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An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse: Should Therapists Ask About Thoughts or Behaviour Involving Sex with Children?

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AN EXPLORATION OF COUNSELLING PRACTICES WITH WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE SHOULD THERAPISTS ASK ABOUT THOUGHTS OR BEHAVIOUR INVOLVING SEX WITH CHILDREN?

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ABSTRACT

Helping professionals and women, themselves, have been reluctant to recognize or acknowledge that females can and do sexually abuse children and adolescents Research has also demonstrated that females most at risk to abuse children are those who were themselves victims of severe child sexual abuse (CSA) The purpose of this research was to explore whether or not current counselling practices with women survivors of CSA reflect the belief that women do not sexually abuse children This study also focuses on whether or not therapists create space for discussion about thoughts and behaviour involving sexual abuse of children and adolescents with their women survivor clients, and if so, how this is done

This mixed methodological study examined social workers' and other counsellors' beliefs about what constitutes CSA, who commits sexual abuse, and the relationship between their beliefs and their self-reported behaviour in counselling practice with women survivors During the first phase of the study, therapists from across Canada who work with women survivors were surveyed Telephone interviews were conducted in the second phase with selected study participants to further examine their practice with women survivors

The survey demonstrated that 70% of respondents thought it was important to inquire about thoughts or behaviour involving sexual abuse of children, however, a key finding was the apparent discrepancy between the therapists' stated ideals and their description of their actual practices Also, the respondents' beliefs about what constituted sexually abusive behaviour differed significantly depending on the gender of the person perpetrating the behaviour Male perpetration was identified as more inappropriate than

female-perpetration for a similar scenario The telephone interviews provided further information regarding how to best approach women survivors about the possibility of thoughts or behaviours involving sex with children and the potential consequences to such an inquiry

The study concludes that counselling practices with women survivors of CSA should include the exploration of the woman's experience in terms of thoughts or behaviours involving sex with children and/or adolescents and that this exploration should be conducted in a sensitive and professional manner Recommendations of how to conduct the explorations sensitively were suggested by participants

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Introduction and Literature Review

Introduction

Although the issue of childhood sexual abuse (CSA) began to receive serious attention from mental health professionals in the 1980s (Allen, 1990), the type of attention received by victims of CSA has depended largely on their gender The prevalence and incidence reports of female victims of CSA, for example, are significantly higher than those for male victims, with the majority of sexual abuse perpetrated committed by men (Briere & Elliott, 2003) It is understandable, therefore, that the majority of treatment interventions designed for victims are based on perceptions of the needs of female victims who were sexually abused by men A review of current literature shows that assessment and treatment approaches with female survivors of CSA tend to reflect the perspective that women do not sexually abuse others In contrast, male victims of CSA are commonly assumed to pose a risk to later sexually abuse others (Glasser et al , 2001, Salter et al , 2003) This perspective informs assessment and treatment interventions with male survivors of CSA, particularly the practice of routinely questioning the male client regarding the possibility of sexually abusive behaviour (Crowder, 1995)

That women do sexually abuse children remains under-recognized and underreported (Denov, 2003, 2004) Studies pertaining to prevalence (retrospective surveys) and incidence (number of occurrences from legal/judicial data) of CSA demonstrate that sexually abusive behaviour by women does occur, although this appears to occur to a lesser extent than sexual abuse by men (e g , Briere & Elliott, 2003, Peter, 2009) Conditions that may contribute to this issue remaining relatively hidden and

under-recognized include how CSA is defined, and commonly held assumptions, beliefs, or stereotypes that women are not at risk to abuse children sexually

The purpose of this research is to explore whether or not current counselling practices with adult female survivors of CSA reflect the perspective or belief that women do not sexually abuse others More specifically, this study is a mixed methodological inquiry about how therapists approach the potential sexual abuse issues of adult female survivors of CSA within the counselling context, with a focus on how space is created (or not) for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents The mixed method research study is approached sequentially by first using a web-based survey to explore the purpose followed by telephone interviews with interested survey participants

Definition of Terms

A brief explanation of terms that are applied throughout this research study is required

Beliefs Based on a dictionary definition, a belief is "an acceptance that something is true especially one without proof , firmly held opinion" (Soanes & Stevenson, 2003, p 149) Regardless of the available empirical research about CSA, therapists will have their own beliefs, assumptions, or opinions about CSA due to their education, work experience, training, and personal ideas about CSA

CSA *Childhood* sexual abuse, for the purpose of this research, will be defined as childhood being under the age of 18 years As will be shown, there is no consensus in the literature as to the definition of childhood (Fergusson & Mullen, 1999, Haugaard, 2000, Holmes & Slap, 1998), however, recent population surveys assessing prevalence of CSA

(Briere & Elliott, 2003) and defining child abuse and neglect (Bensley et al , 2004) have utilized the criteria of under 18 years of age to define children

Additionally, *sexual abuse* has not been defined with any consensus within the literature (Fergusson & Mullen, 1999, Haugaard, 2000, Holmes & Slap, 1998), therefore, the definition of CSA for the purpose of this research will encompass Finkelhor's (1994) required elements "(1) sexual activities involving a child and (2) an 'abusive condition' such as coercion or a large age gap between the participants, indicating a lack of consensuality" (p 32) This "large" age gap will be defined as five years to ensure clarity of the abusive condition in relation to age differential Examples of sexual activities would include "oral-genital, genital-genital, genital-rectal, hand-genital, hand-rectal, or hand-breast contact, exposure of sexual anatomy, forced viewing of sexual anatomy, and showing pornography to a child or using a child in the production of pornography" (Johnson, 2004, p 462)

Perpetrators/sex offenders To ensure a respectful presentation of this sensitive topic, there is a deliberate intent to avoid condemning women (and men) who have abused others sexually by purposely not using the stigmatizing label of "sex offender" or "perpetrator" Reference to both women and men who have sexually abused others are presented in behavioural terms in most cases, however, the occasional use of the term "perpetrator" is applied to differentiate succinctly who had been victimized and who had sexually perpetrated

Sexually Inappropriate Thoughts Throughout this study, the term "sexually inappropriate thoughts" will be used to describe thoughts or fantasies that contain high risk ideas or thinking about engaging in sexual behaviour with children and/or

adolescents by a survivor client There is no presumption that sexual thoughts about children and/or adolescents will result in the commission of CSA but rather the concept of thoughts about engaging in sexual ways with children and/or adolescents is presented as important to opening the discussion with women survivors who may experience these unsettling thoughts Some authors suggest that an admission that a female is having thoughts about engaging in sexual behaviour with children is a risk factor in terms of actually engaging in sexual behaviour with children and/or adolescents (Nathan & Ward, 2002)

Survivors/victims Although the practice of referring to persons who have been sexually abused as "survivors" or "victims" can also be problematic (Denov, 2004, Lamb, 1999), these terms tend to have more positive connotations than the label of sex offender Both the literature and persons who have experienced CSA commonly use the descriptors survivors or victims and these terms may not necessarily be considered stigmatizing This study, therefore, uses these terms to differentiate victims or survivors from individuals who have engaged in abusive behaviour even though some individuals have experienced both being a victim and engaging in sexually abusive behaviour

A "woman" survivor is assumed to be an adult Generally, 18 years and older is the accepted age of an adult (Bensley et al , 2004, Briere & Elliot, 2003, Holmes & Slap, 1998)

Therapist Although social workers commonly provide assessment and treatment interventions with female survivors and the primary concern of this research pertains to social work practice, the more general term "therapist" is used This term is inclusive of other disciplines involved in providing assessment and treatment interventions for women

survivors of CSA and thus, other disciplines have been included in the sample Other disciplines may include psychiatry, psychology, women's studies, nursing, marriage and family therapy programs, community college programs related to social services and counselling services, and persons working in supportive or counselling positions with no formal training As well, these other disciplines contribute to the broader literature base pertaining to CSA

Theoretical Framework

Two overarching theoretical frameworks inform the understanding and context from which this study has been developed social learning theory and a post-modern feminist theoretical perspective Additionally, some pertinent trauma-based conceptual models that aim to increase understanding of the impact of CSA are rooted in social learning theory, and they are also discussed

Social learning theory prevails as the most common theory employed to explain sexual aggression in adult and juvenile males (Burton, 2003, 2008, Burton & Meezan, 2004, Burton, Miller, & Shill, 2002, Sermabeikian & Martinez, 1994) No theory has emerged that can explain fully or provide understanding of all situations of sexually abusive behaviour perpetrated by women (Peter, 2009) However, Bandura's (1973) social learning theory offers the most logical framework and provides the basis from which the phenomenon of sexually abusive behaviour by women is understood The basic premise of social learning theory is that people learn their behaviour by direct or observed experiences that include some form of consequence or reward that reinforces the behaviour, these reinforcing experiences are combined with the unique cognitive processes of the individual, which explains the differences of response among

individuals The individual response differences, however, are believed, in some cases, to be associated with gender

Bussey and Bandura (1999) examined the concept of gender development and differentiation by applying a more broadly-defined concept of social learning that integrates both the psychological and social constructs that extend beyond the influence of family, such as peers, media, and educational practices, they referred to this extension as *social cognitive theory* Although gender role stereotypes continue to influence how society perceives male and female differences, females can acquire aggression-based behaviour similarly to males Bussey and Bandura postulated that females' ability to apply restraint is what differentiates them from males

Within mainstream scholarship, a number of conceptual models have been developed to in an attempt to understand the short- and long-term effects of CSA from varying perspectives, including social learning theory (Davis & Petretic-Jackson, 2000, Freeman & Morris, 2001), however, very few models focus specifically on the impact of CSA on sexual development One of the most recognized models, which is rooted in Bandura's (1973) social learning theory, and provided early theoretical conceptualizations regarding the impact of CSA on sexual development, has been employed in this study This model is Finkelhor and Browne's (1984) model of traumagenic dynamics

The Finkelhor and Browne (1984) model consists of four dynamics posited to contribute to the effects of CSA experiences traumatic sexualization, stigmatization, betrayal, and powerlessness According to Finkelhor and Browne, the interaction of the dynamics of the sexual abuse perpetrated on the child in conjunction with the

psychological impact and behavioural manifestations creates an impact that is considered unique from the effects of other forms of abuse or trauma The most salient traumagenic dynamic for the focus of this study and in terms of sexual development is traumatic sexualization because this dynamic is described as having an impact on subsequent sexual behaviour (Tharinger, 1990) Finkelhor and Browne (1984) described traumatic sexualization as the process of sexualizing the child The person committing the sexual abuse repeatedly rewards the child with "affection, attention, privileges and gifts" (Finkelhor & Browne, p 181), as a means of enticing rather than using force to engage the child in the sexual behaviour, subsequently, the child learns to use sexual behaviour to meet his or her own needs (i e , for affection, attention, etc) The person committing the abuse may also attempt to arouse and/or fetishize the child sexually through stimulation of the child's sexual body parts, promoting the sexualization of the child, thus the child learns to seek out further sexually arousing experiences that are often deemed as inappropriate for their age and developmental level This pairing of "positive reinforcement", such as intimacy, with the sexual abuse stimuli is consistent with Bandura and Walters' (1963) social learning theorizing of how deviant sexual behaviour may develop

The age and developmental level at which a child is introduced to sexual behaviour by an adult is believed to impact the sexualization process (Finkelhor & Browne, 1984) Finkelhor and Browne suggested that younger children (no age provided) might become less sexualized by their sexual abuse experiences until they have more awareness of the sexual implications They theorized that the behavioural manifestations of these CSA experiences can include sexual preoccupation, compulsive

masturbation (not stopping when asked or masturbating in public), earlier peer sexual interaction, victimization of others, sexual dysfunction, and inappropriately sexualizing their own children

Finkelhor and Browne (1984) suggested that some children develop an aversion to sex and intimacy, other children become preoccupied and compulsively seek out sexual experiences Van der Kolk (1989) attributed the compulsion to seek out sexual experiences to behavioural re-enactments of the sexual abuse, with boys more commonly repeating the aggression by identifying with the aggressor and later victimizing others Girls were reportedly more apt to seek repetition by becoming involved with abusive men and "allowing" themselves and their children to be further victimized Although this "repetition compulsion" theory represents a very gender-biased and patriarchal perspective that does not account for female-perpetrated sexual abuse, the importance of recognizing repetition compulsion as a potential response to the traumatic experience of sexual abuse supports aspects of Finkelhor and Brown's (1984) dynamic of traumatic sexualization The many differing factors surrounding the CSA experiences as well as the unique personality aspects of the individual will result in varied responses to the CSA Furthermore, gender expectations and responses of caregivers and other significant persons to the child will also fulfill a role in the interpretation, definition, and reinforcement of subsequent sexual behaviour

Finkelhor and Browne's (1984) model has provided some explanation of possible subsequent sexually abusive behaviour associated with past CSA experiences and has been applied consistently to male survivors within the counselling context (Briere, 1996, Crowder, 1995), however, female-perpetrated sexual abuse has been under-recognized

and less explained in the literature (Denov, 2004) It can be assumed, therefore, that female-perpetrated sexual abuse has been less explored with female survivors of CSA within the counselling context Additionally, female-perpetrated sexual abuse has been described as more difficult to define and recognize (Denov, 2003, 2004, Holmes & Slap, 1998), a phenomenon about which Bandura's (1973) social learning theory can provide some further understanding

Bandura (1973) points out that sexual perpetrating behaviour from the perspective of the victim or those providing support to victims (i e , therapists) is usually understood as aggressive or harmful for the victim, however, Bandura states, "judgmental controversies are most likely to arise when injurious actions take subtle or indirect forms" (p 9) These conditions contribute to the difficulty in defining or labelling aggressive behaviour, particularly when females perform subtle or indirect sexual aggression In this regard, social learning theory provides a useful framework for understanding the challenges in defining sexual abuse perpetrated by women

In addition to social learning theory, which underpins the understanding of how past CSA can potentially lead to later sexual perpetration by some adult female survivors, it is important to establish a second theoretical framework by which this study is informed contextually Although this study incorporated a mixed methodology with a primarily positivistic approach to the research, the decision-making related to the study (e g , use of language in survey design) has incorporated a post-modern feminist theoretical perspective This perspective retains recognition of the important dimensions of patriarchy, power, relationship, sexuality, and woman's agency in relation to CSA, however, it also recognizes "that women have certain kinds of power (for example, over

children)" (Stainton Rogers & Stainton Rogers, 2001, p 141) By retaining these dimensions, I seek to avoid undermining or negating the serious concerns related to violence by men against women and children Furthermore, I do not wish to demonize women by investigating sexually abusive behaviour perpetrated by women, rather, I hope to challenge the conventional feminist thinking that situates women as "victims only" (Renzetti, 1999) and increase the probability that women survivors of CSA who are at risk to abuse children sexually will receive help to avoid this behaviour

A post-modern feminist perspective includes the recognition of multiple realities, truths, and differences between individuals, and challenges the victim stereotypes and generalizations that are so commonly applied to women survivors of CSA (Atmore, 1999a, 1999b, Featherstone, 1996, Fitzroy, 2001, Hetherton, 1999, Lamb, 1999, Pollack, 2000, Renzetti, 1999, Robinson, 1998) By exploring these "women as victim" beliefs in the context of how therapists approach the potential sexual issues of adult female survivors of CSA within the counselling relationship (specifically how they discuss potential sexual boundary crossing or sexually inappropriate behaviour involving children and adolescents), a shift towards greater protection of children from sexual abuse may result as well as more effective help for the female survivor Furthermore, the integration of post-modern feminist theoretical principles, such as "challeng[ing] the dualist categorization that portrays men and women as inherently and essentially different" (Stainton Rogers & Stainton Rogers, 2001, p 143), particularly with regard to the issue of female-perpetrated sexual abuse, will ensure a respectful process regarding a very sensitive and important topic To reiterate, this perspective includes the principle that the realities of broader patriarchal issues are not in question

Literature Review

The exploration of the literature aims to summarize current empirical knowledge about how therapists attend to the potential sexual abuse issues of adult female survivors of CSA within the counselling context, with specific focus on how space is created for discussion of thoughts or behaviour involving sexual activity with children and/or adolescents In order to understand what therapists do and how therapists may be influenced in their practice, available research on treatment interventions for adult female survivors of CSA and a broad understanding of definition, prevalence, and incidence of CSA provides insight into current practices and general knowledge about CSA

Current knowledge about the impact of CSA on female sexual development and women who have abused children sexually may also contribute to informing practice behaviour with female survivors of CSA Regardless of the available information about CSA and counselling practice literature, therapists also apply their own beliefs to their counselling practice, thus, reviewing prior studies of therapists' beliefs and the associated practice implications with CSA is an important part of this literature review It will be shown that counselling with women survivors that includes exploration of potential sexual boundary crossing or sexually inappropriate behaviour involving children and adolescents is rarely recommended or even discussed in the literature This gap in the literature provided the impetus to investigate whether the lack of attention to this issue in the practice literature reflects a similar lack of attention within current practice realities Therefore, the review of literature is organized into the following sections prevalence, incidence and the role of definition of CSA, impact of CSA on female sexual development, studies of sexual abuse perpetrated by women, review of current treatment

interventions with female survivors of CSA, a review of research pertaining to therapists' beliefs or knowledge about CSA, and a synthesis of this literature review

Prevalence, Incidence, and the Role of Definition in CSA

The literature examining CSA has been predicated on studies pertaining to the incidence and prevalence of this issue and the definition of sexual abuse Since the 1980s, incidence and prevalence studies have contributed to the acknowledgement of CSA as a serious issue needing to be understood and addressed (Allen, 1990) A review of these studies demonstrates that the CSA incidence and prevalence rates vary according to the definition of CSA that is provided to the participants of these studies Furthermore, these incidence and prevalence studies reveal the presence of sexually abusive behaviour by women It will be shown that how CSA has been defined within the various studies is a factor contributing to the underreporting of female-perpetrated sexual abuse and possible under-recognition by therapists working with women survivors of CSA

Often CSA studies use masculinized language to define CSA behaviour that is not necessarily reflective of sexually abusive behaviour committed by females For example, the term "penetration" is associated with contact sexual abuse (e g , Briere & Elliot, 2003, Fergusson & Mullen, 1999) and creates the assumption or belief that a penis is required to commit this behaviour This section will first review incidence and prevalence studies of CSA to determine current rates of female-perpetrated sexual abuse based on victim reports while examining the definitions framing these studies Second, incidence and prevalence rates of female-perpetrated sexual abuse based on sexual offence studies and how the sexual offences are defined according to these offence studies will be reviewed A discussion of the issues pertaining to CSA definitions will

follow, including consideration of how this information may influence therapists' beliefs about CSA and affect their clinical practice decisions

Incidence and prevalence studies differ in terms of how they measure CSA Incidence studies determine the number of CSA occurrences that come to the attention of professionals (primarily legal/judicial and child protection data) and have been commonly considered a gross under-estimate of the scope of the problem because not all CSA is reported to child protection agencies and even fewer cases result in any judicial processes or convictions (Bolen, 2001, Finkelhor, 1994, Goldman & Padayachi, 2000) For example, the Canadian Incident Study of Reported Child Abuse and Neglect (CIS-2003) reported that only 39% of substantiated sexual abuse investigations resulted in police laying charges (Fallon et al , 2005) Accurate incidence rates of CSA are extremely difficult to determine due to the inability of some children to communicate, demands for secrecy, forgetting or repression, differences in study definitions, methodology, agency criteria, and terms within definitions referring to "consensual sex" (Johnson, 2004)

In contrast, prevalence studies rely on retrospective surveys involving adults to provide estimates of population groups that have experienced CSA in an attempt to establish a clearer understanding of the scope of the problem Although the majority of studies examined in the context of this review are prevalence based, both approaches to determine the scope and severity of the problem are impacted by discrepancies within the definitions of CSA (Goldman & Padayachi, 2000, Hulme, 2004, Johnson, 2004, Mannon & Leitschuh, 2002)

Distinctions between prevalence rates of CSA based on definitional differences can be traced back to some early influential studies (Badgley, 1988, Finkelhor, Hotaling, Lewis, & Smith, 1990, Laumann, Gagnon, Michael, & Michaels, 1994) that clearly illustrate the differences between prevalence rates associated with using slightly different definitions The large national Canadian sample Badgley (1988) surveyed identified CSA experiences that included sexual contact and non-contact sexual experiences (i e , exposure or invitation to sexual touching) and found that 53% of adult women and 31% of adult men reported sexual abuse as children Finkelhor et al (1990) completed a similar study in the US with a slightly revised definition that included fewer non-contact sexual abuse experiences (still included exposure but not invitation to touch) and found 27% of women and 16% of men reported experiencing CSA, this represents only half as many participants reporting CSA when compared to the Badgley (1988) results Laumann et al (1994) completed an extensive US adult population study of adult sexuality and sexual behaviour, which also examined adult and adolescent sexual contact with children retrospectively, defined as sexual touch experiences Their findings reported that 12% of men and 17% of women identified having been sexually touched as children These studies provide a variation of prevalence rates ranging from 12% to 31% for men and from 17% to 53% for women based on differing definitions The broader the definition of CSA (i e , including non-contact sexual experiences), the greater the prevalence of CSA reported by the sample In addition, however, they consistently identified that more women than men experience CSA or sexual touch by an adult

Briere and Elliott (2003) attempted to clarify prevalence rates of sexual abuse within the general population (US), using a definition based on sexual contact

experiences only (any physical contact of a sexual nature and not exclusive to penetration) They found that 32 3% of women and 14 2% of men identified CSA experiences that satisfied the sexual contact criteria Briere and Elliott considered these prevalence rates to be substantial and pointed out that these rates have remained within the same range as those of other studies (e g , Fergusson & Mullen 1999, Finkelhor et al , 1990, Rind, Tromovitch, & Bauserman, 1998) Contrary to other analyses and in their more recent meta-analysis, Pereda, Guilera, Forns, and Gómez-Benito (2009) reported international prevalence rates of 7 9% of men and 19 7% of women experiencing CSA before the age of 18, with sexual abuse definitions used having no effect, but women reporting significantly higher rates of CSA

Overall, regardless of the CSA definition applied and the population sampled within the research, more women than men have consistently reported CSA experiences With the prevalence of reported female sexual victimization being higher than reported male sexual victimization, the majority of sexual abuse literature and clinical practice information has focused on the victimization experiences of women with fewer studies pertaining to male victimization experiences of sexual abuse (Holmes & Slap, 1998)

Holmes and Slap (1998) found methodological problems with how investigators defined and asked about the sexual abuse experiences in their review of 166 studies on male victims of sexual abuse Subsequently, they found that adult males retrospectively define sexual experiences with older women as "normative rather than abusive" (p 1857) Definitions of CSA often include coercion on the part of the person who sexually abuses others, however, this review found that the women used "persuasion" rather than a more forceful method, identified by 91% of male victims studied (p 1858) Responses

identified as "positive" to the sexual abuse experiences were associated with being abused over the age of 12 and being abused by a woman for 88% of the men in the sample Holmes and Slap suggested that the definition used in such research should include very specific and simple terms that refer to the sexual acts and sexual organs involved, victim and victimizer age differences, and to consider sexual abuse by a woman more carefully regarding issues of coercion and perception of the victim Thus, they concluded that definitional problems and methods of inquiry might be contributing to the underreporting, under-recognition, and under-treatment of male sexual abuse victims, this conclusion can be extended to postulate the under-recognition of sexually abusive behaviour by women

In contrast to the studies of prevalence of sexual victimization, studies pertaining to rates of sexual offending behaviour or sexual offences have most often focused on men This research has demonstrated that men commit the majority of reported sexual offences (Denov, 2003, 2004), but this does not negate the fact that some women also engage in sexually abusive behaviour The most consistently cited prevalence rate of sexual abuse committed by women has been estimated at 5% of all sexual offences against children (Grayston & De Luca, 1999, Nathan & Ward, 2001, Saradjian, 1996), although this rate has not been examined directly since Russell's study in 1986

Denov (2003) investigated the prevalence of sexual abuse by women by reviewing 15 different studies based on case reports and self-reports Although the reported prevalence rates varied across the studies, Denov emphasized that reports of female sexual abuse are generally under-represented in official sources when compared to self-reports For example, Denov found that the Canadian Centre of Justice Statistics

(2001) reported females represented 1 5% of adults within the criminal justice system convicted of sexual offences, however, Denov also concluded from two self-report studies of college students by Fromuth, Burkhart, and Webb Jones (1991) and Fromuth and Conn (1997) that females represented 58% of those students who met the criteria for having sexually abused a child or adolescent The differences in offending rates reported could be a result of varied definitions and the usual contrast between incidence and prevalence rates, however, these differences highlight the probability of under-representation and under-recognition of sexual abuse by females

The assumption that men commit the sexual abuse and women are the victims (Byers & O'Sullivan, 1998) continues to be supported by the empirical data Briere and Elliott (2003) reported that 93% of females who reported CSA had been abused by at least one male Statistically, males are more likely to abuse others sexually than females, however, the Briere and Elliott (2003) prevalence study also found that 9% of the women and 39% of the men who reported CSA experiences indicated they had been sexually abused by at least one female Interestingly, the Canadian Incidence Study (CIS-2003) found that 5% of the substantiated sexual abuse investigations represented biological mothers as the person identified as having sexually abused a child (Fallon et al , 2005) As well, Peter (2009) analyzed data from the previous CIS-1998 data and found that in 10 7% of substantiated sexual abuse cases women had been identified as having perpetrated the sexual abuse The recognition of sexual abuse by women within the literature seems to be increasing (Hilton & Mezey, 1996) This may be due to increased reporting of CSA rather than an increase in sexual abuse by women Emery and Laumann-Billings (1998) suggested that the increased reporting of CSA in general may

be due to being more aware of CSA and more intolerance for this behaviour (see also Finkelhor, 1994 and Putnam, 2003)

Clearly, studies of the prevalence of victims of CSA and sexually abusive behaviour by males and females have established sexual abuse as an issue worthy of the attention of researchers and treatment providers While women and girls have comprised the larger portion of sexual abuse victims and men have been more commonly identified as the perpetrators, male victims of sexual abuse and females who sexually abuse others are also prevalent (e g , Briere & Elliott, 2003, Fallon et al , 2005) Thus, further consideration as to how CSA definitions have been operationalized may contribute to understanding the difficulties in recognizing sexually abusive behaviour by females

As noted above, definitional inconsistencies have been identified as contributing to the varied results of prevalence studies Haugaard (2000) suggested that broad definitions (i e , including acts such as bathing a 14 year old adolescent who is capable of bathing himself or herself) have contributed to the increased concern about CSA, which has resulted in families and children receiving intervention that would not have been otherwise afforded to them These broad definitions serve to have professionals intervene with sexual abuse prior to it becoming more severe or extensive, however, this may also result in research that indicates minimal or no "harm" as a result of the broader definition of CSA experiences (e g , Rind et al , 1998)

Haugaard (2000) articulated the diversity of definitions applied to each term of "child," "sexual," and "abuse" The definition of a "child" could be operationalized as those under the age of 18 (e g , Briere & Elliot, 2003), under 17 (e g , MacMillan et al , 1997), or under the age of 16 (e g , Trocmé & Wolfe, 2001) with some authors

advocating for under the age of 12 (e g , Levine, 2002) Rind (2004) strongly advocated for a differentiation between children and adolescents, as he suggested that adolescents could benefit from a mutually consenting sexual relationship with an adult

Haugaard (2000) highlighted "abuse" as a controversial term that implies harm regardless of the specific CSA experience Rind et al (1998) challenged this notion of CSA causing psychological harm to all who experience this form of abuse and found through their meta-analysis that the evidence did not support the notion of CSA causing psychological harm They proposed a completely different way of describing CSA, such as "adult-child" sex or "adult-adolescent" sex in an attempt to avoid the implication of harm

The term "sexual" has some clearly agreed upon behavioural indicators such as those acts involving penetration or genital fondling, however, more ambiguous behaviours (i e , sleeping with a child, bathing a child capable of bathing him or herself) are less clear (Haugaard, 2000) Whether or not these behavioural aspects are considered sexual is often determined by the adults' intent (i e , for their own sexual gratification or needs), but again, intent is often difficult to determine Lowe Jr , Pavkov, Casanova, and Wetchler (2005) demonstrated some agreement between predominant cultures (white, African, Hispanic) in the US as to what constitutes reportable CSA The scenarios used in their study, however, all refer to sexually abusive behaviour by males and do not provide any insight regarding perceptions of sexually abusive behaviour committed by females

Bensley et al (2004) established some significant levels of consensus among the general population regarding behaviours defined as sexual abuse Their study examined

a number of child maltreatment behaviours, however, of the seven highest consensus behaviours (95%+ surveyed considered the behaviour as abusive), five were related to sexual abuse The highest rated item read "having sexual intercourse with a child" (p 1328) Although this population sample was limited to Washington state residents, they drew their information from a relatively large sample (N=504) This study also highlighted the ambiguity around other sexual behaviours such as knowingly entering an adolescent's room while the adolescent is undressed, allowing a child 11 years and older to sleep with a parent, and an adolescent who sees the parent of the opposite sex naked The item stating, "letting a child watch parents have sex" (p 1328) resulted in moderate consensus (94 4% of respondents considered this abusive), suggesting that approximately 5% of the population may not rate this behaviour as abusive or define this behaviour differently The moderate level of consensus regarding this item could be based on the assumed intent of the behaviour Parents may have accidentally allowed their child to watch them have sex, but one could not accidentally have intercourse with a child without the intent of doing something sexual with the child (such as having simulated intercourse)

In another study of professionals' and non-professionals' definitions of child maltreatment, Portwood (1999) included issues pertaining to the "consequences, severity, and frequency of the act, developmental level of the child, and intent [as well as] sex of the victim and perpetrator and whether the child consents to the act" (p 58) She provided vignettes of potential child maltreatment scenarios that included examples of male- and female-perpetrated sexual abuse to a sample that included a number of professional disciplines and non-professionals (mental health, legal, medical, and

teaching professionals, parents and non-parents) Participants were asked to rate their perception of whether these vignettes constituted abuse The results demonstrated that the highest consensus among all groups pertained to the abuse vignettes of a sexual nature, however, parents kissing a child on the lips yielded significantly less certainty The ambiguous nature of the kissing vignette seems to signify the need to interpret issues of intent, context, and consensus between the adult and child, therefore, Portwood (1999) recommended the importance of establishing multiple definitions that are not as broad as "any sexual act upon a child" (p 66) to address the needs of the varying professionals in their practice contexts For example, although the intent-to-harm factor was considered less important to participants in general, it may be a significant aspect for the legal profession Gender of the person perpetrating the abuse was not found to be a factor in this study, although very few comparisons associated with gender were offered within the vignettes

Okami (1995) highlighted the ambiguity of parental behaviours such as parent-child co-sleeping, co-bathing, parental nudity, excessive displays of physical attention such as kissing on the lips, "sensuous teasing", or "flirting with the child" (p 51), and "visual or auditory proximity to instances of adult sexual behaviour" (p 51) He introduced terms of "maternal seductiveness, emotional incest syndrome (EIS), emotional sexual abuse (ESA), subtle sexual abuse, covert sexual abuse, seductive sexual abuse, and sexualized attention" (p 51) Many of these behaviours are only considered problematic if they occur in a specific context Okami's (1995) review offered many strong clinical opinions about whether or not the above listed ambiguous parental behaviours are problematic or a form of CSA, however, he found little to no evidence that childhood

exposure to parental nudity, parent-child co-sleeping, and "primal scenes" link to psychological harm Additionally, Okami, Olmstead, Abramson, and Pedleton's (1998) longitudinal study found no evidence of psychological harm related to primal scenes and parental nudity, questioning the benefit of labelling the behaviour as abuse Okami (1995) did, however, suggest that the context may alter these results and judgments about these behaviours should be examined within varied contexts

Ambiguity about a clearly abusive scenario was also found in Fromuth and Holt's (2008) study regarding teacher-student relations In general, a gender bias existed in that the male teacher/female student scenario (teacher performing oral sex on a current student) was perceived as more abusive than the same female teacher/male student scenario More ambiguity about whether or not the situation was abuse was reflected by male respondents when the abuse dyad consisted of a female teacher/male student This ambiguity about the female teacher/male student dyad being a situation of abuse increased as the age of the student increased from 9 years to 12 years to 15 years and was reflected in the male response to their rating of how "cool" the victim's friends would perceive the abuse situation Gender biases were also prevalent in Rogers and Davies' (2007) study where the abuse scenarios involving female sexual perpetration were deemed as less serious and less harmful than male sexual perpetration scenarios

The literature indicates that sexually abusive behaviour by a female is one of the most challenging "contexts" to define Terms such as sexual assault, sexual offender, perpetration, or sexual abuse typify male commission of the abuse and female victimization (Byers & O'Sullivan, 1998) CSA has been situated as a male problem defined by masculinized language and the innocence of women has been accentuated

For example, both Denov (2001) and Nelson (1994) studied police response to female sexual offence allegations and found that law enforcement responses were based on the "phallocentric definition of sexuality, sexual violence and the 'sex offender'" (Nelson, 1994, p 82) Thus, sexual abuse has been translated to denote penetration and the phallus, since a woman has no penis, she can inflict no sexual harm or abuse (Paglia, 1990, as cited in Atmore, 1999a) Furthermore, Hetherton (1999) suggested that feminist theorists have contributed to these stereotypical beliefs about CSA by cultivating gender "dichotomy" Her critique of feminist theory's influence in not acknowledging sexually abusive behaviour by females also suggests that feminist influence has supported a masculinized definition of CSA

Lawson (1993) outlined the problem of defining sexual abuse, particularly when committed by a female, and provided a sexual abuse definition that incorporates terms such as "subtle" (i e , bathing a latency-aged or older child), "seductive" (i e , consciously arousing or stimulating a child with nudity or sexual messages), "perversive" (i e , sexual humiliation), and "overt" (i e , sexual contact) Similar to the findings by Holmes and Slap (1998), Lawson (1993) suggested that some of the subtle, seductive, or overt sexual abuse committed by women or specifically mothers can be experienced by the child as pleasurable and some of these forms of abuse are committed without violence or coercion

Etherington (1997) included Lawson's (1993) expanded definition in her study to provide a clearer context for the examples of subtle and seductive abuse often not considered as sexual abuse, such as obsessive washing of the foreskin beyond a reasonable age and how a mother might use her son as a replacement for an adult intimate

relationship Another example of behaviour not included in the more commonly accepted definition of sexual abuse is the humiliation or mocking of a child about their sexuality or sexual aspects Etherington's qualitative study focused on seven men who identified sexual abuse by their mothers Initially, the men were unable to define the sexual behaviour by their mothers as abusive, rather they described it as a "close and loving relationship" or as "over-loving" The behaviour was not necessarily associated with violence or physical abuse for some of the respondents, and this created a context of love and affection received in a sexual manner (i e , fellatio, cunnilingus, frottage, sexualized kissing, vaginal penetration) One respondent indicated that he was socialized to believe essentially that women "were not abusers they were there to be abused upon" (p 114), which contributed to not defining the sexual abuse by his mother as abusive

Others have considered issues with sexual abuse definitions as less problematic For example, Johnson (2004) suggested that CSA definitions are "rarely debated", although he does acknowledge, "a child might not recognise an action as improper, [particularly] if a female caretaker is the perpetrator" (p 462) Regardless of how clearly articulated the definition of CSA, any CSA definition remains vulnerable to interpretations based on differing cultures, expectations, understanding, and norms regarding an adult's interaction with children Consider the example of excessive hand-genital contact on the pretence of cleaning an uncircumcised ten-year-old male by the parent claiming the child is unable to clean properly This action may not be for the purpose of sexual gratification of the adult but may be considered abusive or inappropriate, particularly if the child is uncomfortable with this behaviour and the adult's concerns are unwarranted

In summary, prevalence and incidence studies of CSA have been influenced by problems with defining sexual abuse, particularly sexually abusive behaviour by females Therapists or counsellors working with people presenting with CSA issues can be expected to have a varied range of understanding and beliefs about the prevalence and incidence of CSA, and how CSA is defined, they are also likely to have varied levels of ability to recognize some of the more subtle aspects of sexual abuse by females These varied understandings of CSA experiences would be expected to extend to include the therapists' understanding of the effect of CSA on female survivors Although multiple effects of CSA on victims have been identified and studied (Davis & Petretic-Jackson, 2000, Freeman & Morris, 2001, Rind et al , 1998), the next section of this literature review will focus specifically on the impact of CSA on female sexual development as a potential explanation for sexually abusive behaviour by females

Impact of CSA on Female Sexual Development

Some researchers have argued that CSA does not have as harmful an effect as previously believed (Rind et al , 1998), however, the assumption that sexual abuse will impact on normal sexual development in some way is commonly accepted in Western society (Westerlund, 1992) A body of literature has examined the impact of past sexual abuse on sexual development (Finkelhor & Browne, 1984, Hall, Matthews, & Pearce, 2002, Meston, Heiman, & Trapnell, 1999, Noll, Trickett, & Putman, 2003, Westerlund, 1992) It should be noted that the literature examined presents "normal" sexual development from a heterosexual development perspective and does not account for a more diversified perspective of sexual development (e g , homosexual development) This section will examine research on the impact of CSA on female sexual development

and review the related research pertaining to how it may apply to later sexually abusive or inappropriate sexual behaviour Of key concern are the potential issues pertaining to current counselling practices with women seeking treatment for issues related to CSA

The impact of CSA is most often described from a psychological perspective (Briere & Elliot, 2003, Finkelhor & Browne, 1984, Rind et al , 1998), with fewer studies focusing on sexual development and other sexual behaviour outcomes (Meston et al , 1999, Noll et al , 2003, Tharinger, 1990, Westerlund, 1992) In addition, prevalence studies do not necessarily establish the level of impact experienced by those reporting sexual abuse occurrences and not all studies agree about the impact of CSA Rind et al (1998) challenged the findings of studies that purport a causal relationship between CSA experiences and inevitable psychological harm Participants' ratings of positive, negative, and neutral reactions to the sexual abuse experiences were utilized to examine the concept of harm Their meta-analytic study, focused on college samples, concluded that CSA may not be as harmful to individuals as has been previously reported, however, they acknowledged that females, in particular, may experience more adjustment problems than males This finding about females is similar to the Landis et al (1940) and Laumann et al (1994) reports from female respondents who identified being sexually touched in childhood and also reported more sexual problems, such as emotional problems interfering with sex, and anxiety about sex

Based on the assumption that CSA is psychologically traumatic and can impact the sexual development of women, Westerlund (1992) conducted a qualitative study to examine the impact of childhood incest on women's sexuality in the mid 1980s Although Westerlund's sample (43 respondents) was drawn from a single source (Incest

Resource, a self-help organization that she herself co-founded) and is suggestive of some biases and limitations, her findings discussed the women participants' understanding of how their experience of incest impacted on their sexuality All respondents indicated that they believed that their incest experiences had a negative impact on their sexuality A small portion of these women indicated that they had struggled to understand boundaries with their children and some expressed having sexual fantasies about children No participants indicated that they had acted on their sexual fantasies about children, however, less clarity was provided by the participants about their struggle to differentiate physical boundaries of parental affection and sexual touch with their children The importance of this early study is the recognition that CSA does impact women's sexuality in a variety of ways for some survivors, including potentially inappropriate sexual behaviour with children

In contrast to Westerlund's (1992) findings that CSA has a negative impact on women's sexuality, some studies report an eroticised response to CSA reminiscent of Finkelhor and Browne's (1984) traumatic sexualization response to early sexual abuse experiences Consistent with Rind et al 's (1998) findings, other researchers have reported that these eroticised responses may not necessarily be interpreted by the recipient as negative or harmful Laumann et al 's (1994) examination of the differences between those respondents who indicated they had been sexually touched and those who had not, found that women who had been sexually touched in childhood consistently demonstrated more sexual behaviour in adulthood For example, the number of sexual partners was higher for those sexually touched in childhood and they more often engaged in oral sex, anal sex, masturbation, and group sex

Similarly, Meston et al (1999) found significant associations between CSA and inter- and intrapersonal sexual behaviour (i e , frequency of intercourse, variety of experiences, unrestricted sexual behaviour, and frequency of masturbation, variety of sexual fantasies) with females Krahé, Waizenhofer, and Moller (2003) found a significant link between CSA and sexually aggressive women, whereas the physical and emotional abuse variables in their study were not linked to sexual aggression with any significance The sexually aggressive behaviours most commonly included completed sexual acts of kissing and/or fondling by exploiting a man's incapacitated state These studies offer a description of heightened sexual behaviour in adulthood that should not be interpreted as a judgment about psychological harm or health In addition, these findings are simply correlates of the experiences and cannot provide evidence of cause and effect, however, they suggest that a relationship between CSA and sexual development may influence the adult or adolescent sexual behaviour of some women

