NSW GOVERNMENT | Family & Community Services

Module 5
An Overview of Child Abuse and Neglect

Learner workbook

Casework support worker name:

Workbook completion noted by L&D learning support officer:

Signature: **Date:**

Table of contents:

PURPOSE

The purpose of this module is to familiarise casework support workers with the different types of neglect and the dynamics of emotional/psychological harm, physical and sexual abuse.
The module recognises the personal reactions that may be evoked when learning about child abuse and working within the child protection context. At completion of the module you will be encouraged to consider self-care strategies in recognition of the impact of child protection casework on you as an individual.

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:

http://intranet.FACS.nsw.gov.au/human_resources/workforce_safety_and_wellbeing/health-and-wellbeing

Or contact EAP directly on: 1300 687 327

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

- Identify personal reactions to child protection work and strategies to build resilience
- Develop and use self-care strategies
- Identify the dynamics and impact of psychological abuse
- Identify the dynamics and impact of neglect
- 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 designed to consolidate your learning and provide you with a sound research base for casework practice. The Module 5 'Essential Readings' can be found on the FACS learning portal for this module.

- Emotional abuse in children and adolescents
- Emotional and psychological abuse: behavioural forms
- Summary of FACS (DoCS) neglect policy
- Types of neglect
- Managing neglect
- Vicarious trauma

Audio-visual resources:

For whose sake – accessed via the FACS online learning portal page.

Intranet resources

The FACS intranet site will assist your learning in this module. The following documents can be located on the intranet.

- **FACS (DoCS) neglect policy**

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
- A home visit as a secondary caseworker to increase understanding of the dynamics and impact of neglect on child development.

Workbook completion and suggested activities:

Completion of this workbook is a mandatory learning activity, though not assessed by Learning and Development (L&D). The workbook contains a number of practical field based activities designed by L&D 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 manager and L&D learning support officer know. A checklist for your

manager casework to complete and sign is attached to each module. Your learning support officer will review the MCW checklist for each workbook to confirm all activities have been completed.

PSYCHOLOGICAL AND EMOTIONAL HARM

Emotional abuse refers to a parent or caregiver's inappropriate verbal communication or symbolic behaviours toward a child and/or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Such acts of commission or omission have a high probability of damaging a child's self-esteem or social competence. Emotional abuse generally takes five main behavioural forms:

- **rejecting:** the adult refuses to acknowledge the child's worth and the legitimacy of the child's needs
- **isolating:** the adult cuts the child off from normal social experiences, prevents the child from forming friendships, and makes the child believe that he or she is alone in the world
- **terrorising:** the adult verbally assaults the child, creates a climate of fear, bullies and frightens the child, and makes the child believe that the world is unpredictable and hostile
- **ignoring:** the adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development
- **corrupting:** the adult 'mis-socialises' the child, stimulates the child to engage in destructive antisocial behaviour, reinforces that deviance, and makes the child unfit for normal social experience

Price-Robertson & Bromfield, (2009)

It is suggested you read **'Emotional and psychological abuse: behavioural forms'** from the readings to support learning for this topic.

Access and read **'Emotional abuse in children and adolescents'** from the readings on the FACS learning portal to support learning for this topic.

Scenario – Carlos and Elena Rodriguez

Carlos Rodriquez is eight-years-old and his sister Elena is five-years-old. They both reside with their natural mother, Angelina and her boyfriend Luis. The children consider Luis their father as they have never met their biological fathers. Carlos and Elena both attend the local primary school while their mother works full time at a local café. They have no contact with their paternal or extended maternal families and all the children's social interactions are limited to time spent at school and in the family home.

Within two weeks of joining the family, Luis physically assaulted Angelina for the first time. It followed an argument in the kitchen about money because Angelina had told him that he had not been pulling his weight. Their argument turned violent after Luis pushed Angelina up against the fridge and struck her repeatedly with a saucepan whilst shouting in her face. The children, who had been watching the television, heard their mother screaming and came running into the kitchen. They both saw blood trickling from their mother's lips and began to cry.

