PROFESSIONAL'S RESPONSES
TO
CHILD SEXUAL ABUSE
IN THE
AUSTRALIAN CAPITAL TERRITORY

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1985
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DECLARATION

I declare that this thesis reports my original work, that no part of it has been previously accepted or presented for the award of any degree or diploma by any University, and to the best of my knowledge no material previously published or written by another person is included, except where due acknowledgement is given.
This thesis describes original research carried out by the author in the Department of Psychology of the Australian National University during 1985.
ABSTRACT

This study investigates the relationship between workers' conceptualization of child sexual abuse and their handling of such cases, using a questionnaire to elicit usual case management, and an interview employing vignettes and controversial statements to examine the goals of, and the attitudes behind, case management strategies. The subjects of this research are 60 professionals from agencies in Canberra which deal with child sexual abuse - police, welfare, community health centres, mental health teams, schools and a group of non-government community agencies. The study focusses on intrafamilial child sexual abuse, being the dominant type, and having quite different dynamics from sexual abuse of children by adults outside of the family unit. Child sexual abuse was originally conceptualized as a form of child maltreatment, as cases first came to notice in investigations of other forms of child maltreatment - notably physical abuse. More recently, some writers have included intrafamilial child sexual abuse under the rubric of domestic violence, along with 'wife bashing' and marital rape - all three being seen as an attempt at perpetuation of the traditional patriarchal pattern, and as symptoms of the much described 'crisis' of the family. The effects of such disparate conceptualizations on the intervention strategies adopted by different professional groups, and by different agencies in Canberra, highlights the need for a consensus of approach, not only between different agencies, but by different professional groups working for the same agency. The result of a preliminary study of the incidence of reported child sexual abuse throughout Australia is included in this report, along with discussion of the status of national data collection, and possible reasons for the lack of progress so far. An 'Involvement Index', developed in this study, holds promise as an instrument for comparing the commitment and experience levels of professionals from different agencies, whose roles in dealing with child sexual abuse necessitate working in quite different ways. This study shows that, although child sexual abuse is acknowledged as a serious social problem by workers from all agencies sampled in Canberra, exposure of workers to these cases varies considerably amongst agencies, with doctors and community nurses seeing few cases, and police, welfare and mental health workers, and staff from non-governmental community agencies, being heavily involved. The implications of these findings are discussed, in relation to the introduction of the proposed new Child Welfare Ordinance (ACT).
### TABLE OF CONTENTS

**Chapter 1: Introduction** ............................................ 1
  - Historical Interest in Child Abuse ............................ 1
  - Incestuous or Intrafamilial Child Sexual Abuse ............ 3
  - Child Sexual Abuse as a Form of Child Abuse or Family Violence ................................................ 5
  - Conceptualization of Child Abuse ................................ 5
  - Comparison of Child Sexual Abuse and Child Abuse ......... 10
  - Conceptualization of Marital Rape ............................. 11
  - Comparison of Child Sexual Abuse and Marital Rape ...... 14
  - Incidence .................................................................. 21
  - Problems with Gathering Statistics on Reported Child Sexual Abuse ................................................. 23
  - Relationship between reported Child Sexual Abuse and Actual Incidence ........................................... 25

**Chapter 2: Patterns in Depth** ................................... 30
  - Profile of Victims ............................................ 30
  - Profile of Offenders .......................................... 35
  - Precondition 1: Predisposition to Relate Sexually to Children ......................................................... 38
  - Physiological Abnormalities ................................... 38
  - Antiandrogenic Drug Treatment ................................ 39
  - Precondition 2: Motivation to Sexually Abuse Children .......................................................... 40
  - Factor 1: Emotional Congruence ............................... 40
  - Factor 2: Sexual Arousal to Children ....................... 41
  - Factor 3: Blockage .............................................. 42
  - Abuse by Females ................................................. 45
  - Boys as Victims ................................................ 46
<table>
<thead>
<tr>
<th>Chapter 7: Method</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Selection</td>
<td>102</td>
</tr>
<tr>
<td>Study Design</td>
<td>104</td>
</tr>
<tr>
<td>Procedure for Recruiting Subjects</td>
<td>105</td>
</tr>
<tr>
<td>Composition of the Sample</td>
<td>106</td>
</tr>
<tr>
<td>Development of the Questionnaire</td>
<td>108</td>
</tr>
<tr>
<td>Demographic Data</td>
<td>109</td>
</tr>
<tr>
<td>Involvement Index</td>
<td>112</td>
</tr>
<tr>
<td>Development of the Interview</td>
<td>115</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 8: Results</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothetical Cases found Abusive</td>
<td>121</td>
</tr>
<tr>
<td>Interventions Recommended, By Involvement Group</td>
<td>124</td>
</tr>
<tr>
<td>The Importance of Pressing Charges</td>
<td>140</td>
</tr>
<tr>
<td>Reporting Child Sexual Abuse</td>
<td>143</td>
</tr>
<tr>
<td>Controversial Statements</td>
<td>145</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 9: Discussion and Conclusions</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to the Problem</td>
<td>157</td>
</tr>
<tr>
<td>Reporting Child Sexual Abuse</td>
<td>158</td>
</tr>
<tr>
<td>Involvement Index</td>
<td>160</td>
</tr>
<tr>
<td>Proposed Interventions in the Hypothetical Situations</td>
<td>163</td>
</tr>
<tr>
<td>The Goals of Intervention</td>
<td>165</td>
</tr>
<tr>
<td>Attitudes of Canberra's Child Sexual Abuse Workers to Incest</td>
<td>167</td>
</tr>
<tr>
<td>Implications and Recommendations</td>
<td>170</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bibliography</th>
<th>Page</th>
</tr>
</thead>
</table>

| Appendices |
CHAPTER 1: INTRODUCTION

Historical Interest in Child Abuse

The use (or abuse) of children as sexual objects by adults has been documented throughout history. In very early times, age distinctions between child, adolescent and adult were not strong, and the historical evolution of childhood and sexuality is characterized by superstition, folklore, fanaticism and medical sadism (Schultz, 1982). Until the beginning of this century, parents - fathers in particular - were seen as having absolute rights over their children, who were indeed considered their "chattels". The importance of the parent-child relationship and consistency in that relationship for the development of an adequate adult was first stressed in Freud's pioneering work, and since that time, some focus on the welfare of children has been maintained.

Child abuse was first brought to public awareness at the beginning of the nineteenth century in Victorian England with the enactment of legislation about the prevention of cruelty to animals. But while public sympathy for animals persisted, interest in child abuse waned, to emerge only recently with medical recognition of the "battered baby" in the early 1960's.
It soon became apparent that the term "child abuse" does not refer to a unitary phenomenon, but rather to a range of interactions between child and caretaker. Definitions broadened from an initial focus on physical abuse to include neglect, emotional abuse and sexual abuse, as well as infanticide and traumatic injury. Public interest in child abuse was maintained by the concurrent Human Rights debate, which extended to include a focus on the rights of children. Meanwhile, growing support for the feminist movement compelled public recognition of, and a political response to, the long documented abuse of women, and prevention of the sexual abuse of girls was championed by feminists who realised that gender rather than age differentiated victims of sexual abuse.

This concurrence of emphasis on child sexual abuse from the social control, human rights and feminist perspectives has ensured its prominence as a widespread social concern, but also ensured the involvement of people from diverse backgrounds, with differing and often conflicting attitudes, orientations and prescriptions for change. Consider the impact of these forces via the mass media, in a young multi-cultural nation such as Australia, in a period of social and economic uncertainty, such as the present decade, "and it becomes easier to understand how issues previously hidden have become areas of public concern, and why those who seek certainties sometimes find them missing " (Coleman, 1979, p.3).
Incestuous or Intrafamilial Child Sexual Abuse

Child sexual abuse (particularly if it is incestuous) is reported rarely and is treated even more infrequently. The fact that there is no one clear legal or research definition of incestuous behaviour presents a problem in efforts to obtain data on the incidence and treatment of the phenomenon. The strictest definition would be genital intercourse. However, incestuous behaviour listed in the literature and in state laws includes oral-genital contact, mutual masturbation, anal intercourse, sodomy, exhibitionism, voyeurism and fondling of the genitals or breasts.

Any of these behaviours would be called 'intrafamilial child sexual abuse' if carried out by a person exercising power or authority over the child. That person could be older brother, uncle, father, stepfather, or mother's defacto. Many researchers exclude sibling incest from definitions of child sexual abuse by specifying that the child be 5 years younger than the older person, for a child less than 13 years old, and 10 years younger when the child is aged between 13 and 16. Such definitions of incestuous child sexual abuse seem arbitrary and overly restrictive.

The most significant advances in our understanding of incestuous child sexual abuse have come from the writings and research efforts of feminists. Yet a purely feminist perspective usually suffers from a monocular or myopic vision similar to that which Ward (1984) and other feminists have so poignantly identified in the writings of Freudian misogynous clinicians. By equating all
incest with rape, feminists fail to account for the unknown proportion of incestuous acts which are not "carried out in hatred" (Ward, 1984, p.151). Nor is our understanding advanced by the equation of rape and attempted rape (by the reasoning that all carry the threat of death). Herman's (1981) comparison of incestuous and 'seductive' fathers demonstrates that there are many differences in the fathers, their spouses and daughters, and the dynamics operating in their families, depending on whether incest is committed or just threatened against the girl. Other omissions which distort feminist conceptualizations of intrafamilial child sexual abuse include the overemphasis on female victims, when reports of sexual offenses against boys (and by their mothers) are increasing dramatically. The equation of sexual offences against boys with rape in jails; and disregard of recent explorations of the effect of relatedness (e.g. natural vs step vs foster/adoptive father incest, and rape by mother's boyfriend). Intrafamilial child sexual abuse is a complex and poorly understood phenomenon, and its study is marked by many false starts. A broad, systems perspective, taking in what may at first appear to be tangential issues, seems more prudent, given the current state of knowledge.

From a comparative psychology standpoint, it is interesting that, at the upper end of the phylogenetic scale, the following is observed. In infrahuman species, incestuous liaisons are partially prevented as a result of the domination of all adult females by a single, full-grown male. This is Social Control: it has nothing to do with any lack of attraction between closely related males and females.
Among the animal species in which regular mateships are formed, there appear to be some barriers to extra-mateship liaisons. Even amongst species where the female mates with many different males, it appears that female consort choice promotes male investment - challenging traditional assumptions that male investment is a direct function of paternity certainty (Haraway, 1983; Smuts, 1985). In all human societies every mated man or woman is limited by custom in the establishment of sexual liaisons.

Sexual relations between parent and offspring are prohibited in every human culture. Prohibitions against intercourse between brothers and sisters are nearly as universal. Where sibling unions are permitted or required, the individuals are always of a specific social status, and the permissible unions are mateships rather than casual liaisons.

Anthropologists originally saw the function of the incest taboo as modulating competition between individuals who made up the human family. However, in her 1962 introduction to "Male and Female" (1947), Margaret Mead wrote:

"Clinical materials collected during the last 15 years have underlined the fragility of such taboos and the danger that they may break down where the social sanctions are inappropriate. Present evidence suggests that there are no reliable innate defences against primary incest, and that each society must build its own taboos and must overhaul and redesign them when they become ineffective."
Child Sexual Abuse as a Form of Child Abuse or Family Violence

Conceptualization of a problem has direct bearing on strategies aimed at its study, treatment or prevention. Consideration of whether child sexual abuse is a form of child abuse or a form of family violence, and therefore more aligned with marital rape, has generated considerable controversy in the United States (Breines and Gordon, 1983, Dibble and Straus, 1980) and in this country (Pearn, 1981). Indeed, in the most recent National Conference on Domestic Violence, held in Canberra in November 1985, the deletion of child abuse – and particularly of child sexual abuse – from the programme caused consternation amongst large numbers of attendees. It is contended here that the label 'child sexual abuse' has influenced theory and research along lines taken in the more established field of child abuse, and led to an arbitrary cut-off point such that sexual victimization of a female is labelled and responded to differently once she attains a specified (and variable) age. The following account of approaches to child abuse and to marital rape will expose the family as the locus of struggles between the sexes and between generations, and highlight the need for an approach which takes into account historical, cultural, social and individual factors.

Conceptualization of Child Abuse

The syndrome broadly referred to as 'Child Abuse' was initially detected and identified by the medical profession, after Kempe and his associates at the Denver Medical Centre coined the diagnostic term 'battered child syndrome' in 1961. Public and
professional interest began with consideration of the most urgent and obvious physical pathology, and throughout the 60's the focus remained on physical trauma where neither accidental nor organic origin could be established.

This medical orientation resulted in a strategy for dealing with child abuse which sought to establish a causal relationship from which "at risk" situations could be predicted. It was hoped that strategies for dealing with the more covert and subtle forms of maltreatment would evolve along with conceptual and methodological sophistication. Such an aim implies the possibility of developing a systematic body of knowledge which can inform clinical practice by providing a framework of diagnosis, treatment and intervention.

Limitations on such a task are to some extent determined by the data available (or selected). In addition to making detailed observations using photographs and x-rays of the physical injuries, and gathering information relevant to the history and context of the incident, data collection was soon extended to include an account of the personality characteristics of the caretaker(s). Thus, a psychiatric model emerged complementary to the medical model in the search for "risk factors" to distinguish potential abusers. Fundamental assumptions of this approach are that the causes of abuse are to be found in the personal characteristics of the offending caretaker, and that these may reflect pathological tendencies.
Despite widespread criticism from non-medical workers of its basic tenet that a causal relationship could be established from which 'at risk' situations could be predicted, the medical/psychiatric model remains the dominant orientation in the area. Profiles of abusers are assembled from the medical, personal and demographic data of clinical populations. The personal characteristics cited vary widely in number and proposed significance, but there is a tendency to claim that abusive parents have low self-esteem, a personal history of abuse or neglect and a belief in the value of punishment (Meyer, 1980).

Critics of the psychiatric model argue that such characteristics cannot be used in a preventative way to identify parents 'at risk' of abusing their children. Since it is commonly agreed that child abuse is notoriously under-reported, they maintain that it is likely that clinical populations will over-represent parents from the lower socio-economic classes, since poorer families are more likely to come to the attention of helping agencies. Furthermore, the characteristics delineated may be representative only of these poorer parents, rather than of abusing parents generally. Finally, studies of the prediction of child abuse, as with prediction of behaviours such as violence to others, suicide, delinquency and alcoholism, suggest that "... mental health professionals are extremely inaccurate predictors" (Heller and Monahan, 1977, p137). Current methods of prediction of child sexual abuse (e.g. Steinmetz and Straus 1974) result in more people being incorrectly predicted as child abusers than are accurately predicted to be such, no matter how much information one adds to the predictive equation.
Because the consequence of false prediction could be serious labelling effects, and because effective intervention programs may involve gross deprivation of parental rights, the risks of attempting to predict child abuse could outweigh the benefits.

As previously stated, the aim of providing a framework for diagnosis, treatment and prevention of child abuse is limited by the data available, yet every indication suggests that only the most serious cases of physical abuse are ever reported. Societal attitudes to the family have been posited as the main factors in the reluctance to report maltreatment to outside agencies. Firm beliefs in the autonomy and privacy of the family and in the value of physical discipline in the upbringing of children have been enshrined in the legal principles which govern the conduct of the family. Thus, family autonomy is subject to encroachment only where the parent performs an act or omits a duty which brings him/her within the definition of ordinary criminal law, or if his/her conduct, though short of criminality, falls below the ordinary minimum standards demanded by the community, which are set out by statute (Connors, 1979). Hence a child, if considered to be under threat, may be charged as 'neglected' and either become subject to the supervision of the welfare department, or removed from the custody of his/her parents and placed in a welfare institution. Historically, then, child protective measures have been oriented as ex post facto intervention in family life, focusing on the punishment of the parents and the placement of the child outside the family group. This approach takes no account of the possible rehabilitation of the family,punishes the victims with separation from the family, and fails to protect children who receive less serious abuse.
Thus, the approach to child abuse which attempts to predict would-be abusers has not achieved much success, but the strategy of identifying parents who have inflicted serious abuse, and intervening to protect children from further abuse, has been equally problematic. Both approaches conceptualize child abuse as a pathological response to personal and/or familial problems. More recently, child abuse has been conceptualized as a multifaceted phenomenon requiring an interactional, systems analysis (Roberts, 1984a, 1984b; Parke and Lewis, 1981; Watkins and Bradbard, 1982). In this conception, abusers and their families are not seen as different from non-abusers and 'normal' families, except in terms of degree. The model identifies both necessary and sufficient conditions associated with the occurrence of child abuse. The necessary conditions without which abuse will not occur, include belief in the 'chattels' status of children and the value of physical discipline, and lack of prosocial supports.

The thrust of such models is on prevention, targeted at the community rather than at parents confirmed or at risk of child abuse. Prevention aims at promoting community involvement in the definition of community standards of adequate parenting, improving parenting skills and strengthening social 'connectedness' throughout the community. The promotion of community rather than professional management of families is encouraged via the integration of formal and informal support networks and the maximum use of indigenous support (Roberts, 1984b). Though largely untested, socio-environmental models offer
hope for helping all families by decreasing social isolation and
the resultant "poverty of community that places such inflated
expectations on our intimates" (Breines and Gordon, p.531).

**Comparison of Child Sexual Abuse and Child Abuse**

There are many differences between the physical and sexual abuse of
children. Gender differences are significant in sexual abuse, but
not in physical abuse. Girls are much more likely to be sexually
abused than are boys, and 97% of child sexual abuse is perpetrated
by males. Sexual abusers are predominately family members, including
fathers (and their surrogates), grandfathers, brothers, uncles,
etc., but some children are abused by friends of the family, and
some by strangers. Physical abuse, in contrast is perpetrated mainly
by parents or surrogate parents. Whereas sexual abuse is a male
crime, the mother is responsible for inflicting physical abuse in
about half the cases. Young mothers are more likely to physically
abuse, while the risk of fathers physically abusing their children
increases substantially after age 30 (Leivesley, 1984). Boys and
girls are equally likely to be physically abused, but prematurity
and birth defects have been shown to make a child more vulnerable to
physical abuse. Very young children are physically abused, with
first incidents of abuse occurring before age 3 in the majority of
cases. On the other hand, peak vulnerability for sexual abuse is
between 9 - 12 years, although in a quarter of cases the child is
less than 8 when abuse begins, and babies are sometimes sexually
abused too. Major differences also surround the commission of the
abuse. Establishing privacy to sexually abuse normally entails
premeditation, whereas physical abuse is committed impulsively. And once they have overcome their shame, physically abusing parents are more likely to come forward for help, as the abuse engenders feelings of discomfort and remorse. Consequently, they make better 'clients' than sexual abusers, who persist in denying their responsibility for the abuse longer and are less inclined to voluntarily give up behaviour they find pleasurable.

As many researchers and social commentators argue that child sexual abuse is like marital rape, an examination of the key elements in marital rape will elucidate its similarity to child sexual abuse.

**Conceptualization of Marital Rape**

Conceptualization of marital rape is at a rudimentary stage, as acknowledgement of the seriousness of the problem has been very recent. Estimates from random sample community surveys done in North America (cited in Finkelhor, 1985b) suggest that marital rape is one of the most common kinds of rape, two to three times more common than the stranger rape of popular conception. Three types of marital rape have been delineated (Finkelhor, 1985b):

**Battering Rape** — occurring in relationships where violent physical abuse is also present. The men responsible often have problems with alcohol abuse, and these rapes seem to be motivated by a desire to punish, humiliate, degrade and retaliate against their wives, and have little to do with sexual issues.
Force Only Rape - force employed sufficient to gain sexual access, but not to cause severe injury. The immediate precipitant was more likely to have a specific sexual grievance, and the rapes seem to be motivated less by anger than by a desire to assert power, establish control, or teach a lesson.

Obsessive Rape - These husbands had unusual sexual preoccupations, and were often obsessed with their own sexual problems and with pornography of the sadomasochistic type. Many of these men had highly structured rituals about sex, and found violence and the struggle and humiliation of their wives very stimulating.

In their survey of married women raped by their husbands, Finkelhor and Yllo (1985) found that 45% suffered battering rape, and 45% force only rape, and the remaining 10% obsessive rape. It is proposed that other forms of rape could be classified similarly, but the proportion in each category would probably differ. For example, one would expect a larger proportion of force only rapes by acquaintances and strangers than by husbands, reflecting public awareness of the finding that rape victims who offer resistance are "twice as likely to be hurt badly enough to require hospitalization" than those who submit quietly (Hirsch, 1981, p.79). Finkelhor (1985) reports that "victims of marital rape suffer greater and longer-term trauma than other rape victims", and
attributes this finding to "the three special injuries (sic) of marital rape: the betrayal, the entrapment and the isolation" (p. 5).

**Betrayal** refers to the destruction of the ability to trust others resulting from rape by someone 'loved' and 'needed'. Related to this is the loss of confidence in oneself and one's ability to choose trustworthy male companions.

**Entrapment** refers to the fact that marital rape usually occurs repeatedly in an ongoing, abusive relationship. Anxiety resulting from this never-ending threat of rape is evidenced in the chronic terror, emotional numbing, panic attacks and repetitive nightmares and flashbacks reported by many women long after the relationship is ended. With such symptoms, these women would be classified by DSM III (the latest revision of the Diagnostic System of the American Psychiatric Association) as having Post Traumatic Stress Disorder (see Appendix 1).

**Isolation**, says Finkelhor, results from the failure of friends, relatives and society to acknowledge the devastating effects of marital rape.

Where legislation has been introduced making marital rape a crime, as has happened in some states, and in the Australian Capital Territory since early November, 1985, the isolation of victims should lessen. However, the experience in California, where only 39 charges were brought in the two years following the criminalization of marital rape, would suggest that the community is far from ready to acknowledge the plight of women in violent abusive relationships. If criminalization is to demonstrate society's recognition that such women have been wronged, a greater proportion of cases will need to be reported and prosecuted.
This conceptualization of marital rape has led to two responses—the therapeutic and the political/legal—both championed by the feminist movement. Government endorsement of, and funding for, rape crisis centres, and the more recent criminalization of marital rape, discussed above, represent the political/legal response. The therapeutic response has been based on a feminist analysis of the differential power relations between men and women in heterosexual relationships. Therapy has explicitly aimed at empowering the women. It has comprised individual support, both emotional and practical, tailored in respect of their stress tolerance, adaptive resources, and life stage; and consciousness raising and group therapy, aimed at reducing the isolation and stigma felt by rape victims.

**Comparison of Child Sexual Abuse and Marital Rape**

Two essential differences between child sexual abuse and marital rape involve some perpetration by women and some victimization of boys—chiefly by males—in child sexual abuse. Considerable controversy surrounds both these issues, with some arguing that present indications—of child sexual abuse being largely a crime committed by men against girls—represent the true picture, their opponents in the debate contending that our current knowledge base is skewed. The latter group allege that male socialization inhibits boys from reporting sexual abuse, particularly at the hands of women, and that child-rearing practices afford women licence to engage in activities that would be considered abusive if perpetrated by a male. Until such time as community attitudes about reporting child sexual abuse are
transformed by a more rational and less emotional response to issues linking childhood and sexuality - a utopian ideal - this debate is unlikely to be resolved.

Many clinicians would also contend that the motivation behind marital rape differs from that in child sexual abuse. As already outlined, the battering and obsessive types of marital rape, which are more akin to other rapes, seem motivated by a desire to punish, humiliate or retaliate against a wife rather than being sexually motivated. However, a sexual grievance, an attempt to assert power or establish control or occasionally to teach a lesson seems the problem in almost half of marital rape (the 45% of force-only rapes). Most conceptualizations of father-daughter incest and many accounts by women of their victimizing experiences in childhood incest expose similar dynamics. But in terms of child sexual abuse as reported to specialist units, hospitals, etc., the proportion of father-daughter incest represents more than half of all cases. Although violent and bizarre rapes of children are given disproportionate media coverage, they account for only a minority of child sexual abuse cases. In addition, there appears to be some proportion of such cases motivated by 'pedophilic love', or needs for closeness, dependency and affection unsatisfied (or unsatisfiable) by sexual relationships with age peers.

The 'special injuries' of marital rape - betrayal, entrapment and isolation - are usually listed as sequelae of the trauma of child sexual abuse, particularly of incest (Summit, 1983), and many
Women's lives after incest are scarred by symptoms of Post Traumatic Stress Disorder (Gelinas, 1983).

Similarities between child sexual abuse, physical abuse and marital rape become more apparent when contrasted in Figure 1.

<table>
<thead>
<tr>
<th>PHYSICAL ABUSE</th>
<th>MARITAL RAPE</th>
<th>CHILD SEXUAL ABUSE</th>
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<tr>
<td>60% abusers female, 40% abusers male.</td>
<td>All abusers male.</td>
<td>97% abusers male.</td>
</tr>
<tr>
<td>No sex difference in vulnerability. Boys as vulnerable as girls.</td>
<td>All victims are female.</td>
<td>Girls are 5 times more vulnerable than boys.</td>
</tr>
<tr>
<td>Mostly young children (&lt;3yrs) are abused.</td>
<td>No pattern in age of husband or wife or duration of marriage.</td>
<td>Females of all ages abused. Reported abuse peaks at 9 - 12 years.</td>
</tr>
<tr>
<td>Abuse impulsive.</td>
<td>Premeditation evident in obsessive rapes. Other rapes committed impulsively.</td>
<td>Some premeditation needed for establishment of privacy.</td>
</tr>
<tr>
<td>Abuse engenders feelings of remorse.</td>
<td>Abusers feel justified in their behaviour, acknowledge no harm resulting.</td>
<td>Abusers feel justified in their behaviour, acknowledge no harm resulting.</td>
</tr>
<tr>
<td>Abusers accept their responsibility, seek help.</td>
<td>Most abusers deny their responsibility, though some seek help to control their anger.</td>
<td>Abusers strenuously deny their responsibility.</td>
</tr>
<tr>
<td>Community values re parental/child roles, plus lack of prosocial supports implicated.</td>
<td>Sexual socialization implicated.</td>
<td>Sexual socialization implicated.</td>
</tr>
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**FIGURE 1:** A COMPARISON OF PHYSICAL ABUSE, MARITAL RAPE, AND CHILD SEXUAL ABUSE
It is clear that many similarities exist between marital rape and child sexual abuse that occurs within the family - similarities in the gender of the abuser, in his motivation to abuse, and in the effects of such abuse. Fewer similarities appear between the physical and sexual abuse of children.

If conceptualization is to direct treatment and prevention efforts, it seems as inappropriate to advocate 'rehabilitation' of the family (meaning, in practice, reunite father and daughter in the family) in the treatment of intrafamilial child sexual abuse as it is to recommend 'couples counselling' for women sexually abused in marriage. Treatment which focuses initially on empowering the child and dealing with the emotional sequelae of the abuse, followed by group therapy aimed at reducing feelings of 'differentness' and isolation would seem more appropriate. Concurrent efforts at prosecuting incest offenders, thereby giving legal recognition to society's condemnation of such behaviour, would also seem appropriate.
The consequences of the 'preserve the marriage' type of couples counselling for women who feel abused and victimized by their husbands' frequent violent raping is usually found to be a cycle of:

- Separate and Recuperate
- Re-experience Victimization
- Return and Try again
- Repeat until exhaustion, despair or enlightenment leads to a declaration of 'death of the relationship', suicide, wife murder, etc.

