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Current Knowledge on Child Sexual Abuse in Indigenous Populations of Canada and the United States: A Literature Review

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This literature review was undertaken to assess the state of current knowledge, stemming from scientific research with regards to child sexual abuse (CSA) in indigenous communities. At first, this review was to be restricted solely to the indigenous peoples of Québec. However, since the literature on CSA in indigenous populations is extremely limited, the scope of our research was extended to include results from studies on indigenous peoples of Canada and the United States.[1]

To simplify terminology, rather than "First Nations/Inuit" or "Native Americans/Alaska Natives," we use the term *indigenous peoples*, following the United Nations Declaration on the Rights of Indigenous Peoples.[2] While the United Nations has not yet adopted a single definition for "indigenous peoples," a modern understanding of the concept encompasses the following criteria:

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> Self-identification as indigenous peoples at the individual level and accepted by the community as their member; historical continuity with pre-colonial and/or pre-settler societies; strong link to territories and surrounding natural resources; distinct social, economic or political systems; distinct language, culture and beliefs; form non-dominant groups of society; resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.[3]

Background

Indigenous People in Canada and the United States

In Canada, 1.4 million people (4.2% of the total population) self-identify as indigenous. Canada's indigenous population is composed of three main groups: First Nations (61%), Métis (32%), and Inuit (4%). Within those, there are more than fifty different indigenous nations with their own language and culture.[4] In the United States, 5.2 million people self-identify as indigenous. In a 2010 census, 1.7 percent of all Americans self-identified as American Indian or Alaska Native. There are 566 federally recognized tribes in the United States and close to fifty tribal groupings (the equivalent of Canada's indigenous nations).[5]

As indigenous populations in North America include multiple nations and tribes with distinct cultures, it would be simplistic to consider them as a single homogeneous group.[6] However, they share a common experience of events that include colonization, war, infectious disease outbreaks, the introduction of alcohol for barter, land dispossession, and cultural genocide caused by the institution of residential schooling.[7] Therefore, it is not surprising that indigenous communities are some of the poorest in North America and stricken by many social problems, including CSA.

What is Child Sexual Abuse?

There are many definitions of CSA. Most of them share common ground, but there is still no consensus on the exact boundaries of the concept. Crucial criteria affecting the definition of CSA include variations such as the cutoff age for "childhood" and the specific acts that constitute CSA.[8] It is therefore important to be aware of each study's definitions, since these can have a significant impact on results and may render comparisons between studies invalid. In this paper, CSA is defined as any sexual activity involving a child (defined as the age range from zero to eighteen years) who is unable to give consent, including vaginal/anal intercourse, oral-genital contact, genital-genital contact, fondling, and exposure to pornography or to adults engaging in sexual activity.[9]

CSA is a worldwide problem that does not seem to be associated with a specific nation or culture.[10] Its effects have been documented for many years in the scientific literature. They are pernicious and can have long-term impacts on victims' physical and psychological health.[11]

CSA and Indigenous Populations

CSA is often considered one of the major challenges faced by indigenous communities in North America. However, data available on the issue is often contradictory. Sometimes, reported incidence rates of CSA are comparable to those found in the general population. Other times, incidence is much higher. Moreover, the reported data usually comes from clinical groups that do not accurately represent indigenous populations. Even when groups are representative, it is difficult to generalize results from a single community or region to all indigenous populations.[12]

Researchers usually agree on one point: the data available on CSA in indigenous communities is insufficient given the scope and seriousness of the problem. Indeed, with a population of about 6.4 million in Canada and the United States distributed among approximately 1,200 communities, it is surprising that over the last twenty-five years so few studies have been conducted on this issue. For this reason, we believe that compiling the available information on this issue is crucial.

