Sexual Assault and Abuse of Children

Author: Nettie Flaherty

Topic Reviewers: Judith Hummerston (RAN, Willowra); Yuendumu clinic team; Dr Peter Tait; Dr Tim Hannah (Timber Creek); Dr Ian Dumbrell (Port Keats)

Introduction

Child sexual abuse may be defined as any sexual act/threat that exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. It is the use of a child for sexual gratification by an adult or significantly older young person.1 This broad definition acknowledges that the sexual abuse of children involves a range of behaviours, including those commonly referred to as sexual assault or rape, for example, anal and/or vaginal penetration using a finger, penis or other object. It also refers to behaviours such as exposing a child to, or involving a child in, pornography; fondling and/or masturbation of a child; having the child fondle, touch or masturbate the abuser; and coercing a child to engage in sexual acts with other children.

Understanding this broader definition is important for two reasons. Firstly, sexual assault conjures up images of ‘stranger danger’, though in the vast majority of cases children are sexually assaulted by someone they know, who is in a trusted relationship to them, or to whom they are related.2,3,4 In shifting the focus from the family, or the immediate social network, as the site of abuse attention is also diverted from the dynamics of child sexual abuse, thus compromising the health professional’s ability to respond sensitively to the child’s situation. Child sexual abuse is characterised by issues of secrecy, conflicted loyalties and power amongst people who stand in close relationship to each other. Following discovery of child sexual abuse there are a myriad of vested interests involved in pressuring the child (the least powerful member of the family) to retract, and the non-offending members of the family to disbelieve the child’s allegations.5

Secondly, in perceiving sexual abuse as including a continuum of behaviours that typically progress from less- to increasingly-invasive activity, health practitioners are alerted to those signs and behaviours that may be indicative of abuse, and the possibility of early identification and intervention.

Indicators of sexual abuse

When a child has been sexually assaulted (as in rape) they are often suffering injury and will be brought to the clinic. That they have been injured because of a sexual assault will often be conveyed to the health team.

In the absence of any physical evidence it is important to consider those signs that are suggestive of sexual abuse. Sexual abuse should be suspected when a child is brought to the clinic with any of the following:

- Bruises, bleeding or other evidence of physical trauma in the genital area
- Foreign objects in the genital or rectal openings
- Sexually transmitted diseases
- Pregnancy in a younger girl who refuses to reveal any information about the father and/or complete denial of the pregnancy by the child and her family
- Itching, inflammation or infection in urethral, vaginal or rectal areas
- Trauma to breasts, buttocks or thighs[6]

A number of behavioural indicators are signs that a child is experiencing significant stress, including:

- Regressive behaviour in younger children
- Sudden fears or phobias
- Running away from home
- Noticeable personality changes
- Changes in school performance
- Suicidal thoughts or attempts, or self-harming behaviours
- Withdrawal from peers
- Extreme mistrust[6]

Some behaviours are more directly related to the possibility of sexual abuse, including:

- Drawings of an explicit sexual nature
- Age-inappropriate sexual play
- Bizarre, sophisticated or unusual sexual behaviour or knowledge
- Overtly seductive behaviour
- partial or full disclosure[6]

In some communities children are often allowed to watch videos of their choosing without parental or other adult supervision or guidance. These may include age-inappropriate sexually explicit material. Some remote practitioners suggest that exposure to such material makes drawing any conclusions based on age-inappropriate sexual play or advanced sexual knowledge fraught. Others argue that exposing young children to such material is itself abuse, and may at times be a part of a ‘grooming process’, leading to more explicitly abusive behaviours. (See below ‘Stages of sexual abuse’.) It is important not to assume that children displaying unusual sexual behaviour or knowledge are doing so only as a consequence of exposure to sexually explicit videos, and therefore to discount the possibility of abuse. It may also be helpful to discuss the issue of access by children to sexually explicit material with your local child protection office.

