NSW GOVERNMENT | Family & Community Services

Module 5
An Overview of Child Abuse and Neglect

CSWDP Essential Readings

Table of Contents:

EMOTIONAL ABUSE IN CHILDREN AND ADOLESCENTS

Emotional maltreatment is also referred to as ‘emotional abuse’; ‘psychological maltreatment’ or ‘psychological abuse’. It relates to a parent or caregiver’s inappropriate verbal or symbolic acts towards a child or young person and/or a pattern of failing repeatedly over time to provide a child or young person with adequate non-physical nurture and emotional availability. This can include acts of commission or omission. Such acts are highly likely to damage a child’s self esteem and social competence (Price-Robertson & Bromfield 2009).

The following five categories all fall within the overall definition of emotional abuse and neglect (Glaser, 1993):

Emotional unavailability, unresponsiveness, and neglect:

Includes parental insensitivity. The primary carer(s) are usually preoccupied with their own particular difficulties such as mental ill health (including postnatal depression) and substance abuse, or with, for example, overwhelming work commitments. They are unable or unavailable to respond to the child’s emotional needs, with no provision of an adequate alternative.

Negative attributions and misattributions to the child:

Hostility towards, denigration and rejection of a child who is perceived as deserving these. Some children grow to believe in and act out the negative attributions placed upon them.

Developmentally inappropriate or inconsistent interactions with the child:

- expectations of the child beyond her or his developmental capabilities
- overprotection and limitation of exploration and learning
- exposure to confusing or traumatic events and interactions

This category contains a number of different interactions including exposure to domestic violence and parental (para) suicide. The parents lack knowledge of age-appropriate care giving and disciplining practices and child development, often because of their own childhood experiences. Their interactions with their children, while harmful, are thoughtless and misguided rather than intending harm.

Failure to recognise or acknowledge the child’s individuality and psychological boundary:

Using the child for the fulfilment of the parent's psychological needs.

Inability to distinguish between the child's reality and the adult's beliefs and wishes. Factitious Disorder by Proxy is one variant of this category. Category Four of emotional abuse is also not infrequently found in the context of custody and contact disputes within parents' divorce proceedings.

Failing to promote the child's social adaptation:

Promoting mis-socialisation (including corrupting);

Psychological neglect (failure to provide adequate cognitive stimulation and/or opportunities for experiential learning). This category contains both omission and commission, including isolating children and involving them in criminal activities.

Reference:
Price-Robertson, R. & Bromfield, L. (2009) What is child abuse? NCPC Resource Sheet, retrieved from **http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.html**

Glaser, D. (2002) 'Emotional abuse and neglect (psychological maltreatment): a conceptual framework', *Child Abuse & Neglect*, 26, 6-7, pp. 697-714.

PSYCHOLOGICAL AND EMOTIONAL ABUSE: BEHAVIOURAL FORMS

Type of Parental Behaviour	Infant	Toddler
Rejecting	• refuses to accept child's primary attachment • refuses to return smiles, punishes child for vocalizations • abandons baby.	• actively excludes child from family activities • refuses to allow child to hug caregiver, pushes child away; treats child differently from siblings.
Terrorising	• consistently violates the child's ability to handle new situations and uncertainty • teases or scares infants by throwing them up in the air, despite the child's obvious distress • reacts in unpredictable ways to the infant's cries.	• uses extreme measures to threaten or punish the child • verbal threats of mysterious harm such as attacks by monsters, leaving the child in the dark, etc. alternating rage with warmth.
Ignoring	• fails to respond to the infant's social behaviours which form the basis for attachment • mechanical care giving with no affection; failing to make eye contact with the infant.	• patterns of apathetic treatment and lack of awareness of the child's needs • does not speak with the child at meals, leaves the child alone for long periods of time, or does not respond to requests for help.
Isolating	• denies the child social interactions with others • refuses to allow relatives and family friends to visit the infant • leaves the infant unsupervised for long	• teaches the child to avoid social contact beyond the caregiver-child interaction • punishes child for making social overtures to other children; rewards child for withdrawing from social contacts.

	periods of time.	
Corrupting	• reinforces bizarre habits or creates addictions • creates drug dependencies; reinforces sexual behaviours.	• gives inappropriate reinforcement for antisocial behaviours. Rewards children for aggressive acts toward animals or other children • 'brainwashes' child into racism.
Type of Parental Behaviour	**School-Aged Child**	**Adolescent**
Rejecting	• consistently communicates to children that they are inferior or bad • uses labels such as 'bad child' or 'dummy', tells children they are responsible for family problems.	• refuses to acknowledge the changes in children as they grow up, attacking their self-esteem • treating an adolescent like a young child, excessive criticism, and verbal humiliation.
Terrorising	• places children in 'double binds' or places inconsistent or frightening demands on children. • sets up unrealistic expectations and criticizes the child for not meeting them. • forces the child to choose between parents or primary caretakers. • teases the child or plays cruel games.	• threatens to or actually subjects the child to public humiliation • threatens to reveal embarrassing facts to the child's friends • forces the child into degrading punishments.
Ignoring	• fails to protect the child from threats when caregiver is aware of the child's need for help. • fails to protect the child from assault by other family members • shows no interest in the child's education or life outside the home.	• gives up parenting roles and shows no interest in the child • says, 'this child is hopeless; I give up' and means it • refuses to listen to children's discussion of their lives and activities • focuses on other relationships at the exclusion of children.
Isolating	• attempts to remove the child from social relationships with peers • refuses to allow other children to visit the home; keeps the child from engaging in after-school	• over-controls the child's social interactions, restricting the child's freedom to an extreme degree • refuses to allow and/ or punishes the child for engaging in normal social activities (i.e. dating)

	activities.	• accuses child of lying, doing drugs, etc. whenever the child leaves home.
Corrupting	• continues to involve the child in illegal or immoral behaviour, encouraging the child to be part of this lifestyle at the expense of healthier behaviours • involves the child in prostitution • encourages the child to hit or verbally abuse siblings • encourages drug use.	• continues to involve the child in illegal or immoral behaviour, encouraging the child to be part of this lifestyle at the expense of healthier behaviours • involves the child in prostitution • encourages the child to hit or verbally abuse siblings • encourages drug use.