Methodology

This literature review was conducted using the Ovid search engine in June and July 2013. Initially, we searched three large databases, ERIC, MEDLINE, and PsychINFO, using the index terms "American Indians" and "Child Abuse." As the American Psychological Association explains, the method of using index term searches is effective because "Index terms are controlled vocabulary terms used in database records to make searching easier and more successful. By standardizing the words or phrases used to represent concepts, [there is no] need to try and figure out all the ways different authors could refer to the same concept."[13]

First, we read abstracts to see whether papers were about CSA in indigenous populations of Canada or the United States. The age range we attributed to "childhood" in this review was zero to eighteen years, although some authors defined childhood as zero to twelve years. We included articles in French and English. Articles written before 1990 were rejected. This initial step yielded a selection of fifty-four articles, which were then fully read.

Subsequently, we identified other articles from a bibliography on the subject created in 2009 by the Centre d'expertise Marie-Vincent, an organization that helps CSA victims ages twelve and younger, their parent(s), and/or their accompanying adult. We also searched the grey literature found online: government reports, practical guides, and other documents. Finally, to round out the literature review, we implemented a snowball search, starting from the references contained in the selected documents.

For the final screening, we retained only those articles containing information on the four themes that appeared to be the most significant in the available literature on CSA in indigenous populations of Canada and the United States: (1) incidence and prevalence rates, (2) risk factors, (3) difficulties associated with disclosure, and (4) consequences of CSA.

Results from the Literature on CSA in Indigenous Populations

Incidence Reports from Child Protection Services

Analyzing social service reports is one way to learn more about CSA in indigenous communities. Although these are not representative of actual CSA prevalence—since CSA cases are not always reported to the authorities—they still provide an overview of the situation. According to a meta-analysis by Marije Soltenborgh and colleagues involving a total sample of close to 10 million participants worldwide, incidence rates were thirty times lower than prevalence rates.[14] Specifically, the incidence rate (from informant studies) were 4 per 1,000 children, while the prevalence rate (from self-reported studies) was 127 per 1,000 children.

According to the Canadian Incidence Study of Reported Child Abuse and Neglect conducted in 2008, out of 59.8 substantiated maltreatment cases per 1,000 indigenous children living in the geographic areas served by the sampled agencies, one was a sexual abuse case. In comparison, of the 11.8 substantiated cases per 1,000 in equivalent non-indigenous populations, 0.4 were cases of CSA. Therefore, the rate of substantiated sexual abuse investigations was 2.7 times greater for the indigenous population than for non-indigenous population.[15] Incidence reports from the 2003 Canadian Incidence Study were analyzed by race in a paper by Chantal Lavergne and colleagues. [16] All in all, 9,554 cases of suspected maltreatment were selected in this study. CSA was reported in similar proportions for Caucasians (5.5%) and aboriginals (5.8%), but was slightly less reported for blacks (3.5%) and Asians (3.1%). The proportions of substantiated cases presented a similar distribution, with 21.3 percent of Caucasian, 20.8 percent of indigenous, 11.8 percent of black, and 5.3 percent of Asian cases being substantiated, but intergroup difference was not statistically significant.

According to the Report of the Auditor General of Canada to the Legislative Assembly of Nunavut, there were 44.3 incidents of sexual violation against children per 100,000 people in Nunavut and 4.3 incidents per 100,000 people for all of Canada. The race of the children at risk in Nunavut was not specified, but 84 percent of Nunavut's population identify themselves as Inuit.[17]

Results of social service reports from the United States are also available. In a study covering more than 2,000 maltreatment cases in indigenous populations in the United States, CSA was involved in 28 percent of reported cases. The study reported that 55 percent of the aggressors were biologically related to the child and that 80 percent of the victims were female.[18] In another study with cases documented by social services, a significant gap was found in the results. In the two national databases, CSA cases represented a high proportion (26.7% and 31.5%) of reported maltreatment cases. As for data collected in Alaska and New Mexico, CSA rates were 14 percent and 11.5 percent, respectively. These rates are much closer to the national average observed in 1999, which was 11.3 percent of reported maltreatment cases.[19]

Rates of CSA among Indigenous Peoples in North America

Few studies have documented the rates of CSA in indigenous communities.[20] The available results often come from data collected in a single community or clinical group.[21] The results documenting sexual abuse among indigenous children are particularly varied. The literature reports sexual abuse prevalence rates in indigenous samples ranging from 0.8 percent to 66 percent among boys and 7 percent to 96 percent among girls.[22] The wide gap in reported CSA prevalence rates may be due partly to sampling methods that included individuals from higher-risk groups (such as people with mental illness, people in prison, and sex workers), but it may also be partly due to the heterogeneity of indigenous communities. As an illustration, results from a worldwide meta-analysis on this issue revealed that United States/Canada prevalence rates were 20 percent for women and 8 percent for men.[23] The sections below will discuss in further detail the prevalence rates of CSA found in the literature based on samples that were judged relatively representative of indigenous populations.