Sexual abuse and other types of abuse

There is growing evidence to suggest that different types of violence occur simultaneously within families.[7,8] Two Australian studies in the early 1990s examined the possibility of a relationship between child sexual abuse and domestic violence. Using data from a hospital-based ‘child abuse tracking study’ Goddard and Hiller[9] reported that 40% of identified sexual abuse cases and 55% of identified physical abuse cases were occurring in families

where domestic violence was also occurring. Tominson tracked suspected child abuse and neglect cases within a Victorian regional child protection network.10 This study indicated that domestic violence was a factor in a sizeable proportion of both child sexual and physical abuse cases. Tominson found that 19.4% of child sexual abuse cases also involved the child being physically abused.

Such studies suggest that a violent coercive environment may be almost as likely for sexual abuse cases as for physical abuse, particularly for the more severe cases of physical and sexual abuse. Therefore, health practitioners working with families where domestic violence is a feature should consider whether behavioural indicators of stress in a child may be a sign that other abuse is occurring to the child, including the possibility of sexual abuse.

Sexual abuse in indigenous communities

Accurate data on the rate of sexual abuse of children is not available. In many communities, including the Indigenous community, dialogue about the issue of sexual abuse of children is just beginning to be heard by the wider society. The Aboriginal and Torres Strait islander Women's Task Force on Violence revealed widespread concern amongst many Aboriginal people at the level of sexual abuse of children:[11]

> Throughout the consultations there were calls from both men and women to expose the severity and serious long-term effects of sexual abuse for victims, particularly children, who reportedly are increasingly being sexually violated . . . Time and again the Task Force were told of young girls becoming pregnant at an early age, some of whom had been sexually abused repeatedly throughout their lives. Some, through such abuse, had grown up with a distorted sense of what constitutes a loving, nurturing and caring relationship . . . Whether by coercion or rape, the incidence of sexual abuse of minors was indicated to be far more frequent than is commonly acknowledged. This is an area that warrants urgent attention by way of increased reporting of offences, appropriate interventions, expanded education programs, and the employment of more sexual health workers in all regions, but especially in rural and remote regions.

The clear message from the Task Force was that sexual abuse of children is not acceptable to Aboriginal people, just as it is not acceptable in the non-Indigenous community.

For many children whose wellbeing is the subject of a child abuse notification, including those related to the possibility of child sexual abuse, a picture of chronic neglect often emerges, characterised by very poor growth and multiple admissions to hospital in infancy. The wellbeing of such children is often well below the community norm and they have commonly been considered to be 'at risk' in some way; yet there is no single incident that may have previously brought the child to the attention of child protection authorities. Often the trigger for notification is a positive STI result. It is often unclear who the child's primary carer is; rarely the biological parents, often 'many' people. Alternatively the 'named' carer may be an elderly grandmother, perhaps sick and frail, and receiving little or no help for many grandchildren. These children may, in fact, be 'growing themselves' up. The extended family system of caring does, when working well, provide a safety net for many children whose parents are unable to parent effectively. For some children, however, the

lack of any stable identified carer, or having a carer who has overwhelming demands placed upon them, leaves them at risk throughout their childhood to neglect, abuse or exploitation. A positive STI in a child who is growing up in this environment should always be viewed as strongly suggestive of abuse.

Identifying and reporting suspicions of child sexual abuse creates considerable anxiety among heath practitioners everywhere, and particularly in remote communities. In the absence of a child's disclosure — or compelling physical evidence — primary health care staff express uncertainty in their ability to identify signs that sexual abuse may be occurring, and discomfort with asking questions about such a sensitive issue which may generate conflict within the community and place clinic staff in a vulnerable and potentially unsafe situation. It is vital that if health practitioners suspect that a child may be being abused, but feel uncertain about what they should do next, they consult with the local child protection office for guidance. At a minimum this response attends to your duty of care toward clients: it may also result in a child being protected from further abuse.

Teenagers and sexual activity

An area which causes confusion for remote practitioners concerns teenage sexual activity: a nine-year-old girl engaging in sexual activity causes alarm, and indicates the need for concern for her general wellbeing, not just the possibility of sexual abuse. She is clearly too young to legally consent to sexual intercourse. Who is looking out for her? What are her parents and other family members doing to guide, care and provide supervision? Most practitioners would have little difficulty in identifying this as a case where something is not right, and where notification needs to occur. However, the question is often asked: at what age is sexual activity/experimentation simply that and unlikely to be a marker for abuse?