Noll et al (2003) offered an interpretation of heightened sexual behaviour from their longitudinal study focused on the impact of past sexual abuse on the development of female sexuality The sexually abused females indicated a stronger preoccupation with sex and a more permissive sexual attitude than the non-abused comparison group, although a small subgroup of the abused women tended to express strong aversion to sex that was also different from the comparison group These results present somewhat similarly to the results of Laumann et al (1994) and Meston et al (1999), however, Noll et al 's (2003) interpretation of sexual preoccupation and more permissive attitudes referred to problematic aspects such as compulsions or what they considered to be risky sexual behaviour In addition, Loeb et al 's (2002) review of the research suggested that

this heightened sexual arousal in women can also result in the inability to say no to sexual requests and also to actions that attempt to regain power and control, or from a more extreme perspective can result in sexually aggressive and abusive behaviour toward others, similar to Krahé et al 's (2003) findings

As previously noted, increased sexual behaviour in adulthood may not always be considered problematic (Laumann et al , 1994, Meston et al , 1999), whereas increased sexual behaviour in children provokes more concern (Heiman, Leiblum, Esquilin, & Pallitto, 1998) In testing the Child Sexual Behaviour Inventory assessment tool, Friedrich et al (2001) found that when the sexual abuse was more intrusive (defined by penetration, the number of perpetrators, frequency, and duration of the abuse), an increase in the sexual behaviour exhibited by the child victim was reported Of particular interest was the finding that the use of physical force associated with CSA was not related to the later sexual behaviour

Johnson (1993a) discussed the potential disruption CSA experiences have on the "normal" sexual development process based on her research and clinical experiences The disruption of the sensual/erotic aspect of development to which Johnson (1993a) referred was also illustrated by the studies of McClellan et al (1996) and Hall, Mathews, and Pearce (1998) in conjunction with the theoretical model by Finkelhor and Browne (1984) Johnson (1993a) hypothesized that adult focus on the child's genitalia that is arousing or pleasurable for the child could develop heightened emphasis on pursuing sensual/erotically stimulating experiences, illustrative of the traumatic sexualization dynamic (Finkelhor & Browne, 1984) The child's learned pursuit of erotic experiences could then result in engagement in inappropriate sexual behaviours

The studies by Hall et al (1998) and McClellan et al (1996) suggest further support for the relationship between sexual arousal of the child and later inappropriate sexual behaviours Hall et al (1998) examined clinical records of the sexual behaviour problems displayed by sexually abused children and found that sexual arousal during the abuse experience was the most influential (statistically predictive) factor associated with self-focused (i e , public masturbation) and interpersonal sexual behaviour problems (i e , problematic sexual contact with others)

McClellan et al (1996) also retrospectively examined case reports of the sexually inappropriate behaviour of youth, but in relation to the age of onset of CSA These researchers reported no significant gender differences with respect to the relationships between age of onset and overall rates of inappropriate sexual behaviour (males 39 8%, females 42 2%) However, there was a significant difference between males (28 7%) and females (37 8%) in the rates of hypersexual behaviours (e g , intrusive touch of others or age-inappropriate sexual interests) and between males (20 1%) and females (10 1%) in rates of victimizing behaviours (e g , more forcible/coercive touching than hypersexual category) Furthermore, McClellan et al found that children under the age of seven who had experienced sexual abuse had significantly higher rates of sexually inappropriate behaviours within all the categories

In her review of three studies (Johnson, 1988, 1989, and Friedrich & Luecke, 1988 as cited in Johnson, 1993b) with children (ages 4 to 12) who were known to have sexually abused other children, Johnson (1993b) reported that all the female children (and 50%-75% of males) had experienced past sexual abuse and that the sexual behaviours of these children were more frequent and intrusive (explicit sexual behaviours) when

compared to some preliminary data on normal sexual development with children who had not been sexually abused (collected by Friedrich [1992] as cited in Johnson, 1993b) These "sexualized children" (Johnson, 1993b) tended to sexualize relationships by demonstrating poor boundaries or by using sex as a commodity in exchange for getting their needs met, analogous to the abuser-victim relationship described in Finkelhor and Browne's (1984) traumatic sexualization dynamic She also found that sexualized children have more sexual knowledge about explicit sexual behaviour but not necessarily about conception and reproductive processes Overall, Johnson's (1993a, 1993b) clinical practice experiences and research led to hypotheses and theoretical constructs similar to Finkelhor and Browne (1984)

The research indicates that experiences of CSA appear to affect normal sexual development by leading to an increase in sexually inappropriate behaviours in childhood compared to children who have not been sexually abused (Hall et al , 1998, Johnson, 1993b, McClellan et al , 1996) Johnson (2002) developed a continuum of childhood sexual behaviour as a means to assess the sexual behaviours of children to ensure that children are not mislabelled and interventions with these children are appropriate to their needs She situated the normal childhood sexual behaviours at one end and the children who sexually abuse other children on the opposite end of the continuum However, Johnson (2002) cautioned not to assume that CSA would automatically lead to sexually abusing behaviours and reported that less than 0 5% of the approximated 35% of sexually abused children who display sexualized behaviour would act this out on other children (Kendall-Tackett, Williams, & Finkelhor, 1993 and Johnson, 1998 as cited in Johnson,

2002) Similarly, Putnam (2003) indicated from his review of research that "overt sexualized behaviours may decrease with time" (p 272)

Hall et al (2002) developed a similar typology of sexual behaviours in children to Johnson's (2002) continuum based on their Hall et al (1998) study Again, the purpose of the typology was for assessment and intervention with children who engage in sexually inappropriate behaviours by identifying influential factors that may contribute to the behaviour typology The child who has experienced the most severe aspects of the influential factors, including sexual arousal during his/her own abuse, active participation during the abuse, ambivalence regarding who the child blames for abuse, family violence, and lack of support system, would be most likely to engage in sexually abusive behaviour toward others These influential factors offer a framework that could be helpful in assessing the experiences of adult female survivors of CSA that may contribute to hyper-sexualized behaviours and their confusion about sexual boundaries within relationships

The link between past history of sexual abuse and sexually abusive behaviour in adolescence or adulthood has been minimally studied in women The first study to examine this relationship was completed by Christopher, Lutz-Zois, and Reinhardt (2007) and compared women convicted of sexual offences with women convicted of non-sexual offences Their findings support previous studies that described women who have abused children sexually as almost always having been sexually abused themselves ($p<0$ 05) and provide important empirical evidence to consider in terms of this risk factor for women who sexually perpetrate against children (see next section for this review) The past CSA experienced by the women convicted of sexual offences in this study was longer in duration than that of the women convicted for non-sexual offences, which further

supports the notion that more severe CSA is a factor that increases the risk that woman who have been sexually abused as children may engage in sexually abusive behaviour as an adolescent or adult

These studies and theoretical models provide some evidence of the impact of sexual abuse on normal sexual development and identify critical factors that may be associated with a victim-to-victimizer cycle of sexual abuse However, this victim-to-victimizer cycle does not "explain why most sex abusers are men while the majority of victims are female" (Hilton & Mezey, 1996, p 411), rather, it may be helpful information for therapists who assess and intervene with female survivors of CSA, by alerting them to risk factors that may increase the potential for some women to abuse others sexually

To summarize the impact of sexual abuse on normal female sexual development, the experience of CSA can be framed theoretically as the potential sexualization of the child depending on the dynamics of the abuse experience (Finkelhor & Browne, 1984) The physiological aspects of sexual arousal or pleasurable sensations connected to sexual acts are difficult to separate from the impact of an adult introducing sexual behaviour to a child or adolescent who is not developmentally capable of discerning the meaning of the behaviour In the language of Bandura's (1973) social learning theory, the experience of pleasurable sexual arousal associated with the sexual abuse experience reinforces the sexual behaviour, and may therefore contribute to the subsequent increased sexually inappropriate behaviours demonstrated by some children (Finkelhor & Browne, 1984, Hall et al , 1998, 2002, Johnson, 1993a, 1993b, 2002, McClellan et al , 1996) A small percentage of these children may shift from sexually inappropriate behaviour to engaging

in actual sexual abuse of other children (Hall et al , 1998, 2002, Johnson, 1993a, 1993b, 2002)

The reported prevalence rates of CSA (7 9%-31% for males and 17%-53% for females, depending on the definition) have identified consistently that more females than males experience CSA (Badgley, 1988, Briere & Elliott, 2003, Finkelhor et al , 1990, Laumann et al , 1994, Pereda et al , 2009) In some adult women, the CSA experience has been associated with demonstrating more sexual behaviour, in terms of frequency and variety (Laumann et al 1994, Meston et al , 1999), as well as with having a more permissive attitude towards sex and being more preoccupied with sex that may lead to risky behaviours or compulsions (Krahe et al , 2003, Noll et al , 2003) Additionally, some women with histories of CSA have reported more sexual problems or an aversion to sex (Landis et al 1940, Noll et al , 2003) This research suggests that it may be important to include assessment questions and treatment-focused discussions about sexuality, sexual behaviour, and sexual development issues within the context of women survivor therapy An examination of the current knowledge about females who have sexually abused others is presented below prior to the literature review exploring assessment and treatment interventions with female survivors of CSA

Knowledge of Sexual Abuse Perpetrated by Females

Although sexual abuse perpetrated by females is still considered to be a rarity (Denov, 2003, 2004), studies aimed at better understanding female-perpetrated sexual abuse began to surface in the 1980s These early studies focused primarily on classifying women convicted of sex offences by using descriptions of their offending behaviour and their psychosocial histories (Faller, 1987, Mathews, Matthews, & Speltz, 1989, McCarty,

1986) More recent research has explored sexual abuse committed by juvenile females (Mathews, Hunter, & Vuz, 1997, Moulden, Firestone, & Wexler, 2007, Tardif, Auclair, Jacob, & Carpentier, 2005, Vandiver & Teske Jr , 2006, Vick, McRoy, & Matthews, 2002) and sexual abuse committed by adult females (Lewis & Stanley, 2000, Moulden et al , 2007, Nathan & Ward, 2002, Tardif et al , 2005), with somewhat larger sample sizes (Bader, Scalora, Casady, & Black, 2008, Davin, 1999, Dunbar, 1999, Hislop, 1999, Saradjian, 1996, Vandiver & Kercher, 2004) Literature reviews of previous studies have also been published (Ford, 2006, Gannon & Rose, 2008, Grayston & De Luca, 1999, Johansson-Love & Fremouw, 2006, Nathan & Ward, 2001) This section will review literature focused on sexually abusive behaviour by females and provide a summary of the main characteristics and current knowledge that is available about women who sexually abuse others

The early categorization of sexually abusive behaviour and offences by females can be summarized as 1) independent offending (sexually abusing their victim without another adult), 2) co-offending (mutual responsibility for sexually abusing the victim with a male counterpart), and 3) male-coerced offending (male coercing the woman to engage in the sexual abuse) (Faller, 1987, Mathews et al 1989, McCarty, 1986) These initial studies found that the majority of the women in these categories had reported CSA and/or some other form of past maltreatment (Faller, 1987, Mathews et al , 1989, McCarty, 1986), had difficulties within adult relationships (Faller, 1987, Mathews et al , 1989, McCarty, 1986), and independently tended to abuse victims of a younger age than males who sexually abuse children (Faller, 1987, McCarty, 1986)

The more recent research and reviews highlight commonly identified features of women who have sexually abused others One of the most consistent and commonly reported characteristic of women convicted of or self-reporting sexually abusive behaviour is a history of severe or extensive CSA (Davin, 1999, Dunbar, 1999, Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Johansson-Love & Fremouw, 2006, Lewis, & Stanley, 2000, Mathews et al , 1997, Saradjian, 1996, Strickland, 2008, Tardif et al , 2005, Vick et al , 2002) The prevalence of past sexual abuse experiences reported by these women has ranged from 74% (Hislop, 1999) to 92% (Saradjian, 1996), which differs strikingly from the 20%-40% (Lambie, Seymour, Lee, & Adams, 2002) to 43%-73% (Simons, Wurtele, & Durham, 2008) estimate of men who have abused others sexually and report CSA experiences Hislop (1999) and Strickland (2008) identified the extensive history of severe CSA as a primary risk factor that contributes to sexually abusive behaviour by females Davin (1999) found that women who sexually abuse others independently more often report having been severely sexually abused before the age of 10 than women who have a male co-abuser Mathews et al (1997) and Vick et al (2002) reported similar results from their studies of juvenile females who had sexually abused others When comparing juvenile females and males who had committed sexual abuse, the females were found to have experienced a greater frequency of past trauma including sexual and physical abuse beginning at a younger age (Mathews et al , 1997) Additionally, the use of force and more sexually aggressive behaviour in juvenile females convicted of sexual offences were found to be correlated with an earlier onset of CSA when compared to non-abused females convicted of sexual offences (Roe-Sepowitz & Krysik, 2008)

Another primary factor contributing to female sexual abuse reported by Hislop (1999) included a lengthy history of mental health issues Lewis and Stanley (2000) and Tardif et al (2005) also reported a high rate of psychiatric service use, while Saradjian (1996) reported ongoing mental health concerns Moulden et al (2007) found that mental illness was cited as the motivation for sexually abusing children for 6% of adult females and 3% of juvenile females in their study of child care providers who had sexually offended In contrast, although the presence of mental health issues was high for women convicted of sexual offences, Fazel, Sjostedt, Grann, and Långstrom (2010) found that women convicted of sexual offences were not different with regard to their mental health needs from women convicted of other violent offences Other salient characteristics of women who have sexually abused others included abusive or absent adult relationships along with poor coping skills and inadequate social supports (Davin, 1999, Gannon & Rose, 2008, Grayston & De Luca, 1999, Lewis & Stanley, 2000, Nathan & Ward, 2001, Saradjian, 1996)

The literature indicates that the characteristics of the victim are another aspect common to women who have sexually abused others The victims of female-perpetrated sexual abuse tend to be of a younger age than victims of male sexual abuse (Gannon & Rose, 2008, Grayston & De Luca, 1999, Moulden et al , 2007, Tardif et al , 2005, Vandiver & Teske Jr , 2006, Vandiver & Walker, 2002) The woman who sexually abused usually had a relationship (parent, babysitter, friend) with her victim (Davin, 1999, Dunbar, 1999, Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Lewis, & Stanley, 2000, Mathews et al , 1997, Moulden et al , 2007, Saradjian, 1996, Tardif et al , 2005, Vandiver & Kercher, 2004, Vick et al , 2002) The victim could be of

either gender, although Grayston and De Luca (1999) found a stronger emphasis on female children as victims (also reported by Davin, 1999, Nathan & Ward, 2002, Tardif et al , 2005) This finding contradicted Groth's (1979) earlier hypothesizing that female-perpetrated sexual abuse happens more frequently with male children

Interestingly, in their comparison of juvenile and adult females who perpetrated sexual abuse, Tardif et al (2005) found that the adult females they studied tended to have more female victims whereas the juvenile females they studied tended to have more male victims Bader et al (2008) compared a sample of females convicted of sexual offences from the criminal justice system with a sample of females from the child protection system where sexual perpetration was substantiated and found significant differences between the two samples They found that the women in the criminal justice system were predominantly convicted of sexual offences against male victims (62%) who tended to be older (average age of 12) and women in the child protection system tended to offend against female victims (64%) who tended to be younger (average age of 9) Some other studies have also reported a preference for male victims (e g , Hislop, 1999, Mathews et al , 1997), however, most studies reviewed showed no significant difference between the reported numbers of male or female victims (Lewis & Stanley, 2000, Saradjian, 1996, Vandiver & Kercher, 2004, Vandiver & Teske Jr , 2006, Vandiver & Walker, 2002) Gannon and Rose (2008) and Johansson-Love and Fremouw (2006) found inconclusive results about the preferred victim gender in their reviews

In addition to the studies based on the women who have sexually abused, studies of victims who reported being sexually abused by females also contribute to this knowledge The majority of reported incidents have been reflected in prevalence studies

that identify perpetrator gender (e g ,, Briere & Elliott, 2003) and studies pertaining to male victims However, some difficulties have been identified in terms of obtaining accurate figures when studying male victims of sexual abuse, such as a reluctance to disclose past sexual abuse or to seek help for abuse issues (Holmes, Offen, & Waller, 1997, Lab, Feigenbaum, & De Silva, 2000, Romano & De Luca, 1997) In addition, men have tended not to define their childhood experiences with older females as abusive or to believe the abuse would have a negative impact (Holmes et al , 1997) In fact, male victims have been portrayed as experiencing CSA as positive rather than harmful (Rind et al , 1998), however, the meta-analysis conducted by Rind et al did not provide any data pertaining to the gender of the perpetrators Perhaps the societal response to a boy's sexual abuse experience with an older woman, often considered desirable or a coming of age experience rather than abusive one (Holmes et al , 1997, Romano & De Luca, 1997), has contributed to this perception

Holmes and Slap (1998) reviewed a number of studies focused on male victims of CSA and found that "53% to 94% of perpetrators were men" (p 1857), which alternatively allows one to assume that 6% to 47% of the persons committing the abuse were female Furthermore, they discovered that almost half of the females who had abused were teen-aged babysitters in the large sample studies Other findings of studies focusing on older adolescent and young adult males yielded a range of 27% to 78% of reported female sexual abuse

Kelly, Wood, Gonzalez, MacDonald, and Waterman (2002) conducted a study of men who had self-reported past sexual abuse experiences Of the 67 participants in this clinical population, 28% (19) reported having been sexually abused by a woman The

majority of these women were biological mothers (17/19) Mathews (1996), in his review of sexually victimized males, conveyed that females tended to report sexual abuse more often than males (90% of males do not report vs 75% of females do not report) and males were especially reluctant to report sexual abuse by a female Dunbar (1999) also found that female victims of female sexual abuse were reluctant to report this type of abuse and very few studies have specifically examined female victims of female sexual abuse

To summarize the characteristics that could be considered prevalent among females who have sexually abused others, the literature suggests that the most consistently reported factor is a history of severe or extensive CSA (Davin, 1999, Dunbar, 1999, Faller, 1987, Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Johansson-Love & Fremouw, 2006, Lewis, & Stanley, 2000, Mathews et al , 1997, Mathews et al , 1989, McCarty, 1986, Saradjian, 1996, Strickland, 2008, Vick et al , 2002) In addition, many studies reported women who sexually abuse children and adolescents as having a high incidence of mental health concerns (Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Lewis & Stanley, 2000, Nathan & Ward, 2001, Saradjian, 1996) These women were most likely not strangers to their victims (Davin, 1999, Dunbar, 1999, Grayston & De Luca, 1999, Hislop, 1999, Lewis, & Stanley, 2000, Mathews et al , 1997, Saradjian, 1996, Vandiver & Kercher, 2004, Vick et al , 2002) Victims could be either male or female (Gannon & Rose, 2008, Lewis & Stanley, 2000, Saradjian, 1996, Vandiver & Kercher, 2004) and of a younger age when compared to the age of victims of male sexual abuse (Faller, 1987, Gannon & Rose, 2008, Grayston & De Luca, 1999, McCarty, 1986, Vandiver & Walker, 2002) In addition, sexually abusive

behaviour by females tends to be reported less often by both male and female victims than sexual abuse committed by males (Dunbar, 1999, Mathews, 1996), with the proportion of male victims reporting a higher rate of female sexual abuse than the proportion of female victims (Briere & Elliott, 2003), however, males are generally more reluctant to disclose any past sexual abuse (Holmes et al , 1997, Lab et al , 2000, Romano & De Luca, 1997)

Although no studies have focused on the victim-to-victimizer cycle as a way of explaining why women who have been sexually abused might go on to abuse others sexually, the profile of these women suggests some support for this explanation (Davin, 1999, Dunbar, 1999, Faller, 1987, Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Lewis, & Stanley, 2000, Mathews et al , 1997, Mathews et al , 1989, McCarty, 1986, Saradjian, 1996, Vandiver & Teske Jr , 2006, Vick et al , 2002) It appears that a small proportion of women survivors of CSA potentially could have had their sexual development impacted to the extent that they later sexually abuse others The link between past history of sexual abuse and sexually abusive behaviour in adolescence or adulthood has been minimally studied in women More recently, Christopher et al (2007) did find more severe CSA to be a risk factor for women who sexually perpetrate against children when comparing women convicted of sexual offences and women convicted of non-sexual offences These studies attempting to profile females who are known to have abused others sexually and the reports by victims of female sexual abuse provide valuable knowledge and information for therapists working with women survivors of CSA The following section will explore whether knowledge about sexual abuse of children by females or the potential for females to abuse others

sexually is included within the assessment and treatment practice literature focused on women survivors of CSA

Review of Treatment Interventions with Female Survivors of CSA

Assumptions and stereotypes, along with empirically supported knowledge, sometimes guide the decisions of clinical practitioners or therapists Recommended assessment and treatment interventions with sexual abuse survivors have clearly varied depending on the gender of the survivor The common assumption that boys who have been sexually abused will become men who sexually abuse others has guided assessment and treatment interventions with male survivors (Crowder, 1995) An association between CSA experiences and later sexual perpetration by males has been documented (Glasser et al , 2001), however, the evidence has shown that this occurs less often than presumed (Salter et al , 2003) This section reviews selected recently published descriptions of treatment interventions with female survivors of CSA and studies that have examined survivor treatment experiences It will consider the degree to which they reflect awareness of sexual abuse by females and/or the potential for female survivors of CSA to engage in sexually inappropriate or abusive behaviour with children

The assessment and treatment intervention resources providing direction for work with female survivors of CSA were selected for this review according to their direct relevance to women survivors of CSA and evidence of assessment and treatment intervention content Resources that did not provide an outline of session topics or offered minimal information regarding content/issues to be addressed were excluded The more recent resources were given priority, however, some of the influential earlier

works[1] were included in the review, as they were often referenced and contributed to the structure of many current selections The selected sources (see Table 1) were reviewed according to the theoretical framework(s) that influenced the authors' focus in treatment, specific pre-screening questions within assessments that explored potential sexually abusive behaviour, thoughts, and feelings, and the inclusion of sexuality/sexual behaviour as a topic of focus and whether or not it demonstrated discussion of potential for sexually inappropriate behaviour, thoughts, and/or feelings

[1] Although a number of clinicians avoid using the resources "The Courage to Heal" and "The Courage to Heal Workbook" because of the controversy regarding specific recommendations from the authors to survivors that contribute to the false memory debates, these sources are included because they do reflect detailed treatment content and continue to be widely used amongst CSA survivors and clinicians "The Courage to Heal" has been noted as the most frequently recommended book to clients by feminist therapists who were surveyed (Chrisler & Ulsh, 2001)

Table 1

Review of Women Survivors of CSA Assessment and Treatment Resources

Source	Therapy model	Assessment questions	Content about sex/sexuality
Ainscough & Toon (2000a, 2000b)	Self-help text and workbook, no theory specified	Checklist includes effect of sexual abuse on life with statements referring to sexual abuse of others	References to women as abusers (2000a) Specific checklist statements referring to abusing others, being sexually aggressive, and obsessed with sex (2000b)
Bass & Davis (1988)	Self-help text –experiences of women survivors, no theory specified	Self-assessment includes statement referring to sexual abuse of others	Children and parenting section - explicitly discusses the potential for the woman survivor to sexually abuse children
Briere (1996)	Created the self-trauma model influenced by principles of psychotherapy, traumatic stress, self-psychology, and CBT	Trauma Symptom Inventory (questions related to unwanted sexual thoughts, indiscriminate, and/or inappropriate behaviour)	Brief segment on survivors as "perpetrators" (primarily male focused) – recommends informing survivor of duty to report and referral to an agency that works with perpetrators that have CSA issues
Chew (1998)	Feminist with Ericksonian approach, solution-focused, narrative	Refers to Courtois (1988)	Discussed from perspective as a potential victim of domestic violence, sexuality mentioned peripherally
Courtois (1988)	Traumatic stress, feminist, and family systems	Questionnaire provides space to discuss the initial and long-term after effects from a sexual perspective but no explicit questions	Discussed as a therapy topic but only with male victims and "not as necessary in the therapy of females" (p 285)
Davis (1990)	Self-help workbook – complementary to Bass & Davis (1988), author self-identifies as incest survivor	Self-assessment same as Bass & Davis (1988), assessing coping mechanisms includes "abusing others" (p 145)	In appendix offers guidelines for healing sexually, based on workshops for women but not specific to sexually abusive behaviour

Source	Therapy model	Assessment questions	Content about sex/sexuality
Drauker (2000)	Self-trauma model (Briere, 1996)	No questions related to potential sexual abuse of others	Individual counselling needs to explore potential for sexual abuse of others Not indicated in group therapy information
Engel (2005)	Self-help guide -principle belief that abuse will be perpetuated by victims of intergenerational abuse	Directly questions about thoughts or actions of sexual abuse towards others	Offers direct strategies to challenge thoughts of sexually abusing another or if already engaged in the abusive behaviour, what to do to stop the abuse
Herman (1997)	Traumatic stress, feminist principles	No specific discussion of assessment questions or processes	No specific discussion of sexuality as a counselling topic/issue
Margolin (1999)	Traumatic stress, self – development constructivist, feminist	No questions related to potential sexual abuse of others	Sexuality and intimacy module raises questions about what the abuse experience has taught the survivor about sexuality and intimacy
Marvasti & Dripchak (2004)	Psychodynamic, Herman's (1997) trauma recovery model	Not discussed	Discuss ambivalent feelings about abuse – may have experienced sexual stimulation and pleasure during the abuse experience - these feelings should be accepted and supported by the therapist
Meekums (2000)	Creative therapies, Herman's (1997) trauma recovery model	Refers to Sanderson (1990) and generally suggests assessing risk of harm to others	No specific references
Mitchell & Morse (1998)	Herman's (1997) trauma recovery model, CBT approaches	Not discussed	No specific references other than the general topic of relationships
Oz & Ogiers (2006)	Psychodynamic therapy, EMDR	Interview questions – one question related to sexual fantasies involving children or violence or other	Sexual fantasies discussed as normal and not linked to risk of acting out, goal is to modify the fantasies

Source	Therapy model	Assessment questions	Content about sex/sexuality
Sanderson (1995, 2006)	Emotional, cognitive, behavioural, feminist, psychoanalytic, reviews several models and recommends therapist select according to client need	1995 Refers to Courtois (1988) 2006 risk of abusing addressed as survivor over identifying with abuser	1995 Sexuality reviewed as a recurring theme that should be explored No mention of potential to sexually abuse 2006 Encourages exploration of fears and anxieties of looking at/thinking about children in a sexual way
Saxe (1993)	Feminist, traumatic stress, humanistic – existential, experiential	No questions related to potential sexual abuse of others	Optional module theme intimacy – focuses on current adult relationships only

The reviewed resources tended to follow very similar principles and strategies Many of the group program interventions are based on Courtois' (1988) integration of traumatic stress, feminist theory[2], and family systems models and Herman's (1997) trauma recovery model, which is also rooted in feminist principles The most common concept guiding the development of the programs and counselling interventions for women survivors of CSA seems to be the idea that women survivors internalize the CSA experience primarily as an experience of being a victim (Briere, 1996, Chew, 1998, Courtois, 1988, Herman, 1997, Margolin, 1999, Marvasti & Dripchak, 2004, Meekums, 2000, Mitchell & Morse, 1998, Oz & Ogiers, 2006, Sanderson, 1995, 2006, Saxe, 1993) Thus, the treatment provider is provided with guidelines to assess for depression, self-injury, re-victimization experiences in relationships, suppression of anger, and low self-esteem

Very few authors suggested the possibility that women could sexually abuse others, with the exception of 1) Engel (2005), who based her entire self-help style of text on the cycle of abuse or intergenerational transmission of violence and abuse, 2) Sanderson (2006), who shifted focus in this revised version and identified that the survivor may worry about going on to abuse, 3) Drauker (2000), who briefly indicated that individual counselling needs to explore the possibility of women sexually abusing others, 4) Bass and Davis (1988) and Davis (1990), who acknowledge the survivor's potential to sexually abuse children within their self-help guide and the complementary

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[2]The use of the terms "feminist" or "feminism" are not to be understood as representing homogeneity of thought among feminist theorists, however, the underlying principle of feminism is based on the recognition of the patriarchal oppression of women with "a commitment to social change through the eradication of women's oppression" (Calixte, Johnson, & Motapanyane, 2005, p 2) Feminism in relation to sexual abuse issues has remained strongly aligned with the feminist analysis of male power over women and children and is generally referred to in this context for the discussion of feminist theoretical influence with women survivors of CSA (Westbury & Tutty, 1999)

workbook, and 5) Ainscough and Toon (2000a, 2000b), who provide a similar text and companion workbook with a self assessment checklist that acknowledges that one can be abused by women Although Oz and Ogiers (2006) include the following interview question "Were you ever troubled by sexual fantasies involving children/violence/other? If so, when?", the intent of exploring the fantasies was described as working to reduce the distress the woman survivor may experience as a result of the fantasies rather than addressing sexual fantasies about children as a potential risk factor for engaging in sexually abusive behaviour

Bass and Davis (1988) and Davis (1990) presented the possibility of sexually abusing others by including the explicit statement "I've sexually abused others" (Davis, 1990, p 131) and a similar statement "I have abused children" (Davis, 1990, p 132) in the "Assessing the Damage" sections of both these texts However, of particular interest is a section on children and parenting in the Bass and Davis (1988) text written specifically for women survivors of CSA This section of the text discussed "sexual boundaries", "fear of being abusive", "if you have been abusive", and "if you're feeling shaky" (p 277-287) explicitly in relation to the concern about the potential for the woman survivor to abuse children sexually

Bass and Davis (1988) claimed that no academic research or theoretical framework influenced the information they provided in their book, rather it was based on 50 interviews with women survivors, the authors' practical experiences of counselling women survivors, as well as personally experiencing CSA (Davis) and having a partner who is a survivor (Bass) The research process and interviews were not described with a specific methodology, although the various narratives demonstrate that these authors

recognized that some women survivors are vulnerable to engaging in sexually abusive or inappropriate behaviour Furthermore, very few subsequent sources seem to have included related questions and topics of focus about potentially abusive behaviour within their description of assessment and treatment interventions, even though they may utilize some of the other suggestions for intervention presented by Bass and Davis (1988) and Davis (1990)

Of particular note, Sanderson (2006) reframed assessment concerns in her third edition to include assessing for risk of potential abuse This risk was framed as the survivor bringing forth worry or concern that s/he may be at risk of abusing others and emphasized the importance of exploring this issue rather than not taking the concern seriously This particular reference was the most explicit in recommending the exploration of the risk of further abuse Additionally, Sanderson (1995, 2006) did acknowledge within both editions that women do sexually abuse children

To summarize the review of resources outlining assessment and treatment interventions for women survivors of CSA, most sources generally acknowledge or reflect a feminist perspective in their theoretical framework with the exception of Briere (1996), Drauker (2000), and Engel (2005) The resources that explicitly identify and/or offer suggestions to address potential sexually abusive behaviour by women survivors are Aincough and Toon (2000a, 2000b), Bass and Davis (1988), Davis (1990), Drauker (2000), Engel (2005), and Sanderson (2006) Although Bass and Davis (1988) claimed no theoretical framework, their method of assessing and then providing the information within their text is consistent with some feminist principles of research and therapy, such as privileging the women's voices and experiences (Lorber, 1998) Aincough and Toon

(2000a, 2000b) identify themselves as psychologists but describe their texts as practical help for survivors based on survivors' contributions to the texts They do utilize inclusive definitions of survivors and offenders (meaning men and women are survivors and offenders) Draucker (2000) acknowledged Briere's (1996) self-trauma model, which is theoretically rooted in "psychodynamic, object relations, self-psychology, and cognitive-behavioral perspectives and strategies" (Briere, 1996, p ix) Engel (2005) presented no theoretical framework but acknowledged herself as a licensed marriage and family therapist with many years of experience, as well as having personally experienced past sexual abuse and "struggled against repeating the cycle of abuse" (p 5) throughout her life Sanderson (2006) outlined several theoretical frameworks and suggested the therapist choose what would work best for the survivor client

In addition to assessment and treatment manuals, self-help guides, and other resources, the content and focus of female survivor treatment can also be understood by reviewing available treatment/intervention outcome studies Rather than analyzing aspects of methodology that may impact on results, the purpose of reviewing these outcome studies was to acquire further knowledge about the theoretical framework, content of the treatment, and the reported impact on participants The influence of feminist theory on the theoretical framework of CSA survivor treatment for women, which may or may not be clearly articulated as acknowledged by Westbury and Tutty (1999), was also observable within many outcome studies In addition, the focus of these outcome studies generally relates to how effective the treatment intervention or approach was in reducing symptoms related to CSA

Price, Hilsenroth, Petretic-Jackson, and Bonge (2001), Callahan, Price, and Hilsenroth (2004), and Kessler, White, and Nelson (2003) conducted reviews of female survivor of CSA treatment outcome studies Price et al (2001) reviewed eight studies examining individual therapy outcome, Callahan et al (2004) reviewed five interpersonal-psychodynamic based group studies, and Kessler et al (2003) completed a review of 13 published outcome studies of female CSA survivor group treatment based on peer-reviewed articles Regardless of theoretical approach, the recipients of these therapies reported a significant decrease in symptoms of depression, anxiety, and trauma-related symptomology or PTSD Of the 13 studies Kessler et al (2003) reviewed, only two studies clearly articulated a theoretical framework (feminist theory), while the 11 other studies "were loosely informed" (p 1055) by a variety of theoretical frameworks guiding the treatment interventions Unfortunately, all three of these review articles provided minimal information regarding the specific content of the treatment interventions, however, the reported results do not demonstrate any emphasis on sexual issues or reducing the potential to abuse children sexually

An examination of some of the original studies (e g , Carver, Stalker, Stewart, & Abraham, 1989, Lundqvist & Ojehagen, 2001, Paivio & Nieuwenhuis, 2001, Stalker & Fry, 1999, Westbury & Tutty, 1999) reviewed by the aforementioned authors for more specific program content resulted in only one of these studies providing more explicit treatment content information beyond listing sexuality or sexual problems as a theme Westbury and Tutty (1999) provided a description of the program model they utilized for their study, which indicated an emphasis on the group members' (women's) personal boundary style that the group leaders were to address or challenge if inappropriate

Although the meaning of this statement about boundaries can be interpreted in a variety of ways, it potentially creates the space for therapists to begin to discuss sexual boundary issues within the context of the treatment group that could include sexually inappropriate boundaries with children and adolescents

The other research articles presented minimal information regarding the woman survivor's potential to abuse children sexually Some treatment programs were based on the trauma recovery model (Herman, 1997), which tended to focus on reducing trauma symptoms and recovery skill development with no indication of possible sexually abusive behaviour (Fallot & Harris, 2002, Palmer, Stalker, Gadbois, & Harper, 2004, Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003) Palmer et al (2004) reported exploring participants' views about how helpful the treatment program was with interpersonal relationships as part of their qualitative study, however, the findings did not reflect any emphasis on preventing sexually abusive behaviour even though the program indicated addressing problematic behaviours, such as traumatic re-enactment

Some additional studies, not included in the previous reviews, also provide some further information about treatment of women survivors Rieckert and Moller (2000) also found a reduction of symptoms in their study of a rational-emotive behaviour therapy group for adult survivors They utilized the Golombok-Rust Inventory of Sexual Satisfaction (Rust & Golombok, 1986 as cited in Rieckert & Moller, 2000) as a measure to assess "the prevalence and severity of sexual problems" (p 92), however, sexually abusive behaviour was not specified Gorey, Richter, and Snider (2001) identified themes of personal relationships and parenting in their study of a generalist problem-solving group, however, the focus of this study pertained to a reduction in feelings of

guilt, isolation, and hopelessness In addition, Wilson and Wilson (2008) presented a case study to ameliorate unwanted sexual fantasies as a means of reducing guilt and shame based on the abuse related fantasies Although the unwanted sexual fantasies were not described as having content related to the client engaging in sexually abusive behaviour, this article does emphasize the importance of addressing unsettling sexual fantasies or thoughts as part of the survivor's treatment

Hall and King (1997) presented some interesting information that related peripherally to the creating of space for discussion of potential sexually inappropriate behaviour Their survey of women survivors who had participated in group therapy for CSA at the UK National Health Service reported similar results to many other studies (i e , as reviewed by Callahan et al , 2004 and Kessler et al , 2003) in that a significant proportion of respondents reported finding the group helpful, in particular, it reduced their symptoms of depression Of significance to this study, Hall and King (1997) also included some of the written comments respondents had provided Specifically, one respondent expressed that she did not seem to fit in with the group because she had experienced her sexual abuse as "want[ing] her father to love her and had enjoyed the closeness" (p 418) This woman's description of her experience would provide an opportunity for discussion that recognizes how sexual abuse and intimacy can be interconnected with potential for re-enactment within other relationships, particularly with children In addition, her statement reflects that group facilitators/therapists should not assume that all women survivors approach their issues with CSA as completely negative, consistent with the findings of Rind et al (1998)

Two other related articles provided descriptive summaries of group therapy experiences with female survivors of CSA from the therapists' perspective Gordon and Giles (1999) discussed some of the themes that surfaced during a six-month analytic group for women survivors The group members raised concerns about their capacity for mothering their children Some of their questions identified concerns about boundaries of physical contact with their children and worries that they will abuse their child because of their experiences The authors did not expand this discussion further than the brief paragraph mentioning this theme, however, this particular theme provides an excellent avenue for creating the opportunity to have a discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents This particular theme is consistent with the children and parenting topic Bass and Davis (1988) have outlined within their self-help handbook

Nusbaum (2000) provided a case illustration of a psychodynamic group for women survivors of CSA The article provided an illustration of how the group was able to support one group member with her disclosure of having sexually touched a child she was babysitting when she was ten years old This illustration provided an example of how space had been created for discussion of potential sexual boundary crossing within a particular group experience

Engel (2005) disclosed a very similar experience from when she was 12 years old and performed fellatio on a child she was babysitting She included her own story within her self-help text to demonstrate her understanding of the potential to behave sexually inappropriately with children and the importance of having the opportunity to explore this potential or actual behaviour Had the woman, whom Nusbaum (2000) described,

disclosed that she had sexually touched a child as an adult, a very different response may have resulted, however, the focus of this case illustration and Engel's (2005) personal disclosure in her text serve to emphasize that there are some women who could benefit from more purposeful and deliberate discussion of their own potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents Furthermore, Nusbaum (2000) represents a therapist who was willing to work with this woman survivor's concerns about her own past sexually abusive behaviour, however, Nusbaum did not explicitly discuss the current potential for sexually abusive behaviour as an area of focus

A survey of 60 group leaders who facilitate CSA survivor groups provide some interesting but limited insights to survivor group structure, theory, and practice (Gerrity & Mathews, 2006) Only 15% of the theoretical frameworks guiding the adult group structure were described as feminist Pre-group screening criteria identifying perpetration was indicated for 68% of adult groups and exclusion criteria based on perpetration for adult group membership was 35% according the survey responses However, the main limitation regarding the data provided was the lack of clarity as to what portion of the responses pertained specifically to the female versus male survivor groups Regardless, it could be surmised that some portion of the adult female group leaders were likely screening for perpetration behaviour

To summarize the review of published treatment interventions and outcome studies, very few sources explicitly emphasize or include potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents as part of the assessment and treatment focus The located sources that explicitly identify potential

sexually abusive behaviour by women survivors are Ainscough and Toon (2000a, 2000b) Bass and Davis (1988), Davis (1990), Drauker (2000), Engel (2005), Nusbaum (2000), and Sanderson (2006) Each of these sources also has limitations For example, Bass and Davis (1988) dedicated a chapter to children and parenting in their text that addressed the potential to cross the line in a sexual way with children, yet the complementary Davis (1990) workbook offered no explicit exercises regarding the potential to abuse children sexually Drauker (2000) very briefly suggested the need for individual counselling to explore the possibility of women sexually abusing others, but did not expand on this idea or offer strategies for this exploration Engel's (2005) self-help text was the most explicit and was very specific to breaking the cycle of sexual abuse, however, her strong language and direct approach to the topic may be intimidating rather than engaging for women who may not perceive the context of their sexually inappropriate boundaries as similar to the abusive behaviour examples that Engel has provided Nusbaum (2000) raised the issue of past sexually abusive behaviour but did not include current potentially abusive behaviour as an area of focus