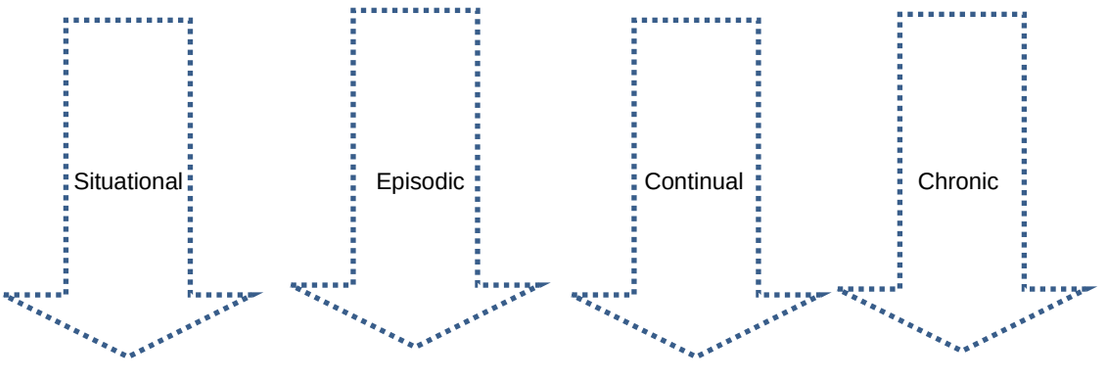
Reference:
This paper was created by Learning & Development and draws from NSW Department of Human Services, Family and Community Services, Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

TYPES OF 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 are an act of omission, or by willful choice, and can be divided into different types of neglect (Child Neglect, cobar.org, 2014, & Horwath, 2013):

- **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. This form of neglect can be difficult to assess due to differing values and ideas about standards of care. Physical neglect is generally the most common type of neglect, and it is also the most likely to receive trivial responses in casework practice. For example providing a skip bin to clean up rubbish in a house, rather than identifying and providing support and a sustainable solution to the underlying cause.
- **Emotional (or psychological) neglect** is characterised by a lack of caregiver's warmth, nurturance, encouragement and support. Many researchers have differentiated this type of neglect from emotional abuse based on the parent/caregiver's intent. It is argued that emotional neglect occurs as an act of omission or inability to provide adequate and appropriate responses to the child's emotional needs. In contrast, the parent/caregiver is emotionally abusive, by deliberately choosing to be unresponsive to the child's emotional needs.
- **Educational neglect** is characterised by a caregiver's failure to provide appropriate educational opportunities for the child by either failing to enroll him/her into a school or providing appropriate educational alternatives such as home schooling or special educational support and training that is needed.
- **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. This includes a parent/caregiver's refusal to provide medical care for an emergency situation or for a child's ongoing illness or disability that may be treatable, which results in the child's frequent hospitalisation or significant deterioration. In non-emergency situation, medical neglect can lead to overall poor health and compounded medical problems.
- **Nutritional neglect** is characterised as the inadequate nutritional provision for a child that impacts on his/her normal growth and development. This is generally termed as 'failure to thrive', which involves the child not achieving their physical and developmental milestones. In recent years, childhood obesity has been acknowledged as a form of nutritional neglect, due to the long-term impact on the child's health and wellbeing.
- **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).

CONTINUUM OF NEGLECT



- response to unusual life stressors/events
- carer may regress to established level of competence
- distraction from child's needs.

- response to periods/episodes of stress or challenge
- between episodes strengths and protective factors evident
- patterns of adaptation evident in many children.

- inability to manage self and complex issues
- poor coping often result of poor childhood experiences
- few alternative templates for coping or functioning.

- often personality based
- primary immaturity – preoccupied with own needs
- chaotic lifestyle/relations
- unresponsive to intervention – potential for change poor/very low
- child's needs rendered invisible.

GOOD ← **PROGNOSIS** → **POOR**

Situational Neglect can be identified as neglect that occurs because of a specific situation or crisis e.g. bereavement, and as such this will tend to only last up to a period of time, depending on the situation.

Episodic Neglect can be identified where an episode of neglect will generally recur at specific times in a person's life cycle e.g. binge drinking.

Continual Neglect can be identified as an ongoing distraction from the child's needs through persistent life difficulties e.g. untreated mental illness.

Chronic Neglect can be identified as where the caregivers are facing an enormity of complex problems, with multiple disadvantages and often with long term involvement with child protection and family support services e.g. chronic hazardous use of alcohol and other drugs.

References:
This paper was adapted from Killen (1982 & 1991) and created by NSW Department of Human Services, Family and Community Services, Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

Child Neglect (2014) Colorado Bar Association, retrieved from **http://www.cobar.org/index.cfm/ID/0/subID/5303/Child-Neglect**

Horwath, J. (2013) The Complex Issue of Child Neglect, Discussion Paper, Hartlepool Safeguarding Children Board.

