

Module 5

Physical and Sexual Abuse of Children

Learner workbook



Caseworker name:

Workbook completion noted by L&D field coach:

Signature:

Date:

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PURPOSE

This module builds on your learning about the dynamics of physical and sexual abuse and the impact this has on child development. The purpose of this module is to reinforce understanding of core content and skills required in casework when identifying and responding to physical and sexual abuse of children and when working with families affected by this.

When addressing sensitive topics such as physical and sexual abuse of children it is important to be aware of the impact this has on you personally.

We encourage staff to contact the FACS Employee Assistance Program (EAP) should they wish to discuss issues that may arise. EAP is available to all staff and their family members.

Further information on EAP can be located at:

[Workforce Safety & Wellbeing/health and wellbeing](#)

Or contact EAP directly on: 1800 337 068

Please note: the content in this module has been developed with an ethical and non-biased approach, and every endeavour has been made to maintain the use of child focussed and respectful language wherever possible.



LEARNING OUTCOMES

At the end of this module you will be able to:

Identify the dynamics and impact of sexual abuse

Identify the dynamics and impact of physical abuse



RESOURCES

Readings

There are a number of suggested readings and activities throughout this module. These readings have been provided to consolidate your learning and provide a sound research base for casework practice. These readings can be found on the Learning Management System (LMS) for this module.

Physical Abuse of Children.

Abusive Head Trauma.

Sexual Abuse and Offender Tactics.

What Sexual Offenders tell us About Prevention Strategies.

Indicators of Sexual Abuse.

The Effects of Child Sexual Abuse.

The Dynamics of Intra-familial Child Sexual Assault.

The Child Sexual Abuse Accommodation Syndrome.

The Disclosure Process: The Impact of Stopping an Interview.

Barriers of Belief for the Non-Offending Parent and Facing the Unthinkable.

Understanding Sexual Behaviour in Children.

Sibling Sexual Abuse.

Understanding Sexually Abusive Behaviour in Children and Young People.

Self Care.

Intranet resources

The FACS intranet site will assist your learning in this module.

The following documents and sites can be located on the intranet.

[iPractice](#)

[casework practice](#)

[Joint Investigation Response Team Criteria](#)

Other resources

There are a number of activities throughout this module that will require you to access a range of resources. These include:

- supervision time with your manager casework

- consultation time with a casework specialist, manager casework (or field coach) to discuss the scenarios relating to recognising injury in children

Workbook completion and suggested activities

Completion of this workbook is a mandatory learning activity, though not formally assessed by Learning and Development (L&D). The workbook contains a number of practical field based activities designed to enhance and consolidate your learning. These activities will assist you in linking theory to practice in a supported environment. Please note that while these field activities are highly recommended they are not assessable.

If there are some activities which you cannot complete due to local restrictions, please note these in the workbook and let your L&D field coach know. Your field coach will review each workbook to confirm its completion. Please note they will not be assessing content, rather reviewing that the learning activity was completed and the skills and knowledge are transferring to your workplace.

A checklist for your manager casework and L&D field coach is attached to each module.

PHYSICAL PUNISHMENT OF CHILDREN



Access and read '**Physical Abuse and Corporal Punishment**' from the readings on the LMS to support learning for this topic.

What questions might you ask a parent or carer in relation to their use of physical punishment?

What questions might you ask a child or young person in relation to the physical punishment/abuse they experienced? (This will be explored more in module 11 – The NSW Investigative Interview Framework).

What are the key things to consider in relation to the impact of harm on a child or young person?

What information could you provide parents that would help them manage their children's behaviour differently?

DYNAMICS AND INDICATORS OF PHYSICAL ABUSE OF CHILDREN

The table below lists many indicators which may identify inflicted injuries on children and young people.

Physical injuries	Indicators or things to consider
Bruises and welts	<p>Bruises to areas of the body that are not 'leading edges' – e.g. – any bruising to soft cheeks, temples, ears, abdomen, buttocks, inner thighs, back of legs.</p> <p>Bruises on knees, shins, foreheads, and elbows may be either inflicted or non-accidental.</p> <p>All bruises on non-mobile children are suspicious.</p> <p>Symmetrical patterns of bruising may indicate intention (e.g. on each earlobe).</p> <p>Loop or belt marks: caused by whipping the child with a looped cord (i.e. an electrical cord) or belt, no disease or accident looks like a loop or belt mark.</p> <p>Other distinctive shapes may indicate the use of an implement.</p> <p>Ligature bruises may be caused by ropes tied around the child's ankles or neck, resulting in a bruise or a burn.</p> <p>Slap marks/small dots - fingers may leave bruises on the face or buttocks.</p> <p>Genital bruises: be suspicious if a parent/carer delays seeking treatment for a child with a genital injury. Bruises in the inner thigh or genital area may indicate sexual abuse.</p>
Lacerations/cuts	<p>Areas of the body which are normally protected by being inside or covered by other body parts - it would be difficult to fall and injure/cut these areas.</p> <p>Cuts to soft tissue areas such as abdomen, throat, buttocks, and thighs may affect internal organs.</p> <p>Injuries to buttocks, lower back, or thighs can be caused by whipping.</p> <p>Lacerations of the ear, nose, or throat do not tend to occur accidentally and should arouse suspicion.</p> <p>A torn fraenum of the upper lip, (which is the tissue connecting the upper lip to the gum) especially in an infant, is very concerning for abuse in the absence of a plausible explanation.</p>
Bites	<p>Human bites appear as distinctive oval to horseshoe shaped marks in which teeth impressions appear as bruises facing each other.</p> <p>Torn flesh is usually a dog bite; compressed flesh is usually a human bite.</p> <p>Difference in size between a child and adult's bite.</p> <p>Adult bite marks are a sign of serious danger to a child – uncontrolled aggression.</p> <p>Victim's teeth should be examined and measured to exclude the possibility of a self-inflicted bite. This would be determined by a doctor.</p>
Burns/scalds	<p>Symmetrical or even burns may indicate intention or force.</p> <p>Burns with a clear, crisp 'waterline' may indicate intention or force of</p>

