A Study of Social Workers' Sensitivity to Intrafamilial Childhood Sexual Abuse

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LOYOLA UNIVERSITY CHICAGO

A STUDY OF SOCIAL WORKERS' SENSITIVITY TO INTRAFAMILIAL CHILDHOOD SEXUAL ABUSE

A DISSERTATION SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL IN CANDIDACY FOR THE DEGREE OF DOCTOR OF SOCIAL WORK DEPARTMENT OF SOCIAL WORK

BY DENNIS RADIGAN GOURLEY CHICAGO, ILLINOIS MAY, 1995
This is to confirm that the following dissertation:

A Study of Social Workers' Sensitivity to Intrafamilial Childhood Sexual Abuse
by
Dennis R. Gourley

has been read and approved by the committee members listed below.

Thomas M. Meenaghan, Ph.D.
Ann Shannon O'Connell, MS.W.
Joseph A. Walsh, Ph.D., Chair
ABSTRACT


This study of Social Work practice sought to evaluate the likelihood of the professional to consider adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial interview.

The sample universe was the 449 ACSW members of the NASW Connecticut Chapter who had listed themselves as practitioners in the mental health area. A survey was conducted in November of 1993, utilizing a mailing of study instruments: a case history, a case history questionnaire, and a social worker profile. A total of 152 surveys were returned, with 136 included in the study.

The dependent variable was the measured by the rate of considering a history of intrafamilial childhood sexual abuse on the case history questionnaire. The independent variables were the characteristics of the respondents as measured on the social worker profile.

In reviewing the returns, 128 respondents (94.1%) indicated consideration of intrafamilial childhood sexual abuse as an etiological factor to one or more of the six symptom based items on the case history questionnaire. No significant correlation was found among items on the two instruments.
ACKNOWLEDGMENTS

There are a number of people to whom I am grateful for the support, guidance and encouragement they have provided in my completion of this study. Dr. Joseph A. Walsh, my chairperson in this study has been a source of unending support and clear guidance in the completion of this work, in spite of the complications created by our being at significant geographic distance. Ms. Ann Shannon O'Connell had provided the clinical supervision that enabled me to first venture into this area of practice, and I am indebted to her for continuing that mentorship as a member of the committee. Dr. Thomas M. Meenaghan, as the third committee member, provided invaluable direction as he rigorously challenged the study through its various stages.

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As through life, my brother, Dr. Theodore J. Gourley, was an endless source of wisdom and support in this befuddling journey.

Cathy, my wife, has remained my soulmate throughout the labyrinth of this quest, as she has through every course, paper and exam since our beginning as undergraduates, a tenacity I can only hope to reciprocate.
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Chapter 1

Introduction

This study of Social Work practice intends to evaluate the likelihood of the professional to consider adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in the initial interview. This study is a modified replication of A Study of Psychologists' Sensitivity to Incest by Karen G. Sagal, Ph.D. (1988). A sensitivity to a history of intrafamilial childhood sexual abuse consists of an understanding of the consequences of intrafamilial childhood sexual abuse and a readiness to consider intrafamilial childhood sexual abuse as an historic factor. The study looks at both critical clinical information items as well as worker characteristics related to this sensitivity in Clinical Social Work practice. In Sagal's initial study, an N of 439 licensed and certified psychologists in the Rocky Mountain Region was surveyed using a mailing of a hypothetical Case History, Case History Questionnaire, Bem Sex Role Inventory (BSRI), and Psychologists Profile form. There were 231 returns, providing a response rate of 52.6%.

In this study, Sagal's Case History, and Case History Questionnaire was utilized; the BSRI was not. A Social Worker Profile Form was developed, and used in place of the Psychologist Profile Form.

The target population for this study is the professional Clinical Social Worker. This study utilizes the definition for Clinical Social Work that has been established by the National Association of Social Workers (1989). NASW defines clinical social work as:

"... the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial contest.

The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues." (p.4)
The sample universe was the 449 ACSW members of the NASW Connecticut Chapter who have listed themselves as practitioners in the mental health area. They are a self identified specialty group coming from the 1579 ACSWs listed as members of the NASW Connecticut Chapter. A questionnaire package was mailed to the subjects for their completion and return. A total of 152 questionnaires were returned, providing a response rate of 33.9%. Of those returns, 136 were complete, and included in the study.

The essential concern of this study is with Social Work assessment, that is, with what the worker sees when engaged in the task of evaluation. Carol H. Meyer, in describing the assessment process in Social Work, states that "it is scientific in its methodology, and rests upon a knowledge base, but that it is also seasoned with the practitioner's intuition and experience--and biases--and the client's willingness and capacity to participate" (p. 299). For this study, the concern with what the worker sees is with this knowledge base for practice. The study looks at the responses as a reflection of the shared knowledge base that informs practice to include a hypothesis of a history of intrafamilial childhood sexual abuse as one of many clinical practice paradigms.

"Intrafamilial childhood sexual abuse" is used here to differentiate the focus of this study from the diversity of relations en-comppassed by the term "incest." As used in this study, intrafamilial childhood sexual abuse refers to the sexual use of a child by an adult who is over 15 years of age and at least five years the child's senior, in a kinship role (parent, stepparent, foster parent, grandparent, uncle, aunt, cousin, or sibling) in the same family group. Intrafamilial is not limited to consanguineous relations. Sexual use includes consensual and non-consensual behaviors intended for the sexual gratification of the adult, and is not limited to physical sexual contact. This definition is based on that provided by Sgroi (1982, p. 10) for incest.

Professional social workers, by the very nature of their activities, their worksites, and their clientele, are very likely to be involved in situations where the families and individuals are at normal to high risk for past, current, or future intrafamilial childhood sexual abuse (Conte, 1984). Clinical social work is an interpersonal activity. It relies on the interactions of the worker and the client, and on the understanding that they each develop of themselves and the other in the context of their interacting. For
the practitioner, both an understanding of the consequences of intrafamilial childhood sexual abuse and a readiness to consider intrafamilial childhood sexual abuse as a historic factor can have a significant impact on the worker-client interaction, and the efficacy of the work that takes place.
Chapter 2
Literature Review

Child sexual abuse as a social problem: issues of values and rhetoric.

The focus on adult-child sexual activity, particularly intrafamilial childhood sexual abuse, as a social issue has been historically tied to the strength of the Feminist movement (Gordon, 1989). In a sampling of 19th century case records from child saving agencies in Boston, Gordon found that these early "child savers" saw intrafamilial childhood sexual abuse as the result of the poor sexual self control of the father, and believed "the problem to occur exclusively among the Catholic immigrant Poor" (p. 39). Gordon points out that the early views of charity and social workers were changed as a result of two events. As Social Work became more professional, and sought a scientific basis to practice, there was a greater turning to the area of psychology, and the Oedipal theories of Freud. At about the same time, the dominant view of the female as victim to the more powerful and impulsive male shifted to one of the victim as seductress with poor parental supervision. The child was seen as a sexual delinquent, and in many cases was subjected to the rehabilitation efforts of social and judicial authorities.

In earlier writings on the subject of intrafamilial childhood sexual abuse and sexual activity between adults and children, it is not uncommon to read findings that the child was culpable, unharmed, or benefited from the sexual activity (Lukianowicz, 1972; Rascovsky and Rascovsky, 1950; Bender and Grugett, 1952; Bender and Blau, 1937; Yorukoglu, 1966).

The social concepts of victim, and of victim culpability are central to the issues of intrafamilial childhood sexual abuse, particularly in the most common form, father-daughter incest. James and Meyerding note that "all women in our culture must in some way come to terms with the fact that their personal value is often considered inseparable from their sexual value" (1977, p. 1384). Jackson and
Ferguson (1983) found relationships between the attribution of blame and the form of help provided. In this same study, the authors found that male respondents were more likely than female respondents to attribute blame to the female victim.

The magnitude of the recent attention paid in the literature to the topics of child sexual abuse and intrafamilial childhood sexual abuse clearly reflects a societal view that sexual activity between adults and children is ethically wrong. In answering the question of "Why is it wrong for adults and children to have sex?", Finkelhor (1979) advances the point that the ethics of sex between persons is based not on the nature of the activity nor the characteristics of the individuals involved, but rather on the presence of consent to the activity and the relationship by all parties involved. The argument holds that true consent requires knowledge of what is being consented to, and the freedom to say yes or no. In advancing his argument of ethics, Finkelhor holds that, in sexual activity with adults, children are unable to know what is being consented to, and, in the relationship with an adult, either intrafamilial or extrafamilial, are prohibited by the hierarchical power difference to say yes or no.

A hierarchy of power is an essential feature of how families organize (Haley, 1976). Parent-child sexual activity triangulates the child and parents (Satir, 1983), developing coalitions across generational lines that disrupt this hierarchy, and leads to the dysfunction of the family as an organization (Haley, 1976).

Research issues in the literature: Definitions of incest and sexual abuse; incidence and prevalence rates; sampling methods

Definitions of incest and sexual abuse direct the Social Work practitioner to what behavior and phenomena will be recognized as aberrant and the focus of intervention and treatment activities. Incident and prevalence rates will inform Social Work practice as to the likelihood of encountering such phenomena in treatment populations. Sampling methods refine that practice knowledge as to those groups most likely to reflect those phenomena discovered through research.

In their review of the child sexual abuse and adult survivors of childhood sexual abuse literature, Wyatt and Peters (1986) cite variations in definitions of what constitutes child sexual abuse as being as
significant a factor as differences in sampling groups in explaining the variations in prevalence rates reported. The inclusionary/exclusionary criteria used in definitions of child sexual abuse are commonly: ages of the participants, contact behaviors, non-contact behaviors, differences in the ages of the participants (i.e. child-adult, child-adolescent, child-child, adolescent-adolescent, adolescent-adult), intrafamilial relationship of the participants, and extrafamilial relationship of the participants.

Vander Mey and Neff (1982) refer to "various and divergent sources to consider when attempting to define incest," pointing not only to differences in the helping professional (social work, psychiatry, and psychology) literature, but also to the differences in the legal definitions. Their thinking is that the differences in legal definitions are reflective of differences in the societal concerns and values. Implicit in the legal issues of sexual abuse of children and incest is the belief that such activity is socially and morally deviant. This is reflected in this professional literature, and may also be an issue in the practices of individual practitioners.

Bender and Blau (1937) are credited by Vander Mey and Neff (1982) as being the first American researchers in the helping professions to report case studies of children who had experienced sexual relations with adults. The purpose of their research was "to present a psychiatric study of the reaction of children who have experienced actual sex with adults" in an effort to look at "the problem of sexuality in children" (p. 500). The focus on child sexual behavior evinces the social view of that time that questioned the child's culpability for child-adult sexual activity (Gordon, 1989), and the study echoes the then contemporary view of the child involved in adult-child sexual relations as incorrigible. In the follow-up study, Bender and Grugett (1952) indicate a view that "sexual activity" during the period of six years to puberty was a common and within normal occurrence in children so long as the sexual activity was only curiosity, and not occurring over a prolonged period of time. However, they refer to these "children's unusually attractive and charming personalities," leading them to speculate that the child may have been the seducer of the adult (p. 825). Culpability of the victim, absent in both the Wyatt and Peters (1986), and the Vander Mey and Neff (1982) reviews of criteria commonly used to define sexual abuse, had often been a crucial consideration in earlier clinical works, as well as in social and judicial judgments. Vander Mey and Neff suggest that, historically, judicial criteria reflects public opinion.
Findings in "Pre-adolescent Contacts with Adult Males" (Kinsey, et. al., 1953) indicated that of the study's 4441 female subjects, 1075 (24%) responded that they "had been approached while they were pre-adolescent by adult males [defined as 'at least fifteen years of age' and 'at least five years older than the female] who appeared to be making sexual advances, or who had made sexual contacts with the child" (p. 117). The very broad criteria utilized was inclusive for intrafamilial and extrafamilial childhood sexual abuse behavior. In reviewing the findings, it is noted that the "approaches" had most frequently occurred in "poorer city communities where the population was densely crowded in tenement districts". It was felt that a greater proportion of study subjects from such childhood environs would have increased the percentage of respondents reporting a history of pre-adolescent contact with adults males. (p. 117). The authors also report that only twenty percent of those with a history of contact with adults reported two or more occurrences. However, repetition of contact was most frequent "when the children were having their contacts with relatives who lived in the same household" (p. 118).

Writing from the perspective of victim literature, Gagnon (1965) presents a reanalysis of the material gathered during these interviews. Gagnon reports that the last 1200 females interviewed by the Kinsey team were asked more extensive items to include their reactions to pre-adolescent contact with adult males. Gagnon's study analyzes the 333 (28%) of these final 1200 participants who reported that they had had pre-adolescent contact with adult males. Using the criterion of participation, Gagnon divided the 333 respondents into four groups: "accidental," "multiples accidental," "coerced," and "collaborative." Gagnon speculates that differences in participation could be functions of either the character of the offender, the character of the child, or the family constellation. Implicitly, participation would effect the designation of the child as victim, and of the activity as abuse. A designation of the participation as a function of the personality of the child would direct treatment at the woman's intra-psychic structure as agent for the phenomena. A designation of the participation as a function of the agency of the adult would direct treatment at the woman's intra-psychic structure as victim of the phenomena.

Butler (1980) advocates a "feminist" analysis of "incestuous assault." Incestuous assault is defined as: "any manual, oral, or genital sexual contact or other explicitly sexual behavior that an adult
family member imposes on a child by exploiting the child's vulnerability and powerlessness" (p. 48).

From this perspective, cooperative participation is not a relevant point. Rather power, equated to the ability to make choices, is the core issue. In the context of the family, Butler argues that, due to the culturally established differences in power, women and children do not have the same ability to exercise choice as the male adult. "Do women and children have the power to say 'yes' when they do not have equal power to say 'no'?" (p. 49). This view would not judge participation, voluntarism, child as seducer, or similar concepts as exclusionary criteria for defining child sexual abuse activity, either intra- or extrafamilial.

Similarly, behavior and relationship criteria are the basis of the definition of child sexual abuse provided by Browne and Finkelhor (1986): "Child sexual abuse consists of two overlapping but distinguishable types of interaction: (a) forced or coerced sexual behavior imposed on a child, and (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (a common definition of 'much older' is five or more years).

The former alludes to peer or sibling sexual activity, and implies the possibility of non-coerced or unforced interactions. Finkelhor (1980) speculates that "A large number, probably a majority, of children engage in sexual activities prior to puberty" (p. 171). While the presence of force or coercion is a criteria for abuse, sex play, "activities of young children of the same age, engaged in mutually, that are limited to the showing and touching of genitals, and that go on for short periods of time" (Ibid. p. 172), is seen as normal. Contrary to the common perception of childhood as a time of sexual dormancy, Finkelhor's study found that there were more experiences of sexual activity in the eight-year-old to 11-year-old latency group than any other of the prepubertal age groups in the sampling.

In this first type of child sexual abuse the definition rests on the existence of force or coercion, which puts one of the peers in the role of offender, and the other in the role of victim. In the second "type of interaction" there is a clear stance that any sexual activity between a child and an older person is wrong. This is consistent with Finkelhor's earlier ethical argument (1979). The intent of the participants is not considered, nor are such issues as the child's culpability, or familial vs. non-familial initiators. The non-abusive intrafamilial interactions of peers are put within the grouping of normal sexual activities of
childhood. All adult-child sexual activity is defined as abuse with the adult culpable for the activity regardless of the child's behavior (Finkelhor, 1979; Finkelhor, 1980; Browne and Finkelhor, 1986).

Based on clinical practice and concerns, Gelinas (1983) provides comparable criteria for intrafamilial childhood sexual abuse: "for clinical purposes, incest can be defined by two criteria: sexual contact and a preexisting relationship between adult and child" (p. 313). This is a tighter definition than most, and evolves from the context of clinical practice, rather than prevalence studies. The initial broadness of "sexual contact" is narrowed to "some form of overt sexual behavior", and "preexisting relationship" to "parent-child relationship" the concept of parent referring to a functional rather than a biological relationship. This is comparable to the definition provided by Sgroi (1982). The clinical consideration underlying the definition is a belief that the critical etiologic factor is betrayal of the child by the nurturing older person. The term incest is used to refer to intrafamilial (not limited to consanguine) adult-child interactions that would fit Browne and Finkelhor's (1986) definition of children sexual abuse, but would not be consistent with the legal, anthropological, or sociological concepts of incest.

In the state of Connecticut, where this study will take place, the legal code for "incest" (The General Statutes of Connecticut, Section 53a - 191) is as a felony based on marriage to a relation. The act of intrafamilial sexual relations between an adult and a child is covered under the Penal Code of "Sexual Assault", also a felony offense (Ibid. Section 53a - 70).

Based on a hypothesis that a betrayal of trust is at the etiologic core of the symptoms presented by adult survivors of childhood sexual abuse seen in clinical settings, Maltz (1988) defines incest as: "any sexual contact between a child or adolescent and a person who is closely related or perceived to be related" (p. 144). The definition of intrafamilial childhood sexual abuse is highly dependent on the changes of a preexisting adult-child relationship. The change primarily takes place psychically in the context of a sexually charged betrayal of trust. It is less the behavior or even the intent of the adult as much as it is the child's understanding of the interaction and the relationship. Similarly, the dynamic of a psychic breach of the parent-child incest taboo is cited by Satir as a source of symptoms for the identified patient child in dysfunctional families (1983, p. 69).
Over the course of time, the definition of incest has reflected not only changing cultural and social values, but also changes in clinical theory as it relates to the view of the individual as the agent of the phenomena, versus the victim of the phenomena. The inconsistencies of how incest is defined has created problems for those involved in research in this area. As can be seen in the diversity of definition criteria reviewed, evaluation of studies requires an initial evaluation of the parameters outlined by the stated and implied definition criteria. Reported incident and prevalence rates are strongly effected by the definition used, as it sets the inclusionary and exclusionary criteria.

In an historical review of child sexual abuse incident figures collected by The American Humane Association through its nationwide data collection system (1,975 cases in 1976, and 22,918 cases in 1982), Finkelhor (1984) attributes the significant increase in reporting to media attention, willingness to report, and improved skills in assessing. Wyatt and Peters (1986) elaborate the difference between incidence rate and prevalence rate. The former refers to the number of new occurrences in a given period of time, while the latter refers to the proportion of a population that has experienced a phenomena. The prevalence of a history of child sexual abuse speaks to a much larger and existing target group, the incidence group being the newer members of that group.

Wyatt and Peters (1986) in their review of the more current general population studies point to differences in methodology and sampling techniques as issues that inhibit comparability of studies in the literature. Vander Mey and Neff (1982) site the use of small case study populations, convenience populations, and institutionalized populations as sampling method limitations in the literature, and point to a general state of problems in measurement, either poorly suited or unreported. In their review of the literature, Browne and Finkelhor (1986) present data from 26 separate studies with sample sizes ranging from 31 participants to 950 participants. Examining the data on the sources of the samplings reveals that only 10.7% are random population samples. In contrast, 25% of the samples were from college populations, while 39.3% of the samples were from treatment populations. It would seem fair to suggest that the greater part of the empirical literature is representative of an atypical population.

Herman and Hirschman observed that "almost all previous clinical studies are based on cases reported to courts, child protection agencies, or public mental health facilities" (1981, p. 967). Most of
the studies available in the research have limits to their generalizability to the general population. Historically, earlier case studies were phenomenological in nature (e.g.: Bender and Blau, 1937; Bender and Grugett, 1952; Kaufman, Peck, and Taguiri, 1954; Lukianowicz, 1972; Rascovsky and Rascovsky, 1950; Riemer, 1939; Yorukoglu, 1966). More recently, the majority of studies have continued to deal with treatment populations. Prevalence studies of the general population have been a less popular focus for researchers. This may in part be due to the dual practitioner-researcher position of those writing and studying this field. Arguably, the relevant population for prevalence studies is the treatment population. As Courtois states, "... it is more useful to address the needs of individuals who are seeking assistance for their incest experience than it is to establish the exact yearly prevalence" (1982, P. 322).