NSW Department of FACS, Centre for Parenting and Research (2005) Neglect Key Issues, Research to Practice Notes **http://docsonline.dcs.gov.au/docsintwr/_assets/main/document/rfba/neglect_key_issues.pdf**

NSW Department of FACS (2014) 'Responding to Chronic Neglect', Facilitator Guide, V2

Price-Robertson, R. & Bromfield, L. (2009) *What is child abuse?* NCPC Resource Sheet, retrieved from **http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.html**

Watson, J. (2005) Child Neglect: Literature Review. NSW Department of FACS

Age Specific Indicators of Child Neglect

Physical	Development	Behavior
Key Features in Infants (0-2)		
• failure to thrive, weight, height and head circumference small • recurrent and persistent minor infections • frequent attendance at G.P, casualty departments. • hospital admissions with recurrent accidents/ illnesses • late presentation with physical symptoms (impetigo, nappy rash).	• late attainment of general developmental milestones.	• attachment disorders • anxious, • avoidance, • difficult to console.
Key Features in Pre-School Children (2-5)		
• failure to thrive, weight and height affected • unkempt and dirty/poor hygiene • repeated accidents at home.	• language delay, attention span limited • socio-emotional immaturity.	• overactive, aggressive and impulsive • indiscriminate friendliness • seeks physical contact from strangers.
Key Features in School Children (5-16)		
• short stature, variable weight gain • poor hygiene, poor general health • unkempt appearance • underweight or obese • delayed puberty.	• mild to moderate learning difficulties • low self-esteem • poor coping skills • socio-emotional immaturity • poor attention.	• disordered or few relationships • self stimulating or self injurious behaviour or both • soiling, wetting • conduct disorders, aggressive, destructive, withdrawn • poor/erratic attendance at school • runaways, delinquent behaviour.

Reference:
Child Neglect (2014) Colorado Bar Association, retrieved from http://www.cobar.org/index.cfm/ID/0/subID/5303/Child-Neglect

Horwath, J. (2013) The Complex Issue of Child Neglect, Discussion Paper, Hartlepool Safeguarding Children Board

NSW Department of FACS (2014) 'Responding to Chronic Neglect', Facilitator Guide, V2.

SUMMARY OF FACS NEGLECT POLICY

The Causes of Neglect

A number of factors have been associated with neglect. They can be categorised as parental, child and environmental factors.

Parental Factors:

Substance misuse, dysfunctional parent – child relationship, lack of affection, lack of attention and stimulation, mental health difficulties, low maternal self-esteem, domestic violence, age of parent/carer (risk generally increased for younger, teenage mothers), negative childhood experiences, history of parenting (previous abuse/neglect), dangerous/damaging expectations upon the child, inappropriate supervision, failure to seek appropriate medical attention, lack of social support.

Child Factors:

Age of the child (the younger the child, the higher the risk), children with disabilities and children with learning difficulties.

Environmental Factors:

Poverty, homelessness, financial stressors, unemployment.

FACS Neglect Policy – key messages

Message:	Implications:

1. Children need predictable, reliable and responsive care:	• All children are born wired for feelings, with a genetic predisposition to form strong attachments with their primary carers. All children are born ready to learn.
	• For healthy development the physical, social, intellectual and emotional needs of the child must be met.
	• Children's early experiences are critical in determining how they develop. Nurturing relationships are essential. Young brains need stimulation to trigger activity and help them grow and develop.
	• Parents and carers need to:
	  ○ be actively involved in the care of their child
	  ○ connect with and be sensitive to their child
	  ○ express warmth and affection with their child
	  ○ try to see the world through their child's eyes
	  ○ be aware of their impact on their child, and change their behaviour if needed
	  ○ adapt their parenting style according to the demands of different situations

2. Neglect seriously harms children:	• Neglect can cause serious and life-long harm. The consequences are particularly serious when neglect occurs during a child's early years. • A single incident of neglect can be fatal.

	• Chronic neglect involves repeated omissions of care. This results in cumulative harm for the child. • Neglected children suffer harm to their physical, cognitive, emotional, psychological, and social development. • If children are ignored or not responded to in their early relationships, or if their early relationships are disrupted, their ability to form healthy relationships can be a life-long problem. • Children who have been neglected are prone to internalising problems. This can result in low self-esteem, depression, social withdrawal, apathy, passivity, and helplessness. • Neglected children are often delayed in their cognitive and language development and have poor communication skills. They can also be delayed in their physical growth and development.

3. We misunderstand neglect if we look only at the current incident	• Neglect can be a single incident. But neglect that comes to the attention of Family and Community Services is usually repeated, and is often chronic.
	• Each incident, if viewed separately, can seem unimportant or even trivial. But repeated incidents result in cumulative harm for the child.
	• Understanding neglect means that we are aware of the possibility of a pattern of neglect when we are investigating an incident of abuse.
	• Understanding neglect means that allocation decisions take account of:
	  ○ the history and pattern of risk and harm.
	  ○ the cumulative harm impacts of neglect.

4. Neglect rarely exists on its own	• Neglect often coexists with other risk issues such as problem alcohol or other drug use, domestic violence, and mental illness. • Parents may be preoccupied with using, obtaining or paying for alcohol or drugs. This can impair their ability to see, prioritise, and meet their child's needs. • Intoxicated or drug-affected adults cannot accurately see risk for their child. Their judgement is impaired. • Babies and infants are at increased risk of serious physical harm if they share a bed with an intoxicated adult. • There is a strong relationship between maternal depression and neglect. • Living with mental illness can absorb a parent's attention and take their focus away from the child. This is particularly true where mental illness is undiagnosed

	or unmanaged. • Domestic violence often co-exists with neglect. Witnessing domestic violence has a serious impact on children. • Any chronic conflict between adults can mean their attention is focussed on each other rather than on their child.
5. Past behaviour is our best clue about a parent's capacity to care for their child	• Realistic assessment of parents' capacity to provide that care is a critical part of neglect casework. • Many parents who neglect their children are themselves experiencing significant problems and difficulties. These parents often do not intend to neglect. • For some caseworkers it can feel unfair to conclude that parenting is inadequate where parents are struggling and their neglect is unintentional. • Our empathy with parents in these situations can lead us to overestimate their capacity to manage their own issues while also providing the care their children need. • Our task is to realistically assess whether, with supports, the parent is both willing and able to provide predictable, reliable and responsive care over the long-term. • A parent's past behaviour is a key factor in determining parental capacity. Without strong and compelling evidence to the contrary, past behaviour is the best predictor of future behaviour. • Children need predictable, reliable and responsive care.
6. We need to understand Aboriginal perspectives to understand neglect in Aboriginal families.	• When working with Aboriginal families, we need to understand the impact of the Stolen Generations and the legacy of past welfare policies and practices. • While we need to understand the consequences of generational social and economic disadvantage, we also need to understand the resilience and strengths of Aboriginal families, kinship networks, and communities. • Cultural awareness and consultation with Aboriginal caseworkers is our best means of understanding and responding in a culturally sensitive way. • Consultation with Aboriginal Caseworkers should occur early in the assessment process and at each significant decision-making point in all cases. • Consultation will enhance engagement and support meaningful participation of Aboriginal families.
7. Understanding Neglect Means Focussing On The Experience	• Neglect may result in children feeling hungry, in pain, afraid, anxious, unloved and worthless. • Neglect shapes what the child is experiencing and

