionally high, reflecting a generally violent pattern of behaviour towards males at all ages. Gilland and Tyler (1983), in an examination of the US data indicating 'homicide as a major cause of pediatric mortality', show that, 'Overall, child homicide predominantly involved young male offenders who were acquainted with their usually male victims. At remarkably early ages, homicide characteristics begin to resemble those of adult homicide.' As a generalization, it may be said that in North America, the preferred mode of abuse of male children is physical; for female children the preferred mode is sexual abuse (Russell 1984).

The rights of parents to cause extensive and regular physical pain to their children have recently been emphasized in Canadian case law (MacPherson 1984). The decisions of higher courts inform the decisions of lower courts. Thus, in the provincial court in Calgary in April 1984 (Howes 1984), a mother was acquitted on a charge of assaulting her 8-year-old daughter. The judge ruled that the mother had 'not used excessive force' in regularly beating her child with a hockey stick, biting the child with such force that welts and bite marks remained on the child's body for days afterwards, and causing bone fractures in the child's hand. The judge accepted the mother's evidence that the child was

wayward in nature, and needed such punishments to prevent yet further naughtiness.

In the same Canadian city, parents protested vigorously to the Minister of Social Services about an advertising campaign in which punishment of a child was depicted with an invitation to call the child abuse hotline. The parents argued that the 'ordinary' punishment depicted in the TV commercial did not constitute child abuse. The Minister acceded, and the campaign was dropped (Ruttan 1981). The new Child Welfare Act in the Province of Alberta introduced in 1985 attempted to define child abuse more carefully, but still defers to the integrity and authority of the family, and its right to discipline children as it chooses. The new limit on this freedom now seems to be that the physical punishment must not leave marks on the child's body that last for more than 24 hours, and must not actually cause fractures (Cavanagh 1983).

However, case law still admits the possibility that parents can lash and fracture exceptionally naughty children with impunity. In the case cited by MacPherson (1984), a judge of the Appeal Court in Alberta overturned a decision of the Family Court, in deciding that the mother of a 12-year-old boy had not, in fact, abused or illegally assaulted him. The boy in question brought home a poor report card from school. The mother had the boy strip naked and lean over a bathtub. She then lashed him twenty-five times with a leather belt, and continued this punishment at half-hour intervals until, by her admission, she was exhausted. The boy was observed at school the following day to have numerous severe welts on his body from lower back to knees, and between his legs. The whole area was bruised dark red and purple, and on top of the general bruising more severe lacerations had been inflicted. The judge of the Higher Court ruled that the child had not been abused in terms of the existing Child Welfare Act.

There are no grounds for supposing that the Province of Alberta is any different in its values with respect to children from any other Canadian province. In the city of Calgary in Alberta, school trustees have consistently acceded to the demands of parents for teachers to strap their children whenever necessary (Serjeant 1985). A similar situation pertains in most schools in Canadian cities (Martin 1976). As Brumitt (1982) has pointed out, schools often set the standard for parents: if schools can strap, so can parents. And how much strapping is too much? Is

daily strapping which causes pain but leaves no marks acceptable? Or is the occasional more severe beating equally acceptable? The law does not tell us, but as Brumitt argues, the example of the schools may 'promote, perpetuate and even legitimize aggressive, violent response' by parents and children.

Corporal punishment, in this model, simply perpetuates or supports the cycle of child abuse through generations. These and other rational arguments such as those of Dubanowski *et al.* (1983) reviewing evidence showing that corporal punishment is counterproductive, while non-punitive methods of socialization and control are far more effective, seem to fall on the deaf ears of the public.

The desire of adults to punish, control, and cause pain to children is probably based in a non-rational ideology, rooted in their own childhood. In Britain in a recent survey, two-thirds of adults questioned supported caning in school. Support was strongest amongst older and working-class people, both groups who had experienced pain as a systematic means of socialization and control in their own lives.

If values supporting child maltreatment pervade family and school, are child protection services themselves influenced by such values? The answer, unfortunately, seems to be 'Yes'. Newberger (1983), a persistent critic of the way in which children's services fail to meet the needs of abused children in the United States writes ominously that 'the helping hand strikes, again'. He continues:

> The assumption of low frequency, the benevolent role for government, and the competency of child welfare programs must be challenged in light of present data, values and experience. The promise implicit in child abuse laws is an empty promise for many children. Hospital recognition of child abuse is defined as much by class and race as by severity. A new propensity to criminalize family problems and the possible advent of government intrusions into the newborn nursery suggest a risk of more harm in the guise of help.
>
> (Newberger 1983:307)

Newberger advocates instead a national programme of prevention and education addressed to every family, not merely to selected groups of stigmatized families. Certainly, the analysis of Bross

(1979) which argues that child welfare systems fail because they have 'no coherent view of childhood' which can inform consistent or effective decisions, is compatible with Newberger's view. At present the system of child care for 'abused and neglected children' in North America and most of Europe abounds with anomalies, including the reabuse of children in foster homes and institutions of various kinds (Bagley andThurston 1988).