If prevalence rates are useful, it is to assist in the estimation of the need for a type of service. Patten, Gatz, Jones, and Thomas (1989) report on the experience of one community mental health center in their efforts to provide specialized services for victims of intrafamilial childhood sexual abuse, and of sexual abuse. Estimates of need based on population prevalence models led the CMHC to expect service utilization at two new cases a month. The actual experience was 15 new cases a month with this population accounting for 40% of the Center's caseload at the end of six months.

While methodologically faulty for the empirical study of prevalence, the intrafamilial childhood sexual abuse literature is extremely relevant to the practitioner. The practitioner does not deal with general populations, and as such is better served by information dealing with special and at risk populations. Studies of inpatient psychiatric populations consistently reveal high prevalence rates of physical assault and sexual assault (Beck and vander Kolk, 1987; Bryer, Nelson, Miller, and Krol, 1987; Carmen, Rieker, and Mills, 1984; and Jacobson and Richardson, 1987). Studies of non-hospitalized populations are not as readily available. Greater focus is on the prevalence of symptoms in population samples of persons identified as having a history of childhood sexual abuse or intrafamilial childhood sexual abuse. The investigation of the prevalence of symptoms in this population has impacted the sampling methods used, and helps to explain the heavy usage of special populations.

Theory and practice: Problems in knowing and seeing
The theoretical concerns of clinical practice in the area of incest, and adult survivors of intrafamilial childhood sexual abuse focus on psychopathology, and discussions of etiologic factors, symptoms, treatment. Rist (1979) has pointed to a difference in the concerns of the theoretical and clinical views that inform the practice knowledge of incest as intrafamilial childhood sexual abuse, and finds that there is a separateness of the literatures, and little integration of the two. The essential issue to be investigated in this dissertation study is the degree to which clinical practice in the study population is informed to consider an etiological explanation that includes adult survivorship of intrafamilial childhood sexual abuse, and if that knowledge is influenced in a significant way by theoretical orientation, practice experience, and professional training.

Clinical practice changes in response to the changes in theoretical, social, and political values. This has certainly been the history of clinical practice in the area of intrafamilial childhood sexual abuse (Gordon, 1989). Early clinical writings reflect the influence of psychoanalytic thought (Bender and Blau, 1939; Rascovskv and Rascovskv, 1950; Kaufman, Peck, and Tagiuri, 1954), and it is still evident in contemporary works (Shengold, 1989). Clinicians struggled in integrating the direction set by traditional psychoanalytic theory and the experience gained in practice (Ferenczi, 1949; Pavenstedt in Kaufman, et. al., 1954). This struggle is significant, and was one faced by Freud as he engaged in postulating clinical theory and clinical practice.

Unlike any other clinical issue, intrafamilial childhood sexual abuse is enmeshed with a conceptualization of proof and culpability that takes on a quasi-legal nature, that influences worker attribution of blame, and worker belief in occurrence. While there is general cultural belief in intrafamilial childhood sexual abuse as "taboo," implicitly there are degrees of wrong (Rascovsky and Rascovsky, 1950; Gagnon, 1965). In a reflection of the culture in which we practice, there is professional denial, and ambivalence about the right and wrongs of sexuality, as well as the ability to control biological impulses (Courtois, 1982; Ganzarain and Buchele, 1986; Rieker and Carmen, 1986; Goldwert, 1986).

Studies of worker attitudes toward intrafamilial childhood sexual abuse have found that attribution of blame to one of the family triad involved (i.e. father, mother, child) affects assessment (Eisenberg, Owens, and Dewey, 1987; Jackson and Ferguson, 1983; Ringwalt and Earp, 1988). Worker
attitude and preconceptions are crucial, and the worker has often felt inadequately prepared to deal with the issues of intrafamilial childhood sexual abuse (Dietz and Craft, 1980; Herman, 1981). The diversity of definition of intrafamilial child sexual abuse is functionally present in the assessments provided by workers in these studies. In practice then, there are differences of definition, comfort level in dealing with issues of intrafamilial child sexual abuse, and, it could be posited, differences in the likelihood of different workers identifying intrafamilial childhood sexual abuse when presented with the same case. There is risk both ways: missing what is there, or seeing what is not there (Emerson, 1988). The former risk is a concern for those advocating on behalf of persons in at risk populations; the latter the concern of those critical of the morass of "psycho-babble" and its experts, and the risk they pose to what progress has been made.

At the core of the debate are Freud's early theoretical formulations on the etiology of neurosis, and at the center, the issue of sexuality. Put in historical context, Freud introduced an importance to sexuality in the field of psychology, particularly infantile and childhood sexuality that was without precedent (Ellis, 1939). *Neurotica* was Freud's early theory of the neurosis. This theory held that the neurosis was the result of the sexual seduction of the child by the parent. In his letter to Wilhelm Fliess dated September 21, 1897 (in Masson, 1985), Freud announced to his friend that "I no longer believe in my *neurotica* . . .," and proposed a revised theory on the etiology of neurosis. This revision, to become known as the Oedipal theory, suggested that the seduction is in fact the child's fantasy of sexual contact with the parent. The role of aggressor moves from the parent to the child. As Masson has summarized, "An act was replaced by an impulse, a deed by a fantasy" (1984, p. 113). Freud comments in this letter to Fliess on the incredulous magnitude of the frequency of the "perversions" that would be necessary to support his *Neurotica*.

"The [incidence] of perversion would have to be immeasurably more frequent than the [resulting] hysteria because the illness, after all, occurs only when there has been an accumulation of events and there is a contributory factor that weakens the defense."

The prevalence of intrafamilial childhood sexual abuse in society would have to be greater than the prevalence of neurosis in that same population.
The power of this change in theory was to give importance to the fantasy experience that was equal to, or greater than that experienced in reality. As Freud explained his logic to Fliess:
"... there are no indications of reality in the unconscious, so that one cannot distinguish between truth and fiction that has been cathetized with affect."

The abandonment of the "seduction theory" made way for recognition of the power of fantasy that was to be the key concept in the development of psychoanalysis.

Anna Freud responded to Jeffrey M. Masson's view that Sigmund Freud was wrong in renouncing the seduction theory that:
"Keeping up the seduction theory would mean to abandon the Oedipus complex, and with it the whole importance of phantasy life, conscious or unconscious phantasy. In fact, I think there would have been no psychoanalysis afterwards." (1984, p. 113)

Leaving Neurotica behind allowed development of the Oedipal theory and the belief in fantasy as powerful. Psychoanalysis became based on intrafamilial sexual attraction that is denied, sublimated, and abandoned. The taboo against incest, intrafamilial adult-child sexual behavior, is viewed as primarily psychological, rather than biological (Freud, 1918), and gained acceptance "as a scientific hypothesis" beyond the field of psychoanalysis (Kroeber, 1939). Neurotica's continued absence allowed psychoanalytic theory to flourish.

One of the possible explanations for the abandonment of Neurotica is Freud's need to deal with the issue of intrafamilial adult-child sexual behavior through the defense of denial. A second is that, in the pursuit of science and the development of a body of explanatory theory, the competing concepts associated with the Oedipal theory, particularly the power of fantasy, appeared more promising. Both explanations underscore the criticisms leveled at the healing professions and their members for failing to identify cases of intrafamilial childhood sexual abuse: individual clinicians in their own denial; and a clinical theory that explains the clinical indicators as fantasy based.

Sandor Ferenczi (1949) found the Oedipal theory, under the weight of the clinical evidence he encountered in his practice, an inadequate explanation. Therapists, either due to their own denial, or the adherence to a theory that viewed parent-child sexual contact as fantasy, present the client with a repetition of the denial that is characteristic of the family of origin. The therapist's ability to provide the
client with an experiential environ that is distinguishable from the traumatic past is crucial (Gelinas, 1983). The key factor is the ability of the client to have "confidence" in the therapist, confidence that "establishes the contrast between the present and the unbearable traumatogenic past" (Ferenczi, 1949, p. 227).

The therapeutic change process is based on repetition of the traumatic past in an environment that is safe and accepting, an environment that allows the meaning of the experience to be re-created rather than reproduced. In the case of intrafamilial childhood sexual abuse, clinical training and adherence to the predominant theories hampered treatment.

Reported characteristics of the individuals and the families involved:

The observed individual, familial, and social characteristics noted as functioning within and providing context for the family are factors associated to the occurrence of intrafamilial sexual abuse (Barrett, Sykes, and Barrett, 1976; Cohen, 1983; Kaufman, Peck and Taguiri, 1954). The contextual family and social characteristics reported in the incest literature will be reflected as historical items in this dissertation study's Case History.

While parent-child sexual activity is generally viewed as deviant and pathological, review of the individual, familial, and social factors of their study samples have led some authors to assert that the incestuous activity is (or was in prior decades and centuries) an accepted sub-cultural activity (Lukianowicz, 1972; Riemer, 1939). Three characteristics frequently cited in the literature could be viewed as support for a social sub-group perspective of intrafamilial adult-child sexual behavior. The intrafamilial adult-child sexual behavior pattern commonly repeats itself from generation to generation (Deighton, and McPeak, 1985; Gelinas, 1983; Giaretto, 1982; and Cohen, 1983). It is associated more strongly with groups living in poverty in both rural areas and industrial-urban areas, and in overcrowded housing (Lukianowicz, 1972; Riemer, 1939; Gordon, 1989; Dixon, Arnold, and Calestro, 1978). The families often live in emotional isolation from others (Shengold, 1989; Barrett, Sykes, and Barrett, 1976; and Blake-White and Kline, 1985). Bender and Blau observed that among the children in their study,
there was little indication of guilt over the sexual behavior until they were exposed to the opinions of their parents and the courts. (1937, p. 510).

Enmeshment, blurred generational boundaries, and a disorganization of roles and functions among members were characteristic of families' relationships where adult-child sexual behavior occurs (Barret, Sykes, and Barrett, 1976; Blake-White and Kline, 1985; Cohen, 1983; Pierce, 1987; and, Summit and Kryso, 1978). The home environment has been characterized as non-protective and non-nurturing (Blake-White and Kline, 1985; Bender and Blau, 1937; and, Dixon, Arnold, and Calestro, 1978). Rascovsky and Rascovsky (1950) note: "The previous loss of the parent of the same sex seems to be a prerequisite in myths [e.g.: Lot and his daughters, Salome and her step-father, and Oedipus and Jacosta] concerning incest." (p. 46). Shengold, whose clinical population includes cases of mother-child incest, states that the non-abusive parent was usually "too weak [to provide protection] or absent" (1989, p. 26). Maternal absence, through death, illness, or abandonment, has been found to be characteristic of father-child childhood sexual abuse (Blake-White and Kline, 1985; Herman, 1981; Kaufman, Peck, and Tagiuri, 1954; Lukianowicz, 1972; and, Riemer, 1939).

Families where adult-child sexual behavior occurs have been described as multiproblem, with multiple forms of abuse present (Blake-White and Kline, 1985; Dietz and Craft, 1980; Finkelhor, 1980; Gordon, 1989; Herman and Hirschman, 1981; and, Pierce, 1987). In addition to the sexual abuse of the child, both physical and emotional abuses were often present, and include child-child abuse, parent-child abuse, and parent-parent abuse. Substance abuse, either by one or both parents (most often the male parent), or by one or both of their parents, was frequently reported (Carmen, Rieker, and Mills, 1984; Dixon, Arnold and Colestro, 1978; Kaufman, Peck, and Tagiuri, 1954; Pierce, 1987; Gordon, 1989; and Riemer, 1939). Gordon reports that these concomitant problems, familial violence, sexual abuse, and alcohol abuse, were all addressed in the rhetoric of the nineteenth century temperance movement (1989, p. 39).

Literature on intrafamilial childhood sexual abuse families has focused primarily on three individuals: the paternal parent, the maternal parent, and the child. The literature most frequently reports the male parent, frequently from a deprived childhood background, in the abusive parent role regardless of
whether the child is male or female (Gelinas, 1983; Giaretto, 1982; and Kaufman, Peck, and Tagiuri, 1954). While the family is reported to be dominated by the male parent (Dietz and Craft, 1980; Blake-White and Kline, 1985; Cohen, 1983; Herman, 1981; and, Herman and Hirschman, 1981), the male parent has been characterized as emotionally immature, dependent, and narcissistically needy (Gelinas, 1983; Giaretto, 1982; Riemer, 1939; Summit and Kryso, 1978; Cohen, 1983; and, Kaufman, Peck, and Tagiuri, 1954). Frequently he is profiled as a man who is introverted, with an emotionally isolative and mistrustful regard for those beyond the family (Blake-White and Kline, 1985; Lukianowicz, 1972; Riemer, 1939; Gelinas, 1983; and, Dixon, Arnold, and Calestro, 1978). In combination with the likelihood of substance abuse, the literature reports this parent as aggressive, and exercising poor judgment and poor impulse control (Herman and Hirschman, 1981; Lukianowicz, 1972; Riemer, 1939; Dixon, Arnold, and Tagiuri, 1978; and, Summit and Kryso, 1978).

Kaufman, et. al. (1954) present a matriarchal family model for childhood sexual abuse characterized by the dominance of the strong bond of maternal grandmother and female parent. This portrayal presented the intrafamilial childhood sexual abuse as a generation to generation repetition, the dynamics involving three generations: grandmother, mother, and female child.

The literature has consistently presented the mother as physically absent or emotionally unavailable for other family members (Blake-White and Kline, 1986; Cohen, 1983; Gelinas, 1983; Herman and Hirschman, 1981; Kaufman, Peck, and Tagiuri, 1954; Lukianowicz, 1972; Rascovsky and Rascovsky, 1950; Riemer, 1939; Summit and Kryso, 1978; and, Shengold, 1989). She is portrayed as weak and passive (Blake-White and Kline, 1985; Cohen, 1983; Herman, 1983; and, Dixon, Arnold, and Calestro, 1978), depleted from the disappointments and demands of her marriage, and low self image (Gelinas, 1983).

The child is described as going through a process of "parentification", that is, the child adopting the role of care-giver to the exclusion of her own emotional needs. "The inception of incest occurs gradually and usually in the context of father's emotional needs, mother's depletion and daughter's parentification" (Gelinas, 1983, p. 321).
The mother abandons the role of mother and spouse, and the child is drawn into filling the caregiver role. In this role the child attempts to provide solace to the nurturing needs of the siblings, as well as those of the father. In relationship to the father, this comes to include the meeting of that parent's sexual needs.

Whether due to the politics of gender role power, social culture, or developmental models, the literature points to strong concern for generation to generation risk. The risk is noted as multicausal and has multiple players, with significant influence from the characteristics of the parents in combination.

Typically, the oldest child has been noted as involved in the intrafamilial childhood sexual abuse (Cohen, 1983; Herman, 1981; and, Dixon, Arnold and Calestro, 1978), and most commonly the daughter. The age of onset is usually prepubertal (Blake-White and Kline, 1985; and, Herman, 1981), and has occurred subsequent to the child assuming non-sexual roles of the mother (Cohen, 1983; Gelinas, 1983; Herman and Hirschman, 1981; and, Summit and Kryso, 1978). The child is isolated from siblings by a perceived status of favoritism, which in physically violent homes may mean safety from the father's non-sexual aggression, and from peers by a fear of disclosure (Blake-White and Kline, 1985; Cohen, 1983; Gelinas, 1983; Herman and Hirschman, 1981; Kaufman, Peck, and Tagiuri, 1985; and, Summit and Kryso, 1978), which risks the disruption of the family.

The literature is retrospective in nature, identifying characteristics of families that have reported a history of intrafamilial childhood sexual abuse. The characteristics of the individuals and families that have experienced intrafamilial childhood sexual abuse have become the basis for risk assessment tools. Risk assessment tools are important to Social Work practice in both clinical and non-clinical settings. They provide indicators that should prompt further inquiry into the possibility of intrafamilial childhood sexual abuse based on socio-economic, and interpersonal factors.

Diane English (1991), Project Director for Washington State Department of Social & Health Services, Division of Children and Family Services' efforts to develop and refine a risk assessment tool for practitioners, has identified "caretaker characteristics" as the most predictive cluster of risk factors. Within that cluster, the most significant factors noted include: a caretaker with a history of childhood sexual victimization; a caretaker with a history of childhood physical abuse, or childhood neglect; a caretaker with a history of substance abuse; a caretaker with a prior criminal record as a perpetrator of
child sexual abuse; and a caretaker with a history of unemployment. In addition, English identifies a parent-child relationship characterized by parentification as a significant risk factor. Findings from both Wynn Tabbert, a researcher in the development of risk assessment tool for the State of California, and Larry Wright, Project director for the Colorado Department of Social Services' risk assessment program, concur with English (1991).

Current risk assessment models are based on casework population research with child welfare cases, and present factors that are congruent with the literature. These tools are exemplars of practice-based research that can guide Social Work in the development of empirically-based practice principles. Berliner and Conte (1990) point out that "Understanding the process whereby offenders target potential victims, engage children in sexual relationships, and maintain their involvement, often over an extended period of time, will help locate areas for prevention education both for already victimized children and for children in general" (p. 29). For Social Work, this is an arena to which clinical practice and casework practice have much to contribute. It provides the "practice relevance" that for Wasserman (1982, p. 178) "is the focal concept that guides the clinical social work movement."

**Symptoms associated with survivors of childhood sexual abuse**

The clinical literature in the fields of social work, psychiatry, and psychology reports a multitude of clinically significant symptoms experienced by survivors of intrafamilial childhood sexual abuse. Just as risk assessment factors provide guidance in casework practice, symptoms and theories on symptom formation provide guidance to intrapersonal factors that prompt inquiry into a history of intrafamilial childhood sexual abuse in clinical Social Work practice. The symptoms reported in this literature will be reflected in the Case History utilized in this study.

In a comparative study of clinical populations using the Millon Clinical Multiaxial Inventory, Wheeler and Walter (1987) reported symptoms of depression and anxiety to "represent the clinical syndrome (the acute symptoms) most likely to be present [in clients reporting a history of intrafamilial childhood sexual abuse]" (p. 600). This would agree with other writers who have reported anxiety and depression as clinically significant in this population (Beck and van der Kolk, 1987; Blake-White and
Kleine, 1985; Browne and Finkelhor, 1987; Cole and Barney, 1987; Emerson, 1988; Ferenczi, 1949; Gelinas, 1983; Herman, Russell, and Trocki, 1986; Roscovsky and Rascovsky, 1950; and, Tsai, Feldman-Summers, and Edgar, 1979). Manifestations of the anxiety and depression have included signs of suicidal risk, low self-esteem, somatic complaints, nightmares, feelings of guilt, feelings of helplessness and vulnerability, and feelings of anger and hostility.

Relationships present a significant problem for women with a history of intrafamilial childhood sexual abuse. The literature indicates that difficulties in developing and maintaining close and intimate relationships with family and friends are frequently characteristic of the individual with a history of intrafamilial childhood sexual abuse, and part of the manifestation that requires clinical consideration (Butler, 1980; Carmen, Rieke, and Mills, 1984; Cohen, 1983; Emerson, 1988; Gelinas, 1983; Gordy, 1983; Herman and Schatzow, 1984; Herman, Russell, and Trocki, 1986; and, Maltz, 1988). Difficulty in developing trust, related to the feelings of vulnerability and helplessness, is a central concern. In the clinical setting, this inability to trust and to develop and maintain relationships presents complications for the treatment process (Carmen, Rieker, and Mills, 1984; and, Ganzarain and Buchele, 1986).