The following day, Carlos asked Luis not to hurt his mother anymore or he would tell the police. Luis laughed in Carlos's face and said 'You are just a stupid, fat kid! No one would ever believe you anyways, so go right ahead; I double dare you to tell someone. Your mum knows that she deserves everything that she gets from me. Your mum said that she would send you to an orphanage if you tell anybody, so you go ahead and do what you please, Fatty!' Carlos ran into his room and wept under the bed. Angelina told Carlos that he was being a baby and that he needed to grow up and mind his own business.

Over the next two years, the domestic violence within the home increased in severity and frequency. Luis would often perpetrate his violence while the children were present within the home and in earshot of the dispute. The children would get very distressed and upset when this occurred and Luis appeared to enjoy watching their reactions.

On numerous occasions, Luis would pick a fight with Angelina regarding her children. He would often say things like 'Elena is too old to get hugs from you like that. Let her go and hug me instead, I love you more than she does!' When Angelina would refuse to stop hugging her daughter, Luis would pick up a nearby object and threaten Angelina until she succumbed to his orders. Afterwards, Luis would tell Elena that her mother didn't love her and that they were thinking about getting rid of Carlos and her so they could live alone. Luis would also play the children against each other by favouring one on any given day and ignoring the other. During these episodes, Luis would also attempt to engage Angelina in the same type of behaviour, which occasionally worked.

Eventually Luis only addressed Carlos by calling him 'Fatty' and urged Angelina and Elena to do the same. They would comply as they were fearful of his reaction if they did not. Carlos' became withdrawn at school and would gorge on food before and after school and started having trouble sleeping throughout the night. Elena started getting aggressive with classmates when she did not get her own way. When the school approached Angelina in the presence of Carlos and Elena, she explained that Carlos was 'just a naughty kid and needed to grow up and obey the rules'. School teachers made two reports to Helpline. The reports highlighted concerns about Carlos sleeping and withdrawing in class, his mother's battered appearance and Elena's increased aggression.

Two years after Luis moved in with Angelina and the children, Carlos and Elena came home from school and found their mother unconscious. They called an ambulance and Angelina was admitted to the emergency department of the hospital with a serious skull fracture. Luis told hospital staff that Angelina had fallen down the stairs and hit her head, however the children knew he was lying but were too frightened to tell anyone. Hospital staff believed Luis's story and allowed him to return home to 'care' for the children while Angelina remained in hospital.

Angelina's skull fracture required an operation and a 10 week hospital stay. She insisted to hospital staff that both her children remain in the home with Luis. During this time, Luis was the full-time, sole carer of both Carlos and Elena while their mother received treatment. Luis did not allow the children to visit their mother while she was in hospital and informed them it was because their mother had requested not to see them. Each day, Carlos was relentlessly cursed and verbally abused by Luis. Both Carlos and Elena's behaviour worsened to the point that they could not function during class. The school made another report to Helpline.

3 month update:

After an initial visit, the children were removed from Luis' care and placed in temporary foster care. Angelina slowly recovered from her head injury, and moved in with her mother to support her recovery. Luis has been attempting reconciliation with Angelina, however after involvement with FACS, it is clear that Angelina can only regain the care of her children if Luis does not to have any further contact with the family, and she attends a Child Protection Counselling Service.

Prior to answering the following questions, please:

i) Take a moment to consider the reaction you have to reading the following case information.

ii) Consider why is it important to acknowledge your reactions to exposure to traumatic material?

From the case study, give examples of the following behaviours (for either/ both children):

Rejecting	
Isolating	
Terrorising	
Ignoring	
Corrupting	

Review the developmental material that was provided in your Module 2 Readings, and consider the effects of this type of abuse for Elena and Carlos.

In your CSW role, you have been asked to complete the referral forms for Angelina to attend counselling. Answer the following questions:

What are the types of abuse the children have experienced?

Provide a brief history and summary of the family's current situation for the counselling referral.