Observers of the effects of the so-called 'humanistic' approach to incest, as it is practiced in Australia, see a similar pattern. Warnings and fines or deferred sentences (but no treatment) offer little deterrent effect to incestuous fathers who frequently re-abuse the victim or her younger sisters. (See, for example, Ward, 1984, p.222 note 54). Such girls may run away from home, sometimes to a youth refuge, more often to the 'city' where they may become involved in prostitution and/or drug abuse. Others wait it out at home until they are 16, and then leave and establish themselves independently (B.Rope, personal communication).
Definition of Child Sexual Abuse

The term 'child sexual abuse' encompasses a wide range of acts committed against minors. It may be defined under criminal law as incest or under sex crimes statutes. A different definition may be used in state child abuse reporting laws and in child welfare acts. It may encompass acts perpetrated by family members or persons in a position of authority over the child as well as acts by acquaintances and strangers. Kempe originally defined child sexual abuse as:

"the involvement of dependent and developmentally immature children and adolescents in sexual activities they do not fully comprehend, to which they are unable to give informed consent, or that violate social taboos or family roles" (Kempe, 1978, p.382).

More recent definitions tend to make some reference to the age difference between the parties and/or to the exploitative aspect of satisfying one's sexual needs at the expense of another. The N.S.W. Government Child Sexual Assault Task Force, set up in 1984, used the following working definition, where 'child' was defined as someone under 18:

"Contacts or interactions between a child and an older person in which the child is used as an object of gratification for the older person's sexual needs or desires".

A distinction has been drawn, both in laws and in conceptualizations of the problem, between abuse that occurs within the family, where a person uses his position of power and authority to gain regular access to and compliance from the child; and abuse that is perpetrated by an older person outside
the family, whether acquaintance or stranger. Abuse by a parent, caretaker or adult household member is termed intrafamilial child sexual abuse. Extrafamilial child sexual abuse refers to abuse by older persons outside the household.

However, distinctions between Intrafamilial and Extrafamilial child sexual abuse are not always uniform, as, in most cases, they are based on the researcher's evaluation of the significance of the relationship between the child and older person. For example, Diana Russell, in her meticulous study of the prevalence and seriousness of incestuous abuse (Russell, 1984), found the issue of whether or not sexual contact is wanted so complex in intimate relationships that she extended her definition of Intrafamilial child sexual abuse to any kind of exploitative sexual contact that occurs between relatives, no matter how distant, before the girl turns eighteen.

The N.S.W. Government Child Sexual Assault Task Force concluded that:

"as all the evidence now suggests that most child sexual abuse is intrafamilial, the term 'incest' is often used instead of child sexual abuse or interchangeable with it" (Task Force report, p.25).

However, in Australia, legal definitions of incest are very narrow, usually confined to intercourse between specified degrees of kin. In many states of the U.S.A., reform of sexual assault laws has resulted in the establishment of hierarchies of offenses with corresponding penalties, in line with factors shown to aggravate the abuse.
Since most child sexual abuse occurs within the family, and because relationship factors make such a difference in the dynamics, it was decided that this study would focus on intrafamilial abuse. The definition used was an amalgamation of Russell's extended definition of relationship, plus others who qualify by virtue of their position in the household of power and authority over the child. Because of the limited legal definition of incest, and community misconceptions about its incidence, care was taken to define 'intrafamilial child sexual abuse' when for convenience, 'incest' was used instead.

Incidence

It is difficult to even estimate the extent of child sexual abuse, because both child abuse and sexual abuse generally are grossly under-reported. It is widely acknowledged that reported cases of child sexual abuse represent the proverbial "tip of the iceberg". Despite the recognised problems of retrospective research, it is believed that large-scale surveys of normal young adults would provide the best sense of the scope of child sexual abuse. The first national survey of child sexual abuse was reported in August 1985 in the 'Los Angeles Times'. Conducted during the summer of 1985 throughout the U.S.A., it reports adults' experiences of sexual abuse during childhood. Using the definition "bodily or genital contact that you experienced as sexual abuse", 27% of the women and 16% of the men reported having been sexually abused as children (Finkelhor, 1985c). These figures are larger and of a different pattern than those reported
in Finkelhor's 1981 survey of adults in Boston (cited in Finkelhor, 1984), where 15% of the women and 6% of the men reported having experienced sexual abuse (similarly defined) during childhood. They coincide closely with Russell's 1978 survey of 930 San Franciscan women, 28% of whom reported having experienced unwanted sexual touching before age 14 (Russell, 1983).

Australian figures are not available. Over the last six years, seven voluntary surveys (six phone-ins and one write-in) have been conducted about incest in various Australian capital cities, and although these are useful for canvassing the need for reform and for women's services, the voluntary survey is not an appropriate technique for estimating prevalence. However, a preliminary report of a recent survey of sexual abuse experienced by New Zealand school children (Haines, 1984) suggests that sexual abuse of children and adolescents is as widespread in New Zealand as it is in the United States. In response to the question

"Has another person touched you in a sexual way when you did not want them to?"

28% of the female and 9% of the male high school students indicated that they had experienced unwanted sexual touching. However, as is so often the case in this type of survey, inconsistencies in definition and ambiguities in questions mean these results may not be strictly comparable to the American findings. (This survey allowed for unwanted sexual contact with peers more than the American surveys.)
Since our cultural values and crime statistics are at least as similar to the United States as are New Zealand's, there is no reason to believe that the incidence in Australia would be substantially different. There is a pressing need for a large-scale survey of the sexual abuse experienced by adolescents and young adults during childhood in Australia. Overseas experiences suggests that surveying a non-clinical population of both young men and women (whose experiences are more comparable with today's children, and whose memory of childhood events is not too distorted), yields information quite different from that obtained from a clinical sample.

Problems with Gathering Statistics on Reported Child Sexual Abuse

In this country, police, child welfare departments, and specialist facilities (e.g., child sexual abuse treatment units, Incest centres), as well as independent committees set up to receive such reports, all keep records of reported child sexual abuse. The format for data collection is not uniform within agencies across states, let alone across agencies. No national register of child abuse exists. In 1979, WELSTAT (the Standardization of Social Welfare Statistics Project), established under the Department of Social Security in 1976, took on the task of developing national standards for the collection of child abuse statistics (Telford, 1981). The standards were envisaged to incorporate all types of child maltreatment, including separate definitions and classifications of sexual maltreatment. Now in 1985, six years later, the standards are complete; a pilot test period for statistics collection was set
for July 1982 to end June 1983; the pilot test period was extended to end June 1984, and is continuing. As of November, 1985, the quality and quantity of data from most states is too poor to do even a preliminary assessment of the standards! WELSTAT has received adequate data from one state only, and the standards may have to be assessed on that basis.

In a preliminary study, reported in Chapter 5, I attempted to gather data on child sexual abuse held in court statistics, police records and specialist units, both government-sponsored and private, throughout Australia. Overall, this attempt at assembling a national picture of reported child sexual abuse was unsuccessful. Speculation on the reasons for the lack of response from agencies to requests for data is presented, along with an analysis of the small amount of data received, in Chapter 5. But it warrants mention here that a more modest attempt was made by the Western Australian Department for Community Welfare to set up a central index of child abuse in that state, in 1980; and a leading researcher and trainer from that department made the following comment in her address at the National Conference on Family Violence, 1979:

"No agency is as yet prepared to give individual identifying information however, so the resultant data will be available only to be utilized for forward planning of services for abused children of all ages". (Hamory, 1980)

It is no wonder, then, that WELSTAT has been so unsuccessful in setting up a National Collection of child abuse statistics.
Relationship between reported Child Sexual Abuse and Actual Incidence

American estimates put the proportion of child sexual abuse that is currently reported at between 10% and 25% of all cases (Finkelhor, 1985a), with estimates of reporting rates for intrafamilial child sexual abuse as low as 2% (Russell, 1984). It could be expected that an even lower proportion of cases are reported to any agency in Australia. In contrast to the American situation, reporting of child sexual abuse is not mandatory in every state of Australia, and even in states where professionals are mandated to report, some

... "were confused about the legal issues involved and feared further psychological trauma to the child..." (Statement on the Care of the Child Victim of Sexual Abuse, p. 75)

Serious under-reporting of child sexual abuse has long been documented, and the debate over the advisability and utility of making reporting mandatory is well known, though still raging. What is less well known, and perhaps more informative to our understanding of the dynamics involved, is the different picture that emerges depending on the source of one's data - be it reported child sexual abuse or large-scale surveys of non-clinical populations.

Surveys of non-clinical populations are arguably the better source of information about the distribution of abusers. They show that abuse by fathers and stepfathers constitutes no more than 7% or 8% of all abuse cases. Abuse by other family members
(most frequently uncles and older brothers) constitutes an additional 16% to 42% Other non-relatives known to the child (including neighbours, family friends, child care workers and other authorities) make up 32% to 60% of offenders. Stranger abusers - the traditional stereotype of the child molester - who make up the remainder, are in almost all studies substantially less common than either family members or persons known to the child. (Russell, 1983, 1984; Finkelhor, 1984a 1985a; Kercher and McShane, 1984).

In contrast, the picture which has dominated the literature until recently, gleaned from studies of reported child sexual abuse (i.e., clinical studies), is substantially different in its implication of fathers and stepfathers in a large percentage of child sexual abuse. Typically

"more than half of reported cases involve a family member as the offender, with a parent or parent figure the largest group of offenders at 42%. Other family offenders are usually brothers, grandfathers or uncles. Only 13% of child victims are assaulted by strangers ..." (Berliner and Stevens, 1982, p.98)

Child sexual abuse reported to Australian Sexual Assault centres invariably replicates this American distribution. The total number of reported incest cases in the United States in 1955 was 500, yet by 1969 the American Humane Association's projected estimate showed a 10 fold increase, the predominant type being father-daughter incest. Greenberg (1979) compared statistics from three studies of juvenile sexual abuse which showed that from 32% to 83% of the offenders were fathers of the sexually abused child.
If the picture obtained from surveys of non-clinical populations is indeed more accurate, why is it that so many more girls are reporting their fathers'/stepfathers'/mothers' boy friends' abuse? Several possible reasons are suggested by clinical knowledge of the dynamics of father-daughter incest, the most likely being that father-daughter incest is more distressing to the girls than is abuse by uncles or older brothers, because of the betrayal element and the duration of the abuse. Another possibility, relating specifically to reporting abuse by stepfathers, is that the girls or their mothers might be more likely to report abuse out of jealousy. Finkelhor (1984a) expressed it thus:

"Something in the Oedipal triangle may make the child more vulnerable. The daughter may feel betrayed by her mother, who has now remarried, or she may feel that her mother is paying less attention to her. She may be competing with her mother for the attention of the step-father." (p. 25)

A final possibility, which warrants urgent investigation, concerns the incidence and significance of abuse by older brothers. There has been a tendency in the past to consider sibling incest nonproblematic, but clinical reports have shown that, in comparison with paternal incest, it has greater potential "for rivalry and unrestrained viciousness" (Gelinas, 1983, p. 313). Rather than asking why so many more girls report abuse at the hands of fathers, perhaps we should ask why so few girls report abuse at the hands of their brothers.
Kingshott (1980) cites an English study of sibling and parent-child incest offenders in which over 90% of the fathers received substantial prison sentences, despite few prior or subsequent convictions. Sibling offenders, on the other hand, received non-custodial sentences, although many of them had prior convictions. In the next 12 years they continued to be heavily convicted. The researchers hypothesize that their high crime rate could be due to sexual maladjustment. Kingshott cautions that sibling incest does not necessarily begin spontaneously as a manifestation of natural interest and/or affection "but is more likely to be initiated through pressure - psychological, physical or both ..." (Kingshott, 1980, p.56). Perhaps girls who complain of sexual and physical abuse at the hands of their older brothers are the most silenced victims.

Boys under 14 cannot be charged with incest under New South Wales law. The Westmead Sexual Assault Centre in that state expressed concern about the incidence of abuse by older brothers:

"Our experience is that a child of 13-14 years is capable of sexual assault. Moreover we believe that such assailants must be given a clear message that sexual assault is not an acceptable act." (N.S.W. Government Child Sexual Assault Task Force Report, p.209).
Need for Consensus of Approach

The sexual abuse of women and children has long been recorded, yet there are still many unknowns. Large-scale surveys are uncovering the extent of the problem, and dispelling some of the myths and misinformation engendered by an exclusive emphasis on pathology - the heritage of the medical approach. We have a long way to go, but contributions from the socio-environmental, feminist, legal, social control and medical perspectives could lead to an advancement in our understanding and a more fruitful debate. Equally, division, territoriality and rigidity of thinking could see a waste of effort, with today's victims, and tomorrow's parents losing out. This study aims at exploring the interventions and the attitudes which shape them amongst Canberra's child sexual abuse workers.
CHAPTER 2 : PATTERNS IN DEPTH

Profile of Victims

Studies abound which list characteristics which many victims share, and behaviours and feelings which are presumed to be a consequence of abuse. Few compare abused and non-abused children to illuminate factors which might make a child more vulnerable to abuse. Findings from three exemplary studies will be examined here - two utilizing non-clinical populations, one of college students (Finkelhor, 1979, 1984a), the other a random sample of San Franciscan women (Russell, 1983, 1984). The third study on which these ideas are based is a comparison of two clinical populations - women receiving psychotherapy to deal with the sequelae of childhood incest, and another group of female psychotherapy patients whose seductive fathers stopped short of actual incest (Herman, 1981).

Finkelhor (1984) found that 19% of the women and 9% of the men in his sample of 796 college students reported they had been sexually abused as children.

Russell (1984), using an in-depth interview rather than a questionnaire handed out in class, and using a slightly different definition (more restricted than Finkelhor's but including abusive experiences up to age 18 rather than 16) uncovered 38% of women having experienced child sexual abuse. When only abuse at the hands of a relative was enquired about, 16% reported intrafamilial child sexual abuse.
Amongst the females in Finkelhor's sample, the factor most strongly associated with sexual victimization, which more than doubled a girl's vulnerability, was having a stepfather. A stepfather was five times more likely to sexually victimize a daughter than was a natural father, amongst Finkelhor's sample of college students.

Russell (1984) also separated stepfathers from biological or adoptive fathers, and found that 1 in 6 women who had a stepfather as a principal figure in her childhood years was sexually abused by him; whereas only 1 in 40 was abused by a biological or adoptive father. Russell suggests that the incest taboo plus the bonding that forms between parent and child in the early years may inhibit biological fathers, for the most part, and account for the greater likelihood of stepfathers to sexually abuse their daughters.

In Finkelhor's study, although virtually half of the girls who had stepfathers experienced sexual abuse as children, they were not necessarily abused by the stepfather. Some of these girls were abused prior to ever meeting their stepfathers! This finding suggests that the risk for these girls does not lie just in their mother's remarrying. Living with a mother who is actively dating exposes daughters to sexually opportunistic men, thus increasing their vulnerability to sexual abuse. Previous clinical findings of inter-generational incest, which suggested that women sexually abused as children were more likely than non-abused mothers to have daughters who experienced incest, could be relevant here.
It could be that heterosexual relationships modeled in these mother's families of origin predisposed them to select as companions and lovers men with attitudes towards sexuality and women that mirrored their parents' unequal (possibly abusive) relationships.

This argument is in line with Herman's (1981) finding that it was characteristics of their mothers, rather than of their abusing fathers, or qualities of the girls themselves, which distinguished the girls who were raped by their fathers from those who were not.

Indeed, Finkelhor (1984a) found that the next four factors, after 'having a stepfather', which determined a girl's vulnerability for sexual abuse, all involved her mother! A mother's importance, in addition to providing an influential role model, lies in the specifically sexual messages she gives her daughter. Having a sex-punitive mother puts a daughter at risk.

"These mothers warned, scolded and punished their daughters for asking sex questions, for masturbating, and for looking at sexual pictures much more often than usual. A girl with a sexually punitive mother was 75% more vulnerable to sexual victimization than the 'typical' girl in the sample " (Finkelhor, 1984a,p.27).

Finkelhor's study did not investigate whether these girls had brothers, and if so, whether they were given an equally repressive sexual education. Ward (1984) suggests that these girls' brothers would receive "the male counterpart of that conditioning : an absolute sanction on the right of males to rape.." (p. 182). One could speculate that the effect of the
double standard of sexual morality, where girls are bombarded with sexual prohibitions and punishment while boys are encouraged to "sow some wild oats" creates great difficulties for these girls in developing realistic standards about what constitutes danger, and perhaps even blinds them to the realization that a heterosexual relationship need not be unequal.

Having a sex punitive mother was found to make a girl more vulnerable to sexual abuse than having no mother at all.

"Girls who ever lived without their natural mother were three times more vulnerable to sexual abuse than the average girl. Similarly, if a girl reported that her mother was emotionally distant, often ill, or unaffectionate, the girl was also at much higher risk. Part of the problem here may be a lack of adequate supervision. However, daughters of mothers who worked were not at higher risk..." (Finkelhor, 1984, p.26).

In line with many other researchers and clinicians, Finkelhor speculates that girls with absent or unavailable mothers may be more susceptible to the ploys of a sexual offender because their unmet emotional needs make them more vulnerable. His study also suggests a connection between the oppression of wives and the victimization of daughters. Women who lacked marital power because of poor education, modeled subordination and dependency in their marital relationships. The daughters learned that they too are powerless (by virtue of their gender) and must obey men. Such was Finkelhor's interpretation of his finding that the fifth strongest factor, after having a stepfather, having a sex-punitive mother or having no mother (or an emotionally distant one) was having a mother who never finished high school.
But lack of education only proved to be an important correlate of a daughter's sexual victimization when her father was well educated and her mother was not.

"If a poorly educated mother is married to a well-educated father, her daughter is significantly more vulnerable than if both parents have little education (44% versus 30% victimized) " (Finkelhor, 1984, p.27)

Finkelhor used these findings to construct an instrument identifying children at risk of sexual victimization. Although as yet unvalidated, the Sexual Abuse Risk Factor Checklist holds promise, since in this sample it shows a linear and dramatic relationship between the number of vulnerability factors and sexual abuse. Among children with no factors in their backgrounds, victimization was virtually absent. Among those with five factors, two thirds had been victimized.

The study was also informative in its demonstration of some myths in current attitudes to child sexual abuse. Although admittedly from only the victims' perspective, 97% of abusive incidents reported in this study were initiated by a male. There was very little evidence of physical abuse connected with sexual abuse, and the girls who were victimized did not report any higher levels of violence in their families. It was also noted that religion, ethnicity, family size and overcrowding were not related to victimization.
Profile of Offenders

The child molester of popular imagination is a 'dirty old man', yet most studies show that the majority of convicted offenders were under 30 years of age at the time of their first known pedophilic offense (Groth, 1979). Since adolescent offenders are typically not charged, the lower end of the age distribution of pedophilic offenders is unknown. It is thought that becoming a sexual offender is a gradual process, beginning during adolescence with repeated masturbation to deviant fantasies, finally leading to the actual commission of the fantasized act (Berliner and Stevens, 1982). Belief in the psychopathology of child molesters - the crazed sex fiend notion - is a legacy of the psychiatric approach to child abuse. Theories proliferated to the absurd state where every male except the undefined 'normal' variant was a potential child molester. Based on convicted offenders, child sexual abusers have been categorized as emotionally immature (pedophiles); neurotic, psychotic, or personality disordered; authoritarian, religious zealots; addicted (to sexually abuse children); mentally deficient or uninformed; and criminal sadists. This chapter will summarize the most comprehensive synthesis of current knowledge, based on an adaptation of Finkelhor's four factor model of child sexual abusers (Finkelhor, 1984a).

Finkelhor proposes 3 factors - emotional congruence, sexual arousal and blockage - to explain how a man develops sexual interest in a child or in children generally. He subsumes these three factors under motivation to sexually abuse children, and
proposes that the variety amongst sexual molesters is explained by the mixture of these factors in an offender's motivation. In many cases, elements are present from each of the three components, although he contends that, for example, a man may sexually abuse a child without necessarily being sexually aroused by the child. Finkelhor then theorizes that, for sexual abuse to occur a potential offender not only needs to be motivated to commit abuse, but must also overcome internal inhibitions, external inhibitions, and resistance from the child. His model thus delineates four preconditions which, if met, result in child sexual abuse.

Although quite comprehensive, this model makes only passing mention of an underlying predisposition to relate sexually to children. This is a poorly conceptualized and researched area, but preliminary findings are suggestive of the essential role of organic pathology - genetic, hormonal and/or neurological abnormalities - in the commission of sexual offences against children in a small proportion of cases. It is thus proposed that, to account for the offender with demonstrable organic pathology, a fifth precondition needs to be added which could provide an alternative to motivating factors for this minority of offenders. Figure 2 outlines this '5 Preconditions' model in diagrammatic form, and a more detailed explanation of each precondition follows.
FIVE PRECONDITIONS: A MODEL

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<td>PREDISPOSITION TO SEXUALLY ABUSE</td>
<td>MOTIVATION TO SEXUALLY ABUSE</td>
<td>INTERNAL INHIBITORS</td>
<td>EXTERNAL INHIBITORS</td>
<td>RESISTANCE BY CHILD</td>
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- HORMONAL ABNORMALITY
- GENETIC ABNORMALITY
- NEUROLOGICAL ABNORMALITY

FIGURE 2:
FIVE PRECONDITIONS OF CHILD SEXUAL ABUSE
Precondition 1: Predisposition to Relate Sexually to Children

There has been recent clinical work suggesting that biological factors, such as hormone levels or chromosomal make-up, contribute to child molesting. Such theorizing stems from findings of

(1) physiological abnormalities among molesters and from
(2) evidence of some success in treating them with antiandrogenic drugs. At the current level of conceptualization, biological factors are seen as a source of instability which may predispose a person to develop deviant patterns of arousal; or they are seen as having a generalized effect on levels of sexual interest and sexual arousability.

Physiological Abnormalities.

Clinicians and researchers working with child molesters have suggested for some time that there are several types of child molester, based on the type of victim they choose;

(a) pedophiles who abuse only prepubescent girls
(b) pedophiles who abuse only prepubescent boys
(c) pedophiles who abuse both boys and girls
(d) incest offenders who abuse only their own children
(e) incest offenders who also abuse children outside the family.

It is estimated that between one third and one half of reported incest offenders have also offended outside the family (Finkelhor, 1985c). Recent clinical studies using the penile
phlethysmograph confirm this typology. Some pedophiles are sexually responsive to only girls, only boys, or both girls and boys, but are not sexually responsive to adults - male or female. Incest offenders and a group of child molesters who choose unrelated victims show minimal penile responses to children, but are responsive to the adult female form. And homosexual pedophiles show no arousal to adult males. Attempts to treat homosexuals which have aimed at changing their physiological sexual response pattern have been largely unsuccessful, leading some to posit that sexual orientation is determined in utero by the sex hormonal balance operating at the critical period of brain development for these feelings or behaviours (McConaghy, 1982). Those molesters who are not sexually responsive to adults, male or female, but are very responsive to young boys or girls may have a similar, pre-determined basis to their behaviour.

Antiandrogenic Drug Treatment

Many child molesters who are interested in controlling their pedophilic tendencies (usually because they do not want to go to gaol) - claim that they have an uncontrollable urge to sexually abuse children. With such offenders, the usual array of treatments, including aversive therapy, often fail. Drug treatment has been tried with variable success, but recently, a 90–95% success rate has been claimed in treating child molesters with Depo Provera, when used in conjunction with behavioural treatments (McConaghy, July, 1985, The Canberra Times). This antiandrogenic drug presumably competes with
testosterone for receptor sites as it is biochemically very similar to testosterone. Lowering testosterone levels diminishes sexual preoccupation and urges, making self-control easier. Preliminary data suggest that there may be an unusually high frequency of hormonal abnormalities (e.g., testosterone levels more than 2 standard deviations above the mean) amongst child molesters (Berliner and Meinecki, 1981) which may predispose them to develop sexual arousal to children. Because of the very wide range of sex hormone levels in the normal population, in addition to huge seasonal and daily fluctuations, further confirmation of these preliminary findings, by comparison with a control group, is needed before success with drug treatment can be confidently claimed.

Precondition 2: Motivation to Sexually Abuse Children

Factor 1: Emotional Congruence

Emotional Congruence encompasses several theoretical accounts of the nonsexual motivations surrounding pedophilic sexual behaviour. Primary amongst them are theories which posit that child molesters have arrested psychological development. They experience themselves as children with childish emotional needs, and thus can relate more comfortably to children than to age peers. These theories also make reference to molesters' lack of social skills and low self-esteem, and the reinforcement they gain from feelings of power and control in relationships with children. In some cases this low self-esteem is seen as a sequel of physical and/or sexual abuse during childhood, and the victimization as 'identification with the aggressor'. Feminist
explanations of sex abuse have a similar underlying theme, but are focused at the sociocultural level. They point to male sexual socialization, with its emphasis on being dominant, powerful and taking the initiative in sexual relationships. Given the feminine sex role stereotype of a person who is younger, smaller and passive, choosing a child as a sex object is just an extension of the gradient along which men's sexual appetites are already focused.

Factor 2: Sexual Arousal to Children

This factor encompasses several theoretical accounts of why some men are aroused by or have stronger arousal to children. These theories have relied primarily on tenets of social learning theory, and have treated sexual arousal as a kind of response that can be evoked or conditioned under the right set of circumstances. There is a suggestion that critical childhood sexual experiences may have compelling qualities as a result of some special kind of fulfillment or frustration involved. Others suggest that what may be important during the experience of being victimized oneself, or seeing one's siblings victimized is not conditioning, but having a model who finds children sexually stimulating.

Misattribution of arousal cues may play a role in creating sexual arousal to children. Certain socialization experiences or subjectively felt sexual deprivation may prompt individuals to label any emotional arousal as a sexual response. The fact that the initial stages of the adult sexual response cycle are not
distinct physiologically from patterns of arousal produced by parental, protective or affectionate emotional reactions allows for such misattribution. Once having labeled a response as sexual, they may find ways to reinforce it through repetition and fantasy, and thus come to have a much more general sexual arousal to a child (or children in general).

The process of how men come to find children arousing may have a social as well as an individual component, illustrated in the possible role child pornography and advertising play in pedophilia. In some pornography, themes of sex with children are mixed in with themes of sex with adults, so by masturbating to this material, adults may come to find children arousing.

In the more usual situation, 'kiddi porn' might increase the strength of the adult's arousability and the variety of child objects to which he becomes aroused. A better documented effect of the proliferation of 'kiddi porn' is to increase the legitimacy and remove the inhibitions about having and acting on such fantasies. The proliferation of home video technology could play a significant role in this but few studies address the interplay of technology and social change.

Factor 3: Blockage

The third component in Finkelhor's model of offenders' motivation to sexually abuse children involves theoretical explanations for some individuals being blocked in their ability to get emotional and sexual needs met in adult relationships. This tallies with
clinical pictures of incest offenders and with some descriptions of child molesters as timid, unassertive, inadequate, awkward, even moralistic types with poor social skills, who have extreme difficulty developing adult social and sexual relationships.

Repressive sexual norms have also been suggested as a form of blockage. According to this theory, norms tabooing extramarital affairs may block the incestuous father from seeking out other adult women, leaving him - from his patriarchal stance - no alternative but to substitute his daughter for his deteriorating sexual relationship with his wife.