Child abuse in North American and some European cultures is but part of a general climate of violence which pervades many aspects of family relationships. Gelles and Straus (1979), in their survey of a large sample of American families, suggest that the violence of society is generalized in family relationships as a method of social control, by men of women and children, and by women of children. These authors observed that, 'with the exception of the police and the military, the family is perhaps the most violent social setting, in our society. A person is more likely to be hit or killed in his or her home by another family member than anywhere else or by anyone else.'

Van Stolk (1978) makes a similar observation with regard to Canada:

> A culture which ignores its own institutional violence may ultimately trigger its own destruction. Canadian society ignores the brutalization and violence which is routinely inflicted on children by parents, but it also ignores the brutalization and violence that is portrayed by television exploiters, by sexual-sadistic pulp magazines, and by cheap journalism…society feeds violence…. Violence is a cultural style.
>
> (Van Stolk 1978:114)

Considered within this cultural context of media as a cultural support for child abuse, the recent flood of well-produced, child-centred video productions aimed at helping children resist child sexual abuse or report it rapidly, is both strange and welcome. The novel element in such production is that these presentations tell children very clearly that they have rights to avoid, resist, and say 'NO' to one of the many unpleasant and demeaning things which adults lay on them: in this case, sexual assault. The strangeness of the message lies in the fact that perhaps for the first time children are told that they have a right to say no, even

though other wrongs and harms imposed on children (including physical punishment) are not specifically mentioned. We would argue, however, that until we have a clearly-defined set of principles establishing the rights of children in many different areas, programmes aimed at sexual abuse prevention will only be partially successful.

What exactly should be the rights of children? They are not exactly the same as adult rights—it is not necessary for children to have rights to vote, drive a car, or drink liquor. Children should have 'protective rights' rather than 'presumptive rights'. Children should have the right to be protected from assault, by the ultimate sanction of legal intervention and punishment of those who assault and abuse them. They also have an 'absolute right' to have their developmental needs (including psychological and spiritual growth) protected and supported.

It is sometimes speciously argued that rights and duties are correlative: that individuals should only have rights if they perform certain duties. But this notion begs the question of 'absolute rights' which transcend the common conundrum of 'correlative rights'.

Paul Sieghert puts the matter well in his book *The lawful rights of mankind* (1985):

> In all legal theory and practice, rights and duties are symmetrical. It is a popular fallacy to believe that this symmetry applies within the same individual: that if I have a right, I must also have a correlative duty. This is not so: If I have a right, someone else must have a correlative duty; if I have a duty, someone else must have a corresponding right.
>
> (Sieghert 1985:94)

Children have the right to be protected from exploitation and maltreatment, and the right to have their developmental needs fostered and protected. Adults have a duty to ensure that these rights are fulfilled. The challenge for adults, and the struggle for cultures in the midst of social change is to ensure that adults whose childhood needs were not met, nevertheless strive to meet the needs and respect the rights of a new generation of children.

CONCLUSIONS

This chapter outlines the need for healing at the level of society. Three levels of prevention are reviewed with eradication of root causes and reduction of prevalence considered primary; rapid and effective treatment of victims seen as secondary; and rehabilitation and the prevention of the cycle of abuse defined as the tertiary level.

Three socialization issues are targeted for change within primary prevention. Although they are recognized as interventive, these three components—the dynamics of power imbalance, sexual objectification, and general violence—are identified as separate components contributing to child sexual abuse. Power imbalance includes the male tradition of patriarchy, and the general subjugation of children's rights within society. Sexual objectification includes the use of language and imagery which obscure the gender realities of abuse as well as sex role stereotyping imposed on children. Pornography is cited as an example of sexual objectification.

Violence is seen as the compulsive repetition of the exercise of power. Adults tend to repeat the violence experienced by themselves as children by perpetuating childhood as a subjugated social stratum. Violence is also extended to children by the social tendency to promote identity through the stigmatization of others. The acceptance by the larger culture of many forms of violence, including the physical chastisement of children, helps perpetuate a climate of violence at a broader and more basic value level. Child abuse, including sexual abuse, will continue so long as society tolerates violence, exploitation and imposed inequality, and powerlessness in a variety of institutions. Children are powerless, and largely without rights. They are powerless, too, in the face of various forms of child abuse.