	<p>holding a child in hot water.</p> <p>Stocking or glove burns caused by immersing the child's hands or feet in hot water or holding the hands or feet under very hot running water; usually shows sharp demarcation.</p> <p>Accidental burns will generally be asymmetrical or have splash marks.</p> <p>Splash burns may be caused by the offender throwing hot liquid at the child. Splash burns on the back or buttocks are highly suspicious.</p> <p>Small round symmetrical burns may indicate intentional use of a cigarette. Can appear on the palms or back of hands, feet, trunk, or external genitalia (impetigo blisters are irregular and can be ruled out by testing for signs of strep).</p> <p>Chemical burns of the mouth and throat, vomiting, and oesophageal damage may indicate forceful ingestion of household cleaners or poisons.</p>
Fractures and dislocations	<p>All fractures on non-mobile children are suspicious.</p> <p>Rib fractures in children two years or younger are suspicious because a child's ribs are cartilaginous. (Comprising of soft cartilage rather than bones.)</p> <p>Spiral fracture: caused by the twisting of an extremity, can occur easily in small mobile children by twisting their own leg or ankle in an accidental injury. Thus, spiral fractures are not necessarily indicative of abuse – but there must be a clear description of the event.</p> <p>Skull fractures.</p>
Internal injuries	<p>Injuries to internal organs are caused by blows to the abdomen or squeezing; significant violent force is required to cause a life-threatening abdominal injury.</p> <p>Signs and symptoms include: abdominal, chest, flank, or back pain; visible bruising of the chest or abdomen; distended, swollen abdomen; tense abdominal muscles; laboured breathing or dyspnoea; nausea or vomiting. However, many children exhibit minimal symptoms after abdominal trauma.</p> <p>Neurological damage from head injuries – force required is generally more than a fall including from a crib/couch/bed/highchair/bath.</p>
Intracranial injuries (previously known as Shaken Baby Syndrome)	<p>A child has been held around the upper chest, under the arms, and shaken back and forth with great force or held upside down by the feet and shaken up and down.</p> <p>A child may also be thrown against an object resulting in a blunt force injury. This may occur alongside other presenting injuries.</p> <p>Many infants die, especially if there is a delay in getting treatment; those who survive often have permanent brain damage and may be paralysed, developmentally delayed, or a small proportion may be diagnosed with cerebral palsy.</p> <p>There is often an absence of externally visible injuries, but retinal haemorrhage and subdural haematoma are common.</p>



Legislative Links

Children and Young Persons (Care and Protection) Act 1998

No. 157

The [**Children and Young Persons \(Care and Protection\) Act 1998**](#) provides the statutory framework for FACS to engage with children, young people and their families.

S.173 – Notice requiring medical examination.

S.23(c) – Child or young people at risk of significant harm – where the child or young person has been, or is at risk of being physically or sexually abused or ill-treated

S.30 – Secretary's investigations and assessment

Assessing Physical Harm

During workshop 2, you watched a DVD and received information about recognising injury in childhood by Dr Bronwyn Gould. You may wish to refer to any notes you made at that time.



Access and read '**Abusive Head Trauma**' from the readings on the LMS to support learning for this topic.



Below are a number of scenarios for you to consider in relation to recognising injury in children.

Once you have reviewed the scenarios, you may wish to discuss these with the casework specialist, manager casework or field coach.



Scenario 1 – Stefan

STEFAN



Stefan is a two year old boy who is quite active. He presented to day care with bruises on his forehead, the bridge of his nose and his chin. When his mother picked him up from the childcare centre, the staff approached her and asked how Stefan had sustained these injuries. She explained that Stefan had been standing up on a chair at the dining table, lost his footing and hit his face on the dining room table.

Does the injury match the explanation provided?

Why/why not?

What further information or action would you require to inform your assessment?



Scenario 2 – Sienna

SIENNA



Sienna is a four month old girl. Sienna and her father, Tony, presented at the Smallville Early Childhood Centre for a general check up. When Tony was asked to undress Sienna in order for her to be weighed (clothes removed to measure her bare weight), the Early Childhood Nurse (ECN) noticed that Sienna had bruises to her right ear, her abdomen and her left knee. When asked how Sienna had got these bruises, Tony responded that Sienna had rolled off the couch and fallen on to the floor.

Does the injury match the explanation provided?

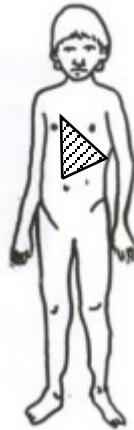
Why/why not?

What further information or action would you require to inform your assessment?



Scenario 3 – Daniel

DANIEL



Daniel is a nine year old boy. His father, Robert, presented Daniel to Woolville Hospital with an even triangular burn to his chest. When asked by the attending doctor as to how Daniel sustained this burn, his father explained that he had been playing and crawling along the floor playing with his toy cars, when he bumped into the ironing board and the iron fell on his chest.

Does the injury match the explanation provided?

Why/why not?

What further information or action would you require to inform your assessment?



Scenario 4 – Huong

HUONG



Huong is a three year old girl who visited her grandmother, Mai, with her aunt, Thuy. During the visit, Mai noticed that Huong had burns on her fingertips. When asked how this had occurred, Thuy explained that Huong had gone into the kitchen and had placed her hands on the oven door, which was hot, as dinner was in the oven.

Does the injury match the explanation provided?

Why/why not?

What further information or action would you require to inform your assessment?



Scenario 5 – Mohammad

MOHAMMAD



Mohammad is an eight month old boy who has presented to Suburbville Medical Centre with his mother, Leena. When asked by the doctor why they had come to see her, Leena stated that she had noticed that every time she put Mohammad down on the floor, he would begin to cry in pain and that he appeared to have some difficulty crawling.

Mohammad was referred to have an X-ray, where it was discovered that he had a spiral fracture to his femur. When asked by the doctor how this could have occurred, Leena stated that he had fallen off the bed two days previously.

Does the injury match the explanation provided?

Why/why not?

What further information or action would you require to inform your assessment?

Assessing physical harm

When assessing physical harm to children or young people, caseworkers need to consider all factors in the child's immediate and extended environments. These factors are associated with increased risk to the child or young person as a vulnerable person in their household.

Key factors might include:

domestic violence or family violence

parental stress e.g. financial pressure, lack of employment, separation

strained extended family relationships with the parents or carers

drug and/or alcohol use

mental health

gender of parent and severity of abuse

lack of or limited alternative parenting strategies

physical abuse as justification for 'discipline'

parents'/carers' description of child's behaviours/temperament, may signify concerns to address

a diagnosis or disability may put stress on the parents' ability to cope with challenging behaviours. Appropriate supportive intervention is required if this is the case which benefits the child or young person

sleeping patterns of children, young people and parents or carers, for example

is the parent sleep deprived and

what intervention is needed if it is ongoing, such as a visit to the G.P for an appropriate referral for strategies with sleep routine

childcare arrangements versus parents' 'timeout' balance, for example

sole parenting, rigid gender roles of caring for children i.e. female carer providing most of the care of the children may place a lot of stress on a parent or carer

breaks are necessary to maintain and improve the quality of the parent-child relationship. What family support does a family have? Social connections?

appropriate stimulation and learning opportunities for children to participate in to benefit their development in many areas.