Finkelhor divides blockage theories into developmental and situational types, which correspond to the 'fixated' and 'regressed' categories of child molester, differentiating those who have never reached the adult sexual stage of development from others who are blocked from their normal sexual outlets by loss of a relationship or some other transitory crisis.

The remainder of the model describes theoretical accounts of the breakdown of internal and external inhibitions which result in a man, motivated or compelled to sexually abuse children as previously described, translating his interest or urge into actual behaviour. Psychological accounts of lack of inhibition against child molesting have implicated poor impulse control, senility, alcoholism, mental retardation and psychosis. Lack of impulse control and psychosis are explanatory in only a small number of cases, senility and mental retardation in almost none,
but alcoholism has been frequently implicated in lowering the inhibitions of men motivated to commit incest.

As with theories about physical abuse, it has been suggested that such stresses as unemployment, relationship breakup or death of a spouse may lower inhibitions against sexually abusing children. Another situational factor implicated is lack of involvement in parenting during the child's early life (particularly for stepfathers and fathers with extended absences from the family).

Explanations of the quasibiological nature of the incest taboo which stress that the taboo comes into play merely as a result of proximity during early stages of development (Shepher, 1971; Van den Berghe, 1983) seem more plausible than those which stress the bond that develops out of empathy and concern resulting from a caretaking role (Herman, 1981). The latter would predict that children would also be more at risk of physical abuse from stepfathers - a pattern not yet noted - whereas mothers appear to be heavily implicated in physically abusing their children.

Social and cultural elements may also encourage or condone sexual behaviour directed towards children (e.g., 'Kiddi porn'). From a feminist perspective, the reluctance within the legal system to prosecute and punish offenders, and the tendency of professionals to blame the victims have reinforced offenders' excuses for sexual abuse and thereby reduced inhibitions. In a similar vein, social approval for the excesses of patriarchy and parental authority not only lower inhibitions in the father - they also negate resistance from the child and opposition from the mother to incestuous child sexual abuse.
Abuse by Females

In the past, some people assumed that sexual abuse at the hands of females never occurred, despite the consistency with which most early studies reported very small numbers of female abusers — usually between 3% and 5% of reported cases. More recent estimates from such large-scale collections of sexual abuse cases as the American Humane Association study and the National Incidence of Child Abuse and Neglect study (both cited in Finkelhor, 1984) are that females perpetrate 14% of reported child sexual abuse against boys, and 6% of abuse against girls. Because of the preponderance of female victims, both studies indicated that female perpetrators more frequently sexually abuse girls than boys. Finkelhor and Russell (1984a) conclude:

"The bulk of evidence from the self-report studies is that sexual contact between children and older women is a distinct minority of child-adult contacts. For boys, with but one exception, the figures show approximately a quarter or less of all contacts. For girls, with again but one exception, the figures show one tenth or less" (Finkelhor, 1984a p.175).

Despite evidence and arguments to the contrary, many experts in the field still maintain that the number of female perpetrators may be seriously underestimated (e.g., Plummer, 1981; Groth, 1979), and they cite the reluctance of male victims to report and the greater opportunities women have to disguise sexual abuse as mothering as possible reasons. Sometimes, such comments appear in summaries of comprehensive reviews which have cogently argued just pages before why rape is a male crime (e.g., Groth), and it becomes patently obvious (to female readers at least) that logic has been overtaken by gender politics.
Looking at the motivation to sexually abuse, Groth (1979) says:

"For a man, rape is a sexual expression of anger and contempt. He retaliates against a woman by doing something to her that he sees as degrading. A woman, on the other hand, is more likely to withhold or deny sex to a man as an indication of her disfavour or anger. We have noted that rape typically reflects deep-seated feelings of inadequacy, and men may, on the whole, feel more inadequate as persons than women do...." (p. 186).

He goes on to describe the psychological and sociological reasons which make it more difficult for a man to achieve a secure sense of identity. These he cites as the need to reject identification with the mother and replace her with a less visible model - the father; and the rejection of emotional, affectionate expression and the promotion of aggression and sexuality in male socialization, making being 'a man' less human than being a woman.

The case studies of female offenders are usually quite bizarre, with psychotic symptoms frequently evident. It is as if a woman needs to be 'sick' to sexually abuse children, whereas male offenders are often described as 'pillars of society'.

Boys as Victims

Much less is known about the sexual abuse of boys than girls. Until about five years ago, few boys were thought to be sexually abused, and many treatment programs saw only a handful of cases. American programs now report that as many as a quarter or a third of their cases involve abuse of boys. The first national survey conducted in America in 1985 found that 16% of males compared with 27% of females had experienced sexual abuse during
childhood. This is substantially higher than estimates of 2.5 - 8.7% from smaller, non-clinical surveys. Boys, like girls, are most commonly victimized by males. There is a presumption, reinforced in pedophilic literature (e.g., Leahy, 1984a), that boys often initiate sexual encounters with older persons. Finkelhor's college survey did not support this - 91% stating that the older person had initiated the contact. It appears that boys are more likely to be sexually abused by someone outside the family than by a family member, but if they are abused at home, their older sisters are often abused as well. Also, intrafamilial sexual abuse of boys is more likely to occur in conjunction with physical abuse than is the case amongst girl victims. So it seems that the sexual abuse of boys more often involves violence, no matter what relationship exists between the boy and his abuser. Although from reported cases, boys appear to be victimized at an earlier age than girls, this may be an artifact of current reporting practices. The abuse of boys is more likely to be reported to police, both in the United States and in Australia, probably because of the preponderance of extrafamilial abuse amongst boy victims. As long as large numbers of boys for whatever reasons, do not report sexual abuse, the community and professionals alike may continue to presume that they initiate sexual contacts with adults, and that they suffer no ill effects from these contacts. This may be inaccurate for the majority of boy victims, judging by recent increases in boys reporting sexual abuse to American treatment programs. Until boys are able to come to treatment centres for help, without prejudice, we will not have an accurate picture of the sexual abuse they suffer at the hands of adults.
CHAPTER 3 : THE SOCIAL CONTEXT

After looking at social factors which have shaped Australian families, this chapter charts our current knowledge of children as sexual beings in the family, where they learn much of what it means to be male and female. Then, following the child through adolescence, to courtship and the formation of intimate relationships, the legacy of early sexual socialization becomes apparent.

This account can do little more than scratch the surface of what is a major topic in its own right. Recent studies of child sexual abuse from a feminist and systems perspective (including this study) show that children's sexual thinking, the learning of sex roles and gender roles and the influence of Western cultural notions of chivalry and romantic love all deserve thorough investigation. Given the scope of this thesis, their inclusion demonstrates the writer's perception of their significance. Their superficial treatment here attests to the current lack of definitive studies of their influence in the incidence of child sexual abuse.

Families in Australia

The typical Australian family exists only in the imagination. Changes occur so rapidly that statistics - if accurate at the time of collection - become obsolete soon after they are published. Australia has become more competitive in the world marketplace, and this is reflected in the increased mobility,
both social and geographic, of a large section of the Australian population (Day, 1980). Although marriage is less popular, Australians show a strong commitment to relationships—trial marriages and de facto relationships are becoming more common. Average family size decreased and stabilized at 2 children by the late 1970's, as couples were marrying later and postponing their first child longer (Wishart, 1984). However, in the 1980's there has been a reversal of this trend, with an upswing in the birthrate coinciding with a greater number of mothers in their 30's who had delayed childbearing. Between 25% and 30% of Australian marriages are destined to end in divorce, but the rate of once-marrieds remarrying is unprecedented. Unfortunately, it has been estimated that as many as half of these second marriages in Australia also end in divorce (Choice Magazine, March 1985). This could account in part for the increase in sole parent families which has been noted over the past fifteen years (Krupinski & Stoller, 1974).

Significant amongst the changes in Australian families is the increasing involvement of women in the world of work. The female labour force increased by 68% between 1966 and 1982 (Clemenger, 1984). Married women now comprise almost two-thirds of employed females, and of women not in the workforce, the Clemenger Report found that 22% are aged over 60 years and 3% are full-time students. Only 36% conform to the 'traditional housewife' stereotype. The Clemenger report revealed a drop in female work force participation from 43% of all Australian women in 1980 to 39% in 1984. Wishart, commenting on the reversal in the 80's of
trends noted throughout the 60's and 70's (viz., the upswing in birthrate and decline in female workforce participation), related these reversals to the coincidence of

"worsening economic opportunities for women, with a variety of propaganda eulogising the virtues of traditional motherhood and with a shrinking job market." (Wishart, 1984, p.93)

At the beginning of this century, Australian married women and children were guaranteed economic security of a kind unparalleled in the rest of the world at that time, by the payment to their husbands of a 'basic wage' (Matthews, 1984). Yet, now that educational and employment opportunities are no longer denied them, large numbers of women and children have formed the 'New Poor' in this country. Although the goals of equal opportunities and equal pay are espoused by the community, in the September quarter of 1984, the average weekly earnings in Australia of all employed men was $386.20, and that of all employed women, $256.20 (Acton, 1985). As Senator Susan Ryan said in June, 1983:

"Statistics give clear evidence of deeply embedded structural inequalities in our society."

For many women the choice may be between remaining in unhappy, perhaps abusive marriages, thereby maintaining their economic and social status, or exposing themselves and their children (unless they desert them) to the hardship of a dramatic drop in income and standard of living.
Childhood Sexuality

Childhood is equated with innocence in most adults' minds, and sexuality is tagged 'adults only'. Mentioning children and sex in the same breath still provokes controversy in our liberated, permissive society. As Jackson stated in her book *Childhood and Sexuality* (1982):

"Many rules and conventions exist to define sex as the preserve of adults: age of consent laws, selective censorship practices, the labelling of erotic books as 'adult literature', and so on. These are the outward signs of the taboo surrounding children and sex...." (p.3)

Yet there is clear evidence that children are sexual beings from infancy (Langfeldt, 1981). They seem interested in and knowledgeable about sex, despite attempts to channel their energy elsewhere.

In a rare cross-cultural study of childhood and early adolescent conceptions of sexuality, Goldman and Goldman (1982) explored what informs children's sexual thinking. Their purpose was to measure the extent of children's sexual knowledge, assess sexual understanding at various ages, and examine the thought processes children use to explain changes in their own bodies. They interviewed boys and girls at ages 5, 7, 9, 11, 13 and 15 in four countries – Australia, Britain, North America and Sweden.

Aspects of their study which are particularly germane to this discussion are children's perceptions of the differences between their mothers and fathers, both in their physical characteristics
and in their behaviour, and children's knowledge of and interest in sexuality at different ages. The Goldmans report that:

"the Australian children do show an increasing awareness of sexual differences between mothers and fathers up to 9 years of age, an awareness that curiously levels off ...." (p.145)

The Swedish children denied their parents' sexuality to an even greater extent, despite progressive programs on human sexuality and relationships in all school grades. When asked why people get married, none of the younger children and only 10% of the 13 year olds and 8% of the 15 year olds gave explicit sexual responses. The Goldmans suggested this might confirm other evidence of taboos preventing children from seeing their parents as sexually active (Goldman and Goldman, 1982, 1984). They cite research which indicates a tendency in children to repress ideas of parental sexuality, and interpret their findings in a similar manner. Speculation about the causes of such inhibitions include the myth of the non-sexuality of older adults, social expectations for parents to be sexually non-permissive, parental inhibitions about discussing sex, and incest fears (Goldman and Goldman, 1984). While most children failed to report overt sexual differences between their parents, teenagers in particular were more likely to see attitudinal differences. Fathers were frequently seen as disciplinarians, and mothers as more loving and accommodating in attitude. Probe questions uncovered that younger children's perceptions of their parents are mainly materialistic, as gift providers, basic sustenance givers and providers of personal services. At the next stage (9-11 years), parents are viewed as comforters, assurance givers and introducers of adult tasks.
Teenagers, on the other hand, want their parents to provide psychological support, sympathy and companionship in a relationship still dependent but more equal.

Particularly surprising to the Goldmans was the acceptance by most children of rigid sex roles in the family. Fathers were seen as worthy of higher status employment than mothers, child-care was relegated to the mother, and very few children perceived parenting as a shared responsibility of both parents.

In emphasizing the need for community education, the N.S.W. Government Child Sexual Assault Task Force reported:

"Shared responsibility for child-care by definition posits a society wherein the 'work' undertaken by men and women is regarded of equal importance, and neither sex functions primarily to service the needs of the other. In short, it posits a society very different from the one in which we find ourselves " (p.32)

It seems from the Goldmans study that children are as aware of gender role expectations as are adults. The Goldmans (1982) conclude that

"children perceive early in their development that a special relationship exists between men and women, even though they do not clearly perceive this relationship as overtly sexual... girls tend to support the view of romantic love as the basis for a relationship between a man and a woman, while boys tend to see friendship and companionship as more basic." (p.383)

These sex differences were even more marked in the teenagers' answers.
Throughout their study, the Goldmans found extensive, compelling evidence for the centrality of mothers and fathers in the internalization of gender role expectations in their children. Because children from other countries gave responses similar to those by children from Sweden, where compulsory sex education courses have been taught at school since 1967 (i.e., while their parents were still at school), the Goldmans conclude:

"It appears that present societal sex-roles are of stronger import than the content of educational courses aimed at lessening such distinctions." (p.168)

Concerning children's knowledge of and interest in sexuality, it was apparent that children of 7 and 9 were more open and forthcoming in response to every question involving the child's recognition of sexuality than were the 5 year olds.

"The youngest age group revealed poorer levels of sexual comprehension certainly but, far from being repressed and ceasing to develop in psychosexual terms, the so-called latency period children revealed increasing knowledge and willingness to discuss their knowledge." (p.382)

Thus, this study fails to confirm Freud's theory of a latency stage in psychosexual development, and provides no support for the notion of children having incestuous desires for the parent
of the opposite sex [1] — they apparently do not even acknowledge that their parents are sexual beings! The Goldmans conclude:

"The Oedipal situation as a norm of development remains unsubstantiated, and sexual inhibitions may be explained by non-Freudian social learning theory.... It is important to emphasize the latency period as a myth, because latency is an impediment to the desirable early provision of sex education in home and school...." (p.383)

Sexism in the Family

If the picture that emerges from the Goldmans' study is accurate, the majority of children see their parents in stereotyped sex roles within the family, and carry this model — perhaps a distorted representation of their parents' actual relationship — into their own marriages. The Goldmans expressed it in this way:

"Each sex tended to reinforce their same-sex parent favouritism during the teenage years, in our view as sex-identity models in preparation for emerging heterosexual friendships and as a preliminary to courtship." (p.383)

When these children marry, they may carry contradictory expectations of their spouses, in relation to themselves, from their childhoods. Their choice of a spouse may be ruled by notions of romantic love (especially amongst the girls), and by

1. These comments, though earnest, are not intended as a serious debunking of Freudian theory, which is beyond the scope of this discussion. Several excellent accounts of the origin of the Oedipus Complex and the influence of this infamous theory on community, clinical and judicial attitudes towards child sexual abuse exist, and the interested reader is referred to Rush (1980) and Ward (1984) for an in-depth coverage of this topic.
friendship and companionship (especially amongst the boys). Both translate to an egalitarian view of marriage as a partnership. But they may also bring from childhood very conservative sex stereotypes of the roles mother/father, wife/husband. This dialectic often surfaces early in a marriage, and probably accounts for the peak of marriage breakdowns that occur within the first year or two of marriage. It is highlighted by the many couples who can 'live together' in bliss, but begin to 'break-up' very soon after they legitimize their relationship. Terry Colling (1981) explains:

"Living with somebody probably carries few preconceived role expectations because, unless our parents lived together and were unmarried, the only models we have are those from the outside world or fantasies." (Colling, 1981, p.24)

Of interest here are the atypical responses to the question "Why do people get married?" from the Swedish children in the Goldmans' study, since it is forecast that

"Within 20 years half of the population of Swedish 8-year-olds will live with a single parent and most of the other half will be living with parents in a de facto marriage." (Goldman, 1982, p.124)

Unlike their English-speaking counterparts, Swedish children do not see marriage as a necessary pre-requisite for having children. For them, the quality of relationship between a man and a woman answering each other's needs is seen as the dominant reason for marriage. However, Swedish children subscribed more strongly to sex role stereotypes in parenting than did the children from English-speaking countries, suggesting that current de jure marriages (from which the Swedish cohort was drawn) may
be ultra-conservative. It would be interesting to question Swedish children of de facto relationships in twenty years to compare their perceptions of the roles of mother and father with the 1982 cohort - one might find less sex stereotyping of parenting functions in their responses.

Changes in Families

Perhaps we are on the brink of a new era in the history of the family. If this generation of children can operationalize shared parenting roles from the available knowledge of what constitutes good parenting, and discard their inadequate models; and if girls can substitute companionate love for their romantic ideals, we may witness the liberation of marriage. That does not seem so utopian, given the state of flux of community norms and values.

This is a period when:

(a) With increasing ease, conjugal pairings can be formed and dissolved.

(b) The sexual revolution has attacked and undercut prohibitions on pre-marital sex, extramarital sex, and other kinds of formerly prohibited sexual activity. Sexual norms are in a state of flux.

(c) The traditional externalized controls over sexual behaviour (e.g., religion, parental authority and tradition) have become less salient.

(d) The sexual revolution has heralded a more dramatic rise in expectations than in actual sexual activity.
The confluence of these factors may account for the apparent increase in child sexual abuse at this time. The sexual revolution may have resulted in many men (and perhaps women too) feeling a sense of sexual deprivation in the face of changed expectations, when their reality in marriage is little different. Many women have altered expectations of their sexual partners — demanding equality and mutuality rather than acting out the innocent, child-like, 'feminine' sexual role. If some men's expectations are changing more slowly, so that they are still looking for passivity and uncritical compliance from their lovers, they may only find their ideal lover in a child.

It has been suggested that accelerated social change and the resulting proliferation of alternative belief and value systems creates stress for some individuals by increasing uncertainty (Meyer, 1980). The child abuse literature contains many references to the link between the stress generated by social change and child abuse, and similar factors may be at least contributory to the current high rates of child sexual abuse. Other factors could be posited which may be unique to Australia, such as:

1. 'No fault' divorce being granted to all who seek it after twelve months separation, including couples where the husband has physically and/or sexually abused his wife and/or children. Many women in Australia face further abuse when they attempt to sever abusive relationships. Economic abuse is salient and easily documented. The 'Supporting Mothers' benefit is grossly inadequate, and is rarely supplemented by 'maintenance' payments because of the Family Court rationale that maintenance and access are separate
issues. If women in such situations seek employment, their 'fringe' benefits are cut to such an extent that they sink even further below the 'poverty line'. They are thus forced to remain 'on welfare', with all that entails for one's self-esteem and feelings of competence.

2. The Family Court may order mothers to allow their abusive ex-husbands access to the children. Women face extreme difficulties in rebuilding their lives and protecting their children when they are ordered to maintain regular contact with their ex-husbands "in the best interests of the child". Often it is apparent that the child's interests would be better served by severing relations with an abusive (ex)father, but it may be "in the best interests" of the Family Court judges and counsellors to pacify a man who is behaving in a violent or disturbed manner with the offering of his child(ren). Such decisions may seriously, and sometimes tragically, backfire - witness media reports of men killing themselves and their children 'on access'.

The N.S.W. Government Child Sexual Assault Task Force remarked on the strength of community opposition to the Family Court policy of granting child sexual abuse offenders access to their victims. (N.S.W. Government Child Sexual Assault Task Force Report, Recommendation 46, p.163-165). The Task Force recommended that such access should not be ordered except where it would "promote the child's welfare". This phrase seems as liable to misinterpretation as the one it seeks to replace (i.e., "in the best interest of the child"). Thus, even if Recommendation 46 is adopted, we may not see the end of this form of 'systems abuse'.
CHAPTER 4 : RESPONSES TO CHILD SEXUAL ABUSE IN AUSTRALIA

Historical Survey

Child sexual abuse, to the extent that it has been acknowledged, has been seen and responded to as a form of child abuse in this country. There has been no coordinated national response - rather, concerned professionals in positions of influence have acted at various state levels. This account of the development of services and legislation concerning child abuse is primarily from a New South Wales perspective. Given the antipathy between states and towards federalism, a national perspective or response is a remote possibility. (Where differences in state legislation and policy are known, they are noted.) A New South Wales historical perspective is appropriate for Canberra, since legislation in the Australian Capital Territory usually follows (sometimes with an appreciable lag) that of New South Wales.

Other accounts of the history of child abuse in N.S.W. (e.g., Lightfoot, 1980a, 1980b; Williams, 1980) have named the 1966 - 1975 period the 'decade of denial', as early exposures of Australian incidents of physical abuse were blamed on Victoria. While Canadian and North American reporting legislation was being enacted, in 1970 the Director of the Department of Child and Social Welfare (now called Youth and Community Services - YACS) concluded that such legislation was unnecessary here. At that time, the provision of welfare services operated from a 'residual welfare' model, characterized by minimal resources, minimal
services and minimal standards of wellbeing. It resulted in action being taken at the point where breakdown had occurred or was imminent, and profound damage to individuals and their life chances had already taken place. The underlying concept of child abuse was derived from the medical/psychiatric model, with the focus entirely on the failures/ inadequacies of the individual. Intervention was based on concepts of deterrence, punishment and/or control, and the maintenance of a minimal standard of physical care for the children concerned.

The early 1970's saw a massive increase in community health services, thanks to the injection of Federal government funds. The community mental health movement emerged, using principally concepts already developed in hospital settings - the multi-disciplinary team, consultation, case discussion and mutual staff support. As community services developed, it became clear that different agencies were involved with many of the same families. Concerned professionals from these different agencies began meeting to share insights and provide mutual support and consultation in cases of abuse and neglect. These groups, which became known as 'Children at Risk Committees', were of varying size, composition and self-determined function, and had no statutory basis for their operation. They aimed to provide non-judgmental, primarily preventive and supportive services to children and families. However their varied composition raised issues of confidentiality and rivalry, and there were misunderstandings concerning the most appropriate roles for the different disciplines and agencies to take.
With the enactment of the Youth and Community Services Act of 1973, the objectives of YACS changed with the introduction of the concept of the rights of the individual to optimal as distinct from minimal standards of care. From this perspective, the State was viewed somewhat less as a hostile (if necessary) intruder in private affairs, and more as an instrument for the direct provision of welfare services in the pursuit of various needs and/or rights. The new 'protective-interventionist' model has as its fundamental tenet the principle of prevention. This principle justifies more extensive intervention to forestall various kinds of catastrophe, - e.g., family breakdown, abuse etc. The model assumes that the interests of those in need and the interests of the State, are served by such expanded intervention.

Gradual changes between 1973 and 1977 saw the implementation in policy of the protective-interventionist model. Significant among them were the introduction of specialized child abuse teams in 1975, mandatory notification in 1977 and the establishment of a 24 hour specialist facility known as the Child Life Protection Unit. With the change of government, new legislation was passed in 1977 which emphasized child abuse as a social problem. Simultaneously, a policy program encompassing mandatory notification, community education and publicly funded treatment services was proposed to support the legislation. This approach implied a new goal, namely that of bringing about significant change rather than the mere control and containment of unacceptable behaviour - the traditional welfare response.
The movement towards a protective-preventative model is accompanied by a blurring of what were previously quite sharp lines of demarcation between education, recreation, health, welfare, criminal justice and corrective services. These various authorities are overlapping more in their commitment to this broader definition of welfare - the result being a closer involvement by government in the lives of people generally. But many helping professionals in other agencies still hold the old welfare image of

"authoritarian, residual, last resort agency aimed at control rather than basic change and/or support of vulnerable families." (Lightfoot, 1980a, p.161)

Although the concept of protective-preventative intervention has been embraced in policy, in reality the older concepts of the privacy of the family and the chattels status of children are still operating. This is seen in the reluctance of police to take action in 'domestics', and community promotion of violence to achieve control (as evidenced in the lack of censure of excessive physical discipline of children by their parents). Lightfoot (1980b) acknowledges our lack of progress in

"raising public awareness of the fact that the traditional concept of 'domestics' produces far more problems for children and for families than has heretofore been recognized." (p.176)

Until such time as the community allows more public scrutiny of 'domestic' situations, the rights of the child cannot be ensured.

Yet, the objective of child protection programs of YACS in 1980 was:

"to establish the rights of children to protection from neglect, abuse, and exploitation as paramount to any presumed or actual right, authority, or power of any adult or institution." (Lightfoot, 1980b, p.177)

Progress towards that objective is slow.
Reporting Child Sexual Abuse

At present, five Australian states have statutes which deal with the reporting of child maltreatment. Each statute has the same basic philosophy - the protection of the maltreated child by early state intervention secured by reporting. But Australian reporting legislation shows no uniformity in its definition of reportable child maltreatment. Sexual abuse, if specified, is often not adequately defined, and physical signs are detectable in only a minority of sexual abuse cases. In contrast, the wide definitions of maltreatment in most states of North America specify sexual abuse.

Legislation in all states except Victoria specifically provides that medical practitioners have a duty to report where maltreatment becomes evident to them in the course of their professional duties. In Tasmania, South Australia and in the A.C.T.'s proposed legislation, other professionals who come into contact with abused children are also mandated to report. Three Australian statutes provide for permissive, as well as mandatory reporting, whereby any person who has reasonable grounds to suspect that child abuse has occurred may make a report. These permissive reports attract the same rights (immunity from legal suit) as those mandated. The Victorian legislation is a purely voluntary statute. No-one is mandated to make a report under the statute, although where such a report is made, it is immune to
legal suit. Although most statutes in the United States provide some penal sanction for failure to report, this is true only for doctors in N.S.W., but it is not policed, and sanctions have never been invoked.

Much controversy exists over the issue of mandatory reporting, and a good case can be made for either side. Proponents of compulsory reporting stress its importance in safeguarding the interests of the abused child. The N.S.W. Government Child Sexual Assault Task Force Report, released earlier this year, found widespread community support for the extension of mandatory reporting requirements, provided that:

(a) education programs are set up to inform individuals of their obligations.
(b) there are sufficient services to cope with the increase in notifications and
(c) workers are given clear guidelines on how to make a notification.

While commending the objective of ensuring that incidents are reported with greater reliability and regularity, YACS response to the Task Force's proposal for the extension of mandatory reporting requirements enumerated the most common opposition to mandatory reporting, and they supported their argument with data.
Their conclusions warrant quotation:

"... the effectiveness of mandatory reporting, has not been established. Indeed an analysis of the Montrose Child Protection Data for the first 6 months of last year shows that nearly half of the notifications (46%) came from the non-professional sector (parents, relatives, neighbours, friends children), and only 9% from doctors, the currently mandated notifiers. Mandatory reporting is also acknowledged to be virtually unenforceable."
(The N.S.W. Government Child Sexual Assault Task Force Report, p.170)

The Legal Response - or What Happens once the Problem is Exposed

Once a worker becomes aware that a child in his/her professional care has been sexually abused - indeed once anyone has firm suspicions - a report should be made to the Child Life Protection Unit. The matter must then be investigated, and usually a maximum period is specified by which time enquiries must be instigated by the Welfare department. In many cases, ongoing welfare involvement with the family will suffice to keep 'the problem' in check. Field supervisors monitor the situation, often in consultation with workers from other agencies, and the family, or interested members thereof, may be referred to workers who specialize in child sexual abuse for therapy, counselling and support. In the most frequent case of intrafamilial child sexual abuse, if the alleged offender denies the accusations, and if the other parent is unsupportive of the child, the child-victim will be brought before the Children's Court and charged with being a neglected child or 'in need of care'. This anomalous situation of the child being 'charged' for offences committed by his/her parent has been corrected in some states to the extent that a 'care and protection application' is made, rather than the child
being 'charged'. But what is manifest to a child removed from the family for his/her protection is that the responsibility for redressing the problem – if not for the problem itself – lies in his/her hands. Most child sexual abuse workers, both in Australia and overseas, are adamant that it should be the alleged offender and not the child who is compelled to leave the home. Law reform in many parts of North America has empowered the courts to order the offender from the family home, sometimes in specific statutes for child sexual abuse, in other cases in clauses added to statutes dealing with domestic violence. The recent N.S.W. Government Child Sexual Assault Task Force, urged by a strong community plea to prioritize removal of the offender, examined alternative mechanisms to bring this about, and concluded that

"analysis of existing laws demonstrates that they are inadequate ..." (The N.S.W. Government Child Sexual Assault Task Force Report, p.199)

Their study revealed the need for a new law, and recommended that an intermin 'no contact' order be provided for, within the soon-to-be-proclaimed Community Welfare Act.