Overall, in the majority of the sources reviewed, the counselling approaches generally affirm a "victim-only" perspective and reflect a lack of attention to the fact that some women survivors of CSA do sexually abuse children and adolescents, with the exception of Ainscough and Toon (2000a, 2000b) Bass and Davis (1988), Davis (1990), Drauker (2000), Engel (2005), Nusbaum (2000), and Sanderson (2006), as well as some limited research findings regarding perpetration pre-screening for members of survivor groups discussed by Gerrity and Mathews (2006) that may pertain to female survivors It appears that, regardless of the available facts or information about CSA, therapists tend to

make clinical practice decisions and judgments based on their own beliefs or assumptions about CSA The next section will review research that explores the link between what a therapist believes about CSA and the practice actions associated with these beliefs

Review of Research Pertaining to Therapist Beliefs about CSA

The previous review of adult CSA survivor assessment and treatment practice interventions documents the general content of counselling practice and programs, however, it does not reveal individual therapists' explicit beliefs about the various aspects of CSA (e g , female-perpetrated sexual abuse) and the relationship between therapists' beliefs and their counselling practices The examination of research pertaining to therapists' beliefs about CSA will offer further insight into how therapists' beliefs may influence their counselling practice and potentially what therapists believe about female-perpetrated sexual abuse

An early national survey conducted by Conte, Fogarty, and Collins (1991) sought to examine CSA professionals' attitudes and knowledge about CSA and how this interacted with their professional practice decisions, particularly with regard to incest In order to examine the attitudes and knowledge of participants, Conte et al created a series of statements seven knowledge statements that they deemed to be false, eight value statements that had no right or wrong responses, and ten statements which were hypothesized to be uncertain Their findings demonstrated "considerable variation" in terms of the degree of correctness of the knowledge responses and the "high level of certainty" in response to the uncertain statements (p 163) The responses to the questions regarding a specific case vignette presented to participants demonstrated that the relationship of the male abuser (did not include female abuser scenario) to the child

victim was a factor in the therapists' decision-making regarding the type of therapy they would recommend for both the victim and the person who perpetrated the abuse of the victim For example, if a teacher abused the child, group therapy was more likely to be recommended for the victim and behavioural treatment for the abusive teacher, if a brother was the abuser, family therapy was more likely to be recommended by the professional The age of the victim was not a factor The relevance of Conte et al 's study rests with the focus on examining therapist knowledge, attitudes, and practice decisions similar to this current study, however, Conte et al 's data were not analyzed to demonstrate the relationship between the knowledge and attitudes and the practice decisions Rather, the knowledge and attitudes were presented only descriptively Thus, the concepts regarding knowledge, attitudes, and practice decisions were applied with variations pertaining to the focus of the current study

Day, Thurlow, and Woollriscroft (2003) examined the level of knowledge about CSA prevalence and understanding of CSA client needs and the level of competence and comfort that a group of mental health professionals had working with CSA issues Although this study found that the mental health professionals surveyed were generally knowledgeable about the prevalence and needs of clients with CSA issues, they identified feelings of discomfort and a lack of competence to work with CSA survivors Again, the knowledge results demonstrated by respondents was not analyzed to determine a relationship with the level of competence, providing only descriptive information about the mental health professionals' level of knowledge to determine that the sample surveyed was generally knowledgeable about CSA However, training and experience was analyzed with the respondents' self-rated competency and findings indicate that the

more experience and training received by the respondents, the more competent and comfortable they felt working with CSA Overall, the knowledge about prevalence and issues pertaining to CSA was not focused on gender of the perpetrator, therefore, this survey offers no insight related to examining female-perpetrated sexual abuse but provides some relevant questionnaire and analysis ideas for examining therapist understanding about and comfort in working with CSA issues in relation to their experience and training

In her dissertation, Tedford (2004) examined the effect of victim gender and the gender of who perpetrated the abuse on the attitudes of licensed psychologists regarding the believability of CSA disclosures She utilized a single vignette that offered variations in victim gender and the gender of who perpetrated to examine the difference in believability Tedford found that the gender of the victim had no impact on the believability, however, the gender of who perpetrated was associated with a significant difference, specifically female-perpetrated CSA vignettes were rated as less believable Tedford's study did not examine how this influenced psychologists' practice decisions, although it does establish evidence that helping professionals exhibit less ability to believe reports about female-perpetrated CSA

Gore-Felton et al (2000) examined the beliefs of psychologists regarding memories of CSA and how these beliefs influenced their beliefs about clients' memories of CSA and treatment decisions Their results demonstrated that if psychologists held strong personal beliefs about the large prevalence of CSA, they were also significantly more inclined to believe the accuracy of the client's CSA memory Furthermore, if psychologists believed the accuracy of the clients' CSA memory then they were more

likely to engage in abuse-focused treatment These findings, therefore, indicated that the psychologists' personal beliefs and beliefs about the accuracy of CSA memory presented by the client predicted the psychologists' treatment decisions Of particular importance to the current research, is the finding that these psychologists struggled to believe both men and women's abuse memories when the memories involved sexual abuse by females Therefore, although the focus of Gore-Felton et al 's study pertained to credibility of CSA memories presented by CSA survivors, it suggests that therapists of female survivors of CSA may also demonstrate more difficulty believing or recognizing female-perpetrated sexual abuse or the potential for women survivors of CSA to engage in sexually abusive behaviour

In a very specific study that investigated the attitudes and decisions of child protection professionals (social workers and police) regarding the gender of who perpetrated the abuse, Hetherton and Beardsall (1998) found that victims of adult female-perpetrated sexual abuse received different protection decisions than victims of adult male-perpetrated sexual abuse Hetherton and Beardsall developed a 22-item attitudes scale specific to female-perpetrated sexual abuse The respondents endorsed the existence of CSA perpetrated by women and considered this form of abuse to be a serious problem Somewhat contrarily, the researchers found that the responses to the case vignettes provided to these same participants indicated that their decision responses reflected a less serious action would be taken if the CSA was perpetrated by a female

In summary, the studies reviewed in this section confirm that the knowledge, beliefs, and attitudes of therapists can affect their clinical practice decisions Of relevance to this current study is the fact that the methodology used in many of these

studies involved the use of some form of vignette or statement to elicit therapists' beliefs The methodology findings of Gore-Felton et al (2000) and Hetherton and Beardsall (1998) related to beliefs about adult female-perpetrated CSA are particularly salient Given that these two studies found that clinical judgments and practice decisions of psychologists and child protection professionals reflected less believability or perception of seriousness regarding female-perpetrated CSA, it would be reasonable to postulate that therapists working with adult female survivors of CSA may exhibit similar beliefs, and if so, these beliefs would be likely to influence their professional practice decisions with women survivors

Synthesis

The idea of whether or not space should be created for discussion of potential sexually inappropriate behaviour with female survivors of CSA in the assessment and treatment context has been the focus of this literature review and guided its structure and content This section synthesizes this review and highlights the gaps in knowledge and consequent direction of the current study It must be acknowledged, however, that substantial risks are involved in creating space for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents The risk of possible disclosure of sexually abusive behaviour by women survivors of CSA creates the dilemma of the "double-edged sword " That is, if the woman discloses having engaged in sexually abusive behaviour, she is at risk of being reported to police and criminally charged, if the woman does not disclose, she will not receive appropriate counselling help and children may continue to be abused This risk must be considered in

conjunction with therapists' decisions to create space for discussion of potential sexually inappropriate behaviour in the assessment and treatment context

To reiterate an earlier point, it is important to preface this discussion with the acknowledgement that the empirical evidence demonstrates that males are more likely to engage in sexual abuse of children and adolescents than females (Badgley, 1988, Briere & Elliott, 2003, Fergusson & Mullen 1999, Finkelhor et al , 1990, Laumann et al , 1994, Rind et al , 1998) However, the fact that some women also sexually abuse children and adolescents has been identified in prevalence studies (e g , Briere & Elliott, 2003) As noted previously, the variance in incidence and prevalence rates may be a result of varying definitions of CSA (Denov, 2003, 2004, Goldman & Padayachi, 2000, Haugaard, 2000, Holmes & Slap, 1998, Johnson, 2004, Mannon & Leitschuh, 2002) Determining who has the power to define CSA and what behaviours therapists or counsellors define as sexual abuse becomes complex particularly when applied to women who sexually abuse children and adolescents For example, feminist theory commonly guides clinical practice with women survivors (refer to Table 1) and has contributed to situating sexually abusive behaviour as a male problem and the promotion of a stereotypical perception of women as incapable of causing harm (Atmore, 1999a, Renzetti, 1999), it has also contributed to the framing of sexually abusive behaviour by females as less serious or subtle (Hetherton, 1999, Robinson, 1998) Other authors also contribute to this perception that sexual abuse committed by females is less serious with the finding that it can be perceived as positive (Haugaard, 2000) Moreover, the masculinized language of sexual abuse that has been translated to denote penetration and the use of a phallus (Nelson 1994) not only has implications for how therapists define and identify sexual

abuse committed by females, but also influences how therapists respond to signs of potentially sexually abusive behaviour

This masculinized language that defines CSA often influences accountability, responsibility, punishment, and/or treatment interventions for sexually abusive behaviour, which "may not accurately reflect the thoughts [or experiences] of a victim" (Fitzroy, 2001, p 8) or a woman who has crossed sexual boundaries with a child To illustrate this further, a nine-year-old child who has received gentle, sexualized caressing of his/her genitals by his/her mother after every bath since s/he was born may not define this experience as abusive Although Etherington (1997) and Lawson (1993) would define this behaviour as subtle sexual abuse, many therapists, other professionals, and the mother, herself, may not define this behaviour as sexual abuse, and thus, the victim and the woman committing the sexual abuse may not receive appropriate treatment interventions

The lack of a clear and comprehensive definition of CSA impacts whether or how therapists may recognize or even believe reports of some of the more subtle aspects of sexually abusive behaviour by females A small qualitative study of therapists who have worked with women who have abused others sexually found that one of the respondents reported that another therapist had told her woman client that her sexually abusive behaviour was "not necessarily sexual offending" (Hovey, 2004, p 17) The message this woman survivor client received from the prior therapist was that her sexually abusive behaviour was a problem with nurturing, not sexual abuse The interpretation communicated by the respondent was that the client's sexually abusive behaviour was not defined or believed to be abusive and thus not taken seriously by this other therapist

It has been empirically demonstrated that a helping professional's beliefs about CSA can influence his or her practice decisions (Conte et al , 1991, Gore-Felton et al , 2000, Hetherton & Beardsall, 1998) and that many therapists or professionals who work with CSA survivors find female-perpetrated sexual abuse less believable than male-perpetrated sexual abuse (Gore-Felton et al , 2000, Hetherton & Beardsall, 1998, Tedford, 2004) Portwood's (1999) recommendation to establish multiple definitions of CSA may be extremely helpful in addressing the needs of varying professionals, particularly for therapists working therapeutically with women survivors of CSA Establishing therapists' current beliefs or understanding of CSA definitions in relation to sexually abusive behaviour by females and how their beliefs or understanding informs their practice interventions is an important first step in this direction

Further influencing therapists' beliefs is research on the impact of CSA on female sexual development that conceptualizes these women as victims, in this literature, female victims are seen as being inclined to avoid sex or internalize the abuse experience in some way (Finkelhor & Browne, 1984) The act of sexually abusing others represents an externalization of the experience rather than a "victim" response of internalization This perspective of the female as "victim-only" who always internalizes the CSA experience is consistent with the ideology of victim feminism that situates "men as somehow always rapists and women, just as inevitably preyed upon" (Atmore, 1999a, p 193) However, not all women (or feminists) have embraced this victim position (Lamb, 1999), thus, it can no longer effectively serve as the only perception of women or women survivors of CSA Examining the extent to which this "victim-only" perspective is held and acted upon by therapists of women survivors of CSA is an important goal in this study

It seems apparent that the more common finding of an internalization response or aversion to sex as the impact of CSA on female sexual development should continue to guide treatment interventions with women survivors of CSA Nonetheless, the need for treatment providers of women survivor programs to create the space for exploration and discussion of thoughts about or actual sexual behaviour that contravenes appropriate sexual behaviour towards others, and in particular towards children, becomes of primary concern with the relatively small proportion of women who may engage in or be at risk to engage in sexually inappropriate behaviour The literature indicates that some women survivors of CSA question the appropriateness of their sexual thoughts and behaviour (Gordon & Giles, 1999, Hall & King, 1997), however, very few resources suggest that aspects of assessment and treatment intervention should include the exploration of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents

Interestingly, one of the earliest resources, "The Courage to Heal" (Bass & Davis, 1988), still noted as the most frequently recommended self-help book by the feminist therapists who were surveyed (Chrisler & Ulsh 2001), clearly suggests that some women survivors are vulnerable to engaging in sexually abusive or inappropriate behaviour However, the majority of the resources reviewed (refer to Table 1) seem to support a "victim-only" perspective from which to approach the assessment and treatment of women survivors of CSA that does not include exploring this vulnerability It could be argued that therapists generally approach their counselling interventions with female survivors of CSA from a "victim-only" perspective Therefore, it is important for this study to explore with therapists who currently provide counselling interventions with

women survivors of CSA, whether their beliefs about what behaviours constitute sexual abuse include a "victim-only" perspective and how their perceptions or beliefs about women survivors of CSA influence their practice with these women

In contrast to the "victim-only" representation, and as reported by some female children in a number of studies, the experience of sexual arousal concurrent with the sexual abuse may contribute to or increase the risk of sexually inappropriate behaviours including the sexual abuse of other children (Finkelhor & Browne, 1984, Hall et al , 1998, 2002, Johnson, 1993a, 1993b, 2002, McClellan et al , 1996) Overall, there is some evidence that past sexual abuse may influence "normal" female sexual development and may contribute to later sexually abusive or inappropriate behaviour depending on certain conditions (Hall et al , 1998, 2002, Johnson, 1993a, 1993b, 2002, McClellan et al , 1996, Westerlund, 1992) These findings regarding the impact of CSA on some women survivors support Finkelhor and Browne's (1984) description of a highly eroticised response to the sexual abuse experience as a behavioural manifestation of the traumatic sexualization dynamic that should not be dismissed or minimized (Noll et al , 2003), particularly by therapists working with women survivors

Studies of women who have sexually abused children and youth provide further evidence to support the contention that some women survivors' sexuality and sexual development can be impacted by past sexual abuse experiences to the degree that they may externalize or "act out" the sexual behaviour in some way Of particular relevance is that the most consistent and commonly reported characteristic of women convicted of or self-reporting sexually abusive behaviour is a history of severe or extensive CSA (Davin, 1999, Dunbar, 1999, Grayston & De Luca, 1999, Hislop, 1999, Johansson-Love &

Fremouw, 2006, Lewis, & Stanley, 2000, Mathews et al , 1997, Saradjian, 1996, Strickland, 2008, Vandiver & Teske Jr , 2006, Vick et al , 2002) It must be noted that although these studies report that a large majority of these women report past CSA experiences, the evidence is based on historical recall rather than documented incidents and would be strengthened by providing collateral documentation (Johansson-Love & Fremouw, 2006) However, even in recognizing that historical recall is a weaker form of evidence, this information contributes to establishing the importance of exploring the potential for sexually inappropriate behaviour by some women survivors of CSA given the current knowledge about sexually abusive behaviour committed by women

Literature guiding professional helpers regarding problems associated with the sexual issues of adult female survivors of CSA has most often been addressed in the context of discussions about intimacy or relationships between adults (Davis, 1990, Margolin, 1999, Marvasti & Dripchak, 2004, Mitchell & Morse, 1998, Sanderson, 1995, Saxe, 1993), however, the specific focus on discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents on the part of some female survivors has received considerably less attention Therapists or counsellors providing treatment for female survivors of CSA presumably have different levels of understanding and knowledge about the various aspects of CSA, particularly sexually abusive behaviour by females, from which they base their interventions In addition, thus far, no research has demonstrated how awareness of or beliefs about CSA committed by females may influence how therapists address the sexual issues of adult female survivors of CSA within the assessment and treatment context This raises concerns about whether the need for space to be created for discussion of potential sexual boundary crossing or

sexually inappropriate behaviour with children and adolescents with female survivors is recognized by therapists

As noted earlier, to discuss or explore potentially inappropriate sexual behaviour with children and youth with women survivors in the treatment context can have extensive consequences for the woman survivor who subsequently discloses this behaviour Interestingly, this same dilemma of the "double-edged sword" could be applied to therapy with male survivors of CSA, however, counselling practice with male CSA survivors has emphasized the importance of exploring for possible sexually abusive behaviour Crowder (1995) strongly specified that "[t]herapists must ask [male] clients if they have engaged in abuse-reactive perpetration" (p 105) The practice of routinely asking male survivors of CSA about their possible engagement in sexually abusive behaviour could be considered prudent counselling practice because it means exploring all potential issues and ensuring protection of children and youth This practice suggests that the risk of consequences for the male survivor is not privileged over the risks for potential child and youth victims

The intent in comparing assessment and treatment intervention approaches for male survivors with female survivors is not to suggest equality in the seriousness of the issues of male-perpetrated sexual abuse Rather, the counselling practice with male survivors of CSA seemingly supports an argument for the need to create space for discussion of the similar possibility of potential sexually inappropriate behaviour by female survivors of CSA In light of the available evidence based on studies of females who have sexually abused others, the incidence and prevalence studies, and the impact of CSA on the sexual development of females, this practice that is common with male

survivors of CSA could be considered the professionally responsible approach to counselling with female survivors of CSA

In summary, this review of the literature has sought information as to how therapists attend to the sexual issues of adult female survivors of CSA within the assessment and treatment context, with specific focus on whether or how space is created for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents The review of the intervention literature found minimal emphasis on the need to create space for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents, suggesting that therapists may be unlikely to explore or discuss these issues Furthermore, treatment interventions described in the literature have not reflected the exploration of potential sexual abuse or boundary crossing with women survivors of CSA

Inquiry as to whether the lack of attention in the literature mirrors a lack of attention within current practice contexts is required and will be an important contribution to the field This current study is focused on whether or not therapists address the potential for sexual boundary crossing or sexually inappropriate behaviour with children and adolescents with women survivors of CSA The results may encourage therapists to consider changing their practices Additionally, the results provide recommendations that could be helpful to therapists about how to best begin to create the space needed to discuss potential sexual boundary crossing or abuse while minimizing the potential risks of having this discussion

Research Question

This sequential mixed methodological study explores therapists' gendered beliefs about what constitutes CSA, who commits CSA, and the relationship between therapists' beliefs, their self-reported behaviour, and perception of their clients' behaviour with regard to inquiring about sexually inappropriate thoughts and behaviours in their counselling practice with women survivors of CSA The first phase of the study involved a web-based survey of therapists from across Canada who provide counselling to women survivors of CSA To obtain a more in-depth understanding of therapists' self-reported counselling behaviour, a second phase of qualitative inquiry followed the first phase The second phase, involving interviews with a subsample of the original sample, specifically focused on therapists' personal practices with regard to discussing potential sexual boundary crossings

The overarching research question guiding the current study and methodology is Do therapists who work with adult female survivors of CSA address the potential by which some of these women may have engaged or are at risk to engage in sexually inappropriate behaviour with children and/or adolescents?

More specific questions arising from this question include

- What do therapists who work with women survivors of CSA believe about what constitutes CSA? How do they understand/define CSA?
- What do therapists who work with women survivors of CSA believe about who commits CSA? What are their beliefs about the prevalence of female versus male perpetration?

- What are therapists' beliefs about women survivors of CSA and female-perpetrated sexual abuse? Do these beliefs represent women as "victims-only"? What are their beliefs about the risks for women survivors of CSA to engage in sexual perpetration?
- Is there a relationship between therapists' beliefs about CSA and the counselling practice of the therapist with women survivors of CSA?
- Have women survivors of CSA brought concerns about sexually inappropriate thoughts or behaviour with children or adolescents to the therapists? If so, what have been the therapists' responses to these concerns?
- Do therapists perceive a difference between initiating discussions about sexually inappropriate thoughts compared to initiating discussions about sexually inappropriate behaviour? Do therapists perceive a difference with respect to clients initiating this discussion?
- Does the therapist routinely ask women survivors of CSA about sexually inappropriate thoughts or behaviour with children or adolescents? If so, how does the therapist approach this discussion? If not, what are the concerns or reasons for not approaching this discussion?

The relationship between these questions and the hypotheses and interview questions are identified within the Method and Procedures chapter

Method and Procedures

Introduction

This chapter will begin with a brief description of the research design and the two phases of data collection The participants and sampling process for each phase of the study will be described Subsequently, an explanation of the type of measures used for each phase and an account of the procedures followed for each phase will be outlined

Design of the Research

A mixed methodological approach was used to conduct this research Much debate has occurred regarding the incompatibility of qualitative and quantitative research paradigms (Greene, 2007, Tashakkori & Teddlie, 1998), happily, this debate has led to researchers applying methods "appropriate for their studies" (Tashakkori & Teddlie, 1998, p 5) rather than rigidly remaining within a single paradigm and methodology Pragmatic mixed methodology theorists emphasize that the research question determines the method rather than the philosophical approach of the researcher The research question for this particular study, although it appears as a simple either/or response style of question, has many complexities that require both quantitative and qualitative methodological approaches

The most appropriate methodological approach for this study was the "sequential explanatory strategy" (Creswell, 2003, p 215), this approach has also been described as an integrated design using *iteration* (Greene, 2007, p 126) where one method is primary and the other secondary as in this study Greene notes that the methods could also be equally weighted depending on the purpose of the study The primary purpose of this approach is for development, which requires that the results from the first method are

used to inform or develop the second method (Creswell, Shope, Plano Clark, & Green, 2006, Greene, 2007) The sequential explanatory strategy implemented for this particular study prioritized quantitative data collection and analysis (Phase 1) including recruitment of participants within the first phase for the next phase (Phase 2), the second phase required qualitative data collection and analysis, with integration of the research questions at the onset, sample selection for Phase 2, and data integration to occur during interpretation of the results in the discussion (Ivankova, Creswell, & Stick, 2006) However, the analysis of narrative comments on the questionnaire within Phase 1 provided a bridge to Phase 2 analysis Additionally, the quantitative results interacted with and informed the qualitative analysis both intentionally and unintentionally because of the sequential process The qualitative findings were used to provide further explanation and understanding of a particular set of questions within the quantitatively based survey (Creswell et al , 2006, Ivankova et al , 2006) The research questions have guided these two phases and the study's hypotheses and interview questions were derived from the research questions See Table 2 for an illustration of how the research questions guided the methodology, hypotheses and qualitative interview questions As well, Table 2 includes a brief rationale for each research question

Table 2

Research Questions, Hypotheses, and Interview Questions

Research Questions	Hypotheses	Telephone Interview Questions	Rationale[3]
Primary question Do therapists who work with adult female survivors of CSA address the potential that some of these women may have engaged or are at risk to engage in sexually inappropriate behaviour with children and/or adolescents?	The majority of therapists who work with women survivors of CSA do not create space for discussion of potential boundary crossing or sexually inappropriate behaviour with children and adolescents	According to your responses on the survey, could you tell me more about what prompts you to ask a client about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice? According to your responses on the survey, could you tell me more about why you do not ask (or rarely ask) women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?	Questions follows from the lack of attention to this discussion within the practice literature (see Table 1 for summary of practice literature) and direct feedback from clients within my own clinical practice
What do therapists who work with women survivors of CSA believe about what constitutes CSA? How do they understand/define CSA?	The therapist's Definitional Orientation[4] will predict the Therapist-Create Climate[5], the more conservatively[6] the therapist defines CSA, the more likely the therapist will create space to explore sexually inappropriate thoughts and behaviour		Follows from the assumption that if a therapist defines CSA to be more inclusive of less explicit behaviours (e g , relative sleeping with a child), they may demonstrate more openness to recognizing that women may be at risk of sexually abusing a child

[3] A brief rationale is provided here, see Quantitative Data Analysis section in Method chapter for further explanation of hypotheses' development
[4] Definitional Orientation – how respondents define the abuse vignettes presented in questionnaire, see Quantitative Data Analysis section for further explanation
[5] Therapist-Created Climate – construct that captures "space creation" by the therapists, see Quantitative Data Analysis section for further explanation
[6] Conservative – represents the respondents' strong agreement that the abuse vignettes illustrate CSA in questionnaire, see Quantitative Data Analysis section in for further explanation

Research Questions	Hypotheses	Telephone Interview Questions	Rationale[3]
What do therapists who work with women survivors of CSA believe about who commits CSA? What are their beliefs about the prevalence of female versus male perpetration?	Therapists would be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA The therapists' belief about the appropriateness of the behaviour indicated in the matched vignettes of the Definitional Orientation scale will differ according to the gender of who perpetrated the behaviour		Arises from assertions in the literature that sexual abuse of children and adolescents by women is less likely to be recognized as abusive by helping professionals (e g , Denov, 2001)
What are therapists' beliefs about women survivors of CSA and female-perpetrated sexual abuse? Do these beliefs represent women as "victims-only"? What are their beliefs about the risks for women survivors of CSA to engage in sexual perpetration? Is there a relationship between therapists' beliefs about CSA and the counselling practice of the therapist with women survivors of CSA?	Therapists' stereotypical beliefs about gender and CSA will relate to whether or not the therapist will create space to explore sexually inappropriate thoughts and behaviour The therapist's beliefs about the gender of the person who commits sexual abuse and what constitutes CSA will relate to whether or not the therapist will create space to explore sexually inappropriate thoughts and behaviour		Each question assumes an interaction between how beliefs can impact behaviour (e g , Conte et al , 1991) Assumes that willingness of clients to disclose or discuss their own thoughts or behaviour to a therapist would be directly related to the therapist communicating openness to the belief that women can commit CSA Based on direct feedback from clients within my own clinical practice and findings from a small prior qualitative study I

Research Questions	Hypotheses	Telephone Interview Questions	Rationale[3]
			completed with therapists who had experienced clients disclosing sexually abusive thoughts and behaviour and had inquired about these thoughts and behaviours (Hovey, 2004)
Have women survivors of CSA brought concerns about sexually inappropriate thoughts or behaviour with children or adolescents to the therapists? If so, what have been the therapists' responses to these concerns? Do therapists perceive a difference between initiating discussions about sexually inappropriate thoughts compared to initiating discussions about sexually inappropriate behaviour? Do therapists perceive a difference with respect to clients initiating this discussion?	Therapists will be more likely to i) experience women survivor clients initiating discussion of sexually inappropriate thoughts rather than sexually inappropriate behaviour involving children and adolescents, ii) initiate discussion with women survivor clients of sexually inappropriate thoughts rather than sexually inappropriate behaviour involving children and adolescents, and iii) indicate that it is more important to inquire about these thoughts rather than the behaviour		Based on direct feedback from clients within my own clinical practice and findings from the aforementioned qualitative study Based on the assumption that it would be safer for clients and therapists to focus on thoughts because of the reporting requirements for sexually inappropriate behaviours involving children and adolescents that may be identified if the therapist asks about such behaviour
Does the therapist routinely ask women survivors of CSA about sexually inappropriate thoughts or behaviour with children or adolescents?		According to your responses on the survey, could you tell me more about what prompts you to ask a client about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?	These research questions were addressed qualitatively to seek deeper understanding from the opinions of therapists with the semi-structured interview

Research Questions	Hypotheses	Telephone Interview Questions	Rationale[3]
If so, how does the therapist approach this discussion?		Are there any behaviours or statements that lead you to ask about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice? When you have asked about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice, how have you phrased the question? What would be the best way to ask?	
If not, what are the concerns or reasons for not approaching this discussion?		According to your responses on the survey, could you tell me more about why you do not ask (or rarely ask) women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice? Do you have any concerns about asking women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice? If so, what are your concerns? If not, why not? Is there any behaviour or communication from a woman survivor of CSA that would prompt you to ask about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice? Have you ever wanted to ask but did not? If yes, what stopped you?	

The first phase of this research consisted of a cross-sectional survey design using a web-based questionnaire format to collect data from therapists who work with adult female survivors of CSA in a counselling context Using a questionnaire was the most appropriate approach to address the research questions outlined because it offered the therapists a private format to respond to the questions and allowed for exploration of sensitive aspects of their practice, specifically, whether or not therapists explore possible sexually inappropriate behaviour with women survivors of CSA Survey research is primarily used to study individuals who represent a population group that would be too large to study directly (Babbie & Benaquisto, 2002) Therefore, a broad spectrum of therapist perspectives from within a large geographical area were accessed in a way that would not be as possible or cost efficient using other designs

In order to elaborate on and refine some of the information acquired about therapist behaviour from the survey (Ivankova et al , 2006), a second phase of research was conducted to explore in more depth the responses related to 1) whether or not therapists initiate discussion with adult female survivors of CSA about sexually inappropriate thoughts or behaviour with children and adolescents, and 2) whether or not therapists think it is important to inquire about sexually inappropriate thoughts or behaviour with children and adolescents If therapists do initiate these discussions and think that it is important to inquire, this phase was designed to explore how these therapists do approach this discussion and why they think it is important to inquire If therapists indicate not initiating discussion with their women survivor clients and do not think that it is important to inquire, this phase was also designed to understand why they

do not inquire, why they believe it is not important and explore whether there are any conditions that would challenge their stance

Ethical Considerations

The methodology for both phases of this research was approved by the Wilfrid Laurier University Research Ethics Board in October 2007 The approval included the pilot study of the survey tool within Phase 1 as well See Appendix A for copy of approval letter

Information was provided to inform consent within the email invitation to each potential survey respondent and organization at the point of the initial invitation and reminder emails As well, information to enable informed consent was discussed within the invitation to participate in the telephone interviews Confidentiality and anonymity were assured Participants were informed that the web-based survey ensured that their email addresses would not be connected to their survey responses All participation was voluntary and participants within both phases could elect to withdraw from the study at any time without any penalty Participants were advised that the data would be kept in a password protected computer/folder and any printed documents would be stored in a locked cabinet in the principal researcher's home office throughout the study until completion of the dissertation and any other products

Survey participants who consented to be contacted by telephone for an interview were promised that no information that would identify them or their agencies would be disclosed, they were also advised that they could ask that the tape recorder be turned off at any time, and that no names or any identifying information would be included in the transcripts See Appendix B and C for details of the informed consent and confidentiality

assurances for Phase 1, See Appendix D for details of the informed consent and confidentiality assurances for Phase 2

Phase 1

Recruitment of Participants

The sample for this study required a specific population therapists who work with adult female survivors of CSA Although the general definition of therapist provides for a broad spectrum of education and expertise, most often this population can be found within agencies that provide sexual abuse treatment or support or within the population of therapists who are in private practice Conte et al (1991), in their national survey of practitioners working with CSA, contributed valuable information about sampling at a national level They utilized a directory of child sexual abuse treatment programs for their national sample

Fortunately, Health Canada (2002) developed a publication entitled, "Combining Voices A Directory of Services for Adult Survivors of Child Sexual Abuse" and this version was available during the quantitative data collection phase This directory contained over 500 programs across Canada Of these women survivor programs, 256 provided email or web contact information Staff members at the National Clearinghouse on Family Violence have continually updated the 2002 version of the directory and these updates were accessible by telephone conversation with a staff member responsible for the updates, however, a more recent directory was not available during the data collection period for this study The directory did not provide any evaluative information about the agencies listed, however, it indicated whether the services are for men, women, and/or children, as well as offering English or French only or bilingual services

A substantial portion of the sample was drawn from the list of all the agencies in the directory that specified that they provide counselling or support services for women survivors of CSA and that are English only or bilingual The French only agencies were not included due to my own language limitations and the financial cost of interpretation services Approximately half of the eligible agencies (256) provided a website or email contact, while some provided their postal and telephone contact only All eligible agencies were investigated regarding their web accessibility and to update the 2002 information Those agencies that did not have internet contact information were not included Approximately 300 agencies met these criteria

Additionally, because the directory was not a current edition, an internet search was conducted for any other Canadian based therapist lists, list-serves, or agencies that indicated they provide counselling for adult women survivors of CSA, had email or web contact information available, and were English-speaking and/or bilingual/multilingual For example, the Canadian Psychological Association online directory of private practice psychologists provided a search mechanism based on expertise and language, therefore, those psychologists listed as working with survivors of CSA and English-speaking were included in the population sample Overall, the sampling strategy essentially attempted to include all eligible therapists with the exception of the exclusion criteria already established and each individual or organization had an equal chance of participating in the survey

The actual number of possible eligible therapists that were made aware of the study could not be determined because data on the numbers of therapists working for each of the organizations were not accessible Therefore, the population from which the

sample was recruited can only be estimated by the number of email addresses that were accessed After collecting all email addresses for organizations/associations (372) and individual therapists (658), the first email invitation to participate in the study including consent and ethics approval was sent out on January 30, 2008 to a total of 1030 email addresses (See Appendix B for email invitation letter to individual therapists and Appendix C for email invitation letter to organizations) A second email reminder was sent on February 10, 2008, however, due to the number of emails that were not delivered during the initial attempt, organization/association addresses were reduced to 246 and individuals were reduced to 611 for a total of 857 email addresses Some of the reasons for emails not being deliverable were accounts exist but mailbox unavailable, host was down, no such account, one association refused to distribute, failed delivery, cannot accept message, and so forth Because some of the reasons were due to mailbox full or host was down, these addresses were attempted again with the reminder email Further emails were not able to be delivered for the similar reasons as listed, therefore, the third and final reminder email total (784) sent on February 18, 2008 was again reduced to 208 organizations and associations, and 576 individuals with only three individuals and two organizations not delivered during this round of emails The final email address total was 779 for those emails that were delivered From the 779 emails that were able to be delivered, 164 individuals responded to and completed the survey for an estimated 21 05% response rate

Measures

The survey questionnaire for phase one was designed by the researcher and is a self-report instrument that consists primarily of Likert rating scale questions, with a

demographic section that explores level of acquired education, type of agency affiliation, years of experience, and so forth, and a final section that invited respondents to participate in a follow-up telephone interview (see Table 3 for survey items and sections) The questionnaire was designed to operationalize the specific research questions outlined previously (see Table 2 for research questions), no existing instrument addressed all aspects of this inquiry However, specific questions utilized concepts from previous studies (Bensley et al , 2004, Conte et al , 1991, Lowe Jr et al , 2005, Okami, 1995, Portwood, 1999) regarding definitional components of CSA, the rating scale approach, and vignette style of questions The rating scales for most of the statements/questions used a range of '1' (representing strong agreement/very likely) through '7' (representing strong disagreement/very unlikely), '4' represented neither agreement/likelihood nor disagreement/unlikelihood to allow respondents to represent that they are non-committal or neutral to the statement Demographic questions used categories and number representation, such as number of years See Table 3 for response rating scales

Table 3

Web-based survey instrument Therapist Questionnaire

Item	Survey Contents	Variable Label(s)	Response Scale
Section 1 Childhood sexual abuse statements			
1	Only men sexually abuse children	Stereotypical Beliefs	1 = strongly agree 2 = agree 3 = somewhat agree 4 = neither agree nor disagree 5 = somewhat disagree 6 = disagree 7 = strongly disagree
2	Women do NOT sexually abuse children		
3	The majority of female adults who engage in sexual behaviour with children were themselves abused as children		
4	The majority of male adults who engage in sexual behaviour with children were themselves abused as children		
5	When women engage in sexual behaviour with children, usually a male partner coerces them into it		
6	Child victims of male perpetrated sexual abuse are more emotionally traumatized than victims of female-perpetrated sexual abuse		
7	In most cases, women who engage in sexual behaviour with children select male children or adolescents		
Section 2 Childhood sexual abuse vignettes			
8	A 30-year-old stepfather watching pornographic (sexually explicit) videos with his 16-year-old stepdaughter	Definitional Orientation scale (Items 8-23) Male-Perpetrated Definitional Orientation subscale (Items 8, 10, 13, 17, 18, 19, 21)	1 = strongly agree 2 = agree 3 = somewhat agree 4 = neither agree nor disagree 5 = somewhat disagree 6 = disagree 7 = strongly disagree
9	Stepmother bathing her 11-year-old stepson		
10	A 35-year-old male neighbour having sexual relations with a 15-year-old male neighbour		
11	Parents having sex while their 4-year-old child is playing in the same room		

Item	Survey Contents	Variable Label(s)	Response Scale
12	Aunt kissing her 15-year-old niece on the lips	Female-Perpetrated Definitional Orientation subscale (Items 9, 12, 14, 15, 16, 20, 22)	
13	Stepfather bathing his 11-year-old stepdaughter		
14	On one occasion, a 25-year-old female teacher kissing a 14-year-old male student on the cheek		
15	A 12-year-old male child sleeping with an adult female relative		
16	A single mother asking her 13-year-old son to give her a full body massage (unclothed) after a stressful week at work		
17	On one occasion, a 25-year-old male teacher kissing a 14-year-old female student on the cheek		
18	Uncle kissing his 8-year-old nephew on the lips		
19	A 12-year-old female child sleeping in the same bed with an adult male relative		
20	A 30-year-old stepmother watching pornographic (sexually explicit) videos with her 16-year-old stepson		
21	A single father asking his 13-year-old daughter to give him a full body massage (unclothed) after a stressful week at work		
22	A 35-year-old female neighbour having sexual relations with a 15-year-old female neighbour		
23	Parents having sex while their 7-year-old child is playing in the same room		
24	If you wish, you may comment about the vignettes here		Narrative
Section 3 Client disclosure			
	Within your counselling practice, please rate how likely is it that WOMEN SURVIVORS of child sexual abuse would DISCLOSE to you	Therapist-Created Climate dimension	1 = very likely 2 = likely 3 = somewhat likely
25	Their concerns about sexually inappropriate THOUGHTS about children and/or	Client-Initiated	

Item	Survey Contents	Variable Label(s)	Response Scale
	adolescents	Discussion scale	4 = neither likely nor unlikely 5 = somewhat unlikely 6 = unlikely 7 = very unlikely
26	Their concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents		
Section 4 Therapist-initiated discussion			
	Within your counselling practice, please rate how likely it is that YOU would INITIATE DISCUSSION with women survivors of child sexual abuse about	Therapist-Created Climate dimension Therapist-Initiated Discussion scale	1 = very likely 2 = likely 3 = somewhat likely 4 = neither likely nor unlikely 5 = somewhat unlikely 6 = unlikely 7 = very unlikely
27	Whether or not they have concerns about sexually inappropriate THOUGHTS about children and/or adolescents		
28	Whether or not they have concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents		
Section 5 Importance			
	Within your counselling practice, please rate how strongly you agree or disagree that it is IMPORTANT TO ASK women survivors of child sexual abuse directly	Therapist-Created Climate dimension Therapist Rated Importance scale	1 = strongly agree 2 = agree 3 = somewhat agree 4 = neither agree nor disagree 5 = somewhat disagree 6 = disagree 7 = strongly disagree
29	Whether or not they have concerns about sexually inappropriate THOUGHTS about children and/or adolescents		
30	Whether or not they have concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents		
Section 6 Demographics			
31	Type of agency in which you currently work	Agency [Recoded *1 - Agency Employed* *2 - Private*]	1 = Sexual assault centre 2 = Counselling agency 3 = Survivor specific agency 4 = Victim services

Item	Survey Contents	Variable Label(s)	Response Scale
			5 = Domestic violence agency 6 = Private practice 7 = Mental health services 8 = Hospital 9 = Other
32	How many years of experience do you have in your current position?	Years in current position	# of years
33	How many years in total have you been in practice?	Total years in practice	
34	How many years have you worked with WOMEN survivors of child sexual abuse?	Years working with Women Survivors	
35	How many years have you worked with MEN survivors of child sexual abuse?	Years working with Men Survivors	
36	What is the approximate percentage of the clients you see who are WOMEN survivors of child sexual abuse?	% Women Survivor Clients	Estimated %
37	What is the approximate percentage of the clients you see who are MEN survivors of child sexual abuse?	% Men Survivor Clients	
38	What is your gender?	Gender	1 = Female 2 = Male
39	Highest level of education achieved	Education [Recoded *1 = College or credits* *2 = BA* *3 = MA* *4 = PhD*]	1 = High school only 2 = Some college credits 3 = Some university credits 4 = College diploma 5 = Bachelor's degree 6 = Master's degree 7 = Doctorate degree