Reported CSA prevalence rates from representative North American indigenous samples. Several studies have been carried out with representative samples of indigenous populations. In a study conducted by Robert W. Robin and colleagues with 582 individuals in a community in the southwestern United States, reported rates of CSA were 49 percent among women and 14 percent among men—which is relatively high for a sample not taken from a clinical group.[24] In this study, 78 percent of CSA had been carried out by family members. The authors created two subgroups: individuals aged fifty or more and individuals younger than fifty. No man aged fifty or more reported suffering sexual abuse as a child. Among women aged fifty or more, the prevalence was 16 percent; among younger women, the rate was 56 percent. In another study conducted in seven communities in five American states, Mary P. Koss and colleagues reported very different prevalence rates from one community to another, ranging from 4 percent to 40 percent among men, and from 10 percent to 53 percent among women.[25] Results from a questionnaire completed by 969 individuals in Nunavik indicated that rates of CSA were 49 percent for women and 16 percent for men.[26]

However, not all studies revealed disproportionate rates. In an epidemiological study involving participants from a reservation in the northern United States and two reservations in the Southwest, sexual abuse rates were much lower than those reported in other studies. The prevalence in the southwestern reservations was 7.6 percent among girls and 2.3 percent among boys, while in the northern reservation it was 7.2 percent among girls and 0.8 percent among boys. According to the authors, these results were somewhat similar to the United States national CSA estimates of 2004.[27]

Many studies have used samples consisting of students (see table 1). Robert W. Blum and colleagues reported the lowest prevalence rates, which were comparable to worldwide findings in terms of self-reported sexual abuse.[28] Elizabeth Saewyc and colleagues found that while indigenous peoples had the highest prevalence rates for CSA both in 1992 and 1998, the rates were not significantly higher than those reported for African American and Latino participants. Caucasian and Asian children

Table 1
Prevalence Rate of CSA in School Samples

Study	Year	Sample	Prevalence of sexual abuse
Blum, et al.	1992	13,454 indigenous high-school students from eight regions in the United States	19% of girls 10% of boys
Saewyc, et al.	2003	All grade 9 and 12 students in Minnesota in 1992 (n=77,374) and 1998 (n=81,247)	17.9% of indigenous children in 1992 16.8% of indigenous children in 1998
Lodico, et al.	1996	A random sample consisting of 10% of Caucasian children (n=4815), and all African-American (n=373) and indigenous children (n=409) in grade 9 and 12 in a Midwestern state in the US who completed a questionnaire on high-risk behavior in 1989	27.5% of indigenous girls 8.3% of indigenous boys
Devries, et al.	2009	445 indigenous girls and 360 indigenous boys attending high school in British Columbia who have already had sexual intercourse	40% of girls 10% of boys

in this sample reported the lowest CSA rates.[29] In another study containing data on ethnic groups, indigenous people reported the highest incidence of CSA, but not significantly higher than African Americans; in this same study, Caucasian children reported the lowest rates of sexual abuse.[30] Lastly, Karen M. Devries and colleagues reported a high prevalence rate for sexual abuse among girls; however, the rate for boys was comparable to results in the general population.[31]

Literature review of the prevalence of CSA in indigenous communities. Unfortunately, there is no systematic study or survey on the prevalence of CSA in indigenous communities that would help us to precisely quantify the extent of the problem. We found only one survey that focuses on the prevalence of CSA among indigenous children in Canada.[32] In the twenty studies (dating from 1989 to 2007) reviewed in this survey, prevalence rates ranged from 16 percent to 100 percent. More specifically, moderate rates (16–36%) of sexual abuse were found in eight studies, high rates (44–67%) in seven studies, and extremely high rates (75–100%) in five studies. After eliminating studies that were either misquoted or that included high-risk groups, the authors believed that a prevalence rate of 25 percent to 50 percent reflected the reality of sexual abuse among indigenous children under the age of eighteen years.