Categories of Offences

In N.S.W. the Crimes Act 1900 allows that sexual offenders against children be charged with:

(1) Sexual assault, indecent assault or acts of indecency (under Sections 61A - E) for sexual acts which may have been aggravated by violence or threats of violence. Consent is not in issue.
(2) Carnal knowledge, characterized by anal or vaginal penetration of a female under 16 whose consent is irrelevant to the commission of the offence; (S.67 - S.74).

(3) Homosexual offences, characterized by anal or oral intercourse between males under the age of 18 where consent is irrelevant to the commission of the offence; (S.78G - S.78T).

The offence of incest is defined in S.78A of the Crimes Act 1900 as "carnal knowledge (vaginal or anal) of a daughter, mother, granddaughter or sister by a son, father, grandfather or brother." (The N.S.W. Government Child Sexual Assault Task Force Report, p.203)

While a feature of this offence is that both parties may be charged, the N.S.W. statute states that a female under 16 and a male under 14 cannot be charged with incest. (Age may vary in other states.)

"The offence was originally ecclesiastically based and only found its way into the Crimes Act of N.S.W. in 1924. The sanction of the Attorney-General must be obtained before a prosecution for incest can be commenced." (The N.S.W. Government Child Sexual Assault Task Force Report, p.203)

The same deterrent to prosecution for incest applies in the A.C.T., although few solicitors or magistrates seem aware of this need to obtain the Attorney-General's leave. Enquiries amongst legal personnel revealed no explanation of the origin or reason for this clause, and given widespread ignorance amongst the legal profession of its existence, it remains an anomaly. An incest charge is brought so rarely that legal ignorance is of no consequence.
The Child Victim of Sexual Abuse Before the Courts

In recent decades, most Western countries have seen considerable controversy about the nature, causes and extent of sexual assaults (almost half of which are committed against children[2]) and the capacity of criminal justice and other agencies to ensure both that those responsible are punished and that additional trauma for the victim is kept to a minimum. Even more controversial is the involvement of the criminal justice system in intrafamilial child sexual abuse — which covers so much more than legal definitions of incest. The 'decriminalization' lobby point to the absurdity of an adversarial system attempting to adjudicate in family matters, especially when it involves a child having to give evidence against a parent. Many who see incest as a social problem (similar to the most popular conception of physical child abuse) would also argue for decriminalization, emphasizing the inappropriateness of punishing a social ill which requires a therapeutic approach. The N.S.W. Government Child Sexual Assault Task Force considered various alternatives to criminal justice handling of child sexual abuse cases, and proposed in their community consultation paper, the establishment

2. Percentages vary depending on whether one focuses on apprehended offenders or victims seeking help. The South Australian Sexual Assault report (July, 1983), using Police department statistics on apprehended offenders, found 45% offenders against children, 10% of them under 15 at time of arrest! In Victoria, the Queen Victoria Medical Centre's Sexual Assault Clinic saw 223 victims in the first half of 1984; 39% were under 16.
of a tribunal comprised of a lawyer, social worker and medical practitioner. The voluminous community response to this proposal was so negative that the Task Force abandoned the idea, and recommended in its place a form of 'pre-trial diversion'. The main objections to the Tribunal centred around its being seen as a 'soft option' for offenders, and as decriminalization of incest.

Current laws and court practices in N.S.W. (and probably throughout Australia) present difficulties for the child victim of sexual abuse. Paramount among them is the problem at law of 'affirmed' or 'unsworn evidence'. Section 418 of the Crimes Act 1900 provides that no conviction may result from unsworn evidence, unless that evidence is corroborated by some other material evidence which implicates the accused. Children 'of tender years' — a phrase variously interpreted but often including those less than 14 years — are considered unable to take the oath, and their evidence must be admitted 'unsworn'. There have been many enquiries by law reform bodies in Australia and overseas (U.S.A., England, Canada) into children's credibility as witnesses. Most conclude that the risks of fabrication, inaccuracy of observation or memory failure are no greater with children than with any other class of witness. (See p.185-6 of The N.S.W. Government Child Sexual Assault Task Force Report). Many also find that even a young child can understand the duty of telling the truth, and conclude that problems in the past have resulted from the failure of judiciary to adjust their diction to the developmental level of the child (Bulkley and Davidson, 1981). Corroboration is not often available in child
sexual assaults, especially incest, as violence and resultant injuries are rarely a feature, and reporting usually occurs long after material (medical) evidence has disappeared. In any case, medical evidence alone will not often assist as to identity, and other evidence linking the accused with the offence must be added if the charge is denied (Naylor, 1985). Without corroboration, the judge directs the jury to acquit the accused. In practice, however, it is unlikely that a prosecution would be mounted if it was clear at the outset that the child 'of tender years' could not be sworn, whether or not corroborative evidence (in medical form only) was available. The best corroborative evidence would come from a witness to the sexual assault (not often available!). Two complainants (sworn or unsworn) each alleging sexual assault occurring at around the same time and place may not corroborate each other, as one may be supporting the other to make her own complaint more credible (Naylor, 1985). However, if the accused has been convicted of similar offences, such evidence may be admissible as corroboration.

Where corroboration of a child's unsworn evidence is available, the judge must still warn the jury of the danger of convicting in these circumstances. Prior to the introduction of S.405C in 1981, judges were always required to warn the jury that it was unsafe to convict a man on the uncorroborated evidence of a woman (of any age). With S.405C the judge may use his discretion in issuing a warning, but in most instances he still chooses to do so. (Naylor, 1985, p.13-14). Section 418 (and section 61 prior to 1981) were based on the law-enshrined myths that women and
children make up allegations of sexual abuse, and that a charge of rape is frequently laid, and much easier to prove than defend. These ideas originated in Freudian theories, and even though the theories have long since fallen into disrepute (Rush, 1980), the legal fraternity - mostly unaware of their origins - continues to reflect their influence. Many popular notions about females and about sexuality are Freudian based. In his address to the Society for Psychiatry and Neurology in Vienna on April 21, 1896, Freud presented his ideas about the origins of hysteria for the first time. He reported that he had found evidence of premature sexual experience in every case of hysteria, sometimes abuse by strangers, sometimes sexual relations between brother and sister, but more frequently sexual initiation by a caretaker - usually the father. The theory was given an icy reception by his medical colleagues. Within two years

"Freud had turned the theory inside out, arguing that his patients had only fantasized childhood sexual seductions; later he concluded that the fantasies were universal." (Tavris, 1984, p.48)

Many reasons have been advanced for Freud's abandonment of the seduction theory, most of them stressing the negative reception it received; his growing awareness of his childhood attraction to his mother and anger at his father (uncovered through self analysis); and his fear that he may have evoked fantasies from his patients and then mistook them for real events. Freud's discovery of childhood sexuality, coupled with his interpretation of his own self-analysis and his rejection of the reality of his hysteric patients' accounts of sexual abuse by their fathers fitted neatly with his theory of the Oedipal Complex, which
attributes to all children incestuous desires for the parent of the opposite sex. Females came to be seen as unable to distinguish fantasy from reality, and female accounts of sexual abuse as the surfacing of deep unconscious, incestuous desires. These myths are still enshrined in many of our laws and influence judges' decisions.

The child also faces many procedural difficulties in court. Currently, the most obvious of these is the considerable delays experienced in having a case heard.

"It is quite feasible for a child to give her statement to the police and still be waiting 18 months later for the trial." (Calvert, 1984)

This creates difficulties for her in recalling the indictment in the detail required. In incest cases, the offender - long since released and reunited with the family - frequently pressures the girl into recanting her story. Family members may collude with him in these efforts, fearing the public shame the family will face if details of the court case are released to the press. Defense counsel often capitalize on the child's confusion over the requirement to give precise details of a specific incident - the offence as charged in the indictment:

"If, as is usually the case, there has been more than one incident, then the child finds it hard to understand the parameters of the indictment ... If she goes outside the particular charge in giving evidence, the trial can be aborted." (Calvert, 1984, p.36)

The time delay in the case coming to trial also prevents the child from resolving the emotional trauma she has experienced.
Rather than being encouraged to put the incident(s) behind her, as a witness, she must continually go over the details, and relive the experience when recounting it in court. She may not have even been adequately prepared for the court appearances. The judge may close the court, and in so doing, deprive the child witness of her 'support person'. (Williams, 1984)

These and other factors relating to the physical conditions and the tactics used, make her court appearance - unnerving to most adults - an ordeal often considered more traumatic for the child than the abusive incident(s).

Plea Bargaining

From the initial police investigations when a complaint of child sexual abuse is first laid, the emphasis is on obtaining an admission of guilt to some charge, as Juvenile Aid officers and CIB detectives are well aware of the difficulties (almost impossibility) of obtaining a conviction against an adult who proclaims his innocence, when the complainant is only a child. The N.S.W. Bureau of Crime Statistics and Research conducted a study of all charges of sexual offences against children laid in N.S.W. in 1982. Of 200 cases of child sexual abuse finalized, only 7 offenders were charged with incest (4 fathers prosecuted under S.78A, and 3 stepfathers prosecuted under S.73). However, the study revealed that a further 18 offenders could have been prosecuted under either of these sections, but were not. The most common charge was for Indecent Assault or Acts of Indecency (S.61E). The bureau study reports that 83 suspects (42%) went
into committal under S.61E whereas 92 (46%) were found guilty under this section; 36 suspects were prosecuted under S.61D (sexual intercourse without consent) and 20 were found guilty. The N.S.W. Government Child Sexual Assault Task Force report states:

"The high rate of convictions under S.61E may also be due to the Crown accepting a plea of guilty to indecent assault at trial where the offender was committed on a more serious charge. For example, in 1982 in 12% of Child Sexual Assault cases which led to committals for trial on charges of S.61D (sexual intercourse without consent), guilty pleas to indecent assault were accepted at trial. Faced with the difficulties inherent in such a prosecution, for example, the lack of corroboration of the child's evidence, the requirement to prove lack of consent, the immaturity of the complainant, the Crown may opt for a certain conviction rather than risk an acquittal." (The N.S.W. Government Child Sexual Assault Task Force Report, p.204)

Thus, it seems that the criminal justice system works (if it can be said to work at all) in cases of child sexual assault to convict the man of a minor offence, often by appealing to his interests in the welfare of the child (i.e., let's not put the child through the horror of a court case). This plea bargaining continues in court, as the bureau's figures attest, when even then, the lesser charges 'do not stick'.

Detective Sergeant Brian Rope, in his paper on Child Rape presented at the Sydney Institute of Criminology Seminar on Incest (27th June 1984), acknowledged that the practice of plea bargaining has been adopted in N.S.W. by the Crown. He recommended updating (and publicly acknowledging) this practice through the use of plea bargaining conferences as used in dealing with sexual offenders against children in California (Rope, 1984, p.18).
Thus, it seems that, while incest and other sexual assaults against children are criminal by Durkheim's definition ("... it is criminal because it shocks the common conscience"), many impediments exist to prosecuting these crimes under the law as it stands. Pre-trial diversion, as proposed by the N.S.W. Government Child Sexual Assault Task Force, seems the best solution. This alternative to criminal prosecution recognises "that punishment is not an effective deterrent for certain classes of offenders, and that other forms of treatment (e.g., counselling) may be more effective in modifying the criminal behaviour. The desire to avoid trial and conviction is assumed to be a powerful motivating factor which ensures co-operation with the program. Such a motivating stimulus is not available when treatment is employed as part of a condition of parole or sentence." (The N.S.W. Government Child Sexual Assault Task Force Report, p.221-222.)

Pre-trial diversion thus involves the offender undertaking specified obligations - most notably successful treatment completion - after which the case is usually dismissed.
CHAPTER 5: INCIDENCE OF REPORTED INTRAFAMILIAL CHILD SEXUAL ABUSE - A PRELIMINARY STUDY

Foreword

The inclusion of this largely unsuccessful preliminary study at this point in the thesis is testimony to why researchers of child sexual abuse do not have a strong data base. Problems in gathering incidence data underscore the lack of respect of 'hands-on-workers' for 'academics', the rift between theory and practice. If this forewarning assists future researchers by highlighting that methodological problems and 'researcher burn-out' are not responsible for the lack of progress in Australian statistics collections, it will more than compensate for the loss of credibility that reporting one's failures entails.

This attempt to obtain data on reported child sexual abuse in Australia was motivated by dissatisfaction with literature reports of incidence which rely on estimates based on American estimates, and others which assure the reader that 'reported' abuse represents the proverbial "tip of the iceberg". Personal visits to service agencies in the Australian Capital Territory, New South Wales and Queensland, as well as discussions with professionals influential in child sexual abuse at workshops and seminars had generated a list of contacts. I was particularly interested in data relating to the relationship between the
victim and offender, the age and sex of both parties, and the proportion of all cases which intrafamilial child sexual abuse represented. Since perusal of the literature suggested that invasion of one's body space was perhaps critical to the victim's experience of trauma, a further breakdown of data by abuse involving oral, anal or vaginal penetration as against abuse which was not invasive seemed appropriate. Designing a format whereby such information could be recorded proved quite time-consuming. By mid-March the forms had been designed and printed, and a covering letter was attached and sent to each of twenty-two contacts in service facilities throughout Australia. (See Appendix 7 for Service Utilization Data Sheets.)

Another line of enquiry involved checking court statistics throughout Australia, to look at the numbers and disposition of offenders. This was facilitated by an officer of the Australian Bureau of Statistics (ABS), Mr John Mordaunt, who made suggestions about changes to the data sheets to comply with ABS data format. He also agreed to having the forms distributed via internal mail to the Deputy Commonwealth Statistician in each state and territory, and for replies and queries to be directed to him. Covering letters addressing the incumbent in each state, along with the revised data sheets were circulated via ABS internal mail in early April, 1985. (See Appendix 8 for Court Data Sheets.)
It was realized that this avenue of data collection could result in duplication of cases, as the same case could be heard in the Children's Court when the abuse first came to light, and later the abuser could come before the District or Supreme Court. Given the lack of published data, and the stated intention of examining disposal of child sexual abuse cases, it was considered a worthwhile exercise despite these drawbacks.

Discussion with Mr Mordaunt led to further changes to the data sheets and their despatch to the Commissioner of Police in each state and territory. This seemed necessary to ensure coverage of all reported child sexual abuse cases, since some cases are reported directly to the police and not to any public or private agency, and further action is taken in only a proportion of such cases. Police data sheets were sent to the Commissioners of Police on 24th April, 1985, with a covering letter and reply-paid envelope enclosed. (See Appendix 9 for Police Data Sheets.)
As foreshadowed in Chapter 1, this attempt at compiling national data on reported child sexual abuse met with little success. Of the 38 sets of forms despatched, 5 sets were returned at least partially completed. These came from ABS and the Police. Two agencies sent data in the format prepared for service evaluation, having had no time to transfer it onto the data sheets. (Usually the format was so different that transferring the data was a major task.) Annual reports were returned from 6 agencies. Three contacts were no longer incumbent in that position, and referred the request to the appropriate person. Letters were received from seven agencies which indicated interest in the proposed data collection, but regret at not having the manpower to do a manual search, or the resources and/or computer time required for the retrieval. In all, there were twenty-four replies.

Although there were only 5 sets of data sheets returned, almost two thirds of those contacted replied in some manner. It could be that the format of the 'Service Utilization' data sheets was inappropriate, but a more likely explanation is that the requests made were too onerous. The five sets of data sheets that were returned partially completed came from Police and ABS, and those data sheets were revised after considerable discussions (with Detective Sergeant Brian Rope in the case of the Police sheets, and with Mr. John Mordaunt, for the ABS sheets). In most cases, responses were encouraging of my efforts and regretful of their inability to meet my requests. I was gratified by the enthusiastic support expressed about my research endeavours.
Service Utilization Data

It is evident, from the majority of replies from both government and private agencies, that variations in statistical data collection by different agencies, or even by the same agency in different states, preclude comparisons or the compilation of a national picture of reported child sexual abuse. The major impediments are:

1. Some states (e.g., Victoria and South Australia) do not compile separate statistics for child sexual abuse as distinct from sexual abuse generally.

2. The age of the victim at the time of abuse may not be recorded, thus women seeking assistance, at Sexual Assault Clinics, with problems originating in childhood incestuous experiences, may not be distinguishable in routine statistics from current incest cases.

3. If distinctions are made between intrafamilial and extrafamilial child sexual abuse, the terms may be variously defined.

4. Agencies primarily serving victims do not usually collect data about offenders (and vice versa).

5. Cases are not often differentiated by penetration versus non-invasive abuse.

6. WELSTAT guidelines suggest registering only one type of abuse for each case – the most serious abuse inflicted, in the worker's estimation; thus, recent figures which comply with these guidelines may underestimate the incidence of child sexual abuse (A. Sheffield, personal communication).
Difficulties such as these, evident to most workers, acted as a deterrent to investing the considerable time that would have been required for completion of the data sheets. Staff shortages and non-computerization compounded this picture of apparent lack of motivation amongst service deliverers for completing the sheets. The multiplicity of agencies servicing the needs of child victims of sexual abuse in most states meant that data received from one agency could not be interpreted without knowledge of the population served, or other agencies involved. This is not true for Tasmania, as the size of this state and of the population it serves has been an advantage in the mounting of a statewide facility - the Child Protection Assessment Board. A summary of their figures for the last twelve years, by type of abuse, shows that incidence of sexual abuse reported to the Board has been steadily increasing to 79 notifications in 1984. A further 30 notifications of sexual abuse were received in the first 3 months of 1985. Further details of these cases were not supplied, but data on the 57 notifications in 1983 indicate that 12 were unsubstantiated, 2 resulted in the issuance of Child Protection Orders, and in 14 cases the perpetrator was charged.

Court Data Collected by the Australian Bureau of Statistics

There are many problems with these data in addition to the possible duplication of cases when the offender appears in a higher court and his victim comes before the Children's Court. (1) Although sexual offences are fairly uniformly classified as rape, carnal knowledge, incest, indecent assault and other sexual offences, these terms vary in definition across
states (and South Australia's offence categories are not as detailed).

(2) Data relate only to the offence proven, and the discussion of the N.S.W. Bureau of Crime Statistics most recent study of sexual assault cases in the previous chapter indicated that the offence 'proven' often corresponds poorly with the offence committed (e.g., incest charged under sexual assault legislation cannot be identified from the routine statistical returns).

(3) No breakdown by sex of victim is currently available, except that male and female victims of indecent assault can be distinguished in some states.

(4) Relationship between the victim and defendant is not retrievable from the usual tables in any state, and age of defendant is known only in some states.

(5) No breakdown of type of detention or type of probation/bond/recognisance is currently available.

(6) Routine statistical returns in some states do not even allow the separation of cases involving child victims from other cases.

(7) Statistical returns from some courts provide data on offenders only and not on the victim or the circumstances of the offence.

Under these circumstances, the data that can be retrieved across every state from the routine statistical returns lack so much detail as to be practically meaningless. Statistical returns need to be standardised, but a basic impediment to standardisation is the variety of classifications and definitions of sexual abuse under different state laws.
I was fortunate to receive a manual compilation of the length of sentences for rape, incest, indecent dealings and other sexual offences for all incarcerated sexual offenders in Western Australia, for the twelve months ending June 1984. One person had been charged with incest during that twelve month period. Sexual offenders spanned all age groups between 16 and 60 years, with concentration in the 25-39 year bracket. Length of sentence under each category of offence showed considerable variation, but overall rapists received heavier sentences than incest offenders. There are 32 men currently serving time for rape in Western Australia, and 5 serving time for incest.

Police Data on Sexual Offences against Children

Lack of uniformity in the categories of sexual offences and procedural differences created problems for police in some states in completing the data sheets. Indeed, even within a state, police in different regions may approach child sexual abuse in a distinctive manner, depending on the philosophy of senior officers and the type of community they serve (B. Rope, personal communication). The policy of recording child sexual abuse under disparate offences, and not recording the age of the victim means the retrieval of child sexual abuse cases in the Northern Territory and South Australia requires a lengthy, manual search. Even the gender of the victim is not recorded in the Northern Territory police reports! Victorian Police are hampered by the lack of a central register of child abuse (and claim to be the only state so disadvantaged). A WELSTAT-approved data collection
The West Australian and Tasmanian Police attempted to complete the data sheets. In Western Australia the age and sex of both victim and offender is recorded, and they were able to supply a breakdown of these data both for cases of 'suspected' and 'registered' (or 'substantiated' or 'founded') intrafamilial child sexual abuse for the 1984 calendar year. They also supplied information about the relationship between the offender and the victim for cases 'registered' in 1983 and 1984. Offenders were uniformly male, and the majority of them aged between 25 and 60. Amongst the 88 cases of suspected intrafamilial child sexual abuse in 1984 there were 2 male victims, both aged between 10-15 years. Of the 88 cases reported, 72 were substantiated, including both cases involving male victims. Female victims were also predominantly between 10 to 15 years of age (42 of 70 cases). The 'unfounded' cases included half of the reported cases involving girls under 5 years, 6 females aged between 10-15, and three over 16. Fathers (including defacto and stepfathers), uncles, grandfathers and brothers, as well as stepbrothers were implicated. Proportions of offenders in these relationships with the children differed over 1983 and 1984, the main difference being in the proportion of biological to defacto and stepfathers, there being more biological fathers amongst the 1983 offenders. There were also 6 brothers and 4 stepbrothers implicated in 1983, and only 1 brother offender in 1984. The male victims were abused by an uncle and a grandfather. A father figure was the offender in 58 of the 72 cases of intrafamilial child sexual abuse in
Western Australia in 1984, and in 45 of the 58 cases substantiated during 1983.

Coincidentally, 88 cases of intrafamilial child sexual abuse were substantiated in Tasmania by the Police during 1984, but there were more male victims than in Western Australia. Male victims spanned all age brackets with the largest number (8 of the 17 male victims) being aged between 10 and 15 years. Female victims (71 in all) were also predominantly over 10 years. Although offenders spanned all ages, the majority were over 25 years, as they were in Western Australia. Fathers - biological, de facto and step fathers - were the main offenders with uncles and grandfathers being implicated to a lesser extent, in the abuse of both boys and girls. Summary data provided for the last five years indicated increasing numbers of male victims.

In Tasmania, the police only make statistical records of "matters that are proceeded with by charge". That is, if a police officer, on investigating a complaint of child sexual abuse, finds insufficient evidence on which to make a charge, or if the alleged offender is not known or cannot be located, he makes a report. This will be followed up by a senior officer, who will merely enter a report in the 'Correspondence Book' under the complainant's name, unless he finds another avenue of enquiry. The 'Correspondence Book' then becomes the only record of 'suspected' child sexual abuse cases, making it "a mammoth task to research and collate all unsubstantiated complaints" (Detective Sergeant Fleming, personal communication).
The Tasmanian Police data can be compared with a recent report on child protection in that state since the inception of the Child Protection Assessment Board in the early 1970's (Lewis, 1982). In an otherwise positive evaluation of Tasmania's community child abuse management program, Lewis notes that great effort has been expended over recent years in improving relations between the Police and the Child Protection Assessment Board. Lewis notes:

"During the last six years the relationship with the State police force has caused concern on occasion as by tradition and training police officers uphold the law at all times and view with suspicion any organization which appears to condone criminal acts.... Police cadets are now lectured on child abuse by a paediatrician who stresses the aetiological factors and methods of management of the child and the family." (Lewis, 1982, p.186)

Lewis also notes that the numbers of notifications from each agency except police have risen since 1972. Indeed, police referred 25% of the cases notified to the Board in the 1972-74 period, but since then, their referrals have declined to 1% of all notifications to the Board in the 1978-80 period. Given the Tasmanian Police Force stated policy of recording only cases where the investigating officer finds - in his estimation - sufficient evidence on which to charge the alleged offender, this declining referral rate to the Child Protection Assessment Board is of concern. It would seem that large numbers of complaints of child sexual abuse may go unheeded when initial police investigations fail to find sufficient evidence to mount a charge. This is a further indication that the victim loses out when professionals dealing with child sexual abuse hold different conceptions of its aetiology and consequent management.
Lightfoot (1980b) has suggested that

"every social problem has a history and develops through a set of stages reflected by changes in who defines the problem, the kind of definition it is given and the resulting actions taken to solve the problem." (p.171)

It would seem that several definitions of child sexual abuse are currently in use, and that they result in different approaches to case management. In some cases, several ideas are combined to provide a multifaceted treatment approach. In other cases, contradictory elements lead to alternative treatment approaches. What also emerges is that people with similar training, working for the same agency, sometimes have dissimilar orientations which seem to reflect differing underlying attitudes to child sexual abuse. Roland Summit (1983) has suggested that the strong emotional reactions which child sexual abuse provokes in the public and professionals alike, result in the problem being either denied or treated as an emergency. Finkelhor (1984a) suggests

"When workers want to take quick action, they often do not want to wait for consultations and evaluations and the normal pace of bureaucratic operation. They often act before they fully know what needs to be done ..." (p.200)

It seems likely that such 'emergency' responses may be more influenced by idiosyncratic worker attitudes than would a calmly considered approach.
After summarizing the problem definitions behind the major treatment approaches, this chapter reviews what is known of professionals' attitudes to child sexual abuse. Exposing the gaps in our knowledge leads directly to this study's aims of identifying the relative contributions of agency orientation and idiosyncratic attitudes in a worker's management of child sexual abuse cases.

The Major Treatment Approaches

An historical review of the establishment of services for child victims of sexual assault has shown that at various times, child sexual abuse has been seen as a form of mental illness, a crime, or (particularly in the case of incest) as a symptom of family dysfunction. More recently, broader societal values and socialization practices have been mooted as responsible for child sexual abuse. This fundamental dilemma over what is child sexual abuse may lead professionals to place more reliance on intrinsic attitudes and personal understanding of life events for direction, especially in a problem area that is emotionally charged and potentially threatening to one's basic values and sense of order. The difficulties inherent in such concepts as 'prosecuting an illness', 'treating a crime', or applying both strategies to a 'family problem' are still being grappled with, and these orientations are reflected in the underlying assumptions of the various treatment models (MacFarlane and Bulkley, 1982).