By assessing the different factors that may be present, we can determine how we work with a family to provide ongoing support to parents/carers, addressing safety and reducing the risk of future harm to the child or young person.



For more information on vulnerability and risk factors to assess in a household to determine safety, welfare and wellbeing, access and read:

[Casework Practice Home > Resources > Child Protection Assessments](#)

> [pointers to vulnerability practice tool](#)

> [pointers to risk questions practice tool](#)

A holistic assessment puts an alleged assault into a context of what happens for the child or young person on a daily basis and informs the caseworker of any ongoing risk of harm concerns to address. This is in line with Practice Standard 3 - Holistic Assessment and Family work and Practice Standard 4: Collaboration. Key expectations 5, 6 and 7 provide strategies for service involvement and the reflective prompts are important reminders of what steps need to be undertaken to ensure a family is well supported.



Refer to the [Care and Protection Practice Standards](#) on the iPractice site.

'Elsa endured years of physical, verbal and emotional abuse from a family member. The effects were devastating, as they are with every child. The beatings, the taunts, the relentless belittling, demeaning and exclusion changed everything inside Elsa. It changed the way she saw the world. It changed the way she saw herself. It impacted on her schoolwork. It affected the way she expressed emotion. It dramatically damaged her health. The secrecy isolated her from other family members. It made her feel 'apart' from her friends. It made her want to hurt herself and it made her want to die. She was overcome with feelings of guilt, hopelessness and anger'

Australian Childhood Foundation website.

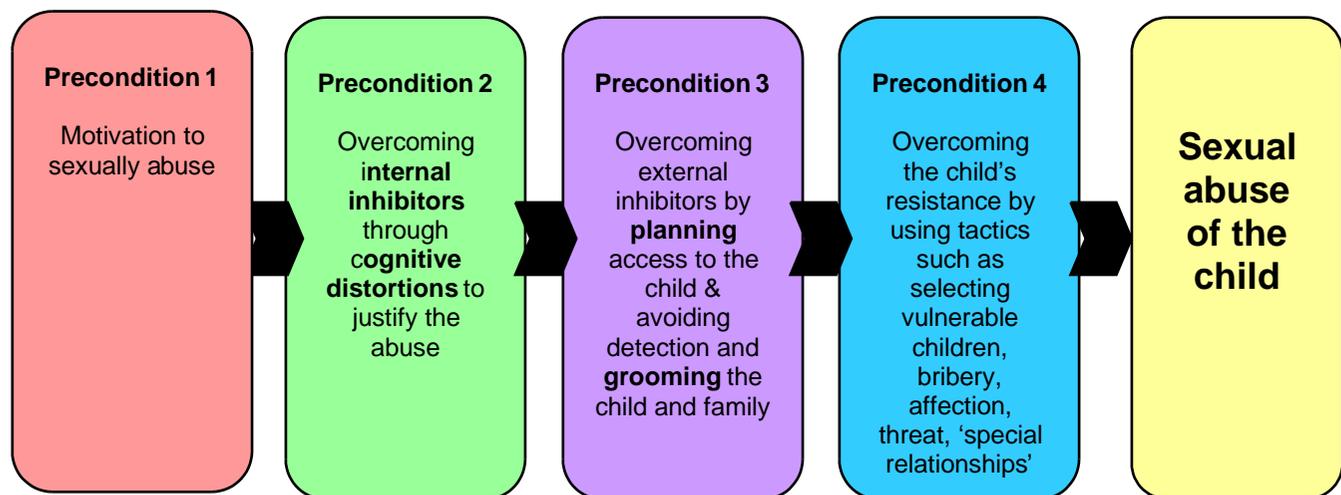
CONDITIONING AND OFFENDER TACTICS

During workshop 2 you were presented with considerable information about the role of 'conditioning' in child sexual abuse and the many tactics offenders use to set up and maintain an environment that enables sexual abuse to occur. The term 'grooming' was previously used to describe the dynamics of child sexual abuse. The term 'conditioning' describes the difficulty in seeing what is going on for the child for those who are included in the tactics by the offender. During the workshop these tactics were discussed through the presentation of Finkelhor's model (1984) explaining why and how sexual abuse happens.

Please note:

The content of child sexual abuse can trigger many different emotions and feelings for caseworkers, in particular, exposure to the deliberate tactics that are used by offenders. It is important when reading the material required for this activity, and others in this module, to be aware of the need for self care strategies as well as other professional support strategies e.g. debriefing and supervision.

Finkelhor's (1984) four factor model



Four preconditions for abuse

Precondition 1 : The motivations for and reasons why the abuse happens. Remember, regardless of the motivation or reasons provided to explain why abuse happens – sexual abuse is always a behaviour of choice. The potential abuser needs to have some motivation to sexually abuse. Finkelhor (1984) proposes that there are three central components included under the first precondition; Motivation to sexually abuse children:

- emotional congruence in which sexual contact with a child satisfies profound emotional needs
- sexual arousal in which the child represents the source of sexual gratification for the abuser
- blockage when alternative sources of sexual gratification are either not available or are less satisfactory.

These factors are not actual preconditions and not all three need to be present for sexual abuse to occur. These three components explain the behaviours of those who sexually abuse children, who are not sexually motivated but enjoy degrading child victims, using power.

Precondition 2: The internal voice that inhibits harmful or socially unacceptable behaviour and says this is not OK and will or may hurt the child is overpowered with cognitive distortions. Cognitive distortions are mental rationalisations that we all do at times to justify our actions and/or behaviour. Examples of cognitive distortions an offender may use are:

‘it is educative for her’

‘it’s an expression of love’

‘children are able to have sexual relationships – society is unenlightened’.

Precondition 3: There are many things that keep children safe such as supervision, education, supportive communities and positive parent-child relationships characterised by open communication. All these represent barriers – or external inhibitors – to the sex offender. The offender therefore has to overcome these by conditioning children and families into relationships of trust.