Item	Survey Contents	Variable Label(s)	Response Scale
			8 = Other
40	What is your age?	Age	# of years
41	In which region do you work?	Region	1 = Atlantic 2 = ON/PQ 3 = Prairies 4 = West 5 = Northern territories 6 = Other
42	Please provide any comments or information you with to add		Narrative
Section 7 Willing to be contacted for a follow-up telephone interview?			
43	Would you be interested in participating in a short anonymous telephone interview regarding the responses to this survey?	Telephone Interviewee Sampling	1 = Yes 2 = No
44	If you responded YES to question 41, please provide your first name and email address so that I can contact you to arrange for a convenient time to conduct a short telephone interview as a follow-up to this survey (PLEASE NOTE not all who respond will be contacted)		

Note Full survey as distributed to respondents is available in Appendix E

The questionnaire was divided into seven sections The first section, 'Childhood sexual abuse statements,' was designed to assess beliefs and knowledge about sexual abuse and gender (see Table 3, items 1-7 for exact statements) The items listed a series of stereotypical statements related to who perpetrates sexual abuse and victim gender concepts Therapists were to rate how strongly they agree or disagree with the accuracy of the statement Each statement (with the exception of item '3' the majority of female adults who engage in sexual behaviour with children were themselves abused as children) would not be considered completely accurate and represents more stereotypical beliefs about who perpetrates sexual abuse Conte et al (1991)[7] is credited for the concept related to assessing accuracy of knowledge about CSA in this section Furthermore, these statements were designed to represent a "female as victims only" belief and examine the gendered perspectives of the therapists regarding CSA

The second section, 'Childhood sexual abuse vignettes', provided a series of eight paired vignettes that vary according to the gender of who is perpetrating and the gender and age of the recipients of the behaviour in each paired vignette (see Table 3, section 2, items 8-23) The purpose of this section of the survey was to evaluate the differences in responses of therapists to how strongly they agreed (1) or disagreed (7) that the vignette represented CSA and allowed for analysis of male- and female-perpetrated vignette comparisons These vignettes were presented in a random order to prevent each pair from being presented too close together An area for respondents to comment about the vignettes was created as item 24 in this section of the survey

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[7] Although no statements are replicated from the Conte et al study, two of the statements are a variation of Conte et al 's knowledge statement "Almost all adults who have sex with children were themselves abused as children" (p 156) The two varied statements specify gender in each and offer a different phrasing than Conte et al , e g , Item 4 "The majority of male adults who engage in sexual behaviour with children were themselves abused as children "

The concept of using paired vignettes was similar to the study of Lowe Jr et al (2005) who utilized paired vignettes to differentiate severity of the form of CSA presented to their US university student sample followed by evaluative questions regarding what constitutes reportable CSA The scenarios or vignettes used in Lowe Jr et al 's study, however, clearly indicate the commission of a sexual offence pertaining to Indiana State laws Their instrument was designed specifically for a non-professional population and was limited to undergraduate students at one university There was no validity or reliability established for this instrument As well, all of their vignettes refer to sexually abusive behaviour by males and do not provide any means of evaluating sexually abusive behaviour committed by females This format was conceptually replicated as Lowe Jr et al 's scale was inappropriate for use in the current research

Each of the paired vignettes in this section was also influenced to some degree by Bensley et al (2004) and Portwood (1999) Bensley et al (2004) examined a number of child maltreatment behaviours and established some significant levels of consensus regarding behaviours defined as sexual abuse It was the ambiguity of other sexual behaviours examined, particularly the following questions "6 Looking at pornographic videos or pictures with a child 14 Letting a child watch parents having sex 33 A child older than 11 sleeping with a parent" (p 1328), that contributed conceptually to the paired vignettes that were created for the current study As noted previously, Bensley et al were not gender specific in their vignettes, however, the ambiguous sexual behaviours listed above offered some relevant vignette suggestions that were tailored according to gender and with victim gender and age variations for the purposes of this inquiry (see Table 3, items 8, 11, 15, 19, 20, 23)

In addition to Bensley et al (2004), Portwood (1999) contributed useful ideas for the paired vignettes Although she provided vignettes related to various aspects of child maltreatment committed by parents, Portwood's scenarios included examples of male- and female-perpetrated sexual abuse with varying ages and gender of the child recipients Each participant was asked to rate their perception of whether these vignettes constituted abuse, which is a similar procedure implemented for the current study As well, ambiguous vignettes such as parents kissing a child on the lips elicited significantly less certainty among members of the professional disciplines and the non-professionals surveyed by Portwood Neither Portwood's (1999) nor Bensley et al 's (2004) studies provided reliability or validity for their instruments, however, Bensley et al (2004) did develop their questionnaire based on a focus group research process In spite of the limitations, the information elicited from their studies offered valuable guidance in the development of the current study's survey instrument

The next three sections, 'Client disclosure,' 'Therapist-initiated discussion,' and 'Importance,' of the questionnaire obtained therapists' ratings of their practice experiences and practice opinions (see Table 3, sections 3, 4, and 5 for exact items and rating response scales) The 'Client disclosure' section inquired about how likely the client would initiate disclosure (from the therapist's perspective) about their sexually inappropriate thoughts and behaviour, the 'Therapist-initiated discussion' section inquired about how likely the therapist would initiate discussion with their women survivor clients about her possible sexually inappropriate thoughts and behaviour, and the 'Importance' section inquired about the therapist's opinion about how important it is to inquire about these thoughts and behaviour with women survivor clients Consistent with

the previous studies of Conte et al (1991), Gore-Felton et al (2000), Hetherton and Beardsall (1998), and Lowe Jr et al (2005), the questions pertaining to these three sections were created to focus on therapist ideas, behaviour, and experience in counselling practice, which allowed for evaluation of the relationships between what the therapist believes about CSA and how these beliefs are likely to be enacted within the counselling context

The 'Demographic' section of the survey requested various demographic information from the respondents These demographics questions provided information about the therapists' level of education, type of agency in which they work, years of experience working with survivors, percentage of clients who are survivors, age, gender, and their general region of Canada (Atlantic, Ontario/Quebec, Prairies – Manitoba, Saskatchewan, West – Alberta, BC, North - territories) See Table 3, Section 6 for exact questions and response rating scales Additional space for comments was provided at the end of the demographic section to allow for any other feedback or comments the respondent wished to contribute

The final section of the survey was used to recruit the sample for phase two of the study It contained a question that invited respondents to participate in a telephone interview, and if the respondent agreed, space for contact information was provided

Prior to collection of data for the formal study, a pilot study of the questionnaire was conducted with a subgroup of 27 MSW students who worked with women survivors of CSA in their practicum placements This process provided the opportunity to receive feedback from a population similar to the study participants about the clarity of the concepts and questions, the length of time needed to complete the questionnaire,

practicality of the layout, and any other detailing of the questionnaire One minor adjustment was made to the wording of item '7'[8] to improve clarity of the statement, however, no other content was changed

Quantitative Data Collection

The method of data collection for phase one used an online web-based survey format The benefits of this format included reduced response time, lowered cost, ease of data entry, and the fact that it tends to be less time consuming for participants than pencil and paper surveys (Granello & Wheaton, 2004) The software package, Survey Gold, was selected because it ensured a secure link for confidentiality of responses, ease of survey completion, and easy transmission of the results to SPSS for analysis Each individual therapist who met the criteria received an email message (see Appendix B) that introduced the purpose of the survey, risks of participation, consent to participate, and a link to access the survey When email addresses were unavailable for all therapists within a particular agency, the available email contact address for the agency received a similar introductory email explaining the purpose of this research, risks of participation, consent to participate, a link to the web-based survey, and request that the email be forwarded to each therapist associated with the agency The first email to all potential participants was sent on January 30, 2008 Each email contact address received two follow-up emails on February 10 and 18, 2008 to encourage a higher rate of return (Gore-Felton, Koopman, Bridges, Thorensen, & Spiegel, 2002)

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[8] Pilot study version "In most cases, *victims of* women who engage in sexual behaviour with children *are male*" was changed to "In most cases, women who engage in sexual behaviour with children *select male children or adolescents* "

To promote the completion of the questionnaire by the respondents, the introductory email assured the respondents of the anonymity, confidentiality, and privacy of their personal responses and did not include a personalized greeting (see Appendix B) When Joinson, Woodley, and Reips (2007) personalized an introductory email, fewer people responded to sensitive information questions, therefore, they recommended a more anonymous approach to inviting survey participation As well, a web-based survey allowed for more anonymity than a survey embedded in an email (Granello & Wheaton, 2004) My university email address, as well as Carol Stalker's (Committee Chair) contact information, was included within the introductory and follow-up emails for any questions respondents may have had about this research

This study did not include a direct incentive for participating, rather, participants were informed that a $2 donation would be made for every response to a reputable national charitable organization supporting efforts to address child abuse (Kids Help Phone at http //www kidshelpphone ca/en/home asp) Although no research reviewed had identified this approach as a viable incentive or suggested that it may produce greater return rate, this approach may have appealed to the respondents' concern regarding a related social problem that needs financial support and was not privileging a participating agency that would benefit directly from completing the survey Other research has shown conflicting results for both direct incentive lottery and no incentive on participant response rates (Fink, 2006, Hager, Wilson, Pollak, & Rooney, 2003, Singer & Bossarte, 2006, Ulrich et al , 2005) Informal feedback from participants indicated that they thought the donation was a "very good idea" A total of $400 00 was donated as the survey and pilot participants totalled 191

Survey responses were collected from January 30 through August 6, 2008 The formal survey request indicated that the survey would be available until February 20, 2008, however, the link was left open and 15 surveys were completed after the closing date Survey Gold provided notice via email for new surveys that were completed which triggered me to download the available completed surveys The link was removed as of August 8, 2008 All surveys received were completed fully as the online process did not allow a respondent to continue until each question in the section was answered

Quantitative Data Analysis

A data analysis plan was developed for each of the hypotheses, all of which were based on the content of the questions within the survey (see Table 4 for outline of data analysis plan) In addition, further analyses were completed comparing the pilot results with the full survey results, as this process provided two distinct groups for comparison practicing therapists and MSW students SPSS software was used to analyze the quantitative data results

Table 4

Analysis plan for Phase 1

	Hypothesis	Variables	Analysis Plan
1	The majority of therapists who work with women survivors of CSA do not create space for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents	Therapist-Created Climate dimensions = aggregated averaged score of Client-Initiated Discussion scale (items 25, 26) Therapist-Initiated Discussion scale (items 27, 28) Therapist Importance scale (items 29, 30) (See Table 3 for items description)	Descriptive statistics – provide frequencies, percentages, means, standard deviations, range from sample for each item (25-30), each scale, and the overall Therapist-Created Climate Correlate the three scales to determine if there is a relationship between the scales If a relationship exists between the three scales, develop an aggregated score for Therapist-Created Climate by using mean scores of items of each scale in the dimension, offer an analysis of reliability of this measure using Cronbach's Alpha, an index of internal consistency

	Hypothesis	Variables	Analysis Plan
1 a	Therapists will be i) more likely to experience women survivor clients initiating discussion of sexually inappropriate thoughts rather than sexually inappropriate behaviour involving children and adolescents, ii) more likely to initiate discussion with women survivor clients of sexually inappropriate thoughts rather than sexually inappropriate behaviour involving children and adolescents, and iii) more likely to indicate that it is more important to inquire about these thoughts rather than the behaviour	Independent variables Thoughts versus behaviours (items 25/26, 27/28, 29/30) Dependent variables Client-Initiated Discussion scale (items 25, 26) Therapist-Initiated Discussion scale (items 27, 28) Therapist Importance scale (items 29, 30) (See Table 3 for items description)	Use paired *t*-test (i e , dependent, within-subjects') to compare thoughts versus behaviour responses within each of the Therapist-Created Climate dimension scales (i e , difference between client initiating discussion about thoughts versus behaviour)
2	The therapist's Definitional Orientation will predict the Therapist-Created Climate, the more conservative the therapist's Definitional Orientation, the more likely the therapist will create space to explore sexually inappropriate thoughts and behaviour	Definitional Orientation scale = aggregated averaged score of 16 vignette items 8-23 (See Table 3 for description of all survey items)	Descriptive statistics – provide frequencies, percentages, means, standard deviations, range from sample for each item (8-23) and the overall Definitional Orientation scale Construct Ordinal Definitional Orientation Groupings (ODOG) from Definitional Orientation scale scores with scores between 1-1 99 = conservative, 2-2 99 = moderately conservative, and 3-7 = liberal, offer an ANOVA of these groupings to determine success of the groupings

	Hypothesis	Variables	Analysis Plan
		Independent variable Definitional Orientation scale (as described above), ODOG	Correlate the Definitional Orientation scale score and the ODOG with the aggregated Therapist-Created Climate dimensions score
		Dependent variable Therapist-Created Climate dimensions (as described in Hypothesis 1)	Conduct an ANOVA to compare the ODOG with the Therapist-Created Climate dimensions
2 a	Therapists will be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA	Independent variable gender of perpeptrator Dependent variable abuse situation	Create a Male-Perpetrated Definitional Orientation subscale, offer an analysis of reliability of this measure using Cronbach's Alpha, an index of internal consistency – eliminate items that detract substantially from internal consistency
		Two subscales based on the 16 item Definitional Orientation scale	
		Male-Perpetrated Definitional Orientation subscale – aggregating 7 items 8, 10, 13, 17, 18, 19, 21	Create a Female-Perpetrated Definitional Orientation subscale, offer an analysis of reliability of this measure using Cronbach's Alpha, an index of internal consistency – eliminate items that detract substantially from internal consistency
		Female-Perpetrated Definitional Orientation subscale – aggregating 7 items 9, 12, 14, 15, 16, 20, 22	
		(See Table 3 for items description)	Descriptive statistics – provide frequencies, percentages, means, standard deviations, range from sample for each subscale
			Paired *t*-test (i e , dependent, within subjects') comparing responses on the Male-Perpetrated Definitional Orientation subscale score to the Female-Perpetrated Definitional Orientation subscale score for each participant to allow for the assessment of the differential effects of perpetrator gender

	Hypothesis	Variables	Analysis Plan
2 b	The therapists' belief about the appropriateness of the behaviour indicated in the matched vignettes of the Definitional Orientation scale will differ according to the gender of who perpetrated the behaviour	Independent variable gender of perpetrator Dependent variable abuse situation Definitional Orientation scale was dismantled to compare individual scenarios Pairs as follows 8/20, 10/22, 13/9, 17/14, 18/12, 19/15, 21/16 (See Table 3 for items description)	Paired *t*-test (i e , dependent, within-subjects') were used to compare responses to the same 'abuse' vignette perpetrated by a male versus a female
2 c	The therapist's beliefs about the gender of the person who commits sexual abuse and what constitutes CSA will be associated with whether or not the therapist will create space to explore sexually inappropriate thoughts and behaviour	Independent variables Male-Perpetrated Definitional Orientation subscale (Items 8, 10, 13, 17, 18, 19, 21) Female-Perpetrated Definitional Orientation subscale (Items 9, 12, 14, 15, 16, 20, 22) Dependent variables Therapist-Created Climate dimension scales Client-Initiated Discussion scale (Items 25, 26) Therapist-Initiated Discussion scale (Items 27, 28) Therapist Importance scale (Items 29, 30) (See Table 3 for items description)	Correlate means scores of each of the three Therapist-Created Climate dimension scales with the mean score for each Male- and Female-Perpetrated Definitional Orientation subscales

	Hypothesis	Variables	Analysis Plan
3	Therapists' scores on Stereotypical Beliefs items (statements about gender and CSA) will be associated with whether or not the therapist creates space to explore sexually inappropriate thoughts and behaviour	Independent variables Stereotypical Beliefs – 7 statements (items 1-7) Dependent variables Client-Initiated Discussion scale (Items 25, 26) Therapist-Initiated Discussion scale (Items 27, 28) Therapist Importance scale (Items 29, 30) (See Table 3 for items description)	Correlate mean scores between each of the 7 Stereotypical Beliefs statements and each of the three Therapist-Created Climate dimension scales

	Hypothesis	Variables	Analysis Plan
4	Exploratory analysis of demographic information with survey scales and items as the dependent variable	Independent variables/groupings Gender (item 38), age (item 40), agency type (item 31), years of experience (general-33, with survivor clients-34,35, current workplace-32), percentage of survivor clients (items 36, 37), education level (item 39) , workplace geographical region (item 41) Dependent variables Definitional Orientation scale (Items 8-23) Male-Perpetrated Definitional Orientation subscale (Items 8, 10, 13, 17, 18, 19, 21) Female-Perpetrated Definitional Orientation subscale (Items 9, 12, 14, 15, 16, 20, 22) Therapist-Created Climate dimensions Client-Initiated Discussion scale (Items 25, 26) Therapist-Initiated Discussion scale (Items 27, 28) Therapist Importance scale (Items 29, 30) (See Table 3 for items description)	Descriptive statistics– provide frequencies, percentages, means, standard deviations, range from sample for each demographic variable/grouping Conduct independent *t*-tests comparing gender (male and female therapist responses) on dependent variables Conduct independent *t*-tests comparing agency type (private versus organization) on dependent variables listed Correlate mean scores between each of age, years of experience items, percentage of survivor clients, educational level (coded as ordinal) and the dependent variables listed Conduct ANOVA to compare workplace geographical regions on Definitional Orientation scale and subscales, and the aggregated Therapist-Created Climate dimensions score

	Hypothesis	Variables	Analysis Plan
5	Exploratory analysis – Pilot study versus full study sample comparison	Independent variables Pilot versus full study participants Dependent variables Definitional Orientation scale (Items 8-23) Male-Perpetrated Definitional Orientation subscale (Items 8, 10, 13, 17, 18, 19, 21) Female-Perpetrated Definitional Orientation subscale (Items 9, 12, 14, 15, 16, 20, 22) Client-Initiated Discussion scale (Items 25, 26) Therapist-Initiated Discussion scale (Items 27, 28) Therapist Importance scale (Items 29, 30) (See Table 3 for items description)	Conduct independent *t*-tests comparing the two samples (pilot and full study participant responses) on the dependent variables listed

The first hypothesis, 'the majority of therapists who work with women survivors of CSA do not create space for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents,' was developed based on the lack of attention to this kind of discussion within the practice literature (see Table 1 for summary of practice literature) In order to determine how therapists create space, several variables contributed to the construct of 'Therapist-Created Climate' in order to measure overall 'space creation ' The Therapist-Created Climate refers to the general tone or environment that the therapist creates for their clients Three scales assess the dimensions of the Therapist-Created Climate They are 1) Client-Initiated Discussion scale – containing two questions about the therapists' perception of the likelihood that women survivors of CSA clients will disclose sexually inappropriate thoughts and behaviour involving children or adolescents (see Table 3, items 25 and 26, for exact questions), 2) Therapist-Initiated Discussion scale – containing two questions about the likelihood that the therapist will initiate discussion about sexually inappropriate thoughts and behaviour involving children or adolescents (see Table 3, items 27 and 28, for exact questions), and 3) Therapist Importance scale – contains two questions about how important the therapist believes it is to ask about this issue (see Table 3, items 29 and 30, for exact questions) Refer to Table 4 for analysis plan for this hypothesis

Building on the first hypothesis, Hypothesis 1 a 'Therapists will be i) more likely to experience women survivor clients initiating discussion of sexually inappropriate thoughts than sexually inappropriate behaviour involving children and adolescents, ii) more likely to initiate discussion with women survivor clients of sexually inappropriate thoughts than sexually inappropriate behaviour involving children and

adolescents, and iii) more likely to indicate that it is more important to inquire about these thoughts than the to inquire about behaviour,' explores the differences between discussion of thoughts versus behaviours The Therapist-Created Climate scales explored both the question of 'sexually inappropriate thoughts' and 'sexually inappropriate behaviour' Since therapists are required to act on reported behaviours and not necessarily on reported thoughts, this led to the question of whether or not there was a difference between asking about thoughts or behaviour For example, a therapist has a "duty to report" any known or suspected sexually inappropriate behaviour involving children or adolescents that the client identifies by engaging in the discussion (Child and Family Services Act, 1990, Section 72 (1)3) Therefore, because reporting would not necessarily be required if a client identifies sexually inappropriate thoughts involving children or adolescents, it is assumed that therapists may believe it is 'safer' to discuss these kinds of thoughts rather than behaviour Additionally, clients may also perceive it to be safer to discuss these kinds of thoughts knowing that the therapist has the obligation to report any known or suspected sexual abuse behaviours Refer to Table 4 for analysis plan for this hypothesis

Hypothesis 2, 'The therapist's Definitional Orientation will predict the Therapist-Created Climate, the more conservative the therapist's Definitional Orientation, the more likely the therapist will create space to explore sexually inappropriate thoughts and behaviour,' seeks to ascertain how strongly therapists agree that the 16 vignettes presented in the questionnaire constitute CSA (see Table 3, items 8-23) and then determine whether or not there is a relationship between the Definitional Orientation and the Therapist-Created Climate dimensions (Client-Initiated Discussion, Therapist-

Initiated Discussion, and Therapist Importance scales) This hypothesis was developed based on the findings that helping professionals' beliefs about CSA can influence their practice decision (e g , Conte et al , 1991, Gore-Felton et al , 2000, Hetherton & Beardsall, 1998) Applying this premise, it logically can be hypothesized that if a therapist defines or believes CSA to be inclusive of less explicit behaviours (e g , kissing, bathing, any behaviours that are more ambiguous) including those behaviours committed by women, this therapist is considered more conservative in how he or she defines CSA and as a result may demonstrate more openness to recognizing that women may be at risk of sexually abusing a child On the other hand, if a therapist does not include less explicit behaviours or behaviours committed by women in his or her definition of CSA (and is consequently less conservative in how he or she defines CSA), then the therapist may be less likely to explore these kinds of behaviours with his or her women survivor clients

The Definitional Orientation scale is comprised of the aggregated scores of all 16 vignettes A therapist's Definitional Orientation refers to how strongly the therapist agrees or disagrees that the adult–child sexual interaction vignettes constitute CSA A *conservative* Definitional Orientation is defined as a respondent's aggregated score that reflects "agreement" that the vignettes constitute CSA (e g , aggregated score within the range of '1- strongly agree to 3- somewhat agree') A *liberal* Definitional Orientation is defined as a respondent's aggregated score that reflects no agreement and disagreement that the vignettes constitute CSA (e g , aggregated score within the range of '4- neither agree nor disagree to 7- strongly disagree') The Ordinal Definitional Orientation Groupings were determined by the distribution of scores on the Definitional Orientation scale scores, which were then subsequently placed into groupings that were

representative of the levels of conservatism and liberalism to determine if these groupings have a relationship with the Therapist-Created Climate dimensions Refer to Table 4 for analysis plan details for Hypothesis '2'

Hypothesis 2 a 'Therapists will be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA,' addresses assertions in the literature that sexual abuse of children and adolescents by women is less likely to be recognized as abusive by helping professionals (e g , Denov, 2001, Johnson, 2004) Using the same group of vignette statements as those which formed the basis of the Definitional Orientation scale (with the exception of items 11 and 23 due to both genders represented rather than a male or female, see Table 3), two subscales were created, Male- and Female-Perpetrated Definitional Orientation subscales The Male-Perpetrated Definitional Orientation subscale was created by aggregating responses pertaining to the specific vignettes that contained male-perpetrated sexual behaviours and the Female-Perpetrated Definitional Orientation subscale was created by aggregating responses pertaining to the specific vignettes that contained female-perpetrated sexual behaviours

The subsequent hypotheses of 2 b and 2 c also examine the therapists' beliefs about gender differences These hypotheses were intended to test the assertions in the literature that sexual abuse of children and adolescents by women is less likely to be recognized as abusive by helping professionals (e g , Denov, 2001, Johnson, 2004), however, hypothesis 2 b seeks to compare the specific behaviours based on gender of the perpetrator referenced in the vignettes and hypothesis 2 c seeks to examine the relationship between the Male- and Female-Perpetrated Definitional Orientation

subscales with the Therapist-Created Climate dimensions Refer to Table 4 for analysis plans specific to these hypotheses (2 a , 2 b , 2 c)

Hypothesis 3, 'Therapists' scores on Stereotypical Beliefs items (statements about gender and CSA) will be associated with whether or not the therapist creates space to explore sexually inappropriate thoughts and behaviour,' examines the seven statements that are based on stereotypical beliefs rather than facts about CSA Some of these belief statements were created to represent "woman as victim" type of beliefs about CSA (e g , see Table 3, items 1, 2, and 5) The concept of "woman as victim" in relation to CSA commonly influences clinical practice and contributes to framing sexual abuse committed by women as less serious (Hetherton, 1999, Robinson, 1998) This hypothesis is associated with the evidence that suggests there is an interaction between therapists' beliefs and their practice behaviour (e g , Conte et al , 1991) The assumption then follows that if therapists believe women are capable of committing CSA, they may be more apt to address this potential within their counselling practice Furthermore, it is assumed that the willingness of a female client to disclose or discuss her own thoughts or behaviour with a therapist would be related to the therapist presenting openness to the belief that women can commit CSA Some of these practice assumptions are based on my own practice experiences and on the findings from a small qualitative study I completed with therapists who have experienced clients disclosing sexually abusive thoughts and behaviour and have initiated this discussion with their survivor clients See Table 4 for analysis plan regarding this hypothesis

Exploratory analysis of demographic information allowed for examination of other factors, such as age, years of experience, educational level achieved, and so forth,

which may influence the interpretation of the various scales and subscales developed for this study See Table 4 for plan details of the exploratory analysis for demographics

Additional exploratory analysis regarding a comparison of the pilot study participants (MSW students) versus full study participants was conducted to determine any differences between participants who are training in the field of counselling women survivor clients with those who are already working in this field See Table 4 for details of the analysis plan for the pilot and full study comparison

The survey instrument allowed for respondents' comments at two points within the questionnaire The first point at which the questionnaire invited comments was within the second section following the vignettes (see Table 3, Item 24) where a statement invited respondents to provide comments about the vignettes It was assumed that respondents would find the ambiguity of some of the vignettes challenging to rate and may have some additional input regarding this section The second point at which the questionnaire invited comments was following the therapist practice questions/sections and demographics section (see Table 3, item 42) inviting respondents to provide any other comments or information they wished to add It was assumed that the survey might stimulate comments about counselling practice or some respondents might want to clarify their information within the demographics The comments sections were analyzed separately according to the two areas 1) pertaining to vignettes, and 2) pertaining to therapist practice and any other comments

A thematic analysis, as described by Ezzy (2002) and Braun and Clarke (2008), was applied to the qualitative "comment" data All comments that were written into the section of the questionnaire immediately following the vignettes were reviewed and as

recurrent words appeared, these words were highlighted and colour coded (completed on paper rather than electronically) The analysis focused on the repetition of similar comments/words, and these similarities were the basis of the categories that emerged The frequency of comments within each category was primary to the development of categories The next stage of analysis involved sorting the categories according to the main theme that emerged for this section of comments This same process was repeated for the comments that were entered into the section of the questionnaire immediately following the questions that asked about the therapist's practice and the therapist's demographics Comments referring to clarification of the respondent demographic information were removed

Phase 2

Recruitment of Participants

For phase two of this mixed methodological study, responses to a question on the survey indicated which respondents were willing to participate in the interview phase of the study The sampling strategy, although purposive, was limited to only those participating in the web-based survey to remain consistent with the sequential explanatory strategy Of the 164 respondents, 58 (35%) responded with "yes" to the question inviting them to participate in the telephone interview From this list of the "yes" respondents, the original plan was to select two groups of respondents (maximum of 10 in each for total of 20) prioritized according to the most extreme representation of scores (very likely/strongly agree and very unlikely/strongly disagree) on the Therapist-Initiated Discussion and Therapist Importance scales These scales consisted of the specific questions about therapist-initiated discussions and therapist-rated importance of

asking women survivors of CSA about sexually inappropriate thoughts and behaviour with children and adolescents (see Table 3, Items 27-30)

Initially, respondents were invited to participate in the telephone interview by means of a follow-up email (see Appendix D) or a phone call (depending on the contact information provided) from the researcher to arrange an interview time A maximum of three attempts to contact were made to the first choice of 20 respondents and when participants did not respond, the interested respondents next on the list were contacted Because a number of the first-choice participants did not respond to the invitation to a telephone interview from the initially selected group that represented more extreme points of view, the selection process needed to be altered so that all those who followed through or responded to my attempts to arrange an interview were included in the sample, regardless of their scores on the scales Of the 58 respondents who indicated interest in participating in the telephone interview, 22 respondents (38%) followed through with the interview, this number exceeded the original goal of 20 interviews

Semi-structured interview guidelines

A set of open-ended questions developed for each type of respondent group guided the interview process The specific questions depended on which group the participant fell into based on the Phase 1 data Group A questions were those designed for therapists who reported that they would likely initiate discussion and agreed it would be important to ask about sexually inappropriate thoughts and/or behaviour with women survivors of CSA This group was asked about how they inquire with their survivor clients, what prompts them to ask, the client reactions to inquiring, agency stance on inquiring, and they were invited to offer other information they thought important for

therapists who may not ask or know how to ask/broach this topic with clients Group B questions were designed for therapists who reported that they would be unlikely to initiate questions about sexually inappropriate thoughts and/or behaviour with women survivors of CSA and did not believe it was important to ask The questions for this group inquired about why these therapists did not ask, what their concerns about asking were, if there were any conditions that would prompt them to ask, how their agency may support or challenge their practice style, and any other information they felt was important for other therapists with regard to this topic The two sets of questions were developed based on the expectation that there would be a dichotomy of responses, however, it should be noted that a combination of both interview guidelines were utilized with participants who provided neutral responses to the survey questions about initiating discussion and when rating importance of asking See Appendix F for exact questions and additional probes

This phase of inquiry required a more flexible approach to explore the risks or concerns about why therapists do not or are neutral about initiating or asking questions of this sensitive nature As well, with the therapists who reported that they do initiate this discussion, their perceptions about the importance of this discussion and how it is best to initiate the discussion were investigated Using a semi-structured approach to the interviews provided me with a guideline to remain conscientiously aware of my own biases and avoid using the interview to promote my own beliefs about the topic

Situating of Researcher

As a clinician-researcher, it is important to acknowledge biases that may have affected this second phase of the research design Considering the logical positivistic

emphasis of the first phase, I needed to make a deliberate shift to a more flexible and open-minded approach to this second phase I appreciate the post-modern arguments for different approaches to research that can be contradictory (Ezzy, 2002, p 15) The biases inherent in my own beliefs about female-perpetrated sexual abuse and counselling adult female survivors of CSA are based on my own counselling practice experiences and the extensive review of literature for this research These biases and judgments needed to be set aside and I made deliberate attempts to remain open and curious about any responses or information presented by the participants

My intent was not to criticize the understanding or practices of the participants but rather to learn from the experiences they wished to share with me That being said, I do situate myself most emphatically as a woman who encompasses the potential to engage in sexually abusive behaviour rather than the "othering" position of some viewpoints that have narrowed the lens pertaining to women as potential "victims only " I consider myself to be situated within the post-modern feminist philosophy that strives to challenge the victim position placed on women and the oppression or exclusion of women who do not fit within the conventional feminist theories (Stainton Rogers & Stainton Rogers, 2001) I was aware that this particular position was occasionally in conflict with the stance of some of the interviewee respondents, specifically those who held the perspective of women as "victims only" In the same vein, my belief, which was that it was equally important to explore multiple perspectives, helped me to remain open to the all the contributions that I was privileged to receive

Qualitative Data Collection

Respondents who accepted the invitation to participate in a telephone interview provided their name, email address, a contact telephone number, and consent to have the telephone interview tape recorded All contact information will be destroyed after the completion of the study and defence of this dissertation All electronic data has been stored on a password protected computer and in a password protected folder Any printed data and the taped recordings of the telephone interviews are stored in a locked cabinet in the home office of this researcher for a period of five years or until completion of the dissertation and any other products (articles, presentations etc), after which the data will be destroyed

The data for phase two was collected by tape recording the telephone interview in order to ensure accuracy of the responses At the onset of each interview, the consent to participate was reviewed and verbal agreement was received The interviews were guided by the questions as well as additional questions that arose from the content of the interview I was very conscious of my own biases throughout the interviews and made a concerted effort to refrain from answering any opinion questions that the interviewee posed (Richards & Morse, 2007) I would indicate that we could discuss any questions pertaining to my opinion after the completion of the formal interview which worked well throughout the process

The interviews lasted from 20-50 minutes, depending on the interviewee's length of explanation or response to questions As the 30-minute mark approached, interviewees were informed that we had almost reached the agreed upon time frame and all consented to continue if the questions were not completed Most interviews were

completed on time or before 30 minutes, however, two interviews went overtime Once the tape was turned off, the interviewee was invited to debrief and I responded to any questions they had about the survey or my research

Qualitative Data Analysis

The data from the telephone interviews were transcribed, checked for accuracy, and imported into NVivo software Demographic information about the 22 interviewees was analyzed with SPSS software Thematic analysis methodology was applied to the analysis of the qualitative data Initially, a grounded theory approach was intended as the qualitative analysis methodology, however, several 'rules' of grounded theory were not able to be reconciled For example, sampling with grounded theory requires "saturation" of the category in order to develop a theory (Creswell, 1998) Sampling for this study was based solely on the willing participants identified within the survey and theory development was not the primary goal of the qualitative phase of this research Additionally, the grounded theory process of analysis requiring an inductive approach to identify a "central phenomenon" that is then explored for strategies and consequences as described by Creswell did not fit with the overall research purpose of this study Consequently, other methods of data analysis were explored

Thematic analysis, as described by Ezzy (2002) and Braun and Clarke (2008), resembles grounded theory analysis in that coding strategies and theme development are somewhat similar, however, thematic analysis allows for flexibility of process such as predetermination of the general focus of interest and analysis occurring after the collection of data whereas grounded theory requires data collection and analysis to follow a concurrent process in which sampling is guided by the emerging analysis Thematic

analysis is appropriate for qualitative studies where the research questions, semi-structured interview questions, and predetermined sampling and completed data collection procedures provide the parameters for the data analysis (Braun & Clarke, 2008), this approach is consistent with the structure of phase two of this study Furthermore, having completed the quantitative data analysis and results, these quantitative data and results underscored and influenced how the qualitative data were analyzed, such that emphasis or importance of concepts, statements, and words tended to be placed on the number of times particular concepts, statements, and words were repeated by independent interviewees The prevalence of responses across the data set was emphasized for theme development (Braun & Clarke, 2008)

Consistent with Braun and Clarke's (2008) description of the thematic analysis process, initial coding of interesting data was completed across the transcribed interviews Through constant comparison of the initial codes, including review of larger transcript segments encapsulating the coded data, and meanings attributed to the initial codes within my journal notations, the data were grouped according to similarities and differences and a beginning structure of categories was developed The second level of coding involved a second review of my journal notations, further grouping of the coded data, and the identification of categories based on the data groupings Some of the interview questions provided some natural categories, however, many of the natural categories grew and changed as the analysis progressed The second level of coding resulted in 21 categories of which seven included subcategories ranging from 2 – 24 for a total of 93 subcategories

In the next stage of the analysis, themes were identified by refining the 21 main categories After determining two main themes and their categories and sub-categories to present in the results, a process of re-examination of the original taped interviews occurred along with another review of the journal notations This process allowed a fresh review of the data using auditory rather than visual means of re-connecting with the actual words, voice inflections, and expressiveness of the interviewees A further reduction of the categories occurred with the goal of identifying practice recommendations and more detailed explanations of some of the quantitative results

While conducting the interviews and analyzing the data, I endeavoured to receive even the most unexpected information without judgment by remaining open to the process and findings as a researcher using a sequential explanatory mixed method (Hanson, Creswell, J , Plano Clark, Petska, & Creswell, D , 2005), therefore, efforts were made to avoid predetermining the potential responses I remained acutely aware of my own experiences in counselling practice with women survivors who had perpetrated against children and how the interviewee responses interacted with my own ideas about counselling Having completed the quantitative analysis of the survey responses during Phase 1, a natural process of triangulation between the qualitative data, the survey responses, and my own experiences occurred within the this integration juncture Further triangulation of the data with findings from prior studies was also applied in the final phase of data analysis using extracted statements from the data to support each theme and the categories and sub-categories as a means of increasing trustworthiness (Hanson et al , 2005)

Results

The results chapter is organized sequentially according to the phases of the data collection Phase one of the study consisted of quantitative data collection, therefore, the first section of the results chapter, the Quantitative Results, contains the results from the analysis of the survey data according to the hypotheses Phase two of the study consisted of qualitative data collection, therefore, the second section of the results chapter, the Qualitative Results, consists of the results from the analysis of the telephone interviews

Quantitative Results

Sample Demographics

A total of 164 respondents completed the survey of which 131 (79 87%) were female and 33 (20 12%) were male with a mean age of 51 years The average age of the female respondents was 50 years of age and the average age of the male respondents was 56 years of age The female respondents reported fewer years of experience in their current positions, working with women and men survivors, as well as fewer years of experience in the helping profession than the male respondents The female respondents did indicate that a higher percentage of their clients were women survivors as compared to the male respondents A greater proportion of male respondents reported having a PhD and identified working in private practice than the female respondents See Table 5 and Table 6 for detailed demographic statistics

Table 5

Demographics Age and Experience Descriptive Statistics

Demographic		*N*	*M*	*SD*	*Mdn*	Min-Max
Age	Female	131	50 05	11 73	52	25-73
	Male	33	56 30	7 80	57	34-69
	Total	164	51 31	11 31	54	25-73
Years experience in current position	Female	131	10 78	8 98	8	0 25-46
	Male	33	16 61	7 64	17	3-36
	Total	164	11 97	9 01	10	0 25-46
Years in practice as a helping professional	Female	131	19 07	10 52	20	0-46
	Male	33	26 52	8 30	27	3-39
	Total	164	20 57	10 52	20	0-46
Years working with women survivors	Female	131	14 45	9 44	14	0-40
	Male	33	20 36	7 11	20	3-39
	Total	164	15 64	9 31	15	0-40
Years working with men survivors	Female	131	10 65	9 91	10	0-38
	Male	33	20 36	7 73	20	3-39
	Total	164	12 61	10 26	12 5	0-39
Approximate % of clients are women survivors	Female	131	46 24	32 50	40	0-100
	Male	33	19	14 62	15	1-66
	Total	164	40 76	31 69	30	0-100
Approximate % of clients are men survivors	Female	131	11 42	17 83	5	0-90
	Male	33	11 94	10 13	10	0 5-40
	Total	164	11 53	16 55	5	0-90

Table 6

Demographics Agency, Education, and Region Descriptive Statistics

Demographic		Female		Male		Total	
		n	%	*n*	%	*N*	%
[a]Agency *n*=160	Organization	81	63 77	7	21 21	88	55
	Private Practice	46	36 22	26	78 78	72	45
[b]Education *n*=162	College or university credits or college diploma	17	13 17	0	0	17	10 49
	BA	23	17 82	1	3	24	14 81
	MA/MSW	69	53 48	15	45 45	84	51 85
	PHD	20	15 5	17	51 51	37	22 83
Region *N*=164	Atlantic	14	10 68	2	6 06	16	9 8
	ON/PQ	50	38 16	13	39 39	63	38 4
	Prairies (MB, SK)	26	19 84	10	30 30	36	22
	West (AB, BC)	39	29 77	8	24 24	47	28 7
	Northern Territories	2	1 5	0	0	2	1 2

Note [a]Agency (*n*=160) was coded as a nominal variable such that agency employed=1, private practice=2, [b]Education (*n*=162) was coded as an ordinal variable such that College or credits=1, BA=2, MA=3, PhD=4

Hypothesis 1

The majority of therapists who work with women survivors of CSA do not create space for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents

The Therapist-Created Climate was assessed by three dimensions Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales Correlations were conducted between the Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales to determine whether or not a relationship

existed between these three dimensions The correlations were positive and significant, therefore, the dimensions were combined to form the Therapist-Created Climate

Each of these 2-item scales contained the survey question responses pertaining to therapists' practice experiences exploring the following therapist experience with client disclosure (Q25, Q26), therapist initiation of discussion with women survivors of sexual abuse regarding their sexual thoughts and behaviour with children and/or adolescents (Q27, Q28), and the therapist rating of importance of exploring this issue (Q29, Q30) Item content is found in Table 3 The results of the 6-item Therapist-Created Climate dimensions (Cronbach's Alpha = 0 82 demonstrating strong internal consistency) indicated that 45% of therapists self-report that they do create space while the remaining 55% of therapists responded less favourably, thus, the data somewhat supports the hypothesis that the majority of therapists do not create a climate for discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents when working with women survivors