Sexual dysfunction issues are widely cited as a component of the symptom profile of an individual who has a history of intrafamilial childhood sexual abuse (Blake-White and Kline, 1985; Browne and Finkelhor, 1986; Butler, 1980; Cohen, 1983; Deighton and McPeek, 1985; Emerson, 1988; Ganzarain and Buchele, 1986; Gelinas, 1983; Gordy, 1983; Herman and Schatzow, 1984; Herman, Russell, and Trocki, 1986; Maltz, 1988; Molnar and Cameron, 1975; Meiselman, 1980; and, Tsai, Feldman-Summers, and Edgar, 1979). Studies in this area would indicate that individuals in treatment with a history of intrafamilial childhood sexual abuse may tend to present issues of sexual dysfunction more frequently than the general clinical population.

The relationship between sexual dysfunctions and dissociative disorders in individuals with a history of childhood sexual abuse is suggested by the work of Ganzarain and Buchele (1986), as well as the work of Deighton and McPeek (1985). Deighton and McPeek in discussing the issues identified by their "adult victim group" point out that "group members who were either married or involved insignificant heterosexual relationships all reported emotions ranging from fear to disgust with sexual
contacts because sexual contact might trigger mental flashbacks to childhood" (p. 409). Ganzarain and Buchele similarly report that in their experience with group members, that sexual functioning is effected by fears of intrusive flashbacks during moments of sexual intimacy. In a third report on work with a group for adult survivors, Gordy describes a "splitting phenomenon" (1983, p. 303). The members of Gordy's groups consistently described issues of "sexual incompatibility" with husbands and boyfriends. Gordy found it a common occurrence for group members to separate emotions and sexuality, "They could have sexual relations without any affection and emotional closeness or they could have the affection but could not perform sexually." For these group members, the two conditions were dissonant. To bring them together would "run the risk of bringing back the overpowering memories." Maltz (1988) has observed that as the relationship grows in commitment, there is a steady decline in the "sexual interest and pleasure" (p. 146), and that individuals with a history of childhood sexual abuse may numb themselves to avoid the sensations of physical contact during sexual activity.

Blake-White and Kline (1985) view dissociation as a defensive process that many victims learn to utilize during the childhood experience of sexual abuse. In addition to the context of sexual activity, dissociation continues to be used in adult life as a defensive process to stresses and affective experiences (Ellenson, 1985; Gelinas, 1983; Herman, Russell, and Trocki, 1986; Herman and Schatzow, 1987; and, Rieker and Carmen, 1986). Herman and Schatzow (1987), in a study of fifty-three women involved in therapy groups for adult survivors, noted a relationship between memory and dissociation: "Patients who reported full recall often commented that they wished they could repress their memories. Lacking this defensive option, they tended to depend heavily on dissociation and isolation of affect to protect themselves from the overwhelming feelings associated with the abuse." (p. 5).

They further noted that, when this process failed to work, these patients were prone to more maladaptive coping strategies (e.g.: somatizations, impulsive risk taking, substance abuse, and transient psychotic episodes).

Impaired recall and denial are defensive strategies that are also reportedly used by survivors to protect against the overwhelming affect associated with the event. In their study population, Herman and Schatzow (1987) reported that 65% of the patients had either moderately or severely impaired recall of the
traumatic events. In this small convenience population, they found "a strong association" indicating that the earlier the age of onset of the abuse, the greater the degree of recall impairment. Similarly, their data indicated that the degree of violence associated positively with the degree of recall impairment. Denial of the experience is an adaptive behavior employed by both the individual and the family. However, this creates a situation in which the child is faced with overwhelming emotions that are without an acknowledged base in reality (Bryer, Nelson, Miller, et al. 1987).

This maladaptive coping strategy leaves the individual with an affect state sans experience, or an experience sans affect. Rieker and Carmen (1986) identify a three step process that is engaged by an individual adjusting or accommodating to the judgments of others:

1. Denying the abuse;
2. Altering the affective responses to the abuse;
3. Changing the meaning of the abuse: i.e., disconfirming and transforming the abuse.

This is presented as the core of the "victim-to-patient" process.

The defensive strategies that are commonly observed in victims of intrafamilial childhood sexual abuse, and the intrusive experiences have been compared to the post-traumatic stress disorder syndrome (Blake-White and Kline, 1985; Cole and Barney, 1987; Emerson, 1988; Herman, Russell, and Trocki, 1986; Herman and Schatzow, 1987; Kilgore, 1988; Patten, Gatz, Jones, and Thomas, 1989; and, Rieker and Carmen, 1986).

Intrusive phenomena are generalized into the individual's life (Deighton and McPeek, 1985; Ellenson, 1985; Ferenczi, 1949; Gelinas, 1983; Herman, Russell, and Trocki, 1986; and Rieker and Carmen, 1986). Ganzarain and Buchele describe the individual's situation as one in which the "multilayered conflicts [the conflicts of knowing and not knowing, of trusting and not trusting, of being good and being not good, . . . etc.] culminate in a confused loss of self" (p. 556). Ferenczi refers to the "almost hallucinatory repetitions of the traumatic experiences," and the "severe nightmares" experienced by his patients (p. 225).
Ferenczi postulates that the developing child, under the anxieties and stresses of intrafamilial childhood sexual abuse, is at risk for increasing numbers of "splits in the personality," to the point of each of the "fragments" behaving as a "separate personality," unaware of the existence of the others (p. 229). Saltman and Solomon, in their discussion of the multiple personality phenomenon, point out that the "majority of published cases had incestuous backgrounds" (1982, p. 1127). While the issues of intrafamilial childhood sexual abuse and the etiology of the multiple personality disorder is beyond the scope of this paper, the statements from Ferenczi, and from Saltman and Solomon stress the more severe end of the dissociative phenomena.

**Theory and the etiology of symptoms:**

The clinician utilizes theoretical perspectives to assign meaning to the symptoms presented. It is this understanding of the symptoms that guides practice. In "The Aetiology of Hysteria" (1986), Freud postulated on the ability of "the symptoms of a hysteria to make themselves heard as witnesses to the history of the origin of the illness . . . The symptoms of hysteria are determined by certain experiences of the patient's which have operated in a traumatic fashion . . . " (p. 192). Following this guideline in the case of intrafamilial childhood sexual abuse, survivors' symptoms should provide guidance to such issues as age of onset, degree of abuse, and duration (Kilgore, 1988).

Herman and Schatzow (1987) found that Freud's speculation bore out in their study sample. They found discriminating evidence of a relationship between the age of onset and intensity of abuse, and the symptoms/defenses presented:

"Massive repression appeared to be the main defensive resource available to patients who were abused early in childhood and/or who suffered violent abuse . . . Women whose predominant experience of abuse was in latency and whose abuse was not particularly violent or sadistic rarely resorted to massive repression; instead, they seemed to employ a combination of defenses including partial repression, dissociation, and intellectualization." (p. 11-12).

They further note that puberty appeared as the dividing point at which the abuse was not repressed in memory and did not manifest as hysteria.
Ferenczi refers to the personalities of these individuals getting "stuck," and that the resulting psychic structure "consists only of the Id and Super-Ego" (1949, p. 228). Cohen (1981) asserts that trauma negatively affects the child's "normal patterning of memory traces and affects, and consequently with more or less ordinary repression" (p. 95). This interferes with the individual's ability to structure experience. Rosenthal (1988) holds that in the long term it is in the "derailment of the development of self-esteem and the growth of injured narcissism" that the individual is most effected by the experience of intrafamilial childhood sexual abuse.

The family issues of enmeshment and role confusion have, as corollaries on the level of individual development, the issues of individuation, merging, and the ability to differentiate from other. Maltz (1988), noting a pattern in cases with a history of intrafamilial childhood sexual abuse, provides a concrete indicator of this issue in the definition of self. Maltz has pointed to this group's passivity in expecting others to respect their "physical boundary space," the approximately nine inch invisible protective space surrounding an individual, as an indicator of a lack of awareness of their own separateness. Reiker and Carmen (1986) identify this lack of individuation as a critical developmental failure with the result that the individual is "devoid of self-protective mechanisms and more vulnerable to abuse and exploitation outside their families" (p. 364).

Ferenczi describes the process of the child's identification with the aggressor, and eventual introjection of the aggressor. This introjection, changing extra-psychic reality to intra-psychic reality, allows the child, via primary process, to maintain the needed parental image as tender and nurturing through a modifiable hallucinatory reality while experiencing the trauma and the aggressor-parent (1949, p. 228). Shengold (1967) discusses the individual's need to maintain the parent as protector, and to defend against the loss of this same parent in the face of the assault. The introjection of the aggressor functions as a childhood adaptation. Shengold (1963) refers to the rage that results for the victim as an "affect [that] involves a combination of feeling both the subject and object of destructive angry forces" (p. 749). The "child" in the adult is confronted in therapy with the challenge of beginning "to look truly and therefore critically at the parents, and this is the first step toward giving up an identification with them" (Shengold, 1989, p. 315).
Shengold (1963, 1967, 1989) refers to the affect experienced by the seduced child as "overstimulation," an issue that remains a central problem throughout their lives. "The effects of the traumata and the means the child took to try to deal with them and with the overexcitation" become the subject of repetition in life and in therapy, "by way of defences, symptoms, and fantasies" (1967, p. 404). The effect of the seduction is the introduction of affective experience that is beyond the capacity of the forming ego of the child. These effects, initially ego serving adaptations for the child, resurgently appear through adult life in the form of symptoms, and thematic repetitions as the trauma is reenacted.

Bowlby (1979) has noted that children commonly exercise a process of "selective exclusion" to accommodate the preferences of their parents. The preferences may be either overtly or covertly expressed, and effect the child's choice in what affective and cognitive materials from experience remain consciously accessible. While "most children are indulgent towards their parents, preferring to see them in a favorable light," Bowlby contends that the parent, in order to get compliance from the child in their selective exclusion process, must exert pressure. The child then is a conflicted participant in the altering of the memory of the experience. Similarly, Shengold (1963) notes that seduced children, through the process of introjection of the aggressor, characteristically not only assume the guilt of the parent, but also "renounce their own ability to see what is and has been" (p. 732).

Freud viewed the compulsion to repetition as the patient's "way of remembering" (1914, p. 150), Hartmann (1959), as a form of adaptation. Based on clinical experience, Herman and Schatzow (1987) suggest:

"The purpose of reliving the experience with full affect is not simply one of catharsis, but of reintegration. Symptoms, feelings, and behaviors that previously seemed inexplicable bizarre, and ego-alien become more comprehensible; the patient becomes more comprehensible to herself, and more able to construct meaning in her life history." (p. 12).

Silver, Boon, and Stones (1983) suggest that the process of reviewing the incest allows the individual to develop a context of meaning for the experience, a process they judge to be similar to Freud's concept of "working through" (1914).

From these perspectives development of "the self" and "the ego" present as the core clinical issues. Ego analysis, and self analysis are areas for clinical Social Work practice (Federn, 1992, p. 13) as
it has developed from the earlier roots of supportive casework, and supportive treatment. These clinical issues call for "clinical social workers who do social work" (Ibid.). Treatment of adults who have experienced intrafamilial childhood sexual abuse requires interventions that address the unconscious affects and cognitions of those earlier traumas. This allows them to enhance their interactions with their current environment, a dynamic that Patricia L. Ewalt cited as "the primary mission of social work" (1980, p.89).

The therapist - client relationship

Ferenczi (1949) had observed in the patient-therapist exchange a process similar to the process of child-parent accommodation:

"Gradually, then, I came to the conclusion that the patients have an exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies, and antipathies of their analyst, even if the analyst is completely unaware of this sensitivity." (p. 226).

In this observation rests Ferenczi's insight into the repetition of the parent-child trauma in the therapist-patient relationship. As the child had structured experience to accommodate the parent, so the patient structures for the therapist. The patient's repetition includes identification with the therapist and the concomitant issues of the transference/countertransference. Reiker and Carmen (1986) point out that this "is seldom understood by either victims or clinicians as being a repetitive reenactment of real events from the past" (p. 366). This is the result of the "considerable resistances" that Ferenczi viewed as within the therapists themselves, as well as in the patient.

In discussing these "resistances", Ferenczi points to a disadvantage often faced by the "analyst" in the therapeutic relationship. That is, that the "analyst" has commonly only had the benefit of the brief analysis that accompanies his or her training regime. The "patient," on the other hand, eventually has the benefit of greater "analysis." The caution for the therapist is toward the risk of significantly incomplete knowledge of "all our [clinician's] unpleasant external and internal character traits" and in this deficit state, the inability to understand both the transference and the countertransference issues at play (p. 226).

Ganzarian and Buchele (1986) discuss their own experiences of countertransference issues, including projective identification, in their group work with adults with a history of intrafamilial
childhood sexual abuse. More liberally defining countertransference as "... the whole of the therapist's unconscious and conscious attitudes and behaviors toward the patient," they provide the following description of the therapist's affective dilemma:

"Clinicians treating patients with histories of incest experience intense, perplexing, contradictory feelings, such as horrified disbelief, excited curiosity, sexual fantasies, related guilt, need to blame someone, and wishes to rescue. These countertransference feelings affect how one treats these patients." (p. 550).

The therapist's discomfort at knowing, and at dealing with the issues of intrafamilial childhood sexual abuse can themselves become dynamic forces that direct the therapeutic relationship, as well as the work done and the work left undone. The assessing social worker's "emotional involvement can also make a worker deny what he or she sees" (Orten and Rich, 1988, p. 613).

The client's tendency to accommodate the therapist's discomfort and desire not to know is part of the transferential dynamics that are "acted out". Rosenfeld (American Journal of Psychiatry, 1979) identifies the client's withholding the particulars of a history of intrafamilial childhood sexual abuse as compliance with the therapist's regard of the client's memories as fantasy. Rosenfeld cites Shengold's impressions that many clients with a history of incest may "wish ... very strongly that their memories could be regarded as fantasies" (footnote, p. 743). Historically, the models and theories of clinical practice could be said to have fostered a tradition of disbelief. Herman (1981) attributes this to the dominance of the psychoanalytic school of thought in clinical practice which has emphasized "the incestuous fantasies of children and virtually ignores the incestuous behavior of adults." (p. 78).

In their study of worker knowledge base, Attias and Goodwin (1985) report that "there is [in the area of intrafamilial child sexual abuse and its effects] as yet no solidly agreed upon scientific data base ..." (p. 529). Faria and Belohlavek (1984) termed it a "gap" in the clinical literature. The absence of a clear theory of practice has added to the continued reliance on the existing practice theory base, a condition that led Herman to claim that "At present, mental health professionals are poorly prepared to offer appropriate help and support to these victims." (1981, p. 78).

Attias and Goodwin (1985) compared the knowledge base of private practitioners (psychologists, psychiatrists, pediatricians, and family counselors) to the information found in the literature on
intrafamilial childhood sexual abuse. This study found significant differences between the beliefs held by members of the sampling and the research findings in the literature. The participants overwhelmingly acknowledged a need for more information (96%), and training (86%) in this area (p. 531).

Dietz and Craft (1980) had similar findings in an earlier study of child protective service workers with the Iowa Department of Social Services. Of the workers sampled, 76% reported "believing that their skills and training for working with incestuous families are inadequate," and 95% believed that they needed more information and intervention training (p. 606).

Eisenberg, Owens, and Dewey (1987), in a study of attitudes and beliefs about intrafamilial childhood sexual abuse among 299 individuals from health care practice professions, also found a high incidence of practitioners underestimating prevalence. More than 50% of the sample reported the belief that the frequency was 1 in 500 or less, a sharp contrast to recent prevalence studies. Eisenberg, Owens, and Dewey express the concern that "the low incidence expected may lead to an insensitivity to the possibility of sexual abuse." (p. 115).

In a study of seven medical and non-medical groups, Hibbard and Zollinger (1990) found that social workers had the highest rate (67.4%) of formal training in the area of child sexual abuse, and the highest rate (34.1%) of seeing five or more child sexual abuse victims per month. The social work group also had the highest mean score (85.9%) on an instrument designed to survey knowledge on child abuse and neglect, to include sexual abuse (p. 350). However, this study found that "the training received as part of the professional's professional or pre-service training" was only "somewhat helpful in enabling the professional to more correctly respond to the items on the questionnaire...." Those with the most frequent responses were those professionals with at least two years of professional experience beyond their professional training (p. 353).

Taubman (1984) identifies denial, compartmentalization, and blaming as methods used as defenses to intrafamilial childhood sexual abuse, defenses that are also used by the helping professional. Their use "leads to a restricted view of incest, in which it is removed from its full psychosocial context." (p. 35).
The individuals involved in intrafamilial childhood sexual abuse are "fragmented" in the process of treatment. The fragmentation occurs along the line of the treatment and intervention theories followed. Conte (1984) points out that the helping professionals consistently view intrafamilial childhood sexual abuse as a mental health problem. Conte identifies incest and pedophilia as the two conceptual categories into which the work and study of child sexual abuse is separated, providing the theory and practice context for whom is treated, and how.

The source of disbelief may often be the attitudes and values that are the social workers' borrowings from the culture around them. The practitioner must be able to reach beyond the influences of community and practice culture to integrate new practice based theory (Germain, 1979, p. 60). Conte (1984, p. 260) refers to "professional efforts to recognize that the problem [intrafamilial childhood sexual abuse] exists" as the first stage of professional intervention.
Chapter 3
Methodology

This chapter will discuss the theoretical and conceptual hypotheses, the study questions, and the research design. It will also include a discussion of the three instruments used, and a discussion of the similarities and differences of these vis-à-vis those of the Sagal study (1988). The study sample universe was the 449 ACSW members of the NASW Connecticut Chapter who have listed their practice area as mental health, with a sampling N comprised of the 136 respondents to return completed questionnaires.

The study methodology used a case history vignette of a client's initial presentation portraying historical and symptomatic details that are supported in the literature as commonly presented by an adult survivor of intrafamilial childhood sexual abuse. The participants were asked to speculate on the etiological factors that they would consider in evaluating the case. The study then solicited information from the participants about their gender, age, theoretical orientation, practice experience, training experience, and clinical supervision. Through this approach, the study intended to investigate if differences in these worker characteristics were associated with differences in the consideration of an etiological hypothesis of adult survivorship of intrafamilial childhood sexual abuse as a historic issue in the client's initial presentation.

Statement of Theoretical and Conceptual Hypotheses

The theoretical hypothesis in this study was that there is a correlation of significance between the social worker's personal characteristics, theoretical orientation, professional experience, professional training, and professional supervision, and their frequency of identifying particular etiologies in association with a client's manifestation of symptoms.
The conceptual hypothesis in this study was that the social worker's characteristics as indicated by gender, age, theoretical orientation, professional experience, professional training, and professional supervision, will have a correlation of significance to the social worker's identifying the presence of a history of intrafamilial childhood sexual abuse as an etiological hypothesis for clusters of symptoms and family history factors among their adult female clientele.

Assumptions

1. In the case of an adult with a history of intrafamilial childhood sexual abuse, it was assumed that the time interval from the period of abuse as a child to the point of treatment as an adult functions as an aid to the individual developing a strong hold on the secret through the use of denial, or dissociation (Carmen, et al., 1984; Ellenson, 1985; Ferenczi, 1949; Ganzarian and Buchele, 1986; Gelinas, 1983; Herman, et al., 1986; Herman and Schatzow, 1987). As Rosenfeld (1979) points out, the client will infrequently volunteer the history of abuse, and therefore it becomes the job of the clinician to uncover this information.

2. It is assumed, based on the prevalence and incidence literature in the area of intrafamilial childhood sexual abuse (Brown and Finkelhor, 1986; Gagnon, 1965; Herman and Hirschman, 1981, Kinsey, et al., 1953; Patten, et al., 1989; Wyatt and Peters, 1986), that experienced social workers practicing in the area of mental health will have had contact with clients where intrafamilial childhood sexual abuse is a case history factor.