Precondition 4: Children will almost always resist sexual abuse either loudly or silently and the offender must engage specific tactics to overcome this resistance. Offenders therefore engage in threats, exploiting vulnerable children who have no-one to believe them or children who have already been abused. They bribe or force children into sexual abuse and foster relationships with the children they intend to abuse, redefining the sexual abuse for the child as a relationship or imposing other distorted interpretations on the child.

Some of the key messages from workshop 2 that underpin our understanding of the dynamics of child sexual abuse include:

sexual abuse of children is a behaviour of choice

there is a clear process of planning and decision making by the offender

sexual abuse is not a spontaneous act that occurs out of the blue

the child is discredited by the offender as a witness to the abuse he/she experienced

the vast majority of conditioning is not easily identifiable by families - or professionals including caseworkers

there are two things offenders need to sexually abuse a child: access (to engage a child) and opportunity (to perpetrate the abuse).

The child may be vulnerable due to the parents or carers having mental health conditions, drug and or alcohol dependencies, a single parent who is relying on the assistance of the offender , or the offender may exert control as in the case of perpetrating domestic violence.



Access and read **‘Sexual Abuse and Offender Tactics’** and **‘What Sexual Offenders tell us about Prevention Strategies’** from the readings on the LMS to support learning for this topic.

It is evident from the Conte, Smith and Wolfe (1989) article that each of the offenders meets the first precondition of Finklehor’s (1984) model: Motivation to sexually abuse children.



Identify quotes from the Conte, Smith and Wolfe (1989) article that demonstrate an offender's ability or tactics to overcome the other three preconditions. List these in the table below.

<p>Precondition 2: Internal inhibitors (mental rationalisations to justify what is being done)</p>	<p>Precondition 3: External inhibitors (planning access to a child, avoiding detection)</p>	<p>Precondition 4: The child's resistance</p>
<p>Example: 'I thought they would be victims willingly because they were being overly friendly with me' (p296).</p>	<p>Example: 'Generally they would be under my care. In most cases they would be over at my place' (p297).</p>	<p>Example: 'I would choose the youngest one or the one I thought would not talk about it' (p296).</p>

**Practice point:****A note on child vulnerability**

Conte, Smith and Wolfe (1989) state that offenders do not adhere to a specific 'child profile' when choosing a child to target and harm. It is a matter of access and individual preference. The offenders in the article describe a wide range of children including those who are friendly, those that 'hang back', those who have distracted parents and those whose parents are befriended by the offender. Children of all ages and appearances are selected to be harmed by offenders demonstrating that all children are vulnerable.

INDICATORS AND EFFECTS OF CHILD SEXUAL ABUSE

Children and young people often find it difficult to find the words to disclose that sexual abuse is happening, especially when they've been told to keep it a secret, often with associated threats. Young children and children with a disability may not have the language skills or understanding that what is happening to them is abusive. Delays in disclosing sexual abuse are common. Some children disclose immediately, while others wait until adulthood. Intra-familial and extra-familial sexual abuse is a factor in time delays with victims of intra-familial abuse finding it harder to disclose due to closeness in the relationship with the offender. Age is a predictor of disclosure with young children being less likely to disclose than older children. Girls disclose more often and sooner than boys. Physical or behavioural signs may be the only indicators of sexual abuse in the absence of a verbal disclosure.

Indicators of Sexual Abuse



Access and read '**Indicators of Sexual Abuse**' from the readings on the LMS to support learning for this topic.



Read the following scenario and answer the questions below.



Scenario – Cassie

Cassie is a 12 year old girl who attends Jewsun Park High School. She is a friendly and co-operative student who participates in all school activities (academic and social) and particularly enjoys playing sport. For the last couple of days Cassie has been away sick. Today, Cassie's PE teacher, Ms Jones has decided that the class is going to participate in netball training in preparation for the regional try-outs. While getting changed into her sports uniform (a polo shirt and a netball skirt), Ms Jones, observed Cassie to be wearing lycra bike pants under her school uniform. Cassie seemed to be uncomfortable when sitting down on the ground to listen to instructions about the training and it was noted that she was sitting alone at the back of the class. When the instructions regarding the training were being delivered, Cassie appeared to be withdrawn and paying little attention to the teacher.

When the students were about to begin the training, Cassie approached Ms Jones and stated that she did not feel well and said she had a headache and a sore throat and Cassie spoke with a croaky voice. Cassie said she needed to go to the sickbay. At the end of the class, Ms Jones overheard Cassie talking to friends and she was not speaking with a croaky voice and appeared to be in good spirits. Ms Jones overheard Cassie say that she is not allowed to attend the school disco, which she was actively involved in organising as her father does not want her to dance with boys.

What hypotheses might explain what is going on in Cassie's life?

Name the indicators for each scenario that you hypothesised?

What further information do you need to gather for your assessment, and where would you source this from?



Practice point:

When planning to assess risk of significant harm reports where physical and/or sexual abuse is suspected it is important to keep an open mind and not assume anything . There may be alternative explanations for the indicators of sexual abuse or injuries that a child presents with. These explanations must be explored. For example, the reporter could have an ulterior motive, or there may be instances where mental health issues may skew a reporters understanding, the reporter may have misinterpreted something the child said or the presenting physical condition of the child turns out to be something else other than caused by abuse etc.

At times an interview may not take the course that the caseworkers thought it would. It is important to present impartial to the child as the caseworker 's verbal and non-verbal communication may be interpreted by the child as suggestive and this may in turn influence the child's responses and could also have an impact on a child's ability to disclose information.

An interview of a child aims to provide the child with a setting in which the child feels comfortable and safe to disclose abuse if it has occurred. To do this well a caseworker needs to put into practice their knowledge and skill around child development, engagement techniques , and apply the interview framework . Ongoing critical reflection and practice of all interviews/interactions and cases is encouraged to enhance your practice.

Remaining objective and gathering sufficient information to inform the assessment of the safety and welfare concerns is crucial in determining what happened if anything did, to the child.

The dynamics between the interviewer and child will be covered more in Module 11 – NSW Interviewing Children Framework

Effects of Sexual Abuse

There are a range of factors that may influence how sexual abuse impacts a child. These may include the:

- the relationship of the offender to the child e.g. is it a parent or carer in a position of trust or a family member?
- frequency of sexual harm
- duration of abuse
- the use of force
- conditioning tactics
- type of sexual act e.g. penetration
- disbelief at the time of disclosure by the non-offending parent (often due to the interaction of the person causing harm with the non-offending parent before and after disclosure; and the associated tactics of blaming the child).