NEGLECT

Neglect refers to the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing. Neglectful behaviours can be divided into different sub-categories, which include:

- **physical** neglect is characterised by the caregiver's failure to provide basic physical necessities, such as safe, clean and adequate clothing, housing, food and health care;
- **emotional** (or psychological) neglect is characterised by a lack of caregiver warmth, nurturance, encouragement and support (note that emotional neglect is sometimes considered a form of emotional maltreatment);
- **educational neglect** is characterised by a caregiver's failure to provide appropriate educational opportunities for the child;
- **medical neglect** is characterised by a caregiver minimising or denying a child's health needs, and failing to seek appropriate medical treatment or the administration of necessary medication.
- **nutritional neglect** is characterised as the inadequate nutritional provision for a child that impacts on his/her normal growth and development.
- **supervision/guidance**; this is categorised in three different forms of neglect:
    - Inadequate supervision
    - Exposure to hazards
    - Lack of appropriate guidance
- **environmental neglect** is characterised by the caregiver's failure to ensure environmental safety, opportunities and resources (Price-Robertson & Bromfield, 2009).

Consider the brief scenarios listed below where you have observed the following details. Complete the table by noting the type/s of neglect that the scenario may fall into, what information you have observed or been told, and why this information concerns you.

Please note: these scenarios are very brief, and for the purpose of learning only. Comprehensive and holistic assessment of children and families would always need to take place to determine to safety and wellbeing of children in any of these situations.

a. A three month old baby in the care of her 5-year old sibling for 2 hours. The baby is dressed appropriately and does not seem distressed.

b. A 4 year old child clothed in dirty shorts and a t-shirt on a very cold and wet day. The child looks unusually thin and says that Mum has gone to the club for the night (it is 5pm).

c. A 6 year old child telling you that Dad works on the mines 3 weeks on and 3 weeks off. He is boasting that while Dad is away he and his brother (9yo) can do what ever they want because Dad leaves them with enough money.

d. A grandparent is telling you about some concerns she has for her grandchildren aged 2 & 4yo. She says that her daughter and son-in-law care for their children's physical needs (food, clothing etc), but just don't seem to care for them. She gives the example that the children are left to their own a lot; don't get talked to, and just are not 'loved'. There are no routines they just watch TV. Dad works very long hours, and she thinks her daughter is clinically depressed, as she does not leave the house.

Scenario	Type/s of Neglect	What have you observed? What are your concerns?
a) 3 mnth old in care of 5 year old		
b) 4 year old unsupervised		
c) 6 and 9 year olds left by dad		
d) 2 and 4 year olds with their grandparent		

Access and read **'Summary of FACS (DoCS) neglect policy'** and **'Types of neglect'** from the readings on the FACS learning portal to support learning for this topic.

Access and read **'Managing neglect'** from the readings on the FACS learning portal to support learning for this topic.

Talk with an experienced Caseworker or Casework Specialist about the different strategies that are used to assist families where neglect is the primary issue.

Discuss how the different strategies mentioned in your reader, together with other types of support that caseworkers use, assist families in making positive changes for the care of their children. Document some ideas in the space below:

Legislative links

Children and Young Persons (Care and Protection) Act 1998

The *Children and Young Persons (Care and Protection) Act 1998* provides the statutory framework for risk of harm assessment and protective action by FACS.

- **s.23 (2) – Children and young people at risk of significant harm**

Any such circumstances may relate to a single act or omission or to a series of acts or omissions.

The amendments to legislation following the Special Commission of Inquiry into Child Protection in NSW recognises cumulative harm under risk of significant harm.

PHYSICAL ABUSE OF CHILDREN

Physical discipline of children

Access and read **'Physical discipline of children'** and **'Corporal Punishment'** from the readings on the FACS learning portal to support learning for this topic.

Reflective question: (no written response needed here)

Spend a moment to think about **your** experiences of discipline as a child. How do you think that the following influenced your experiences?

- your family identity, values and beliefs/make-up of your family
- the country, state, suburb you were raised in
- your family's cultural identity
- the economic resources of your family (ie: socio-economic status)

Why is it important to engage in reflective practice when working in child protection, especially when considering physical punishment/ abuse?

From your reading material, review the terms physical discipline, physical abuse and lawful correction in the spaces provided below.