3. For the purpose of this investigation, participants, while sharing comparable status as members of the Academy of Certified Social Workers, and practicing in the area of mental health, will vary in their sensitivity to intrafamilial childhood sexual abuse as a case history factor based on differences in personal characteristics, theoretical orientation, professional experience, professional training, and clinical supervision (Beck and vander Kolk, 1987; Bryer, et al., 1987; Carmen, et al., 1984; Courtois, 1982; Jacobson and Richardson, 1987; Patten, et al., 1989).

4. Based on the literature, a commonality in patterns of symptom presentation, and family history factors in adults with a history of intrafamilial childhood sexual abuse is assumed. (Barrett, et al.,

5. It is assumed that there are differences in social workers' interests in the issue of adults with a history of intrafamilial childhood sexual abuse, and their preparedness to recognize them. (Conte, 1984; Courtois, 1982; Eisenberg, et al., 1987; Emerson, 1988; Ferenczi, 1949; Ganzarian and Buchele, 1987; Goldwert, 1986; Pavenstadt, 1954; Rieker and Carmen, 1986; Taubman, 1984).

Design of the Study

Professional training and experience form the social worker's theoretical and practice knowledge base (Ewalt, 1979; Federn, 1992; Frank, 1979; Germain, 1979; Wasserman, 1982). For the purposes of this study, the clinical social worker was defined as a social worker possessing the Academy of Certified Social Workers (ACSW) credential who had self identified to the NASW Connecticut Chapter as a practitioner in the area of mental health. In this study of social work practice, it was expected that the worker's training and previous experience with a clinical issue, and the professional community's definition of a clinical issue as within its service mission would influence the frequency of the social worker identifying a clinical issue. This study hypothesized that the worker's training and previous experience with adult survivorship of intrafamilial childhood sexual abuse as a clinical issue, and the professional community's definition of this clinical issue as within its service mission would influence the social worker's readiness to identify a history of intrafamilial childhood sexual abuse in adult clients as a possible etiological issue in the evaluation of a client presenting for treatment (Hibbard and Zollinger, 1990; Johnson, et. al., 1990; Saunders, 1988).

The Sample

The sample universe was the 449 ACSW credentialed social workers who, as members of the NASW Connecticut Chapter, had listed themselves as practitioners in the mental health area. This represented a specialized population from within the 1579 ACSW members of the NASW Connecticut
Approval for access to the membership roles for this study's purposes was secured through the NASW Connecticut Chapter Executive Director.

The ACSW credential had been chosen as the indicator of professional Social Worker for this study. The ACSW is a nationally recognized standard among the Social Work profession. The ACSW was established through the National Association of Social Workers (NASW) in 1962 as the credential to recognize status within the profession as a professional Social Worker. Initially, the requirements were two years of post-Masters practice, documented through transcript and supervisory reference. In 1972, testing for proficiency in the main areas of Social Work practice was added to these initial requirements. Connecticut has only recently legislated the "Certified Independent Social Worker (CISW) credential. This credential, while arguably a more discriminating credential of clinical Social Work status, had become unattractive to many as its future has been threatened by State fiscal policy proposals, and legislative lobbying efforts by conservative political groups.

Study Hypotheses

Study hypothesis 1: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a female social worker is more likely to identify adult clients with a history of intrafamilial childhood sexual abuse, than is a male social worker.

Study hypothesis 2: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, younger social workers, as measured by chronological age, are more likely than older social workers to identify adult clients with a history of intrafamilial childhood sexual abuse.

Study hypothesis 3: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, more experienced professional social workers, as measured by years of social work practice experience since obtaining their MSW, are more likely than less experienced professional social workers to identify adult clients with a history of intrafamilial childhood sexual abuse.
Study hypothesis 4: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, the social worker's sensitivity to identifying adult clients with a history of intrafamilial childhood sexual abuse will vary with their theoretical orientation.

Study hypothesis 5: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports having had previous treatment experience with adult clients with a history of intrafamilial childhood sexual abuse through professional practice is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse than is a social worker who reports not having had previous experience with adult clients with a history of intrafamilial childhood sexual abuse.

Study hypothesis 6: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports having had professional training, through formal educational curricula, or continuing education workshops and seminars, in the area of adult clients with a history of intrafamilial childhood sexual abuse is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse, than is a social worker who reports not having had professional training in the area.

Study hypothesis 7: As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports working in a setting that recognizes adults with a history of intrafamilial childhood sexual abuse as a clinical issue through introduction of it as a clinical issue in supervision, is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse, than is a social worker who reports not working in a setting that recognizes adults with a history of intrafamilial childhood sexual abuse as a clinical issue.

The correlation of gender to sensitivity to a history of intrafamilial childhood sexual abuse was one that was addressed by Sagal (1988) through the structure of the "Psychologist Profile." While that study did not find gender to be "significantly related to incest sensitivity" (p. 77), Attias and Goodwin (1985, p. 532) found gender to be an "important predictor" in worker management of intrafamilial...
childhood sexual abuse. Gender as a factor in incest sensitivity was reexamined to allow comparison to the Sagal study. Further, this reexamination of worker gender as a factor addressed the issue of male versus female practitioners' abilities to empathize with this predominantly female victim population. Gender based differences were felt to also indicate an important potential bias in treatment.

Sagal found differences in incest sensitivity between psychologists over fifty years of age, and psychologists under fifty years of age. Inclusion of chronological age in "Study hypothesis 2" allowed comparison to the Sagal study. It also allowed for examination of differences in overall life experience as a factor in incest sensitivity separate from the issue of professional experience. As with gender, age-based differences could indicate an important bias in treatment.

Study hypotheses 3 and 5 addressed the areas of differences of incest sensitivity based on cumulative professional social work experience. Based on the prevalence and incidence studies cited earlier, it was expected that with cumulative professional social work experience a social worker would also have more experience with clients who have a history of intrafamilial childhood sexual abuse, and with this experience a greater sensitivity to this history as an etiological factor.

The influences of theoretical orientation, and training as bases for consideration of a history of intrafamilial childhood sexual abuse in the initial presentation of an adult client were addressed through study hypotheses 4 and 6. Study hypothesis 7 looked at supervision in the practice setting as an influence on practice.

**Instruments used in the study**

The instruments utilized in this study were borrowings from the Sagal (1988) study, as well as newly developed instruments. This study did not utilize the Bem Sex Role Inventory (BSRI). This study is a new and distinct study in the field of Clinical Social Work with potential for comparisons between the Sagal study's psychologists sample and this study's social worker sample.

The instruments were submitted to a population of professional social workers for pre-test and comments on design. The pre-test population was drawn from the clinical social workers at the community mental health centers in the Pennsylvania cities of Wilkes-Barre and Scranton, as well as from
the clinical social workers at Friendship House, a child and adolescent treatment and residential facility, also in Scranton.

Based on input from the pre-test trial of the instruments, they were reformatted from a nine sheet, single-side printed packet, to a single 17 x 11 inch sheet, double-side printed packet that was folded vertically to a four page 8.5 x 11 inch survey instrument, then horizontally to an economic and user friendly mailer. The survey consisted of the Letter of Transmittal, the Case History, the Case History Questionnaire, and the Social Worker Profile each presented in its entirety on a single page. They appear under this cover as Appendices A-1 through A-4.

**Case History**

Sagal's case history vignette was utilized in this study. The single modification made for this study was to indicate that the subject grew up in Connecticut, rather than in the Southwest as in Sagal's study. (Appendix A-2)

The case history vignette was of a hypothetical adult female client. It provided a description of the presenting problem with reported symptomatology, and a review of the client's personal history. Sagal identified sixteen details of symptomatology, familial, social, and personal background that have been associated in the literature with adults who have experienced intrafamilial childhood sexual abuse that were included in the development of the case history. They were identified as the following:

1. current severe depression
2. marital problems
3. problems parenting children
4. being the oldest daughter in the family
5. having a mother who was frequently absent from home
6. having a father who frequently drank
7. having a father who was overly restrictive
8. having responsibility for household chores and younger siblings during childhood and adolescence
9. drug use in adolescence
10. running away in adolescence
11. promiscuity
12. suicide attempts in adolescence
13. sexual dysfunction
14. distrust of relationships
15. feelings of depersonalization
16. suicide attempt in adulthood (pp. 46-47).

The inclusion of multiple indicators was important in order to prompt diagnostic identification by clinicians from varied theoretical and practice orientations.

Sagal utilized a panel of four experts in the area of adults with a history of intrafamilial childhood sexual abuse to validate the case history. These experts were provided with copies of the case history and asked to "(1) describe whether the case history was typical of an adult incest survivor, and (2) choose the characteristics which were symptomatic of the incest" (p. 47). A separate panel of experts in the area of adults with a history of intrafamilial childhood sexual abuse was utilized in this study to again validate the case history. (See Appendix B).

**Case history questionnaire**

In Sagal's study, the study participants were asked to complete a six item questionnaire after reading the Case History. The items were open ended case history questions, designed to elicit from the participant clinicians hypotheses on diagnostic and etiologic issues that they would want to further investigate to more fully complete their evaluation. The participants were asked to respond to each of the six items in a few sentences.

While the original Sagal questionnaire was used with only minor changes in word choice during a pre-test of the instrument, this study utilized a questionnaire with major revisions in word choice and sentence structure, as follows:
Question 1 was changed from Sagal's "What additional historical information would you suspect to uncover, given the symptoms presented in the case history?" to "What additional historical information would you expect to uncover, given the symptoms presented in the case history?" The change from "suspect" to "expect" was one of word choice, providing a less investigatory tone to the question.

Question 2 was changed from Sagal's "What do you hypothesize was a major reason for Teresa's having run away from home?" to "What do you hypothesize was the one or two most likely reasons for Teresa's having run away from home?" Sagal noted a trend of decreasingly frequent references to incest from case history questionnaire item 1 to case history questionnaire item 6 (i.e., fewer references on item 2 than 1, fewer references on 3 than 2, fewer references on 4 than 3, fewer references on 5 than 4, and fewer references on 6 than 5), Sagal had speculated that there may have been a tendency on the part of the respondents to not want to appear repetitious in their responses. By asking specifically for "the most likely." rather than "a" it was hoped that the respondent's strongest speculation would be elicited, even if it meant appearing repetitious. In addition the request for "one or two" (stressed in italics) was intended to allow room for hypotheses development by the respondent, while limiting that development from becoming a treatise.

Question 3 was changed from Sagal's "What family dynamics in childhood or adolescence might have contributed to the suicide attempts in her teens?" to "What do you hypothesize was the one or two most likely reasons for Teresa's suicide attempts in her teens?" In addition to the rationale for revisions given above in reference to question 2, this revision did not steer the respondent to "family dynamics in Teresa's childhood or adolescence," a phrase that could implicitly put limits, historic and possibly theoretic, on hypotheses speculations.

Question 4 was changed from Sagal's "What historic information would provide you with more clues as to Teresa's sexual dysfunction?" to "What do you hypothesize was the one or two most likely reasons for Teresa's sexual dysfunction?" Again, the rationale for revisions given above in reference to question 2 were followed. And, as in 3, the revision was designed to avoid steering the respondent to historic issues, a potential limit to some theoretic rationales. The revision continued the parallel structure of 2 and 3, a structure that was also used in 5 and 6.
**Question 5** was changed from Sagal's "Do you think anything happened in Teresa's childhood to contribute to the dissociative feelings of 'being here but not here'?" to "What do you hypothesize was the one or two most likely reasons for Teresa's feelings of 'being here but not here'?" The rationale for revisions given above in reference to question 2 was again followed. The term "dissociative" was not used as it was felt to carry strong biasing powers, diagnostically and theoretically, particularly toward the literature on childhood sexual abuse.

**Question 6** was changed from Sagal's "What issues in Teresa's childhood or adolescence may have contributed to her current mistrust of relationships?" to "What do you hypothesize was the one or two most likely reasons for Teresa's current mistrust of relationships?" The rationale for revisions given above in reference to question 2 were again followed. The revision attempted to avoid exclusion of hypotheses that might be based on theoretical tenets that do not rely on client case history.

In the Sagal study, gradations of "sensitivity" was a significant research question. Sagal's original scoring plan for the instrument was to rate each response to each question utilizing a key-word approach on a scale of zero to ten (0 = no mention of incest, sexual abuse, or child abuse; 10 = mention of incest), allowing a scoring range for each participant of zero to 60 (six items X 10). While this scoring plan was felt to be valid in the pre-test, it was found to be less so in the actual study. Sagal substituted a revised scoring plan after the questionnaires were returned. In this revised plan, each questionnaire was read and then placed into one of four overall categories.

**Category 1**: Incest was not considered or suggested in the subject's answers.

**Category 2**: Incest was considered to be possible but not consistently stated or suggested in answers.

**Category 3**: Incest was considered probable and was stated or suggested in most answers.

**Category 4**: Incest was considered as most probable, with the theme carried throughout subjects' answers.

As a measure of reliability, Sagal's scores as the primary investigator were compared to the scores of two independent judges with comparable expertise in the subject area. Sagal reports satisfactory results.
The original scoring plan was intended to allow investigation of inter-item relationships based on gradations of "sensitivity." The revised scoring plan did not look at inter-item relationships, but rather sought to establish "levels of sensitivity" to a history of intrafamilial childhood sexual abuse. The previously noted speculations on respondents' possible attempts to avoid the appearance of redundancy by not repeating intrafamilial childhood sexual abuse throughout the questionnaire, and that many seemed to utilize the six items as prompters for an overall response, led to scoring difficulties in the Sagal study.

For this study, a revised scoring plan was utilized. Responses to all six items on the Case History Questionnaire were read by the investigator, and, based on a total content assessment of the six item responses, collapsed to a single answer and placed into one of two categories:

**Category 1:** Intrafamilial childhood sexual abuse was not considered in the subject's answer.

**Category 2:** Intrafamilial childhood sexual abuse was considered in the subject's answer.

This scoring method was better suited to this study's interests in identification of intrafamilial childhood sexual abuse as a possible issue. The scoring plan was still prone to the validity and reliability issues inherent in the judgment of the reader. However, the use of a two category scoring plan was used to reduce threats to validity posed by a more complex scaling approach.

Similarly to Sagal, this investigator submitted a sampling of responses for scoring to two independent judges, comparing the scores of the three readers for inter-rater reliability. This procedure yielded a 100% agreement in the judges' assessment of the answers as "category 1" or "category 2." In addition, the instrument, as previously noted, was submitted to a population of professional social workers for pre-test and comments on design.

**Social Worker Profile**

Each participant was provided with and asked to anonymously complete a copy of the "Social Worker Profile." The profile collected data utilizing nine items designed to elicit information in the following areas:

1. confirmation of ACSW status
2. how ACSW was obtained
3. gender of respondent

4. age of respondent

5. years of practice since obtaining MSW

6. theoretical orientation

7. professional practice experience

8. professional training

9. professional supervision

Item #1 was designed to function as a check on the individual participant meeting criteria for the sample population. Item #2 was designed to differentiate between those study participants who obtained the ACSW through testing, and those study participants who obtained the ACSW through "grandfathering." Item #3 differentiated male versus female for the purpose of testing study hypothesis #1.

Items #4 and #5 placed age of the respondent, and the respondents post-MSW years of experience into grouped frequency distributions. Item #4 was designed to differentiate younger respondents from older respondent for the purpose of testing study hypothesis #2. Item #5 was designed to differentiate more experienced respondents from less experienced respondents for the purpose of testing study hypothesis #3.

Item #6 categorizes clinical orientation into one of seven areas. The chapter heading structure utilized by Turner in Social Work Treatment (1974) was very influential in deciding on the categories. Item #6 was designed to differentiate theoretical orientation of the respondents for the purpose of testing study hypothesis #3.

Items #7, #8, and #9 utilized a listing of ten areas of clinical concern of which "incest and childhood sexual abuse victims" was one. The intent was to embed this topic in a listing of topics that are associated with presentations of symptoms similar to those presented in this study's Case History instrument. The responses to these items were recorded in a "yes" or "no" category. Item #7 is designed to differentiate respondents experienced in the area of intrafamilial childhood sexual abuse from respondents who are not experienced in this area for the purpose of testing study hypothesis #5. Item #8
is designed to differentiate respondents trained in the area of intrafamilial childhood sexual abuse from respondents who are not trained in this area for the purpose of testing study hypothesis #6. Item #9 is designed to differentiate respondents supervised in the area of intrafamilial childhood sexual abuse from respondents who are not supervised in this area for the purpose of testing study hypothesis #7.

The Pre-Test of the Instrument

The instruments were pre-tested on a voluntary sampling (n= 18) of professional social workers at the community mental health centers in the Pennsylvania cities of Wilkes-Barre and Scranton, as well as from the clinical social workers at Friendship House, a child and adolescent treatment and residential treatment facility, also located in Scranton. The choice of these facilities was based on the remoteness of this sample's geographic location from the intended Connecticut population. In addition, these facilities were chosen on the basis of the convenience of this investigator's professional and personal familiarity with the administrators. The purpose of the pre-test was to obtain feedback on the user-friendliness of the instrument package. The nine-page packets of study instruments were mailed to and distributed through administrative contacts. These contacts were themselves clinical social workers with authority to sanction these sampling activities in their agencies. The packets were collected in person by this investigator, at which time participant comments were gathered.

During this investigator's interviews with the contacts at the three agencies, they all reported that completion of the study took less than the predicted 20 minutes. Suggestions were made to reword the six items on Case History Questionnaire, limiting the answers to one choice per item. Reformatting of both the Case History Questionnaire, and the Social Worker Profile was suggested as means of reducing the number of pages, and creating a more user friendly instrument packet. The initial reaction to the packet of study instruments was that it was unfriendly, being formidable in size, and leaving the participant feeling that it would require more than the predicted 20 minutes. This led several participants to procrastinate in completing their packets. It was also suggested that a category be added to the Social Worker Profile to discern the participant's work setting. It was thought that social workers in non-community mental health center settings would be less familiar with seeing adults with a history of intrafamilial childhood sexual abuse, and would be less likely to routinely inquire after such information.
Three changes were made based on the input of the participants of the pre-test of the instruments. The packet of study instruments was reformatted as previously described, and evidenced in Appendices A-1 through A-4. Second, the Case History Questionnaire items were reworded to limit responses. The third change was to plan to follow the mailing of the instrument packet with a postcard reminder at the end of the first week to ten days, rather than sending follow-up instrument packets as the second wave. The original plan to monitor returns, and utilize a second mailing of the instrument packets as needed was retained and modified with the second packets only to be mailed in the event that the desired number of responses was not prompted by the end of the two weeks following the postcard mailing.

While there was merit to the suggestion of adding an item to discern the participant's work setting, the late addition of this category would have unnecessarily increased the complexity of the study beyond its proposed boundaries.

There was an assumption in the pretesting of the instrument that this small convenience sampling population of social workers could not be reliably viewed as representative of the study's intended sampling of the ACSW population of Connecticut NASW members who had indicated their practice area as health and mental health. In addition, the method of instrument distribution through the supervisory channels at the worksite was significantly different than the study's plan to mail individual packets of instruments directly to the targeted Connecticut social workers at their homes. The worksite distribution plan left wide open the potential that the colleague participants in completing the instruments at the agency might compare responses.