An understanding of the dynamics of child sexual abuse can assist caseworkers when responding to a child or young person who has been sexually abused as it:

- can assist in understanding any causal factors i.e . what is the underlying factor of the child or young person's presenting behaviour
- can provide a context and rationale for the behaviour of the child or young person
- can identify the young person's individual experience and impact based on the specific characteristics of the abuse
- can help expose (to the caseworker) the offender 's tactics and make the link between what the offender has done and how it has impacted on the child.

The caseworker needs to identify an appropriate service of support and intervention for the child and the non-offending parent. The caseworker needs to ensure safety of the child from the offender both physically, emotionally and psychologically. A child having supervised contact with the offender may not protect the child emotionally and psychologically from further impact of harm due to conditioning tactics at play which may be subtle and only recognised by the child.



For further information on resources and websites refer to the Intranet:

Helping to make it better

Helping your child. Important information for parents and carers about the sexual assault of children. You can access copies of this resource:

<http://www.ecav.health.nsw.gov.au/online-shop/booklets-manuals/helping-to-make-it-better/>

Victims Services, Attorney General's Department

For more information about sexual assault and the criminal justice process :

http://www.sexualassault.nsw.gov.au/VOSA/sexual_assault.html

'We share a bed when I visit my mum because she lives in a small place. She was patting my leg sort of stroking me. I rolled over and she said 'did you get a hard on'.....Later when she rolled over to sleep I had tears in my eyes. I think mum thinks I am her boyfriend.'

Sebastian – 10 years
Field Quote

THE DISCLOSURE PROCESS

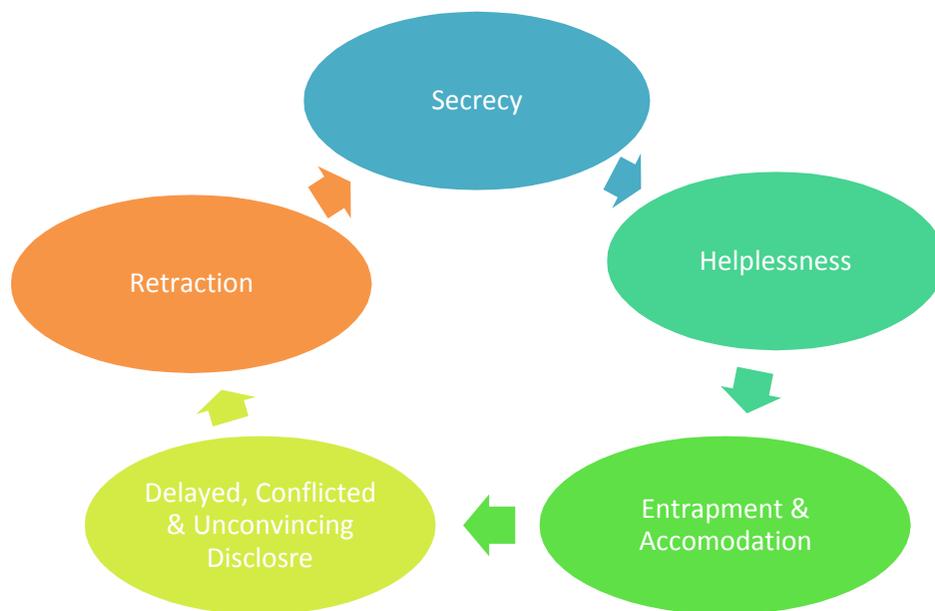


Access and read '**Child Sexual Abuse Accommodation Syndrome**' and '**The Disclosure Process**' from the readings on the LMS to support learning for this topic.

During workshop 2 you were introduced to the Accommodation Syndrome. This model explained how offenders set up a situation where sexual abuse can occur and be maintained. Also how children and young people psychologically, physically and emotionally accommodate themselves to the actuality of the abuse in the face of helplessness.

The Summit model (1983) is a linear model which identifies the successive phases of the disclosure process. The model explains how children disclose and why they may be reluctant to do so. This model is widely understood and referred to in terms of the sequences and stages of disclosure.

Child Sexual Abuse Accommodation Syndrome



Summit (1983)

A recent report authored by Dr Catherine Esposito of the Office of the Senior Practitioner (2014) highlighted that there is a higher incidence of retraction when a disclosure is made within a therapeutic context, as compared to a child protection setting such as forensic interviews.

Her report also identified the lowest rates of retraction were found where the abuse was substantiated by authorities or there was certainty that abuse had occurred. However, only a small percentage of disclosures are reported to authorities. Evidence indicates that the majority of abused children do not reveal abuse they experienced during their childhood, reflecting the

pressures that a child may experience from influential adults which can lead a child who has been abused to retract.

The Accommodation Syndrome assists our understanding of the disclosure process through the following points:

- the offender uses tactics such as fear, bribery and coercion
- tactics that are used by the offender impact on the child/young person's ability to disclose what is happening
- there is an increased risk associated with disclosure for a child or young person
- learning to accept and accommodate the sexual abuse into their reality
- a child needs safety to be able to disclose
- recanting or retraction is a part of the disclosure process
- a child may give conflicting information and this is not an indicator that a child is telling lies
- helplessness due to power imbalance between themselves and the offender.