It is important not to place overwhelming confidence in the age of your client as being a protective factor for abuse: adult women are raped, and their age does not protect them from this. Nonetheless, young people are engaging in consensual peer-related sexual experimentation and activities at younger ages than many realise, or necessarily approve of. Further, in some communities, the age of marriage is comparatively young — fourteen and fifteen year olds may be married and parents. Is this OK?

The interface between mainstream Australian law and accepted cultural practices of minority groups is frequently marked by confusion and ambiguity. Female circumcision (or genital mutilation), for example, is specifically outlawed under the child protection legislation of every State and Territory in Australia. The situation regarding many Indigenous cultural practices is vague: the NT Criminal Code, for example, makes it an offence for an adult to attempt to have sexual intercourse with a minor (i.e. under 16). However, authorities in the Northern Territory and elsewhere have, of necessity, taken a common sense interpretation of the law: it would be rare for a nineteen-year-old to be charged with having consensual sex with his fifteen-year-old girlfriend. The purpose of this provision of the criminal code is to protect a vulnerable group from exploitation, and to acknowledge the real power adults have over children and young people. Even though a technical or literal interpretation of the code would suggest an offence has occurred, where the circumstances

demonstrate that no such exploitation exists, such as in the example given, charges are unlikely to be laid.

Child protection legislation generally defines ‘child’ as a person under 18. The purpose of this legislation is not to regulate sexual activity among young people, nor to arbitrarily intervene in cultural practices that affect young people, but rather to protect them from abuse and exploitation. There is, and always will be, a ‘grey’ area at the border of any accepted cultural practice, and what over time that culture continues to find acceptable. It is important to remember there is considerable, although not complete, agreement across cultures about what constitutes child abuse and neglect. A fourteen-year-old may be ‘married’ and abused, or not married and abused: there may be considerable disagreement across cultures about whether a fourteen-year-old should be allowed to get married, and surprising agreement about whether her partner’s behaviour toward her is abusive. If you have concerns about a young person, even if vague, it may be helpful to consult with your local child protection office.

Stages of sexual abuse

Our understanding of the ‘progressive nature’ of sexual abuse tells us that if we do nothing, not only will it not go away, it will most likely get worse.[6,12] The abuse may have begun with subtle behaviours at age six, and progressed through a range of increasingly intrusive behaviours over a number of years. It also helps us understand why children, when they tell their story (and particularly under cross-examination) get muddled.

The following stages in the sexual abuse process have been described but, like most stages in a process, do not necessarily unfold in such a linear fashion for every child.[13]

Engagement or entrapment phase

The offender initiates the contact with the child or young person by offering bribes or rewards, or special attention or affection. This stage requires the offender to have access and opportunity, and for the offender and the child to have some form of relationship: sometimes this stage is the building to this relationship, and has been called the ‘grooming’ stage.

Sexual interaction stage

Once the child responds favourably to the special attention, some form of sexual activity begins. This may begin as subtly as ‘accidentally’ looking at the child undressing. However, it typically progresses toward more obviously sexual behaviours, often involving penetration.

Secrecy stage

Once the sexual activity has begun secrecy must be maintained. This is usually achieved by:

- Threatening that no-one will believe the child if they tell;
- Threatening that telling will mean something bad will happen to the offender and it will be the child’s fault
- Threatening that the young person will be punished and will be removed from the home
- Threatening that everyone will think the child/young person ‘asked for it’ because they let it go on for so long

- There may also be threats of, or actual, physical abuse to intimidate the child.

Disclosure

Occurs when the secret is told, or discovered. Although all types of disclosure results in a crisis for the child, and their protection must be paramount, accidental disclosures (e.g. the discovery of a pregnancy) mean the child is completely ill prepared for the disclosure.

When a child does disclose it is usually tentative and hesitant, characterised by forgetting, minimising, distancing and discounting.[14] The response of the person listening to the disclosure will be communicating to the child whether it is safe for them to continue.[15] (See below 'Appropriate professional response to disclosure'.)