The medical-psychiatric model, defining the offender as 'the problem', centres treatment around him - usually a multi-modal
approach which aims to reduce his undesired sexual behaviour and increase desired sexual behaviour, using a combination of behavioural and cognitive techniques. Sexual therapy and marital therapy may form part of the treatment program, which is individualized and intensive, and generally long-term. Usually some external 'incentive' is required - such as the threat of family break-up, loss of job or jail. Success rates vary, but therapists need support and a variety of other interests and types of clients to sustain working with this difficult clientele. Dr Warwick Williams' work at the Northside Clinic, Sydney, exemplifies this approach (Williams, personal communication, 6.11.84).

Dysfunctional family models locate the causes of child sexual abuse in the early experiences of parents in their families of origin - experiences such as emotional deprivation and perhaps physical or sexual abuse, which equip them poorly for the roles of parent and spouse. The fathers are often dictatorial and the mothers are seen as weak and ineffectual. A daughter - often the eldest - takes over increasing amounts of the housework and child care responsibilities until she is mothering her parents. Treatment is humanistic and family centred, with the explicit goal of rehabilitating the family. Therapy focuses on having the parents accept responsibility for the incest, re-defining family roles, strengthening the mother-daughter bond while reinforcing generational boundaries, and marital work with the couple. It is intensive and usually requires several therapists working concurrently with the family, using groups for therapy and support after some initial individual and dyad therapy. Results are reported as good when treatment is aligned with the
criminal justice system [3], as it is in Giaretto's program [4] and others modelled after it.

Kroth's (1979) evaluation of Giaretto's program found that 3 in 4 families who had completed this treatment eventually reunited. Victims showed a decrease in nervous symptoms, but their unmolested siblings showed a concomitant rise in symptomatology by termination. Having completed treatment, 41% of couples reported improved marital/sexual relationships, but they were more likely to admit they might not report a future molestation than were parents just entering the program. Despite the philosophy of equal parental responsibility for the incest, 37% of the mothers Kroth surveyed, who had been through the program, denied feeling responsible for what had happened in their families.

Feminist family therapy models place less emphasis on rehabilitation of the family, and stress treatment of the negative consequences of the incest for the victim. Bearing in mind the responsibility of parents and the loyalty dynamics in families, these models stress the accountability of the father for the occurrence of the incest,

3. MacFarlane and Bulkley (1982) subdivide these models further into 3 categories; in terms of the changes they have brought about within the legal system: (1) post-conviction therapeutic sentencing; (2) pre-trial diversion and (3) co-ordinated criminal and juvenile court processing. Models in Australia are not yet so diversified.

while avoiding scapegoating by the technique of multilaterality
(Gelinas, 1983, p.328-329). Short-term, structured group treatment,
aimed only at the victim, preferably employs two female therapists.
With group support and the option of individual treatment sessions,
the victim is helped to rebuild her life, and after working through
her 'traumatic neurosis' (Gelinas, 1983, p.325), to recontact her
father and build a more healthy relationship with him.

Socio-environmental models seek to locate the causes of child sexual
abuse in the society rather than in individuals or families (See
Roberts, 1984(a) and (b)). A basic assumption of this orientation is
that individual behaviour reflects the beliefs and values of the
wider society, internalized in the course of formal and informal
socialization. Thus, rather than identifying abnormal fathers as the
problem in incest, the society which condones and justifies violence
and patriarchal ownership as measures of interpersonal control is
seen as being at fault. Such an orientation results in a greater
emphasis on preventative rather than rehabilitative objectives.
Short-term strategies are aimed at protecting the child by removing
the father rather than the child from the home; but the long-term,
educative objectives aim at raising the consciousness of women and
children to their ability and right to control their own bodies and
their lives. Within this orientation lies a strong opposition to
professional 'ownership' of social problems such as child sexual
abuse – a belief in the enforcement of individual rights by methods
not entailing excessive state intervention. Rather, the
strengthening of natural social networks and community promotion of
improved parenting skills are seen as preferable to intervention by
legal authorities or professional 'experts'.
Professional Attitudes to Child Sexual Abuse

The variety of philosophies about the nature and handling of child sexual abuse has resulted in a proliferation of treatment programs, each containing specialized components, to deal with various aspects of this problem. Indeed, by 1981, the National Centre on Child Abuse and Neglect had identified more than 300 programs throughout the U.S.A. specifically designed to treat intrafamilial child sexual abuse (MacFarlane and Bulkley, 1982). Few independent evaluations have been undertaken - Kroth's 1979 study of the efficacy of Giarretto's program being the most well known. Certainly nothing is known of the relative contribution of specific components to the efficacy of any treatment program. This lack of validation must add to the confusion of workers who cannot be sure that the approach adopted is the most helpful or appropriate. Throughout the U.S.A. it has been reported that professionals are frustrated and concerned about the lack of uniformity in handling cases, the conflict amongst agencies, and the inept handling of cases by inexperienced workers (Finkelhor, 1984a).

The situation is similar in Australia, but on a smaller scale. As Warren Simmons expressed it back in 1980:

"We must sort out who will be responsible for this area; this problem is so constant in N.S.W. it is almost becoming boring. Is it a police matter, a medical problem, a legal problem, a child welfare problem, and if it is all those, who is going to take primary responsibility and how are we going to get our act together?"  (Simmons, 1980, p.278)
In his study of the parents of sexually abused children, Simmons found that 28 families had contacted 104 agencies looking for help! It is doubtful whether inter-agency collaboration has improved dramatically over the last 5 years.

Anecdotal remarks come from various sources, but little systematic evidence has been collected on how professionals and agencies are responding to the problem. Two American studies published in 1984 will be reviewed here. One survey of doctors examined the relative effects of physician mastery and of perceived victim culpability on physician involvement in the management of child sexual abuse (Anglin, 1984). The second study surveyed 790 professionals working with child sexual abuse from all agencies in Boston, to examine their knowledge about the problem and local facilities to deal with it; and to look at the relationship amongst agencies and the differences in their philosophies (Finkelhor, 1984a).

Anglin (1984) conducted interviews with a random sample of 75 paediatricians and 75 general practitioners from a Midwestern city. During the interview, she presented each doctor with 5 vignettes which portrayed either a 6 year old or 15 year old girl in a sexually abusive relationship. The vignettes depicted an incestuous relationship with the father at each age, sexual abuse by an adult stranger in the park at each age, and an adolescent date rape. The vignettes designed varied in victim and parent culpability. The doctors were then asked about their:
A. **Acute evaluation and management:**

1. Would you think this patient requires medical care?
2. Would you refer the patient on for care?
3. Would you see her personally?

B. **Follow-up care:**

1. Would you follow up this patient?
2. If so, at what interval? (<1 wk, 1-3 wks, 4-11 wks, or >12 wks)

C. **Psychological management:**

1. Does this patient require counselling? If so,
2. Would you let the medical referral group manage?
3. Would you phone the girl and reassure her?
4. Would you arrange an appropriate referral?
5. Would you see the patient personally?

The three areas were chosen to represent patient management decisions which a doctor must make when he encounters a sexual abuse victim (86% of Anglin's sample of doctors were male). Each step allows the doctor to withdraw and avoid further contact with the sexual abuse victim (Anglin, 1984, p.70). The doctors' answers to these questions were scored, and the scores summed to provide an 'involvement in management index'.

Anglin's other major interest in this study was in physician mastery or "self-perceived clinical competence in the area of sexual abuse" (p.35). Factors which she expected to increase perceived competence were knowledge about sexual abuse; comfort with sexuality (especially adolescent sexuality) issues; personal
experience with sexual abuse; professional experience in handling such cases; and professional experience with cases of physical abuse. In addition, data were gathered on age, sex, type of practice, areas of specialty and perceived adequacy of professional training in child sexual abuse.

Anglin found that:

1. Doctors view patients with psychological problems as their responsibility, but describe counselling such patients as troublesome.

2. A doctor's knowledge about sexual abuse did not ensure a feeling of competence in professional skills in this area.

3. Characteristics which were positively associated with a better fund of knowledge about child sexual abuse in this sample of doctors included younger age, paediatric training, previous personal experience with sexual abuse; previous professional experience with sexual abuse and practicing in a group setting.

4. The sex of the doctor did not appear to influence perceptions of the victim's culpability for the abuse.

5. Level of involvement in the girl's care was not influenced by the doctor's perception of her culpability.

6. The doctors' involvement in the management of young sexual abuse victims was greater when:
   - they had confidence in their competence in this area,
   - they were knowledgeable about child sexual abuse,
   - they had had professional experience with the management of abused children.
Thus, contrary to expectations, Anglin found that the doctors in her sample did not allow their feelings of negativity (as measured by physician attribution of patient culpability) to direct their management decisions in child sexual abuse cases. She also found that "increased mastery in management of sexual abuse problems influences both physician behaviour and attribution of culpability for the sexual abuse situation," where "mastery is based on professional socialization, experiences and self-expectation", and "attribution of culpability is based on personal attitudes that are not necessarily profession-bound." (Anglin, 1984, p.28)

This sample of doctors did not seem to respond to hypothetical cases of child sexual abuse in an 'emergency' fashion. Anglin's report provides no information about the problem being denied by the doctors - which presumably could have been indicated by evaluations suggesting the patient did not require medical care or counselling. But these doctors were making verbal responses to hypothetical material, and a major difficulty in interpreting these results lies in the unknown correspondence between an expressed attitude and actual behaviour.

"Many good intentions and good ideas are short-circuited in practice. Good intentions may be thwarted by lack of time, lack of interest, lack of support from agency or superiors, or simply by ingrained habit patterns." (Finkelhor, 1984a,p.207)

A more stringent test of a worker's tendency to deny the problem or take ill-advised, hasty action in child sexual abuse cases would entail looking at actual worker behaviour.
Finkelhor's (1984) study of the responses to child sexual abuse of professionals in Boston overcomes this deficiency to some extent. Professionals representing all agencies with involvement in this problem were interviewed, and in addition to being presented with a vignette depicting a girl sexually molested by her stepfather, workers were questioned about their handling of their most recent case. Finkelhor found agency more influential than profession in determining 'workers' behaviour and attitudes towards child sexual abuse cases (Finkelhor, 1984, p. 202). Although no details are available of his comparative analysis by profession and agency, he provides evidence indirectly of the greater predictive power of agency. For example, respondents from two of his agencies - mental health clinics and Department of Social Security (DSS), were predominantly social workers, and the case load of both agencies comprised mainly parent-child incest (rather than abuse by a non-family member). But DSS social workers were much more likely to have had contact with offenders than were mental health social workers.

Finkelhor's study revealed that different agencies seem to 'attract' different types of child sexual abuse cases. Criminal justice workers are more likely to come in contact with extrafamilial child sexual abuse than are other workers, who see a preponderance of intrafamilial child sexual abuse. In this, they are quite distinctive.

"Where abuse occurs at the hand of someone outside the family, such as a stranger or a neighbour, families and agencies give priority to catching the offenders, punishing them, and referring cases to criminal justice agencies. When abuse occurs at the
hands of a parent, however, those involved often wish to avoid prosecution of the offender. In these cases, there is much more concern about the wellbeing of the child, so that child protective, mental health and social service agencies are called into play."
(Finkelhor, 1984a, p.203-4)

Another example of an agency 'attracting' a certain type of case is seen in the larger proportion of women reporting abuse that occurred during their childhoods to mental health workers. Other agency workers see predominantly recent abuse cases, where people are in crisis.

Apart from these trends, which have been noted elsewhere, workers' reports about their handling of their last case revealed a marked tendency for agencies to operate on cases in an isolated way within their own networks. When asked about the referral source of their last case, it became apparent that an agency receives a large number of referrals from other agencies of the same type. This could be related to above comments about the typical mental health or criminal justice case - perhaps the agencies 'attract' certain types of cases by a process of active referral. In addition to different agencies working in an isolated way, many workers consulted no one else about their last case. Almost half of the school counsellors and 'other' agencies staff, and 40% of mental health workers sought no outside assistance.

Because they were reporting only the handling of their last case, and because the cases of workers in different agencies varied so greatly - partly for reasons outlined above - clear patterns of interaction amongst agencies were not very apparent. Differences
In responses to the vignette - a uniform stimulus - would be more likely to reflect real differences in workers' training, attitudes, knowledge and predispositions concerning sexual abuse.

In fact, workers from different agencies did show distinctive patterns in their proposed interventions in the hypothetical case:

1. DSS workers proposed many more interventions than did workers from other agencies. Being the agency with the ultimate responsibility for the disposition of sexual abuse cases, they have both the motivation (even the mandate) for making a thorough investigation and the resources (experience plus established contacts) for carrying it out.

2. School personnel recommended far fewer interventions than staff from other agencies. They were more likely to recommend only reporting the case to the mandated authority.

3. Criminal justice workers were isolated from workers in other agencies both because they had different approaches to handling child sexual abuse, and because other agencies tended to steer clear of them. Reporting to the police was by far the least favoured intervention with workers from other agencies, yet amongst the criminal justice workers there was a substantial inclination to involve both the police and social security personnel. Their favoured pattern of recommended interventions - interview the child and the mother, report to both police and to DSS, and have the child physically examined - shows a pronounced anti-therapeutic orientation. This interpretation finds further support in their preference for removing the stepfather and pressing charges, and the low priority they
give to keeping the family together. It would seem that the 
criminal justice workers interviewed in Boston view child 
sexual abuse as a crime and proceed with prosecution.

4. DSS workers were at the other end of the spectrum. Amongst 
all workers, they were the least likely to report to the 
police, but strongly endorsed every other intervention. Only 
5% of DSS workers would encourage the mother to press 
criminal charges against the stepfather, but they had the 
highest percentage of all agencies (85%) advocating keep the 
family together.

Finkelhor concluded that, while Boston professionals are quite 
knowledgeable about child sexual abuse,

"there is a high degree of institutional insularity. 
Agencies do not readily cooperate with one another. 
They tend to rely heavily on other professionals 
within their own immediate institution. There appear 
to be some strong barriers to interaction, 
particularly between criminal justice and child 
protective professionals, but also to some extent 
between other agencies as well." He went on to say 
"There exists a high degree of disagreement among 
agency personnel about the proper approach to 
handling sexual abuse. Different agencies give 
priorities to different kinds of interventions and 
are at odds with one another about basic objectives 
in the management of cases." (Finkelhor,1984a, p.211)

Aims of This Study

This study set out to build on what was learned from Anglin's 
(1984) and Finkelhor's (1984a) studies. It aimed to examine the 
relative influence of a worker's attitudes, amount of experience 
and knowledge of child sexual abuse in case management. Since it 
seems apparent that worker behaviour is influenced by the wider 
climate of inter-agency disagreements and tensions, this study
also aimed to investigate further the patterns of collaboration between agencies in Canberra, and the differences in their philosophies which shape policy and handling of child sexual abuse. A satisfactory instrument for assessing a worker's attitudes to child sexual abuse has not yet been developed. Anglin's and Finkelhor's results suggested the need for comparison of a worker's usual case management with responses to a variety of vignettes depicting sexually abusive situations with children, so that one could infer attitudes from worker behaviour. It was hoped that attitudes could also be tapped more directly from workers' responses to statements incorporating myths about child sexual abuse. From these sources, the study aimed to explore attitudes towards child sexual abuse amongst Canberra's workers.

Furthermore, while surveying child sexual abuse workers from diverse agencies is critical to the discernment of patterns of collaboration and differing philosophies amongst agencies, Finkelhor's findings concerning divergencies in types of cases seen and role prescriptions in different agencies suggest that the resulting comparison of workers may be inappropriate. To correct for these constrictions on worker behaviour, this study aimed to developed an 'involvement index' incorporating a combination of a worker's case experience and usual role in case management.
Since this area of study is still in its infancy, this research is necessarily exploratory. However, on the basis of Finkelhor's results and anecdotal remarks from local professionals, one might hypothesize that:

1. Police would be more punitive, and less therapeutic than workers from other agencies.

2. Lack of collaboration from police would be pronounced in a climate of interagency distrust.

3. Each agency would have a proportion of workers with 'low' and with 'high' involvement.

4. Workers with high involvement would be less likely to intervene in a hasty, ill-considered manner. That is, in situations where the referral data left such workers with suspicions that something was amiss, but no firm evidence of sexual abuse, they would be more likely to continue with a carefully planned investigation, rather than alerting other workers involved, and switching to a crisis mode of intervention.

5. Workers would be fairly knowledgeable about child sexual abuse, but being informed may not preclude the holding of contradictory attitudes and myths.
CHAPTER 7: METHOD

Sample Selection

Canberra, the National Capital of Australia, is a city with a population of 225,000 people. Although lacking the autonomy of self-government, it has its own police force (the Australian Federal Police), and government departments (e.g., A.C.T. Health Authority, A.C.T. Schools Authority, Welfare Department, etc.) to service this rapidly growing community. In addition, there are two Rape Crisis Centres, two Women's Refuges and an Incest Centre (opened in April 1984) - all partly subsidized community agencies catering for abused women and children.

Child sexual abuse falls into competing professional and institutional domains, and workers from different agencies and even within the same agency have different philosophies about the nature and handling of the problem. This situation complicates any attempt at obtaining a truly random sample of child sexual abuse workers, even in a city the size of Canberra. Thus, for this study, two approaches were considered for selecting a sample of professionals whose work might bring them in contact with sexually abused children:

(a) A random selection of participants at a two-day workshop on Child Abuse, held in Canberra in October 1984.
A direct approach to the Directors of all agencies in the A.C.T. whose personnel, according to American and English studies, might come into contact with child sexual abuse cases, and a request for access to their staff.

An examination of the register of attendees at the October workshop showed that not all relevant agencies were represented, while some agencies were over-represented. Thus, the register of participants was not an appropriate source from which to draw this study's sample, as a sample so drawn would be representative only of the workshop attendees, and not of Canberra's child sexual abuse workers.

The alternative strategy was implemented. The Directors of Canberra's agencies were approached via the Director of Child Health in the A.C.T., who had been influential in the organization and running of the October Child Abuse Workshop, and who had until recently, worked intensively with child sexual abuse cases in South Australia. The aims and procedures of the study were outlined to her, and an agreement was reached whereby access to the team of salaried doctors working in A.C.T. schools, as well as salaried doctors working in community health centres, would be facilitated once she had vetted the study's instruments. Several drafts of the questionnaire and structured interview were preferred and discussed, after which access to the doctors at their regular meeting venue was arranged. In addition to this assistance, after discussing the range of agencies that such a study might cover, she provided names of the Directors of some of these agencies.
During the three month period from June until September 1985, questionnaires and interviews were completed by 60 professionals from a variety of agencies throughout Canberra, which provide support services for sexually abused children and their families. Agencies sampled included schools, community health centres, police, the Welfare department, mental health division of the Health Authority, and representatives from other government subsidized agencies involved in community welfare (e.g., Parent Support Service, the Incest Centre and Canberra Rape Crisis Centre).

Study Design

The questionnaire was designed to elicit basic demographic data (e.g., age, sex, occupation and employer, and number of years in practice), as well as an estimate of the number of cases of child sexual abuse that each worker had been involved with. In addition, it was designed to elicit each worker's usual way of working with such cases. On the basis of the number of cases a worker had dealt with, and his/her modus operandi, an Involvement Index was calculated for each worker. A structured interview of one hour's duration looked at each worker's proposed interventions in six vignettes depicting hypothetical situations which may or may not be seen as abusive. Proposed interventions could then be compared with the Involvement Index. The interview also examined each worker's attitudes towards twelve controversial statements drawn from the literature. These statements explored a worker's beliefs about the role of the
offender, the victim, and her mother in intrafamilial child
sexual abuse, as well as the broader issue of whether or not
incest is intrinsically harmful.

In every instance the questionnaire was completed prior to
scheduling the interview, the usual interval between them being
two weeks. The main reason for the separate scheduling of the
questionnaire and the interview was to enable the respondent to
report on his/her usual handling of child sexual abuse cases
prior to a consideration of how he/she would ideally handle
hypothetical cases. This would be more likely to result in an
accurate report of the handling of child sexual abuse cases,
uncoloured by the interview stimuli. A further benefit of this
scheduling was that respondents were more easily assured of
confidentiality when identifying demographic data had been
requested separately.

Procedure for Recruiting Subjects

Telephone contact was made with the Director of each agency, and
permission was obtained to address the staff at their next
meeting. A brief description of the aims of the study was
followed by an estimate of the time required of participants, and
the procedure for scheduling the interview. Questionnaires and
reply-paid envelopes were then distributed to those interested in
participating. When completed questionnaires were returned, each
participant was contacted by telephone, and a convenient time and
place for the interview was arranged.
Such a procedure for recruiting participants had a number of drawbacks. It did not produce a sample of professionals that was representative of professionals working in the Canberra district. Since it consisted of people who volunteered to give up an hour of their time during working hours to be interviewed about child sexual abuse, it probably overrepresents those who were more knowledgeable about, more sensitized to, and had more experience with the problem.

On the other hand, this recruitment procedure had some advantages. By including in the agenda an introduction to this study, the Directors legitimized their staff's participation, which resulted in a high participation rate from the people approached. The requirement to complete and return a brief questionnaire prior to scheduling the interview reduced the attrition rate and further ensured cooperation at the interview. Since the study focuses on the handling of child sexual abuse cases, the possibility that these professionals had more experience and interest in such cases could be viewed as an advantage rather than a drawback.

**Composition of the Sample**

The sample was predominantly female (72%), with the median age falling between 35 and 40 years. As might be inferred from the median age, this group of professionals was, on the whole, quite experienced, the majority having worked for about 10 years. The proportion of their working lives which exposed them to child sexual abuse is unknown, but it seems significant, considering
their ages, that 1 in 6 had had no exposure to child sexual abuse, and almost half the workers had seen 5 cases or less. There were a few respondents who had seen upwards of 30 cases — one had seen close to 100 cases — but the remaining one third of the sample had dealt with between 10 and 25 cases.

Little has been written about the amount of exposure of workers from different agencies to child sexual abuse, or what constitutes an experienced worker. Finkelhor (1984a, p.203 and p.216) considered child sexual abuse a problem 'not foreign' to the professionals he interviewed if they had seen one or more victims or offenders during their professional careers. Given that the definition of 'experienced' is problematic, for the purpose of this study it will be assumed that workers gain skill and confidence in working with child sexual abuse after handling 5 cases. Ideally, one would seek to define firmer criteria but given the spread of experience within this sample, placing the cut-off point for 'experienced' at 5 cases seems not unreasonable, despite its arbitrariness.

Respondents came from a variety of professions including nursing, medicine, education, social work, psychology and law enforcement. Table 1 shows the composition of the sample by agency, profession and sex.
<table>
<thead>
<tr>
<th>Agency</th>
<th>% of N</th>
<th>Profession</th>
<th>M</th>
<th>F</th>
</tr>
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<td>4</td>
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<tr>
<td></td>
<td></td>
<td>Social Worker</td>
<td>2</td>
<td>2</td>
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<td>Nurse</td>
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<td></td>
<td></td>
<td>Doctor</td>
<td>3</td>
<td>5</td>
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<td>Social Worker</td>
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<td>2</td>
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<tr>
<td></td>
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<td>2</td>
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<td></td>
<td></td>
<td>C.I.B. detective</td>
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<td>1</td>
</tr>
<tr>
<td>Community Welfare</td>
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<td>Rape/Incest Worker</td>
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<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others</td>
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<td>3</td>
</tr>
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<td>Public Sch Counsellor</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Private Sch Counsellor</td>
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</tr>
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<td><strong>100.0</strong></td>
<td><strong>60</strong></td>
<td><strong>17</strong></td>
<td><strong>43</strong></td>
</tr>
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</table>
In comparison with Finkelhor's (1984) study of professionals, this sample is made up of the same types of agencies, and similar proportions of professionals from mental health, law enforcement, education and 'other' agencies. But community health centres are more strongly represented (23% compared with only 9%), while welfare workers are underrepresented (13% compared with 25%). These differences may represent sampling differences as well as cultural differences in the types of agencies dealing with child sexual abuse in the respective communities.

Development of The Questionnaire

The questionnaire was designed as a brief instrument for:

(a) eliciting demographic data: Information about one's attitudes and method of handling child sexual abuse cases is personal, and its release threatening, so in the interests of confidentiality, demographic data was obtained prior to the interview, and only the date and subject number was recorded with the responses to the interview.

(b) calculating an Involvement Index: The number of cases each worker had been involved with, and the extent of involvement indicated by the worker's management strategies, were used to calculate an Involvement Index.

(c) reducing dropout rate: It was expected that the worker who took 5 - 10 minutes to complete it, and who bothered to return it, would be more likely to remember the appointment for the interview and to comply fully with requests for information.
Demographic Data

The few studies which have investigated a worker's management of child sexual abuse cases (e.g., Anglin, 1984 and Finkelhor, 1984a) have elicited information about the following worker characteristics:

- Age
- Sex
- Profession
- Employer
- Number of years experience
- Extent of experience with child sexual abuse cases.

There are many more studies of reporting behaviour, and although

"...reporting of suspected child abuse to the appropriate mandated local government agency is legally the crux of even the most limited personal physician involvement in management..." (Anglin, 1984, p. 44).

Anglin did not include reporting behaviour in her involvement index. Even when reporting is mandated, professionals often do not comply with the law. Finkelhor (1984) cites the reporting rate of child sexual abuse cases in the USA in 1979 as "56% of those known to professionals" (Finkelhor, 1984, p. 205). A variety of factors have been found to influence reporting behaviour, including fears about adverse effects on the child resulting from the court appearance, parents blaming the child, or family break-up; and a sense of futility arising from awareness of the small percentage of offenders who are convicted and charged, the paucity of helping agencies, inappropriate laws and ineptness of the legal system (Shamley, 1984).
Thus, although reporting behaviour has been elicited in studies of professionals' beliefs and attitudes, and the volume of literature on this subject attests to the controversy that still rages, it does not seem to reflect a professional's involvement in the cases of child sexual abuse he/she handles.

Anglin (1984) was surprised to find that cognitive knowledge concerning child sexual abuse and perceived victim culpability for the abuse were unrelated to a professional's involvement in her study of physician management of child sexual abuse. Factors which Anglin's study found to be positively associated with involvement were previous personal experience with sexual abuse and confidence in one's competence in this area.

On the basis of the limited number of published studies concerning professional involvement, it was decided to concentrate on behaviours exhibited by professionals with various degrees of exposure to child sexual abuse, rather than trying to assess personal characteristics or attitudes in a professional which would predispose him/her to become involved with these cases.

Exploration of the ways different professionals handle child sexual abuse cases, both in Australia and overseas, based on discussion with various workers and a study of the literature, revealed the following strategies:
1. Refer the case to another agency or 'expert' for substantiation.

2. Investigate further to try to establish whether or not the abuse occurred.

3. After substantiating that abuse occurred, refer the case to another agency for management.

4. Substantiate, refer for management, but maintain contact with the family/case worker by phone.

5. Help the family through the crisis after disclosure, by informing them of the likely course of events, advising them of local services, and possibly arranging temporary placement for the child (crisis intervention).