In short, given the wide-ranging diversity that characterizes indigenous people throughout North America, as shown by the results cited above, which range from 0.8 percent to 40 percent among men and from 7.2 percent to 53 percent among women, it is difficult to establish a comprehensive overview of CSA among indigenous communities. Reported rates among indigenous peoples, which are often greater than rates in the general population, suggest that CSA is a major problem in these communities.

Risk Factors Associated with CSA in Indigenous Communities

Numerous risk factors associated with child and family environment characteristics seem to influence the incidence of CSA in indigenous communities. In a majority of studies on the prevalence of CSA, the difference between men and women was statistically significant: considerably more women than men were victims of CSA.[33]

With respect to family environment characteristics, alcohol abuse also seemed to be a risk factor in indigenous communities. Robin and colleagues reported that 74 percent of participants in their study who suffered sexual abuse as children had parents who were alcoholics.[34] Embree and DeWit showed a correlation between CSA and a drinking problem for either parent.[35] According to McKenna (cited in Morin & Lafortune), 95 percent of sexual offense trials in an itinerant court were directly related to alcohol consumption in adults.[36] In addition, Saylors and Daliparthy stated in their study that 100 percent of female participants who suffered sexual abuse with penetration in childhood reported that the offender was under the influence of substances or alcohol and 54 percent reported that they themselves had been under the influence of drugs or alcohol.[37]

A poor parent-child relationship is a risk factor associated with sexual abuse.[38] According to social workers interviewed in the Far North of Québec, lack of parental supervision is another risk factor that should be considered.[39] The social and geographical isolation of some indigenous communities is considered as serious a risk factor for sexual abuse as are overcrowded accommodations.[40]

In summary, being female, living with alcoholic parents, having an unhealthy parent-child relationship, being under little or no parental supervision, living in an isolated region, and being subjected to overcrowded family living conditions have all been identified as risk factors associated with CSA in indigenous communities.

Difficulties Associated with Disclosure of CSA in Indigenous Communities

There seems to be a lack of understanding regarding the problem of CSA in indigenous communities as well as a lack of resources available to victims. In addition, indigenous practitioners sometimes experience difficulties dealing with their own history of sexual victimization, which may lead them to neglect reported cases of sexual abuse.[41] Intergenerational resentment toward authority, fear of the legal system, and anxiety with regards to confidentiality may also be present. These factors are additional variables that contribute to low sexual-abuse disclosure rates.[42] The "code of silence" seems to be widespread in indigenous communities. A study conducted in Nunavik reported that CSA cases are often camouflaged.[43] Certain members of the community go so far as to intimidate victims of CSA to protect themselves, a member of their family, or a friend from being identified as a sexual offender.[44] It appears that CSA cases were more often revealed when major crises occurred—for example, when extreme violence or self-destructive behavior by victims occurred.[45] According to results collected by Groupe de recherche et d'intervention psychosociale en milieu autochtone (Aboriginal Research and Psychosocial Intervention Group, or GRIPMA), 51 percent of sexual abuse victims revealed to practitioners that they had

not disclosed the abuse because they had been threatened by the offender's family or friends; however, the practitioners believed that the actual rate of nondisclosure due to this reason was 77 percent. Moreover, 47 percent of sexual abuse victims told practitioners that they had not made a disclosure because they had been threatened or intimidated by their own family or friends.[46]

According to GRIPMA, the reasons most often cited by victims for not disclosing sexual abuse are fear (93%), shame (84%), and unwillingness to engage with the legal system (77%).[47] Collin-Vézina and colleagues agree. According to them, children do not disclose sexual abuse not only because they fear authority, but also because they fear they will be ostracized by their extended family.[48] Moreover, CSA victims experience guilt and shame. In geographically isolated communities, revealing sexual abuse forces victims to leave the community to obtain the care and support they need, which is yet another obstacle to disclosure.[49]

The Consequences of Sexual Abuse in Indigenous Children

The consequences of CSA in the general population are extensively documented in the literature. Few studies, however, have focused specifically on the consequences of CSA in indigenous populations.