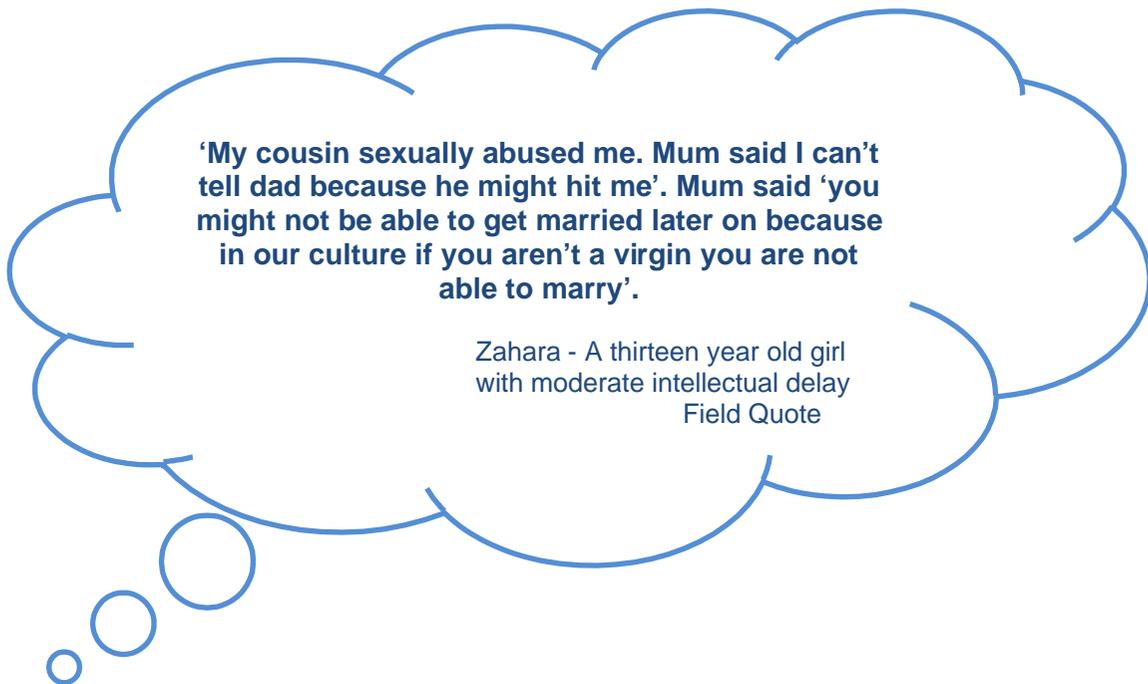
Disclosure is a process rather than an event. It is important to take the following points into consideration when conducting assessments and gathering information:

- provide opportunities for children to talk again (if no initial disclosure)
- anticipate likelihood of initial denial
- anticipate the likelihood that retraction of the information will occur. This highlights the importance of getting enough concrete and specific detail at the investigative interview stage
- be aware of possible impact of fear and pressure – denial or retraction or recanting
- if there is a disclosure, talk with the child/young person about the possible feelings they may have in the future including pressure to retract what they said
- acknowledge the concerns the child will have about 'what will happen next' and 'what will happen to the offender'
- observe and don't discount behaviours and language – they can be strong indicators within our overall assessment
- workers need to have an understanding of age and developmental issues which impact on the disclosure process
- when working with non-offending parents (if relevant), explain the process and planning for child's possible retraction
- consider the impact on child's immediate safety
- consider the impact on child's placement.

As a caseworker you can support a child who has disclosed sexual abuse by:

- listening to the child and staying focussed on their personal experience
- using a calm reassuring tone and age appropriate language
- believing the child
- providing safety and protection
- not making promises you cannot keep
- comforting the child
 - not expressing judgement, doubt or shock
- making an appropriate referral to a counselling service
- conveying messages that it is not their fault; it was right to tell; and that it is not OK for adults to harm children.

What else might you do to support a child in the process of disclosure?



BARRIERS TO BELIEF FOR A NON-OFFENDING PARENT AND DYNAMICS SET UP BY THE OFFENDER

Overwhelmingly evidence tells us that offenders are more likely to be male, have regular access to children, and could be within the child's immediate family structure. Possibly the most challenging scenario to work with is an offender in the parent or carer role, as they will hold a number of conflicting roles for the child and other family members e.g. they are an offender, a father or stepfather, and a husband or partner. The non-offending parent will therefore most often be a mother or stepmother. There are four spheres of influence in which abusive men in a parental role operate, to create a barrier between a mother and her child and increase the opportunity for abuse to occur. The diagram in the reading listed below describes these four spheres, which can be considered as conditioning techniques, not only of the child, but of their closest adult ally – their mother.



Access and read '**Barriers to Belief for the Non-Offending Parent**' from the readings on the LMS to support learning for this topic.

What tactics can you identify that might undermine a woman's confidence in herself as a woman and as a mother. For example, criticism & undermining of her parenting ability?

The impact of offender tactics on the relationship between the non-offending parent and the child can be significant and can impact on:

- attachment
- the emotional availability of the non-offending parent
- the non-offending parents' feelings; a mother's feelings about herself as a woman/mother may impact on positive role modelling for the child
- responsiveness to the child's needs
- trust between the non-offending parent and the child
- the parenting style; it could become punitive, or overly permissive
- the ability to communicate with each other.

It is extremely challenging and difficult for a non-offending parent to hear their child has been sexually abused by a family member or other person trusted by the family. A number of factors might influence a mother's belief about abuse and may include:

- the nature of the relationship with the offender
- the nature of the relationship with the child
- the nature of the manner of disclosure
- the professional and respectful interactions/interview undertaken by the caseworker

Sometimes the actual detail provided by a child assists the non-offending parent or carer to recognise that the disclosure is true.

Following the disclosure of sexual abuse by their child, non-offending parents often move through a process that includes shifting from a position of belief to ambivalence, to non-belief and back to belief. This is a normal process in dealing with the shock and fallout of the disclosure, particularly when the offender is the spouse or partner of the non-offending parent.

Think about strategies you could use as a caseworker to support a non-offending parent regardless of their position of belief. For example, provide information about the conditioning process.

Your engagement and support of a non-offending parent can increase the safety for a child following disclosure through:

- providing an objective reality for the non-offending parent
- providing an opportunity to talk about the reactions, thoughts and fears held
- enabling the parent to move through the process of belief to a position where they can acknowledge the child's experience and respond to the child in a supportive, non-blaming way
- ceasing the offender's contact with the child
- emotional support for the child can be provided by a non-offending parent who is supported with their own emotional needs.
- providing information about the risks following disclosure and the needs of the child.

SEXUALISED BEHAVIOUR PROBLEMS IN CHILDREN AND YOUNG PEOPLE



Practice point:

It is important to highlight the difference between the two terms, **'Problematic Sexual Behaviour'** and **'Sexually Abusive Behaviour'**.

'Problematic Sexual Behaviour'

Problematic Sexual Behaviour

Sexual behaviours that are outside of normal child development and sexual exploration. They can vary from excessive self-stimulation, sexual approaches to adults, obsessive interests in pornography, and sexual overtures to other children that are excessive to developmental bounds. These acts would be considered abusive if not for the child's young age.

Sexually Abusive Behaviour

Sexual behaviour that poses a risk to the safety, welfare and well-being of the child or young person and to other children or young persons. These abusive behaviours tend to continue even after the child or young person has been told to stop. Sexual activity may include fondling, masturbation, oral sex, penetration of a vagina or anus using a penis, finger or object, or exposure to pornography.