6. Crisis intervention plus maintaining contact with the child.

7. Crisis intervention followed by acting as the principal worker (therapist) for the family (or members of it).

8. Crisis intervention as member of a multidisciplinary team, then as principal therapist for child or offender.

9. Principal therapist and member of multidisciplinary team from disclosure through to prosecution in court.

The ordering of the statements, both here and in the questionnaire, is on the basis of increasing energy, time and commitment required. They were included in the questionnaire, following several questions on demographic data and a question on reporting behaviour (See Appendix 2 for complete questionnaire).
Involvement Index

Responses to the questionnaire were coded, and an Involvement Index was calculated for each subject prior to the interview. As mentioned previously, responses to only nine statements were included in the calculation, reporting behaviour having been shown in previous studies to have complex motivation, not necessarily correlated with involvement. To calculate the Involvement Index, the number of cases respondents had dealt with during their careers was utilized, in conjunction with the pattern of responses to the nine statements, thus:

Step 1: Each respondent in the sample was allocated to one of three groups, based on the number of cases dealt with during his/her career. The 3 groups will hereafter be designated "No Exposure", "Low Exposure" and "High Exposure".

No Exposure: those who haven't been involved with any cases of known or suspected child sexual abuse during their careers. (Since one could not answer how one had responded to a case if the opportunity to work with such cases had not arisen, these subjects were omitted from the following calculation of an involvement index. Their involvement is zero.) Ten subjects had had no exposure to child sexual abuse cases.
Low Exposure: those who have been involved with 5 or fewer cases. Twenty six respondents fell into this group.

High Exposure: those who have been involved with 6 or more cases. Twenty four subjects fell into this group.

Step 2: Patterns of response to the nine statements were examined for the low exposure group and the high exposure group. Only those statements which showed a differential pattern for these two groups were used in the calculation of the involvement index.

Using the numbers 0, 1, 2, 3 and 4 to correspond with 'never, rarely, sometimes, usually and always', the mean score was calculated for the low exposure and the high exposure group for statements B through J (excluding statement A on reporting). Where the mean of the high exposure group was significantly higher (using t-test) than the mean of the low exposure group, it is suggested that workers with more professional experience with child sexual abuse cases are more likely to manifest the form of involvement depicted in this statement than workers with
very little professional experience. Similarly, where the mean of the high exposure group was significantly lower than the mean of the low exposure group, it follows that workers with more case experience are less likely to manifest the form of involvement depicted in this statement. Statements which failed to reveal a statistically significant difference between the means of the low and high exposure groups were omitted from calculation of the Involvement Index.

Step 3 : To calculate the index for the 50 subjects in the low and high exposure groups, the relevant number (0 through 4) was substituted for each subject's response to Statements B through J, and the involvement index was computed by adding those numbers for Statements B, F, H, I and J (those for which the high exposure group had a significantly higher mean). The difference between the means for Statement C - the only instance where the high exposure group had a lower mean - failed to reach significance. Obtained T-values for each statement appear in Appendix 3. The maximum range of Involvement Indices so computed (B + F + H + I + J) is 0 - 20.
The distribution of the Involvement Indices for the entire sample (60 respondents) is shown in Table 2 below.

<table>
<thead>
<tr>
<th>INDEX</th>
<th>FREQUENCY</th>
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<th>CUM.PERCENT</th>
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<td>1</td>
<td>1.7</td>
<td>100.0</td>
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</table>

TOTAL 60 100.0

It can be seen that the Involvement Indices span almost the entire range of possible index scores.

Development of the Interview.

The interview was designed to:

(a) determine whether workers from different agencies define sexually abusive behaviour similarly.

(b) examine the intervention strategies recommended by workers from different agencies for hypothetical situations which they rate as sexually abusive.

(c) look at workers' attitudes and beliefs about incest, in particular the role of the abuser, the abused and her mother
in the prototypic father-daughter incest scenario.
The interview began with a slightly modified version of an exercise developed by an education officer of the Child Protection Services, Department of Youth and Community Services, N.S.W. (Heilpern, 1981). The exercise consists of a series of vignettes of hypothetical situations which may or may not be considered abusive. Vignettes depicting physical abuse and neglect, emotional abuse and sexual abuse have been developed, and selection of the type of abuse depicted has varied with the targeted training group. This study employed a variant comprising six vignettes of hypothetical situations where sexual abuse was the theme.

The exercise has been found extremely useful as an 'ice breaker' at the beginning of a variety of group training programmes. The author reports that

"....the exercise encourages people to look at their own attitudes towards child abuse and neglect, and their reason for these attitudes; confronts people with the range of 'normal' attitudes and the implications of the existence of this range; focuses attention onto the effects of adult behaviour on the child; and highlights the need for consultation before and during intervention."

(Heilpern, 1981 p.211)

Ms Heilpern was contacted, and she agreed to this use of her exercise. The slight changes in wording were introduced with her approval, following pilot testing of this format of the exercise.
This sexual abuse variant of the exercise has been used extensively in workshops on incest. However, to date, no measures of reliability or validity have been undertaken. Prior to this study, the exercise had never been adapted for individual use.

While group administration enhances an appreciation of the range of attitudes amongst one's fellow trainees, use of the exercise with individuals undoubtedly promotes scrutiny of one's values and attitudes. This assertion is based on the fact that many respondents commented quite spontaneously that spending an hour considering the six vignettes and the twelve controversial statements had raised issues that they had not considered before, or brought forth painful memories. Indeed, such comments were made both by people without much professional exposure to child sexual abuse and by workers from rape and incest centres. In some instances, an extended debriefing ensued.

A methodological point that bears consideration in future studies using hypothetical material is the use of neutral names in the vignettes. In some instances, a name may connote oddity (e.g. Violet) because of rare usage in the community. Other names (e.g. Dimitri) introduce cultural stereotyping that distracts respondents from consideration of more relevant issues. Other researchers seem to have ignored the importance of such cues.
The verbal instructions originally used for the group exercise were unmodified for this study. A brief introduction focused attention on the wide continuum of child sexual abuse, pointing out the large 'grey area' compared with clear-cut examples which leave no doubt that the child needs protection from his/her caregivers. Respondents were then told they would be given a series of cards, each depicting a hypothetical situation. Order of presentation of the hypothetical situations was randomized by shuffling the cards before each administration. After reading the card, respondents were to rate the situation on a scale from one to five, where one represents an O.K., non-abusive situation, and five represents extreme child abuse. (See Appendix 4 for Instructions and Vignettes). Administration up to this point varies little from Heilpern's original instructions, except that in the group administration subjects were given a sheet of paper on which were typed all six vignettes, with a graphic rating scale anchored by the numbers 1 and 5 following each vignette, whereas in this study, subjects read the vignettes from cards, and their verbal rating was recorded by the interviewer onto an answer sheet. The remaining methodological details were developed for individual administration for this study.

Respondents who rated a situation one or two were asked what criteria they used to make the rating. Those who made a rating of three were asked whether three meant 'abusive' to them, or 'not abusive'. If three meant 'not abusive', they were asked why they rated that situation as non-abusive. Respondents were queried about the meaning of the middle position on the rating scale because the use of odd number steps often introduces response
style, with individual differences accounting for the greater or lesser use of the middle step, which is seen as neutral. Heilpern attempted to counteract response style by requesting her subjects to "try not to be a 'fence sitter'" (Heilpern, 1981, p. 208).

Reasons given for ratings of one, two or three (non-abusive) were noted verbatim. Respondents who rated a situation three (where three meant abusive), four, or five were given another card on which was listed ten interventions, and were asked:

"In this situation, which of these intervention strategies would you recommend?"

To allow for the fact that some situations depicted a worker in a role which might have been foreign to a particular respondent, it was stressed that recommendation of any intervention need not imply that the respondent would carry it out him/herself, but only that he/she considered it an appropriate intervention in this situation.

Following selection of interventions recommended by the respondent, he/she was asked three questions, followed by two probe statements, to explore the goals of their recommended interventions. The first question and the last statement focused on the continuing debate over whether or not it is important to bring criminal charges to bear against the abuser. The question looked at whether the respondent would actively encourage a parent to prosecute, while the statement probed the respondent's stand on the issue of prosecution of child sexual abuse per se.
The second and third questions explored what priority the respondent would give to removing either the child or the offender, in order to prevent a recurrence of the sexual abuse. The other statement probed the priority the respondent would give to preserving the family unit in the aftermath of sexual abuse. (See Appendix 5 for Interventions and Probes).

The list of interventions, the three questions about the goals of intervention and the two probe statements were taken directly from Finkelhor's (1984) study of professionals' responses (Finkelhor, 1984a, p. 206-210). The above procedure was repeated for each of the six vignettes.

In the final section of the interview, twelve controversial statements about father-daughter incest, incorporating many of the myths about the deviant father, the collusive mother and the precocious daughter, were presented individually on a series of cards. The twelve statements were selected from a series of controversial statements gleaned from the literature and presented, along with confirming or discrepant corroborative material, in an unpublished address. (Whale and Calvert, 1984). Order of presentation of the controversial statements was randomized by shuffling the cards before each administration. Respondents were instructed to read each statement, say whether they agreed or disagreed with it, and give a brief explanation of their reasons. Responses to each statement were noted verbatim. (See Appendix 6 for the Twelve Controversial Statements).
Table 3 shows the distribution of Involvement Indices across agencies at each index score.

### TABLE 3 : DISTRIBUTION OF INVOLVEMENT INDEX BY OCCUPATION

<table>
<thead>
<tr>
<th>INDEX</th>
<th>POL</th>
<th>SCH</th>
<th>WEL</th>
<th>PSY</th>
<th>SOC</th>
<th>MED</th>
<th>OTH</th>
<th>ROW TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6*</td>
<td>15</td>
<td>8</td>
<td>4*</td>
<td>5*</td>
<td>14</td>
<td>8</td>
<td>60</td>
</tr>
</tbody>
</table>

**POL** = Police  
**SCH CSL** = School Counsellor  
**WEL** = Welfare Worker  
**PSY** = Psychologist  
**COM NUR** = Community Nurse  
**OTH** = Others (Workers from Rape Crisis, the Incest Centre, Parent Support Service and the Migrant Resource Centre).

* N.B. N.B. Throughout the analysis, when the sample is subdivided by agency - and particularly by profession - N's become small. In these instances, descriptions of trends will replace statistical analysis to avoid non-compliance with the assumptions of particular statistics, and hence the risk of over-interpretation.
The most salient feature of Table 3 is the large number of medical agency personnel with an Involvement Index of zero. The majority of doctors and nurses (10 of 14) appear at Index 0 in Table 3, and overall a quarter of the sample is represented here. Two-thirds of those with zero involvement are respondents who have had no experience with child sexual abuse cases. The remainder (5 workers) either have had minimal contact with such cases, or have worked in ways untapped by the questionnaire. Further inspection of the pattern of scores in Table 3 suggests that respondents fall naturally into 3 groups:

The No Involvement Group—Those whose index is 0, as described above (15 respondents).

The Low Involvement Group—Those whose Involvement Index falls between 1 and 8 (23 respondents).

The High Involvement Group—Those whose Involvement Index is 9 and above (22 respondents).

Figure 3 depicts graphically in a bar chart the percentage of respondents from each agency/occupation in the No, Low and High Involvement Groups.
Figure 3: Percentage of respondents in no, low, and high involvement groups, categorized by agency.
It can be seen that 71% of medical agency personnel fall in the No Involvement group, with the remainder of the doctors and nurses equally represented in the Low and High Involvement groups. School Counsellors predominantly fall in the Low Involvement group, and comprise 75% of this group. Workers from Welfare and Police fall in the Low and High Involvement groups, with a greater proportion of both in the High Involvement Group. Some representatives from the 'Other' agencies category appear in each group, although the majority (87.5%) have low or high involvement. Mental health workers are represented by occupation rather than by agency because, while all the psychologists fall in the High Involvement Group, social workers appear in all 3 groups, with 40% having no involvement, 20% falling in the low group and the remaining 40% in the High Involvement Group. Combining psychologists and social workers under Mental Health agency would conceal the extreme range of indices (compared with psychologists) in this sample of social workers.
<table>
<thead>
<tr>
<th>NUMBER OF CASES FOUND ABUSIVE</th>
<th>POL n=6</th>
<th>SCH n=15</th>
<th>WEL n=8</th>
<th>MEN HTH n=9</th>
<th>MED n=14</th>
<th>OTH n=8</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

It is evident that only one worker (in sixty) rated all 6 hypothetical cases as abusive, while two workers rated only 1 of the 6 cases abusive. One third of the sample defined half the situations as abusive, and a further half of the sample found either 2 or 4 cases abusive. Community workers from 'other' agencies in this sample more frequently suspected Child Sexual Abuse in these 6 vignettes than did school counsellors, welfare workers or mental health professionals. But Table 4 also indicates that there is considerable variation amongst workers within an agency in the number of cases rated as abusive.
An examination of the number of cases rated as abusive by involvement group of workers is even more informative. Table 5 shows this breakdown.

<table>
<thead>
<tr>
<th>NUMBER OF CASES FOUND ABUSIVE</th>
<th>NO INV n=15</th>
<th>LOW INV n=23</th>
<th>HIGH INV n=22</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>12</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Almost half of the High Involvement Group (10 of 22) rated only 1 or 2 of the 6 cases as abusive, while the majority of respondents with zero involvement (11 of 15) judged 3 or 4 of the 6 cases abusive. The Low Involvement Group fell between the No and High Involvement Groups in terms of how many cases they rated as abusive - half of them (12 of 23) rated 3 cases abusive. Thus, there seems to be an inverse relationship between Involvement Index and the number of these hypothetical cases rated as abusive. The lower one's Involvement Index, the more likely one is to judge more of the hypothetical situations abusive.

In order to determine whether workers from different agencies define child sexual abuse similarly the hypothetical cases will be examined one by one. Tables 6 to 11 show the numbers of workers in each agency, and the percentage of workers overall, who rated the 6 hypothetical cases A to F as abusive. In most instances, workers have been classified by agency rather than by occupation, except where workers of different professional affiliation, from the same agency, responded differently.
CASE A:

The Parker family have always been uninhibited about being naked in their home since their children were little. Now the children are 10 and 12 and they still wrestle with their father on the floor. Last week Mrs Parker talked to her doctor about an incident where Mr. Parker got an erection while wrestling with Cathy. Mrs. Parker intervened but wondered if it was the first time that had happened and what would have happened if she had not been there.

The rating of Case A as abusive or non-abusive by the 60 respondents, classified by agency and occupation, is shown in Table 6.

<table>
<thead>
<tr>
<th></th>
<th>FOL</th>
<th>SCH</th>
<th>CSL</th>
<th>WEL</th>
<th>MEN</th>
<th>HTH</th>
<th>COM</th>
<th>NUR</th>
<th>DOC</th>
<th>OTH</th>
<th>ROW</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-ABUSIVE</td>
<td>4</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>37</td>
<td>(61.7%)</td>
</tr>
<tr>
<td>ABUSIVE</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>23</td>
<td>(38.3%)</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
<td>6</td>
<td>15</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>60</td>
<td>(100.0%)</td>
</tr>
</tbody>
</table>

It is evident from Table 6 that the majority of respondents (61.7%) rated Case A as non-abusive. However, community nurses and staff from other agencies showed a preponderance of workers rating Case A as abusive.
CASE B:

Joan was in a dilemma. Her 8 and 10 year old daughters were usually truthful with her. They described to her how their stepfather sometimes took them to the garage and masturbated in front of them. Joan had only remarried a year ago and wanted this marriage to work.

<table>
<thead>
<tr>
<th>TABLE 7 : CASE B - RATING AS ABUSIVE , BY AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>POL</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>NON-ABUSIVE</td>
</tr>
<tr>
<td>ABUSIVE</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
</tr>
</tbody>
</table>

Respondents almost unanimously rated Case B as abusive. Only 4 respondents (of 60) rated Case B as non-abusive.
Mr. and Mrs. Johnson and their son Steven had always been close. Steven used to go into his mother's bed after his father left for work every morning from when he was a toddler till the end of primary school and occasionally since he entered high school. His parents were surprised when requested to come to an interview with the school counsellor and principal to discuss Steven's depression and poor adjustment at high school. Steven is 15.

Most respondents (81.7%) rated Case C as non-abusive. Incest and Rape workers were conspicuously different - the majority of these workers (3 out of 4) rating Case C as abusive.
CASE D:

Dimitri was in Sixth Class and a real problem for his teacher. The other boys told how he played with himself and got an erection in the playground and boasted about how he went to bed with his 10 year old sister. He was an aggressive and often lonely boy.

<table>
<thead>
<tr>
<th>TABLE 9 : CASE D - RATING AS ABUSIVE , BY AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>NON-ABUSIVE</td>
</tr>
<tr>
<td>ABUSIVE</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
</tr>
</tbody>
</table>

The respondents were almost equally divided in their rating of Case D - 45% rating it as non-abusive and 55% rating it as abusive. Police and welfare workers, and medical agency personnel were more likely to rate it non-abusive than were other workers.
CASE E:

Mrs. Wilson was staying with her daughter and son-in-law and their two small children Josephine 6 and William 4. She came across some photos which her son-in-law had taken of his wife and Josephine naked. There was also one of a friend of Josephine wearing only a top. Mrs. Wilson's son-in-law explained that the family were sun lovers.

<table>
<thead>
<tr>
<th>TABLE 10: CASE E - RATING AS ABUSIVE, BY AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>POL</td>
</tr>
<tr>
<td>NON-ABUSIVE</td>
</tr>
<tr>
<td>ABUSIVE</td>
</tr>
<tr>
<td>COLUMN TOTAL</td>
</tr>
</tbody>
</table>

Case E was rated as non-abusive by 90% of respondents.
CASE F:

Violet was 15. She was slightly retarded. She lived with her grandparents and rarely went out. They had cared for her since she was 3. When Violet became pregnant and the baby was to be adopted, her grandfather admitted that he was the father of the baby. Violet was very fond of her grandfather and had not complained to anyone about his sexual advances.

| TABLE 11: CASE F - RATING AS ABUSIVE, BY AGENCIES |
|-----------------|----------------|----------------|----------------|---------------|---------------|---------------|----------------|
|                 | POL | SCH | CSL | WEL | MEN | HTH | MED | OTH | ROW TOT |
| ABUSIVE         | 6   | 15  | 8   | 9   | 14  | 8   | 6   | 60  | (100.0%) |
| COLUMN TOTAL    | 6   | 15  | 8   | 9   | 14  | 8   | 6   | 60  | (100.0%) |

Case F was rated as abusive by all respondents.

In order to compare how workers from the various agencies in Canberra approach and handle a case where they suspect child sexual abuse, it is necessary to have agreement that most respondents rate the case abusive. Once a sample of 60 respondents is divided into 6 groups by agency, or 10 groups by occupation, N's in individual cells become quite small. Without an almost unanimous rating of abusive by respondents, N's become so small that interpretation is meaningless.
The data supplied in Tables 6, 7, 8, 9, 10 and 11 are pooled in Table 12 below, with respondents classified by agency rather than by occupation.

### TABLE 12: Total Number of Respondents from each agency rating Cases A - F as abusive.

<table>
<thead>
<tr>
<th>HYPOTHETICAL CASE</th>
<th>POL</th>
<th>SCH</th>
<th>WEL</th>
<th>MEN</th>
<th>MED</th>
<th>OTH</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=6</td>
<td>n=15</td>
<td>n=8</td>
<td>n=9</td>
<td>n=14</td>
<td>n=8</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>B</td>
<td>4</td>
<td>14</td>
<td>8</td>
<td>8</td>
<td>14</td>
<td>8</td>
<td>56</td>
</tr>
<tr>
<td>C</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>E</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>F</td>
<td>6</td>
<td>15</td>
<td>8</td>
<td>9</td>
<td>14</td>
<td>8</td>
<td>60</td>
</tr>
</tbody>
</table>

N.B. Entries in "Bold Face" indicate that the majority of respondents rate that case as abusive.

Subsequent analyses of how workers from Canberra's agencies handle child sexual abuse will concentrate on responses to hypothetical cases B and F, as the reduced samples of workers rating cases A, C, D and E as abusive would preclude confident interpretation.
Comparison of Workers' ratings of abusiveness for Case B and Case F

The majority of workers gave Case F a higher rating for abusiveness than Case B. A few respondents rated the two situations equivalently abusive, and one respondent judged Case B to be more abusive than Case F. By far the most popular rating for Case F was '5' (47 out of 60 rated it so). While the rating for Case B showed more variability than ratings for Case F, half the sample gave Case B a rating of 4, and a further 25% of the sample rated it 5.

Interventions Recommended by Agency

The number of interventions recommended in Case B and in Case F is examined, first by agency and then by involvement group. Table 13 shows the interventions recommended by each agency in Case B. Because four respondents judged this case non abusive (2 Police, 1 school counsellor and 1 psychologist), they did not recommend intervening. Sample size is therefore reduced to 56 due to the omission of these 4 respondents from the table.
<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>POL</th>
<th>SCH</th>
<th>WEL</th>
<th>MEN</th>
<th>MED</th>
<th>OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=4</td>
<td>n=14</td>
<td>n=8</td>
<td>n=8</td>
<td>n=14</td>
<td>n=8</td>
</tr>
<tr>
<td>Interview Mother</td>
<td>4</td>
<td>12</td>
<td>7</td>
<td>8</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Interview Children</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Interview Step Father</td>
<td>3</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Interview Family</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Report to Police</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report to C.L.P.U.</td>
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<td>3</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Home Visit</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>11</td>
<td>4</td>
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<tr>
<td>Physical Examination</td>
<td>1</td>
<td>1</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych. Eval of Child</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych. Eval of Family</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

\[
\bar{X} = \begin{bmatrix}
5.2 \\
3.5 \\
5.7 \\
5.0 \\
5.8 \\
4.3 
\end{bmatrix}
\]

\* n = 56 because 4 respondents rated Case B non-abusive.

\** \bar{X} = the mean number of recommended interventions by agency and 4.9 = the overall mean number of interventions.**

**N.B. : Small N's preclude statistical analysis of the significance of differences in cell frequencies.**
The number of interventions recommended by each agency in Case F is shown in Table 14. Respondents were unanimous in rating Case F abusive, hence the total sample is represented in Table 14.

**TABLE 14: INTERVENTIONS RECOMMENDED BY AGENCY - CASE F**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>POL</th>
<th>SCH</th>
<th>WEL</th>
<th>MEN</th>
<th>MED</th>
<th>OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=6</td>
<td>n=15</td>
<td>n=8</td>
<td>n=9</td>
<td>n=14</td>
<td>n=8</td>
</tr>
<tr>
<td>Interview Grandmother</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Interview Child</td>
<td>6</td>
<td>12</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Interview Grandfather</td>
<td>6</td>
<td>9</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Interview Family</td>
<td>4</td>
<td>10</td>
<td>5</td>
<td>6</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Report to Police</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Report to C.L.P.U.</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Home Visit</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Psych. Eval of Child</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Psych. Eval of Family</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>\bar{X}</td>
<td>8.3</td>
<td>4.8</td>
<td>6.2</td>
<td>5.8</td>
<td>5.6</td>
<td>5.1</td>
</tr>
</tbody>
</table>

**\bar{X}** = the mean number of recommended interventions by agency and 5.9 = the overall mean number of interventions.

N.B.: Small N's preclude statistical analysis of the significance of differences in cell frequencies.
Comparison of Tables 13 and 14 reveals that, overall, more interventions were recommended in Case F than in Case B (X = 5.9 and 4.9 respectively). In both Case B and Case F, school counsellors recommended fewer interventions than workers from other agencies. Workers from welfare and medical agencies not only recommended more interventions than other workers in Case B, but they also recommended interventions that were unpopular with other workers - e.g. making a home visit and reporting (to the Child Life Protection Unit and/or to the Police). Workers from medical agencies were also much more likely to recommend a physical examination of the children in Case B - an intervention rarely recommended by other workers in this hypothetical situation. In contrast to the many interventions recommended by medical and welfare workers in Case B, involvement of school counsellors rarely went beyond interviewing. The majority of school counsellors settled for further interviews with the mother and the family, and half of them also recommended separate interviews with the stepfather and the children.

For Case F, rated "extremely abusive" by 47 of the 60 respondents, workers from every agency except medical recommended more interventions than they had recommended for Case B. Police surpassed all other workers in the number of interventions they recommended (X= 8.3 of 10 possible interventions). The only intervention that was recommended less often for Case F than for
Case B by most agencies was interviewing the (grand)mother and for most workers (except medical agency), this appeared to be related to their perception of Violet as a client in her own right. That is, a worker was less likely to interview the (grand)mother when perceiving Violet as needing and/or able to take charge of her own life. Reporting of the abuse, both to the Police and to the Child Life Protection Unit, was recommended more frequently by all workers in this more abusive case. Most agencies, except Police and welfare workers, were more likely to report to the Child Life Protection Unit than to the Police, even though the grandfather's admission and collaboration (pregnancy) favoured successful prosecution. Uncertainty about the wisdom of prosecuting, - and its doubtful outcome - in a case where a crime had certainly been committed, probably accounts for police recommending more interventions than other workers in Case F. Police are usually loath to push for prosecution of child sexual abuse cases where they have little likelihood of obtaining a conviction, and, as their rate of recommended interventions suggests, it is these cases that they refer to other agencies.
Interventions Recommended, By Involvement Group.

Tables 15 and 16 (below) show the number and distribution of interventions recommended, by involvement group, in Case B and Case F. Once again, sample size is reduced to 56 in Case B, 4 respondents having rated Case B nonabusive. All 60 respondents are included in Table 16. Chi square was used to determine whether differences between the groups in recommending interventions were statistically significant. Caution is urged in interpreting $\chi^2$ in Table 15, as the expected frequency was less than 5 in 27% of the cells.

It is evident from Table 15 that the No, Low and High Involvement Groups do not differ significantly in the interventions they recommend in Case B. Table 16 shows that, in Case F, workers in the High Involvement Group recommended an interview with Grandfather significantly more often ($p < 0.01$) than did other workers, and they also more frequently recommended a psychiatric evaluation of the child ($p < 0.05$). Of the interventions listed, these two are probably the most difficult, requiring a considerable degree of expertise, and a greater commitment in terms of time and energy. Other differences between the groups in the interventions they recommended failed to reach significance.