In a review of their responses, it was found that ten (10) of the respondents worked with an exclusively adult population, while the remaining eight (8) worked with an exclusively adolescent population. The distribution of male to female respondents was equal (8 males, and 8 females). All of the respondents were in the 26 to 55 years of age range (26 to 35 years = 4; 36 to 45 years = 9; and 46 to 55 years = 5). The range of post-MSW years was 0 to 30 (0 to 5 years = 6; 6 to 10 years = 3; 11 to 15 years = 1; 16 to 20 years = 6; and 26 to 30 years = 2). Theoretical orientation was reported in five (5) of the seven categories (psychodynamic = 6; behavioral = 1; systems = 2; cognitive = 2; and other = 6). Sixteen (16) of the respondents indicated practice experience in the area of incest and childhood sexual abuse.
victims, eleven (11) reported specialized training in that area, and ten reported professional supervision in that area. Sixteen (16) of the eighteen (18) respondents included intrafamilial childhood sexual abuse in their responses to one or more of the six Case History Questionnaire items. The by item percentages of respondents including intrafamilial childhood sexual abuse in their Case History Questionnaire responses were as follows:

- Item # 1 72%
- Item # 2 50%
- Item # 3 22%
- Item # 4 39%
- Item # 5 72%
- Item # 6 33%

The two respondents who did not include intrafamilial childhood sexual abuse as a consideration in their responses to the Case History Questionnaire items were both from Friendship House, in the 26 to 35 years of age interval, in the 6 to 10 years post-MSW interval, and both reported practice experience and professional supervision in the area of incest and childhood sexual abuse victims. One was male, and the other was female. This pre-test population was small and select in comparison to the intended study sample, and, retrospectively, at variance from the study's respondent population on their characteristics reported on the Social Worker Profile, and in their pattern of responses to the items on the Case History Questionnaire (see Chapter 4, Results of the Study). The equal distribution of nine males and nine females is particularly inconsistent with membership profiles of either NASW, or the Connecticut Chapter of NASW.

Data Collection Plan

The packets of study instruments, the Transmittal Letter, the Case History, the Case History Questionnaire, and the Social Worker Profile, with preaddressed stamped return envelopes were distributed by a direct mailing to the 449 individuals in the sample universe. Each packet of study
instruments was coded to indicate the addressee's NASW Connecticut Chapter region. The original plan, to utilize a bulk rate permit and postal box, was abandoned on the basis of cost following discussions with the local postmaster. Reminder postcards were mailed ten days after the original mailing of the instruments.

The targeted number of completed returns for the study was one hundred, with the first one hundred completed returns to be utilized as the study sample. The rate of return by region was to be monitored, with second packets of instruments to be sent by region as needed. The by region monitoring was designed to allow targeting of the areas of low returns, rather than repeating the entire statewide mailing.

A total of 152 returns were received by the end of six weeks. All retrieved packets were reviewed, and a total of 136 were identified as complete and acceptable for the study. The decision was made to include all 136, as this would provide a 30% sampling of the target population.

Statistical Analysis Plan

The study examined the relationships between the respondents' sensitivity to a history of intrafamilial childhood sexual abuse, as measured by their responses on the Case History Questionnaire, and the respondents' characteristics as measured by their responses on the Social Worker Profile.

Responses to all six items on the Case History Questionnaire were read by the investigator, and, based on a total content assessment of the six item responses as a single answer, placed into one of two categories:

Category 1: Intrafamilial childhood sexual abuse was not considered in the subject's answer.

Category 2: Intrafamilial childhood sexual abuse was considered in the subject's answer.

The assessment of content for the designation of "Category 1" or "Category 2" was based on the respondents' use of terms or phrases that were judged as conceptually equivalent to this study's use of intrafamilial childhood sexual abuse as the sexual use of a child by an adult who is over 15 years of age and at least five years the child's senior, in a kinship role in the same family group. A complete list of the respondents' terms or phrases assessed as fulfilling the "Category 2" response is provided in Appendix E.
In addition, responses to each item on the Case History Questionnaire were also recorded as fitting into "Category 1" or "Category 2." Frequency distributions on the scores obtained for the six items on the Case History Questionnaire were computed, as were frequency distributions for the nine items on the Social Worker Profile.

All data categories on the Case History Questionnaire were at the nominal level of measurement. Data reported in Social Worker Profile items 1, 2, 3, 6, 7, 8, and 9, were also at the nominal level of measurement. Items 4 and 5 on the Social Worker Profile were at the ordinal level of measurement. The statistical analysis plan was for nonparametric statistical procedures to be utilized, with alpha = .05 level.

The overall responses on the Case History Questionnaire, as well as responses to each of the six items on the Case History Questionnaire (dependent variables) were compared to the items on the Social Worker Profile (independent variables) using the "StatView" software for MacIntosh computers. The statistical analysis plan was for the degree of association among these variables to be determined utilizing chi-square and contingency table analysis, yielding coefficients of correlation for each variable. In addition, the statistical analysis plan was for a multiple regression to be computed to examine the magnitude and statistical significance of the relationships among the variables indicated on the Social Worker Profile in predicting sensitivity, as measured by their overall response to the Case History Questionnaire.
Chapter 4
Results of the Study

This chapter will discuss the data gathered through the 136 returned Case History Questionnaires, and Social Worker Profiles that were judged to be complete, and utilized as the study sampling. The data will be reviewed as it relates to the study hypotheses presented in Chapter 3. The chapter will also include a discussion of the difficulties encountered in following the statistical analysis plan outlined in Chapter 3, and the revisions of the statistical analysis plan that became necessary.

The data is initially presented in frequency distributions drawn from the responses to items on the Social Worker Profiles and on the Case History Questionnaires. The study sample population's responses to the Social Worker Profile items are then compared to their responses on the Case History Questionnaire to examine the nature of the relationship among the personal and professional characteristics of the social workers included in the study to their consideration of intrafamilial childhood sexual abuse as an etiological issue in the assessment of the Case History vignette provided in the study. These comparisons are presented in contingency and percentages tables. In addition, the responses to the six items on the Case History Questionnaire are reviewed through the use of the Friedman two-way analysis of variance by ranks.

Frequency Distributions for the Social Worker Profile

The sample universe was the 449 ACSW members of the NASW Connecticut Chapter who have listed themselves as practitioners in the mental health area. A total of 152 questionnaires were returned, providing a response rate of 33.9%. Of those returns, 136 were complete and included in the study. All 136 respondents reported being credentialed as ACSWs, with 102 (75%) stating that they had obtained the ACSW through testing.

Results on Social Worker Profile item 3, which asked for the respondents' gender, indicate that 98 (72%) were female, and 38 (27%) were male. Respondents' chronological ages were gathered on item 4, and reported across five of the six age intervals, with the largest group (mode) in the 46-55 years of age
interval (n=54, 40%) which was also the median. Age distribution is displayed below in Table 1.

**Table 1: Age distribution of respondents**

<table>
<thead>
<tr>
<th>Interval</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-35 years</td>
<td>9</td>
<td>6.62</td>
</tr>
<tr>
<td>36-45 years</td>
<td>43</td>
<td>32.62</td>
</tr>
<tr>
<td>46-55 years</td>
<td>54</td>
<td>39.71</td>
</tr>
<tr>
<td>56-65 years</td>
<td>26</td>
<td>19.12</td>
</tr>
<tr>
<td>over 65 years</td>
<td>4</td>
<td>2.94</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Item 5, which gathered information on the number of post-MSW years the respondent had been practicing, elicited responses in all nine intervals, with the largest number (n=32, 24%) falling into the "11-15" year interval. Years since receiving MSW is reported below in Table 2.

**Table 2: Years since receiving MSW**

<table>
<thead>
<tr>
<th>Interval</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>6</td>
<td>4.41</td>
</tr>
<tr>
<td>6-10 years</td>
<td>31</td>
<td>22.79</td>
</tr>
<tr>
<td>11-15 years</td>
<td>32</td>
<td>23.53</td>
</tr>
<tr>
<td>16-20 years</td>
<td>27</td>
<td>19.86</td>
</tr>
<tr>
<td>21-25 years</td>
<td>19</td>
<td>13.97</td>
</tr>
<tr>
<td>26-30 years</td>
<td>11</td>
<td>8.09</td>
</tr>
<tr>
<td>31-35 years</td>
<td>5</td>
<td>3.68</td>
</tr>
<tr>
<td>36-40 years</td>
<td>2</td>
<td>1.47</td>
</tr>
<tr>
<td>41+ years</td>
<td>3</td>
<td>2.21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Item 6 of the Social Worker Profile requested respondents to indicate the clinical orientation that most closely described their practice orientation. In those situations where the respondent indicated more than one clinical orientation (e.g., psychodynamic and systems), this was interpreted as a combination of orientations, and placed in the category "other." The category most frequently indicated was "psychodynamic" (n=63, 46%). The results of the respondents' indications of clinical orientations follow in Table 3.
Table 3: Clinical practice orientation

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychodynamic</td>
<td>63</td>
<td>46.32</td>
</tr>
<tr>
<td>behavioral</td>
<td>1</td>
<td>0.74</td>
</tr>
<tr>
<td>existential</td>
<td>1</td>
<td>0.74</td>
</tr>
<tr>
<td>systems</td>
<td>20</td>
<td>14.71</td>
</tr>
<tr>
<td>cognitive</td>
<td>4</td>
<td>2.94</td>
</tr>
<tr>
<td>feminist</td>
<td>2</td>
<td>1.47</td>
</tr>
<tr>
<td>other</td>
<td>45</td>
<td>33.09</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>136</td>
<td>100</td>
</tr>
</tbody>
</table>

On item 7 of the Social Worker Profile, "With 'professional practice experience' defined as "direct clinical social work with individual clients, couples, families, and/or groups to provide treatment and prevention of psychosocial dysfunction, disability or impairment, including emotional and mental disorders," 131 (96%) of the respondents reported professional practice experience in the area of "incest and childhood sexual abuse victims." On item 8 of the Social Worker Profile, which asked respondents to indicate areas in which they had received professional training, 106 (78%) reported that they had received such training in the area of "incest and childhood sexual abuse victims." On item 9 of the Social Worker Profile, 104 (76%) respondents indicated that they had received "professional supervision" in the area of the "incest and childhood sexual abuse victims."

**Summary Description of Respondents**

Based on the modes of the responses gathered through the Social Worker Profile, the "typical" respondent in this study might be characterized as a female (n = 98, % = 72), ACSW (N = 136, % = 100), who obtained her ACSW through testing (n = 102, % = 75), and has had professional practice experience (n = 131, % = 96), professional training (n = 106, % = 78), and professional supervision (n = 104, % = 77) in clinical work with "incest and childhood sexual abuse victims." This typical respondent is most likely between the ages of 36 years and 55 years. (The 36-45 years of age category had an 'n' of 43, and the 46-55 years of age category had an 'n' of 54. This twenty year interval represents 72.3 percent of the
respondents.) The respondent is most likely to have chosen either "psychodynamic" (n = 63, % = 46.3), or "other" (n = 45, % = 33.1) from the clinical practice orientation categories provided.

**Frequency Distributions for the Case History Questionnaire**

In reviewing the returns, 128 respondents (94.1%) indicated a consideration of intrafamilial childhood sexual abuse as an etiological factor in their response to one or more of the six items on the Case History Questionnaire. The scoring plan criteria established in the study design called for a total content assessment of the six item responses to arrive at a single overall score for the Case History Questionnaire, placing it into one of the following two categories:

**Category 1:** Intrafamilial childhood sexual abuse was not considered in the subject's answer; or,

**Category 2:** Intrafamilial childhood sexual abuse was considered in the subject's answer.

In accord with the scoring plan, the returns from those 128 respondents who indicated consideration of intrafamilial childhood sexual abuse as an etiological factor to one or more items met the definition for an overall Category 2 score. A listing of the key words and phrases assessed as meeting the Category 2 criteria is presented in Appendix E. The frequency of Category 2 responses on individual Case History Questionnaire items are reported below in Table 4.
Table 4: Category 2 response to Case History Questionnaire

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 What additional historic information would you expect to uncover, given the symptoms presented in the case history?</td>
<td>120</td>
<td>88.24</td>
</tr>
<tr>
<td>#2 What do you hypothesize was the <em>one or two</em> most likely reasons for Teresa's running away from home?</td>
<td>97</td>
<td>71.32</td>
</tr>
<tr>
<td>#3 What do you hypothesize was the <em>one or two</em> most likely reasons for Teresa's suicide attempts in her teens?</td>
<td>58</td>
<td>42.65</td>
</tr>
<tr>
<td>#4 What do you hypothesize was the <em>one or two</em> most likely reasons for Teresa's sexual dysfunction?</td>
<td>96</td>
<td>70.59</td>
</tr>
<tr>
<td>#5 What do you hypothesize was the <em>one or two</em> most likely reasons for Teresa's feelings of &quot;being here but not here&quot;?</td>
<td>50</td>
<td>36.77</td>
</tr>
<tr>
<td>#6 What do you hypothesize was the <em>one or two</em> most likely reasons for Teresa's current mistrust of relationships?</td>
<td>49</td>
<td>36.03</td>
</tr>
</tbody>
</table>
The Returns: Testing of the Study Hypotheses

In following the scoring plan for the Case History Questionnaires outlined in Chapter 3, 128 of the respondents indicated an etiological speculation of intrafamilial childhood sexual abuse on one or more of the six items. This high number of respondents meeting the Category 2 criteria presented a significant issue for the original statistical analysis plan to utilize chi square and contingency table analysis, as well as multiple regression. The chi square and multiple regression statistical procedures, as well as calculations of the phi coefficient, the Cramer's V statistic, and a correlation matrix of variables were completed utilizing "Statview" for MacIntosh. In developing contingency tables to examine the relationships that might exist between the dependent variables (responses on the Case History Questionnaire), and the independent variables (responses on the Social Worker Profile) the distribution of scores across the cells was judged on face value to be too disparate. A statistician's consult was obtained (Thiel, 1994), and it was determined that based on the data, percentages were the most appropriate statistical analysis that could be computed.

Percentage tables were utilized to study the relationships that existed between the dependent variables as measured by the responses to the Case History Questionnaire, and the independent variables as measured by the responses on the Social Worker Profile. In utilizing the percentage table method, the strength of the relationships between dependent variables and independent variables is indicated by the magnitude of the percentage score, and the relative strength of the independent variables' relationships to the dependent variable is measured by the column percentage differences, or epsilons, displayed across the row. Percentages, while allowing an evaluation of bivariate and multivariate relationships, are a relatively elementary level of statistical analysis, and do not lend themselves to tests of significance that would allow judgments on whether the differences of scores between the independent variables is a real difference, or a chance variation. This limitation allows review of the study hypotheses on face value only. The seven study hypotheses are presented sequentially.
Study hypothesis 1, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a female social worker is more likely to identify adult clients with a history of intrafamilial childhood sexual abuse than is a male social worker," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 3. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 3 on the Social Worker Profile was the measure of the independent variable. The reported frequency and percentage table for responses to Social Worker Profile item 3, gender, follows as Table 5.

Table 5: Social worker gender by Case History Questionnaire response.

<table>
<thead>
<tr>
<th>Category 1 response: Intrafamilial childhood sexual abuse was not considered</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Category 2 response: Intrafamilial childhood sexual abuse was considered</td>
<td>34</td>
<td>89.5</td>
</tr>
<tr>
<td>Totals</td>
<td>38</td>
<td>100</td>
</tr>
</tbody>
</table>

Epsilon = 6.4

The percentage differences between males and females yields an epsilon of 6.4, indicating a higher association of Category 2 answers among the female social workers' responses than among the male social workers' responses. While this would indicate that a larger percentage of female social workers in the study sample than male social workers in the study sample considered adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their responses to the Case History Questionnaire, the disparate
frequency distribution across the cells does not support a testing for significance.

**Study hypothesis 2**, "As measured by the rate of considering adult survivorship of intrafamilial childhood's sexual abuse as an etiological factor based on material presented in an initial case history, younger social workers, as measured by chronological age, are more likely than older social workers to identify adult clients with a history of intrafamilial childhood sexual abuse," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 4. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 4 on the Social Worker Profile was the measure of the independent variable. The scores on Social Worker Profile item 4 were dichotomized by grouping the first three categories (a. under 26, b. 26-35, and c. 36-45) as a "45 yrs. and less" interval, and the last three categories (d. 46-55, e. 56-65, f. over 65) as a "46 yrs. and more" interval, allowing a comparison of "younger social workers" to "older social workers."

The observed frequency and percentage table for all response categories to Social Worker Profile item 4 follows as Table 6. The reported frequency and percentage table for the dichotomized age intervals of younger and older to Social Worker Profile item 4 follows as Table 7.

As displayed on Table 7, "Social worker age, dichotomized as 45 years and less, and 46 years and more, by overall Case History Questionnaire response," the percentage
Table 6: Social worker age, in years, by overall Case History Questionnaire response

<table>
<thead>
<tr>
<th>Category 1 response:</th>
<th>26 to 35 yrs.</th>
<th>36 to 45 yrs.</th>
<th>46 to 55 yrs.</th>
<th>56 to 65 yrs.</th>
<th>66 or more yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrafamilial childhood sexual abuse was not considered.</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Category 2 response:</td>
<td>9</td>
<td>100</td>
<td>40</td>
<td>93</td>
<td>53</td>
</tr>
<tr>
<td>Intrafamilial childhood sexual abuse was considered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Totals | 9 | 100 | 43 | 100 | 54 | 100 | 26 | 100 | 4 | 100 |

Table 7: Social worker age, dichotomized as 45 yrs and less, and 46 yrs and more, by overall Case History Questionnaire response.

<table>
<thead>
<tr>
<th>Category 1 response:</th>
<th>45 yrs and less</th>
<th>46 years and more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrafamilial childhood sexual abuse was not considered.</td>
<td>3</td>
<td>5.8</td>
</tr>
<tr>
<td>Category 2 response:</td>
<td>49</td>
<td>94.2</td>
</tr>
<tr>
<td>Intrafamilial childhood sexual abuse was considered.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Totals | 52 | 100 | 74 | 100 |

Epsilon = 1.0
difference between younger social workers and older social workers yields an epsilon of 1.0, indicating a higher association of Category 2 answers among younger social workers' responses than among older social workers' responses. While this would indicate that a larger percentage of younger social workers in the study sample than older social workers in the study sample considered adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their responses to the Case History Questionnaire, the disparate frequency distribution across the cells does not support a testing for significance. In addition, the low epsilon of 1.0 indicates a weak, almost not existent, difference in the degree of association between younger and older social workers and a Category 2 response on the Case History Questionnaire.

Study hypothesis 3, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, more experienced professional social workers, as measured by years of social work practice experience since obtaining their MSW, are more likely than less experienced professional social workers to identify adult clients with a history of intrafamilial childhood sexual abuse," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 5. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 5 on the Social Worker Profile was the measure of the independent variable. The scores on Social Worker Profile item 5 were dichotomized by grouping the first four categories (a. 0-5 yrs., b. 6-10 yrs., c. 11-15 yrs., and d. 16-20 yrs.) as a "20 yrs. and less" interval, and the last five categories (e. 21-25 yrs., f. 26-30 yrs., g. 31-35 yrs., h. 36-40 yrs., and i. 41+ yrs.) as a "21 yrs and more" interval, allowing a comparison of "less experienced social workers" to "more experienced social workers." The observed frequency and percentage table for all response categories to Social Worker Profile item 5 follows as Table 8. The reported frequency and percentage table for the dichotomized age intervals of younger and older to Social Worker Profile item 5 follows as Table 9.
As displayed on Table 9, "Social worker post-MSW years of experience, dichotomized as 20 years and less, and 21 years and more, by overall Case History Questionnaire response," the percentage difference between less experienced social workers and more experienced social workers yields an epsilon of 9.4, indicating a higher association of Category 2 answers among less experienced social workers' responses than among more experienced social workers' responses. While this would indicate that a larger percentage of less experienced social workers in the study sample than more experienced social workers in the study sample considered adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their responses to the Case History Questionnaire, the disparate frequency distribution across the cells does not support a testing for significance. The epsilon 9.4 does indicate a difference in the degree of association between less experienced and more experienced social workers and a Category 2 response on the Case History Questionnaire.