The responses to each of the three sets of 2-item Therapist-Created Climate dimension scales were reviewed to determine if one of the scales influenced the Therapist-Created Climate composite dimension Two of the three scales did not support Hypothesis 1 when reviewed as separate scales The Therapist-Initiated Discussion 2-item scale (r = 0 90, p<0 0001 between these 2 items) indicated that 60% of therapists agreed with the likelihood that they would initiate a discussion with women survivors The Therapist Importance 2-item scale (r = 0 95, p<0 0001 between these 2 items) indicated that 70% of therapists agreed that it is important to inquire about potential sexually inappropriate thoughts or behaviour with women survivors

One Therapist-Created Climate dimension scale did support Hypothesis 1 The Client-Initiated Discussion 2-item scale (r = 0 80, p<0 0001 between these 2 items) was the only dimension of the Therapist-Created Climate that supported Hypothesis 1 According to this dimension, only 35% of therapists indicated that they believed their women survivor clients would likely disclose their inappropriate sexual thoughts or behaviour involving children and/or adolescents, indicating that the majority believed that their women survivor clients would not disclose these thoughts or behaviours This dimension, which is not in the direct control of the therapist, was also the least strongly correlated with the other two dimensions, therefore, one could argue that it is not really an adequate indicator of the Therapist-Created Climate dimensions By including only the items within the direct control of therapist (i e , the Therapist-Initiated and the Therapist Importance scales), the Revised Therapist-Created Climate dimensions (Cronbach's Alpha = 0 90) fail to support Hypothesis 1 with 60% of therapists indicating that they supported the idea of creating space for the discussion of potential sexual boundary crossing or sexually inappropriate behaviour with children and adolescents Nonetheless, each of the 6-item Therapist-Created Climate dimensions are correlated and demonstrate strong internal consistency, therefore, Hypothesis 1 is supported when considering all Therapist-Created Climate dimensions See Table 7 for descriptive details about each item and Table 8 for exact correlations

Table 7

Therapist-Created Climate Dimensions Scales and Individual Item Descriptive Statistics

Item	*M*	*SD*	*Mdn*	Mode	Min - Max	%*
Client-Initiated Discussion (scale – 2 items)	4 17	1 58	4	4	1-7	35%
Q25 How likely it is that women survivors of CSA would disclose to you their sexually inappropriate **thoughts** with children	4 00	1 68	4	3	1-7	48%
Q26 How likely it is that women survivors of CSA would disclose to you their sexually inappropriate **behaviour** with children	4 34	1 66	5	5	1-7	37%
Therapist-Initiated Discussion (scale – 2 items)	3 15	1 58	3	2	1-7	60%
Q27 How likely it is that you would initiate discussion with women survivors of CSA about sexually inappropriate **thoughts** with children	3 15	1 63	3	3	1-7	66%
Q28 How likely it is that you would initiate discussion with women survivors of CSA about sexually inappropriate **behaviour** with children	3 15	1 60	3	2	1-7	65%
Therapist Importance (scale – 2 items)	2 93	1 50	3	2	1-7	70%
Q29 It is important to ask women survivors of CSA directly about their sexually inappropriate **thoughts** with children	2 96	1 51	3	2	1-7	71%
Q30 It is important to ask women survivors of CSA directly about their sexually inappropriate **behaviour** with children	2 90	1 53	3	2	1-7	73%

Item	*M*	*SD*	*Mdn*	Mode	Min - Max	%*
Therapist-Created Climate (combined 3 dimensions)	3 42	1 17	3 33	3	1-6 3	45%
Revised Therapist-Created Climate (combined 2 dimensions Therapist-Initiated Discussion and Therapist Importance scales)	3 04	1 37	3	2	1-6	60%

Note *N*=164, *% = percentage who fell on the "agree" or "likely" side of the response scale (i e , 3 0 or less on the 7-point scale)

Table 8

Correlations between Therapist-Created Climate dimensions Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance Scales

	Correlation		
Dimensions of Therapist-Created Climate	Client-Initiated Discussion scale	Therapist-Initiated Discussion scale	Therapist Importance scale
Client-Initiated Discussion scale	-	0 31**	0 16*
Therapist-Initiated Discussion scale	0 31**	-	0 58**
Therapist Importance scale	0 16*	0 58**	-

Note *N*=164, *p<0 05, **p<0 0001

Hypothesis 1 a

Therapists will be i) more likely to experience women survivor clients initiating discussion of sexually inappropriate thoughts than sexually inappropriate behaviour involving children and adolescents, ii) more likely to initiate discussion with women survivor clients of sexually inappropriate thoughts than sexually inappropriate behaviour involving children and adolescents, and iii) more likely to indicate that it is more important to inquire about these thoughts than inquire about the behaviour

A matched pairs *t*-test was conducted between each of the two items within each scale (Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance) to determine if there were any differences between the focus on discussion of sexually inappropriate *thoughts* versus *behaviour* with children and/or adolescents There was a significant difference between the two items on the Client-Initiated Discussion subscale ($t_{(163)}$=-4 08, p<0 0001) Therapists indicated that clients were more likely to disclose their sexually inappropriate thoughts (M=4 00) about children rather than sexually inappropriate behaviour (M=4 34) with children There were no significant differences between the Therapist-Initiated Discussion thoughts and behaviour items ($t_{(163)}$=0 00, *ns*) and Therapist Importance of inquiring about sexually inappropriate thoughts and behaviour items ($t_{(163)}$=1 68, *ns*)

Hypothesis 2

The therapist's Definitional Orientation will predict the Therapist-Created Climate, the more conservative the therapist's Definitional Orientation, the more likely the therapist will create space to explore sexually inappropriate thoughts and/or behaviour

The responses to individual items about what constitutes CSA (see Table 3, items 8-23) were examined The individual items were rank-ordered according to mean responses (i e , the lower the mean, the more agreement that the vignette represented CSA) to determine on which items there was most consensus regarding what constituted CSA The following items had a cumulated agreement percentage that ranged from 95%-99% of respondents (meaning these items were clearly considered abusive by the vast majority of responding therapists), beginning with the most agreed upon response 'father asking daughter for body massage' (Item 21), 'adult/teen male neighbours having sexual relations' (Item10), 'adult/teen female neighbours having sexual relations' (Item 22), 'stepfather/step daughter watching sexually explicit videos' (Item 8), 'mother asking son for a body massage' (Item16), ' stepmother/stepson watching sexually explicit videos' (Item 20), and 'parents having sex while 7-year-old in room' (Item 23) These items constituted more explicit sexual behaviour The remaining nine items resulted in less agreement with cumulated percentages ranging from 26%-88% The item of least agreement was 'aunt kissing niece on lips' (Item 12) The lower agreement items also tended to have a greater standard deviation, which indicated a larger spread in scores with higher median and modes, and a broader range of minimum to maximum scores See Table 9 for exact results

Table 9

Definitional Orientation of Therapists Descriptive Statistics relating to Individual CSA Scenario Items and the Rated Agreement

Item		*M*	*SD*	*Mdn*	Mode	Min - Max	% Agree
21	A single father asking his 13-year-old daughter to give him a full body massage (unclothed) after a stressful week at work	1 38	0 69	1	1	1-4	97%
10	A 35-year-old male neighbour having sexual relations with a 15-year-old male neighbour	1 41	0 82	1	1	1-6	96%
22	A 35-year-old female neighbour having sexual relations with a 15-year-old female neighbour	1 41	0 80	1	1	1-6	96%
8	A 30-year-old stepfather watching pornographic (sexually explicit) videos with his 16-year-old stepdaughter	1 45	0 75	1	1	1-6	98%
16	A single mother asking her 13-year-old son to give her a full body massage (unclothed) after a stressful week at work	1 47	0 77	1	1	1-5	96%
20	A 30-year-old stepmother watching pornographic (sexually explicit) videos with her 16-year-old stepson	1 47	0 67	1	1	1-4	99%
23	Parents having sex while their 7-year-old child is playing in the same room	1 62	0 87	1	1	1-5	95%
11	Parents having sex while their 4-year-old child is playing in the same room	2 09	1 21	2	1	1-6	88%
13	Stepfather bathing his 11-year-old stepdaughter	2 32	1 36	2	1	1-6	79%

Item		*M*	*SD*	*Mdn*	Mode	Min - Max	% Agree
9	Stepmother bathing her 11-year-old stepson	2 68	1 56	2	1	1-7	69 5%
19	A 12-year-old female child sleeping in the same bed with an adult male relative	2 90	1 50	3	2[a]	1-6	64%
15	A 12-year-old male child sleeping with an adult female relative	3 27	1 59	3	4	1-7	52%
17	On one occasion, a 25-year-old male teacher kissing a 14-year-old female student on the cheek	3 47	1 63	3	2	1-7	52%
14	On one occasion, a 25-year-old female teacher kissing a 14-year-old male student on the cheek	3 66	1 75	4	4	1-7	48%
18	Uncle kissing his 8-year-old nephew on the lips	3 77	1 52	4	4	1-7	38%
12	Aunt kissing her 15-year-old niece on the lips	4 24	1 52	4	4	1-7	26%
Male-Perpetrated Definitional Orientation subscale (7 items 8, 10, 13, 17, 18, 19, 21) Cronbach's α = 0 70		2 38	0 74	2 29	2 29	1-5	83%
Female-Perpetrated Definitional Orientation subscale (7 items 9, 12, 14, 15, 16, 20, 22) Cronbach's α = 0 71		2 60	0 79	2 57	2 86	1-5	76%
Definitional Orientation scale (16 items 8-23) Cronbach's α = 0 87		2 41	0 72	2 44	2 56	1 06-5	

Note *N*=164, [a] Multiple modes exist - smallest value is shown, % agree = percentage who fell on the "agree" side of the response scale (i e , 1, 2, or 3 on the 7-point scale) meaning the vignette was perceived as CSA

A Factor Analysis (Principal Axis Factoring) was conducted to determine whether or not the Definitional Orientation scale was uni- or multi-dimensional The results suggested that there were two major factors (Factor 1 – 'parent-child inappropriateness' accounted for 36% of the scale variance, Factor 2 – 'other familial-child inappropriateness' accounted for 15% of the scale variance), these two factors accounted for 51% of the scale variance Another three factors accounted for an additional 23% of scale variance Consequently, for the sake of parsimony and because of the internal consistency (Cronbach's $\alpha = 0\ 87$), the 16 items were aggregated into one scale This 16-item Definitional Orientation scale mean score was 2 412 ($SD = 0\ 72$) Table 7 contains descriptive statistics regarding this aggregate Definitional Orientation scale

Correlations were calculated to determine whether or not there was a relationship between how conservatively the therapist defines CSA (i e , as defined by aggregated Definitional Orientation scale) with the likelihood of the therapist creating space to explore sexually inappropriate thoughts and/or behaviour (i e , as defined by the Therapist-Created Climate dimensions Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales) The correlations were not significant, therefore, the Therapist's Definitional Orientation scale was not related to the Therapist-Created Climate dimensions in any meaningful way Correlations were also calculated between the Definitional Orientation scale and each individual item of the Therapist-Created Climate dimensions, none of these evidenced significant relationships This analysis fails to support Hypothesis 2 Exact results can be found in Table 10

Table 10

Correlations between Therapist-Created Climate Dimensions and Definitional Orientation (DO) Scale and Ordinal Definitional Orientation (ODO) Groupings

Dimensions of Therapist-Created Climate	Correlation	
	DO 16-item Scale	[a]ODO Groupings
Q25-Q26 Client-Initiated Discussion subscale	0 04	0 04
Q27-Q28 Therapist-Initiated Discussion subscale	0 05	0 07
Q28-Q29 Therapist Importance subscale	0 14	0 19*

Note N=164, [a]ODO Groupings 1 = Conservative, 2 = Moderately Conservative, 3 = Liberal
*p<0 05

In order to address Hypothesis 2 further, the Definitional Orientation scale scores were categorized into three groups to form ordinal variables "Conservative" (28% of respondents) with mean scores that ranged from 1-1 99, whereby they considered most of the vignettes as representing CSA, "Moderately Conservative" (51% of respondents) with mean scores that ranged from 2-2 99, whereby they considered many vignettes as CSA, and "Liberal"[9] (21% of respondents) with mean scores that ranged from 3-7, whereby they considered fewer vignettes as describing CSA Ninety-seven percent of respondents fell above the midpoint of the scale, responding more conservatively in general

Correlations were calculated to determine whether or not there was a relationship between the new variable of ordinal groupings (i e , Conservative, Moderate, and Liberal Definitional Orientation groupings) with the likelihood of the therapist creating space to

[9] "Liberal" grouping combines the18% slightly conservative therapists (M scores between 3-3 99) and the remaining 3% of therapists who are defined as slightly to more liberal (M scores between 4-7) in their orientation These participants were combined into one group because of the small numbers in these categories The use of the term "Liberal" rather than "Slightly Conservative" is applied to indicate that the stance of this group represented the most liberal orientation within the sample of participants

explore sexually inappropriate thoughts and/or behaviour (dimensions of the Therapist-Created Climate) The correlations between the Ordinal Definitional Orientation grouping variables and the Client-Initiated Discussion and Therapist-Initiated Discussion scales were also not significant, however, the correlation between the new ordinal grouping variable and the Therapist Importance scale resulted in a significant but weak relationship That is, the more conservative therapists thought it was more important to ask about sexually inappropriate thoughts and behaviour compared to the more liberal therapists Exact correlations can be found in Table 10

Given that there was a weak but significant correlation between the Ordinal Definitional Orientation groupings variable and the Therapist Importance scale, the three Ordinal Definitional Orientation groupings (Conservative, Moderate, and Liberal) were used as a grouping or quasi-independent variable to determine if the therapists' Ordinal Definitional Orientation Groupings differed significantly in response to items related to the therapist creating space to explore sexually inappropriate thoughts and behaviour regarding children and/or adolescents

The three groups were compared based on their 16-item Definitional Orientation scale scores using an ANOVA and were established as being significantly different from each other with equal variances assumed ($F(2,161)=397\ 51$, $p<0\ 0001$) This significant effect is what would be expected because the groups are based on the Definitional Orientation scale The test indicates that the three conceptual groups were, in fact, distinct from one another in terms of therapist orientation See Table 11 for descriptive statistics associated with this test

Table 11

Comparison of Means of Ordinal Definitional Orientation Groups on Therapist-Created Climate Dimension Scales

Scales and Items	Orientation	*M*	*SD*	*n*	*F*(2,161)
Definitional Orientation (16-item scale)	Conservative	1 58	0 26	46	397 51**
	Moderate	2 44	0 26	84	
	Liberal	3 47	0 42	34	
Client-Initiated Discussion (2-item scale)	Conservative	4 03	1 65	46	0 25
	Moderate	4 24	1 56	84	
	Liberal	4 19	1 60	34	
Therapist-Initiated Discussion (2-item scale)	Conservative	2 91	1 58	46	0 78
	Moderate	3 27	1 59	84	
	Liberal	3 18	1 55	34	
Therapist Importance (2-item scale)	Conservative	2 51	1 50	46	2 97*
	Moderate	3 01	1 38	84	
	Liberal	3 29	1 70	34	

*p<0 055, **p<0 0001

A One-way ANOVA was conducted to compare the Conservative, Moderate, and Liberal Ordinal Definitional Orientation groups on their responses to the dimensions of Therapist-Created Climate (Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales) Only the Therapist Importance scale resulted in a marginally significant difference between the groups (consistent with the correlational analysis in Table 10) with the Conservative group rating the importance of asking as more important than the Liberal group (see Table 11 for associated statistics)

Overall, no substantive evidence was found to support the hypothesis that the CSA definitional orientation, as defined by the Definitional Orientation scale, would predict the Therapist-Created Climate regarding CSA discussions However, by sorting the Definitional Orientation responses into Ordinal Definitional Orientation groupings (Conservative, Moderate, and Liberal), a weak but significant relationship resulted on the Therapist Importance scale with the "Conservative" group agreeing more strongly with the importance of asking women survivors about their sexually inappropriate thoughts and behaviour with children and/or adolescents than those in the "Liberal" group Due to the number of tests conducted, the interpretation is tentative as these significant results could be due to Type I error

Hypothesis 2 a

Therapists will be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA

Male-Perpetrated Definitional Orientation (7-items) and Female-Perpetrated Definitional Orientation (7-items) subscales were created from the individual gender-specific matched items within the Definitional Orientation scale Both subscales demonstrated weak but acceptable reliability (Male-Perpetrated subscale Cronbach's α=0 70, Female-Perpetrated subscale Cronbach's α=0 71) The subscales were correlated strongly (r= 91, p<0 0001) meaning that those who believed male-perpetrated behaviour constituted CSA tended to believe that female-perpetrated behaviour constituted CSA A paired samples t-test was conducted in order to determine if beliefs about male-perpetrated (M=2 38, SD=0 74) versus female-perpetrated (M=2 60, SD=0 79) situations constituting CSA differed The results indicated a significant difference between the two

subscales ($t_{(163)}$=-8 19, p<0 0001) Therefore, the hypothesis that therapists would be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA was supported by this data

Hypothesis 2 b [10]

The therapists' belief about the appropriateness of the behaviour indicated in the matched vignettes of the Definitional Orientation scale will differ according to the gender of who perpetrated the behaviour

The Definitional Orientation scale vignettes (Q8-Q22) were matched based on the gender of who was perpetrating with similar behavioural descriptions Paired samples *t*-tests were conducted for these 14 matched items (i e , 7 pairs) All matched items were significantly correlated (p<0 0001) Five of the seven paired samples *t*-tests revealed significant differences indicating that therapists' beliefs were associated with the gender of who engaged in the behaviour For these five matched vignette pairs, the male-perpetrated behaviour was deemed more inappropriate than the same female-perpetrated behaviour The statistics associated with these analyses can be found in Table 12

Paired samples *t*-tests of the two paired vignettes that were not significantly different were those describing an adult neighbour having sex with an adolescent and a step-parent watching sexually explicit videos with a step-child These results indicate that the gender of the perpetrators was not relevant to the therapists' belief about the inappropriateness of the behaviour for these two vignettes Thus, a step-parent watching pornography with a step-child and an adult neighbour having sexual relations with their teen-aged neighbour were both behaviours that were considered to be equally abusive regardless of the gender of the adult who engaged in the behaviour

[10] Note Hypothesis 2 b is a breakdown by specific abuse scenario of Hypothesis 2 a findings

Table 12

Paired Samples t-Test Definitional Orientation Scale Individual Items – 7 Pairs of Matched Vignettes that Varied Gender of Perpetrator

Pair	Matched Items	*M*	*SD*	*r*	$t_{(163)}$
	12 - Aunt kissing her 15-year-old niece on the lips	4 24	1 52		
1				0 71**	-5 17**
	18 - Uncle kissing his 8-year-old nephew on the lips	3 77	1 52		
	15 - A 12-year-old male child sleeping with an adult female relative	3 27	1 59		
2				0 74**	-4 17**
	19 - A 12-year-old female child sleeping in the same bed with an adult male relative	2 90	1 50		
	9 - Stepmother bathing her 11-year-old stepson	2 68	1 36		
3				0 69**	-4 05**
	13 - Stepfather bathing his 11-year-old stepdaughter	2 32	1 36		
	16 - A single mother asking her 13-year-old son to give her a full body massage (unclothed) after a stressful week at work	1 47	0 77		
4	21 - A single father asking his 13-year-old daughter to give him a full body massage (unclothed) after a stressful week at work	1 38	0 69	0 91**	-3 56**

Pair	Matched Items	*M*	*SD*	*r*	$t_{(163)}$
5	14 - On one occasion, a 25-year-old female teacher kissing a 14-year-old male student on the cheek	3 66	1 75	0 89**	-3 01*
	17 - On one occasion, a 25-year-old male teacher kissing a 14-year-old female student on the cheek	3 47	1 63		
6	20 - A 30-year-old stepmother watching pornographic (sexually explicit) videos with her 16-year-old stepson	1 47	0 67	0 67**	-0 54
	8 - A 30-year-old stepfather watching pornographic (sexually explicit) videos with his 16-year-old stepdaughter	1 45	0 75		
7	22 - A 35-year-old female neighbour having sexual relations with a 15-year-old female neighbour	1 41	0 80	0 79**	0 00
	10 - A 35-year-old male neighbour having sexual relations with a 15-year-old male neighbour	1 41	0 82		

Note N=164, *p<0 01, **p<0 0001

Hypothesis 2 c

The therapist's beliefs about the gender of the person who commits sexual abuse and what constitutes CSA will be associated with whether or not the therapist will create space to explore sexually inappropriate thought and behaviour

Pearson correlations were calculated for the Male-Perpetrated and Female-Perpetrated Definitional Orientation subscales, with the Therapist-Created Climate dimension scales None of these correlations were significant, therefore, the gender of the person who commits CSA (Male- and Female-Perpetrated Definitional Orientation subscales) is not associated with the therapist's self-report of counselling interaction with women survivors of CSA See Table 13 for exact correlations

Table 13

Correlations between Gender of Perpetrator Definitional Orientation Subscales and Therapist-Created Climate Dimension Scales

	Scales		
Items	Client-Initiated Discussion (2 items)	Therapist-Initiated Discussion (2 items)	Therapist Importance (2 items)
Female-Perpetrated Definitional Orientation 7 item subscale (Q9, 12, 14, 15, 16, 20, 22)	0 03	0 05	0 11
Male-Perpetrated Definitional Orientation 7 item subscale (Q8, 10, 13, 17, 18, 19, 21)	0 08	0 03	0 14

Note N=164

Hypothesis 3

Therapists' scores on Stereotypical Beliefs items (statements about gender and CSA) will be associated with whether or not the therapist creates space to explore sexually inappropriate thoughts and behaviour

In order to address Hypothesis 3, participant responses to the seven Stereotypical Beliefs items (see Table 3, items 1-7) were correlated with the Therapist-Created Climate dimension scales to determine if there was a significant relationship Only two correlations were statistically significant, therefore, it cannot be concluded that therapists' stereotypical beliefs about gender and CSA is related to whether or not therapists create space with women survivors of CSA to explore sexually inappropriate thoughts and behaviour The Therapist-Initiated Discussion scale was negatively, albeit weakly, correlated (r=-0 17, p<0 05) with the belief that female adults who engage in sexual behaviour with children were themselves abused, the more strongly the therapist believed the statement, the less likely the therapist would inquire about inappropriate sexual thoughts or behaviour In addition, the Therapist Importance subscale was positively, albeit weakly, correlated (r=0 17, p<0 05) with the belief that male adults who engage in sexual behaviour with children were themselves abused, suggesting that the more strongly the therapist agreed with the statement, the more important the therapist believed it was to ask women survivors about inappropriate sexual thoughts or behaviour These two significant correlation results appear contrary Exact correlations are found in Table 14

Table 14

Correlations between Therapist Stereotypical Belief Statements and Therapist-Created Climate Dimension Scales

Items	Scales		
	Client-Initiated Discussion (2 items)	Therapist-Initiated Discussion (2 items)	Therapist Importance (2 items)
1 - Only men sexually abuse children	-0 02	-0 11	-0 05
2 - Women do not sexually abuse children	0 01	0 02	0 03
3 - The majority of female adults who engage in sexual behaviour with children were themselves abused as children	0 00	-0 17*	0 10
4 - The majority of male adults who engage in sexual behaviour with children were themselves abused as children	0 06	-0 03	0 17*
5 - When women engage in sexual behaviour with children, usually a male partner coerces them into it	-0 07	-0 06	0 06
6 - Child victims of male-perpetrated sexual abuse are more emotionally traumatized than victims of female-perpetrated sexual abuse	-0 02	0 05	0 06
7 - In most cases, women who engage in sexual behaviour with children select male children or adolescents	0 02	0 04	0 07

Note N=164

*p<0 05

The descriptive statistics outline how strongly the respondents agreed with each of the seven statements pertaining to therapists' stereotypical beliefs about gender and CSA The majority of therapists disagreed with most of the statements that identify women as not blameworthy of sexually abusing children and/or adolescents, particularly with the statements 'only men sexually abuse children' (1) and 'women do not sexually abuse children' (2) Thus, gender stereotypes of "perpetrators" and women as "victims only" were not endorsed However, 68% of the responding therapists believed that both male and female adults who engage in sexual behaviour with children had been previously abused themselves The least variable spread of responses pertained to the statements that only men do and women do not sexually abuse children (Items 1 and 2) See Table 15 for descriptive statistics

Table 15

Therapists' Stereotypical Beliefs about Gender and CSA

Item (order based on *M* agreement)		*M*	*SD*	*Mdn*	Mode	Min-Max	% Agreeing
3	The majority of female adults who engage in sexual behaviour with children were themselves abused as children	3 07	1 46	3	2	1-7	68 3%
4	The majority of male adults who engage in sexual behaviour with children were themselves abused as children	3 20	1 53	3	2	1-7	68 3%
7	In most cases, women who engage in sexual behaviour with children select male children or adolescents	4 95	1 62	5	6	1-7	22%
5	When women engage in sexual behaviour with children, usually	5 33	1 41	6	6	2-7	14 6%

Item (order based on *M* agreement)		*M*	*SD*	*Mdn*	Mode	Min-Max	% Agreeing
	a male partner coerces them into it						
6	Child victims of male-perpetrated sexual abuse are more emotionally traumatized than victims of female-perpetrated sexual abuse	6 03	1 25	6	7	3-7	6 7%
1	Only men sexually abuse children	6 58	0 86	7	7	1-7	3%
2	Women do NOT sexually abuse children	6 69	0 65	7	7	1-7	0 6%

Note *N*=164

Exploratory Analysis Using Therapist Demographics

Further data exploration included comparison between groups (*t*-tests) or correlational calculations where appropriate between demographic variables and survey scales, subscales and individual survey items to determine any significant differences resulting from the gender of the therapist, type of agency for which the therapist worked, the region in which the therapist worked, the age of the therapist and amount of experience the therapist reported, and the level of education therapist had achieved

Therapist Gender

Independent samples *t*-tests were conducted for gender of the therapist as the grouping variable with the Definitional Orientation scale, Male-Perpetrated Definitional Orientation and Female-Perpetrated Definitional Orientation subscales, Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales, and Stereotypical Belief statements Only one item from the Stereotypical Belief statements

differentiated male and female therapist responses The male (M=4 24, SD= 1 66) and the female (M=5 12, SD=1 56) therapist responses to 'In most cases, women who engage in sexual behaviour with children select male children or adolescents' (Item 7) differed ($t_{(162)}$=2 85, p<0 01) such that female therapists disagreed with this statement more than male therapists

All other comparisons indicated no significant differences between female and male therapists in their responses Given the number of tests conducted, the one significant gender difference was likely a function of Type I error Thus, there was generally no significant difference in responses based on therapist gender in relation to their perceptions regarding their beliefs about women and men who engage in sexual abusive behaviour with children, what constitutes child sexual abuse, and therapist interventions

Agency Type

Independent sample t-tests were conducted using agency type (private versus organization) as the grouping variable and the Definitional Orientation scale, Male-Perpetrated Definitional Orientation and Female-Perpetrated Definitional Orientation subscales, Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance subscales, and the seven belief statements as the dependent variables

The analysis resulted with only one area of significant difference Therapists in private practice (n=46, M=6 75, SD=0 83) responded differently than agency-based therapists (n=81, M=6 42, SD=1 00) to the belief statement 'only men abuse children' (Item 1) with private practice therapists more strongly disagreeing with this statement

($t_{(148)} = -2\ 54$, $p<0\ 05$, equal variances not assumed) Given the number of tests, this is likely a Type I error

Workplace Region

The region in which the therapist works was not significantly associated with any of the dependent variables (ANOVA conducted with no significant results)

Age and Years of Experience

The reported age of the therapist and the years of experience (total years of practice, years experience in current position, years working with men and women) were correlated with the following scales and subscales Definitional Orientation scale, Male-Perpetrated Definitional Orientation and Female-Perpetrated Definitional Orientation subscales, Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales

Correlations were significant, albeit some weakly, between the "experience" items (32-35) and the Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales (ranging from -0 16 to -0 25) The more experience the therapist reported, the more likely they were to report that they created a climate that inquires about inappropriate sexual thoughts and behaviour with women survivors (Items 25-30) Therapist age was weakly correlated with the Male-Perpetrated Definitional Orientation subscale and correlated with the Client-Initiated Discussion scale The older the therapist, the more likely the therapist was to report that a client had disclosed inappropriate sexual thoughts and behaviour Overall, Table 16 indicates a weak pattern of age/experience correlations with the Therapist-Create Climate dimensions

Table 16

Exploratory Analyses Correlations of Demographic Variables and Definitional Orientation and Therapist-Created Climate Scales and Subscales

Demographic Characteristics	Definitional Orientation 16-item scale	Male-Perpetrated Definitional Orientation 7-item subscale	Female-Perpetrated Definitional Orientation 7-item subscale	Client-Initiated Discussion 2-item scale	Therapist-Initiated Discussion 2-item scale	Therapist Importance 2-item scale
40 - age	-0 11	-0 18*	-0 07	-0 21**	-0 10	-0 12
32 - years experience in current position	0 06	-0 02	0 11	-0 26**	-0 24**	-0 20**
33 - total years practice	0 00	-0 07	0 04	-0 10	-0 13	-0 18*
34 - years worked with women survivors	-0 03	-0 06	-0 00	-0 16*	-0 25**	-0 24**
35 - years worked with men survivors	-0 05	-0 10	-0 01	-0 16*	-0 24**	-0 24**
36 - approximate % of women survivor clients	-0 10	-0 06	-0 10	-0 00	-0 04	0 05
37 - approximate % of men survivor clients	-0 05	-0 07	-0 10	0 03	-0 15	-0 11
[a]Education	-0 01	-0 05	-0 01	-0 03	-0 19*	-0 10

Note Items Q33-Q41 (N=164), [a]Education (n=162) was coded as an ordinal variable such that College or credits=1, BA=2, MA=3, PhD=4

*p<0 05, **p<0 01

Education

Level of education was correlated, albeit weakly, with the Therapist-Initiated Discussion subscale, however, no other significant associations or relationships were found See Table 16 for exact correlations

Exploratory Analysis – Pilot (MSW student sample) versus Full Study

A comparison between the Pilot Study sample and the Full Study sample was conducted to determine if there were any significant differences in responses between these samples The Pilot Study and Full Study samples were found to be significantly different on the Definitional Orientation scale, Male-Perpetrated and Female-Perpetrated Definitional Orientation subscales, and the Therapist-Initiated Discussion scale The Full Study respondents agreed more strongly that the vignettes constituted abuse, therefore, those who were already working in the social work field were more conservative in their definitions of CSA than the MSW students of the Pilot Study The Full Study respondents were also more likely to inquire about potential sexually abusive thoughts or behaviour with women survivor clients and create a climate for exploring the potential of sexually abusive thoughts or behaviour than the MSW students This result is consistent with the 'experience' findings in the demographic analysis of the Full Study where more experienced therapists were also more likely to create a climate for exploring the potential of sexually abusive thoughts or behaviour See Table 17 for exact results of the *t*-test comparisons between these two groups of participants

Table 17

Pilot versus Full Study Participant Comparison on Definitional Orientation and Therapist-Created Climate Scales and Subscales

	M (*SD*)			
Dependent Variable	Full Study *N*=164	Pilot Study *n*=27	$t_{(df)}$	*Sig*
Definitional Orientation 16-item scale	2 41 (0 72)	3 01 (0 81)	$3\ 93_{(189)}$	$p<0\ 0001$
Male-Perpetrated Definitional Orientation 7-item subscale	2 38 (0 74)	3 05 (0 86)	$4\ 22_{(189)}$	$p<0\ 0001$
Female-Perpetrated Definitional Orientation 7-item subscale	2 60 (0 79)	3 25 (0 88)	$3\ 89_{(189)}$	$p<0\ 0001$
Client-Initiated Discussion 2-item scale	4 17 (1 58)	4 54 (1 35)	$1\ 14_{(189)}$	*ns*
Therapist-Initiated Discussion 2-item scale	3 15 (1 58)	3 83 (1 40)	$2\ 11_{(189)}$	$p<0\ 05$
Therapist Importance 2-item scale	2 93 (1 50)	3 44 (1 88)	$1\ 36_{(32)}$[a]	*ns*

[a] *df* adjusted for unequal variance

Questionnaire Comments Analysis

The survey respondents provided 118 separate comments, they were written in two areas of the questionnaire The first, followed the vignettes (74 comments), and second, followed the section of questions related to therapist behaviour and demographics (44 comments) The analysis of these comments yielded two primary themes that parallel the focus of the two comment sections 1) Defining Sexual Abuse, and 2) Therapist Practice Behaviour Comments were sorted into categories and subcategories under these

two themes, and the numbers of comments in each category were counted to determine those that reflected the most frequent opinions

Defining Sexual Abuse

Responding to the sexual abuse vignettes items in the questionnaire generated 38 comments about the difficulty in determining if the situation represented sexually abusive behaviour These comments were sorted into two main categories interpretation of ambiguous context and behaviours and cautions about defining sexual behaviour The interpretation of the vignettes was a challenge for many survey respondents, indicated by their comments about the need for more information or more knowledge about the context of the behaviour For example, one respondent said, *"I answered neither agree nor disagree several times That means I would need more information before deciding"* (Respondent 62) Another said, " *there needed to be more context to make a decision"* (Respondent 6) Many respondents referred to the importance of " *understand[ing] the context of what and why something is happening"* (Respondent 100) and that " *most of these leave room for interpretation"* (Respondent 157) Some pointed out that the behaviour would be interpreted differently depending on the cultural context Cultural context was identified in 33 comments (45%) as a possible reason for not judging the vignette as abusive e g , *"some of the scenarios are culturally dependent"* (Respondent 36)

Kissing, bathing, and sleeping were identified as ambiguous sexual behaviours that were difficult to determine whether or not it was abuse The scenarios or vignettes referring to "kissing" were identified most frequently (28 comments with 12 of these comments specific to the teacher vignettes) as the contexts that could be culturally

appropriate or needing more information to determine abuse, for example, *"Some of the questions involving a kiss on the lips or cheek could be abusive in one culture and perfectly normal in another"* (Respondent 45) Other respondents were clearer about their perspectives on kissing For example

> *The questions about a teacher kissing a child on the cheek or a relative kissing a child on the lips once could have to do with cultural differences However, from my own cultural perspective I consider these acts sexual abuse* (Respondent 141)

Reactions and comments related to the sleeping (13 comments) and bathing (12 comments) vignettes were also prevalent noting that participants found it difficult to determine whether or not the situation represents abuse Many of the bathing vignettes generated comments about situations where an older child would require adult assistance such as this comment

> *[A]n opposite sex or even same sex adult giving a bath to an older child can be provocative or neutral depending on how it is done- if they wash the genitals or have the child wash their own--- also if the child is handicapped and unable to bathe themselves is also an issue* (Respondent 88)

Interestingly, one respondent identified his/her gender bias about the bathing vignettes by stating, *"Bathing children, even older children, seems more acceptable for women to do in our culture, whether they're the biological parent or not"* (Respondent 64)

A second category identified within the theme of 'Defining Sexual Abuse' focused on cautions about defining sexual behaviour as abuse (11 comments) when, in the participant's opinion, the behaviour was simply inappropriate Some examples of these comments

Sexual abuse should not be used as a blanket term Inappropriately intimate behaviour is NOT sexual abuse (Respondent 125)

Some of the vignettes described could be considered sexually inappropriate yet not meet the criteria for sexual abuse We must be careful not to over "diagnose" a behaviour If we do, we can ruin lives instead of helping and at the same time water-down the meaning of "sexual abuse" (Respondent 65)

Intent was raised as a factor in distinguishing abusive from inappropriate behaviour (13 comments) The following example identified intent as a factor when considering the vignette referring to sleeping with a relative *"If a child is sleeping in the same bed as his/her aunt, is there "always" intent to harm?"* (Respondent 20) The dilemma of distinguishing abusive from inappropriate behaviour is summarized as follows

many of the scenarios can be innocent or abusive, depending on the motives of the adults involved Many of the vignettes border on inappropriate, but not necessarily abusive (Respondent 110)

In summary, the primary concerns that were identified under the theme of defining sexually abusive behaviour included understanding the context, interpretation of ambiguous behaviours, and determining the intent of these ambiguous behaviours These comments provided supplementary understanding about the variation of the Definitional Orientation results and provided a preliminary understanding of how some of the telephone interviewees may have approached their interpretation of the survey questionnaire

Therapist Practice Behaviour

The second area for comments on the questionnaire followed the section including questions related to therapist practice behaviours and demographic questions, which generated a total of 44 comments Most of these comments (29) offered clarification about the respondent's demographic information, therefore were not included in this analysis Only 15 of the comments applied to the theme of 'Therapist Practice Behaviours' and were sorted according to the following categories routine practice, conditions of asking, risks of asking, and how the survey has influenced the respondents' practice

Routine practice was referred to in 6 of the 15 comments Three of these comments suggested that the routine practice should apply to all women clients, not just women survivors

> *The questions about asking female clients of sexually abuse thoughts or behaviours towards children is one sided These types of questions should always be explored when issues of difficulties with children are brought up, whether the woman has been sexually abused or not* (Respondent 14)

Another respondent supported this perspective but also raised a caution about inquiring routinely with women survivors

> *Is the question coming from an assumption that those who have been sexually abused will abuse? If so, I think that is a dangerous assumption that risks playing into some very damaging stereotypes of survivors of childhood sexual abuse whether male or female If not, then why is the question only about female survivors shouldn't it be about any female client?* (Respondent 40)

The caution about asking routinely was also raised by this respondent who suggested, *"While asking about thoughts of abusing are important if there are other signs present, to do so routinely is to further pathologize a victim of abuse and "predict" dysfunction"* (Respondent 47) This statement points towards the importance of raising the issue sensitively

Conditions about if, when, or how a therapist should inquire about sexually inappropriate thoughts or behaviour were commented on by eight of the respondents, of which four required some sign or cue that the question should be asked For example, one respondent said, *"[it] depends for me on whether I sense there may be a concern"* (Respondent 141) Three respondents referred to the readiness of the client in relation to timing For example

> *It is important to explore the thoughts and behaviours regarding sexual deviance with survivors of sexual abuse However, timing of that intervention is crucial First and foremost a therapeutic relationship, which will include a sense of safety, needs to be established The exploration needs to be done in a supportive rather than a critical manner* (Respondent 122)

Some respondents identified hesitancy in asking because, *"Asking the question seems like an accusation"* (Respondent 118) Another participant noted the risk that the question *"would be so offensive to the average survivor that she/he would not return to therapy"* (Respondent 81) Two respondents expressed the assumption that clients who had abused a child or were abusing a child would not answer the question if they did inquire about abusive behaviour For example,

If a client is told at the outset of therapy, as they should be, what is reportable and exceeds the bounds of confidentiality, the average currently active offender is not going to report such behaviour anyway (Respondent 81)

Finally, the remaining comments related to how education and research on this topic has influenced some of the respondents' behaviour The following respondent provided insights about the relationship between education and behaviour as a therapist

I answer that I would ask women about sexual thoughts and behaviours toward children/adolescence because I attended a presentation about women perpetrators Had I not done this, I do not think that I would have been orientated to consider these questions and initiate them Also, I notice that I really have to remind myself to ask and don't always I believe this is the result of a continued blind spot around women as perpetrators (Respondent 121)

Other respondents remarked specifically about this particular study

Excellent study – made me examine my own assumptions and practices! (Respondent 94)

You have given me some new possibilities to mull over (Respondent 118)

The comments pertaining to the theme of therapist practice behaviour appeared to be somewhat contradictory with several therapists clearly indicating that questions about sexually inappropriate thoughts and behaviour should be posed to women survivors (some suggested posing the question to all women clients routinely), while others expressed concerns and risks about inquiring Education, research, and information about women who do perpetrate sexually appear to influence how therapists practice In summary, the comments on the questionnaire related to therapist practice behaviour

provided some similar data to what emerged from the subsequent telephone interviews and are discussed in conjunction with that qualitative data in the next section of this chapter

Qualitative Results

The analysis of the 22 interviews yielded specific themes based on the ideas and experiences of the therapists with respect to inquiring about sexually inappropriate thoughts and behaviours with women survivors of CSA The qualitative results have been organized into the following sections description of the interviewees, and then the two primary themes, to ask or not to ask about inappropriate sexual thoughts and behaviour, and recommendations for therapists