Access and read **'Understanding Problem Sexual Behaviour in Children'** from the readings on the LMS to support learning for this topic.



Access and read **['Sexual behaviours considered developmentally appropriate and sexually abusive behaviours in children and young people'](#)** on the intranet



The following scenario provides an opportunity for you to explore some of the key issues when addressing sexualised behaviour in children. Read the scenario and answer the following questions.



Scenario – George

George (6 years old) and his sister Christina (3 years old) reside with their maternal grandmother, Anna, in a supported care placement. Anna has reported to an OOHC caseworker that George has been 'pinching' Christina's vagina and tends to do so in Christina's bedroom when he thinks Anna's attention is elsewhere.

At times, when Anna is sitting on the couch watching TV with the children, George has tried to touch Anna on her breast under her clothing and has tried to put his hand on Anna's crotch, also under her clothing.

George has been in Anna's care for approximately 12 months. Prior to this he was living with his parents Helen and Steve. This relationship was violent and George was frequently exposed to this. Helen ended the relationship when George was 3yrs old. She then began a relationship with Marco, who is the father of Christina. This relationship was characterised by violence and drug use. When Helen and Marco were arrested and sentenced on drug charges, a family arrangement saw the children placed in Anna's care. This arrangement was initially a voluntary family agreement, however, Anna contacted FACS and commenced a supported care arrangement 12 months ago with a view to formalise the placement.

George's father Steve resides in Anna's home with the children from time to time. Anna reports that she has observed Steve lavish attention on George and virtually ignore Christina. Anna reports that when Steve is around, George's behaviour becomes uncontrollable, and that he 'idolises' his father. Anna has asked Steve not to stay there, as he disrupts the children's routines, but Steve continues to turn up, saying he has nowhere else to go.

When Steve is around he insists on sleeping with George. Anna has observed that Steve will sleep nude with George and never closes the bathroom door when using the toilet or showering. Anna reports that on one occasion she walked into the bedroom and saw both Steve and George on the bed watching pornography on the TV. Anna stated that she asked Steve to turn it off as she didn't think it was appropriate for George to be watching this. Steve responded by saying 'He's gotta learn some time!'

Is George's behaviour developmentally appropriate? Why/why not?

What further information would you need to gather to have a better understanding of the interaction between George and Christina? Is there reason to believe George has been or is being sexually abused?

Given the information presented in the scenario, what are some of the factors that may explain George's sexualised behaviours?

SIBLING SEXUAL ABUSE

Sibling abuse differs to other forms of sexual abuse in that:

- it is likely to happen more frequently
- it is more likely to involve penetration
- it is easier to abuse someone in your own home
- the relationship between siblings will impact on the initial information that will be disclosed leading to hesitancy/partial disclosure, frequency of retraction
- the response of those around the child following the disclosure has further impact on the child's recovery, for example support is likely to be chaotic in the case of sibling sexual abuse
- the response of others will also influence whether the child's discloses again in the future.



Access and read '**Sibling Sexual Abuse**' from the readings on the LMS to support learning for this topic.

How might parents/carers respond if they are informed that one of their children is sexually abusing another sibling?

The following strategies may be useful to ensure the needs of both children are met in a situation of sibling sexual abuse:

- talk with parents about how they want to help their children
- do not label either child
- discuss the abuse as 'behaviours' and that behaviour can be changed through intervention
- explain why a safe placement for their child is in the best interests of both children and the family
- be sure that responsibility always remains with the child or young person who sexually abused
- provide further information to parents and children
- talk about challenges that can arise through intervention.

It is important to remember that if the victim child or young person (including the child or young person displaying sexually abusive behaviours) is under 18 years, they are both our clients. It would be a conflict of interest however, to have both clients on your caseload

Also, should a sibling sexual abuse matter be accepted by JIRT, the JIRT unit will case manage the victim child, while the CSC will case manage the young person with the sexually abusive behaviours.



The Sibling Case Coordination procedures should be referred to in this instance.
<http://cwp.docsonline.dcs.gov.au/en/Procedures/Specific-Report-Types/>



KEY POINTS FOR PRACTICE

There is no 'typical' offender blueprint or demographic. Whilst more likely to be male, a person who perpetrates child sexual abuse may be of any age, occupation, walk of life, religious belief, culture and have differing sexual preferences. In assessing a child's safety the dynamics of intra-familial sexual abuse and the risk to other children in contact with the alleged offender will need to be considered.

FACS maintain a position of belief when responding to a child's disclosure of sexual abuse. It is important to reinforce that a child or young person's disclosure is believed and also be aware of any message, body language or facial expression that could be conveyed to the child. Acknowledgement of their trust in making a disclosure is essential.

The non-offending parent will often waver between belief and non-belief as they manage the shock of a child's disclosure. The conditioning/grooming tactics used by the offender against the non-offending parent may continue to occur or affect them following the child's disclosure. It is vital to be aware that caseworkers may also be vulnerable to an offender's conditioning tactics and should implement strategies such as utilising critical reflection during case reviews or supervision to manage this. Whilst it is important to case plan strategies that engage the non-offending parent and work toward them establishing a position of belief and support, our primary focus is the safety and welfare of the child.

During assessment, consider any factors that may be contributing to the child's sexualised behaviour. Discuss with the child, their parents and any professionals as to how best to implement appropriate supervision and a practical safety plan. This will reduce the risk both to the child and other children who may be at risk. Therapeutic intervention is required to address the behaviour.

Siblings not only usually live in the same household, they generally attend the same school, family functions, social and sporting events and cultural activities. A case plan will not only need to include appropriate placement arrangements for the safety of all children at risk but must also consider their safety in other circumstances (e.g. school and family functions) as well as how to maintain their sense of identity.

SELF CARE



'It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself.'

*Ralph Waldo Emerson
(American essayist, lecturer and poet 1803-1882)*

In Module 1 you were referred to the [Self Care Toolkit](#) located in the 'key resources' section on the LMS.



For this module, access and read the "**Warning signs and symptoms of stress**" fact sheet from the LMS.

Print and complete the '**Taking your stress Temperature tool**' worksheet.

Discuss this self care topic with your MCW in supervision.



WHERE TO GO FOR FURTHER LEARNING SUPPORT

Readings

You will find a number of additional references and resources listed below and in the Module 5 Readings booklet . These references will extend your learning for the topics covered in this module and will be useful resources which you can refer to in your future casework practice.