Suppression

If family members blame or punish the child, or dismiss their allegations, the disclosure may be withdrawn. The child will then believe the offender's previous threats: this is most common where the abuse has occurred within the family and the family do not believe the child. Some commentators perceive retraction as a 'normal' part of the process.[12] Whether this is true or not, it is important to bear it in mind, so that if it occurs you do not get 'thrown' when it occurs, and as a consequence decide not to report the disclosure.

Reactions to the disclosure

Offenders generally react with alarm, and almost always deny the allegation. After the child's disclosure the offender can be expected to exploit his power to control the child, other family members, and the professionals involved. This may involve threats to harm.[13,12]

It is important to be mindful, when deciding which health worker or community member to seek assistance or advice from, that there will be people who have an interest in convincing the child to retract their statement. Therefore, it is preferable to seek this advice from someone who is not related to the alleged offender.

The non-offending parent is usually a mother.[2,3,4,16] Many will react immediately by expressing concern and responding protectively, but not all will be able to maintain this stance throughout. Others may react with disbelief and anger, particularly if she is dependent economically or socially on the offender, or is fearful of retribution.

The vulnerability of the 'non-offending parent' is often underestimated. When mothers do not respond 'appropriately', i.e. with a stance of belief and support, they are often conceived of as somehow responsible for creating the circumstances which have allowed the abuse to occur.[5,17] There is limited research available which considers the process of belief for mothers. This shows that the 'attainment of belief was inextricably linked to the process of disclosure and discovery', and even for those mothers who were able to maintain a stance of belief, a period existed where they were unconvinced that the sexual abuse of their child had occurred.[5,17] All mothers also experienced periods of ambivalence where they did not know what to believe, and this ambivalence included both cognitive and emotional aspects. Humphrey's[5] study over a six month period following disclosure showed that mothers could move from belief to ambivalence to disbelief and vice versa.

> Such movement suggests that the mother's perception of the event is not fixed and needs to be understood by practitioners who make judgements about the mother's position early in the assessment . . . The difficulties in sustaining a stance of belief, protection and support, however, were much greater for women who were attached or who had ambivalent feelings towards the abuser who had been her partner prior to disclosure.

Thus, the safety of the child is a matter that requires ongoing assessment and evaluation: the mother's ability to provide protection and support for her child is affected by her ability to attain and maintain belief. When there is no collaborative physical evidence to support the child's disclosure, the non-offending parent is often left alone to defend the child. Her subjective assessment of the validity of the child's claim becomes the arena for a power struggle between the abuser's denial and the child's version.

> This struggle is an uneven contest in which mothers reported that the abuser and the forces which sustained him through his cultural, emotional, economic and legal position had the upper hand.[5]

Appropriate professional response to disclosure of child sexual assault

It is important, if possible, to refrain from an overly emotional reaction to a child's disclosure of sexual abuse. In the absence of any injury that needs attention, your role is to listen and provide support to the child, and not to investigate the allegation. The best response is one where you:

- Show the child that you believe them
- Tell the child it is not their fault, whatever happened
- Say that adults sometimes do the wrong thing
- Tell the child this has happened to other children, not just them
- Tell the child they did the right thing by telling you
- Tell the child you will now try to stop it happening, and to do that you have to tell the child protection agency.

Given one of the central issues in child sexual abuse is the betrayal of trust, it is important you do not unintentionally demonstrate this by making promises you cannot keep. One of these promises may be to reassure a child you will not tell anyone: this is not a promise you can keep. The risk to the child is high once they have disclosed, and considerable pressure may be exerted to get the child to retract. Trying to confront the perpetrator yourself, to 'sort it out', is not appropriate, and may undermine subsequent police and/or statutory child protection investigations. The end result may be a child who is at greater risk.

Do not push the child into telling you details of the abuse. Interviewing children who have disclosed sexual abuse, in a manner that attends to both therapeutic and evidentiary needs, is a specialist skill. Repetitive questioning of the child is not only stressful for the child, and may be experienced by the child as disbelief, it increases the opportunity for the verbal evidence to be 'contaminated'. Whilst the successful prosecution of offenders is not the domain, or necessarily the interest, of the health professional, it is important they do nothing to obstruct this process. Even if criminal charges are not forthcoming, there may need to be a Court hearing to arrange protection of the child. Further, for some victims a successful prosecution, though unlikely, is part of the healing process.