Of The Child	learning about her or himself, about other people and about the world around them. • We need to remain aware of the possible serious impacts of neglect on the child as she or he grows up. • Our focus can shift from the child to the parents without us noticing – we need to remain alert to this possibility. • Losing our focus on the child is a particular risk when the parents themselves are experiencing significant problems and difficulties. • It is never helpful to allow parents to lose sight of the fact that we are there for the child. • Transparent casework practice means being clear with parents that our assistance with their problems and needs is given to improve the experience of their child.

References:

NSW Department of FACS (2006) Policy on Child Neglect
http://docsonline.dcs.gov.au/docsintwr/_assets/main/business_help/documents/policies/neglect_policy.pdf

NSW Department of FACS, Centre for Parenting and Research (2005) Neglect Key Issues, Research to Practice Notes
http://docsonline.dcs.gov.au/docsintwr/_assets/main/document/rfba/neglect_key_issues.pdf

MANAGING NEGLECT AND CASE PLANNING

Neglect is, in general, more likely to be overlooked than any other type of child maltreatment and abuse. This is because neglect is often accompanied by some other forms of abuse that tend to be the focus of intervention. Neglect issues are therefore trivialised. However research has shown that the effects of neglect can be potentially fatal, cause great distress to children, and lead to a wide variety of negative impacts during childhood and later in adulthood depending on the type, severity and frequency of the neglect. This can include; medical and mental health issues, poor educational attainment, difficulties in forming and maintaining relationships, and substance abuse etc. (Daniel et al, 2011 cited by Hartlepool Safeguarding Children Board, September 2013).

It is therefore crucial that we recognise the types of neglect and their impact on children, as well as identifying the underlying causes of the neglect to provide the most appropriate intervention. The following suggestions are some of the most effective strategies to help families manage neglect issues, and should be considered in your case planning:

- interventions must be prioritised to meet a family's immediate needs, such as homelessness or inadequate housing, unemployment and poverty
- interventions must be concrete and specific to a family's needs, for example; providing food, nappies, fixing a broken washing machine, setting up cab vouchers to attend appointments, setting up childcare, connecting parents to parenting educational courses etc
- more intensive support should be given when there is a child under 12 months old in the family, or if the child has a disability
- services and interventions should be offered in view of providing long-term solutions and support.

Interventions to improve outcomes for neglected children and young people might include:

1. High Quality Childcare

Given the lack of stimulation and nurturing in neglectful families, the most effective way of improving outcomes for these children may be to target them directly in the form of high quality child care and education.

2. Home Visiting programs

Although the evidence that home visiting reduces the rate of child abuse and neglect is still not conclusive, home visiting can act as an early detection mechanism prior to cases entering the statutory child protection system.

3. Co-located multi-component programs

Greatest gains are made when programs offer co-located services for both parents and children.

For example, where services such as high quality child care and pre-school are co-located and there are strong links to health care services (e.g. baby immunisation)

and parent education and support, developmental outcomes for children are improved.

Reference:
This paper was created by Learning & Development and draws on material from the NSW Department of Human Services, Family and Community Services Caseworker Development Course, Child Protection Dynamics, Trainer's Manual, January 2009, V1R6.

Horwath, J (2013) The Complex Issue of Child Neglect, Discussion paper, Hartlepool Safeguarding Children Board.

Watson, J. (2005) Child Neglect: Literature Review. NSW Department of FACS

PHYSICAL DISCIPLINE OF CHILDREN

More than nine out of ten (92%) of the 80 children aged between five and 14 years interviewed in a New Zealand study said they had been or that they believed children were smacked. Some reported being hit around the face and/or head and with implements and many described it as the first line of discipline the parent used, rather than a last resort.

The children reported parents were often angry or stressed when they smacked– and would later express regret or offer 'treats' to compensate. Children said smacking made them feel angry, upset and fearful – and was not an effective form of discipline. The studies also found children were more often hit by fathers and male members of the household and were more often physically punished for hurting others.

Discipline for children involves training and helping them develop judgement, a sense of boundaries, self-control, self-sufficiency and positive social conduct. Discipline is frequently confused with punishment, particularly by caregivers who use corporal punishment in an attempt to correct and change children's behaviour. There are several differences between discipline and punishment.
Positive strategies of discipline recognise children's individual worth. They aim to strengthen children's belief in themselves and their ability to behave appropriately, and to build positive relationships.

On the other hand, punishment involving either physical or emotional measures often reflects the caregiver's anger or desperation, rather than a thought-out strategy intended to encourage the child to understand expectations of behaviour. Such punishment uses external controls and involves power and dominance. It is also frequently not tailored to the child's age and developmental level.

Corporal punishment entails the use of physical force. It has been commonly used in many societies in the past and the exact form it takes varies according to culture and religion. Research has shown, though, that it is not effective in promoting the desired change in behaviour in any lasting way. The behavioural and emotional consequences of corporal punishment vary according to how frequently and how severely the punishment is applied, as well as to the age, developmental state, vulnerability and resilience of the child. Corporal punishment can cause relationships to break down. It serves to humiliate children and can lead to physical injury and serious impairment in development.
Any strategy addressing child maltreatment must decide what level, if any, of corporal punishment is acceptable before it becomes abuse. Factors to consider here include the age of the child, the reason for the corporal punishment and the alternatives available. It is, however, never appropriate for corporal punishment to be of such severity that it causes injury – including bruising, physical mutilation or emotional harm – to the child.