Addiction. The experience of sexual abuse in childhood appears to have repercussions on alcohol and drug addiction in adulthood. Studies by Libby and colleagues have compared two indigenous groups—one consisting of individuals from the southwestern United States, and the other from the northern United States. In the northern community, sexual abuse in childhood was associated with alcohol abuse in adulthood as well as substance abuse and addiction, but was not associated with alcohol addiction.[50] In the southwestern communities, only drug addiction was significantly associated with sexual abuse in childhood. More extensive analyses of the same data revealed that sexual abuse in childhood increased the likelihood of substance abuse in adulthood in the northern community but not in the southwestern communities.[51] These results are a telling example of the differences between communities and serve as a reminder that results from a particular indigenous community may not be generalized. In a study that examined the link between sexual abuse in childhood and alcohol addiction in adulthood, results revealed that young boys who were physically and sexually abused face a greater risk of developing an addiction to alcohol; the same was found in the case of girls who had been sexually abused.[52] Excessive alcohol consumption in adulthood among males was also correlated with sexual abuse in childhood in another study.[53]

Psychological problems and psychiatric disorders. Libby and colleagues reported that in their studies CSA was also associated with post-traumatic stress disorder (PTSD) in both sets of participants (from the northern and southwestern United States).[54] In the southwestern group CSA was also associated with the development of depression/dysthymia and anxiety disorders. Robin and colleagues also reported a link between sexual abuse in childhood and PTSD, and showed that sexual abuse was associated with the development of other psychiatric disorders.[55] Men who were victims of sexual abuse in childhood were more likely to be diagnosed with antisocial personality

disorder, addicted to drugs, and more subject to affective disorders. Women who were victims of sexual abuse in childhood were at greater risk of developing antisocial personality disorder, substance-related disorder, affective disorder, anxiety disorder, and PTSD. Another study by Robin and colleagues found that 63 percent of women who received long-term treatment for a mental disorder or substance-abuse problems had been victims of sexual abuse in childhood.[56] The corresponding proportion reported for men was 20 percent. Men who had been victims of sexual abuse in childhood were more likely to seek long-term hospital treatment for their mental health problems rather than regular check-ups. In addition, adults who had been victims of sexual abuse in childhood were at greater risk of experiencing symptoms of three or more mental disorders than men who had not been sexually abused. According to Deters and colleagues, CSA victims are more likely to avoid stimuli associated with sexual abuse, which is a symptom of PTSD.[57] However, CSA victims in this study did not exhibit sufficient criteria to establish a PTSD diagnosis.

Suzanne L. Barker-Collo's study compared Caucasian women who had been victims of sexual abuse in childhood with indigenous women.[58] Both groups were alike with regard to various socio-demographic variables: level of education, age when sexual abuse first occurred, relation to the offender, extent and frequency of sexual abuse, and marital status. The study showed that indigenous women developed significantly more symptoms than Caucasian women. More common symptoms in indigenous women were divided in three categories: somatic symptoms (headaches, weight loss without dieting, uncontrollable crying); symptoms associated with sleep disturbance (insomnia, waking early in the morning, waking in the middle of the night); and symptoms associated with sexual difficulties (unsatisfying sex life, disturbing thoughts and feelings during sexual intercourse, and sexual thoughts at inappropriate times). Blum and colleagues reported that adolescents experiencing severe distress were two and a half times more likely to have been sexually abused (21.9% as compared with 8.5%).[59]