Description of Interviewees

The final question of the web-based questionnaire requested that respondents indicate if they were interested in participating in the telephone interview portion of this research study A total of 58 out of 164 (35%) respondents indicated a positive response to this question Of the 58 respondents interested in participating in the telephone interview, 22 respondents (38%) followed through with the interview See Table 18 for demographics of the interviewees' gender, type of agency in which they work, education background, and region in which they practice Additional demographics related to age, years of experience, and so forth, can be found in Table 19 Both of these tables include the survey respondent demographics and show that the interviewees are relatively similar to the full survey sample

Table 18

Telephone Interviewees' Gender, Workplace, Education, and Region Demographics Compared to Phase 1 Sample

		Interviewees *n*		Phase 1 Sample *N*	
Demographic		Frequency	%	Frequency	%
Gender	Female	19	86	131	80
	Male	3	14	33	20
Agency[a]	Organization	10	45	88	55
	Private Practice	11	55	72	45
Education[b]	College or University Credits, College Diploma	2	9	17	10 5
	BA	3	14	24	14 8
	MA/MSW	12	55	84	52
	PhD	5	22	37	22 9
Region	Atlantic	2	9	16	9 8
	Ontario/Quebec	9	41	63	38 4
	Prairies (MB, SK)	6	28	36	22
	West (AB, BC)	5	22	47	28 7
	Northern Territories	0	0	2	1 2

Note n=22, N=164, [a]n=160, [b]n=162

Table 19

Telephone Interviewees' Age, Years of Experience, and Survivor Client Percentages Compared to Phase 1 Sample

	Interviewees *n* (Phase 1 Sample *N*)			
Demographic	*M*	*SD*	*Mdn*	Min-Max
Age	52 5 (51 3)	12 14 (11 31)	55 5 (54)	27-73 (25-73)
Years experience in current position	13 39 (11 79)	12 42 (9 01)	9 75 (10)	0 25-46 (0 25-46)
Years in practice as helping professional	21 25 (20 57)	12 63 (10 52)	20 00 (20 00)	2-46 (0-46)
Years working with women survivors	15 04 (15 64)	9 99 (9 31)	16 5 (15)	1-33 (0-40)
Years working with men survivors	11 68 (12 61)	10 05 (10 26)	10 00 (12 5)	0-33 (0-39)
Approximate % of women survivor clients	40 00 (40 76)	24 64 (31 69)	32 5 (30)	10-90 (0-100)
Approximate % of men survivors clients	7 59 (11 51)	9 75 (16 55)	5 00 (5 00)	0-40 (0-90)

Note n=22, (N=164)

As noted previously, the original plan for selecting the interview participants was to include only those participants with extreme scores on the Therapist-Created Climate dimensions (Client-Initiated Discussion, Therapist-Initiated Discussion and Therapist Importance scales) This process would have provided for a dichotomy of responses, however, the scores of the participants who agreed to be interviewed did not fall into extreme scores only Interestingly, the distribution of the scores for the Therapist-Initiated Discussion scale and the Therapist Importance scale (representing the scales

over which the therapists had direct control) ranged from one (very likely/strongly agree) through six (unlikely/disagree) Consequently, they reflected a broad spectrum of opinion and a range of varied responses rather than only opinions at the extremes See Table 20 for the combined scores on the Therapist-Initiated Discussion and the Therapist Importance scales

Table 20

Interviewees' Combined Scores of Therapist-Initiated Discussion and Therapist Importance Scales

Score	Interpretation	Frequency	%	Cumulative %
1-1 99	(Very likely/strongly agree)	5	22 7	22 7
2-2 99	(Likely/agree)	3	13 6	36 4
3-3 99	(Somewhat likely/agree)	4	18 2	54 6
4-4 99	(Neither)	3	13 6	68 2
5-5 99	(Somewhat unlikely/disagree)	3	13 6	81 8
6	(Unlikely/disagree)	4	18 2	100

Note *n=22*

The therapists who agreed to be interviewed also reported a wide range of ideas, beliefs, and practices with regard to their counselling interactions with women survivors of CSA Of the 22 interviewees, 11 (50%) indicated that they had explored inappropriate sexual thoughts and/or behaviour about children and/or adolescents with some of their adult women survivor clients (ten directly inquired, of which two inquired about thoughts only and one inquired about behaviours only, one indirectly inquired) Eleven (50%) reported they had never inquired, however, four of these 11 therapists had experienced women survivor clients disclosing inappropriate sexual thoughts and/or behaviour within

their counselling relationship Additionally, the Definitional Orientation scale scores of the interviewees provided further evidence of varied representation of opinion, attitudes, and beliefs about how they define CSA Consistent with the demographic comparison, the scores are also relatively representative of the full survey participant sample (see Table 21 for Definitional Orientation scores of interviewees and Phase 1 participants)

Table 21

Definitional Orientation Scale Scores Interviewees Compared to Phase 1 Sample

		Interviewees *n* (Phase 1 Sample *N*)		
Score	Interpretation	Frequency	%	Cumulative %
1-1 99	Conservative	8 (46)	36 4 (28)	36 4 (28)
2-2 99	Moderately Conservative	10 (84)	45 4 (51)	81 8 (79)
3-7	Liberal	4 (34)	18 2 (21)	100 (100)

Note *n=22, (N=164)*, Phase 1 sample scores and % are noted in parentheses

The primary research question guiding this study pertained to whether or not therapists explore the potential for inappropriate sexual thoughts and behaviours involving children with their women survivor clients The data from the telephone interviews provided more depth in answering this overarching question Two main themes emerged from the analysis of these interviews 1) To ask or not to ask about inappropriate sexual thoughts and behaviour, and 2) Recommendations for therapists Each theme contains categories and subcategories that contribute to the overall themes See Table 22 for the organization of these themes, categories, and subcategories

Table 22

Qualitative Results Themes, Categories, and Subcategories

Themes	Categories	Subcategories
To ask or not to ask (women survivor clients) about inappropriate sexual thoughts and behaviour	Impact on women survivor clients	▪ Client benefits ▪ Legal consequences for the client ▪ Client potentially being harmed ▪ Client experience as accusation
	Impact on therapeutic relationship	▪ Risk of damaging the rapport ▪ Therapist judgment of client ▪ Client discontinuing therapy ▪ Impact of 'duty to report' on rapport ▪ Client readiness
	Level of therapist (dis)comfort	▪ Discomfort with the topic ▪ Difficulty asking the question ▪ Not wanting to hear the answer ▪ The human factor
	Cues and indicators	▪ Poor boundaries with children ▪ Sexual thoughts or feelings about a child ▪ Sexual acting out behaviours ▪ Expressions of fear of sexually abusing a child ▪ Body language changes ▪ Therapist intuition
	Therapist training and experience	▪ Theoretical and agency stance ▪ Perspective of women survivors
Recommendations for therapists	Strategies to explore inappropriate sexual thoughts and behaviour	▪ Normalizing ▪ Using context ▪ Ensuring understanding ▪ Indirect inquiry ▪ Direct inquiry ▪ Routine inquiry
	Therapist needs	▪ Education and experience ▪ Comfort with own sexuality and topic ▪ Supervision ▪ Self care

To ask or not to ask about inappropriate sexual thoughts and behaviour

The first theme focused on whether or not therapists should ask their women survivor clients about inappropriate sexual thoughts and behaviour involving children or adolescents The 22 interviewees offered many contrasting perspectives and reasons as to whether or not they should ask or explore these thoughts and behaviours with their women survivor clients Some therapists indicated that *"[t]here should be a good reason for asking the questions"* (Interviewee 5-111) and that the therapist needs to be *"really clear about being able to articulate to the client the reason for asking the question"* (21-103) Additionally, this therapist indicated, *"I'd be considering, is this something that would be helpful [to the client]?"* (Interviewee 12-99) Inquiring must be meaningful to the client or as another therapist indicated, *"I don't think I'm necessarily automatically going to bring up that question if there is no relevance to what we are working on"* (Interviewee 6-126) In contrast, other therapists indicated that inquiring creates space for discussion, as this therapist suggested,

> *I think that would be a good question to ask Whether or not a woman chose to answer it, it would just open the door to a possible discussion later* (Interviewee 14-174)

Because the dialogue regarding the dilemma of whether or not to ask women survivors about inappropriate sexual thoughts and behaviour elicited so many contrasting opinions and discussion, the responses were sorted into five major categories impact on women survivor clients, impact on the therapeutic relationship, level of therapist (dis)comfort, cues and indicators, and therapist training and experience Each of these categories contains subcategories that contribute to the broader category and theme

Impact on Women Survivor Clients

Many interviewees described the potential and actual (depending on the therapist's experience) impact of inquiring about such a sensitive topic on clients as both positive and negative The positive and negative impact is organized within the following subcategories of this section, beginning with the potentially positive effects and moving to the concerns about potentially negative effects benefits to the client, legal ramifications for the client, client potentially being harmed, and client experiencing the question as an accusation

Approximately a quarter (5/22) of the interviewees (not all of these five have inquired with their clients) identified specific client benefits related to the importance of asking, which supports the overall survey results that indicated a strong belief that it is important that therapists should ask or inquire about sexually inappropriate thoughts and behaviour with children As this therapist suggested, "*[T]o be able to talk about it one way or another is certainly very helpful [to the client]*" (Interviewee 4-95) Additionally, the following benefits were articulated

1 Providing the opportunity for the client to explore and understand her inappropriate sexual thoughts and/or behaviour - *you have to also acknowledge that if they are having those [inappropriate sexual] thoughts that they are connected to the therapeutic process as well and it's part of emptying things that they are uncomfortable about and need to clarify or change* (Interviewee 21-103)
2 A sense of relief was identified by three interviewees, one therapist stated, *"One I really remember is the one who was terrified about caring for her children and was just incredibly relieved to be able to talk about it"* (Interviewee 3-48)

Another therapist indicated, *"Relief at this coming out, because it's hard to carry, if that's what's going on for [the client]"* (Interviewee 12-99)

Regardless of how important therapists thought it was to inquire about sexually inappropriate thoughts or behaviour, making an inquiry of this nature with women survivors of CSA certainly raised some level of concern for all 22 of the interviewees The impact on the client may include the potential for serious consequences such as "*legal ramifications*" (Interviewee 4-95) The legal reporting requirement was discussed by 10 of the 15 therapists who had experience with inquiring with women survivor clients or receiving a disclosure from women survivor clients The following situation is an example of a scenario in which the therapist had the requirement to report

> *I know one situation I felt I had a mandatory duty to report because the woman did then express as part of the impact of her abuse that she felt she had been sexually inappropriate with children So I explored it enough to get some preliminary information so that I made a referral to Children's Aid* (Interviewee 7-68)

The consequence for the client is then becoming involved in legal situations that could potentially result in losing their children or ultimately being charged and convicted of a sexual offence

A little less than half of the therapists (9/22) identified concerns about doing harm to the client, as in this therapist's response *"I wouldn't want to do any harm"* (Interviewee 15-33) Several therapists also indicated that inquiring could make the client more vulnerable For example, one therapist suggested, *"I think presenting that question could open up such a vulnerability on their part to hear it"* (Interviewee 10-63)

Another interviewee expressed concerns consistent with "false memory syndrome" issues with regard to inquiring, she expressed concern about planting ideas in the client's mind, stressing the vulnerability of women survivors

> *[I would not ask] unless I had something to indicate that it was warranted I don't want to be planting anything in people's minds that they're not doing, necessarily Because that might come up as well Because some of these women are really vulnerable So I have to be really careful that I don't just say things to them Like if they haven't had [those thoughts] before then they might start getting worried that maybe they would* (Interviewee 6-126)

Negative reactions from clients were also described by therapists who had previously inquired about sexually inappropriate thoughts and/or behaviour with women survivors Four of these eleven therapists indicated that clients experienced the question as an accusation The following quotes are examples of this reaction

> *The reaction was, "Oh, my God! Never! I would never!" That's been the reaction that I have received* (Interviewee 18-151)
>
> *[Client response] "How could you think I would ever do that! Why would you ever think I could do anything like that! What kind of a horrible person do you think I am?"* (Interviewee 13-66)

The overall impact on the woman survivor client was anticipated and experienced, from the perspective of the therapist, as having the potential to be both positive and negative with regard to being asked about inappropriate sexual thoughts and behaviour involving children Any negative impact on the client also impacts how the client experiences the overall therapeutic relationship In the next category, 'Impact on

Therapeutic Relationship', several concerns and some contradictions regarding the dilemma of whether or not to ask this kind of question are presented

Impact on the Therapeutic Relationship

With the therapeutic relationship identified as being core to the counselling process (regardless of educational background or level of education achieved) by the therapists, the complexities of the impact on the therapeutic relationship were commonly discussed by most of the interviewees in relation to posing a controversial question about the client's potential to engage in sexually inappropriate thoughts and behaviour This discussion parallels the comments presented within the web-based questionnaire as presented in the previous results section The concerns were subcategorized as risk of damaging rapport, impact of legal consequences on the relationship, client feeling judged by the therapist, and client leaving treatment Additionally, the quality of the therapeutic relationship was described as a determinant for therapists to recognize when the client might be ready to engage in this type of exploration

Most of the therapists (17/22) identified concerns about the impact inquiring about sexually inappropriate thoughts or behaviour would have on the therapeutic relationship with a woman survivor As this therapist indicated, *"The main concern is to offend the trust that this person has established already"* (Interviewee 9-71) Concerns identified were as pointed as *"destroying the relationship"* (Interviewee 20-113) or *"It would harm my therapeutic connection with them"* (Interviewee 21-103) Others were less emphatic by stating, *"I might have some concern about damaging the rapport that I have with a client"* (Interviewee 22-148) and *"I think it would complicate the treatment relationship for sure"* (Interviewee 7-68)

The client's negative reaction to the question as indicated above can be interpreted as a judgment of the client by the therapist as indicated by this interviewee

> *They would be offended by it There would be some reaction to me immediately going to that, like I am judging them Because you've been abused you are automatically an abuser* (Interviewee 20-113)

This perceived judgment also has an impact on the therapeutic relationship as described by this therapist

> *If I had a negative response or a denial then what I'm looking at is a possible barrier in the therapeutic relationship [Client response] "How could you think that I would do anything like this?" So that would impair the trust relationship, so that was always a huge part that I had to continue to foster* (Interviewee 12-99)

For several therapists, the rapport would be damaged because, *"there is always the concern that [a client] is going to be offended by such a question"* (Interviewee 18-151) A similar response was presented within the questionnaire comments by a different questionnaire respondent from this interviewee Grappling with how to best word the question or even how to approach the topic in a way that does not upset the client was commonly expressed as indicated by these therapists that were interviewed

> *If I'm asking it, am I thinking it? So, to somehow word it and not be accusatory?* (Interviewee 10-63)

> *Asking them if they have sexual thoughts about children I don't know how I would bring that out of the blue Just asking the question might suggest that I think they might be doing that Or else they are going to wonder why is she*

asking that? Is she assuming or thinking that I am doing that? (Interviewee 22-148)

In addition to the concern about therapists coming across as judgmental, concern about revictimizing the client within the therapeutic relationship was prominent for this therapist

[The client] might begin to wonder about how you see them That it might be an indication on their part that I, as a clinician, see them as possibly creating or participating more actively in their own abuse How much healing [is needed] to have enough faith in themselves and enough trust in you as a clinician to be able to have that kind of frank conversation without being offended and without feeling as though you are now almost assaulting them again (Interviewee 17-81)

Along with interpreting the question as an accusation, almost half of the therapists (9/22) expressed concerns *"that [the client] would quit"* (Interviewee 15-33) or not follow through with therapy, similar again to the questionnaire comments This therapist identified a further risk with quitting therapy

I think there could be a negative consequence to that of women not engaging in counselling for their own victimization (Interviewee 7-68)

Therapists were sensitive to the effort and courage required to seek treatment for their experiences of being victimized As this therapist articulated with regard to a client

I think one of the reasons that I haven't asked her outright is because I don't want to jeopardize the fact that she's coming here and acknowledging some of the

> *abuse that's happened in her life for the first time I don't want to scare her away, basically* (Interviewee 1-140)

The general sentiments for those therapists concerned about women not remaining in treatment if they inquired about potential sexually inappropriate thoughts and/or behaviour with children could be summarized with the statement by this therapist

> *It feels to me like you would have to tread quite cautiously in that area if you expected the woman to stay in or to continue on* (Interviewee 11-67)

Few of the 11 therapists who have inquired, identified the challenges of women acknowledging behaviour such as sexually abusing a child As this therapist suggested, *"It is very hard in our society for women to acknowledge some of their behaviours"* (Interviewee 9-71) Being truthful about this kind of behaviour, however, could result in severe consequences for the woman, therefore, therapeutic rapport was compromised even more if there were to be *"a break in the trust if I needed to take that anywhere further"* (Interviewee 10-63) These therapists grappled with the potential consequences on the therapeutic relationship if asking about inappropriate sexual thoughts and/or behaviours led to their reporting responsibilities This therapist shared some of her struggles

> *I've thought about should I be asking this question? But then it gets to a point where if I ask that question I'm going to have to report Or, were I have to report, what is that going to look like? Those things do run through your mind as much as you wish they didn't* (Interviewee 13-66)

The legal requirement to report was obvious, as she continued, *"We all know what the discussion is, that we must report"* (Interviewee 13-66), however, some therapists also

acknowledged that reporting and subsequent child protection intervention does not necessarily end the therapy or have a negative outcome For example,

> *You call CAS when that first happened I just didn't want to do it and I dreaded doing it and I just felt awful to have to do it But actually, it's always been to the benefit of the client I haven't had horrible things happen as a result of that What is important is that it's taken seriously* (Interviewee 4-95)

As a result of her experiences, this same therapist emphasized that it is important to,

> *Wait until you have a really good connection with your client And that there's been a well established frame of therapeutic structure of mutual trust I would rather go slower, have a really good therapeutic alliance, than rush into something because it's a good question, and whatever* (Interviewee 4-95)

Determining when a client is ready to discuss a difficult topic such as whether or not they struggle with inappropriate sexual thoughts and behaviour within the context of a *"good therapeutic alliance"* was an issue identified by 16 of the 22 therapists, as well as some of the questionnaire comment respondents These therapists identified the need for *"a really strong therapeutic bond with each other to unpack something like that"* (Interviewee 10-63) Developing a level of trust between the client and therapist often takes time and helps the therapist to detect client readiness or the client's ability to manage the question For example, this therapist suggested, *"if [the question] was asked later on when there was therapeutic trust established"* (Interviewee 7-68) then, as this therapist indicated, *"I feel confident that if I want to ask a very difficult question I can do it in a way that will be relatively comfortable to the person I'm asking"* (Interviewee 4-95) Another therapist indicated that taking the time to develop rapport would ensure

that, *"I understood that the person knew where I was coming from and this was appropriate and reasonable for me to do"* (Interviewee 20-113)

More specifically, several therapists (9/22) expressed a strong belief that one should not inquire in the first session For example, one therapist stated, *"I don't think it's something you pop off the top at your first meeting"* (Interviewee 13-66) This belief was tied to the previously discussed risk of the client not returning to treatment because of not taking the time to develop the necessary rapport For example,

> *I think that if it was something that I brought up initially [early in the counselling relationship], that that could lead to them not coming back* (Interviewee 1-140)

Another therapist provided an example of how timing was important for the client to experience the question more positively

> *Flat out direct questions like, have you ever abused others? Depending on the client and the rapport that you have They don't get offended because I've waited until there is that rapport Like, with that one lady, she's kind of admitted that, yes, she has but she's not willing to talk about it yet And I respect that And slowly and slowly and slowly she's giving me more and more pieces of that But it's not something that I push* (Interviewee 1-140)

The therapist's approach to accessing difficult material with clients interfaced with their treatment philosophy For example, as this therapist described, "*I might have questions or thoughts or wonder, but not be able to get at it until the client is ready for that The client really is the one who determines what gets talked about"* (Interviewee 17-81) For some of the therapists, it was preferable that the client initiated the

discussion rather than the therapist initiating any questions One therapist specified client-initiated discussions regarding thoughts specifically

> *If we want to talk about thoughts themselves I'd leave that for people to bring up themselves Then they are presenting with that as an issue So then I would talk about it* (Interviewee 5-111)

In addition, therapeutic rapport was also identified by some therapists as a means of determining that possible sexually inappropriate thoughts and/or behaviour was not an issue for the client because the client did not raise as an issue For example,

> *I don't think it's ever really been much of an issue for the women that I've worked with Because I have pretty good rapport with a lot of my clients and I'm pretty sure they would have said something That "I'm having these thoughts"* (Interviewee 6-126)

Another therapist indicated similar ideas but challenged her own thinking and recognized that this was not necessarily an appropriate assumption She stated,

> *By the time you have established a relationship with the client, there is a kind of sense of knowing this person and knowing they would never do that, which is not founded in reality and which is probably doing a disservice to the client* (Interviewee 21-103)

Determining whether or not to ask clients about inappropriate sexual thoughts and behaviour should consider issues pertaining to therapeutic rapport Concerns were expressed regarding the impact this type of question could have on the relationship, however, establishing a solid therapeutic rapport was identified most consistently by therapists (the interviewees and some respondents who provided comments on the

questionnaire) as a requirement for exploration of such a difficult topic It was also noted by some therapists that the therapeutic relationship can contribute to untested assumptions of therapists that may not be helpful to clients who may struggle with sexually inappropriate thoughts or behaviour with children

Level of Therapist (Dis)Comfort

The concept of inquiring about or knowing that a women survivor client has sexually abused a child unsettled some therapists personally and professionally, while other therapists were more comfortable with this concept For over half of the therapists (12/22), being faced with their own discomfort with the concept of women as potentially being sexually abusive with children was identified as a barrier to their inquiring about this potential with their clients The level of the therapist's discomfort can vary

> *I think that it's not really a comfortable topic for me either in terms of asking women or any client really about any kind of abuse that they have inflicted on others It's something, I don't know, it's just not something that I'll bring up usually* (Interviewee 1-140)
>
> *[T]here is all kinds of people have all kinds of sexual baggage and attitudes so you never know what you are getting into And, of course, I'm human So there is always that moment where you take a deep breath because it's a touchy topic* (Interviewee 13-66)

The following insight about discomfort with the exploration of sexually inappropriate thoughts or behaviour was offered by this therapist

> *In my experiences with that, I have found it difficult to initiate that [discussion] You sit back and wait for them They are protecting you and you are protecting*

them It's a very uncomfortable place to go I think it's about protecting the client (Interviewee 21-103)

In addition to the challenge of asking the question, therapists expressed awareness that they would find it difficult to hear an answer in the affirmative that the client has had inappropriate sexual thoughts or engaged in inappropriate sexual behaviour For example,

Maybe not really wanting to hear the answer That would be my biggest worry is how anything I might ask or any way in which I might explore there may be that they have thought about doing what happened to them to somebody else That, as a clinician, particularly after you've developed a relationship with somebody, that's going to be tough to hear (Interviewee 17-81)

Not wanting to hear a particular response was reiterated as a concern observed by this therapist who has inquired with clients

People won't tell us if we are afraid And [therapists] get afraid to ask these questions because they don't want to hear the answers And they don't want to hear the answers sometimes because it's just uncomfortable in general or it means they may have to act on it, in terms of child protection (Interviewee 3-48)

Not wanting to hear the response indicated more than just discomfort, it also meant that the therapist must act or *"deal with the answer"* (Interviewee 13-66) As this therapist suggested

There is a defensive position on my part that says, "what am I going to do with this " This means I am going to have to [initiate] a child protection investigation (Interviewee 21-103)

In particular, some therapists who have not inquired about inappropriate sexual thoughts or behaviour with their women survivor clients were able to express the impact this may have on them as a therapist and as a human being The greatest challenge for one therapist was *"the ickiness factor"*, however, even more important was recognizing the potential for these thoughts personally

> *One gets desensitized to male perpetrators because it's so common So I felt much more comfortable pursuing any thoughts and feelings towards males Having ickiness is about recognizing that women do perpetrate sexual abuse and that one of the consequences in both cases, male and female, is that you [as therapist] can have those very same thoughts and reactions that they might* (Interviewee 12-99)

Another therapist was able to identify several issues including the "human factor" that may affect her ability to inquire with her clients

> *What would stop me from asking the question? I guess I would bring my humanness to it, so I would be thinking how that would affect me knowing about this about her I'm taking ownership for part of that because I could have some fear about what I would want to hear I have three of my own little children and then, with that, the work that I do in being a mom, I have my own history too So, that's part of who I am Part of who I am in the work and who I am as a mom and a person in the world So I think that would be a really tough question to put out there* (Interviewee 10-63)

The level of (dis)comfort that therapists have regarding this topic can impact their ability to inquire, willingness hear responses from their clients, and have a personal

impact The personal insights these therapists were able to express demonstrate some relevant considerations as to how this topic can affect professionals and in turn how they may respond with women survivor clients who struggle with issues pertaining to sexually abusing children Regardless of the level of comfort, therapists recognize the importance of responding to cues or indicators of sexual abuse of children The next section presents the various cues or indicators identified by these therapists

Cues and Indicators

As stated previously, there was a strong belief for some of the therapists that *"[t]here should be a good reason for asking the questions"* (Interview 5-111) A number of therapists indicated that the reason for asking would come in some way from the client, as this therapist recommended

> *I think that there would have to be some clear indication from the client that that was an area of concern I just don't see myself out of the blue saying, "Have you ever thought about molesting a child?" or "Have you ever had sexual thoughts about kids?"* (Interviewee 22-148)

Examples of indicators or cues from clients that would stimulate further exploration about inappropriate sexual thoughts or behaviour were widely discussed by 20 of the 22 interviewees Half of these therapists provided examples of cues based on their practice experience or observations in their work with women survivors The other half of the therapists based their examples on cues that they believed would precipitate an inquiry about sexually inappropriate thoughts or behaviour if the cue were to surface during their sessions with women survivors, even if they had not previously attended to the cues As previously discussed, four respondents to the questionnaire comments also indicated that

they would explore sexually inappropriate thoughts and behaviour if cues were present The subcategories of cues and indicators are organized as follows poor boundaries with children or adolescents, sexual thoughts or feeling about a child, sexual acting out behaviours, expressions of fear of sexually abusing children, body language changes, and therapist intuition

Poor boundaries between the woman survivor and children or adolescents were identified by 11 interviewees (who identified cues) as an indicator that would precipitate an inquiry about potentially sexually inappropriate thoughts or behaviour One therapist suggested that she would inquire further, *"if [women survivor clients] were to start identifying behaviours in the home that I felt weren't keeping clear boundaries between themselves and those youth or if they were in a social situation and I had a sense that boundaries didn't exist"* (Interviewee 17-81) Another therapist indicated overt cues related to boundaries,

> *If a woman brings up any form of poor sexual boundaries with children or directly states that she feels that she has been sexually inappropriate, then for sure I would be exploring it* (Interviewee 7-68)

A few therapists reported that they had asked the question based on direct observation of client interactions with children, as this therapist stated

> *In my experience, it's mostly watching children who are in proximity with the woman behaviours from women that are kind of fawning and touching, behaviours then I would stop and ask a question* (Interviewee 11-67)

The boundary issues most commonly identified were sleeping arrangement concerns (6/11 Interviewees identifying cues), bathing of children (4/11 Interviewees),

and care-giving activities not appropriate to the age of the child For example, " *a woman was describing bathing her children past a certain age [or] a woman was talking about sleeping naked with her children"* (Interviewee 7-68) Another therapist provided this experience as an example using a specific age " *[a woman survivor client] who said that her thirteen year old son when she was home was sleeping in the same bed"* (Interviewee 19-150)

Other boundary issues identified as potential flags to explore further included, *"watching inappropriate material on TV [with children]"* (Interviewee 17-81), *"if they are no longer the primary care giver of their own children or their children have been removed"* (Interviewee 10-63), and *"inappropriate attachments to either their own children, or other children, or if they are working with children"* (Interviewee 4-95) An example of an inappropriate attachment was provided by one therapist

> *a particularly dependent child who is isolated or a teen who is isolated mother seems to really enjoy the fact that the child comes to her and she is the one who helps solve all the problems and so on* (Interviewee 18-151)

Additionally, another therapist described her experience with a non-parent situation of attachment that elicited concern about boundaries

> *very emotionally intimate with her children in her care Talking to a nine year old about how he would feel better about his penis if he was circumcised she was very controlling about who else had any effect on these children she was talking about doing sex education in the dorm and it wasn't her job* (Interviewee 3-48)

The most blatant cue, identified by 8 of the 20 therapists who provided information about cues, pertained to the woman survivor client indicating she *"might have sexual feelings or sexual responses or thoughts about that child"* (Interviewee 12-99) or demonstrating *"a sexual kind of way of thinking about and talking about the children that they have contact with"* (Interviewee 4-95) Some therapists described less overt cues related to sexual thoughts or feelings, such as, "*Any type of language of attractiveness or attractability of a child"* (Interviewee 7-68) This therapist suggested, "*If the client started talking about their sexual abuse and what happened with that sexual abuse, then I would ask what kind of behaviour that creates for them"* (Interviewee 11-67) The statements from clients were often described as indirect, such as this *They say things like, "sometimes they think there is something wrong with me because sometimes I look at children"* (Interviewee 13-66) Participants indicated that if the woman survivor raised these issues without prompting or questioning by the therapist, it would be seen as a stronger cue

A few therapists indicated that when *"sexually inappropriate behaviour has been normalized"* (Interviewee 19-150) or when *"promiscuity is pretty common"* (Interviewee 5-111), these cues would prompt inquiring about whether or not the woman survivor has engaged in sexually inappropriate behaviour Another aspect of sexual acting out could include the client identifying this as a past or childhood behaviour Although it may not immediately be used as a cue to further inquiry, this therapist suggested, *"if I had heard of a woman talking about being sexually inappropriate or coercive when she was under 12 with a sibling, I'd probably be more alert to listening to how she is talking about her own relationships with her children"* (Interviewee 7-68)

Situations where a woman survivor client expressed fear of sexually abusing a child were identified as possible indicators by 8/20 therapists (who identified cues) Some of the fears were expressed directly by women survivor clients as *"what if I'm like my father or my mother or my aunt? what if I do it to someone else and that's a child?"* (Interviewee 15-33) Women survivor clients comparing themselves to their abuser was identified by two therapists as an obvious cue to explore further

Five of the eight therapists identified experiences where women survivor clients raised these worries in therapy in relation to their own children For example, one therapist indicated, *"[women survivors] would speak about concerns about some of the reactions they might have to their child especially around the time that the child became the same age that they were when their abuse started"* (Interviewee 12-99) The age of the child in relation to the age at which the woman was sexually abused triggered these particular worries For example, this therapist indicated,

> *I've had a couple of clients state "my child is the same age as I was and I'm kind of concerned that maybe I will want to do something " Scared that maybe they would do that to their own child* (Interviewee 6-126)

Worries and fears may also surface in relation to parenting This therapist indicated that *"It would usually come up with regards to children in questioning whether they are good mothers"* (Interviewee 8-75) One therapist had experienced women survivor clients being fearful of having sexual thoughts rather than reporting the actual presence of sexual thoughts

I've had women come to me who have had babies who have been terrified that they will have sexual thoughts about their babies as they are changing their diapers (Interviewee 3-48)

When clients express these fears, the same therapist indicated that rather than just dismissing the fear as a minor concern, it provided the opportunity for exploration of this very difficult topic

Six of the twenty therapists who identified cues, described body language changes as an indicator for inquiring about potentially sexually inappropriate thoughts or behaviour with children For example, one therapist described it as incongruence

Talking about one thing but your body language and facial expression is saying something different I would react to that (Interviewee 12-99)

Two therapists offered more detail about their observations of the body language changes they have experienced

Very long pauses when they are telling me their story with a fairly high degree of fluency and then all of a sudden it becomes very jagged or long gaps Sometimes they are flushed Their face turns red, or their neck The physiological reactions that something is not being handled as openly as the previous statements (Interviewee 9-71)

What they do with their bodies when they talk about things when somebody tells you something really awful happened to them, [they] have one look they have a different kind of a look of fear on their face, like the fear of being found out, to me it looks different if they squirm on the chair like maybe they feel they are in trouble (Interviewee 2-93)

The body language cues appeared to be strongly linked to shame and guilt reactions Some therapists who had previously worked with women who had sexually abused others indicated that a woman survivor's experience of shame and guilt could be a cue to other issues For example, one therapist stated, *"They'd have a lot of shame and guilt and there were some things that they still felt like they couldn't talk about"* (Interviewee 3-48) Another therapist provided an interpretation of the body responses that suggested a shame based reaction

> *The hesitancy to talk about it, they're not looking at you, looking down, the indications that they are ashamed or embarrassed, avoidance in general they've been looking at me the whole time and then suddenly they're not going to look at me anymore for however long* (Interviewee 1-140)

One therapist offered the following description

> *The best I can do is to describe it as a look of shame Someone might look down and away They might flush slightly* (Interviewee 12-99)

The therapist's own response to interactions with women survivor clients may also serve as a strong indicator or cue for the therapist to inquire about sexually inappropriate thoughts or behaviours Five of the six therapists who identified intuitive cues based their discussion on actual experience This therapist provided the following explanation

> *some of this is for me a level of intuition, I would also pay attention to my reactions Meaning that something might pop into my head that there is something not quite right about this and I'm going to pay attention to those internal cues for me Sometimes it was just a thought Sometimes it was a*

> *bodily sensation I'd pay a lot of attention to what I'm feeling If I would have an emotional reaction myself I would ask myself what this was all about* (Interviewee 12-99)

Some participants suggested that internal cues that therapists may experience should be explored As one therapist, who did explore unsettling internal cues, stated,

> *I listen to my intuition Which doesn't go across scientifically but I'll tell you, it works for me I blew the whistle on a female [colleague convicted of sexual abusing children at the workplace] that was all based on my intuition [before evidence was discovered]* (Interviewee 3-48)

These participants stressed the importance of attending to any intuitive cues or emotional reactions that a therapist may experience when counselling women survivors of CSA

Other therapists also explored possible sexual thoughts or behaviour with clients when cues, as this therapist experienced, were more of a "*sense that there is something [the client] want[s] to tell [her] around that whole area and they're not*" (Interviewee 1-140) or similar to this therapist, " *The client perhaps talking about being in a social situation where they became offended or saw themselves feeling unsettled or agitated*" (Interviewee 17-81)

Any cues or indication that there is a risk to children was one of the primary reasons for inquiring or attending to the cues for most of the therapists Attending to the cues in order to address any potential issues for the woman survivor that can include inappropriate sexual thoughts and behaviour was more prominent with those therapists who had experience working with women clients who have sexually abused children or adolescents

Therapist Training and Experience

Therapist training and counselling experience were identified as impacting whether or not the therapist inquires with a women survivor client about inappropriate sexual thoughts or behaviour with children The survey data also demonstrated a relationship between years of counselling experience and therapists creating a climate for this discussion The two primary theoretical stances described by the therapists were the "client-centered" approach[11] to counselling and feminist theory Additionally, some therapists indicated they were not inclined to think about the potential that some women survivors may engage in sexual abuse of children, this was seen as a lack of training regarding the topic

The most commonly identified theoretical stance within the study was referred to as being "client-centered" as a rationale for not initiating discussion with women survivor clients The following therapists described how their client-centered approach influenced their practice with women survivor clients and created a barrier for inquiring about inappropriate sexual thoughts and/or behaviour

> *The client really is the one who determines what gets talked about I think that's why I'm having a little bit of difficulty, because we wouldn't ever be that directive in asking specific questions* (Interviewee 17-81)
>
> *Well, I'm always client led So whatever they are talking about or if they come in with an issue, I'm led by what they want to talk about So I don't necessarily ask the question it is intrusive It just doesn't come up* (Interviewee 6-126)

[11] Therapists described their approach as being 'client-led' or following the 'client's lead' for which I have interpreted this to be "client-centered" theory, consistent with Carl Rogers' (1973) theory

Normally what I do is allow the client to give whatever information they do voluntarily (Interviewee 9-71)

Even when there are cues present, this particular therapist still would not inquire unless it was an issue the client raised

There are some cues and you wonder but we don't probe in that way if it comes up, we'd certainly talk about it but it's not something we necessarily ask about (Interviewee 13-66)

Agency policy influenced by a feminist theoretical stance was also identified as a barrier to inquiry with women survivors by some therapists This therapist indicated agency policy as the reason for not inquiring about sexually inappropriate thoughts and behaviour

I guess our policy is kind of, we don't bring that up I have a client right now that I know has been charged with abusing her kids because we were involved with her children, but she has not told me that and I am not pursuing that I've waited for her to tell me on her own It's not something that I consider part of my usual routine kind of questions that I ask (Interviewee 1-140)

Another therapist was very clear about the agency philosophy and the lack of support for inquiring

Well, primarily when I've worked with adult female survivors it's been in a feminist based agency and very much the model of that agency is you look at beginning where the woman is at and really focusing on her experiences certainly the political framework of that organization wouldn't really support my exploring whether or not she's had experiences with touching children in the past

> *Also, in that organization it very politically, being a feminist agency, holds the contention that males are primarily responsible for the victimization of children So my work in that agency, it would be clinically quite contentious for me to explore that with a woman* (Interviewee 7-68)

In contrast to the theoretical stance inhibiting a therapist's ability to inquire about sexually inappropriate thoughts and behaviour was an assertion by this therapist that she *"doesn't want to be the kind of feminist whose model gets in the way of reality"* (Interviewee 12-99) This poignant statement reflects the importance of recognizing that theoretical models guide how therapists behave in practice but also may require therapists to approach their use of models with flexibility

The therapist perspective or assumptions about women survivors based on their training and experience was also identified as impacting whether or not therapists inquire about inappropriate sexual thoughts or behaviour in their practice For some therapists, it just never occurred to them to inquire, as this therapist indicated

> *When I filled out your survey over the internet I had never thought of asking any of my clients whether they have sexual thoughts about children No, it never occurred to me* (Interviewee 22-148)

Another therapist provided the following perspective

> *I think from my experience, seeing [women survivors] as perpetrators wasn't part of my thinking So I didn't ask them whether they were appropriate with children or not I was just focusing on what happened to them So it wasn't triggering me to do that* (Interviewee 20-113)

Some therapists (5/22) did not perceive women as having the potential to engage in sexually abusive thoughts and/or behaviour

> *I think my resistance to it would be my personal viewpoint that the rate of women having sexually offended in my work with children and my work with child protection in the last 20 years, my experience has kind of reflected that it is a very low rate* (Interviewee 7-68)

Another aspect of not viewing women survivors as having the potential to abuse others can be about the therapist relating to the women survivor client as a "victim-only" This therapist shared the following conceptualization of why this may occur

> *I think, for myself, that this is the other side of being empathetic Pathological empathy or codependency is me over-identifying with my client and not being clear about some of the other areas that need to be explored such as their potential for abuse Do they need to talk about other parts of their experience and the way they view their lives that may have been "contaminated" (is a judgmental word), may have been "influenced" by their victimization [The pathological empathy is really] a barrier in me that stops me* (Interviewee 21-103)

In summary, training and experience with regard to the theoretical stance from which the therapist works and the perception therapists have about the issue of women sexually abusing children can impact whether or not the therapist will inquire about this potential with their women survivor clients

Exploring inappropriate sexual thoughts and behaviour with women survivor clients was a topic that was unsettling and challenging for many of the therapists

interviewed Essentially, all of the interviewed therapists indicated that they would explore this topic in some capacity However, five therapists were not prepared to initiate the discussion for a variety of reasons such as their theoretical stance of being client-led, their concerns about the therapeutic relationship, or simply not knowing how to approach the topic Being uncomfortable with raising the issue and not wanting to hear the response was a predominant concern identified by some of the therapists, including those who were not as prepared to initiate the discussion or inquire about the potential for sexually abusing a child To ask or not to ask about this potential raised many contrasting opinions, however, if a child is at risk of being sexually abused by the woman survivor client, each therapist recognized the importance of addressing the issue Several respondents offered excellent suggestions about how to explore the issue and how to handle the topic from both a personal and professional perspective The next section reports these suggestions

Recommendations for Therapists

The second theme focused on recommendations for therapists regarding their counselling practice in the context that inappropriate sexual thoughts and behaviour may be an issue for their women survivor clients Many recommendations came from therapists who have had experience exploring the topic of potential sexual abuse of children, however, suggestions were also from therapists who have not inquired with their survivor clients but were able to identify what would be helpful to them in the future There were two primary categories within this theme strategies to explore inappropriate sexual thoughts and behaviour, and therapists' needs