All children need discipline and it is best if children can be supported in developing their own self-discipline. An approach to discipline should be encouraged that uses alternative methods such as distraction and redirection, the fixing of a cooling-off period, the setting of rules and limits appropriate to the child's age and developmental level, problem-solving and the withdrawal of privileges.
In the New Zealand study children suggested that parents should stop being angry, and talk to children explaining what the child had done wrong before administrating any family discipline, as this would have better outcomes for both children and

parents. They said that talking with children about the rules the child had broken would assist the child's understanding, rather than using physical punishment, which did not. They said using 'time-out', having privileges removed or being grounded were more effective means of discipline.

Reference:
http://www.savethechildren.org.nz/new_zealand/newsroom/insights.html Save the Children, Kids Say Physical Discipline Doesn't Work, Save the Children, New Zealand, posted 27 September 2005, viewed August 2009

CORPORAL PUNISHMENT

This reading is a summary from: Corporal punishment: Key issues, Australian Government, Aust. Inst. Of Family Studies, Child Family Community Australia Fact Sheet— March 2014

- Corporal punishment, or physical discipline, has long been a contentious and much debated issue among legal, health and care practitioners. Legislation and literature have sought to make a distinction between physical discipline and physical abuse, however there are many factors that have prevented this clarification.
- Corporal punishment is defined as the use of physical force towards a child for the purpose of control and/or correction, and as disciplinary punishment inflicted on the body with the purpose of causing some degree of pain or discomfort.
- Punishment of this nature is referred to as hitting, smacking, spanking, and belting (Cashmore & de Haas, 1995), can involve the use of a hand or an implement (such as a belt or wooden spoon), or can include actions such kicking, shaking, biting and forcing a child to stay in uncomfortable positions.
- The desired outcome of physical punishment is child compliance with adult directives; and research has shown that corporal punishment is effective in achieving immediate child compliance. (Gawlik, Henning, & Warner, 2002; Smith, Gollop, Taylor, & Marshall, 2004).
- However, the findings also highlight that corporal punishment fails to teach a child self-control or reasoning, and models for a child that problems can be addressed through physical aggression.
- The degree of physical punishment that a parent or carer can use with a child is dependent on legal regulation in Australia. In most states and territories, 'lawful correction' by a parent/carer is acceptable provided that it is carried out for the purpose of correction, control or discipline, and that it is 'reasonable' in regard to;
    - the age of the child
    - the method of punishment
    - the child's capacity for reasoning (i.e., whether the child is able to comprehend correction/discipline)
    - the harm caused to the child (Bourke, 1981).
- *The Crimes Amendment (Child Protection-Physical Mistreatment) Act 2001 (NSW)* introduced an amendment specifying that physical punishment by a parent should not harm a child more than briefly and specifies the parts of a child's body that can be subject to force. This amendment to the Crimes Act 1900 (NSW) did not entirely remove parental capacity for corporal punishment nor explicitly ban the use of physical force towards children, but it did introduce strict guidelines on what is acceptable.
- Corporal punishment is 'unreasonable' if the force is applied to any part of the head or neck of a child or to any other part of the body of a child in such a way as to be likely to cause harm to a child that lasts for more than a short period.
- If the use of corporal punishment is considered unreasonable in the circumstances it may be classified as physical abuse and could lead to intervention by police and statutory child protection.
- Reviews of the literature suggest that corporal punishment may lead to poor child outcomes. For example, in a review of the research, Smith et al. (2004) reported a

number of negative developmental consequences for children who had experienced corporal punishment, including: disruptive and anti-social behaviour; poor academic achievement; poor attachment and lack of parent-child warmth; mental health problems (particularly internalising problems such as depression); and substance and alcohol abuse.

- However, the effects of corporal punishment are likely to be affected by other factors, including: the quality of the parent-child relationship; how often and how hard a child is hit, whether parenting is generally 'hostile', clear and consistent boundary setting, whether other disciplinary techniques are also used, particularly ones that are suited to a child's age, and are likely to contribute to his or her learning and capacity for reasoning (Gershoff, 2002; Smart, Sanson, Baxter, Edwards, & Hayes, 2008).
- Therefore, it cannot be conclusively said that there is a causal link between the use of corporal punishment by parents/ carers and negative outcomes for children.
- What is clear is that there is little to no evidence to support any positive outcomes associated with corporal punishment.
- Research shows that children more likely to receive corporal punishment are;
    - male
    - between the ages of 3 and 5
    - display challenging behaviours or difficult temperaments
- Contextual factors that may also increase the likelihood that parents will resort to physical punishment include;
    - family structure, ie higher number of children
    - economic disadvantage
    - family/ parental stressors (Smith et al., 2004).
- In addition, research shows that children with disabilities are 3.6 times more likely than children without a disability to experience physical violence, including 'smacking' (Jones, et al., 2012).
- The main goal of any disciplinary strategy should be to educate children about acceptable and unacceptable behaviour. Other disciplinary techniques that parents can use include;
    - providing appropriate supervision
    - setting and enforcing boundaries (appropriate to the child's age and development)
    - firmly saying 'no'
    - explaining why certain behaviour is inappropriate and giving consequences
    - withdrawing privileges, using 'time out' or quiet time.

  Further information should be gained in regard to these strategies to implement them as they were intended to be used as tools.
- Other steps parents can take to minimise misbehaviour include;
    - minimising the need for discipline by planning ahead to prevent problems from occurring (e.g., avoiding being on the phone when a toddler is tired or irritable, taking activities and toys to entertain a child while out)
    - being consistent with children
    - modelling desired behaviours
    - praising, encouraging and rewarding children and providing them with warmth and affection (Parenting SA, 2010).