Behavioral problems. CSA is also associated with certain behavioral problems. In Blum and colleagues' study, adolescent sexual abuse victims were more likely to run away from home than teenagers who had not been sexually abused.[60] They also faced greater suicide risk. More of them had attempted suicide in the past year, with continuing suicide ideation, or to have made several suicide attempts in the course of their lives. In a study by Robin and colleagues, participants who had been CSA victims were more likely to report behavioral problems in adolescence or adulthood.[61] In adolescence, young men who had been sexually abused were more likely to be suspended from school, break rules, be arrested, be summoned to appear in court, lie, steal, damage private property, run away from home, and have sexual intercourse at an early age. On top of those behavioral problems, girls also had poor school attendance and drank alcohol in excess. In adulthood, the behavioral problems in both men and women who had been sexually abused included greater likelihood of attempting suicide, financial difficulty, and poor social networks. Men also reported more episodes of drunkenness. In their study, Stephen J. Kunitz and colleagues found that sexual abuse was a risk factor for conduct disorder in adolescence.[62] Conduct disorder is a psychiatric condition characterized by behaviors that violate other people's rights and social standards.[63]

Sexual behavior problems. CSA is also associated with sexual behavior problems. Study results from Mark A. Lodico and colleagues indicate that CSA victims were at greater risk of being sexually abused as adolescents and were also more likely to use sexual coercion.[64] According to data collected from a group of indigenous schoolchildren, sexual abuse was also associated with a greater likelihood of pregnancy in adolescent girls. Boys who had been sexually abused were more likely to have had a blood-borne and sexually transmitted infection and to have caused a pregnancy.[65] Data collected in other studies seems to corroborate the hypothesis that girls in indigenous populations who were sexually abused were more likely to experience teen pregnancy.[66] In a study conducted among indigenous and Caucasian women in a Calgary community center, victims of sexual abuse were more likely to contract a blood-borne and sexually transmitted infection, to smoke, and to have many sexual partners, regardless of ethnic background. Study results by Stevan E. Hobfoll and colleagues showed that CSA was associated to both the risk of blood-borne and sexually transmitted infection and to having had sexual partners who were infected.[67]

Relational problems. According to the literature, being sexually abused in childhood has an impact on a victims' ability to form relationships in adulthood. Sexual abuse in childhood was negatively correlated with relationship satisfaction among couples.[68] In addition, victims of physical or sexual abuse in childhood reported experiencing more situations of abuse in adulthood.[69] Anne M. Libby and colleagues' results suggest that sexual abuse in childhood was a factor that influenced parental dissatisfaction in adulthood.[70]

Discussion

Culturally Adapted Therapies and Intervention

A number of social programs have been developed and implemented in response to the needs of indigenous communities. However, given indigenous peoples' wariness of non-indigenous social authorities, great care must be taken to create relationships of trust before launching new intervention programs. As the National Aboriginal Health Organization has asserted, research conducted in indigenous communities has generally been more helpful to researchers than to the communities themselves.[71]

To be helpful to minority ethnic groups, therapy must be culturally adapted.[72] Accordingly, there is a growing call to adapt practices to respond more effectively to indigenous communities' needs in several areas.[73] For example, Marianne Rolland Ashby and colleagues criticize the use of therapeutic treatment for sexual abuse victims based on the nuclear family model. Since this model is not found in indigenous communities, this type of clinical intervention is inappropriate from a cultural perspective.[74]

As Irene S. Vernon and Roe Bubar have pointed out, intervention programs will not necessarily be accepted in indigenous communities simply because program administrators are well-intentioned and wish to adapt their practices to the cultural context.[75] An in-depth understanding of the issue and the context is a first step toward cultural adaptation, but target communities must be receptive to the program. Before

carrying out these intervention programs, one must make sure that the communities are ready and willing to implement it.[76] Sherry L. Hamby agrees, emphasizing that each community's resources and strengths should be taken into account in addressing the issue of sexual abuse.[77] Measures implemented in support of communities must be relevant to their history and culture. In short, change must come from the communities and never be imposed on them. One way of fostering acceptance of intervention programs may be to use a participative approach. By involving communities at every step of program development and implementation, such an approach should, in theory, favor acceptance.[78] Conclusions of a report on community-based participatory research in American Indian and Alaska Native communities suggest this method holds great promise but also presents many challenges.[79] Therefore, before approaching indigenous communities, researchers should determine how the potential results of the study will truly benefit the communities; inform themselves about the beliefs, religion, and culture of the people with whom they will work; design the study as a partnership project between indigenous communities and researchers; and finally, as much as possible, participate in cultural sensitivity workshops or training to refine intercultural communication skills and foster respect for cultural diversity.[80]