Strategies to Explore Inappropriate Sexual Thoughts or Behaviour

Several strategies to inquire about sexually inappropriate thoughts or behaviour with women survivors of CSA were identified by the interviewees The strategies to consider when inquiring with women survivors identified by the interviewees included normalizing the behaviour, connecting the question to a particular context when inquiring, and ensuring understanding of the purpose by having a common language to discuss the issues and being non-judgmental as a therapist In addition, specific ways to inquire were identified indirect approaches, direct approaches, and routinely inquiring Several of the strategies and each way of inquiring were also supported with examples of how questions could be posed to the client with sensitivity

Normalizing the behaviour or letting the client know that a common response to past sexual abuse can be to engage in sexually inappropriate thoughts or behaviour was identified as a strategy to approach the discussion with women survivor clients by 12 of the 22 therapists interviewed One therapist provided the following example of how to introduce the question by using the normalizing strategy

> *Sometimes I'll say, for some people who have been abused, it's not uncommon for them to then turn around and abuse others, and I would maybe say something like, "Is that something that you've ever done?"* (Interviewee 1-140)

The "normalizing" was qualified by clarifying that the therapist was not condoning the behaviour but rather offering a feasible explanation as to why the behaviour may occur For example, this therapist suggested

> *talking about how, when sometimes that happens to somebody because they can feel that was the way in which to act with children So, by no means, agreeing*

with [the] behaviour but also trying to express an opinion about how this could happen Not that it is right, but that's how it could happen (Interviewee 14-174)

Additionally, one therapist included that, along with the normalizing strategy, it could also be acknowledged that historically these discussions have not occurred with women

I might also say, and I think I have said, "You know, in times gone by, we hadn't really talked about these things before with women But now we tend to try to be more open about that and become more aware that these thoughts can come up and sometimes even acting on the thoughts " (Interviewee 18-151)

Normalizing was also described as an opportunity to broach the topic from a psycho-educational perspective by several of the 12 therapists who suggested "normalizing" as a strategy These therapists provided the following examples of how they could or have approached women survivor clients

I do a lot of psycho-education so I might talk about how it wouldn't be unusual or out of the ordinary for these things to happen, that we tend to project these learned kinds of behaviours We think that's the only way to make connections with youth Whatever I might say in terms of giving it a kind of background and a kind of normalizing (Interviewee 4-95)

I might phrase it as, "You read in literature and knowing more about this, we know that sometimes this happens Can you reflect on whether you've thought about that kind of thing?" what I'm doing is saying if you put these circumstances together there is a certain percentage of people who will themselves abuse and be vulnerable to doing things when their boundary lines have been blurred in the past (Interviewee 20-113)

Another strategy identified by 9 of the 22 therapists referred to using a context (such as something the client has identified within the session or an intuitive sense from the therapist) when inquiring about sexually inappropriate thoughts and behaviour with women survivor clients One therapist indicated that *"it's typically around the context [of what is being discussed during the session] it's because of some context that I would raise this"* (Interviewee 4-95) The specific contexts identified by the interviewees included the impact of past abuse, worries the client identified, feelings of shame, the therapist's experience, and descriptions of current relationships with children

For example, this therapist used the context of the impact of the survivor's past abuse experience as follows

> *Earlier on, I would ask if [the abuse] has left them with any thoughts that are uncomfortable to them or any fantasies about doing anything else to children who were the same age as when they were, with their children You know, the same age they were when they were abused* (Interviewee 3-48)

The context of worries that the woman survivor clients shared with their therapists in sessions was applied in these two examples

> *You've mentioned a couple of times that you are worried and that you might be a freak (or whatever word they use) or there is something the matter with you because you have those thoughts Well, in what context? Are you worried that you are going to go out and do inappropriate things to children? Have you in the past?* (Interviewee 13-66)

> *I would probably say something like Have you ever been frightened by any thoughts that come up or concerned about any thoughts that come up in your*

relationship with children or adolescents or family members? In that context if those thoughts have come up it might cause some distress (Interviewee 18-151)

Another therapist identified shame as the context in which potential sexually inappropriate thoughts or behaviour were explored

Sometimes I'll ask if they've done something that they are ashamed of The answer is almost always, yes Now, thoughts that you are ashamed to have? (Interviewee 8-75)

A different therapist presented her own sense about the discomfort that was being experienced as a context for inquiring

I might start by saying, I sense some discomfort here so basically, focusing on what I was feeling and then if I got a positive response, "Yes, I am feeling uncomfortable" then we would be exploring what that discomfort is about, what is going on in their body (Interviewee 12-99)

One therapist identified how the context of discussing the client's relationships with children or adolescents would be used as a strategy to inquire further about potential sexually inappropriate thoughts or behaviour

I'd probably go at it from finding out more about their relationships with young people and what would that look like and what is the meaning of those relationships for them (Interviewee 17-81)

More explicitly, another therapist explored the context of relationships by using the sleeping arrangements the client shared about for inquiring

> *I might ask if when they are sleeping with the child, what are their affectionate responses? Have they ever had urges themselves to touch the child in sexual ways?* (Interviewee 4-95)

Ensuring an understanding of why the question was being asked was identified by six interviewees from three perspectives, the client's understanding of the purpose of the question, the client's understanding regarding their own thoughts or behaviour, and the therapist's understanding of the impact discussing this issue can have on the client Most commonly, the therapists described ensuring that the client understands the question and/or the intent of the question The concern regarding understanding raised by this therapist was, *"How would I get that person to understand where I'm coming from?"* (Interviewee 20-113) Another therapist provided a response to the concern raised by suggesting, *"[the question] needs to be couched in such a way that [clients] need to understand"* (Interviewee 3-48) Additionally, this therapist offered a concrete example of how to inquire to ensure that the client understands the therapist's motivation

> *Because part of my job is protection of children, part of my job is protection of you to make sure you don't have to live with such a huge burden that you don't have anywhere to unload It would be really important for me to ask this question* (Interviewee 3-48)

Another perspective of understanding referred to the understanding needed by the client regarding their own thoughts or behaviour For example,

> *I kind of frame it so that this is a process by which you can acknowledge an unacceptable impulse, an unacceptable thought, or an unacceptable behaviour*

> *and understand where it could come from without a single dimension of shame or feeling so unforgiveable or so dark you can never recover* (Interviewee 9-71)

The client's understanding is further enhanced by having a common language to discuss the issues As this therapist suggested, " *they need to know the language they can use to bring it up Just as kids need to know, adults need to know"* (Interviewee 3-48) One therapist identified a non-threatening approach to providing a language, " *we just called it 'this issue'"* (Interviewee 8-75), when discussing the woman survivor's sexually abusive behaviour

The third perspective of understanding referred to the importance of the therapist's understanding of the impact on the client in discussing such a sensitive issue As this therapist emphasized

> *The obligation of the therapist is to try and understand how difficult it is for this person in front of you to open up They've been traumatized They've been mentally damaged The concern is how is the therapist going to handle both questions and the answers that they get with the welfare of the person in mind* (Interviewee 20-113)

Respondents agreed that the therapist can demonstrate this understanding by being non-judgmental Although therapists strive to be non-judgmental with all clients, it was identified as particularly important in the approach to inquiring about sexually inappropriate thoughts or behaviours with women survivors by four interviewees

Some therapists were concerned about shutting down the therapeutic process or scaring the client away from therapy Being non-judgmental in their approach was suggested as a strategy to reduce these risks, as this therapist said

> *I try to be very non-judgmental because a lot of these women have all the shame, blame and guilt heaped on them and they do it to themselves often as well* (Interviewee 6-126)

Another therapist suggested some examples of how to approach questions non-judgmentally

> *It's very important to remain non-judgmental and say, "Oh, what do you mean by that?" or "Has this happened?" or "What can we do to ensure that this doesn't happen?"* (Interviewee 6-126)

Using indirect inquiry when exploring sexually inappropriate thoughts or behaviour was identified by 6 of the 22 therapists interviewed Several of the previously discussed strategies, such as normalizing, were applied to the indirect approach to exploring this sensitive topic With some therapists, the indirect approach was a stylistic preference For example, this therapist stated, *"I tend to beat around the bush with people and then they actually use the word 'offending' anyway So I think it's better if they come up with it themselves"* (Interviewee 5-111) Another therapist suggested the following approach to inquiring in the context of worries that the client raised

> *[Client statement] "I'm worried if what if I did this to someone " [Therapist responses] "Well, why would you worry about that? What makes you kind of worry about that?"* (Interviewee 13-66)

Indirect inquiry was commonly discussed within the context of 'normalizing' for exploring the sexually inappropriate thoughts or behaviour This therapist expanded on this concept as follows

what I would do is look at how history can repeat itself and talk to them about it in more generalities and see if anything comes up for them Being early exposed to arousal and things like that and how people sometimes do repeat learned behaviour and what they've had as role models I would try to make it as gentle as possible Sometimes these things can come up in our minds or in people's minds as thoughts and things like that making it more general rather than just, "are you doing this?" (Interviewee 15-33)

Another rationale for inquiring indirectly referred to the potentially negative influence that a specific line of questioning can have on a client For example, this therapist provided a strategy to avoid influencing the client's thinking

Sometimes the direct asking can plant an idea In fact, often it can So I avoid that as much as I can I'll say, "Is there anything else you want to tell me? What else? What else?" And, that's one strategy that often brings out stuff that they didn't intend to talk about I'd just like to say that getting the information is important, but therapeutically how you get it may be even more important And sometimes you just ask about it Other things you find out indirectly

(Interviewee 8-75)

Indirect inquiry was also positioned as an effective means of exploring this sensitive topic and providing a level of ambiguity to the discussion in order to create a non-threatening atmosphere This therapist offered the following indirect strategy

I will start off with a question like, "Why do you think that most sexual abuse seems to be perpetrated by males?" And then I try to find out how much they've thought about these things If not at all, then I ask more abstract questions

> *walking a balanced line between are you talking about me or are you talking about "people "* (Interviewee 9-71)

Indirect strategies were commonly identified as a bridge to moving toward a more direct line of inquiry about possibly sexually inappropriate thoughts or behaviour As this therapist suggested, "*Just get a bit more information even before I started to ask those more direct questions"* (Interviewee 17-81)

Using a direct inquiry approach was recommended by five interviewees As this therapist suggested, *"it has to be pretty direct and clear, otherwise you're not going to get a very direct and clear answer"* (Interviewee 13-66) Another therapist provided the following rationale for inquiring in a direct manner

> *I think being quite explicit in questioning would be important I would ask directly in terms of "Have you ever had any thoughts about sexual activities with children and have you ever acted on these thoughts?" so that women would be understanding what the question was as opposed to skirting around it Not only to model the talking about it, but also that they could understand what was being asked of them* (Interviewee 14-174)

This therapist offered a strategy for inquiring directly but with sensitivity

> *I try to form it in a way where they can say 'yes' or 'no' so that it's not seen as an aggressive interviewing technique* (Interviewee 9-71)

Another example of inquiring directly in the context of the woman's abuse experience was suggested by this therapist

> *"Has the reverse ever happened?" Has this ever happened that after being abused herself, does she ever feel that she wants to either reciprocate or she has*

fantasies about having sex with someone who might not want to have it with her (Interviewee 16-127)

Of the 22 interviewees, only two indicated that they routinely inquire about sexually inappropriate thoughts or behaviours with their women survivor clients, however, one other interviewee identified that as part of the intake process or initial interview in a mixed practice, she would routinely inquire about inappropriate sexual thoughts and behaviour with clients who reported a history of sexual abuse The web-survey also had the suggestion from three participants (not included in the interviewee sample) that routine inquiry should occur with all clients This therapist provided a rationale for inquiring routinely

I would ask that question in that initial part of the discussion, where it seemed appropriate, of course And then later on, guess what? It usually showed up again (Interviewee 2-93)

Almost half of the respondents (9/20), who do not routinely inquire, were very open to the concept of routinely asking or standardizing the question as part of their intake process They recognized that the question is normalized if it is asked as part of a standard process For example, this respondent suggested that if it became *"part of the whole intake process and [you] say these are all standard questions that we ask everyone, whoever calls doesn't feel like they are being pinpointed for that particular behaviour"* (Interviewee 19-150) Other respondents indicated

I think it should probably be something that is standardized I think it's something that I'm going to start including more in what I'm doing because I think that if it's something that you bring up with all your clients, it gives them a

chance to talk about it and it gives them a chance to understand that this is not something that I can't even bring up with my therapist (Interviewee 1-140)

As part of my intake process well if I did it like that, that would make it a more reasonable thing to do with the client, I think (Interviewee 21-103)

Some therapists were able to offer some suggestions about how to present the question in a standardized way For example,

I think what I would say is "I ask everybody this question because of the work I've done over the years There is nothing about you that's telling me I need to ask the question But I also know that you may not answer it because it's not comfortable, but just remember I may ask it another time, another day, or you could bring it up to me " Make it so that it's not focused on something that's visible about them (Interviewee 3-48)

One therapist suggested a resource for survivors of sexual abuse that incorporates questions related to inquiring about sexually inappropriate thoughts or behaviour and this therapist has used this resource as an assessment tool, although not routinely

it's not something that I go into with every client I go case by case The assessment that I have in mind covers a whole wide range of issues around sexual abuse and it's just one or two questions on it that directly ask about abuse of other people "Surviving Childhood Sexual Abuse Workbook" by Carolyn Ainscough and Kay Toon (Interviewee 1-140)

Having the questions within an assessment tool seemed to legitimize the presence of the question and therefore, legitimize the asking of the question

In summary, the strategies for inquiring focused on approaching the woman survivor with sensitivity and ensuring that the motivation for inquiring was to help her address all her issues within a non-judgmental and supportive relationship Interviewees noted that working on these issues with clients can impact the therapist personally The next section provides recommendations about what can be done to support the therapist's needs

Therapist Needs for Inquiring with Women Survivors

Over half of the therapists interviewed (13/22), provided recommendations regarding the needs of therapists when exploring sexually inappropriate thoughts or behaviour while counselling women survivors of sexual abuse These areas included education and experience, comfort with their own sexuality and sexual abuse issues, the use of supervision, and self care strategies

Increasing awareness and education about the potential for women survivors to sexually abuse children and adolescents, particularly for new graduates of any counselling program, were identified by nine of the therapists who provided recommendations One therapist suggested

> *I would certainly recommend getting some knowledge Knowing that [inquiring about sexually inappropriate thoughts and/or behaviour] is part of a sexual abuse treatment* (Interviewee 12-99)

For some of the therapists, the knowledge was as simple as knowing that women can sexually abuse others

I think a lot of "newbies", let's say, don't think that women do sexually abuse They think that it's only men So I think there is some room for training in that in terms of the potential for women also, for starters (Interviewee 15-33)

For other therapists, it was a matter of gaining more years of experience working with women survivors

I think that the ability to pick up these nuances is also an experiential thing as well When I'm five years into the profession, I might not have been picking up what I'm picking up now (Interviewee 17-81)

Overall, education to increase knowledge and gaining experience in the field both contributes to a greater understanding when counselling women survivors of sexual abuse As this therapist summarized

I think, like anything else, when you become more informed then you understand the connections, then you realize that people abused can be perpetrators as well (Interviewee 20-113)

Being comfortable with one's self and one's own sexuality was discussed by six therapists as an area of need for therapists working with women survivor clients One therapist said

I think the person working with them have to be so mature and so confident in their own sexuality and their own identity around sex and sexual abuse and also in the ability to provide the safe context for these unsafe subjects And I'm not talking about the age I'm talking about that confidence and that maturity and that true comfort with their own stuff around sexuality and what constitutes sexual abuse (Interviewee 11-67)

In order to achieve this level of comfort, this therapist suggested a process of learning to be more comfortable with asking the difficult questions

> *with a scary question you need to first become comfortable in yourself and then, the next scary part I needed to do was I needed to find somebody to practice with Somebody that I could say, I need to learn how to ask these questions and I wanted to get comfortable enough so that when I ask it, people don't think I'm a freak And so, saying to a colleague, this is the question I want to ask or these are the questions I want to ask* (Interviewee 2-93)

Other recommendations, particularly regarding supervision, were suggested by these therapists

> *For new people, they have to have good clinical supervision And they need to know there is a place to go to discuss this, because it's frightening* (Interviewee 3-48)
>
> *As a clinician, I'm sharing the experience with the client, so there could be all sorts of character transfer and stuff going on to me as a clinician I might do a process recording after I see the client, or I would use supervision* (Interviewee 17-81)

Supervision can include aspects such as this therapist recommended

> *I think we should always address those things that make us feel uncomfortable Look at that and see where are those feelings coming from and look at how we can change what we are doing to provide better service* (Interviewee 1-140)

Self-care strategies, including a strong network of support and appropriate supervision, were also recommended This therapist described the importance of self care for this issue as for any work involving sexual abuse

> *I think the same cautions that I would advise people for any enquiries about sexual abuse You have to make sure you are very comfortable with this issue, that you can talk about things that are dark and can be very distressing and that you, yourself, have an active support network for yourself And that you've dealt with your issues* (Interviewee 22-148)

By applying these recommendations to practice, therapists can become more confident and are able to indicate their ability as therapists to cope with and respond to the client's issues

> *I think it's important that [therapists] pick up on it, to ask I think it gives people freedom that even if they've never done anything and they've had thoughts and it disturbs them that they've had the thoughts, they'd at least be able to explore that so they can understand where that is coming from and how to deal with it I've let them know I'm not afraid [by asking the question] If I'm not afraid, they have the freedom to be open* (Interviewee 3-48)

In summary, all of the therapists interviewed indicated that they would explore inappropriate sexual thoughts and behaviour with children and adolescents with some clients in spite of the wide range of combined scores on the Therapist-Initiated Discussion scale and the Therapist Importance scale dimensions (see Table 20) The challenges associated with asking women survivor clients about inappropriate sexual thoughts and behaviour, however, remains a dilemma for some therapists The

interviews offered a continuum of opinion about when or under what circumstances it is appropriate to inquire, at one end of the continuum were therapists who wait for the client to initiate the discussion and at the other end were therapists who report they routinely inquire with every woman survivor client The process of the interview and participation in this research study elicited considerations of change in practice for some therapists for whom it had never occurred to consider the potential that their women survivor clients may be struggling with inappropriate sexual thoughts and behaviour The interviewees identified several recommendations and strategies regarding how therapists could best inquire with their clients about such a sensitive topic In addition, the need for further education for therapists was identified

The data, therefore, points towards strategies that may encourage a change in how therapists think about and interact with women survivor clients Therapists' handling of this issue can be shifted by training and education that encourages therapists to maintain awareness and recognition of potential risks for possible sexual boundary crossing with children and adolescents by their survivor clients A recommended strategy to create the environment for exploration of this difficult topic was routine inquiry about inappropriate sexual thoughts and behaviour involving children with all survivor clients This strategy would normalize the process of inquiring during assessment and thereby reduce the risk of the survivor client reacting negatively to the question Admittedly, changing to this way of practicing will pose legal risks for the woman survivor client if she responds positively to a question about having engaged in inappropriate behaviour Concern about this risk must be balanced with the importance of ensuring children are not at risk of abuse, similar to the issues raised by the duty to report any risk of abuse or harm to a

child that therapists become aware of within the therapeutic relationship Concern about the risk should also be balanced by recognition that talking about and sharing thoughts about sexual behaviour with children or youth and even disclosing actual abusive behaviour to a therapist can, in the long term, if handled sensitively, benefit the survivor by encouraging and supporting increased self-understanding, self-acceptance, and change in the level of risk

Discussion

The overarching research question focused on whether or not therapists who work with adult female survivors of CSA address the possibility that some of these women may have engaged or could be at risk to engage in sexually inappropriate behaviour with children and/or adolescents The research question was addressed with a mixed-methodological sequential approach that began with a web-based survey that inquired about therapists' beliefs about, definition of, and practice experiences with women survivors of CSA Additionally, a subgroup of the therapists who responded to the survey was also interviewed via telephone to inquire further about their practice beliefs and practice experiences with women survivors of CSA

This chapter begins by integrating the discussion of hypotheses supported by statistically significant results and the qualitative findings Following the discussion of the findings is a discussion of the theoretical and practice implications in relation to the literature Concluding the chapter is the identification of the limitations of this research and suggestions regarding future areas of study that could extend or clarify the findings and a final summary

Interpretation of Findings

Whether or not therapists who work with women survivors of CSA create the space to discuss potential inappropriate sexual thoughts and behaviour with their survivor clients was addressed both quantitatively and qualitatively These findings are integrated and presented thematically Hypothesis 1, which addressed the primary focus of this research, was The majority of therapists who work with women survivors of CSA do not create space for discussion of potential sexual boundary crossing or sexually

inappropriate behaviour with children and adolescents The three two-item scales that constituted the Therapist-Created Climate dimensions were designed to assess whether or not therapists created the space needed to discuss these thoughts and behaviours with their survivor clients The overall combined percentage score (45%) for all dimensions included in the Therapist-Created Climate supported this hypothesis in that just over half of sampled therapists were not creating this space according to their self-reports Although the findings supported the hypothesis, it was expected that an even lower percentage of therapist scores would result given the minimal emphasis on inquiring about inappropriate sexual thoughts and behaviour that was found in the women survivor treatment literature (as outlined in Table 1)

The qualitative findings and survey comments offer information that can be interpreted to suggest that this lack of creating space may not be necessarily intentional, but rather due to a lack of knowledge (e g , did not know how to ask the question) or based on mistaken assumptions or beliefs (e g , the client will leave therapy) The qualitative findings indicated that, for some therapists, it just never occurred to them to discuss sexually inappropriate thoughts or behaviour involving children with women survivor clients Comments from the survey also suggest that, in the process of completing this survey, some respondents found themselves reconsidering how they practice with women survivors Thus, the data indicates some openness among participants to including such a discussion and explains how therapists appear to be more likely to create a climate for inquiring than was anticipated

The probability of creating a climate for inquiring appears to have a relationship with the therapists' practice experience The therapists' practice experience with women

survivors was correlated with all three dimensions of the Therapist-Created Climate (Client-Initiated Discussion, Therapist-Initiated Discussion, and Therapist Importance scales) Thus, the more experience therapists had in the field of working with women survivors of CSA, the more often they reported the likelihood of experiencing client-initiated disclosure, the likelihood that they would initiate discussion of sexually inappropriate thoughts and behaviour involving children and adolescents, and the more they agreed that it was important to inquire about these thoughts and behaviours These results were substantiated further by comparing Pilot Study results (based on MSW Student participation) with the Full Study results The MSW student participants in the Pilot Study clearly reported having less experience in counselling women survivors of CSA, although they were not necessarily younger in age in comparison to the Full Study participants That is, the findings from the Full and Pilot Study comparison support the notion that, regardless of the therapists' age, the more experience they had providing counselling to CSA survivors, the more likely they will be to initiate discussion with their survivor clients about possible risky sexual thoughts and behaviours involving children and adolescents

A key finding was the apparent discrepancy between the therapists' stated ideals and their description of their actual practices in relation to whether or not they create space for discussing potential inappropriate sexual thoughts and behaviours with women survivor clients While the overall score (45%) for all three dimensions included in the Therapist-Created Climate supported Hypothesis 1, it is also important to consider how each of the scales contributed to the overall Therapist-Created Climate independently Two of the scales, Therapist-Initiated Discussion and Therapist Importance,

demonstrated that 60% of therapists indicated a likelihood that they would initiate a discussion with their clients and 70% of therapists surveyed agreed that directly inquiring about inappropriate sexual thoughts and behaviour was important, however, only half of the interviewed therapists had actually inquired with at least one client and only two of these therapists had done so routinely In addition, the interviewed therapists and comments from survey respondents overwhelmingly identified (compared to the benefits) more risks to the client, more risks to the therapeutic relationship, and more discomfort with the idea of their women survivor clients engaging in sexual abuse of children This discrepancy between therapists' ideals and actual practice may not be reconciled easily given the complexities and risks associated with deciding whether or not to inquire about inappropriate sexual thoughts and behaviour

For about a quarter of the therapists who were interviewed, the ideal way to approach this issue was for clients to initiate the discussion or a disclosure They referred to being 'client-led' or 'client-directed' and, therefore, they have not inquired or may be unlikely to inquire because of this theoretical position Only four of the therapists interviewed (35%) had actually experienced clients disclosing sexual thoughts or behaviour involving children This was consistent with the Client-Initiated Discussion scale results which revealed that 35% of the survey respondents believed that clients would disclose risky sexual thoughts or behaviours about children to them without being asked Research indicates that relying on the client to raise the issue within therapy does not address the potential risk for children sufficiently given the prevalence of CSA reportedly committed by women (e g , Briere & Elliot, 2003, Fallon et al , 2005)

Interestingly, the Client-Initiated Discussion scale was correlated with the age of the therapist in that the older the therapist, the more likely s/he thought clients would initiate a disclosure about their thoughts or behaviour involving sex with children or adolescents, however, age was not correlated with Therapist-Initiated Discussion or Therapist Importance scales This finding suggests that an older therapist may have experienced more client-initiated disclosure about sexually abusive behaviour or related thoughts than younger therapists It is not possible to know whether this correlation is based on the older therapist having seen more clients overall or whether the older therapist may be more able to create a therapeutic climate that is conducive for clients to disclose such a difficult issue

Creating an atmosphere for client-initiated disclosure poses many challenges and in this researcher's opinion it is unrealistic to expect client-initiated disclosure regardless of the atmosphere created by the therapist Clearly, other issues, such as the therapist's (dis)comfort, may impede the creation of an atmosphere for discussion of potential inappropriate sexual thoughts and behaviour Of great importance, according to some interviewees, was their own apprehension about hearing the response from the client and then needing to report this behaviour to child welfare authorities Some therapists suggested that it is more comfortable and safer (for therapists) to avoid exploring the client's potential for sexually abusing a child Essentially, the message was that by not asking the questions, the therapist does not have to deal with the answers from both a professional and personal perspective These findings appear to support the argument that many therapists may not create the space needed to discuss potential sexually

abusive thoughts and behaviour with women survivors even though, in principle, they may believe it to be important

On the other hand, several therapists recognized that if they do not inquire and the client is engaging in sexually abusive behaviour with a child and/or adolescent, this child remains at risk of further harm The possibility that children are currently at risk of abuse was identified as a compelling reason for inquiring by all interviewees, however, some interviewees acknowledged that this risk was not often considered during interaction with their women survivor clients It seems apparent from both the findings about ideal and actual practice, and the statements regarding the lack of risk, that appropriate assessments of the risk do not occur because of the reliance on the therapist's judgment of the degree of risk without direct exploration If a therapist perceives that women are rarely sexually inappropriate with children and a woman survivor is very unlikely to 'do to a child' what had occurred to her, such a therapist is unlikely to assess the situation as a high risk This approach to thinking about a client situation could be comparable to assuming a client presenting with some depression is not suicidal without asking the question or exploring this potential risk

Given the discomfort that the therapists identified with initiating discussion and the concerns about reporting, it was expected that therapists would be more likely to initiate discussions about risky thoughts than about risky behaviour because of the reporting requirements with regard to actual behaviour In most cases, therapists would not be required to report to authorities about sexually abusive thoughts that the client may have identified Surprisingly, when comparing whether therapists indicated stronger likelihood to inquire about thoughts rather than behaviour, no significant differences were

found The Client-Initiated Discussion scale scores were the only exception to these findings comparing thoughts versus behaviours Survey respondents indicated that clients were more likely to disclose their sexually abusive thoughts about children rather than their behaviour This result appears to support the expected outcome, which was based on reporting requirements for professionals regarding behaviours rather than thoughts, although only from the anticipated client behaviour perspective

In addition to needing a good reason to inquire, such as a compelling cue or an indicator of imminent risk of abuse for children, many of the interviewees indicated that determining that the client was ready before asking the question was important, however, readiness was not easily defined by the interviewees For many interviewees, established rapport was identified as an indication that the client is ready to hear the question or have the discussion and was perceived to reduce the risk of the client reacting negatively to any inquiry The telephone interview participants also commented that rapport allowed the therapist to have a better understanding of the client's general functioning and reaction to the therapy However, some interviewees based their judgment of the client being ready on the client's initiation of the discussion As previously noted, the findings (qualitative and quantitative findings regarding client-initiated discussion) suggest that therapists are not creating space for discussing potential sexually abusive thoughts and behaviour involving children and adolescents if they are relying solely on the client's initiation of the discussion

The creation of a climate to support this difficult discussion can also be impacted by how the therapist defines CSA, particularly when it pertains to perpetration by women Hypothesis 2 stated The therapist's overall CSA Definitional Orientation will

predict the Therapist-Created Climate, the more conservative (the more strongly a therapist agreed the vignettes represented CSA) the Definitional Orientation, the more likely the therapist will create space to explore sexually abusive thoughts and behaviour with children and adolescents Defining CSA according to the vignette descriptions was identified as challenging for the survey respondents They inserted 38 comments specific to this challenge Similar to Okami (1995) and Portwood (1999), most of these comments suggested that more context was needed to assist in their decision, and that the results must be interpreted cautiously Nonetheless, how the vignettes were rated provided some important information about the therapists' definition of CSA The analysis supported this hypothesis, revealing a significant positive relationship between how conservatively the therapist defined CSA and how important he or she thought it was to inquire, thus, the more agreement that the survey vignettes represented CSA, the more important the respondents rated asking women survivors about their sexually abusive behaviour with children and/or adolescents

Although there was a significant relationship between the therapists' Definitional Orientation (as organized into Ordinal Definitional Orientation groupings, i e , conservative, moderately conservative, and liberal) and the Therapist Importance scale, the relationship between the Ordinal Definitional Orientation groupings and Therapist-Initiated Discussion scale was not significant These differing results may again be associated with differences between the philosophical beliefs and attitudes of the therapists and what the therapists may be prepared to do in practice As stated previously, only half of the respondents who were interviewed reported having actually initiated a discussion about sexually abusive thoughts and/or behaviours with at least one

women survivor and only two of them initiated this discussion routinely As well, the identified concerns and risks to inquiring suggest a strong hesitation to engage in the discussion, regardless of how the therapist defines an abuse vignette

The gender of who perpetrated the abuse may also impact how therapists define CSA and, subsequently, whether or not they create an atmosphere to discuss any potential for abuse by women survivors Hypothesis 2 a explored the role of gender in defining abuse Therapists will be more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constitutes CSA This hypothesis was supported by survey data showing that the participants were more likely to believe that male-perpetrated abuse rather than female-perpetrated abuse constituted CSA Therefore, the significant difference in definition of CSA based on the gender of the perpetrator suggests that gender biases may be a factor contributing to therapist behaviour in work with women survivors of CSA This result differs somewhat from Portwood's (1999) findings, she found that gender was less of a factor (20^{th} out of 21 factors) than actual physical/psychological harm (first/second) or sexual nature of the act (third) in defining CSA across the vignettes in her study The comparison of this study to Portwood's is limited by the lack of other similar comparators and the Portwood study contained substantially fewer vignettes that represented both male and female-perpetrated sexual abuse (only three pairs versus seven pairs in this study) To summarize, there was a significant difference in how strongly survey respondents agreed that male-perpetrated abuse scenarios constituted CSA compared with the female-perpetrated abuse scenarios suggesting that therapists who work with CSA survivors have gender biases similar to

those sampled in other studies (e g , Denov, 2001, Etherington, 1999, Fromuth & Holt, 2008, Lawson, 1993, Nelson, 1994, Rogers & Davies, 2007)

Furthermore, the current study investigated the gender differences in more detail by comparing the seven matched vignettes The next hypothesis (2 b) guided this analysis The therapists' belief about the appropriateness of the behaviour indicated in the matched vignettes assessed by the Definitional Orientation scale will differ according to the gender of who perpetrated the behaviour The comparison on a vignette by vignette basis found that five of the seven vignette pairs were rated as significantly different with male-perpetrated behaviour representing more agreement that the vignette constituted CSA when compared to the same vignette with female-perpetrated behaviour

The two vignette pairs that were not significantly different according to the gender of the perpetrator represented the most sexually explicit behaviour scenarios (watching pornographic videos with a teenaged step-child and having sexual relations with a teenaged neighbour) and were deemed as equally abusive regardless of gender More specifically, the current study found a strong consensus that viewing pornographic videos with a teenaged step-child and an adult having intercourse with a teen neighbour constituted CSA These findings support previous research Bensley et al (2004) found that having intercourse with a child and showing a child pornographic material resulted in 99 8% (intercourse) and 96 1% (pornography) consensus that the behaviours were abusive, however, in this study perpetration gender was not varied in the vignettes Similarly, Portwood (1999) found that participants rated sexual intercourse with a child and showing pornography to a child as more definitively abusive than other behaviours Essentially, the findings regarding the two situations of intercourse and pornography with

children are consistent with Bensley et al (2004) and Portwood (1999) in that there was consensus as to the inappropriateness of these behaviours Both this current study and Portwood (1999) found that defining these particular behaviours was not associated with the gender of the person who perpetrated the behaviours

The qualitative findings, again, suggest there may be a difference between what therapists believe is ideal practice behaviour and what they actually do in practice, based on the gender of the survivor and in relation to the gender of the perpetrator The qualitative findings indicated that respondents acknowledge that women do sexually abuse children and adolescents, but there remains a reluctance to accept this as fully as they do with respect to men Some interviewees indicated that they would practice differently with male survivors Exploring the differences between how therapists practice with male survivors versus female survivors was beyond the scope of the survey and only briefly explored in the qualitative interviews These findings, therefore, cannot be generalized to how therapists work with male survivors

Overall, the data demonstrates that therapists seem to be more open to creating space for exploring inappropriate sexual thoughts and behaviour than anticipated However, the data also leaves one questioning whether the openness reported may reflect a difference between the philosophical beliefs of participants and their actual practice behaviour The expressed concerns, cautions, and risks in relation to inquiring by the interviewees suggest that although many agree philosophically that inquiring is the direction to which they believe they should shift their practice, actually following through on this belief would be challenging and would not necessarily occur

Theoretical Implications

Two theories influenced the focus of this research Although no one theory explains the sexual abuse of children and adolescents by women (Peter, 2009), Bandura's (1973) social learning theory provides a framework for understanding why sexual abuse committed by females may occur Finkelhor and Browne's (1984) traumagenic dynamic of traumatic sexualization was also included as an extension of social learning to support this framework Additionally, the post-modern feminist theoretical perspective provides a context that honours women's agency, sexuality, power, and the influence of patriarchy, while challenging the conventional feminist position of situating women as "victims only" and recognizing the existence of multiple realities and truths (Atmore, 1999a, Fitzroy, 2001, Hetherton, 1999, Lamb, 1999, Pollack, 2000, Renzetti, 1999, Robinson, 1998) This theoretical perspective guided the choice in methodology, the use of language and approach with the survey and subsequent interviews, as well as the balance between respecting the "victim" position of women survivors and therapists with regard to CSA who support this view, and inviting and exploring other perspectives and opinions of therapists and women survivors

Some respondents who were interviewed appeared to make their practice decisions based on an underlying belief that women rarely sexually abuse children and adolescents, contrary to a social learning theory perspective, even though the survey results indicated that respondents do recognize and acknowledge that some women do sexually abuse children and adolescents These underlying beliefs appeared to be influenced somewhat by more traditional feminist principles, such as males being

primarily responsible for the abuse of women and children including CSA, however, this was explicitly articulated by only two interviewees

One of the most common characteristics of women who have committed sexual offences against children is a past history of severe sexual abuse (Davin, 1999, Dunbar, 1999, Gannon & Rose, 2008, Grayston & De Luca, 1999, Hislop, 1999, Johansson-Love & Fremouw, 2006, Lewis, & Stanley, 2000, Mathews et al , 1997, Saradjian, 1996, Strickland, 2008, Tardif et al , 2005, Vick et al , 2002) This characteristic identified within the current research literature, as well as the study by Christopher et al (2007) support the social learning theory tenets, in that CSA experiences can influence subsequent adult behaviour Similarly, some respondents indicated their belief that early learning can influence women survivors to the extent that sexually abusive behaviour can become an issue for some women

One therapist interviewee described sexually abusive behaviour as falling within the "bell curve", that there are extremes of sexual offending and no sexual offending for women, but most offending by women would be placed somewhere in the middle and constitute some of the boundary crossings or more ambiguous sexual behaviours that are not easy to define or clearly established as sexual offending behaviour Bandura and Walters (1963) described cases where mothers were sexually seductive, sleeping in the nude and showering with their teen-aged children, while positively reinforcing the sexual interactions with affection, however, they did not define these behaviours as 'abuse' but rather as "modeling of atypical patterns of sexual behaviour" (p 160) The complexities of recognizing and defining sexually abusive behaviour perpetrated by women as identified in this study align with the original social learning theory (Bandura, 1973,

Bandura & Walters, 1963) and are extended by the later social cognitive theory perspective on gender (Bussy & Bandura, 1999)

Research about the attitudes and beliefs about female sexual abuse suggests that, although professionals recognize that female-perpetrated sexual abuse does occur, their level of belief and practice decisions indicate that they respond in a less serious manner to issues pertaining to female-perpetrated sexual abuse (Conte et al , 1991, Gore-Felton et al , 2000, Hetherton & Beardsall, 1998, Tedford, 2004) The therapist questionnaire investigated how strongly therapists agreed with the belief statements that "only men abuse" and "women do not abuse" The lack of agreement with these belief statements suggests that therapists are more open to believing that CSA is committed by women than previously indicated in the literature Hypothesis 3 examined these two belief statements as assessed by the Therapist-Created Climate scales, which resulted in findings somewhat similar to the findings of Gore-Felton et al (2000), and Hetherton and Beardsall (1998) The therapists' rating about the importance of asking and the likelihood that women survivor clients would disclose and that the therapists would inquire with women survivors of CSA about inappropriate sexual thoughts and behaviour involving children and adolescents were not associated with what they believed about male- or female-perpetrated sexual abuse

The finding that therapists were more open to believing that women do perpetrate sexual abuse than what has been reported in the literature elicited questions about how the traditional feminist position of women as "victims only" would impact the findings of this study The survey findings revealed a difference in the beliefs of therapists in private practice compared to therapists who worked for an agency Private practice therapists

disagreed that "only men sexually abuse children" more frequently than agency-based therapists, which suggests that the traditional feminist position regarding beliefs about men being primarily responsible for victimization of children may be more influential with therapists working in agency settings Although this appears to be logical given that many of the agencies represented in the study were sexual assault centres rooted in conventional feminist theory, it is also noted that the mean scores for both the private practice and agency-based therapists fell within the disagreement range and the difference is likely due to a Type 1 error

Apart from the belief statement results, some of the interviewee statements about the perception of agency direction with respect to women survivor clients are particularly reminiscent of the generalizations about women being "victims only" that has been challenged in the literature by several authors (e g , Atmore, 1999a, 1999b, Featherstone, 1996, Fitzroy, 2001, Hetherton, 1999, Lamb, 1999, Pollack, 2000, Renzetti, 1999, Robinson, 1998) This position appeared to surface somewhat indirectly from explicitly stating a "victims only" position with the interviewees who acknowledged that their personal theoretical stance and as well as agency policy may create barriers to inquiring about inappropriate sexual thoughts and behaviour For example, participants said that being "client-directed" in their approach to therapy or an agency policy that asserts that males are primarily responsible for the sexual abuse of children was a reason why they would not ask about these issues with their survivor clients

That therapists identify as being "client-led" or "client-directed" has theoretical implications that require consideration The interviewees described this as a way of practicing in the context of why they do not inquire about inappropriate sexual thoughts

and behaviour, however, they were not explicit about referring to Carl Rogers' (1970) "client-centered" therapy or any specific theory Nonetheless, this raises a concern about how therapists use theory somewhat vaguely as a reason for not addressing an issue with clients in therapy, it seems similar to the way some therapists may use traditional feminist ideas without being completely aware that they are doing so

In summary, the theoretical implications of this study include support for Bandura's (1973) social learning theory framework for understanding sexual abuse committed by women A post-modern feminist perspective was applied to the methodology and understanding of women survivors of CSA from a broader perspective than traditional feminism These theoretical lenses underpinned an interpretation of the findings that both challenged and supported the literature, particularly regarding the definition of what constitutes CSA, gender biases, and the use of client-directed therapy principles of practice

Implications for Practice

Several implications for practice emerge from this study The implications range from the role of the therapeutic relationship and expectations regarding disclosure to specific strategies for approaching discussions with women survivors of CSA about inappropriate sexual thoughts and behaviour Education and training for therapists regarding the topic of women committing sexual abuse would also be recommended