Physical discipline:

Physical abuse:

Lawful correction:

Summarise the main points of difference between these terms:

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	• 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. • Bruises on knees, shins, foreheads, and elbows may be either inflicted or non-accidental. • All bruises on non-mobile children are suspicious. • Symmetrical patterns of bruising may indicate intention (e.g. on each earlobe). • 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. • Other distinctive shapes may indicate the use of an implement. • Ligature bruises may be caused by ropes tied around the child's ankles or neck, resulting in a bruise or a burn. • Slap marks/small dots - fingers may leave bruises on the face or buttocks. • 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.
Lacerations/cuts	• 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. • Cuts to soft tissue areas such as abdomen, throat, buttocks, and thighs may affect internal organs. • Injuries to buttocks, lower back, or thighs can be caused by whipping. • Lacerations of the ear, nose, or throat do not tend to occur accidentally and should arouse suspicion. • A torn fraenulum 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.
Bites	• Human bites appear as distinctive oval to horseshoe shaped marks in which teeth impressions appear as bruises facing each other. • Torn flesh is usually a dog bite; compressed flesh is usually a human bite. • Difference in size between a child and adult's bite. • Adult bite marks are a sign of serious danger to a child – uncontrolled aggression. • Victim's teeth should be examined and measured to exclude the possibility of a self-inflicted bite. This would be determined by a doctor.
Burns/ scalds	• Symmetrical or even burns may indicate intention or force. • Burns with a clear, crisp 'waterline' may indicate intention or force of holding a child in hot water. • 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. • Accidental burns will generally be asymmetrical or have splash marks. • Splash burns may be caused by the offender throwing hot liquid at the child. Splash burns on the back or buttocks are highly suspicious. • 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). • Chemical burns of the mouth and throat, vomiting, and oesophageal damage may indicate forceful ingestion of household cleaners or poisons.
Fractures and dislocations	• All fractures on non-mobile children are suspicious. • Rib fractures in children two years or younger are suspicious because a child's ribs are cartilaginous. (Comprising of soft cartilage rather than bones.) • 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. • Skull fractures.
Internal injuries	• 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. • 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. • Neurological damage from head injuries – force required is generally more than a fall including from a crib/couch/bed/highchair/bath.
Intracranial injuries (previously known as Shaken Baby Syndrome)	• 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. • A child may also be thrown against an object resulting in a blunt force injury. This may occur alongside other presenting injuries. • 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. • There is often an absence of externally visible injuries, but retinal haemorrhage and subdural haematoma are common.

Why is it important to have this knowledge as a CSW?

If you noticed a mark on a child that causes you some concern, how would you ask a child about their injury?

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.

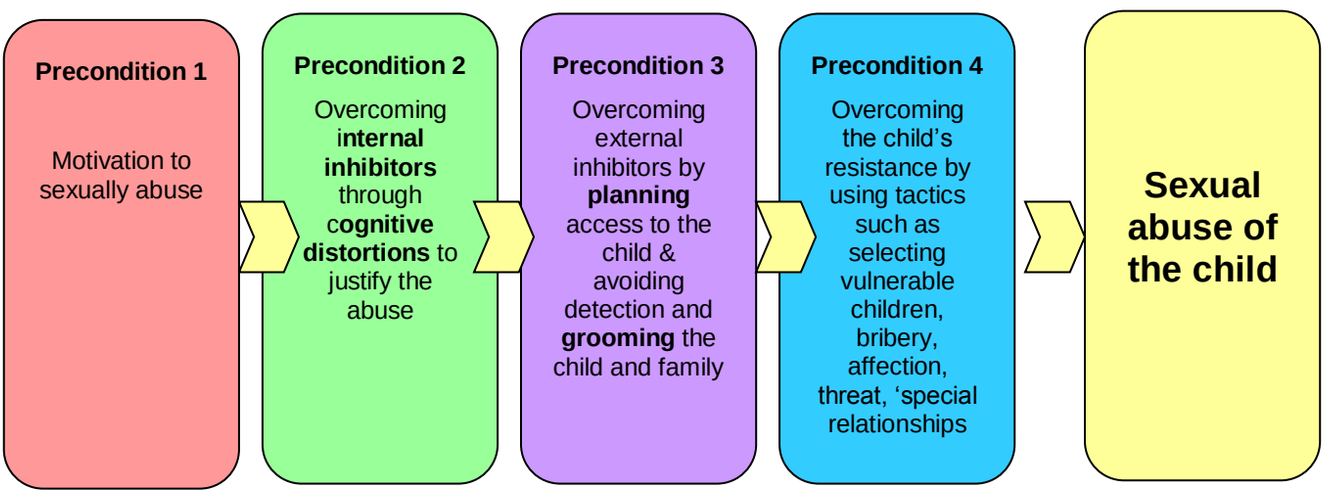
- S.173 – Notice requiring medical examination.
- S.23(c) – Child or young people at risk of significant harm – where the child or young person has been, or is at risk of being physically or sexually abused or ill-treated
- S.30 – Secretary's investigations and assessment