Another issue raised by some researchers is the possibility of reconciling evidence-based therapies and culturally adapted therapies. In many cases, however, culturally adapted therapies lack the empirical grounding of evidence-based interventions. Joseph P. Gone recommends, as a first step, that recognized therapies be evaluated with groups representing ethnic minorities to see if they retain their efficacy.[81] Arthur L. Whaley and King E. Davis agree with this approach, arguing that established therapies should be validated with groups representing ethnic minorities to determine whether they should be adapted.[82]

While Jami Bartgis and Dolores Subia BigFoot agree with the above, they see culturally adapted and evidence-based practices as not two sides of the same coin, but rather two different approaches with the same goal of improving the lives of those served.[83] Therefore, understanding how they can complement one another is an important step in addressing health disparities among indigenous people. *Honoring Children—Mending the Circle*, an adaptation for indigenous people of an evidence-based child trauma treatment, is an example of these kinds of practices. In this treatment approach, an intervention shown to be effective is implemented within a framework that supports indigenous traditional beliefs of wellness, spirituality, and well-being.[84] These new approaches, which involve culturally adapting evidence-based practices to indigenous communities, represent an important first step; however, they must be evaluated to determine their relevance and flexibility.[85]

CSA Knowledge Transfer Needs in Indigenous Communities in Canada

As mentioned above, it is important to use effective, scientifically proven facts whenever possible. To be effective, however, interventions must address real needs. In this section, we focus on the needs expressed by indigenous communities and documented in the literature in Canada.

The literature provides information about the needs of practitioners who work with CSA victims in indigenous communities. One conclusion of an Ontario research report on family violence within indigenous communities was that indigenous practitioners wanted to pursue further training in dealing with cases of family violence.[86] Among the few agencies that offered this type of training, it was reported that more information and guidance was desperately needed to address the needs of victims of CSA. Practitioners also said that they needed more support and therapy to help them deal with difficult work-related situations. They reported high levels of stress and professional fatigue and great difficulty detaching themselves emotionally from their cases.

More recently, a Québec report uncovered a lack of knowledge and training among indigenous practitioners with respect to sexual abuse.[87] Indeed, nearly 60 percent of practitioners believed that they were not sufficiently well-equipped to manage sexual abuse cases. Of these, nearly all (93%) stated the need for more training programs for practitioners to reduce the incidence of sexual abuse in indigenous communities. One of the report's recommendations was that the federal government, in partnership with communities and agencies, create a screening and intervention training program for frontline practitioners—including early childhood educators—as is offered to practitioners in the health, social service, and education sectors.

In Closing: Effective Tools for More Effective Action

CSA is a major issue in indigenous communities, as indicated by the prevalence rates cited in the literature. However, not all studies report alarming rates, and some communities have made considerable efforts to address the situation. Unfortunately, sexual abuse in indigenous communities remains a taboo subject; given the low rate of disclosure and related constraints, it is difficult to bring cases of sexual violence to light. This is especially problematic because sexual abuse can have many long-term consequences for victims. That is why it is important for more research to address this issue—adding to the current body of knowledge, raising awareness, and fostering prevention and treatment—in order to help indigenous victims, their families, and their communities.

While doing this review, we were surprised by the lack of research on protective and prevention factors. In fact, only a single study on protective factors against the adverse correlates of CSA was found.[88] Considering the high prevalence rates and confirmed consequences of CSA, research in these areas might give meaningful insight to guide and improve actions leading to victims of CSA well-being, as well as preventing it. Consequently, we recommend that further research focus on prevention and protective factors of CSA.

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Notes

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