Study hypothesis 4, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, the social worker's sensitivity to identifying adult clients with a history of intrafamilial childhood sexual abuse will vary with their theoretical orientation," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 6. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 6 on the Social Worker Profile was the measure of the independent variable. The reported frequency and percentage table for all response categories to Social Worker Profile item 6 follows as Table 10.
Table 8: Social worker post-MSW years of experience by overall Case History Questionnaire response

<table>
<thead>
<tr>
<th>Category 1 response: Intrafamial childhood sexual abuse was not considered.</th>
<th>0-5 yrs</th>
<th>6-10 yrs</th>
<th>11-15 yrs</th>
<th>16-20 yrs</th>
<th>21-25 yrs</th>
<th>26-30 yrs</th>
<th>31-35 yrs</th>
<th>36-40 yrs</th>
<th>41+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3.2</td>
<td>2</td>
<td>6.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>100</td>
<td>30</td>
<td>96.8</td>
<td>30</td>
<td>93.7</td>
<td>27</td>
<td>100</td>
<td>10</td>
<td>90.9</td>
</tr>
<tr>
<td>11</td>
<td>100</td>
<td>27</td>
<td>100</td>
<td>16</td>
<td>84.2</td>
<td>10</td>
<td>90.9</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>100</td>
<td>2</td>
<td>100</td>
<td>2</td>
<td>100</td>
<td>3</td>
<td>100</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 9: Social worker post-MSW years of experience dichotomized as 20 years and less, and as 21 years and more, by overall Case History Questionnaire response.

<table>
<thead>
<tr>
<th>Category 1 response: Intrafamial childhood sexual abuse was not considered.</th>
<th>20 yrs and less</th>
<th>21 yrs and more</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>3</td>
<td>3.1</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2 response: Intrafamial childhood sexual abuse was considered.</th>
<th>20 yrs and less</th>
<th>21 yrs and more</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>93</td>
<td>96.9</td>
<td>35</td>
</tr>
</tbody>
</table>

Totals | 96 | 100 | 40 | 100 | Epsilon = 9.4
The display of the clinical practice orientations in Table 10 indicates the three most frequent to be "psychodynamic" (n = 63), "other" (n = 45), and "systems" (n = 20). The response frequencies in the remaining four orientations were extremely low, with all respondents in those intervals scoring a Category 2 response on the Case History Questionnaire. Social Worker Profile item 6 response choices were at the nominal level, unlike items 4 and 5, and did not lend themselves to being dichotomized as had the responses to items 4 and 5. The values of three percentage differences were calculated between the scores in the "psychodynamic," "other," and "systems" categories, the epsilons were as follows:

- Systems orientation to Psychodynamic orientation, epsilon = 6.3
- Systems orientation to "Other" orientation, epsilon = 8.9
- Psychodynamic orientation to "Other" orientation, epsilon = 2.6.

While the percentages provided on Table 10 would indicate that differences in the degrees of association exist in this study population between the social workers' indicated clinical orientation and consideration of adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their Case History Questionnaire responses, the differences appear to be weak.

**Study hypothesis 5**, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports having had previous treatment experience with adult clients with a history of intrafamilial childhood sexual abuse through professional practice is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse than is a social worker who reports not having had previous experience with adult clients with a history of intrafamilial childhood sexual abuse," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on
Table 10: Social Worker clinical orientation, by overall Case History Questionnaire response.

<table>
<thead>
<tr>
<th>Category 1 response: Intrafamilial childhood sexual abuse was not considered</th>
<th>Psychodynamic</th>
<th>Behavioral</th>
<th>Existential</th>
<th>Systems</th>
<th>Cognitive</th>
<th>Feminist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>4</td>
<td>6.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Category 2 response: Intrafamilial childhood sexual abuse was considered</td>
<td>59</td>
<td>93.7</td>
<td>1</td>
<td>100</td>
<td>1</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>63</td>
<td>100</td>
<td>1</td>
<td>100</td>
<td>1</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>
Social Worker Profile item 7. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 7 on the Social Worker Profile was the measure of the independent variable. The reported frequency and percentage table for responses to Social Worker Profile item 7, practice experience, follows as Table 11.

**Table 11: Social worker practice experience with incest and childhood sexual abuse by overall Case History Questionnaire response.**

<table>
<thead>
<tr>
<th>Category 1 response: Intrafamilial childhood sexual abuse was not considered.</th>
<th>No practice experience with incest and childhood sexual abuse</th>
<th>Practice experience with incest and childhood sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>1</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Category 2 response: Intrafamilial childhood sexual abuse was considered</td>
<td>4</td>
<td>80</td>
</tr>
<tr>
<td>Totals</td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>

Epsilon = 14.7

As displayed on Table 11, "Social worker practice experience with incest and childhood sexual abuse, by overall Case History Questionnaire response," the percentage difference between social workers with practice experience in this area and social workers without practice experience in this area yields an epsilon of 14.7, indicating a higher association of Category 2 answers among social workers whose responses indicated practice experience in this area than among social workers whose responses indicated no practice experience in this area. While this would indicate that a larger percentage of social workers in the study sample with practice experience in the area of incest and childhood sexual abuse than social workers in the study sample with no practice experience in the area of incest and childhood sexual abuse considered adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their responses to the Case History Questionnaire, the disparate frequency distribution across the cells does not
support a testing for significance. The epsilon 14.7 does indicate a difference in the degree of association between social workers in this study sample with practice experience in this area and those without practice experience in this area, and a Category 2 response on the Case History Questionnaire.

Study hypothesis 6, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports having had professional training, through formal educational curricula, or continuing education workshops and seminars, in the area of adult clients with a history of intrafamilial childhood sexual abuse is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse, than is a social worker who reports not having had professional training in the area, "was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 8. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 8 on the Social Worker Profile was the measure of the independent variable. The reported frequency and percentage table for responses to Social Worker Profile item 8, training in the area of incest and childhood sexual abuse, follows as Table 12.

| Table 12: Social worker training in the area of incest and childhood sexual abuse, by overall Case History Questionnaire response. |
|-------------------------------------------------|-----------------|-----------------|
|                                                   | No training in the area of incest and childhood sexual abuse | Training in the area of incest and childhood sexual abuse |
| Category 1 response: Intrafamilial childhood sexual abuse was not considered. | n   | %   |
|                                                   | 2   | 6.7 |
| Category 2 response: Intrafamilial childhood sexual abuse was considered | n   | %   |
|                                                   | 28  | 93.3|
| Totals                                           | 30  | 100 |
|                                                   | 106 | 100 |

Epsilon = 1.0
Social worker training in the area of incest and childhood sexual abuse, as displayed on Table 12 indicates that there is a percentage difference between social workers with training in the area, and social workers without training in the area, yielding an epsilon of 1.0, indicating a higher association of Category 2 answers among responses of social workers with training in the area of incest and childhood sexual abuse than among responses of social workers without training in this area. While this would indicate that a larger percentage of social workers in the study sample with training in this area than social workers in the study sample without such training considered adult survivorship of intrafamilial childhood sexual abuse as an etiological factor in their responses to the Case History Questionnaire, the disparate frequency distribution across the cells does not support a testing for significance. For this study sample, the epsilon 1.0 indicates a weak, almost not existent, difference in the degree of association between social workers trained in the area of incest and childhood sexual abuse and those not so trained, and a Category 2 response on the Case History Questionnaire.

Study hypothesis 7, "As measured by the rate of considering adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in an initial case history, a social worker who reports working in a setting that recognizes adults with a history of intrafamilial childhood sexual abuse as a clinical issue through introduction of it as a clinical issue in supervision, is more likely to identify cases of adults with a history of intrafamilial childhood sexual abuse than is a social worker who reports not working in a setting that recognizes adults with a history of intrafamilial childhood sexual abuse as a clinical issue," was analyzed for association of the independent variable to the dependent variable by comparison of percentaged distributions (Leonard, p. 272) of the responses gathered on Social Worker Profile item 9. The score of the response to the Case History Questionnaire was the measure of the dependent variable, and the score of the response to item 9 on the Social Worker Profile was the measure of the independent variable. The reported frequency and percentage table for responses to Social Worker Profile item 9, professional supervision in the area of incest and childhood sexual abuse, follows as Table 13.
Professional supervision in the area of incest and childhood sexual abuse among the study sample is displayed on Table 13. The percentage difference between those social workers indicating professional supervision in this area and social workers indicating no professional supervision in this area yielded an epsilon of only 0.5. While this would indicate that a larger percentage, the difference between the groups is negligible. The disparate frequency distribution across the cells does not support a testing for significance.

**The Case History Questionnaire Item Analysis**

An additional revision to the original statistical analysis plan was the decision to study the responses to the six individual items on the Case History Questionnaire. The pattern of Category 2 responses to the Case History Questionnaire items (see Table 4) did not seem to support Sagal's speculation that respondents, wanting to avoid an appearance of redundancy, might not continue to venture a speculation of adult survivorship of intrafamilial childhood sexual abuse as they progressed through the questionnaire. The expected answer response to support this speculation should have created a pattern of decreasing Category 2 responses as the study respondents progressed from item 1 through item 6. This did not appear to be the case, and it was felt possible that a Category 2 response might
correlate to the respondent's interpretation of the symptom. An etiological hypothesis based on the 
elements of the client's presentation has different implications than an etiological hypothesis based on the 
personal and professional characteristics of the social worker.

A statistical analysis of the responses to the Case History Questionnaire was conducted utilizing 
allows testing for statistically significant differences in the respondents ranking of the six Case History 
Questionnaire items as prompters for consideration of an etiological hypothesis of intrafamilial childhood 
sexual abuse in their responses. The ranking of each Case History Questionnaire item is based on the 
percentage of respondents in each category of a Social Worker Profile item that scored a Category 2 
response in their answer to that Case History Questionnaire item. The rationale behind the use of the 
Friedman two-way analysis is to test whether differences between the observed rankings of the Case 
History Questionnaire items, and chance rankings of the Case History Questionnaire items are statistically 
significant. The null hypothesis approach is utilized. The null hypothesis would state that there is no 
difference between the observed rankings and chance rankings. The Friedman test was employed to test if 
the observed rankings were discrete enough from chance rankings, allowing rejection of the null hypothesis.

The Friedman two-way analysis of variance by ranks allows analysis of nonparametric data in a 
two way classification through the comparison of the rank ordering of the respondent groups' frequency of 
item selection. The rank ordering is established through the use of percentage tables that permit the 
conversion of the nominal level data collected in this study to ordinal level. The data is displayed through 
the use of contingency tables, with the rank order score for each dependent variable (Case History 
Questionnaire item responses) occurring in columns, and the ranking by the study's respondent groups 
(defined by Social Worker Profile item Category 2 responses) of the dependent variables occurring across 
the rows. The ranks within each column are summed, with these sums represented by the Rj's. The test 
statistic is symbolized as 

\[ X_r^2 \]

and the tables for "Distribution of \( X^2 \) " (Leonard, p.373) are utilized. The data is
displayed in rank order on Table 14 through Table 20. For all of the statistical tests performed on the data displayed, the degrees of freedom are 5, and, at an alpha level of .001, the test statistic value must be equal to or greater than 20.517 to allow rejection of the null hypothesis.

**Table 14: Social workers' by gender rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses.**

<table>
<thead>
<tr>
<th></th>
<th>question 1</th>
<th>question 2</th>
<th>question 3</th>
<th>question 4</th>
<th>question 5</th>
<th>question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>1</td>
<td>2.5</td>
<td>4</td>
<td>2.5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>female</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>4.5</td>
<td>8</td>
<td>5.5</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

\[ X^2_r = 78.2 \quad df = 5 \]

The test statistic value of 78.2 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by male respondents, and female respondents.

**Table 15: Social workers' by age rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses, with age dichotomized as 45 or less years, and 46 and more years.**

<table>
<thead>
<tr>
<th></th>
<th>question 1</th>
<th>question 2</th>
<th>question 3</th>
<th>question 4</th>
<th>question 5</th>
<th>question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 45 yrs</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>&gt;= 46 yrs</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

\[ X^2_r = 77.88 \quad df = 5 \]

The test statistic value of 77.88 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents 45 or less years of age, and respondents 45 or more years of age.
Table 16: Social workers' by years of post-MSW practice rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses with years of post-MSW practice dichotomized as 20 or less years, and 21 or more years.

<table>
<thead>
<tr>
<th></th>
<th>question1</th>
<th>question2</th>
<th>question3</th>
<th>question4</th>
<th>question5</th>
<th>question6</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 20 yrs</td>
<td>1</td>
<td>2.5</td>
<td>4</td>
<td>2.5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>&gt;= 21 yrs</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>4.5</td>
<td>8</td>
<td>5.5</td>
<td>10.5</td>
<td>11.5</td>
</tr>
</tbody>
</table>

\[ X^2 = 78.5 \quad df = 5 \]

The test statistic value of 78.5 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents with 20 or less years post-MSW practice experience, and respondents with 20 or more years post-MSW experience.

Table 17: Social workers' by theoretical orientation rankings of the questions on the Case History Questionnaire, as indicated by Category 2 responses,

<table>
<thead>
<tr>
<th></th>
<th>question1</th>
<th>question2</th>
<th>question3</th>
<th>question4</th>
<th>question5</th>
<th>question6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Behavioral</td>
<td>2.5</td>
<td>5.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Existential</td>
<td>2.5</td>
<td>5.5</td>
<td>5.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Systems</td>
<td>1</td>
<td>2.5</td>
<td>5.5</td>
<td>2.5</td>
<td>5.5</td>
<td>4</td>
</tr>
<tr>
<td>Cognitive</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Feminist</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>4.5</td>
<td>3</td>
<td>6</td>
<td>4.5</td>
</tr>
<tr>
<td>Rj</td>
<td>11.5</td>
<td>25</td>
<td>27.5</td>
<td>17</td>
<td>32.5</td>
<td>33.5</td>
</tr>
</tbody>
</table>

\[ X^2 = ( -3.7 ) \quad df = 5 \]
The test statistic value of (-3.7) is less than 20.517, and should not allow rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents grouped by clinical orientation. However, the cell frequencies for the "Behavioral," "Existential," "Cognitive," and "Feminist" clinical orientation categories are extremely small. As in the attempt to utilize chi square analysis, these small and desperate frequencies present a situation where the data is spurious. With this distribution, the use of the Friedman two-way analysis of variance by ranks is unable to accomplish its intended purpose.

Table 18: Social workers', by practice experience with incest and childhood sexual abuse, rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses.

<table>
<thead>
<tr>
<th>Practice experience</th>
<th>question 1</th>
<th>question 2</th>
<th>question 3</th>
<th>question 4</th>
<th>question 5</th>
<th>question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice experience</td>
<td>1</td>
<td>2.5</td>
<td>4</td>
<td>2.5</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>No practice experience</td>
<td>1</td>
<td>2.5</td>
<td>2.5</td>
<td>4.5</td>
<td>4.5</td>
<td>6</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>5</td>
<td>6.5</td>
<td>7</td>
<td>10</td>
<td>11.5</td>
</tr>
</tbody>
</table>

\[X^2_r = 75.5 \quad \text{df} = 5\]

The test statistic value of 75.5 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents with professional practice experience with incest and childhood sexual abuse victims, and respondents with no professional practice with incest and childhood sexual abuse victims.
Table 19: Social workers', by training in the area of incest and childhood sexual abuse, rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses.

<table>
<thead>
<tr>
<th></th>
<th>question 1</th>
<th>question 2</th>
<th>question 3</th>
<th>question 4</th>
<th>question 5</th>
<th>question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>No training</td>
<td>1</td>
<td>2.5</td>
<td>5</td>
<td>2.5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>4.5</td>
<td>9</td>
<td>5.5</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 76.7 \quad df = 5 \]

The test statistic value of 76.7 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents with specialized training in the area of incest and childhood sexual abuse victims, and respondents with no specialized training in the area of incest and childhood sexual abuse victims.

Table 20: Social workers', by supervision in the area of incest and childhood sexual abuse, rankings of the six questions on the Case History Questionnaire, as indicated by Category 2 responses.

<table>
<thead>
<tr>
<th></th>
<th>question 1</th>
<th>question 2</th>
<th>question 3</th>
<th>question 4</th>
<th>question 5</th>
<th>question 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>1</td>
<td>2.5</td>
<td>4</td>
<td>2.5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>No supervision</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Rj</td>
<td>2</td>
<td>4.5</td>
<td>9</td>
<td>5.5</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 76.7 \quad df = 5 \]

The test statistic value of 76.7 is greater than 20.517, allowing rejection of the null hypothesis that there is no difference between the observed rankings and chance rankings of the Case History Questionnaire items by respondents with professional supervision in the area of incest and childhood sexual abuse victims, and respondents with no supervision in the area of incest and childhood sexual abuse victims.
Case History Questionnaire item 1, which asked the respondents to speculate on the "additional historical information" that they might expect to uncover based on the overall symptom and family history profile presented was ranked highest of all the Case History Questionnaire items. The other five items asked the respondents to hypothesize on the basis of specific behaviors or symptoms presented by the client portrayed in the Case History. Case History Questionnaire item 2, which addressed running away behavior, was consistently the second most highly ranked item, and item 4, which addressed sexual dysfunction, was consistently the third most highly ranked of the six items. It might be speculated that, compared to the attempt to discern personal or professional characteristics among those included on the Social Worker Profile, the client's historic, symptomatic, and behavioral characteristics might have been more fruitful foci in this investigation of discriminating correlates to the consideration of a history of intrafamilial childhood sexual abuse as an etiological hypothesis.

**Statistical and Practical Significance of the Findings**

The statistical significance of the findings as well as the practical significance of the findings are limited to the participants of this study. The sampling method allowed members of the targeted population of NASW Connecticut Chapter ACSW members who had listed themselves as practitioners in the mental health area who were mailed the study instruments to choose to participate or not participate. It can not be assumed that with the degree of self-selectivity afforded the target population that it is accurately reflected in the respondent population. In addition, it should not be assumed that the practice beliefs and characteristics of this Connecticut population would accurately reflect those of other clinical social work groups defined by other demographic parameters. While similarities in responses might be found between the respondent population and the Pennsylvania based pre-test population, the methodologies of population selection, instrument distribution, instrument design, as well as original intent of the pre-test as an evaluation of instrument user friendliness, precludes the ability to use the two samplings in a comparative manner of either statistical or substantive merit.

In the original statistical analysis plan utilizing the "Statview" for Macintosh program, the only variable from the Social Worker Profile yielding a statistically significant measure of association to the consideration of intrafamilial childhood sexual abuse in responses to the Case History Questionnaire was
item number 4, "What was your age at your last birthday?" This item was used as a measure of study hypothesis 2, and tested in its null hypothesis form by use of a 2 cell by 5 cell contingency table, computing chi square as a test of significance. The obtained chi square value, 16.46 with df equal to 4, was found to be significant at the .0025 level, and allowed rejection of the null hypothesis with alpha = .05, as indicated in the data analysis plan. Statistical significance was indicated through the use of the "Statview" for MacIntosh program. However, the data, particularly when taken beyond the original 2 x 5 contingency table (see Table 6) and dichotomized (see Table 7), does not hold practical significance.

While the data analysis did not indicate a statistical significance in the testing of the remaining study hypotheses, there is a practical or clinical practice significance that can be attributed to study hypothesis 1, study hypothesis 3, and study hypothesis 5.

Study hypothesis 1 looked at the association of respondent's gender to the consideration of intrafamilial childhood sexual abuse in the responses to the items on the Case History Questionnaire. While statistical significance was not indicated, the epsilon (6.4) reported on Table 5, indicating the presence of a higher rate of Category 1 responses among the male respondents in the study, holds a practical significance that would continue to point toward the study hypothesis that female social workers are more likely than male social workers to consider an hypothesis of intrafamilial childhood sexual abuse. On a clinical practice level, it indicates a need to be sensitive to a likelihood of male social workers being less likely than female social workers to identify intrafamilial childhood sexual abuse as an etiological factor.