SEXUAL ABUSE & OFFENDER TACTICS

Sexual abuse offenders are the most widely researched among types of abusers of children. The evidence indicates that the majority of sexual abuse is perpetrated by known males. The victim-offender relationship is most often a familiar relationship. It is often an emotionally close and significant relationship to the victim. Offenders tend to pick vulnerable children whose lack emotional needs are not being fulfilled and they exploit their sexuality and their needs for attention and affection. As a result, victims often have ambivalent and confusing feelings about offenders. Some children express concern for the abuser when they disclose their sexual victimisation.

Sexual abuse is vastly unreported and there could be a higher proportion of female offenders that we are unaware of. This may be because female physical contact with children is more usual and hence inappropriate touching may be missed or confused by the victim (Banning, 1989; Rowe, 2009).

Conditioning: the grooming process

Research has highlighted a range of tactics used by offenders to engage children in a relationship where sexual abuse can occur. Sexual abuse perpetrators rely on access, opportunity and secrecy in order to establish and maintain sexual abuse of the child or young person. The process involves intent, planning and ongoing evaluation (checking for risks of being found out) on the part of the offender. Sexual abuse of a child or young person is rarely impulsive and does not usually happen out of the blue. Often the offender fills deficits in the child's life and many children may describe their relationship with the offender in positive ways, other children may hate the offender or just want the abuse to stop.

Tactics are used to manipulate the child and potentially protective adults. A trusting relationship is often developed with the victim's family. This is used in order to gain and maintain total control over the victim. Through conditioning of the child, the abuser gradually overcomes the child's resistance through a sequence of psychologically manipulative acts which silence the child.

Tactics used by offenders include (but are not limited to):

- using a series of gradual steps (overt and covert) to select the victim, entangle the child in the abuse, and maintain secrecy and to avoid responsibility
- using their position of authority and/or trust
- developing a close relationship with the child with attempts to build trust
- using play to introduce sexual games to children, gradually violating adult-child boundaries
- desensitising the child to touch
- sexualising the child & environment
- entrapping the child: secrecy, blame, fear, isolation, sense of responsibility, shame
- isolating or alienating one child from others in the family (siblings and parent/s)
- using favouritism and deprivation
- using bribes (extortion)
- creating doubt and confusion

- emotional blackmails
- threats, intimidation and/or force
- denigration of victim
- plant and foster a negative reputation of the child (especially to the non-offending parent)
- gradual violation of adult-child boundaries often in the context of intimate care i.e. bathing, bed routines, and changing/dressing.

The literature suggests that children with a disability face a much higher probability of being victims of sexual abuse than children without a disability. The disability could be visual, hearing, speech/language, health impairment, cognitive, learning, physical, or behavioural. Children with disabilities are likely to experience greater barriers to disclosure due to their functioning capacities and are less likely to be viewed as credible in legal settings.

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WHAT SEXUAL OFFENDERS TELL US ABOUT PREVENTION STRATEGIES

(Note: The following reading has been extracted from the original article – full reference at the end of this summary. Care should be taken for own personal wellbeing when reviewing the material in this article.)

Abstract: This article relates to a sample of 20 adult sexual offenders who were interviewed about the process whereby they selected, recruited and maintained children in a sexual abuse situation. Offenders were selected if they were making 'successful' progress in treatment in order that they might be less likely to distort their descriptions.

Offenders were interviewed by their therapist in a community treatment program using a semi structured interview guide. Results suggest that this sample of offenders claim a special ability to identify vulnerable children, to use that vulnerability to sexually abuse a child that sexual abuse is inherently coercive, even though many offender statements minimize the level of coercion and violence, and that offenders systematically desensitize children to touch. Implications for prevention of sexual abuse are highlighted.

Results: Information on selected key questions answered by the offenders is presented below. Given the small sample size and the exploratory nature of these data, trends in the offender's responses will be reported rather than the specific proportion of offenders making each response. The presentation of specific proportions of respondents who made each statement might tend to disguise the preliminary nature of the information provided by these 20 sexual offenders.

How many victims have you had? Offenders abused between one and forty children, with an average per offender of 7.3. The youngest victim was an 18-month-old infant. Female children were more often targeted than males, although some offenders abused both males and females. Most offenders targeted both children who were related to them and unrelated children. A few abused only one type (relationship) of child. Rarely did an offender abuse a child who was not related or not known to the offender.

Was there something about the child's appearance which attracted you to the child? Most of the offenders interviewed expressed a preference for specific physical characteristics (e.g., generally smooth skin, long hair, dresses; or slim body, darker skinned, darker hair, a cute face, and not particularly boyish). A number of offenders described a markedly similar behavioural characteristic of a preferred victim in their responses to this appearance questionnaire. This characteristic seems to describe a friendly, open child:

Key Questions – direct quotes from study participants

- 'Mostly vivaciousness, friendliness, proximity, close to me. No physical characteristics. I felt they would be victims willingly because they were being overly friendly with me.'
- 'The look in their eyes. It's a look of trust. They like you. If they are going to show resistance, they'll look away.'
- 'Has a look of being vulnerable in some way. May not be assertive; may not be outgoing. Trusts adults. You can see this in their body language, the way they look with their eyes. The way they hold themselves.'

If there were more than one child with this physical appearance available, why did you select one over the other? Although most offenders used different ways to describe it, their responses to this question suggest a capacity to target vulnerable children. One offender indicated he would select the child who was the most friendly, the most receptive, and the child who would respond back to him. Such a child would be targeted even if her physical appearance did not fit his preference:

- 'I would choose the youngest one or the one whom I thought would not talk about it.'
- 'I would probably pick the one who appeared more needy, the child hanging back from others or feeling picked on by brothers or sisters. The one who liked to sit in my lap. The one who likes attention and stroking.'