Policy

[Joint Investigation Response Team Criteria](#)

[Sibling Case coordination procedure where a JIRT and a CSC are involved](#) - Casework Practice guidelines for responding to risk of harm reports about siblings living in the same household where one sibling's case has been accepted for investigation by JIRT.

[Responding to reports involving registrable offenders](#) - Casework Practice guidelines for responding to risk of harm reports about children or young people who reside or have regular contact with persons on the NSW Child Protection Register.

[Guidelines for responding to a report about a child or young person who has displayed sexually abusive behaviour toward another child or young person](#)

People

Manager casework – Your manager casework can provide you with information and support in relation to all aspects of casework, in particular working with children, young people and families where physical and sexual abuse are notified ROSH issues requiring assessment.

Casework specialist – casework specialists work with caseworkers and managers to support your practice and integration of knowledge and theory into case practice skills in the field with families. They are also available for consultation, coaching and case practice reviews for complex and sensitive matters.

Joint Investigative Response Team (JIRT) – your local JIRT office works collaboratively with NSW Police & NSW Health in assessing and investigating reports of serious neglect, physical and sexual abuse that meet the JIRT referral criteria. To locate your nearest JIRT see the contact list at: <http://docsonline.dcs.gov.au/service-delivery/joint-investigation-response-team>

Departmental psychologist – psychologists are available for consultation on complex child abuse issues, including cumulative harm and its impact. They also work with families and children. There are psychologists based in most CSCs. There is a psychology team leader in each district based in a district office. If you are unsure of who your local psychologist is, contact Psychological.Services@facns.w.gov.au

Child Protection Unit (CPU) NSW Health – CPUs are located at major Children’s Hospitals such as Sydney Children’s Hospital in Randwick, Westmead Children’s Hospital and John Hunter Hospital in Newcastle. They work with children who are victims of sexual abuse and their carers. CPU can conduct forensic medical examinations of children who have been reported to be physically or sexually abused. <http://www.kidsfamilies.health.nsw.gov.au/current-work/child-protection-and-violence-prevention/child-protection-units-and-counselling-services/>

Child Protection Counselling Service (CPCS) NSW Health is a counselling service that takes referrals exclusively from FACS. This service works with children, young people and non-offending parents where substantiated physical abuse, emotional abuse or neglect has occurred. <http://www.kidsfamilies.health.nsw.gov.au/current-work/child-protection-and-violence-prevention/child-protection-units-and-counselling-services/>

Resources

‘Child Sexual Abuse and Disclosure, What does Research tell us?’ authored by Dr Catherine Esposito, Office of the Senior Practitioner.

Child Sexual Abuse seminar presented by Dale Tolliday (Clinical Advisor NewStreets & Cedar Cottage Services), March 2014. You can watch the presentation via YouTube [here](#) (14.28 mins).

NewStreet Adolescent Service works with children and young people who display sexually abusive behaviours and has locations in Parramatta, Hunter New England (Newcastle and Tamworth), Central Coast and Dubbo (Rural Newstreet).

The Office of the Children’s Guardian have a list a counsellors who are qualified to work with children or young people (as well as adults) who display sexually harmful behaviour toward other children and young people.

Services for children and young people who display or are victim of sexually abusive behaviours provides a list of services for victims or offenders of sexual abuse, mental health services, and family counselling.

Adolescents with Sexually Abusive Behaviours and their Families - A Victorian resource. Safety planning for adolescents who engage in sexually abusive behaviours.

Australian Childhood Foundation aims to safeguard children by raising awareness about child abuse and neglect, and providing information and resources.

NSW Ombudsman - publications in child protection.



EXTENDING PRACTICE

Now that you have completed this module, you may wish to consider tasks to extend your practice.

These activities are designed and suggested as optional, additional activities to further develop skills, knowledge and attitudes in relation to neglect and psychological abuse. These tasks are **not** assessed and may be undertaken at anytime after this module is completed.

Practice ideas

Preparation for supervision

Use this opportunity to consider topics for reflection in supervision with your manager. As a starting point you might like to consider personal attitudes to physical discipline and how this will impact on your casework. Reflect on your attitudes and beliefs in regard to working with victims, non-offending parents and offenders of child sexual abuse.

Interagency visit – Child Protection Unit or Child Protection Counselling Service (CPCS) NSW Health

Consider arranging a visit or telephone call to a NSW Health Child Protection Unit (CPU) or Child Protection Counselling Service (CPCS). You may wish to discuss service provision (including differences from other child and family outpatient Health services), referral criteria and processes. In the case of CPU you may also wish to discuss outcomes for clients and non-offending parents working with the service and communication between FACS and the Child Protection Unit. In the case of CPCS you may also wish to discuss how the service works in collaboration with FACS to reduce the risk of harm to a child or young person.

Visit to a JIRT

In consultation with your manager, consider contacting your local JIRT office and asking if they have an information session about the JIRT service coming up. Often JIRT's will schedule an upcoming information session for their local CSCs and students on placement interested in finding out about JIRT when they have enough numbers.

Section 173 Medical assessment

Where a case requires an s.173 medical assessment, consider undertaking a secondary role. Prior to attending, assist in the preparation of documentation as required under s.173 and service of documents in this regard. Arrange the medical appointment, and where appropriate, observe the medical assessment. Obtain, review and follow up any issues identified in reports following the medical assessment.

Sharing information

By now you may have already sought and/or shared information with NSW Health under Chapter 16a or s.248 of the Act. Consider a case that has involved physical or sexual abuse of a child or young person that requires further information from a prescribed service. In consultation with your MCW, prepare any documentation required to request information. Use this opportunity to formulate appropriate questions to ask the agency and send to the relevant authority. Review and analyse the information that is received and consider how it applies to your case planning for this child or young person. Ensure you record information on KiDS appropriately.

References:

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Lawrence A. (1998) *Facing the unthinkable: A survival guide for mothers whose children have been sexually abused*. Dymna House, pp2-48.

South Eastern Centre Against Sexual Assault (2010) The four preconditions model: A model to understand why/how someone may sexually abuse, retrieved from <http://www.secasa.com.au/pages/theories-on-why-sexual-abuse-happens/the-four-preconditions-model/>

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Tolliday, D. (2014) *Child Sexual Abuse and Managing Risk*, Research to Practice seminar, NSW Department of FACS.

http://docsonline.dcs.gov.au/internal-services/research--evaluation-and-data/research-to-practice/past-seminars/child_sexual_abuse.html