Study hypothesis 3 looked at the association of the respondent's years of post-MSW experience to the consideration of intrafamilial childhood sexual abuse in the responses to the items on the Case History Questionnaire. While statistical significance was not indicated, the epsilon (9.4) reported on Table 9, indicating the presence of a higher rate of Category 1 responses among those respondents in the study with the greater number of years post-MSW holds a practical significance that would point toward the reverse of the study hypothesis. That is, more experienced social workers, as measured by years of social work practice experience since obtaining their MSW, are less likely than less experienced social workers, as measured by years of social work practice experience since obtaining their MSW, to
consider an hypothesis of intrafamilial childhood sexual abuse. On a clinical practice level, it would indicate that a sensitivity to social workers with a greater number of years of post-MSW experience being less likely than social workers with a lesser number of years of post-MSW experience to identify intrafamilial childhood sexual abuse as an etiological factor is warranted.

Study hypothesis 5 looked at the association of the respondent's practice experience in the area of incest and childhood sexual abuse to the consideration of intrafamilial childhood sexual abuse in the responses to the items on the Case History Questionnaire. Statistical significance for an association between experienced/not experienced with incest and childhood sexual abuse victims and a consideration of an etiological hypothesis of intrafamilial childhood sexual abuse was not indicated. The high rate of respondents indicating that they have practice experience with incest and childhood sexual abuse victims (96%), however, does have a practical significance as an indicator of the practitioners' knowledge and belief in the historic existence of this event in the life of their clientele. This is of significance as a reflection of changing practice beliefs from those attributed to Freud in the denial of the Neurotica theory to those in the current literature on incest and sexual abuse. It has been argued that Freud's theoretical stance resulted in a denial of what was there (incest), with a 96% rate of clinicians believing they have identified incest in their patients' histories, it could be argued that current clinical beliefs may be resulting in seeing what is not there. This experience rate (96%) is considerably higher than either the reported professional training rate (78%), or the reported professional supervision rate (76%). This could point toward experience as the more significant source of practice belief over either professional training, or professional supervision.

Clinical theoretical orientation as measured by item 6 on the Social Worker Profile lacked either statistical significance, or practical significance. In a study intended to look at worker characteristics influencing clinical etiological hypothesis building, this presents a certain element of irony. While this may well have been a problem with the structuring of the item, it may also reflect a shared practice belief system about our clients that is independent of any one clinical theory.
Chapter Five
Discussion

This chapter will provide a discussion of the results of the study, limitations of the study, and implications for further research. The initial ambitions of this study, to identify correlations between social workers' personal and professional characteristics, and their consideration of an etiological hypothesis of intrafamilial childhood sexual abuse, were not realized.

Arriving at that statement is difficult, particularly when this researcher's end purpose is to produce a dissertation that carries with it the ambition of announcing the writer's coming of age in the professional arena. But the discovery of not meeting an intended outcome brings with it the opportunity of learning from the unintended results. The dissertation process entails the development of a question worthy of professional and scholarly investigation, followed by the need to construct the rationale for asking the questions and expecting the answers. It brings with it an anticipation of what will be found. Certainly in analyzing the returns and the data they yielded, there was an overwhelming need to make that data fit into the statistical analysis plan, and for those statistical procedures to support the researcher's hypotheses. In the end it is the unintended results that is the value of this study, not only in its implications about the state of Clinical Social Work practice, but also in its reminder that presuming to know is not the same as knowing.

Discussion of the results of the study

In total, 94.1% of the respondents considered the possibility of intrafamilial childhood sexual abuse in their etiological hypotheses of the client presented in the Case History vignette. In comparison, if the responses to the Sagal (1988) study were collapsed into the same single "yes/no" scoring on the Case History Questionnaire, that sampling would have yielded a 96% rate of considering intrafamilial.
childhood sexual abuse in their etiological hypotheses. Considering the concerns of clinician "insensitivity" to considering a history of intrafamilial childhood sexual abuse frequently voiced in the literature in this area, this is a notable finding. These high rates might lead to concerns of an "oversensitivity" to child sexual abuse as an etiological factor, reminiscent of the "pendulum swinging the other way" concept.

These high rates might also point to a sharing of practice beliefs among clinicians about the interpretation of clients' histories, behaviors, and symptoms. These high rates did not meet the expectations of this study, and thwarted the statistical analysis plan that was based on the assumption that the differences in the interpretation of the Case History vignette include larger groups of social workers who would not consider the possibility of intrafamilial childhood sexual abuse in their responses. The commonality of the interpretation of the Case History is itself the most significant finding of this study. It is in variance to this investigator's expectations. More importantly, it is in variance to a large body of literature and commentary over the last several decades that has warned that there is an insensitivity among practitioners to identifying the influences of intrafamilial childhood sexual abuse in the clinical presentation of adult clients.

This commonality of interpretation may also be an indicator of the tendency of professions to "institutionalize" a thought and belief system toward practice. In the area of sexual abuse of children, the significance of our newly shared awareness of the frequency and effects of such abuse in our society may lead us to risk "false positive" hypotheses in our clinical practices. This phenomenon has led to more recent concerns that some practitioners in their zeal may begin with assumptions that such data is in the client's history, and with that conviction, lead the client to share in erroneous beliefs concerning their history.

This study focused on the social worker's consideration of an etiological hypothesis of intrafamilial childhood sexual abuse, and the discussion of the responses to the Case History Questionnaire have been limited, up to this time, to only those hypotheses. It is important to note that intrafamilial childhood sexual abuse was not the only etiological hypothesis considered. In reexamining the returned Case History Questionnaires, there were many other clinical issues indicated by the
respondents that might bear further evaluation and information gathering. The areas respondents' indicated for additional consideration follow as Table 21.

Table 21: Areas other than intrafamilial childhood sexual abuse that were considered as etiological issues, by number of respondents indicating it as an area of consideration on their Case History Questionnaire.

<table>
<thead>
<tr>
<th>Etiological issue</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>54</td>
<td>39.7</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>33</td>
<td>24.3</td>
</tr>
<tr>
<td>Attention deficit disorder</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Family history of affective disorders</td>
<td>12</td>
<td>8.8</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Borderline personality traits/disorder</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>Multiple personality disorder</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Narcissistic personality traits/disorder</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Spouse abuse</td>
<td>14</td>
<td>10.3</td>
</tr>
<tr>
<td>Sexual trauma</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td>Marital dysfunction</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Physical and/or emotional abuse as a child</td>
<td>51</td>
<td>37.5</td>
</tr>
<tr>
<td>Dissociative disorders</td>
<td>49</td>
<td>36</td>
</tr>
<tr>
<td>Abuse of Teresa's children</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td>Childhood witnessing of intrafamilial abuse</td>
<td>9</td>
<td>6.6</td>
</tr>
</tbody>
</table>

The respondents did indicate consideration of intrafamilial childhood sexual abuse in their responses to the Case History Questionnaire items most frequently, but it was not to the exclusion of other possible areas. This would indicate that, while the Case History presented what met a shared criteria for consideration of intrafamilial childhood sexual abuse, it was not the only criteria met in the practice knowledge base of the respondents. The 94.1% rate of consideration of intrafamilial childhood sexual abuse was not a case of a single mindedness on the part of the respondents. This an important consideration in counterbalance to concerns that the rate of considering intrafamilial childhood sexual abuse by the respondents might indicate an "oversensitivity."
The Sagal study found a significant correlation for younger respondents versus older respondents considering intrafamilial childhood sexual abuse. Similarly, Conte, Fogarty, and Collins (1991) found in a study of professionals (48% of those surveyed were MSWs) practicing in the area of child sexual abuse that these practitioners tended to be younger. This study did not find age, even on the face value basis of percentages to have an association with considering a hypothesis of childhood sexual abuse.

Sagal had also found that sensitivity was related to years of practice, with those practitioner with fewer years of practice showing a stronger sensitivity than those practitioners with more years of practice. In this dissertation study, there was, as measured by percentage tables (Table 9), a larger percentage of social workers with 20 years and less of practice experience who were identified as considering intrafamilial childhood sexual abuse, than there was in those social workers with 21 or more years of practice experience. The percentage difference found is 9.4. In seeming contrast to Conte, Fogarty, and Collins' (1991) findings in their study of professionals practicing in the area of child sexual abuse, this study's negligible association for age to consideration of intrafamilial childhood sexual abuse, but positive association for fewer years of practice may be indicative of the respondents completing their MSW at an older age, that the area of childhood sexual abuse is a more recent introduction to the MSW curriculum, or of the relative newness of the public and professional attention being given to the area of child sexual abuse and its victims.

As in this study, Sagal did not find gender to be a significant factor among respondents in sensitivity to considering a history of intrafamilial childhood sexual abuse. Similarly, neither this study nor the Sagal study found the theoretical orientation variable to significantly associate to sensitivity among respondents.

The high rate (96.3%) of respondents reporting experience with "incest and child sexual abuse victims" was far greater than had been anticipated. [By way of contrast to this study of Connecticut practitioners, a recent study of practice found only a 33% rate of experience treating adult victims of intrafamilial childhood sexual abuse among a sampling of therapists in the Western Massachusetts area (Fortgang, 1992).] Table 11 displayed a percentage difference of 14.7, indicating that those social workers with practice experience in incest and childhood sexual abuse had a higher rate of considering
intrafamilial childhood sexual abuse in their answer than did social workers without experience with this practice area. The sparsity of respondents without practice experience in the area of incest and childhood sexual abuse skews the data, and severely limits the import of the 14.7 epsilon, the largest indicated in the analysis of factors from the Social Worker Profile.

The diversity of clinical theory orientations reported by the respondents in this study is compatible with recently published findings of diverse clinical theory orientations among practitioners in the area of child sexual abuse and its victims (Conte, Fogarty, and Collins, 1991; Conte, Sorenson, Fogarty, and Rosa, 1991; Reidy and Hochstadt, 1993; Shay, 1992; and, Strean, 1988). There does not appear to be a single clinical theory or clinical orientation that dominates or guides the body of knowledge in this field.

Limitations of the Study

This study is limited by the validity questions related to small study sample size, and participant self selection from the sample universe posed by the mail survey method utilized (Berdic, 1974; Isaac, 1981; and Leslie, 1972). The 94.1% rate of considering intrafamilial childhood sexual abuse may be a reflection of the influence of participant self selection among that portion of the sample population that recognized the researcher's efforts to embed the study's focus on intrafamilial childhood sexual abuse in the study instruments. The data that might have been contributed by non-respondents from the sampling universe has the potential to significantly alter data gathered, and the findings of this study. The results of this study should be regarded as limited in applicability to the respondent group.

The study was limited in its ability to distinguish differences in sensitivity among social workers. This ability to discriminate may have been improved with changes in the instruments employed, or through changes in the sampling methods. A major limitation was the homogeneity of the respondents' consideration of intrafamilial childhood sexual abuse. On the rationale that a greater heterogeneity should exist, changes that could increase the heterogeneity of the responses on the Case History Questionnaire would be helpful. In particular, a sampling from multiple geographic regions could have introduced a greater heterogeneity in professional community influences than were present in this study's sample. The
gathering of data from a less self-selecting population than that provided through the mailing method utilized in this study would also have had an effect on the degree of heterogeneity.

The intent of the design of the Case History used in this study was to elicit responses indicative of sensitivity to considering intrafamilial childhood sexual abuse in the forming of etiological hypotheses. The high rate of sensitivity elicited could indicate that the vignette was too obvious about its focus on incest and childhood sexual abuse, and that this became a weakness in this instrument. However, the intent of the Case History was to present the type of data that would be routinely gathered, which it appears to do, and not to obscure essential data needed for a reasonable assessment.

The items on the Case History Questionnaire appeared to have stronger abilities to provide discreet indicators of relationships to a consideration of intrafamilial childhood sexual abuse than did the items on the Social Worker Profile. In contrast to the Social Worker Profile which looked to characteristics in the worker as predictors of consideration of intrafamilial childhood sexual abuse, the review of the response patterns to the Case History Questionnaire seemed to indicate a predictive quality to a shared interpretation of areas of client symptoms and behavior. In the former instrument, the influence of personal and professional characteristics could be indicators of bias, in the latter it could be indicative of a shared base of practice belief and knowledge. In addition, concurrent use of two or more Case History Questionnaire instruments that focused the questions on different sets of client symptoms, behaviors, and historic factors, or that varied the order of the questions, might have elicited more discriminate patterns of response.

Implications for Future Research

This study, even with its limits for generalizing to larger populations, found very high rates on its measures of sensitivity (Category 2 responses to the Case History Questionnaire items), experience, training, and supervision in the area of incest and childhood sexual abuse and its victims. Repetition of this study in various states or regions, as well as with non-social worker professionals might yield interesting data about clinical practice differences as functions of geographic influences, and professional knowledge in this field. A repetition of this study focused on the interaction of the social worker's
evaluation of symptoms, behaviors, and historic factors presented by the client as correlates of
consideration of a history of intrafamilial childhood sexual abuse rather than on the personal and
professional characteristics of the worker would most likely be more fruitful. Such a study would more
clearly address the issue of worker knowledge by examining the data elements workers use to construct
the hypotheses that guide their work with clients.

Certainly in this study, the Case History vignette evoked a shared response from the study sample
of ACSW members of the NASW Connecticut Chapter who had listed themselves as practitioners in the
mental health field. Social work would be well served if we understood how a relatively uniform
professional population, with a diversity of personal characteristics, arrived at a similar client evaluation
with a 94.1% rate of unanimity. This rate of unanimity identifies the presence of a common set of clinical
beliefs, shared among the members of a single professional group, and may well speak to the cumulative
effect of the Social Work profession's efforts to establish and maintain standards of curriculum in the
educational process, standards of practice in the field, and standards of knowledge informed through
professional scholarship and research. A revision of this study that looks at the iatrogenic nature of the
relationships among experience, training, and clinical supervision would speak to the nature of
professional Social Work's evolitional process.
Reference List


Thiel, Robert P., interviewed by Dennis R. Gourley, 15 July 1994, Southern Connecticut State University, New Haven, CT.


Appendices
Appendix A: Instruments used in the study

A - 1 Transmittal letter
A - 2 Case History
A - 3 Case History Questionnaire
A - 4 Social Worker Profile

Appendix B: Panel of experts verification of case history

B - 1 a. Letter of request to Carol F. Thomas, PhD, for verification of Case History
b. Response from Carol F. Thomas, PhD.
B - 2 a. Letter of request to Rosemary Niedzwicki, ACSW/CISW, for verification of Case History
b. Response from Rosemary Niedzwicki, ACSW/CISW

Appendix C: Application for review of research involving human subjects

Appendix D: Approval of Institutional Review Board

Appendix E: Key words and phrases from the respondents' answers on the Case History Questionnaire judged to satisfy the condition of considering a history of intrafamilial childhood sexual abuse.
Dear Colleague,

Your participation is being sought in a study of etiological hypotheses formulation in clinical social work. This study is part of a dissertation project that I am completing through the School of Social Work at Loyola University in Chicago. You are one of a small group of ACSWs in Connecticut who is being asked to participate in this important project.

This study is anonymous and strictly voluntary. The only identifying data on both the survey forms and the mailing envelope is coding by NASW Connecticut Chapter region. The coding by region is for purposes of tracking rates of return only.

Nearly all social workers use information from initial interviews to begin formulating etiological hypotheses about their clients. The extent to which client symptoms and characteristics contribute to this hypotheses building is unclear. It is equally unclear to what extent the characteristics of the worker contribute to this hypotheses building. This study is interested in examining the influence of the evaluating social worker's gender, age, theoretical orientation, professional experience, and professional training on etiological hypotheses formulation.

Directions
You are asked to read the CASE HISTORY on page two of this brochure, then respond to it on the following page. Feel free to review the CASE HISTORY as often as necessary. You are then asked to complete the SOCIAL WORKER PROFILE on page 4.

Completion time is approximately 20 minutes. Please return this brochure with all questions answered in the postage-paid envelope provided by December 20.

Your participation in this project is greatly appreciated, as your response is essential to the success of the research.

Sincerely,

Dennis R. Gourley
CASE HISTORY

Teresa

The client is a 29 year-old Anglo female who is currently married and has three children, ages 11, 4, and 2. Teresa has worked as a sales clerk in a department store, but has recently left her job because of depression and feelings of hopelessness. She has been divorced from her first husband for ten years and is currently experiencing marital difficulties with her present husband. She also has expressed having problems parenting her children.

The client grew up in a small town in Connecticut. She was the oldest of five children, having two younger sisters and two younger brothers. Her father was a skilled machinist and her mother stayed at home but was often hospitalized for tuberculosis. The client reported that her parents fought frequently and her father was often drunk. She recalled that her father was very restrictive and did not permit her to attend after-school activities or associate with other children. The client reported that as a child she was responsible for most of the household chores and looked after her younger brothers and sisters.

The client reported that she began to experiment with drugs at the age of 13. At 14, she ran away from home and often spent days away from her family. At about this time, she became promiscuous and by age 16, she had had an abortion and had made two suicide attempts. The client left home for good at 17, became pregnant, and married the father of the child. They were divorced two years later. The client remarried three years after her divorce and had two more children.

During both her marriages, the client experienced sexual dysfunction. She is currently reporting feelings of severe depression. She feels most distrustful of relationships, reports having feelings of being "here but not here," and has made a recent suicide attempt for which she was hospitalized.
CASE HISTORY QUESTIONNAIRE

The case history you have just read is from information provided in an initial interview between Teresa and a therapist. Like most information from initial interviews, it may be incomplete. Please respond to the following questions about the case, limiting your conjectures to a few sentences. It may be necessary to repeat issues that you see as central to Teresa’s problem.

1. What additional historical information would you expect to uncover, given the symptoms presented in the case history?

Making use of the case history and your response to question 1, please answer the following.

2. What do you hypothesize was the one or two most likely reasons for Teresa’s having run away from home?

3. What do you hypothesize was the one or two most likely reasons for Teresa’s suicide attempts in her teens?

4. What do you hypothesize was the one or two most likely reasons for Teresa’s sexual dysfunction?

5. What do you hypothesize was the one or two most likely reasons for Teresa’s feelings of “being here but not here”?

6. What do you hypothesize was the one or two most likely reasons for Teresa’s current mistrust of relationships?
SOCIAL WORKER PROFILE Please provide the following information about yourself.