Thus, although workers in the High Involvement Group recommended more interventions than other workers in both cases ($X = 5.47$ in Case B, compared with 4.7 and 4.3, and $X = 6.72$ in Case F, compared with 5.26 and 5.21), the differences between the groups in the interventions they recommended were largely non-significant.
### TABLE 15: INTERVENTIONS RECOMMENDED BY INVOLVEMENT GROUP
**CASE B (n=56)**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>NO INV (n=14)</th>
<th>LOW INV (n=23)</th>
<th>HIGH INV (n=19)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Mother</td>
<td>13</td>
<td>20</td>
<td>18</td>
<td>0.85 NS</td>
</tr>
<tr>
<td>Interview Children</td>
<td>9</td>
<td>16</td>
<td>17</td>
<td>3.34 NS</td>
</tr>
<tr>
<td>Interview Stepfather</td>
<td>11</td>
<td>13</td>
<td>15</td>
<td>3.18 NS</td>
</tr>
<tr>
<td>Interview family</td>
<td>8</td>
<td>15</td>
<td>11</td>
<td>0.33 NS</td>
</tr>
<tr>
<td>Report to Police</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>3.27 NS</td>
</tr>
<tr>
<td>Report to C.L.P.U.</td>
<td>7</td>
<td>11</td>
<td>13</td>
<td>2.00 NS</td>
</tr>
<tr>
<td>Home Visit</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>0.73 NS</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>2.44 NS</td>
</tr>
<tr>
<td>Psych Eval of Children</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0.56 NS</td>
</tr>
<tr>
<td>Psych Eval of family</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>0.13 NS</td>
</tr>
<tr>
<td>Mean Number of Interventions</td>
<td>4.7</td>
<td>4.3</td>
<td>5.47</td>
<td></td>
</tr>
</tbody>
</table>

* n=56 because 4 respondents rated Case B non abusive.

n.b. should be treated with caution as e.f. < 5 in 27% of cells

### TABLE 16: INTERVENTIONS RECOMMENDED BY INVOLVEMENT GROUP
**CASE F (n=60)**

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>NO INV (n=15)</th>
<th>LOW INV (n=23)</th>
<th>HIGH INV (n=22)</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Grandmother</td>
<td>11</td>
<td>15</td>
<td>16</td>
<td>0.44 NS</td>
</tr>
<tr>
<td>Interview Child</td>
<td>10</td>
<td>18</td>
<td>21</td>
<td>5.22 NS</td>
</tr>
<tr>
<td>Interview Grandfather</td>
<td>13</td>
<td>13</td>
<td>20</td>
<td>8.55 **</td>
</tr>
<tr>
<td>Interview family</td>
<td>10</td>
<td>13</td>
<td>16</td>
<td>1.32 NS</td>
</tr>
<tr>
<td>Report to Police</td>
<td>5</td>
<td>9</td>
<td>10</td>
<td>0.56 NS</td>
</tr>
<tr>
<td>Report to C.L.P.U.</td>
<td>13</td>
<td>19</td>
<td>16</td>
<td>1.24 NS</td>
</tr>
<tr>
<td>Home Visit</td>
<td>7</td>
<td>9</td>
<td>14</td>
<td>2.79 NS</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>3.93 NS</td>
</tr>
<tr>
<td>Psych Eval of Child</td>
<td>3</td>
<td>9</td>
<td>13</td>
<td>5.70 *</td>
</tr>
<tr>
<td>Psych Eval of family</td>
<td>5</td>
<td>10</td>
<td>13</td>
<td>2.53 NS</td>
</tr>
<tr>
<td>Mean Number of Interventions</td>
<td>5.26</td>
<td>5.21</td>
<td>6.72</td>
<td></td>
</tr>
</tbody>
</table>

* P < 0.05  ** P < 0.01
The Importance of Pressing Charges

There was a high degree of correspondence, for both Case B and Case F, between responses to the question "Would you encourage the parents to press charges?" (Question I) and to the statement "It would be important to press charges" (Question V). Thus, the following will be illustrative of answers to both the question and the statement, although the data presented refer to the statement. Tables 17 and 18 compare responses to the statement for Cases B and F respectively, analysed by agency.

**TABLE 17: THE IMPORTANCE OF PRESSING CHARGES, BY AGENCY**
**CASE B. (QUESTION V)**

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>N</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>UNCERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>4</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Community Nurses</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Doctors</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>56</td>
<td>36</td>
<td>13</td>
<td>7</td>
</tr>
</tbody>
</table>

**TABLE 18: THE IMPORTANCE OF PRESSING CHARGES, BY AGENCY**
**CASE F. (QUESTION V)**

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>N</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>UNCERTAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>15</td>
<td>13</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Welfare</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Community Nurses</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Doctors</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>60</td>
<td>27</td>
<td>20</td>
<td>13</td>
</tr>
</tbody>
</table>
A few more respondents (33% compared with 23%) favoured pressing charges in the more abusive Case F. This was due mainly to more affirmative responses from doctors and police officers in Case F. Perhaps they are more 'results oriented'. Police may be less likely to encourage pressing charges when they have little chance of winning a conviction, as in Case B (where no police recommended pressing charges), than when they have a good case, as in F (where 2 of 6 recommended legal action). Doctors may be more likely to encourage pressing charges where they have irrefutable proof, as in Case F (pregnancy, and grandfather's admission of paternity). But the significance of Tables 17 and 18 lies, not in the greater preference for taking legal action in Case F (as these differences are very small), but in the overall reluctance of workers to press charges in either case. Welfare workers are distinctive in their desire to prosecute, even in the less abusive Case B (50% in Case B, and 75% in Case F). Amongst mental health and other community workers, the severity of the abuse and the likelihood of a conviction seem to have no bearing on whether or not they encourage pressing charges. School counsellors never recommended legal action, in either case.

The Importance of Family Unity in the Aftermath of Incest

Respondents were asked whether they would favour removing the child or the offender to prevent a recurrence of the abuse, and whether they agreed or disagreed with the statement "Every effort should be made to keep the family together". Tables 19 and 20 examine responses to these questions for Cases B and F respectively.
Table 19 shows that, in Case B, removing the children is a most unpopular strategy for ensuring their protection, and over half...
of the respondents favour removal of the stepfather. In contrast, removing Violet is quite a popular strategy in Case F, 58% of the sample suggesting that. Only 23% recommended removing the grandfather, the majority justifying their suggestion in terms of Violet's need to establish a social network of her own, as well as grandmother's dilemma of choosing between siding with her lifelong partner or supporting her granddaughter. It is perhaps noteworthy that psychologists do not favour removing the child to safety in either of these situations; and that half of them advocate removing the offender in the case where this strategy is less popular (23% suggest removing grandfather), yet no psychologist suggests removing the stepfather when 52% of respondents would. Preservation of the family unity was not considered of paramount importance in either case (23% and 15% favouring preserving family unity in Cases B and F respectively).

Reporting Child Sexual Abuse

This study provides five sources for exploring each respondent's reporting behaviour. In the questionnaire, respondents were asked to consider all cases of known or suspected child sexual abuse which they had come across in their professional careers. They were then asked to circle the word which best described their behaviour with these cases, in relation to reporting the abuse to police, welfare or to a body designated to received such reports. (In Canberra, that could be the Child Abuse Committee of the
Health Authority (CAC) or the Child Life Protection Unit of Welfare department (CLPU). The alternatives to be circled were Never, Rarely, Sometimes, Usually and Always. The other four sources of information about reporting behaviour are from the interview. Reporting to the police or to the CLPU (or CAC) were two of the ten interventions each respondents was asked to consider recommending for the hypothetical cases they rated as abusive. Responses to Cases B and F will be considered here, as too few respondents rated the other four cases as abusive.

Table 21 shows responses to the questionnaire concerning the frequency across agencies of reporting suspected child sexual abuse.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>N</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOME TIMES</th>
<th>USUALLY</th>
<th>ALW AYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>6</td>
<td></td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>15</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Welfare</td>
<td>8</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Psychologists</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Workers</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Medical</td>
<td>14</td>
<td>10</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>60</td>
<td>20</td>
<td>11</td>
<td>13</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>
Examination of Table 21 indicates great variation amongst workers in reporting behaviour. One third of respondents claim to have never reported a case of suspected child sexual abuse. However, this number is inflated by the 10 respondents in the sample who have never come across child sexual abuse. At the other extreme, 26% of the sample claim to have always reported suspected child sexual abuse, with the remaining 41% of the sample having reported some, but not all cases. Medical agency personnel stand out as the group of workers least likely to have reported (10 of 14 doctors and nurses claim to have never reported). Once again, this number is inflated by the over-representation in this sample of medical personnel with no experience of child sexual abuse (6 of the 10 with no experience were doctors or nurses). Even so, these figures are suggestive of the antipathy towards reporting (and perhaps even noticing child sexual abuse) amongst doctors, one of the few groups currently mandated to report child sexual abuse in the ACT. Police and welfare workers—also mandated to report—show less variability in their behaviour than other groups. Indeed, they are the only agencies not represented in the 'never having reported' column. Table 22 examines frequencies of respondents' recommendations to report to the police and to CLFU (or CAC) in Case B and Case F, by agency.
TABLE 22: FREQUENCIES OF RECOMMENDATIONS TO REPORT, FROM EACH AGENCY, IN CASE B AND CASE F.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>CASE B - REPORT TO</th>
<th></th>
<th>CASE F - REPORT TO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N POLICE</td>
<td>CLPU</td>
<td>N POLICE</td>
<td>CLPU</td>
</tr>
<tr>
<td>Police</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>School Counsellors</td>
<td>14</td>
<td>3</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Welfare</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Psychologists</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Social Workers</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Medical</td>
<td>14</td>
<td>7</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>31</td>
<td>60</td>
<td>48</td>
</tr>
</tbody>
</table>

(25%) < (55%) < (40%) < (80%)

The most salient feature of Table 22 is the preference for reporting to a specially designated body (e.g. the Child Abuse Committee or the Child Life Protection Unit) rather than to the Police. In both Case B and Case F, workers were twice as likely to report to the CPLU. Many more workers recommended reporting in Case F, which was rated as more abusive than Case B. Psychologists were the only group who chose not to recommend reporting to the police in either case. Social workers and school counsellors were also unlikely to report to the police.

Comparison of Tables 21 and 22 indicates the degree of correspondence between a worker's actual practice and his/her beliefs and intentions. The group which stands out as having the least correspondence between reported practices and recommendations in hypothetical cases is medical agency personnel, the majority of whom say they have never reported a case (10 of 14). Yet when presented with hypothetical cases, half of them recommend reporting...
the less abusive case, and 12 of 14 recommend reporting in Case F. No other obvious discrepancies are evident between a group's reported practices, and intentions as evidenced from recommended interventions in hypothetical cases.

Controversial Statements

The reasons given by respondents for agreeing or disagreeing with each of the twelve controversial statements were examined. It was found that, on average, 7 different reasons covered all responses offered. Each reason was given a code number, and responses were analysed across agencies, by sex, and by involvement group, for each statement. The analysis is mainly descriptive, as small N's precluded the legitimate use of statistical tests of significance. Nevertheless, some interesting trends emerge, particularly in relation to different attitudes of male and female workers, and direct quotes are included to substantiate/illustrate points made.

Statement 1: Children and adolescents often make up stories, or lie or fantasize about being sexually abused.

The majority of respondents (90%) disagreed with this statement. Many (35%) stated emphatically that children and adolescents never make up such stories without there being at least an element of truth. The reason most commonly given (by 22%) was that most children don't have the knowledge to make up stories about being sexually abused. Some respondents linked these two most common responses by citing incidents where children embellished accounts of abuse after being exposed to pornography.
A small percentage of respondents acknowledged that the statement might sometimes be true, but disagreed with the suggestion that it happened often. It is significant that, of the 5 respondents who agreed with the statement, 3 were police and 1 a welfare officer. Four of the five were from the high involvement group. Some of their comments, such as "a lot of adolescents' stories are proven untrue" and "I always leave the door open so the kid can retract the statement" were grossly at odds with the sentiments expressed by the majority of respondents.

**Statement 2**: Children are very sexy and often provoke adults by the way they act. Sometimes they really seem to ask for it.

Most respondents (95%) disagreed with this statement. There were two frequently given reasons which together accounted for 80% of the reasons offered. It was argued that children are sexual beings, not sexy, and that they never "ask for it"; that it is the adult who infers sexual motivation to a child's behaviour; and that he has an obligation to not respond to what he perceives as an invitation to sexual activity. The three respondents who agreed with the statement cited having read 'Lolita', but stressed that the child may be seeking recognition rather than sex.
**Statement 3:** Incest is an accepted part of some subcultures. It's a way of life in some families. They just seem to accept it and don't feel horrified like we would.

There was more uncertainty and a greater variety of responses to this statement, 37% disagreeing, 13% saying they didn't know, so wouldn't accept the statement, and half the respondents agreeing. Dissenters cited the universality of the incest taboo, while those who agreed with the statement mentioned theories of geographic isolation, meaning remote primitive tribes or 'hillbillies'.

**Statement 4:** Incest reflects a caring relationship, in some instances. If we take a blanket view and condemn all incest, we could be disrupting something meaningful.

The majority of respondents strongly disagreed with this statement, and of the 13% who agreed with it, many made reference to situations where the incestuous relationship provided the only form of caring the girl experienced. The most common response (38%) was that incest reflected a relationship that had originally been 'caring', but had gone awry. Frequent mention was also made of the power imbalance, and the exploitative nature of incest (28%).
Statement 5: Incestuous relationships are harmless or less destructive for the child victim than a sexual assault by an outside perpetrator.

Most respondents (97%) disagreed with this statement. They frequently spoke of the betrayal of trust, and the child's loyalty to the offender and consequent concealment of the incest, leading to intense feelings of guilt. They compared this with the greater ease in putting the blame 'out there' and the child not losing all allies in the case of an outside assault. The two respondents who agreed with the statement had had experience with cases of physical trauma caused by a 'child molester'. Fourteen respondents claimed that both were terrible, and that it was impossible to say which was worse in every case.

Statement 6: Over-reaction by parents or society to incest causes the damage. Intervention is intrinsically harmful and cases are better left undiscovered or ignored.

Only one male respondent from the High Involvement Group agreed with this statement, and suggested that, if the victim does not know it is wrong, intervention can be harmful. Many were so preoccupied with disagreeing with this triple-barrelled statement that they did not remember to offer reasons for disagreeing. But where offered, reasons stressed that over-reaction may contribute to, but does not cause the damage. That intervention, although painful and disruptive of family unity at the time, is essential if the girl is to come to terms with what happened, and that it
also provides the only hope of the offender and the family receiving help. Many made reference to the damaging effect of ignoring, as evidenced by the many women seeking help for the sequelae of childhood incestuous experiences.

**Statement 7**: Incest is harmless; most participants in incest suffer no dire consequences and it can even be a positive and consensual experience.

There were two respondents who agreed with this statement, both male, one stating (as he had in response to another statement) that if the child does not know it is wrong, there may be no dire consequence; the other claiming to have read comments in this vein in the literature. However, the majority of respondents (77%) strongly disagreed, saying that their practical experience with incest victims backed up claims in the literature of far-ranging negative sequelae. A small number of respondents (13%), all from the Low Involvement Group, stated that adult-child sex can never be consensual.

**Statement 8**: The family dynamics in incest cases are very complex, but really the mother is the only possible agent of incest control within the family group.

Once again, most respondents disagreed strongly with this statement, and those four subjects who agreed all gave the same reason - that the mother should know what's happening in her own home, playing "watch dog" is part of the maternal role. The most
common reason given for disagreeing was that, although the mother is a very important agent of control, she is by no means the only one. Many respondents (30%) from all agencies except other community workers gave this reason. Community workers were amongst those who nominated the perpetrator as the agent of control, or stressed that children can learn to say "No". Another response commonly given (by 20% of the sample) was that this statement is an instance of "mother blaming", that she may be a victim of abuse in the family too, and that blaming the mother effectively means treating the father like a child.

Statement 9 : The reason men turn to their daughters for sex is because their wives are denying them sex, and they have no other outlet.

A quarter of the respondents agreed with the first part of this statement, citing as support the correspondence between the breakdown of marital relations and the disclosure of incest. Half of these respondents (one-eighth of sample) were from the High Involvement Group. 27% disagreed with the statement overall, but saw denial of sex by the wife as just one possible reason for incest. The majority, however, were vehement in their disagreement. All respondents took issue with the last part of the statement, claiming that, particularly in this age of sexual licence, it is absurd to speak of a man having no sexual outlets. Many mentioned the ubiquitous outlet of masturbation, or the falsity of the myth that sexual frustration has dire consequences for men. Incest and rape workers saw this statement as a reflection of the basic need of men to be powerful, and 18% of respondents said there is no evidence for this statement at all.
Statement 10: Mothers know, either consciously or unconsciously, that the incest is occurring, and choose to stay with their husbands rather than to protect their daughters.

There was less consensus in responses to this statement than to any other. 55% of respondents agreed with the statement overall, saying that some proportion of mothers know, that they have a lot to lose by disclosing, and that there are many reasons why they stay with their husbands. The majority of respondents who disagreed (38%) gave reasons similar to those given by the 55% in agreement with the statement. Their disagreement was based on their reluctance to make such a sweeping generalization, and on their insistence that the woman's powerlessness obviates choice.

Statement 11: Everyone in the family is equally responsible for the incest.

Most respondents (88%) disagreed with this notion of equal responsibility of all family members for the incest. They saw the father (perpetrator) as the only person responsible or as most responsible, with 28% citing the parents as equally responsible. Many saw the victim as least responsible, or remarked that little children cannot be accountable for their parent's behaviour. 7% stated that allowing incest to occur does not make all family members responsible for it, but the remaining 5% felt that knowledge implied responsibility to do something, and they therefore agreed with the statement.
Statement 12: He must be sick or deviant: there's got to be something wrong with a father who does that sort of thing to his daughter.

The words 'sick' or 'deviant' came in for a lot of comment from respondents from all agencies. In all, 57% objected to the implication in these words of psychiatric problems in the father. Many respondents cited the literature or personal experience in support of the 'normality' of incest offenders. A reason frequently given for disagreeing with the statement was that the abuse of power, rather than individual disturbance, is the important feature in incestuous families. 50% of respondents giving this reason were incest or rape workers. However, there was a sizeable number of respondents (23%), representing most agencies, who agreed that such a father is definitely psychiatrically disturbed.
CHAPTER 9: DISCUSSION AND CONCLUSIONS

Exposure to the Problem

In this sample of 60 professionals from agencies throughout Canberra, child sexual abuse was not an unfamiliar subject - many had attended workshops and seminars, or read extensively on the topic. However, experience in handling these cases was not uniform amongst agencies. Medical personnel - community nurses in particular - had seen few cases. In fact, of the 10 workers without practical experience, 6 were medical people. In comparison with Finkelhor's sample of workers in Boston (Finkelhor, 1984a, p.216), experience levels were comparable, but more uniform amongst the American workers. School personnel were the least likely to come in contact with child sexual abuse in Boston - 40% having had no experience - whereas in Canberra, only 20% of the school counsellors sampled had no experience. The different procedures used for recruiting subjects in this study and Finkelhor's should have favoured Finkelhor, as regards experience, since he recruited his subjects from attendees at seminars and workshops on child sexual abuse. Presumably they were interested in (and thus more likely to have been exposed to) child sexual abuse. The fact that both studies sampled a comparable proportion of inexperienced workers is surprising, in that child sexual abuse is a more visible problem in the United States, and has been researched more extensively there than in Australia.
Finkelhor found agency to be a more powerful predictor of behaviour and attitudes than profession, whereas, amongst certain professions, that was not true in this study. In mental health facilities, social workers at times responded quite differently from psychologists, and in community health centres, doctors' and nurses' ratings of abusiveness, and the goals of their interventions, were disparate enough to warrant separate analysis. In addition, there was more consensus amongst doctors and amongst psychologists, although their responses were at times quite distinctive from the overall sample; whereas the responses of social workers and community nurses spanned a much broader range - there was less agreement about management of child sexual abuse within these professions. Results have been tabulated by profession in these instances.

**Reporting Child Sexual Abuse**

When this sample of workers from Canberra answered questions about the child sexual abuse cases they had handled during their professional careers, one third indicated they had never reported child sexual abuse, while a quarter (26%) answered that they always reported. The figure for those who have never reported is inflated by the inclusion of workers who have never handled a case of child sexual abuse. When these subjects are excluded, the proportion who never report drops to 17%. Almost half of the experienced workers who never report are medical personnel (i.e., the 17% comprises 7% doctors and nurses, 10% workers from all other agencies combined). Police and welfare workers were the only agencies without representatives amongst those who never
report - they report either always or usually. Thus, of the three groups currently mandated to report child sexual abuse in Canberra, welfare workers and police comply in most cases, whereas amongst medical personnel, there are some who always report, some who choose not to, and others who have never recognised a sexually abused child amongst their patients. Reasons for this failure to recognise (or, perhaps, failure to acknowledge having recognised) child sexual abuse by community nurses, and by doctors working in schools and community health centres in Canberra, were not tapped by the structured interview format of this study. Experiences in both England and the United States suggest that a professional in such a role

"may well be the first person to recognise child sexual abuse, either as a result of disclosures by parent or child, or because of suspicions aroused whilst seeing the child." (Porter, 1984, p.94)

When recommending interventions in hypothetical cases, Canberra's workers were twice as likely to report the abuse to the Child Life Protection Unit as to the police. Fifty-five percent recommended reporting Case B to the Child Life Protection Unit, while 80% recommended reporting Case F. Case B is quite similar to the vignette Finkelhor used. Both involve a stepfather as the perpetrator, but while Finkelhor's vignette involves 'molestation', the one in this study specifies only masturbation in front of the stepdaughters. Finkelhor reports that 66% of workers recommended reporting the abuse in the hypothetical situation to Department of Social Security, DSS (the designated authority). This figure corresponds closely with the 64% of those who should have and actually did report their last case
(Finkelhor, 1984a, p.205 & 207). Furthermore, allowing for the fact that Finkelhor's vignette depicted a more abusive situation, it appears that similar proportions of workers recommended reporting child sexual abuse to the designated authority in Boston (66%) and Canberra (55%).

It would seem, from both this study and Finkelhor's, that actual behaviour and recommendations in a hypothetical case correspond quite closely, as regards reporting child sexual abuse. Workers in both studies were less likely to report child sexual abuse to the police than to the designated authority, but both studies found some resistance to reporting amongst those workers mandated to report. Antipathy towards the police was stronger amongst workers from Boston.

**Involvement Index**

The 'Involvement Index' devised for this study holds promise as a means of evaluating the commitment of child sexual abuse workers from different agencies. The following modes of working with cases differentiated workers whose involvement (in terms of time, energy and commitment) could be described as 'high' from those with 'low' involvement:

- Whenever I come across a case of known or suspected child sexual abuse, I:
  - Investigate further to try to establish whether or not abuse occurred.
Help the family through the crisis by informing the parents of the likely course of events, advising them of local services/facilities, and in cases of intrafamilial abuse, I arrange temporary placement for the child if this seems necessary to ensure that abuse stops.

- handle the family crisis following disclosure, then try to maintain equilibrium in the family.

- Work intensively with the victim, perpetrator or other family members, as part of a multidisciplinary team.

- As principle therapist and member of a multidisciplinary team, see the case through from the family crisis following disclosure to court, if prosecution is pursued.

Discriminant function analysis of responses to the questionnaire items confirmed that the above items accounted for the majority of variance between the High and Low Involvement groups. The centroids for the Low and High Involvement groups were -0.90 and 0.98 respectively, indicating that the Low and High Involvement groups were very well discriminated - there being little overlap between the groups in the scatter of scores. Appendix 10 shows the discriminant function analysis ranking of questionnaire items from most to least discriminatory between the Low and High Involvement groups. This instrument requires validation using another sample of workers from different agencies before its utility in gauging worker commitment is confirmed.
One of the most interesting findings in this study is that the lower a worker's involvement index, the more likely he/she is to judge a situation 'abusive'. A frequent comment was that the vignettes provided insufficient information for a worker to make a confident rating of abusiveness. Yet, workers who had no case experience, and/or those who never or rarely worked with cases in the 5 ways outlined above, were likely to rate the case abusive on what experienced workers would call 'insufficient grounds'. Referral information is usually also incomplete, and one could surmise that a worker who rated a hypothetical situation as abusive on the basis of insufficient evidence might rush in, perhaps inappropriately, where experienced workers would exercise more caution. This tendency amongst some workers to "act before they fully know what needs to be done" (Finkelhor, 1984a, p.200) may be more attributable to inexperience than to idiosyncratic worker attitudes, as hypothesized at the beginning of Chapter 6. It could be premature intervention that concerned American professionals refer to as "the inept handling of cases by inexperienced workers".

In addition to finding that workers in the High Involvement group rate fewer cases as abusive, the results also show a tendency, amongst these highly committed workers, to become more involved with these cases than do other workers. However, the differences between the mean number of interventions recommended by the High, Low, and No Involvement groups (6.72, 5.26 and 5.21 in Case F; 5.47, 4.7 and 4.3 in Case B) failed to reach significance. This trend is noted, but awaits confirmation from further research.
These results also show, in Case F, that highly committed workers recommend more 'difficult' interventions. Thus, those in the High Involvement group recommended an interview with the grandfather and a psychiatric evaluation of the girl much more often than did other workers. The differences between involvement groups on these interventions are significant ($p<0.01$ for interviewing grandfather; $p<0.05$ for psychiatric evaluation).

The distribution of Involvement Index scores across agencies show that there are some highly committed workers in each agency, but the pattern of index scores across professions, in this sample at least, is quite distinctive. Earlier comments about the preponderance of doctors and nurses in the No Involvement group were in relation to their lack of exposure to child sexual abuse. It would seem reasonable to suggest 'denial' as an explanation of the finding that 71% of this sample of doctors and community nurses fell in the No Involvement group. However, anecdotal remarks and informal feedback, from the nurses in particular, led me to discount that explanation as too simplistic, but failed to indicate alternative explanations. This area warrants investigation.

**Proposed Interventions in the Hypothetical Situations**

This study confirms some but not all, of the patterns shown by workers from different agencies in Finkelhor's study, in the interventions they recommend. In particular, the school personnel in this sample recommended fewer interventions than other workers, and welfare workers not only recommended more
interventions - they also chose some interventions that were unpopular amongst other workers (e.g., making a home visit and reporting to the police). The workers in this sample were less likely to recommend a physical examination than were the Boston workers, but placed a higher priority on interviewing the offender than did the workers in Finkelhor's sample. The group of workers which differed most from Finkelhor's workers was the police. Canberra police recommended more interventions than workers from any other agency in Case F, whereas the Boston Police were loath "to propose interventions that went outside their own realm" (p.208). This is surprising, since sexual abuse law reform in most states of America should facilitate prosecution (and thus involve the police); whereas, in Canberra, some of the statutes, dating back to early this century, severely limit the chances of successful prosecution. Perhaps it is this very factor - the low likelihood of successful prosecution - that accounts for Canberra police recommending so many interventions. Once police have an admission of guilt, they may not necessarily want to push for prosecution, since there is a strong tradition against prosecuting incest in this country, and rehabilitative programs do not operate in jails. In addition, police have such limited contact with the Department of Corrective Services, and so little sway in the courtroom, that once prosecution proceedings commence, the case may be taken out of their hands and they may lose contact with the offender.
The Goals of Intervention

Particular interest surrounds the issue of whether one should treat or punish child sexual abuse. Case B will not be considered with respect to pressing charges, as a stepfather masturbating in front of his daughters is not breaking the law in the A.C.T. Case F, in contrast, clearly involves a crime. The results indicate a reluctance to press charges in workers from all agencies, except welfare. Seventy-five percent of welfare workers thought charges should be brought against the grandfather, compared with thirty-three percent of workers overall. Finkelhor also found that pressing charges was favoured by only one group - the criminal justice workers! His DSS workers (the equivalent of welfare workers in the A.C.T.) were quite opposed to taking legal action.

Removing an abused child from the family is a most unpopular strategy amongst workers from both Boston and Canberra. Focusing on the scenario in Case F is less appropriate here, since the girl is 15 and pregnant, and living with grandparents. Many respondents were more concerned about her need to make a life for herself independent of aging caretakers, than about the need to protect her from further abuse. In Case B, only 4% of workers in Canberra recommended removing the children. This is comparable to the 7% of Boston workers favouring this option. But the goals appear different - Bostonian workers did not favour removing the stepfather either (12%), and were predominantly supportive of preserving family unity (62%). In contrast, 52% of Canberran workers favoured removing the stepfather, even though the
Vignette specifies that the mother "wanted the marriage to work". The proportion advocating that the family should be kept together was quite low - 23%. These results suggest that, while workers from both Boston and Canberra would prefer not to remove a sexually abused child from her family, Canberran workers may be more concerned about the literature reports of self-blame experienced by victims as a result of this strategy; workers from Boston, preferring not to remove either victim or offender, may be motivated by a desire to preserve family unity.