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

Society needs to move in a non-patriarchal, non-sexist, and non-violent direction to promote healing. Programmes for the prevention of child sexual abuse must address the issue of empowerment, not only for those who have been victimized, but

for all children, all potential victims, and all potential offenders. This includes holding offenders responsible in ways that are non-stigmatizing so that they too are empowered to become responsible citizens. Increased involvement of males in early child care is one means of reducing sexism, and increasing non-sexual tenderness. Legal changes to curtail child pornography are also necessary for the further protection of children from sexual abuse. Elimination of violence in the media and at all levels of society is also a component of social healing.

Social healing is the culmination of individual and community programmes. It is the achievement and expression of social values which promote mutuality, respect, and optimal development for all members of society.

Chapter Eleven

IMPLICATIONS FOR PRACTICE AND RESEARCH

> Social work is a profession committed to the goal of effecting social changes in society and the ways in which individuals develop within their society for the benefit of both. Advancement toward this purpose is achieved through the complementarity of social reform and therapeutic approaches premised in the belief that social conditions of humanity can be bettered.
> Preamble to Canadian Association of Social Workers (1983), *Code of ethics*

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

INTERFACE OF SOCIAL WORK AND HEALING

The nature of social work intervention is based on developmental principles rather than on social control. Three different

specializations will be highlighted to illustrate the view that social work encompasses the full spectrum of intervention from social work encompasses the full spectrum of intervention from individual treatment to social change. Clinical practice, child advocacy, and social development each provide unique but complementary aspects of healing.

Clinical Practice

This area of social work specializes in individual healing. While work may occur in group or family formats, the focus is on empowering each person to become a more healthy individual and more nurturing of both self and others. The treatment issues and principles developed in Chapters 7 to 9 are not exclusive to social work and can be adapted by any clinical programmes dealing with survivors and offenders involved in child sexual abuse.

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

Child Advocacy

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

Services for children need to address the totality of their needs, from nutrition and health care to intellectual stimulation and emotional security. Child advocacy includes concern and action about a range of issues such as support for families, day care services, educational programmes, playground and street safety, and recreational opportunities as well as basic emotional and

financial securities. This list is not meant to be exhaustive, but illustrates the many levels at which the needs of children are overlooked. An excellent example of child advocacy in the disciplines of architecture and town planning is provided in Colin Ward's treatise on *The child in the city* (1978).

The prevention of child sexual abuse is an important focus within child advocacy concerns. Educational programmes designed to teach children personal safety, awareness programmes to sensitize parents to the possibilities of abuse are needed, as well as professional development programmes to improve services offered by the range of helping agencies. For example, the legal system is often more interested in prosecuting young prostitutes than their adult customers (Conte 1984a). This often perpetuates the sexist ideology that the young people are at fault while denying that without the adult male participation, there would be no exploitation.

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

Social Development

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

A helpful perspective for understanding the context of political change in relation to sexual values (including those involving children) is presented by Valentich and Gripton (1984). They suggest that any political position in relation to social action and reform is dependent on ideology. Ideology is defined as 'a set of ideas and values that provide an integrated and comprehensive

view of the world and human nature' (1984: 449). The differences between conservative, liberal, and radical ideologies can be clearly identified. Each political stance has its own particular impact on the development of social service programmes and the possibility of social change. But it is clear that even politically conservative administrations can initiate social change in the 'healing' direction!

Following Gripton and Valentich's (1985) analysis, a conservative ideology tries to maintain traditional values oriented to family unity and a male-oriented political and economic system. Such an ideology would tend to see child sexual abuse within a public order perspective, with emphasis on social work in minimizing deviance, and maintaining family integrity. Service to the child would include crisis counselling and therapy to strengthen the family unit without challenging the underlying nature of gender roles in the larger social structure.

A liberal ideology leans more towards individual freedom and opportunity; it challenges traditional gender-role stereotypes and promotes a somewhat fuller recognition of women's rights in society. Such an ideology would see child sexual abuse in light of gender socialization and social inequality. Services will include both direct treatment and public education programmes. Both child and offender are seen as equally victimized by their specific socializations. Educational activities include professional in-service and multi-disciplinary planning to improve the awareness and responsiveness of all community programmes.

A radical ideology, supported by some feminist groups, calls for social action to end patriarchy and the oppression of women and children. Child sexual abuse is seen as another expression of women and children's lack of political and economic power. Service will be directed towards consciousness raising by helping women realize their oppression and organizing political action. Individual work is seen as a catalyst to social change as the economic and political structures are the true targets of intervention.