If the child does want to talk, carefully document what was said, by the child and by your self. In most health settings information is elicited using focussed questions, and this type of question implies a desired response. It is vitally important that you endeavour to keep focussed questions to a minimum, because focussed questions carry with them, on a continuum, a degree of risk regarding suggestibility. Focussed questions, which draw information from recognition rather than recall memory, increase inaccurate responses. This can be minimised by following a focussed question by and open-ended question, thus placing the burden back on the more accurate recall memory:[18]

In talking with the child it is important:

- Not to ask questions that contain the answer. For example, better to ask ‘Where did it happen?’, rather than ‘Did it happen at your house?’
- Not to ask questions that contain a choice of answers. For example, better to ask ‘How did you feel?’ rather than ‘Were you scared, or angry or sad?’
- Not to name the suspected offender before the child has identified the person. For example, better to ask ‘Who touched you?’ rather that ‘Did your dad touch you?’

Prevalence

Boys and girls of all ages and from all cultural groups can be the victim of sexual abuse. Most sexual abuse, like most sexual assault, goes unreported.[19] Child sexual abuse is characterised by secrecy: most ongoing sexual abuse is rarely disclosed outside the immediate family. Reported or investigated cases are the exception, not the norm.15,16 Sexual abuse is often an area members of the public and professionals feel uncomfortable about reporting because the allegation and the consequences, if proved, are significant.

There are methodological problems with determining prevalence. These include:

- Different definitions of sexual abuse across jurisdictions
- Questions of whether to include contact and non contact types of abuse
- Whether to use the victim’s subjective experience of an experience as abusive, or whether to define abuse by things such as the age difference between victim and offender
- Varying upper age limits on what constitutes a child.

Figures are frequently quoted estimating that one in every three to four girls, and one in every seven to eight boys, have experienced some form of sexual abuse by the time they are eighteen.[16,20]These figures have remained relatively stable over the past decade or so, but they do include all forms of behaviour that falls within the continuum of sexually abusive behaviours.

It is not possible to have reliable data that sexual abuse has occurred, even amongst those cases that are reported. One is usually faced with a child’s disclosure that abuse has occurred, and an opposing adult statement that it has not. It is rare for there to be witnesses, and unlikely to be collaborative physical and/or medical evidence. In the NT in 1999–2000 11% (42 children) of substantiated child abuse cases involved sexual abuse, in Western Australia 27% (311 children) and in Queensland 6% (398 children).21

How many of these substantiated cases were what would commonly be referred to as sexual assault is not known.

Do children make up stories of sexual abuse?

It is rare for children to make stories up about sexual abuse.[3] In fact, most sexual abuse of children and young people remains undisclosed and unreported.[3,12,16] Research has shown that, even where there is physical evidence that suggests sexual abuse, disclosure does not always follow. Lawson and Chaffin[15] highlighted the difficulties that children, from age three through to adolescence, had in disclosing sexual abuse. Over half of the sample (57%) who were diagnosed with an STD did not disclose sexual abuse. Sauzier [22] studied 156 children who had been referred to a program for sexually abused children. Only 50% had disclosed abuse: the discovery of abuse in the remaining children came about through the suspicions of others. Two factors that decreased the likelihood of a child disclosing abuse emerged in this study. Although aggression was equally likely to lead to non-disclosure as to reporting immediately, threats and manipulation inhibited disclosure. Children were also less likely to disclose when the perpetrator was their father, or father figure.

After a review of the literature, Salter concluded that false reports by children are rare and may occur in no more than 2% of cases.23 While it is important to determine when a child is lying, and to ensure that we do not support false allegations, the reality is that proving genuine disclosures and protecting children from repeated abuse is the more pressing problem.3

How do protective workers decide whether sexual abuse has occurred or not?