Was there something about the child's behaviour which attracted you to the child? The responses to this question were markedly similar to the child described in previous questions. This is the warm and friendly child or the vulnerable child:

- 'Friendly. Showed me their panties.'
- 'The way the child would look at me, trustingly. The child who was teasing me, smiling at me, asking me to do favors. Someone who had been a victim before; quiet, withdrawn, compliant.'
- 'Someone who had not been a victim would be more non-accepting of the sexual language or stepping over the boundaries of modesty.'
- 'Quieter, easier to manipulate, less likely to object or put up a fight, goes along with things.'

After you had identified a potential victim, did you think about the possibility of getting caught? Most of the offenders indicated that they thought about getting caught, and many indicated that this fear was taken into account in how and when they victimized children:

- 'In general, no. I selected victims that I thought wouldn't report me.'
- 'Yes, this would be a primary part of my strategy in picking the time and place and victim. That's why most of my victims were 7 and below. Some were even 3 years old, and I don't think they knew what was going on. I went after the victims that had a low potential for telling someone.'
- 'Yes, but I excused myself by telling myself that I wasn't really molesting her. I was just being curious.'
- 'Yes, it was a fear the entire time I was molesting her. Toward the end, it got to be a contest to see if I could get away with it.'

After you had identified a potential victim, what did you do to engage the child into sexual contact? A few offenders describe offering material enticements (e.g., purchases from the store) to engage the child in sexual abuse. Others described no engagement process (e.g., 'I didn't say anything. It was at night, and she was in bed asleep'.) The majority of offenders described a process of engaging the child in a relationship prior to beginning sexual contact:

- 'Talking, spending time with them, being around them at bedtime, being around them in my underwear, sitting down on the bed with them. Constantly evaluating the child's reaction. A lot of touching, hugging, kissing, snuggling.'
- 'Play, talking, giving special attention, trying to get the child to initiate contact with me. Get the child to feel safe to talk with me. From here I would initiate

different kinds of contact, such as touching the child's back, head. Testing the child to see how much she would take before she would pull away.'

- 'Isolate them from any other people. Once alone, I would make a game of it (e.g. red light, green light with touching up their leg until they said stop). Making it sound fun.'
- 'Getting comfortable with the child. Doing things that they liked. Making them feel comfortable with me. Make them laugh and have a good time. When they give an outward sign that they like you, like a hug, start touching their arms, legs, and hugging them.'
- 'Most of the time I would start by giving them a rub down. When I got them aroused, I would take the chance and place my hand on their penis to masturbate them. If they would not object, I would take this to mean it was OK. I would isolate them. I might spend the night with them. Physical isolation, closeness, contact are more important than verbal seduction.'

After you identified a potential victim, what did you say to engage the child into sexual contact? Information on what the offenders said to engage their victims is missing for most offenders. What is available suggests two strategies: talking about sex or making sexual jokes or conversation intended to further develop a relationship.

- 'Certainly a lot of off colour jokes. There are different categories for different kinds of jokes. With younger kids you don't have to say anything. With older kids you have to use a lot of verbal seduction.'
- 'Use a very smooth voice, very nicely and nonthreatening. Get on their level, ask how their day was going, what did they like, listen to the children. When with a group of kids and adults, sit with the adults, and let them know you are interested in them.'
- 'With the 15 year old, I told her I loved her and if she loved me she would let me do it.'

How did you gain control over the victim? Offenders describe the use of adult authority, adult physical presence, and efforts to isolate the victim from others as means of controlling the victim.

- 'Generally they would be under my care. In most cases they would be over at my place. All force. I was stronger than her. Early on during the grooming process I used a lot of conversation with my daughter and spent time alone with her.'
- 'I kept telling her how proud I was of her and how special she was. I would go along with anything she (stepdaughter) wanted, even my wife thought we were getting along.'
- 'Heavy handed discipline. I wouldn't encourage her or my wife to make friends outside of the house. This kept the family isolated, and there was less chance of getting caught.'
- 'I think they were confused because I was appearing to be someone they could trust, but I was doing something they didn't like. I would continue in a playful way to pretend that what I was doing was not sexual.'
- 'By buying her presents, letting her stay at her girlfriend's, letting her have favors, buying her things that I didn't buy other kids.'

Did you threaten the victim? The majority of offenders responded to this question with a response indicating that they had not threatened their victim. The majority of offenders then proceeded to describe specific ways that they threatened their victims by use of their superior size and strength, the authority they had over the victims, or by suggesting that they (the offenders), the victim, or others would be hurt by knowledge of the abuse.

- 'Not threatening her, never hurt any of them. Did tell L. that if she said anything, her girl friends are not going to like her. Also said I would go to jail.'
- 'No, but the kids had seen me be physically violent with my wife at least twice.'
- 'No. Certainly with my physical size, but never verbally. I did hold her arms tight so she couldn't get away, but not in a power sense.'
- 'No. I might have said to be careful not to tell anyone.'
- 'I would withdraw my affection.'
- 'No, but I think they were threatened because I was their parents' age, and I commanded respect. I focus in on a lot of eye contact.'
- 'I told her that if her mom found out she would be real mad, and I would have to move out of the house.'
- 'If your mom finds out, she will probably kill me and beat you. This really made her afraid of her mom.'
- 'The only force I really showed was with the younger kids who couldn't vocalize. They would show resistance, and would stop, then go back. I did use force of just holding them still so that they couldn't squirm around.'

Write a manual on how to sexually abuse a child. In response to this question, the offenders described a range of activities intended to befriend needy children, gradually desensitize children to sexual behaviours, or frighten and intimidate them.