Identification of Research Needs

A number of research needs were identified in earlier chapters. Effective management of treatment agencies will always depend on the collection, utilization, and integration of information from different professionals involved with the various individuals

associated with a child sexual abuse case (MacLeod and Wachtel 1984). The focus on individual healing raises issues concerning diagnostic assessment, establishing degrees of abuse and trauma, and the effectiveness of different kinds of intervention and treatment. Larger questions to be addressed include the nature and effects of different forms of socialization aimed to protect children, and make sexual abuse less likely.

Earlier authors identified the need for more empirical studies to clarify diagnostic evaluation (Johnston 1979). Studies are still required to separate the effects of child sexual abuse from other traumatic factors in family background (Brown 1979; Fromuth 1986; Bagley and Young 1988), and from other traumas such as physical abuse or extreme neglect which may be happening simultaneously (Mrazek 1983; Bagley and MacDonald 1984).

Little is known about the nature and antecedents of adult erotic desires and fantasies concerning children (Conte 1982). Research is also needed to distinguish individual characteristics from personal history and family structures for both offenders and victims (Giles-Sims and Finkelhor 1984). For example, it is known that many offenders were abused as children; but not everyone abused as a child becomes an offender. Identification of the dynamics which make the difference would allow earlier screening and intervention with high-risk individuals. More information is also needed about the adaptations in later life of adolescent perpetrators (Mrazek 1983).

Similarly, not all children who are abused are traumatized. The psychodynamic consequences of unresolved sexual incidents have a variety of implications for adult identification and the development of sexuality (Burgess, Holmstrom, and McCausland 1978). More needs to be known about developmental processes—for example, how an early assault influences adult personality (Herman 1981a) and whether particular types of victimization lead to specific kinds of problems (Painter 1986).

The skills and strengths of victimized children whose lives were not negatively affected need to be identified (de Young 1981). As well, a comparison of children in the same types of 'risk' environment, only some of whom were actually abused, will help identify factors of vulnerability (Jones, Gruber, and Timbers 1981).

More needs to be known about which factors determine whether a young victim will, in the long-term, express a specific symptomatology, and what the long-term prognosis will be (Mian

et al. 1986). More specific information is needed about the predictors of self-destructive behaviour as a survival response (Lindberg and Distad 1985b; Bagley and Young 1988), and the relationship between sexual abuse and running away (McCormack *et al.* 1986; Bagley and Young 1987).

Methods of crisis resolution for victims need to be identified which are most appropriate for each developmental stage (Elwell 1979). Testing the effectiveness of different types of treatment modalities is an integral part of any clinical programme. Single-subject designs are suggested by Conte (1984a). The advantage of this type of evaluation is that the need for a control group is eliminated. Care must also be taken to ensure that treatment outcomes are not altered by research observations (Coulters *et al.* 1985).

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

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

The question has been addressed by a number of authors. Bagley (1988a) found in a national Canadian survey, that the amount of sexual assault in childhood recalled by adults varied significantly with the age of the person reporting only for the youngest subjects (aged 18–20) who reported significantly more abuse. On the other hand, Russell (1986) who compared reported incidents over ten-year intervals, found a significant increase in both intrafamilial and extrafamilial abuse: 'Both incestuous abuse before eighteen and extra-familial child sexual abuse before fourteen have quadrupled between the early 1900s and 1973' (1986:81). Clearly, more studies are required to confirm these figures and determine regional and cultural differences. This problem could be addressed by large-scale studies which ask large samples of young adults to recall events of sexual abuse in their childhood. If there is a real increase in prevalence, then 25-year-olds should report a lower prevalence than, say, 21-year-olds. On the other hand, if prevention programmes are beginning

to have an effect, then 18-year-olds should report a lower prevalence than 25-year-olds. Both Finkelhor (1984a) and Russell (1986) argue that the increased prevalence reported by young adults could be a function of the higher rate of divorce and separation since 1950, and the increased risk which stepfathers and cohabitees represent for children in 'blended' families. More research needs to be done into the dynamics of such blended families.

More information is also required about the numbers of 'at risk' children and their ages in relation to biological versus stepfather abuse (Phelan 1986). Stepfathers and cohabitees usually have access to children in a family when these children are at a later developmental stage. Is interaction with a much younger child an 'inoculating' factor inhibiting sexual interest in the child as Parker and Parker (1986) suggest?