Emphasis on the importance of creating a sense of safety in the therapeutic relationship, as rooted in humanist theory and particularly in Rogers' (1970) client-centered therapy, was repeatedly identified as a condition for inquiring with women survivors about inappropriate sexual thoughts and behaviour involving children,

however, creating this safety in the relationship and also asking such a difficult question clearly presents a complex practice problem for many therapists One participant suggested that asking the question put the therapist into a dual role – one of protecting children and the other of being a therapist Gilbert et al (2009) found that many professionals may determine that the harms of reporting outweigh the benefits of reporting child maltreatment as a rationale for the under-reporting that clearly occurs in comparison to the maltreatment identified in self-reports by families in community surveys For many of this study's interview participants, it appears that having the duty to report possible CSA committed by a client in therapy is an enormous dilemma and one that many prefer to avoid, which is consistent with Gilbert et al 's findings This dilemma, referred to as the "double-edged sword," recognizes that the therapist has a responsibility to provide appropriate treatment to the survivor client but also to protect any children at risk of abuse, this dilemma is not easily reconciled because of the potential for severe consequences for the survivor client and the likely negative impact this would have on the therapeutic relationship

In addition to the reporting dilemma, wanting to maintain a positive therapeutic relationship was also identified as a rationale for not inquiring in conjunction with the "client-led" approach to counselling practice One interviewee stated that she believed that because of the positive rapport she experienced with her clients, any thoughts or behaviours related to sexually abusing children would have been reported to her by her clients if such were occurring As well, some therapists identified being "client-led" in their way of practicing and that was their rationale for not initiating the discussion with clients Both of these arguments for not asking about risky sexual thoughts or behaviour

with children were based on an assumption that if the woman survivor client is struggling with inappropriate sexual thoughts and behaviour involving children, she would disclose this issue to the therapist These interviewees are clearly relying on the client to bring this difficult and complex issue forward, and did not see themselves as responsible to initiate the question or discussion These therapists apparently believe that if a therapist experiences good rapport with a client, the client will be able to overcome the enormous fear, shame, and stigma that would likely be associated with having had these thoughts or acting on them and initiate the needed discussion

This researcher would argue that female survivor clients are very unlikely to initiate disclosure of sexually abusive behaviour and that this argument has considerable empirical support Research indicates that only a very small proportion of survivors will initiate disclosure to counsellors and other health professionals about being *victims* of sexual abuse if they are not asked According to Read, McGregor, Coggan, and Thomas (2006), only 15% of the women survivors they surveyed had disclosed their past sexual victimization to a counsellor and they concluded that women survivors took an average of 16 5 years after occurrence to disclose their past abuse experiences In addition, Read, Hammersley, and Rudegeair (2007) reported only 6% of psychiatric in-patients had initiated disclosure about their past sexual abuse without being asked compared to 47% of psychiatric in-patients who had disclosed after being asked about past abuse

Furthermore, Follette, La Bash, and Sewell (2010) found that when issues convey an element of stigmatization, clients may be less likely to discuss these issues with therapists Being a *victim* carries less stigmatization than being the *perpetrator* of CSA Women who sexually abuse children or have thoughts about this behaviour are clearly

stigmatized by society in that their sexually abusive behaviour is often perceived as unbelievable or considered more abhorrent than sexual abuse committed by men (Allen, 1990, Denov 2003, 2004, Ford, 2006) These stigmatizing attitudes can extend to counselling professionals and the therapeutic climate they create For example, O'Leary and Barber (2008) indicate that male survivors of CSA are less likely to disclose their past abuse to counselling professionals than female survivors of CSA because of the attitudes of professionals that under-recognize the sexual victimization of males This type of reasoning could also be extended to explaining why women may be reluctant to initiate discussion with therapists about their potential sexual thoughts and sexually abusive behaviours involving children Considering the societal disbelieving and stigmatizing attitude regarding the possibility of sexual abuse of children by women (e g , Allen, 1990, Denov, 2003, 2004, Ford, 2006), the idea that a woman survivor will initiate disclosure of sexually abusive behaviour and/or thoughts about sexually abusive behaviour with children to a therapist appears to be highly unlikely as reflected in the results regarding client-initiated discussion

As noted in the literature review, the content of existing guidelines for treating women survivors of CSA may also offer some explanation regarding therapist resistance to inquiring with women survivors and preference for client-initiated discussion Very few authors provide guidelines or even recommend that the therapist should initiate a discussion of thoughts about sexually abusive behaviours and/or actual sexually abusive behaviours with women survivor clients (see Table 1) Even those who provide a statement about inquiring (e g , Aincough & Toon, 2000a, 2000b, Bass & Davis, 1988, Davis, 1990, Drauker, 2000), discuss the topic minimally and tend to simply list it in the

assessment or checklist type tools Only Engel (2005), who focuses on the risk of intergenerational transmission of abuse throughout her text, and Sanderson (2006) emphasize the importance of discussing the potential for sexually abusive thoughts and/or actual sexually abusive behaviours

It seems reasonable to assume that therapists who are more open to the possibility of women sexually abusing children and/or adolescents would be more likely to create a climate that promotes client-initiated disclosure about sexually abusive thoughts and behaviour with children and adolescents, initiate the discussion with their clients, and more strongly agree with the importance of asking this question On the other hand, the idea that it might be wise to inquire about sexually abusive thoughts and sexually abusive behaviour involving children and adolescents with women survivors is a relatively new idea For example, Oliver (2007) only quite recently reviewed literature based on what was known about female sexual abuse and recommended prevention strategies, such as supporting women survivors of sexual abuse more substantially by attending to cues that may suggest risk of abusing children and by acknowledging this potential with women survivors Similar suggestions were made in the unpublished manuscript by Hovey and Stalker (2005), however, a review of literature reveals that no other research has identified these suggestions as a recommended approach to intervening with women survivors with the exception of Engel's (2005) intergenerational abuse treatment focus and Sanderson's (2006) discussion about risk assessment if the woman were to initiate discussion of worries or concerns about sexual thoughts involving children

The participants who were interviewed provided several recommendations and suggestions for inquiring about high-risk sexual thoughts and sexually inappropriate

behaviour involving children and adolescents Underlying these suggestions is the assumption that, prior to engaging in any assessment or treatment with clients, the therapist must be clear with the client about the limits of confidentiality The interviewees provided several ideas about how to create an atmosphere for disclosure along with examples of how to phrase the questions in a sensitive manner These suggestions are categorized as follows ensuring understanding, normalizing the behaviour, using a context, indirect inquiry, direct inquiry, and routine inquiry

The emphasis on ensuring understanding assumes the therapist's ability to create an atmosphere of safety where the client is able to express herself completely without fear of judgment The therapist must be able to communicate the ability to accept whatever disturbing or difficult material the client brings to the session The underlying message to client should be that whatever she brings to therapy, the therapist will be able to work with her in a caring and sensitive manner In addition, the therapist must be able to facilitate a process by which the client is able to gain self-understanding and insight regarding her disturbing thoughts or behaviours

Normalizing is a strategy that informs clients that it is not uncommon for inappropriate sexual thoughts or behaviour to occur in light of their past experiences The intention of posing a question about inappropriate sexual thoughts or behaviour within a context of having normalized such experiences is consistent with Bandura's (1973) social learning theory because it provides the survivor with a plausible and possible explanation as to why this behaviour might occur rather than interpreting the behaviour as simply rooted in evil or insanity Participants believed that such an approach would be perceived by clients as less accusatory or judgmental and more sensitive The following statement

and question (similar to the participant's suggestion) could be used "In my counselling practice with survivors, I have found that some survivors of sexual abuse have subsequently abused others I am wondering if this is something you are worried about or if something like this has happened with you "

By using a context, the therapist provides some form of rationale for why s/he would be inquiring about such a difficult topic Examples of contexts that might be used to preface the question would include worries about their own children, fears about parenting, or statements about behaviour that may be considered questionable The context could be introduced by the therapist as follows "When you [stated, acted] , it made me wonder about "

The most common approach to inquiring with women survivors discussed by the interviewees was indirect inquiry Interview participants were considerably more accepting of indirect methods of inquiry, as it "felt" less accusatory particularly if it turned out that the client had not engaged in an abusive behaviour By using an indirect approach, participants argued that the therapist is able to explore difficult topics without labelling the behaviour or *"plant[ing] an idea"* (Interviewee 8-75) Indirect inquiry was often described as a first step before moving towards direct inquiry, for many of the interviewees indirect inquiry was perceived as less intrusive

Direct inquiry was a strategy recommended by five of the interviewees By being explicitly clear and direct, there was no concern about misinterpretation of the question or response The treatment literature that did include questions within the assessment tools used direct questions as well (Aincough & Toon, 2000b, Bass & Davis, 1988, Davis, 1990) Interviewees emphasized the importance of being sensitive in the direct approach

and this sensitivity was best communicated when the direct inquiry was approached from a context

Although routine inquiry was only reported as having been used by two of the interviewees, other interviewees also acknowledged the wisdom of this approach Similar to research findings reported by Read et al (2007), it was recognized that if therapists do not inquire routinely, clients will likely not initiate disclosure of such a difficult topic to discuss The strongest argument for routine inquiry is that it opens the door for possible discussion later by providing the client with the message that, by asking the question, you are willing to receive or hear the answer Ultimately, routine inquiry ensures that the client is not being singled out by the question because of some character flaw or underlying deviance that the therapist may perceive about her Again, using the context of a routine practice to introduce the question is recommended Therapists could use the following example

> As part of the assessment process, I need to ask you these next two questions that may be uncomfortable or unsettling for you and you may wish to not answer them today but I do ask everyone these same questions who come for counselling We will also take some time to talk about how you experienced these questions afterwards if you wish The first question Have you ever had any sexual thoughts about children or adolescents? The second question is have you ever touched a child or adolescent in a sexual way?

In addition to making this a routine inquiry, this example uses language that does not define the thoughts or behaviour as abusive This use of language is an application of recommendations made by authors regarding asking clients about experiences of

victimization (Read et al , 2007) Additionally, by avoiding the use of the word "abuse", one recognizes that sexual behaviour experienced in childhood may not have been experienced as abusive

Ultimately, the goal of inquiring about inappropriate sexual thoughts and behaviour is to ensure that the therapist is helping the client to talk about all experiences involving the "self", not just the parts that the client thinks the therapist wants to hear or the parts about which are easier to discuss Level of comfort with CSA was an issue that Day et al (2003) found to be related to mental health professionals' training and experience, these authors reported that with more training and experience working with CSA, the mental health professionals were more comfortable with the issue

In summary, the findings of this study clearly support the need for stronger attention within the curricula and training programs of future therapists regarding female-perpetrated sexual abuse and the importance of asking about it when conducting assessments of women clients, particularly women survivors of CSA Furthermore, by enhancing the education curriculum regarding sexual abuse issues to include female-perpetrated sexual abuse and information about the known characteristics of women who have perpetrated against children and/or adolescents sexually, the treatment literature about working with women survivors of sexual abuse may shift in focus This shift is necessary to encourage therapists to align their actual practice more strongly with their philosophical ideas about practice The recommended strategies support this shift in practice and support clients to explore all issues that impede their healing process

Strengths and Limitations of the Study

Several strengths and limitations of this study can be identified Beginning with the method, the mixed methodological design approach to this research was clearly a strength, as it can be argued that it enabled more accurate interpretation of the findings The qualitative findings were used to achieve deeper understanding and explanation of the quantitative findings Furthermore, the qualitative phase of the investigation allowed for inquiry about the details of actual practice experiences and this data served to supplement the limited information about actual practice acquired by the survey questions

The broad range in terms of age, counselling experience, educational background, and representation of areas across Canada of the survey participants and telephone interview participants were strengths of this study In addition, the sample included a stronger representation of the male therapist population than anticipated, given the focus of this study on counselling practice with women survivors of CSA and large number of female therapists in the counselling field and educational programs, it was expected that the sample would be predominantly female therapists This inclusive sample in terms of these demographics not only allowed for varied opinions but also affirmed that most beliefs, attitudes, and counselling practices about this issue are common regardless of education, training, therapist gender, or geographical location

On the other hand, the way in which the demographic information was collected was a limitation with respect to the lack of specificity in the questions For example, the region of Canada in which the participant resided was requested and categories were based on the organization of regions in the existing resource employed for recruiting

participants (National Clearinghouse on Family Violence, 2002) In retrospect, it would have been preferable and more exact to request the actual province or territory in which a therapist worked As well, education was based on level achieved (e g , BA, MA, PhD) rather than the discipline and degree (e g , PhD – Social Work) Specifying the discipline would have allowed some comparison, for example, between psychology and social work trained respondents

An overwhelming number of written comments within the areas of the survey inviting comments and the expressed desire to participate in the telephone interviews can be interpreted as meaning that participants were very interested in discussing and grappling with this controversial topic It may also indicate that participants recognized the importance of this study in terms of increasing therapists' knowledge about sexual abuse perpetrated by women Most comments followed the vignette section (60% of participants provided a comment) and some additional but fewer number of comments followed the Therapist-Created Climate dimension questions (35% of participants provided a comment) Additionally, the response to the invitation to participate in the telephone interviews was very positive with 35% of the survey respondents indicating an interest in the follow-up interview All of these responses have been affirming of the research focus and demonstrate a strong interest in spite of the controversial elements

An important strength of this study was the ability of the researcher to create an atmosphere of honesty and safety for the therapists to express themselves in the telephone interviews The interviews provided very informative and, at times, contentious or controversial responses, that enriched the findings Many of the interviewees responded to questions with an unexpected honesty, which suggests that the participants felt a sense

of safety in order to take risks in their responses The interviewees were able to put into words many fears that may be experienced by therapists, but are often not acknowledged For example, several therapists were able to acknowledge that they were uncertain about their own potential response to hearing from a woman survivor client that she has sexually abused a child, similarly several interviewees were able to admit that they might not 'ask the question' in order to avoid reporting requirements (consciously or unconsciously), as found by Gilbert et al (2009)

The atmosphere of safety created for interviewees combined with the use of direct questions and questions with follow-up probes within the telephone interviews could be seen as a parallel to some degree with the climate or atmosphere required for inquiring about stigmatized behaviour with women survivor-clients Perhaps because the researcher presented difficult topics and questions from a non-judgmental, inquisitive, and genuinely interested and caring perspective, the participants were able to make relative 'disclosures' about behaviour that may be considered less than professional or ethical by the interviewees This experience provided some additional insights to the researcher about how sensitive topics can be approached, and may have been similarly recognized by the participants The researcher does recognize, however, that the consequences to responding honestly for the study interviewees do not carry the same gravity as does disclosing abusive behaviour with a child

On the other hand, a possible limitation was the inexperience of the researcher that may have inhibited responses by how questions were framed A seasoned researcher may have developed a stronger survey tool with more clarity in the phrasing of questions, specifically regarding the therapist practice questions (see Table 2 items 25-30) These

questions sought information from an anticipatory perspective by inquiring about the "likelihood" of initiating discussion or "likelihood" of the client-initiated discussion This phrasing restricted the information obtained to anticipated behaviour rather than the actual behaviour of the therapist The failure to ask specifically whether the therapist had actually inquired or the client had actually disclosed was a limitation and should have been phrased as "Have you inquired about potentially sexually abusive thoughts and/or behaviour with your women survivor clients? If so, how many times?" This question would have addressed the actual behaviour of the therapist rather than their philosophical beliefs about what they may do or should do in practice

As a result of this limitation, a cautious interpretation is required, only the qualitative interviews allowed for more detailed inquiry about the actual practice of the 22 therapists that were interviewed These qualitative results support the notion that the climate the therapists create that would support women survivors to talk about sexually abusive thoughts and behaviours may be one that is viewed as ideal rather than what actually happens in practice Moreover, hindsight from the analysis of the qualitative phase has highlighted the importance of having well-designed questions to guide the interview more intentionally, such as having some structured and standard questions from the onset of the interviews For example, it would have been useful to have structured questions about how often they had inquired with clients, details about the context of the inquiry, and when they inquired within the therapy process Perhaps a more seasoned researcher would have solicited more in-depth responses than were achieved within the interviews, but this would be merely speculation based on the inexperience Nonetheless, the survey questions certainly inspired the respondents to consider how they practice with

women survivors and may influence a shift from the ideal philosophical stance to one that is more likely to create space in actual practice for inquiring about sexual thoughts and/or behaviour with children and/or adolescents

Another limitation of this study was the comparison between the two groups The number of participants in the comparison group (Pilot Study n= 27) was considerably smaller than the Full Study group This limitation may have also affected the non-significant results between the two groups on the Client-Initiated Discussion and Therapist Importance scales In addition, the Pilot Study sample consisted of WLU MSW students only, whereas the Full Study sample was more educationally and regionally diverse

Overall, in spite of some limitations, the results of this study make a contribution to knowledge about female sexual abuse of children and/or adolescents and counselling practices with women survivor of CSA regarding the creation of an atmosphere or climate to assess and address the potential risk for these clients to engage in sexually abusive behaviour By increasing this knowledge and understanding, this study ultimately contributes to the prevention of further sexual abuse of children

Implications for Further Research

The findings of this study contribute to our practice knowledge by exploring how therapists work with a client population that is potentially at risk of engaging in abusive behaviour given the current knowledge about female sexual perpetration Although there is no clear causal link to perpetration, it seems reasonable to suggest that how we work with woman survivors of CSA may contribute to the prevention of female-perpetrated abuse (Hovey & Stalker, 2005, Oliver, 2007) Further research is required to understand

more fully how to prevent sexual abuse by females In addition, research that improves our understanding of the effects on women survivors that result from therapist-initiated discussions about high risk sexual thoughts and/or inappropriate sexual behaviour with children and/or adolescents is clearly indicated More specifically, a study that explored the effects on the therapeutic relationship of routinely initiating such discussions would be very useful

Other research could build on this current study by developing more specific questions about actual practice and by seeking input from women survivor clients about how they might experience a therapist-initiated discussion about potentially high-risk sexual thoughts and/or sexually abusive behaviour with children and/or adolescents by testing this practice Women survivors who have disclosed high-risk thoughts or sexually inappropriate behaviour with children and/or adolescents are also an important group on which to focus further study, a study that asked them about the conditions that prompted their disclosure could be very enlightening

In summary, the attention to the topic of female sexual perpetration has certainly expanded in the past ten years, however, more research is needed as our knowledge of this topic remains in its infancy As more information and knowledge is acquired, a shift in therapists' attitudes and beliefs will continue as has been demonstrated by this study Of further importance is the shift needed in counselling behaviour with women survivors that currently appears to fall short of what many therapists believe would be "best practice" Knowing that all therapists are trained adequately to provide a climate that allows women survivors to discuss openly and explore even the most taboo parts of themselves would be the ideal future outcome of this current study

Concluding Summary

Whether or not therapists create space for women survivors of CSA to explore their potential inappropriate sexual thoughts and behaviour was not an easy question to answer based on the findings of this study Overall, there was agreement that women do commit sexual abuse against children and these issues should be explored with women survivors of CSA The creation of this space to explore such a sensitive issue can have its consequences but these consequences should not impede responsible behaviour on the part of the therapist Several strategies were recommended to explore the issue with sensitivity for the woman survivor client Therapists clearly need ways to explore this issue that addresses the discomfort they may experience, limits the negative impact on the client and the therapeutic relationship, and promotes attention to the cues or indicators that may be presented in therapy Education and training to improve therapist knowledge and understanding of the needs of their clients where female-perpetrated sexual abuse may be an issue is important given that inexperience with the topic and with survivor clients will impact how likely therapists address the issue

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Appendix A Ethics Letter

LAURIER
Research

Friday, October 12, 2007

Angela Hovey
Department of Social Work
Wilfrid Laurier

Dear Ms Hovey

Re REB Reference 1612

Your Research Proposal Entitled, "An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse Do therapists ask about sexual thoughts or behaviour "

I have reviewed the changes (pilot survey) to the above proposal and determined that they are ethically sound

If the research plan and methods should change in a way that may bring into question the project's adherence to acceptable ethical norms, please contact me as soon as possible and before the changes are put in place

Yours sincerely,

B Marr, PhD
Chair, WLU Research Ethics
Board

cc C Stalker
N Coady

Office of Research Services
Wilfrid Laurier University, Waterloo, Ontario, Canada N2L 3C5
Telephone 519 884 0710 Ext 3130 Fax 519 884 1020 www wlu ca/research

Appendix B Email Invitation Letter for Individuals

Email Invitation Letter to Individual Therapists to Participate in Survey

Subject PLEASE PARTICIPATE IN THIS NATIONAL SURVEY

Have you worked with women survivors of childhood sexual abuse?
If you can answer YES, then you are invited to participate in an anonymous web-based national study titled An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse Do Therapists Ask About Sexual Thoughts or Behaviour with Children?
Principal Investigator Angela Hovey, PhD Candidate
Dissertation Research Chairperson Dr Carol Stalker, PhD

This email letter serves as the WILFRID LAURIER UNIVERSITY INFORMED CONSENT STATEMENT and includes a direct link to the survey at the end of this letter

This national study is exploring current therapy/counselling practices with women survivors of sexual abuse More specifically, this study will inquire how you as a therapist/counsellor work with the sexual issues of adult female survivors of childhood sexual abuse within your counselling role, as well as exploring some general questions about childhood sexual abuse This study is being completed by Angela Hovey in partial fulfillment of the requirements for the PhD in Social Work under the supervision of Dr Carol Stalker at Wilfrid Laurier University, Waterloo, Ontario

Your participation is completely voluntary and anonymous The survey is web-based, meaning that your response is NOT linked to your email address No information that identifies you, your email address, or your workplace will be disclosed as a result of your participation You may decline to participate without penalty at any time by closing the web page, however, most questions will require a response to continue through the survey The time required to complete the questionnaire is approximately 10-15 minutes The individual questionnaire responses will remain confidential and anonymous within the web-based site, therefore, follow-up emails will be sent to everyone on the initial mailing list to encourage participation All completed responses will be stored in a password protected computer/folder and any printed documents will be stored in a locked cabinet in the principal researcher's home office throughout the study until completion of the dissertation and any other products (publications, articles, presentations etc), and no longer than a period of 5 years Only the dissertation committee will have access to any raw data provided during this period of time

With the exception of a caution about some sexually explicit questions, there are no foreseeable risks to you or your agency for participating in this study

Your participation in this national study will contribute important knowledge regarding counselling practices with women survivors of childhood sexual abuse As a way to acknowledge your participation, a $2 donation will be made to Kids Help Phone at

http //www kidshelpphone ca/en/home asp for every completed survey Kids Help Phone is a reputable national charitable organization supporting efforts to address child abuse If you have questions at any time about the study or the procedures, or to receive a summary of the findings of this study, you may contact the principal researcher, Angela Hovey, at Wilfrid Laurier University, 1-519-589-8644, email hove7420@wlu ca or you may contact the Chair of my Dissertation Committee, Dr Carol Stalker, Wilfrid Laurier University, 1-519-884-1970, extension 5217

This project has been reviewed and approved by the University Research Ethics Board If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, 1-519-884-0710, extension 2468

By clicking on the link below and entering the survey, you agree to have read and understood the above information You also agree to participate in this study Completion and submission of the survey is considered an alternative to your signed consent and permission that your submitted information may be included with the data

http //www wlu ca/ahoveytherapistsurvey/TherapistQuestionnaire htm

The link will be available from January 30 through until February 20, 2008

PLEASE FORWARD this email participation request to colleagues that you feel could contribute to this research

Thank you in advance for your support with this national research project!

First Email Reminder

Subject REMINDER Please participate in this National Survey

Dear Colleague
Thanks to those of you who have already responded! Those of you who have not yet responded, this is the first of two reminders to invite you to participate in this national survey I have moved the link to the beginning for your convenience with the understanding that you have already reviewed the full contents of the email below
http //www wlu ca/ahoveytherapistsurvey/TherapistQuestionnaire htm

Final Email Reminder

Subject LAST REMINDER to Please Participate in this National Survey
Dear Colleague
Thanks to many of you who have already responded! Those of you who have not yet

responded, this is the LAST reminder to invite you to participate in this national survey before it closes at midnight on February 20th I have moved the link to the beginning for your convenience with the understanding that you have already reviewed the full contents of the email below
http //www wlu ca/ahoveytherapistsurvey/TherapistQuestionnaire htm

Appendix C Email Invitation Letter for Organizations

Email Invitation Letter to Organizations to Participate in Survey

Subject PLEASE PARTICIPATE IN THIS NATIONAL SURVEY

You are receiving this email invitation because your organization has been selected to participate in an anonymous web-based national study titled An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse Do Therapists Ask About Sexual Thoughts or Behaviour with Children?
Principal Investigator Angela Hovey, PhD Candidate, Wilfrid Laurier University
Dissertation Research Chairperson Dr Carol Stalker, PhD, Wilfrid Laurier University

PLEASE FORWARD this email to the MEMBERS in your organization who work with women survivors of sexual abuse

The following email letter serves as the WILFRID LAURIER UNIVERSITY INFORMED CONSENT STATEMENT and includes a direct link to the survey at the end of this letter

This national study is exploring current therapy/counselling practices with women survivors of sexual abuse More specifically, this study will inquire how you as a therapist/counsellor work with the sexual issues of adult female survivors of childhood sexual abuse within your counselling role, as well as exploring some general questions about childhood sexual abuse This study is being completed by Angela Hovey in partial fulfillment of the requirements for the PhD in Social Work under the supervision of Dr Carol Stalker at Wilfrid Laurier University, Waterloo, Ontario

Your participation is completely voluntary and anonymous The survey is web-based, meaning that your response is NOT linked to your email address No information that identifies you, your email address, or your workplace will be disclosed as a result of your participation You may decline to participate without penalty at any time by closing the web page, however, most questions will require a response to continue through the survey The time required to complete the questionnaire is approximately 10-15 minutes The individual questionnaire responses will remain confidential and anonymous within the web-based site, therefore, follow-up emails will be sent to everyone on the initial mailing list to encourage participation All completed responses will be stored in a password protected computer/folder and any printed documents will be stored in a locked cabinet in the principal researcher's home office throughout the study until completion of the dissertation and any other products (publications, articles, presentations etc), and no longer than a period of 5 years Only the dissertation committee will have access to any raw data provided during this period of time

With the exception of a caution about some sexually explicit questions, there are no foreseeable risks to you or your agency for participating in this study

Your participation in this national study will contribute important knowledge regarding counselling practices with women survivors of childhood sexual abuse As a way to acknowledge your participation, a $2 donation will be made to Kids Help Phone at http //www kidshelpphone ca/en/home asp for every completed survey Kids Help Phone is a reputable national charitable organization supporting efforts to address child abuse If you have questions at any time about the study or the procedures, or to receive a summary of the findings of this study, you may contact the principal researcher, Angela Hovey, at Wilfrid Laurier University, 1-519-589-8644, email hove7420@wlu ca or you may contact the Chair of my Dissertation Committee, Dr Carol Stalker, Wilfrid Laurier University, 1-519-884-1970, extension 5217

This project has been reviewed and approved by the University Research Ethics Board If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, 1-519-884-0710, extension 2468

By clicking on the link below and entering the survey, you agree to have read and understood the above information You also agree to participate in this study Completion and submission of the survey is considered an alternative to your signed consent and permission that your submitted information may be included with the data

http //www wlu ca/ahoveytherapistsurvey/TherapistQuestionnaire htm

The link will be available from January 30 through until February 20, 2008

Thank you in advance for your support with this national research project!

First and Final Reminders

Subject REMINDER Please participate in this National Survey

Subject LAST REMINDER to Please Participate in this National Survey

Dear Colleague,
Many thanks for the responses so far! The survey will close at midnight on February 20 so please encourage the members of your organization to participate Thanks again for any support you are able to provide!

Appendix D Email Invitation Letter for Telephone Interviews

Email Invitation Letter for Telephone Interviews

Subject: Follow up to National Survey you participated in

Hello *[Name]*,

Thank you for your participation in the web-based national study titled An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse Do Therapists Ask About Sexual Thoughts or Behaviour with Children?
Principal Investigator Angela Hovey, PhD Candidate
Dissertation Research Chairperson Dr Carol Stalker, PhD

You are receiving this email because you had identified an interest in participating in a follow-up 30 minute telephone interview within your web-based survey responses and have been selected for this portion of the research study I have outlined the consent information below according to the WILFRID LAURIER UNIVERSITY informed consent requirements

Please review the TELEPHONE INTERVIEW INFORMED CONSENT and respond to this email with the following information pertaining to the next several weeks

Telephone # to reach you
Can messages be left for you at the number you provided Yes No
Please identify the time zone you reside in
If you require a specific date and time, what date and time would work best?
If you have more flexibility,
Best day of week to reach you M TU W TH F SAT
Best time of day to reach you mornings afternoons evenings

TELEPHONE INTERVIEW INFORMED CONSENT

You are invited to participate in a brief telephone interview the purpose of which is to further exploring your response to the survey questions about therapist initiated discussions with women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents The telephone interviews will be conducted by Angela Hovey, principal researcher

Your participation is completely voluntary and no information that identifies you or your agency or will be disclosed, you may decline to participate without penalty If you decide to participate, you may withdraw from the study at any time without penalty If you withdraw from the study before data collection is completed your data will be destroyed The time required for the telephone interview is approximately 20-30 minutes The telephone interview responses will remain confidential and anonymous

You will be asked to have the telephone interview tape recorded to ensure an accurate account of your responses The tape recorded interviews will be transcribed The transcriber will hold all information in confidence You may ask that the tape recorder be turned off at any time during the interview No names or any identifying information will be included in the transcripts The tapes will be erased upon completion of the study The transcripts will be stored in a password protected computer/folder and the tapes and any printed documents will be stored in a locked cabinet in the principal researcher's home office throughout the study until completion of the dissertation and any other products (articles, presentations etc), and no longer than a period of 5 years Only the dissertation committee and external examiner will have access to any raw data provided during this period of time

The data will represent the findings of the interviews collectively with no names or any identifying information In the unlikely event that a quote or passage that potentially identifies you would be considered for the report, you will be contacted to review the passage or quote and it will only be included with your permission Confidentiality is strictly maintained, except as required by law

There are no foreseeable risks to you or your agency for participating in this study Your participation in the interview portion of this national study will expand on the survey information and contribute important knowledge regarding counselling practices with women survivors of childhood sexual abuse

If you have questions at any time about the telephone interview aspect of the study, the procedures, or to receive a summary of the findings of this study, you may contact the principal researcher, Angela Hovey, at Wilfrid Laurier University, 1-519-589-8644, email hove7420@wlu ca or you may contact the Chair of my Dissertation Committee, Dr Carol Stalker, Wilfrid Laurier University, 1-519-884-1970, extension 5217

This project has been reviewed and approved by the University Research Ethics Board If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, 1-519-884-0710, extension 2468

By responding to this email message, you agree to have read and understood the above information You also agree to participate in the taped telephone interview At the time the telephone interview is conducted, this informed consent will be review with you and you will be asked to provide verbal consent that will be tape recorded and considered an alternative to your signed consent

Thanks again for your interest in participating!

Follow-up Email Invitation to Telephone Interview

Subject: Follow-up to National Survey

Dear *[Name]*,
I sent an email on *[date]* following up with your positive response to the National Survey
An Exploration of Counselling Practices with Women Survivors of Childhood Sexual Abuse Do Therapists Ask About Sexual Thoughts or Behaviour with Children?
Principal Investigator Angela Hovey, PhD Candidate
Dissertation Research Chairperson Dr Carol Stalker, PhD

You had indicated that you would be willing to participate in a 20-30 minute telephone interview regarding your responses to some of the survey questions Please let me know if you are still interested in participating and please provide your telephone number that you would like me to reach you at and the possible times you would be available, i e , Monday afternoons or Thursday mornings etc

Thanks for your willingness to participate and I look forward to hearing from you

Sincerely,

Angela Hovey, PhD Candidate

Appendix E Web-Based Survey

Therapist Questionnaire

Instructions

Please answer each question according to the instructions provided NOTE Some questions in this survey are sexually explicit

Childhood sexual abuse statements

Please rate each of the following statements about childhood sexual abuse according to how strongly you agree or disagree with the accuracy of the statement

1 Only men sexually abuse children

(Select only one)

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

2 Women do NOT sexually abuse children

(Select only one)

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

3 The majority of female adults who engage in sexual behaviour with children were themselves abused as children

(Select only one)

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

4 The majority of male adults who engage in sexual behaviour with children were themselves abused as children.

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

5 When women engage in sexual behaviour with children, usually a male partner coerces them into it.

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

6 Child victims of male perpetrated sexual abuse are more emotionally traumatized than victims of female perpetrated sexual abuse

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

7 In most cases, women who engage in sexual behaviour with children select male children or adolescents

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree

Disagree
Strongly disagree

Childhood sexual abuse vignettes

Please rate each of the vignettes according to how strongly you agree or disagree that the vignette REPRESENTS childhood sexual abuse

8 A 30-year-old stepfather watching pornographic (sexually explicit) videos with his 16-year-old stepdaughter

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

9 Stepmother bathing her 11-year-old stepson

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

10 A 35-year-old male neighbour having sexual relations with a 15-year-old male neighbour

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

11 Parents having sex while their 4-year-old child is playing in the same room

(Select only one)

Strongly agree
Agree

Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

12 Aunt kissing her 15-year-old niece on the lips

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

13 Stepfather bathing his 11-year-old stepdaughter

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

14 On one occasion, a 25-year-old female teacher kissing a 14-year-old male student on the cheek.

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

15 A 12-year-old male child sleeping with an adult female relative

(Select only one)

Strongly agree
Agree

Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

16 A single mother asking her 13-year-old son to give her a full body massage (unclothed) after a stressful week at work

(Select only one.)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

17 On one occasion, a 25-year-old male teacher kissing a 14-year-old female student on the cheek

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

18 Uncle kissing his 8-year-old nephew on the lips

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

19 A 12-year-old female child sleeping in the same bed with an adult male relative

(Select only one)

Strongly agree
Agree

Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

20 A 30-year-old stepmother watching pornographic (sexually explicit) videos with her 16-year-old stepson

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

21 A single father asking his 13-year-old daughter to give him a full body massage (unclothed) after a stressful week at work

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

22 A 35-year-old female neighbour having sexual relations with a 15-year-old female neighbour

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

23 Parents having sex while their 7-year-old child is playing in the same room

(Select only one)

Strongly agree

Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

24 If you wish, you may comment about the vignettes here.

Client disclosure

Within your counselling practice, please rate

25 How likely it is that WOMEN SURVIVORS of child sexual abuse would DISCLOSE to you their concerns about sexually inappropriate THOUGHTS about children and/or adolescents

(Select only one)

Very likely
Likely
Somewhat likely
Neither likely nor unlikely
Somewhat unlikely
Unlikely
Very unlikely

26 How likely it is that WOMEN SURVIVORS of child sexual abuse would DISCLOSE to you their concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents

(Select only one)

Very likely
Likely
Somewhat likely
Neither likely nor unlikely
Somewhat unlikely
Unlikely
Very unlikely

Therapist initiated discussion

Within your counselling practice, please rate

27 How likely it is that YOU would INITIATE DISCUSSION with women survivors of child sexual abuse about whether or not they have concerns about sexually inappropriate THOUGHTS about children and/or adolescents

(Select only one)

Very likely
Likely
Somewhat likely
Neither likely nor unlikely
Somewhat unlikely
Unlikely
Very unlikely

28 How likely it is that YOU would INITIATE DISCUSSION with women survivors of child sexual abuse about whether or not they have concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents

(Select only one)

Very likely
Likely
Somewhat likely
Neither likely nor unlikely
Somewhat unlikely
Unlikely
Very unlikely

Importance of asking

Within your counselling practice, please rate how strongly you agree or disagree

29 It is IMPORTANT TO ASK women survivors of child sexual abuse directly about whether or not they have concerns about sexually inappropriate THOUGHTS about children and/or adolescents

(Select only one)

Strongly agree
Agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Disagree
Strongly disagree

30 It is IMPORTANT TO ASK women survivors of child sexual abuse directly about whether or not they have concerns about sexually inappropriate BEHAVIOUR with children and/or adolescents

(Select only one)

- Strongly agree
- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree
- Strongly disagree

Demographics

31 Type of agency in which you currently work.

(Select only one)

- Sexual assault centre
- Counselling agency
- Survivor specific agency
- Victim services
- Domestic violence agency
- Private practice
- Mental health services
- Hospital
- Other

32 How many years of experience do you have in your current position?

(Provide one response only)

33 How many years in total have you been in practice as a helping professional?

(Provide one response only)

34 How many years have you worked with WOMEN survivors of child sexual abuse?

(Provide one response only)

35 How many years have you worked with MEN survivors of child sexual abuse?

(Provide one response only)

36 What is the approximate percentage of the clients you see who are WOMEN survivors of child sexual abuse?

(Provide one response only)

37 What is the approximate percentage of the clients you see who are MEN survivors of child sexual abuse?

(Provide one response only)

38 What is your gender?

(Select only one)

Female

Male

39 Highest level of education achieved

(Select only one)

High school only

Some college credits

Some university credits

College diploma

Bachelor's degree

Master's degree

Doctorate degree

Other

40 What is your age?

(Provide one response only)

41 In which region do you work?

(Select only one)

Atlantic

ON/PQ

Prairies

West

Northern territories

Other

42 Please provide any comments or information you wish to add

Willing to be contacted for a follow-up telephone interview?

We would like to contact a small number of people to do a brief follow-up interview during the weeks of [dates]

*PLEASE NOTE Any identifying information you provide will be deleted from the rest of the survey once we have conducted the interview so that your responses remain anonymous If contacted, you are free to decline to participate in the telephone interview at any time

43 Would you be interested in participating in a short anonymous telephone interview regarding the responses to this survey?

(Select only one)

Yes

No **(End of survey)**

44 If you responded YES to the previous question, please provide your first name and email address so that I can contact you to arrange for a convenient time to conduct a short telephone interview as a follow-up to this survey (PLEASE NOTE not all who respond will be contacted)

Appendix F Telephone Interview Guidelines

Interview Guidelines

The selected telephone interview participants were divided into two groups according to their responses to Therapist-Initiated Discussion and Importance sections of the survey for the purpose of conducting the semi-structured interview Group A participants indicated that they are likely to initiate discussion with women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in their counselling practice and agree that it is important to inquire Group B participants indicated that they never or rarely ask women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in their counselling practice However, there were a few participants who responded that they are neither likely nor unlikely to initiate discussion and that they neither agreed nor disagreed that it was important to ask about sexually inappropriate thoughts and/or behaviour with children and adolescents in their counselling practice A combination of Group A and B Guidelines were used with an adaptation to the first question reflecting their neutral response in the survey

Group A Guidelines

1 According to your responses on the survey, could you tell me what prompts you to ask a client about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?

2 Are there any behaviours or statements that lead you to ask about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?

Probes Can you think of any other examples? Could you expand on that?

3 When you have asked clients about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice, what has been your experience with responses from women survivors of CSA?

Were there any negative reactions to the question?

Were there any positive or appreciative responses?

Probes Have you ever regretted asking the question? Can you think of anything further?

4 When you have asked about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice, how have you phrased the question?

What would be the best way to ask?

Can you think of an example when you have regretted how you phrased your question that you?

5 How does your agency support or challenge your inquiring about sexually inappropriate thoughts and/or behaviour with clients? Is there anything your agency could do to provide more help around this issue?

6 Is there anything further that you would like to add that you feel would be important information for other therapists who might not know which client to ask or how to broach the topic with clients?

Group B Guidelines

1 According to your responses on the survey, could you tell me more about why you do not ask (or rarely ask) women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?

Probes Can you expand on your response any further? Would you like to add anything else?

2 Do you have any concerns about asking women survivors of CSA about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?

If so, what are your concerns?

If not, why not?

Probes Is there anything else you would like to add?

3 Is there any behaviour or communication from a woman survivor of CSA that would prompt you to ask about sexually inappropriate thoughts and/or behaviour with children and adolescents in your counselling practice?

Could you provide an example?

If not, would [provide an example as prompt]?

Can you think of any other examples?

4 Have you ever wanted to ask but did not? If yes, what stopped you?

5 How does your agency support or challenge your style of practice with women survivors of CSA? Is there anything your agency could do to provide more help around this issue?

6 Is there anything further that you would like to add that you feel would be important information for other therapists with regard to asking clients about sexually inappropriate thoughts and/or behaviour?