A more specific comparison between workers charged with primary responsibility for child protection (Welfare and DSS workers) highlights the differing goals behind their apparently similar levels of intervention. Finkelhor (1984a) reports that DSS workers have a "positive attitude toward trying to keep the family together and a negative attitude towards pressing criminal charges" (p.210). Welfare workers here, in contrast, give preservation of the family lower priority and seem more punitive, in that they favour pressing charges (while the majority of Canberra workers do not).

There appear to be few barriers to inter-agency collaboration in Canberra, in that the philosophies of different agencies, inferred from goals of interventions, coincide. It seems quite appropriate - given their responsibility for child protection - that welfare workers press harder for criminal charges to be brought against adults who sexually abuse children.
Attitudes of Canberra's Child Sexual Abuse Workers to Incest

From the responses of workers to the twelve controversial statements, the following picture of the attitudes of Canberra's child sexual abuse workers emerges:

Professional opposition to incest seems to be based on the inability of a child to give free and informed consent to sexual relations with an adult—particularly if that adult is in a position of trust and authority, as is true in incestuous child sexual abuse. Opposing incest on moral grounds was never mentioned as a primary reason. Workers justified intervening where parents fail to act in terms of the necessity to protect the child's rights. In this respect, they are professing to act in accordance with YACS's 1980 objectives:

"To establish the rights of children to protection from neglect, abuse, and exploitation as paramount to any presumed or actual right, authority, or power of any adult or institution." (Lightfoot, 1980b, p.177)

Most workers in Canberra are aware of the pro-incest lobby, but none had found support for this point of view in their professional or personal experience. Some professionals had come across families where incest is an accepted fact of life. In such situations, where obvious trauma to the victim does not necessarily result from the incestuous relationship, it was thought that the realization of community condemnation—sometimes occasioned by intervention, more often an inevitable result of the greater awareness of community values that comes with age and life experience—causes severe distress. Some workers hold that such realization is more traumatic for the
victim than is an ongoing, non-violent incestuous relationship of several years' duration.

All workers stressed the responsibility of the perpetrator for his own behaviour, and resisted ideas which seek to place blame for incest on the victim or her mother. Childhood is still equated with innocence and naturalness, although most workers hold that children of all ages show an awareness of and interest in sexuality. Most workers emphasise the importance of taking a child's account of sexual abuse as factual - some making explicit mention of the need to counteract the habit of many adults of disputing such accounts. Police personnel, in particular, profess to having no difficulty discerning instances where a child has embellished a story. Some workers stressed the greater likelihood of a child failing to mention significant aspects of the abuse, rather than making false accusations. There was little professional endorsement of some adults' accounts of children initiating sexual contact. Rather, most workers take the view that a child's needs for nurturance may be misperceived by adults as requests for sexual contact, and a child will gladly accept an incestuous relationship in an environment devoid of nurturance.

The variety of responses about the role of the mother in incest revealed this as the area most influenced by early psychoanalytic writers. Many workers without practical experience in handling child sexual abuse thought a mother must know if incest is occurring, although they were often at a loss to reconcile this with the 'natural' inclination to protect one's children. The dilemma mothers face seemed more apparent to experienced workers,
some of whom stressed the unreasonable standards of surveillance and protection that society expects of mothers. Regardless of how a worker sees a mother as implicated in incest, all agree on her centrality in effecting change in the family. Workers who focused on the ability of children to combat incest through educative programs also emphasized the perpetrator taking responsibility for his behaviour. All recognized the aggravation of family disruption that intervention entails, but saw this as short-term, and preferable to the further trauma of untreated incest. Sexual deprivation was rejected as the prime motivation for incest, although many workers interpreted the coincidence of expressed dissatisfaction with the marital relationship and father-daughter incest as evidence for its role in the dynamics of 'incestuous families'.

But the importance of theoretical models seemed minimal in these workers' handling of cases, as most of this sample of professionals stressed understanding the uniqueness of each case, rather than looking for commonalities. Statements which tried to tap a worker's conceptualization of the role of the mother, or underlying reasons for the abuse, frequently provoked comments about gross generalizations involved, suggesting that such questions pose great difficulty for many of these Canberra professionals. (Indeed, the generalizations which most of the statements entailed could have justified similar responses, but did not).
The responses of this sample of Canberra professionals to the vignettes and the statements reflects a preference for operating with child sexual abuse cases from an action-oriented, pragmatic mode, with little reference to underlying constructs. Given the number of competing models and the variety of untested treatment programs that have evolved, this is not an unexpected finding.

**Implications and Recommendations**

Interest in child sexual abuse has come mainly from feminists and child protection workers, but, despite differences in philosophy and case management styles, workers in this area have managed to amalgamate these disparate orientations quite successfully. In this sample of workers from various professions and agencies in Canberra, the similarities in objectives and strategies to achieve them are more striking than are their differences. What appears more problematic is the rift that is evident between theory and practice. Theory development and evaluation of case management alternatives requires much more interface between researchers and 'hands-on' workers than has occurred so far. This problem is not unique to Australia - Finkelhor (1984a) cites it as the major deterrent to progress in this area in the United States at this stage.

However, there are other problems which, while they may not be more pressing, at least seem to have more evident solutions. The most critical in Australia is definition of child sexual abuse. If WELSTAT definitions and classification were incorporated into each state's reporting legislation, the objective of gathering
national data for planning and evaluation of services would be more achievable, at least in states where reporting is mandated. Current anomalies would need to be addressed (e.g., the failure to record the sexual abuse of a child suffering other forms of maltreatment), and the system modified by feedback from users. There is also an urgent need for a large-scale survey of the sexual abuse experienced during childhood by Australian adolescents and/or young adults. We have relied on estimates based on 'clinical' incidence in other countries for too long. Of particular importance in clarifying our knowledge of incidence of child sexual abuse is study of the sexual abuse of boys, and by boys of their younger sisters. Definitions will need to be broad enough to avoid the arbitrary exclusion of 'sibling incest'.

But the most immediate problem in Canberra would appear to be determination of the sources of medical personnel discontent with current reporting and/or treatment practices. The antipathy expressed by medical personnel involved in this study towards even talking about child sexual abuse contrasts markedly with the widespread acknowledgement of the problem by other workers, coupled with the desire for community education and collaborative efforts to improve clinical skills and service provision. This unexpected resistance (to participating in the study and to confronting child sexual abuse even verbally) could reflect discomfort with a perception of ultimate medical responsibility
for this problem. The widespread distrust of police and welfare workers amongst clinicians in Canberra was not expressed to this researcher during in-depth (but highly structured) interviews, despite the apparentness of these rifts between agencies to even a novice Canberra clinician. The 'small town' exposure of Canberra workers may have militated against candour.

With the introduction of the new Welfare Ordinance so imminent, workshops with attendees from different agencies and the judiciary, set up to investigate how to routinize A.C.T. responses to child sexual abuse, and to operationalize the role of the Youth Advocate, seem crucial. Committee and ministerial discussion and bureaucratic red tape have obstructed the passage of this legislation for far too long.
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APPENDICES

Appendix 1: DSM III - Description of Post-traumatic Stress Disorder

Appendix 2: Questionnaire

Appendix 3: Obtained T values

Appendix 4: Instructions and vignettes

Appendix 5: Interventions and probe questions

Appendix 6: Twelve controversial statements

Appendix 7: Service Utilization data sheets

Appendix 8: Court Statistics data sheets

Appendix 9: Police data sheets

Appendix 10: Discriminant Function Analysis
Appendix 1

DSM III - Description of Post-traumatic Stress Disorder

236 Diagnostic Categories

308.30 Post-traumatic Stress Disorder, Acute

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture) and others produce it only occasionally (e.g., car accidents). Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor may be noted on Axis IV (p. 26).

The traumatic event can be reexperienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is reexperienced. In rare instances there are dissociativelike states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal sleep disturbance may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are
often avoided. Symptoms characteristic of Post-traumatic Stress Disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or uniformed guards for death-camp survivors, hot, humid weather for veterans of the South Pacific).

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder. Increased irritability may be associated with sporadic and unpredictable explosions of aggressive behavior, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behavior can occur, such as sudden trips, unexplained absences, or changes in life-style or residence. Survivors of death camps sometimes have symptoms of an Organic Mental Disorder, such as failing memory, difficulty in concentrating, emotional lability, autonomic lability, headache, and vertigo.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after a latency period of months or years following the trauma. When the symptoms begin within six months of the trauma and have not lasted more than six months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than six months after the trauma or last six months or more, the chronic or delayed subtype is diagnosed.

Impairment and complications. Impairment may either be mild or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may result in occupational or recreational impairment. "Psychic numbing" may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Substance Use Disorders may develop.

Predisposing factors. Preexisting psychopathology apparently predisposes to the development of the disorder.

Prevalence. No information.

Sex ratio and familial pattern. No information.

Differential diagnosis. If an Anxiety, Depressive, or Organic Mental Disorder develops following the trauma, these diagnoses should also be made. In Adjustment Disorder, the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.
Appendix 1

DSM III - Description of Post-traumatic Stress Disorder

238 Diagnostic Categories

Diagnostic criteria for Post-traumatic Stress Disorder

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:
   (1) recurrent and intrusive recollections of the event
   (2) recurrent dreams of the event
   (3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:
   (1) markedly diminished interest in one or more significant activities
   (2) feeling of detachment or estrangement from others
   (3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:
   (1) hyperalertness or exaggerated startle response
   (2) sleep disturbance
   (3) guilt about surviving when others have not, or about behavior required for survival
   (4) memory impairment or trouble concentrating
   (5) avoidance of activities that arouse recollection of the traumatic event
   (6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

SUBTYPES

Post-traumatic Stress Disorder, Acute

A. Onset of symptoms within six months of the trauma.

B. Duration of symptoms less than six months.

Post-traumatic Stress Disorder, Chronic or Delayed

Either of the following, or both:
   (1) duration of symptoms six months or more (chronic)
   (2) onset of symptoms at least six months after the trauma (delayed)

300.00 Atypical Anxiety Disorder

This category should be used when the individual appears to have an Anxiety Disorder that does not meet the criteria for any of the above specified conditions.
Throughout this survey the word 'incest' will be used to mean sexual abuse of a child by an adult in an authority position (e.g. parent [de facto, step or biological] or relative). Could you please answer the following questions either by providing the required information or circling the appropriate response.

1. AGE [21 - 25] [26 - 30] [31 - 35] [36 - 40] [41 - 45] [46 - 50] [51+] (optional)

2. SEX:

3. OCCUPATION:

4. NO. OF YEARS IN PRACTICE:

5. SPECIALIST INTEREST:
   (e.g. Autism, Dyslexia, Childhood sexuality).

6. EMPLOYER:

7. DURING MY CAREER, I HAVE BEEN INVOLVED WITH [ ] CASES OF KNOWN OR SUSPECTED INCEST

8. EXTENT OF INVOLVEMENT: (PLEASE CIRCLE)

When I have come across a case of known or suspected incest, I:

(a) Reported the abuse to Police, Welfare or to a body designated to receive such reports. NEVER RARELY SOMETIMES USUALLY ALWAYS

(b) Investigated further to try to establish whether or not abuse occurred. NEVER RARELY SOMETIMES USUALLY ALWAYS

(c) Referred the case to Health, Welfare, Police or other agency for substantiation. NEVER RARELY SOMETIMES USUALLY ALWAYS

(d) Referred the case to Welfare department for management. NEVER RARELY SOMETIMES USUALLY ALWAYS

(e) Referred the case to the Health Authority for intensive treatment and maintained telephone contact with the family. NEVER RARELY SOMETIMES USUALLY ALWAYS
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**Appendix 2: Questionnaire**

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<tr>
<td>Helped the family through the crisis by informing the parents of the likely course of events, advising them of local services, and arranging temporary placement for the child.</td>
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<td>Handled the family crisis following disclosure, then tried to maintain confidentiality of the child.</td>
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<tr>
<td>Handled the family crisis following disclosure, then maintained equilibrium in the family by acting as the family's therapist.</td>
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<tr>
<td>As member of a multidisciplinary team, helped the family through the crisis of disclosure, then worked intensively with the victim or perpetrator as therapist.</td>
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<tr>
<td>As principle therapist and member of a multidisciplinary team, saw the case through from the family crisis right through to court, where I played a role in the prosecution or defence of the case.</td>
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</table>

Thank you for supplying the above data. Your cooperation is very much appreciated.
Appendix 3: Obtained T Values

For Questionnaire Items B - J.

( d.f. = 48 )

Q B \quad t = 1.916 \quad \text{Significant (p < 0.05)}
Q C \quad t = 0.473 \quad \text{N.S.}
Q D \quad t = 0.687 \quad \text{N.S.}
Q E \quad t = 0.242 \quad \text{N.S.}
Q F \quad t = 4.36 \quad \text{Significant (p < 0.001)}
Q G \quad t = 1.604 \quad \text{N.S.}
Q H \quad t = 2.878 \quad \text{Significant (p < 0.01)}
Q I \quad t = 2.878 \quad \text{Significant (p < 0.01)}
Q J \quad t = 3.032 \quad \text{Significant (p < 0.01)}
Appendix 4: Instructions and Vignettes

Child Sexual Abuse can be readily recognised when it involves clear-cut horrific examples which leave no doubt that the child needs protection from his or her caregivers. However there is a large grey area of situations about which there is much less consensus. I shall give you a series of cards on which are outlined situations which you may or may not think abusive. Please read each example carefully, and then rate the situation on a scale from 1 to 5, where 1 represents O.K. parenting, and 5 represents extreme child abuse.

1. The Parker family have always been uninhibited about being naked in their home since their children were little. Now the children are 10 and 12 and they still wrestle with their father on the floor. Last week Mrs Parker talked to her doctor about an incident where Mr Parker got an erection while wrestling with Cathy. Mrs Parker intervened but wondered if it was the first time that had happened and what would have happened if she had not been there.

2. Joan was in a dilemma. Her 8 and 10 year old daughters were usually truthful with her. They described to her how their stepfather sometimes took them to the garage and masturbated in front of them. Joan had only remarried a year ago and wanted this marriage to work.

3. Mr and Mrs Johnson and their son Steven had always been close. Steven used to go into his mother's bed after his father left for work every morning from when he was a toddler till the end of primary school and occasionally since he entered high school. His parents were surprised when requested to come to an interview with the school counsellor and principal to discuss Steven's depression and poor adjustment at high school. Steven is 15.

4. Dimitri was in Sixth Class and a real problem for his teacher. The other boys told how he played with himself and got an erection in the playground and boasted about how he went to bed with his 10 year old sister. He was an aggressive and often lonely boy.

5. Mrs Wilson was staying with her daughter and son-in-law and their two small children Josephine 6 and William 4. She came across some photos which her son-in-law had taken of his wife and Josephine naked. There was also one of a friend of Josephine wearing only a top. Mrs Wilson's son-in-law explained that the family were sun lovers.

6. Violet was 15. She was slightly retarded. She lived with her grandparents and rarely went out. They had cared for her since she was 3. When Violet became pregnant and the baby was to be adopted, her grandfather admitted that he was the father of the baby. Violet was very fond of her grandfather and had not complained to anyone about his sexual advances.
Appendix 5: Interventions and Probe Questions

INSTRUCTIONS

How did you rate this situation? Remember No. 1 represents an Ok, non-abusive situation and No. 5 represents extreme child abuse.

1 2 3 4 5

(If rated between 3 and 5)

What intervention strategies would you recommend?

a. Interview mother
b. Interview child
c. Interview alleged perpetrator
d. Interview family
e. Report to Police
f. Report to Child Abuse Committee
g. Home visit
h. Physical examination
i. Psychiatric evaluation of child
j. Psychiatric evaluation of family

Amongst your recommended interventions, would you

I. Encourage the parents to press criminal charges? Y/N
II. Try to get the child removed from the family? Y/N
III. Try to get the perpetrator removed from the family? Y/N

With this situation in mind, would you agree or disagree with the following statements:

IV. Every effort should be made to keep the family together.

AGREE / DISAGREE

V. It would be important to press charges.

AGREE / DISAGREE

(If rated 1 or 2)

Why did you rate it "x"?
Appendix 6: Twelve controversial statements

Now I am going to make some controversial statements, and I would like you to state whether you agree or disagree, and then give a brief explanation of your reasons. Take as little time as necessary to consider your remarks. I will ask questions if I am unsure whether I have understood what you mean; otherwise I will simply note your responses.

Statement 1.
Children and adolescents often make up stories or lie or fantasize about being sexually abused.

Statement 2.
Children are very sexy and often provoke adults by the way they act. Sometimes they really seem to "ask for it".

Statement 3.
Incest is an accepted part of some sub-cultures. It's a way of life in some families. They just seem to accept it and don't feel horrified like we would.

Statement 4.
Incest reflects a caring relationship, in some instances. If we take a blanket view and condemn all incest, we could be disrupting something meaningful.

Statement 5.
Incestuous relationships are harmless or less destructive for the child victim than a sexual assault by an outside perpetrator.

Statement 6.
Over-reaction by parents or society to incest causes the damage. Intervention is intrinsically harmful and cases are better left undiscovered or ignored.

Statement 7.
Incest is harmless; most participants in incest suffer no dire consequences and it can even be a positive and consensual experience.

Statement 8.
The family dynamics in incest cases are very complex, but really the mother is the only possible agent of incest control within the family group.

Statement 9.
The reason men turn to their daughters for sex is because their wives are denying them sex, and they have no other outlet.

Statement 10.
Mothers know, either consciously or unconsciously, that the incest is occurring, and choose to stay with their husbands rather than to protect their daughters.

Statement 11.
Everyone in the family is equally responsible for the incest.

Statement 12.
He must be sick or deviant; there's got to be something wrong with a father who does that sort of thing to his daughter.
CHILD ABUSE SERVICE UTILIZATION DATA

Please send a copy of the national data on service utilization to:

Name:
Address:

1. Percentage of substantiated cases reported to your agency in 12 months ending 31-12-84 of:

<table>
<thead>
<tr>
<th>PHYSICAL ABUSE</th>
<th>EXTRAFAMILIAL SEXUAL ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRAFAMILIAL SEXUAL ABUSE</td>
<td>OTHER ABUSE</td>
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</table>

intrafamilial = the abuse that took place in the child's home, abuser regularly resident in the house or the abuser was a blood relation.

2. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-84 by age and sex of victim and offender (Abuse not involving oral, anal or vaginal penetration).

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<tr>
<th>AGE &amp; SEX OF OFFENDER</th>
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</table>
3. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-84 by age and sex of victim and offender (Abuse involving oral, anal or vaginal penetration).

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</table>
4. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-83 by age and sex of victim and offender (Abuse not involving oral, anal or vaginal penetration).

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<th>AGE &amp; SEX OF OFFENDER</th>
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5. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-83 by age and sex of victim and offender (Abuse involving oral, anal or vaginal penetration).

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<tr>
<th>AGE &amp; SEX OF OFFENDER</th>
<th>16 - 19</th>
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</table>
6. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-82 by age and sex of victim and offender (Abuse not involving oral, anal or vaginal penetration).

<table>
<thead>
<tr>
<th>AGE &amp; SEX OF OFFENDER</th>
<th>16 - 19</th>
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<th>25 - 39</th>
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<td>AGE &amp; SEX OF CHILD</td>
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7. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-82 by age and sex of victim and offender (Abuse involving oral, anal or vaginal penetration).

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<th>AGE &amp; SEX OF OFFENDER</th>
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8. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-81 by age and sex of victim and offender (Abuse not involving oral, anal or vaginal penetration).

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<th>AGE &amp; SEX OF OFFENDER</th>
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9. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-81 by age and sex of victim and offender (Abuse involving oral, anal or vaginal penetration).
10. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-80 by age and sex of victim and offender (Abuse not involving oral, anal or vaginal penetration).

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<th>AGE &amp; SEX OF OFFENDER</th>
<th>AGE &amp; SEX OF CHILD</th>
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11. Substantiated cases of intrafamilial child sexual abuse reported to your agency in 12 months ending 31-12-80 by age and sex of victim and offender (Abuse involving oral, anal or vaginal penetration).

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<th>AGE &amp; SEX OF CHILD</th>
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## CHILD ABUSE SERVICE UTILIZATION DATA

12. **Age of child at time of reporting, by age of child when abuse began:**

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<th>CURRENT AGE OF CHILD</th>
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13. **Substantial cases of intrafamilial child sexual abuse reported to your agency each twelve months ending 31st December by relationship of offender to victim.**

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**MOTHER'S BOYFRIEND:** Casual, non defacto relationship.

**FATHER'S GIRLFRIEND:** Casual, non defacto relationship.
Appendix 8: Court Statistics data sheets

PAGE 1

HIGH COURT DATA

Sexual assault and other sexual offenses committed by an adult against a child (proven) during the periods indicated, by age of offender, relationship to victim and victim's sex.

1. 12 MONTHS ENDING 31-12-80

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G = girls  B = boys  Family = father (incl step & de-facto), brother  
Kin = uncle, grandfather or cousin
### Appendix B: Court Statistics data sheets

#### PAGE 2

2. **12 MONTHS ENDING 31-12-81**

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* = girls  B = boys  Family= father(incl step & de-facto), brother  
*Kin= uncle, grandfather or cousin

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3. **12 MONTHS ENDING 31-12-82**

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* = girls  B = boys  Family= father(incl step & de-facto), brother  
*Kin= uncle, grandfather or cousin
### Appendix 8: Court Statistics data sheets

#### PAGE 3

**4. 12 MONTHS ENDING 31-12-83**

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= girls  B= boys  Family= father(incl step & de-facto), brother
Kin= uncle, grandfather or cousin

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**5. 12 MONTHS ENDING 31-12-84**

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= girls  B= boys  Family= father(incl step & de-facto), brother
Kin= uncle, grandfather or cousin
6. Type of penalty given sexual offenders against children during **1984**.

### TYPE OF PENALTY

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Sexual assault and other sexual offenses committed by an adult against a child (proven) during the periods indicated, by age of offender, relationship to victim and victim's sex.

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G = girls  B = boys  Family = father (incl step & de-facto), brother  
Kin = uncle, grandfather or cousin
### Appendix 8: Court Statistics data sheets

#### PAGE 2

2. **12 MONTHS ENDING 31–12–81**

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= girls  B= boys  Family= father(incl step & de-facto), brother  
Kin= uncle, grandfather or cousin

3. **12 MONTHS ENDING 31–12–82**

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= girls  B= boys  Family= father(incl step & de-facto), brother  
Kin= uncle, grandfather or cousin
Appendix 8: Court Statistics data sheets

PAGE 3

4. 12 MONTHS ENDING 31-12-83

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<td>DSL</td>
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</tr>
</tbody>
</table>

- girls  B= boys  Family= father (incl step & de-facto), brother  
  Kin= uncle, grandfather or cousin

5. 12 MONTHS ENDING 31-12-84

<table>
<thead>
<tr>
<th>GE OF FENDER</th>
<th>16 TO 19</th>
<th>20 TO 24</th>
<th>25 TO 39</th>
<th>40 TO 59</th>
<th>60+</th>
<th>NOT STATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>-</td>
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<td>-</td>
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<td>ST</td>
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<tr>
<td>DSL</td>
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<td>G</td>
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<td>B</td>
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</tr>
</tbody>
</table>

- girls  B= boys  Family= father (incl step & de-facto), brother  
  Kin= uncle, grandfather or cousin

6. Type of penalty given sexual offenders against children during 1984.
## Type of Penalty

<table>
<thead>
<tr>
<th>Type</th>
<th>Detention</th>
<th>Probation</th>
<th>Medical/Welfare</th>
<th>Fine</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRISON</td>
<td>HOSPITAL</td>
<td>REPORT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAPE</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARNAL</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>KNOWLEDGE</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCEST</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDECENT ASSAULT</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>G</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Percentage of substantiated cases, reported to police in your state, in the 12 months ending 31-12-84, of:

<table>
<thead>
<tr>
<th>PHYSICAL ABUSE</th>
<th>EXTRAFAMILIAL SEXUAL ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRAFAMILIAL SEXUAL ABUSE</td>
<td>OTHER ABUSE</td>
</tr>
</tbody>
</table>

intrafamilial = the abuse that took place in the child's home, abuser regularly resident in the house or the abuser was a blood relative.

2. Cases of suspected intrafamilial child sexual abuse reported to the police in your state in 12 months ending 31-12-84, by age and sex of victim and offender:

<table>
<thead>
<tr>
<th>AGE &amp; SEX OF OFFENDER</th>
<th>16 - 19</th>
<th>20 - 24</th>
<th>25 - 39</th>
<th>40 - 59</th>
<th>60 +</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>M M</td>
<td>F F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 9</td>
<td>M M</td>
<td>F F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - 15</td>
<td>M M</td>
<td>F F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 +</td>
<td>M M</td>
<td>F F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3. Substantiated (founded, registered) cases of intrafamilial child sexual abuse reported to the police in your state in the 12 months ending 31-12-84, by age and sex of victim and offender:

<table>
<thead>
<tr>
<th>AGE &amp; SEX OF OFFENDER</th>
<th>16 - 19</th>
<th>20 - 24</th>
<th>25 - 39</th>
<th>40 - 59</th>
<th>60 +</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 9</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 - 15</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 +</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 4. Age of child at time of reporting, by age of child when abuse began:

<table>
<thead>
<tr>
<th>AGE OF CHILD WHEN ABUSE BEGAN</th>
<th>CURRENT AGE OF CHILD</th>
<th>M</th>
<th>F</th>
<th>M : F</th>
<th>M : F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>0 - 5</td>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6 - 9</td>
<td>0 - 5</td>
<td>M</td>
<td>F</td>
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<tr>
<td>10 - 15</td>
<td>0 - 5</td>
<td>M</td>
<td>F</td>
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<tr>
<td>16 +</td>
<td>0 - 5</td>
<td>M</td>
<td>F</td>
<td></td>
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</tr>
</tbody>
</table>
5. Substantiated (founded, registered) cases of intrafamilial child sexual abuse reported to the police in your state each 12 months ending 31st December, by relationship of offender to victim:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>BIOLOGICAL FATHER</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>STEP, FOSTER FATHER</td>
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</tr>
<tr>
<td>MOTHER'S BOYFRIEND</td>
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<tr>
<td>BIOLOGICAL MOTHER</td>
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<tr>
<td>STEP, FOSTER MOTHER</td>
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<tr>
<td>FATHER'S GIRLFRIEND</td>
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<tr>
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</tr>
<tr>
<td>GRANDFATHER</td>
<td></td>
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</tr>
<tr>
<td>GRANDMOTHER</td>
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<td></td>
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</tr>
</tbody>
</table>

Mother's boyfriend = Casual non defacto relationship
Father's girlfriend = Casual non defacto relationship

6. Comments about data supplied (eg trends that may not be apparent when data is reported in this format)
Appendix 10: Discriminant Function Analysis

Pooled within-groups correlations between Canonical Discriminant Functions and discriminating variables. Variables are ordered by the function with largest correlation and the magnitude of that correlation.

FUNC 1
--------
QF 0.63064
QI 0.46126
QJ 0.45625
QH 0.36134
QG 0.28675
QA 0.24111
QB 0.18869
QC 0.10257
QE 0.07240
QF 0.03619

Canonical Discriminant Functions evaluated at group means (Group Centroids)

GROUP  FUNC 1
--------  --------
1  -0.90421
2  0.97956