DYNAMICS OF CHILD SEXUAL ABUSE

Grooming and offender tactics

During the child protection dynamics workshop you were presented with considerable information about the role of 'grooming' in child sexual abuse and the many tactics offenders use to 'set up and maintain' an environment that enables sexual abuse to occur. During the workshop these tactics were initially discussed through the presentation of the following model (developed by David Finklehor, 1984) explaining why and how sexual abuse happens.

Finklehor's four factor model



Four factor model: four preconditions for abuse

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.

Please note:

Addressing the content of child sexual abuse, in particular exposure of the deliberate tactics that are used by offenders can provoke an emotive response for many caseworkers. It is important when reading the material required for this activity, and others in this module, to stay conscious of the need for self care strategies as well as other professional support strategies e.g.debriefing and supervision.

Access and read **'Offender tactics'** and **'What sexual offenders tell us about prevention strategies'** from the readings on the FACS learning portal 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 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.

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

What is your reaction to this material? What questions does it raise for you? Where might you go to get some answers?

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 victim. 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 victims, 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 FACS learning portal to support learning for this topic.

Read the following scenario and answer the questions below.

Scenario – Trudy

Trudy 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 Trudy has been away sick. Today, Trudy'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 Trudy to be wearing lycra bike pants under her school uniform. Trudy 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, Trudy appeared to be withdrawn and paying little attention to the teacher.

When the students were about to begin the training, Trudy approached Ms Jones and stated that she did not feel well and said she had a headache and a sore throat and Trudy spoke with a croaky voice. Trudy said she needed to go to the sickbay. At the end of the class, Ms Jones overheard Trudy talking to friends and she was not speaking with a croaky voice and appeared to be in good spirits. Ms Jones overheard Trudy 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 indicators could lead you to suspect that Trudy may have been sexually abused?

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).

Four key areas have been identified as important for exploration when attempting to understand the impact and effects of child sexual abuse on the child/young person. These key areas relate to the conditioning and tactics used by offenders and the dynamics set up within the relationship between them, the child and their family. The four areas are:

1. **Responsibility** (child feels responsible for the abuse in some way)
2. **Secrecy** (keeping the abuse secret)
3. **Protection and loyalty** (child may protect others from knowledge of their abuse and protect the offender from being found out.)
4. **Power/powerlessness** (feeling like they have no power to stop or tell someone about the abuse).

These dynamics highlight the complex and challenging nature of working with children who have been sexually abused.

There may be a number of things that children or young people do to adapt and/or resist sexual assault, such behaviours may be to stay away, self harm, use alcohol or drugs, withdraw, experience depression, anxiety, or bed wet.

Access and read **'Common effects of child sexual abuse'** and **'Dynamics of child sexual abuse'** from the readings on the FACS learning portal to support learning for this topic.

Note the main points of learning from this material.

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 underneath the behaviour.
- can provide a context and rationale for effects and behaviour.
- identifies the individual experience and impact based on the specific dynamics of the abuse.
- can help expose (to child and caseworker) the offender tactics and make the link between what the offender has done and how it has impacted on the child.