The protective worker's decision of whether to substantiate sexual abuse is based on gathering relevant data, followed by deciding what degree of confidence could be applied to the decision as to whether sexual abuse has occurred or not. Factors which assist the protective worker decide, in the absence of physical evidence, whether abuse is more likely than not to have occurred include:[6,13,18,24]

- The child's statement, including such things as explicit detail, word and sentence formation, a story that is told from the child's perspective, and the emotional and psychological responses of the child
- The content of the narrative, including the pattern of abuse, the element of secrecy, coercion or threats
- Supporting features include the family history, such as other abusive behaviours, substance abuse issues, and parental history of sexual abuse
- The behaviour of the child during the time the abuse was happening
- The way the disclosure unfolded, who was told and why
- Consistency of the account in relation to different statements made by the child to the core elements of the abuse, but not necessarily to the peripheral aspects
- The child's knowledge of sexual anatomy and function, and whether this is developmentally and culturally congruent.

Perpetrators

Perpetrators of child sexual abuse constitute a markedly heterogenous group.[25,26] Wurtele and Miller-Perrin[25] note that 'the only common denominator

appears to be an offender's lack of sensitivity to the child's wishes and needs, along with a willingness to exploit the child's trust for the abuser's own gratification, profit or selfish purpose'.

At least 85% of perpetrators are known to the child, and they are most commonly heterosexual men.[16] In an Australian study[16] the average age of offenders against girls was about 30 years, and against boys about 22 years. (The average age of the onset of sexual abuse amongst the children is about eight and a half years.)[25]

Of recent concern is the growing number of adolescent sexual offenders.[4] Adolescents displaying the early signs of sexual offending tend to grow up and commit sex offences until they are caught. Like adult offenders, adolescents comprise a diverse group, with few broad characteristics. Perhaps one of the most widely reported is a history of sexual abuse or other maltreatment. While most male children who have been sexually abused do not grow up to become offenders, widely divergent rates of prior abuse have been reported in studies of male perpetrators. The victi-into-victimiser has been estimated at variously between 30% and 70%.[26]

To date work with perpetrators and research studies has failed to typify offenders by class, profession, family status, religion, ethnic group or socioeconomic status.[4] Neither has a psychological profile of a 'typical offender' been able to be constructed. However, Finkelhor has proposed a four-part model which identifies the conditions necessary for abuse to occur:[27]

- A potential offender must have some motivation to sexually abuse a child. They must feel some form of emotional congruence with the child, sexual arousal with the child must be a potential source of gratification, and alternative sources of gratification must be either unavailable or less satisfying.
- Any internal inhibitions against acting on the motivation to engage in sexual abuse must be overcome. For example, drugs or alcohol may be used to lower inhibitions against offending. This may be combined with the greater tolerance shown toward people who commit crimes whilst under the influence of substances.
- Any external impediments to acting on the impulse must be overcome. Inadequate care by a parent or guardian, maternal illness or absence, or being the carer, can provide this opportunity.
- Avoidance or resistance on the part of the child must be overcome. This may involve enticing an emotionally deprived child into accepting inappropriate attention, or using overt coercion to achieve domination.

After abuse has occurred

The effects of childhood sexual abuse can extend well into adulthood, particularly if the child did not receive appropriate help and support. These effects include depression, withdrawal, anger, running away, self-harm, substance abuse, sexual acting-out and suicide attempts.[20] Other reported effects include phobias, panic attacks, nightmares, sleep disturbance, difficulty in establishing and maintaining relationships and sexual difficulties.[28,29]

Although sexual abuse can have a long lasting psychological and emotional impact, some people who are abused appear to suffer no serious trauma or symptoms. Finkelhor20 reviewed the literature and concluded that between one quarter and one third of sexually abused children have adequate

psychological and social resources to cope without experiencing serious trauma or long lasting effects.

The effects of abuse are likely to be less serious if the abuse does not involve force or violence, if there is no penetration, if it is of relatively short duration, and if the abuser is not a father or father figure.

Parental and social attitudes toward the child and their role in the abuse are important determinants of the long-term effects of abuse. Prognosis is best for those children who have been believed, who are not blamed, who have family support, secure relationships, stable home environments and who get appropriate counselling as needed.3,20,29

In order for families to support their child, it is important that they are reassured that their child can lead a normal life, and that they can recover.

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