More also needs to be known about the effectiveness of preventive educational programmes (Conte *et al.* 1985; Bagley and Thurston 1988), including which types of learning will help the child recognize, resist, or report in a practical situation, and how long concepts are retained (Meikle *et al.* 1985; Swan *et al.* 1985).

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

Above all, more needs to be known about the nature and consequences of any kind of childhood sexual experience. 'We know more about rape than we do about rapture,' says David Finkelhor (1980b:192). Society must not lose sight of child sexual health.

SUMMARY OF THE ARGUMENTS

The history of child sexual abuse indicates that this is not a new phenomenon but one that has been manifest in many different ways in all cultures, at all points in time. Services specifically for abused or neglected children, however, have a relatively short history and within that tradition, recognition of the trauma caused by child sexual abuse is even more recent. Much of present awareness can be credited to the consciousness-raising

movements of women's groups who exposed the violence suffered by women and children within their homes.

Child sexual abuse is defined as any sexual activity or experience imposed on a child which is unwanted by the child at the time, and which may result in emotional, physical, or sexual trauma. The key concepts are that the activity is imposed and that it has the potential to cause harm. Ethical questions about a child's participation or the extent of trauma must be considered in the context of nurturance towards optimal health.

A survey of prevalence studies confirms that child sexual abuse is a pervasive social phenomenon, with up to one in four females, and up to one in ten males having experienced part, at least, of the continuum of sexual abuse. The development of a community model serves to introduce the many components of healing which we have outlined in some detail.

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

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

Treatment for family members includes treating non-offending parents and non-abused siblings; and addressing sexual abuse among siblings. Healing within the family involves a similar process of dealing with feelings, and enabling members to respond to each other more directly and supportively. Traditional family therapy is not recommended for families in which sexual abuse has occurred.

Healing of offenders is a complex problem, since it includes dynamics of addiction, developmental trauma, socialization, and

possible neurological problems. Evidence suggests that few offenders voluntarily seek or complete treatment, so effective programmes need to work in conjunction with legal authorities. As well, healing of offenders is often a process of control rather than cure. They must be empowered to accept responsibility for their own behaviour since often there are not recognized 'cures' for many deviant sexual orientations or paraphilias involving children.

Primary prevention of child sexual abuse, at the level of value change in a complex social structure is possible only through healing and change in some basic values concerning children. Three components of contemporary socialization that support the continuation of child sexual abuse are power imbalance between the sexes and between adults and children; justification through a variety of value systems for sexual exploitation; and institutional violence. While a society based on complete respect and mutuality is recognized as an ideal, this is, nevertheless, the model of health towards which political change must focus.

RECOMMENDATIONS AND CONCLUSIONS

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

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

The skills required by social work practitioners in dealing with child sexual abuse have already been developed. What is required is a new sensitivity to the pervasiveness of the problem, to the dynamics of secrecy and socialization, and to the extent of associated trauma; and a fuller understanding of and commitment to the role of social work as a discipline which seeks to bring about social change on behalf of client groups by working with broader social systems which influence the client-community interactions (Germain 1984).

The following recommendations are made in the context of social work practice, although it is understood that many of the implications are interdisciplinary:

(1) Social work and related professions must commit themselves to accessing and understanding new information about child sexual abuse. The overviews of the previous chapters have attempted to provide the background and emerging trends of current literature, recognizing that because of the information explosion no such review can claim to be complete. It is important, however, to maintain an overall perspective so that new information can be placed in specific context. Several bibliographies have been compiled to assist readers in search of more specific information (Bagley 1983a, 1983b, 1985; Bagley and Thurston 1988; Mrazek 1983a; Ryan 1986; Schultz 1979).

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

(3) Social work must expand its knowledge and skill base sufficiently in order to provide effective advocacy within society (Holmes 1981; Germain 1984). This means clinical intervention skills must be matched with basic knowledge such as that concerning legal processes, and the interaction of clients with other social systems. Individual freedoms must always be weighed against the actual or potential oppression of other members of society (Valentich and Berry 1987).

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

(5) Social work must commit itself to continued research at all levels of causality and treatment, continuing the research

which was outlined above. This includes a commitment to act upon recommendations already made, such as those contained in the Canadian Justice Report (Canada 1984).

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

It is important that all persons, lay and professional alike, be sensitized to the trauma of child sexual abuse and motivated to take action towards healing. The words of Kahlil Gibran (1985) offer a fitting conclusion:

> You are good when you walk to your goal firmly and with bold steps.
> Yet you are not evil when you go thither limping.
> Even those who limp go not backward.
> But you who are strong and swift, see that you do not limp before the lame, deeming it kindness.

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NAME INDEX

SUBJECT INDEX