Access and read the section on **'Supporting children's disclosure'** from the readings on the FACS learning portal to support learning for this topic.

Scenario

You are transporting a 12yo boy who has been in out of home care for the past 5 years. His foster carers have voiced concern as he has become withdrawn and uninterested in his favourite activities – especially cricket (which he has excelled at). You are driving him to an appointment for assessment.

On the way you mention that you love cricket and you have heard he really excels at this sport. As he is looking out the window he states angrily underneath his breath (only just audibly) 'Maybe if I wasn't so good, coach would stop feeling me up'.

What would you say next? What might you say to him?

Cumulative harm

Cumulative harm refers to the effects of multiple adverse or harmful circumstances and events in a child's life. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.

Cumulative harm may be caused by an accumulation of a single recurring adverse circumstance or event (such as unrelenting low-level care); or by multiple circumstances or events (such as persistent verbal abuse and denigration, inconsistent or harsh discipline, and/or exposure to family violence).

This means cumulative harm may be a factor in any protective concern (such as neglect, physical abuse, emotional abuse, sexual abuse or witnessing family violence). Also, because cumulative harm can be caused by a pattern of harmful events, it is unlikely that a child will be reported to child protection explicitly due to concerns about 'cumulative harm'. This means that as caseworkers, you need to be alert to the possibility of multiple adverse circumstances and events in all reports, and to consider not just the information presented in the current report but the past history of involvement that may be indicative of cumulative harm.

(Source: **Every child every chance**)

Outline why understanding the effects of cumulative harm for children is so important in child protection?

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 FACS online learning portal.

For this module, access and read the '**Warning Signs and Symptoms of Stress'** factsheet and complete the **'Stress Temperature tool'** from the FACS online learning portal.

Discuss these self care topics with your MCW in supervision.

KEY POINTS FOR PRACTICE

- It is particularly relevant to be alert to the possibility of cumulative harm in cases of chronic neglect that are characterised by an unremitting low level of care. The cumulative effects of chronic low-level neglect are easily missed because the term ‘abuse’ suggests a ring of urgency that ‘neglect’ does not and the effects of neglect are usually not as obvious. It is critical that neglect is not considered a lesser problem than other forms of maltreatment given the evidence that its consequences can be damaging. It is also important that the presence of chronic neglect does not obscure other forms of maltreatment.

- Recent research evidence on cumulative harm has shown that a child can be as severely harmed by the cumulative impact of less severe risk factors and incidents e.g. prolonged exposure to neglect and family violence, as by a single severe episode of harm.

- Caseworkers and casework support workers need to gather information from multiple sources. The parents or carers are usually the starting point for your discussion. However, the extended family and other professionals who know the child and their family should be considered as a valuable source of information and often as a partner in decision making and the process of recovery. Think broadly to identify the people who are close to the child or see them routinely to comment on the changes over time.

- Where there is harm, caseworkers and casework support workers are reminded that a referral to another service will not ensure that the family will engage with that service or that change will occur. There needs to be active casework to ensure the family engages with the service in a meaningful way.

- There is no ‘typical’ perpetrator 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 intrafamilial abuse and the risk to other children in contact with the alleged offender may need to be considered.

- FACS maintains 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.

WHERE TO GO FOR FURTHER LEARNING SUPPORT

Policy

FACS (DoCS) Policy on child neglect

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.html**

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@facs.nsw.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).

EXTENDING PRACTICE

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

These activities are designed/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. These topics could include working with parents who neglect, physically abuse or sexually abuse their children; identifying abuse and neglect in children and young people or personal challenges and attitudes towards abuse and neglect; identifying children suffering from neglect and the impact on developmental milestones.

Agency visit

Consider arranging a visit or telephone call to a NSW Health Child Protection Counselling Service (also known as PANOC). You may wish to discuss service provision (including differences from other child and family outpatient Health services), referral criteria and processes. You may also wish to discuss outcomes for clients and parents working with the service and communication between FACS and the PANOC service. If possible, attend a protection planning meeting and/or case meeting with this service.

Sharing information

By now you may have already sought and/or shared information with NSW Health under Ch 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.

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