1. Are you an ACSW? (circle one) yes no
2. If you are an ACSW, did you obtain it through testing? (circle one) yes no
3. What is your gender? (circle one) female male
4. What was your age at your last birthday? (circle one)
   a. under 26 b. 26—35 c. 36—45 d. 46—55 e. 56—65 f. over 65
5. What is the total number of years since you received your Masters of Social Work? (circle one)
   a. 0—5 b. 6—10 c. 11—15 d. 16—20 e. 21—25 f. 26—30 g. 31—35 h. 36—40 i. 41+
6. Which one of the following clinical orientations most closely describes your practice orientation?
   a. psychodynamic b. behavioral c. existential d. systems e. cognitive f. feminist
g. other (please specify) ___________________________________
7. With "professional practice experience" defined as direct clinical social work with individual clients, couples, families, and/or groups to provide treatment and prevention of psychosocial dysfunction, disability or impairment, including emotional and mental disorders, indicate those areas where you have had professional practice experience.
   PRACTICE EXPERIENCE YES NO
   a. depression b. borderline personality c. adult children of alcoholics d. rape victims e. suicidal behavior f. incest and childhood sexual abuse victims g. domestic violence h. anxiety disorders i. schizophrenic disorders j. eating disorders
8. With "professional training" defined as formal educational coursework taken at a degree conferring institution, and/or continuing education activities in the form of workshops and seminars, indicate those areas where you have had specialized professional training.
   SPECIALIZED TRAINING YES NO
   a. depression b. borderline personality c. adult children of alcoholics d. rape victims e. suicidal behavior f. incest and childhood sexual abuse victims g. domestic violence h. anxiety disorders i. schizophrenic disorders j. eating disorders
9. With "professional supervision" defined as the formalized process of the clinical social worker meeting with a teaching therapist for consultation, guidance and direction around issues that develop for the social worker in the context of professional practice toward the end of enlarging perspectives and deepening knowledge for the practitioner and the agency to better serve the client(s), indicate those areas where you have received professional supervision.
   PROFESSIONAL SUPERVISION YES NO
   a. depression b. borderline personality c. adult children of alcoholics d. rape victims e. suicidal behavior f. incest and childhood sexual abuse victims g. domestic violence h. anxiety disorders i. schizophrenic disorders j. eating disorders

This completes the survey. Please return this form in the envelope provided. Thank you for your participation.
October 31, 1993

Carol Thomas, PhD
Shoreline Psychiatric Associates
9 Allyn Street
Mystic, Ct. 06355

Dear Dr. Thomas,

As we had discussed earlier, I am currently completing my dissertation in the area of adults molested as children at Loyola University of Chicago's School of Social Work. The study will survey professional social workers in Connecticut, asking them to provide etiologic hypotheses based on the enclosed case vignette.

As a clinician specializing in issues of childhood sexual abuse, your assistance is being sought as a subject matter expert. I would very much appreciate your review of the case vignette, originally developed by Karen Sagal, PhD, for her dissertation study at New Mexico State University, and documentation of your judgement on its merits as a valid portrayal of a woman with a history of intrafamiliial childhood sexual abuse.

I would appreciate your written response to this request, and ask that you forward it to my home address indicated above. If it would be helpful to discuss the details of the study, and this request, I may be reached by phone at (203) 449-3631 (work), or (203) 767-2470 (home). As your professional social worker colleagues are among the potential study sample, your discretion in discussing this request is appreciated. Thank you.

Sincerely,

Dennis R. Gourley
ACSW/CISW
Dear Dennis:

Thank you for your letter of 31 October, 1993. I was pleased to read your case history and find an essentially "generic" paradigm relative to women who have been traumatized during childhood. Your case history reflects research as well as case study material gathered from my own private practice during the past ten years. The experiences of "Teresa" as articulated to her case worker, would certainly seem to indicate sequelae in keeping with a variety of abuses in early childhood—physical, psychological, emotional, and/or sexual. Within the case history a number of high risk factors are also present. High risk families tend to manifest a sharp sex role division of labor, "traditional," nuclear, authoritarian values, as well as non-individuated parents, frequent substance abuse, social isolation and restriction. In addition, an older sibling is frequently "parentified" becoming not only a caretaker for other siblings, but may be scripted into fulfilling other emotional and/or psychosexual adult roles as well. In addition, "Teresa's" early experimenting with drugs, her escape patterns, her antisocial and sexual acting out, as well as suicide attempts are frequently indicative of the psychic pain, trauma, and injury associated with childhood abuses. Given the nature of "western" and "public" discourse as well as "doublethink," intimidation, and silencing techniques used in the oppression of children, many adolescents like "Teresa" must bodily act out their injury in a performative demonstration, a "sign action."

In her seminal text, Trauma and Recovery, Judith Herman, M.D. observes that an experienced clinician deeply familiar with childhood sexual trauma and abuse will be able to identify the developmental childhood phase during which abuse occurred. She also points out that the average age at which this abuse occurs is approximately two years of age. In addition, the case history indicates "Teresa's" sexual dysfunction within her adult marital relationships. Given the nature of the most recent literature on female adolescent sexuality (see Jordan, Surrey, Stiver, Herman, and Gilligan, 1992-1993), early female sexual orgasm is rarely experienced and in fact the sexual "trade off" between adolescent males and females seems to be respectively orgasmic ejaculation for the male and a "perceived" sense of affection, validation, and affirmation in relationship (albeit frequently inauthentic) for the female. Female adolescent sexuality is also frequently characterized by an "obsessive-compulsive" and nonconscious nature, repeating earlier and "sexually" conditioned behaviors perpetrated against the child by adults. I have just completed a "white paper" for the Navy addressing these issues in a context of women on board ship and the disturbing patterns of untimely pregnancy and an epidemic of sexually transmitted diseases, behaviors frequently associated with childhood abuses.
Within my private practice and especially during the past five years as well as an additional five years of working in an experimental college for dually diagnosed (usually depression and/or anxiety, anorexia and bulimia, with accompanying substance abuse) and high risk adolescents, male and female, the "generic" components from "Teresa's" case history were and are frequently heard. I refer you to The Journal of Psychohistory, summer, 1993 and articles by Lloyd Demause, Harriet Fradd, Sandra Bloom, and Bernard Flicker. Additional information is to be found in the 1991 Special Issue of The Journal of Psychohistory with articles by Demause, Brett Kahr, Joe Berghold, and comments by David Finkelhor. A brief articulation of the difficulty with regard to trauma, memory, and "false memory," is further provided by Mary Sykes Wylie in the September/October 1993 issue of The Family Therapy Networker. There are also articles which present material from both sides of the debate. From my own perspective, the women and men who enter therapy with a presenting problem of profound depression, anxiety, and/or agoraphobia with feelings most frequently described as "hollow," "bleak," "defective," and as "having one's skin on inside out," believe that childhood injury and abuse may have occurred, but in a context of irony and doublethink, these courageous individuals cannot hold their perpetrators (most frequently family or extended family members) initially responsible as they believe themselves to be not only "bad," and deeply guilty, but also responsible for "abandoning" their families as well. I believe that most individuals prefer to carry the psychic pain of holding themselves responsible rather than examining the nature of family life within which injury may have occurred until this burden results in either profound physical illness or psychological disturbance.

Within her adult life experiences and her relationships "Teresa" also manifests those feelings of "being here but not here," which I most frequently hear from both males and females who have been sexually abused and who have "learned" how to dissociate as a strategy of survival.

To briefly reiterate, the case study of "Teresa" which you have provided manifests many of the "generic" characteristics of individuals with whom I work. The exacerbated life stressors of relationship and very frequently the ages of their children who may symbolically represent these individuals at the age of the onset of abuse, typically precipitate profound depression, anxiety, agoraphobia, suicidality, despair, anhedonia, and a failure to function in family life for individuals who have been injured in childhood. The sequelae of childhood abuse while devastating and terrifying, may, with appropriate therapeutic work, reading, support, care, and empathy, result in healing, recovery, resilience, and a desire to contribute to the ongoing body of knowledge with which to break the silence and to offer prevention.

I enjoyed reading the case history and if I can be of any further
assistance, please do not hesitate to write or call me at the above address. The conference which I most recently attended presented by Harvard and the Stone Center was devoted to women's psychological issues and case material presented during various portions of the program would further validate the essential albeit generic nature of "Teresa's" case history. I would welcome the opportunity of reading your dissertation and of providing any bibliographic information which might prove helpful.

Sincerely,

Carol F. Thomas, Ph.D.
October 31, 1993

Rosemary Niedzwicki, ACSW/CISW
Child Guidance Clinic of S.E.Ct.
Child Sexual Abuse Treatment Program
75 Granite Street
New London, Ct 06320

Dear Ms. Niedzwicki,

As we had discussed earlier, I am currently completing my dissertation in the area of adults molested as children at Loyola University of Chicago's School of Social Work. The study will survey professional social workers in Connecticut, asking them to provide etiologic hypotheses based on the enclosed case vignette.

As a clinician specializing in issues of childhood sexual abuse, your assistance is being sought as a subject matter expert. I would very much appreciate your review of the case vignette, originally developed by Karen Sagal, PhD, for her dissertation study at New Mexico State University, and documentation of your judgement on its merits as a valid portrayal of a woman with a history of intrafamilial childhood sexual abuse.

I would appreciate your written response to this request, and ask that you forward it to my home address indicated above. If it would be helpful to discuss the details of the study, and this request, I may be reached by phone at (203) 449-3631 (work), or (203) 767-2470 (home). As your professional social worker colleagues are among the potential study sample, your discretion in discussing this request is appreciated. Thank you.

Sincerely,

Dennis R. Gourley
ACSW/CISW
The case history describes an individual who has had considerable difficulties throughout her life, both in childhood and adulthood. In looking at her history of symptomatology, there is nothing to contra-indicate the possibility of childhood sexual abuse. Although there are many indicators that suggest that sexual abuse could account for her difficulties, one cannot definitely conclude that she was abused given that she has no conscious memory of the abuse.

Family dynamics which could support sexual abuse as having taken place include a mother who was ill and often gone from the home and marital discord with an alcoholic father. Tension in the marriage, access to the victim, and alcohol use which reduces inhibition can all set the stage for abuse to be able to occur. In addition, when a patient is involved sexually with a child, then tend to be restrictive due to a desire to dominate the victim and to reduce the risk of being caught. Not mentioned are the psychological profiles of the siblings—Did they suffer from similar problems? If so, does this mean this is a family where emotional problems are the norm? The client is described as being responsible as caretaker etc., one could postulate she replaced her mother in many capacities. She may have felt compelled to keep the secret to protect her siblings.

It is important to mention that other factors of family dysfunction could account for much of the symptomatology of this client. Alcoholism, family violence, one parent with a debilitating illness—any one of these factors could lead to
significant emotional difficulties. One symptom which is a little more difficult to account for by the above list of points of family dysfunction is that of early promiscuity and sexual dysfunction. Sexual difficulties are most often correlated with a history of sexual abuse in childhood rather than other kinds of childhood stressors. Childhood drug abuse, depression, suicidality, running away could at least be linked in some way to the other life circumstances described but there is little information given to explain why the client chose to act out sexually at age 16 and that sexual dysfunction continued into adulthood.

It would be helpful to know if the client had any knowledge of memory of masturbation in childhood or sexual interaction with other children. It would also be helpful to know exactly what takes place during the sexual dysfunction. Does the client feel "here but not here" during sex? If so, this is a further strong indicator that sexual abuse occurred. "Here but not here" is a sort of explanation for dissociative feelings often a problem for people who experience trauma.

I would conclude but emphasizing that one cannot conclude that sexual abuse occurred from the information given. Even though red flags abound, one must refrain from hastily citing sexual abuse as the stressor leading to the clients history given the other possible factors in the family.
**IRB FORM A**

Application for Review of Research Involving Human Subjects

**Page 1**

**Instructions**

Please submit THREE copies of this form and THREE copies of a short description of the proposed research. Details of information to be included in this description, please see p. 4 of the IRB Handbook. Those applying for support to a non-University source should please add ONE copy of their full proposal. Graduate students should please add ONE copy of their thesis or dissertation outline.

<table>
<thead>
<tr>
<th><strong>INVESTIGATOR</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Name:</strong> Dennis R. Goorley</td>
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<tr>
<td><strong>Home Address:</strong> 26 Parker Terrace</td>
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<tr>
<td><strong>City:</strong> Essex</td>
</tr>
<tr>
<td><strong>Home Phone:</strong> (area code) 203</td>
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<tr>
<td><strong>Department:</strong> Social Work</td>
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<th><strong>FACULTY SPONSOR</strong> (required unless the INVESTIGATOR is a member of the full-time faculty or administrative staff of Loyola University of Chicago)</th>
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<tbody>
<tr>
<td><strong>Name:</strong> Joseph Walsh, PhD</td>
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<tr>
<td><strong>Department:</strong> Social Work</td>
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**TITLE OF PROJECT:** "A study of social workers sensitivity to intrafamilial childhood sexual abuse"

**PURPOSE OF PROJECT (Please check one box only)**

- [x] Faculty research proposal to be submitted for external funding
- [ ] Faculty research proposal not to be submitted for external funding
- [x] Doctoral dissertation (Ph.D. or Ed.D)
- [ ] Master's thesis
- [ ] Class project (please give number and Course Title:)
- [ ] Other: Please explain in detail in attached project description

**STATUS OF INVESTIGATOR: (Please check one box only)**

- [ ] Faculty member, Loyola University
- [x] Administration or staff, Loyola University
- [x] Graduate student, Loyola University
- [ ] Undergrad. student, Loyola University
- [ ] Other: Please explain in detail: ___________________
SPECIAL CONSIDERATIONS: (Please check one box in response to each question)

Does this research involve:

- drugs or other controlled substances? [ ] YES [ ] NO
- payment of subjects for participation? [ ] YES [ ] NO
- access to subjects through a cooperating institution? [X] YES [ ] NO
- subjects taking internally, or having applied externally, any substance(s)? [ ] YES [ ] NO
- removal of any fluids or tissue from subjects? [ ] YES [ ] NO
- imposition of stress (physiological or psychological) above a level associated with everyday activities? [ ] YES [ ] NO
- deception of subjects about any aspect of the research? [ ] YES [ ] NO
- use of subjects who could be judged to have limited freedom of consent (e.g., minors, the mentally ill)? [ ] YES [ ] NO
- any procedures that might put subjects at risk (whether psychological, physiological or social)? [ ] YES [ ] NO
- any risks to the confidentiality of data or responses? [ ] YES [ ] NO
- any circumstances likely to lessen subjects' voluntariness in participating in the research? [ ] YES [ ] NO
- a written consent form? (If YES, please attach three copies) [ ] YES [ ] NO
- data collection over a period likely to exceed 6 months? [ ] YES [ ] NO

CERTIFICATIONS:

1. I am familiar with the policies and procedures of Loyola University regarding human subjects. I subscribe to the standards described in the IRB HANDBOOK and will adhere to the policies and procedures explained therein.

2. I am familiar with the published guidelines for the ethical treatment of subjects associated with my particular field of inquiry (e.g., those published by the American Psychological Association, American Sociological Association).

3. If changes in procedures involving human subjects become necessary, I will submit these changes for review before they are implemented.

SIGNATURES

Investigator: ___________________________ Date: ___________________________

Faculty Sponsor: _________________________ Date: ___________________________

(required unless the investigator is a full-time LU faculty or staff employee)
CONCISE STATEMENT OF RATIONALE FOR THE STUDY

This study of social work practice intends to evaluate the likelihood of the professional to consider adult survivorship of intrafamilial childhood sexual abuse as an etiological factor based on material presented in the initial interview. This sensitivity consists of an understanding of the consequences of such trauma, and a readiness to consider intrafamilial childhood sexual abuse as an historical factor. The study will look at both critical clinical information items as well as worker characteristics related to this sensitivity in social work practice.

DESCRIPTION OF RESEARCH PROTOCOLS

The study will utilize a clinical case vignette that has been created based on the literature in the field to portray a woman with a history of intrafamilial childhood sexual abuse. As a fiction, there is no risk of breaching client confidentiality. A panel of subject area experts will review the case vignette to verify its accuracy as a portrayal of a client with such a history. The case vignette, a case history questionnaire, and a social worker profile will be mailed to the target subject population. These will be anonymously returned. The data gathered will be analyzed for correlation of specific worker characteristics to a positive identification of intrafamilial childhood sexual abuse as an etiological factor in the symptoms presented.

DESCRIPTION OF SUBJECT POPULATION

The target subject population for this study is the professional Clinical Social Worker. The sampling will be the 438 ACSW members of the NASW Connecticut Chapter who have listed themselves as practitioners in the mental health field. The NASW Connecticut Chapter has agreed to provide there mailing list for this specialty group of there members for the purposes of this study.

DESCRIPTION OF ALL POTENTIAL RISKS

As the case vignette is fictional, based on the characteristics of a client with the intended history, and as the questionnaires will be completed and returned anonymously, there are no potential risks to the human subjects that are anticipated.
PROCEDURES TO BE USED TO OBTAIN INFORMED CONSENT
Participants will be advised in the cover letter sent in the questionnaire package that the study is investigating social work assessment practices. They will be advised that the case vignette is fictional, having been developed for the purposes of this study. They will be asked to participate anonymously. They will be further advised that their participation is strictly voluntary, and that the analysis of the data will be conducted only in terms of group aggregates.

DESCRIPTION OF HOW SUBJECTS' WELFARE AND CONFIDENTIALITY WILL BE SAFEGUARDED
Participation will be voluntary, and anonymous.

ASSESSMENT OF POTENTIAL BENEFITS
The study will provide indication of the sensitivity of professional Clinical Social Workers to the identification of a history of intrafamilial childhood sexual abuse in their initial case assessment. It has implications in evaluating the knowledge base of Clinical Social Work practice in the treatment of this client population. Such a knowledge base is crucial in the appropriate diagnosis and treatment of social work clients.

SUMMARY OF RISK-TO-BENEFIT RATION FOR THIS INVESTIGATION
There is a negligible to minimal risk to participants in this study proposal. There is, on the other hand moderate to significant benefit to Clinical Social Work, its clientele, and its practitioners.
Investigator: Dennis Goorley
Home Address: 26 Parker Terrace
Essex, Connecticut 06426
Home Telephone: 767-2470 [Area Code: 203]

Dear Colleague,

Thank you for submitting the following research project for review by the Institutional Review Board:

Project Title: A Study of social workers sensitivity to intrafamilial children sexual abuse

After careful examination of the materials you submitted, the IRB has determined that this project involves no risk to human subjects that would require further action by the IRB under 45 CFR 46. You are therefore under no obligation to enter into any further correspondence with this office so long as your research protocols remain identical to those already submitted to us for consideration.

Please note however that, should there be any change in your research design (e.g. in the research population, in the content of questionnaire forms, or in the planned treatment of responses), a detailed amended application should be filed with the IRB immediately. In that case, or in any other correspondence with the IRB, please quote file number 1017.

With best wishes for your research,

Sincerely,

Matthew Creighton, SJ

cc: D. Shaw/Graduate School/WTC
    J. Walsh inter-office memorandum
Appendix E: Key words and phrases from the respondents' answers on the Case History

Questionnaire judged to satisfy the condition of considering a history of intrafamilial childhood sexual abuse.

- childhood sexual abuse
- sexual abuse by parent
- in home sexual abuse
- incest
- incestuous abuse
- sexually abused by father
- sexual abuse (in context of discussion of family of origin)
- impaired sexual boundaries between father and daughter
- sexual/physical abuse (in context of discussion of family of origin)
- sexual abuse by mother or father
- sexual abuse by father or brother
- sexual abuse in home or neighborhood
- parental sexual abuse
- childhood sexual abuse by father
- sexual involvement with her father
- sexual molestation by her father
- sexual abuse by a close family member
- sexual victimization by alcoholic father
- sexual abuse by family members/other
VITA

Dennis R. Gourley
26 Parker Terrace, Essex, CT 06426
(203) 767-2470

EMPLOYMENT SUMMARY
1991-present: Clinical Services Supervisor, Navy Family Service Center, Groton, CT
1989-1990: Assistant Administrator, Elmcrest Psychiatric Institute, Portland, CT
1987-89: Director, The Psychiatric Institute at Lincoln West Hospital, Chicago, IL.
1985-87: Director, The Psychiatric Institute at Southside Community Hospital, Corpus Christi, TX.
1983-85: Manager, The Psychiatric Program of Elk County General Hospital, Ridgway, PA.
Community Counseling Services of Northeastern Pennsylvania, Wilkes-Barre, PA 18701
1981-83: Coordinator, Treatment Services
1980-81: Coordinator, Day Hospital Services
1978-80: Clinical Supervisor, Geriatric Service Program
1975-78: Human Service Planner
1972-75: In-patient Psychiatric Technician

EDUCATION
1978: Masters of Social Work, School of Social Work, Marywood College, Scranton, PA
1972: Bachelor of Arts, Wilkes University, Wilkes-Barre, PA