- 'Some way to get a child living with you. If you have a repertoire of jokes that move from risky to pornographic, have porn magazines lying around. Talk about sex. Watch the kids' reactions. Stick your head in their bedrooms while they are in their bedclothes. Act like it's a natural thing. Be sympathetic. Try a lot of complements. Have accidental contact with their breasts.'
- 'Befriend them, be nice to them. Target children who appear to be not close to their parents or children who have already been victimized. Look for some kind of deficiency.'
- 'I would find a child who doesn't have a happy home life, because it would be easier to groom them and to gain their confidence.'
- 'I would find a child that didn't have very many friends, because it would be easier for me to gain their friendship. Look for a kid who is easy to manipulate. They will go along with anything you say. I would approach them by being friendly; letting them think I was someone they could confide in and talk to.'
- 'Be in a position where you are a close friend with someone who is involved with alcohol and drugs and probably has the attitude that kids are like dogs, just around the house. Someone who has a tight control over kids and where if the kid does anything wrong he'll be severely punished. Being a molester, you can pick on that and start showing the kids extra attention. They'll thrive on it and will become easily manipulated to your control. You can also set it up when the

parents trust you and use you as a babysitter. You'll be alone with the kid, and the kid doesn't like his parents.'

- 'Choose children who have been unloved. Try to be nice to them until they trust you very much and give you the impression that they will participate with you willingly. Use love as bait…. Never threaten her. Give her the illusion that she is free to choose to go with it or not. Tell her she is special. Choose a kid who has been abused. Your victim will think that this time is not as bad.'
- 'Identify a child that would be looking for help, who is vulnerable… feed the positive things, like she looks real good. If she didn't have any boy friends, tell her why not; be interested in her. Get the parents to trust the offender. Work slowly. Get as many people who are close to the victim to trust you.'
- 'Observe the victim, if he/she is friendly, if they come to like me a lot, it would be safe to try to touch them… under these conditions I don't think the kids are apt to tell.'
- 'Select an isolated and quiet child. They want somebody and need someone.'
- 'First you would groom your victim by heavy handedness promoting fear… then isolate the victim so that no one else would be around. The next step would involve making the child think that everything is OK so they wouldn't run and tell. You could convince them there is nothing wrong with it or pressure a child not to tell….using force or coercion.'

Discussion:
This article raises a number of issues which prevention workers and professionals need to consider including:

Punitive reactions towards offenders – The offender's words describe a deliberate process which inflicts pain and other consequences on victims. Without lessening the impact of the behaviour of the offenders the authors would argue for rehabilitative interventions including controls on behaviour during the process of rehabilitation.

Identifying vulnerable children – At a minimum, adults who care for children should be aware that offenders claim a special ability to identify vulnerable children and to manipulate that vulnerability as a means of gaining sexual access to children. Identifying those same vulnerabilities, paying special attention to the protection of those children, and efforts to alter the conditions which make children vulnerable are prevention strategies. One of the difficulties, well recognized by prevention professionals, is that in some cases vulnerabilities are inherent in childhood (e.g., being small, not having the language to tell others what is happening.)

Coercion is inherent – Even in this sample of offenders judged to be relatively nonviolent and therefore appropriate for community treatment and who may have been likely to underestimate any violence or coercion in their behaviour, it is clear that they employed a range of coercive behaviours. Protection of children will require adults who have the resources and care to make children less vulnerable. Debunking adult statements before the child has been exposed to them or when the child might have witnessed demonstrations of the adult's power (e.g., when her mother was beaten up) is a difficult task. How children can be prepared ahead of time, without frightening them, to identify coercive and manipulative actions of adults and to cope with them so that they will escape or get help will require further innovation and test.

Offender efforts to desensitize children – Include the sophistication of offender efforts to desensitize children to touch through progressing from nonsexual touch (e.g. touching a leg or back) to sexual touch and through the gradual development of a relationship with the child.
Teaching children that they can withdraw consent or that consenting to one action is not consenting to another, is one approach. Teaching children that potential offenders may be of any relationship to a child is a current strategy that some programs use to deal with the fact that so many children are abused within the ongoing relationships they have with adults. Teaching children about the relationship warning signs so that they can identify risk situations seems virtually impossible, since so many of the relationship risk factors are normal, and often positive aspects (e.g. an adult paying attention to a child) of adult-child relationships.

Increased understanding about this process is a vital aspect of efforts to help children prevent or escape their own abuse.

Reference:
Conte, J. R., Wolf, S. & Smith, T. (1989) 'What Sexual Offenders Tell us about Prevention Strategies', *Child Abuse and Neglect,* 13, pp 293-301.

INDICATORS OF SEXUAL ABUSE

There are numerous emotional and behavioural indicators of child sexual abuse; however none are diagnostic or conclusive. Due to the hidden nature of sexual abuse and often the absence of physical indicators, the onus is on the child to disclose. When and if a child does disclose, there is usually a considerable time delay from when the assault occurred and thus physical indicators may no longer be present for penetrative assaults. However, always consult with an appropriate medical expert to determine the need for a sexual assault examination. The Child Protection Unit of a hospital has experts to consult on this matter.

Behavioural indicators of child sexual abuse may be in some cases the way in which a child or young person is trying to communicate that something has happened to him or herself without any accompanying disclosure. Some children may ask a parent or carer ‘if they have to go to work tonight, can they come home early, this may be an indirect attempt from the child to communicate that something is wrong. It is important to pick up on a child’s cues and explore further with the child what they may be saying.

The following points are indicators that sexual assault may have occurred:

- when a child reports sexual abuse either directly or indirectly in a disguised way e.g. ‘I know a girl who...’
- persistent and inappropriate sexual play with peers, toys, animals or themselves, e.g. child inserting objects in her vagina or sexually aggressive behaviour with others e.g. for a boy 'humping' toys in sexual positions
- detailed and overly sophisticated understanding of sexual behaviour (especially by young children)
- sexual themes in the child's artwork, stories or play
- fear of going home or expressing a desire to live in a foster home or institution
- regressive behaviour e.g. excessive clinginess in pre-school children or the sudden onset of soiling and wetting when these were not formerly a problem
- temper tantrums in young children
- a child may appear disconnected or focused on fantasy worlds
- sleep disturbances and nightmares
- marked changes in appetite
- fear states e.g. anxiety, depression, phobias, and obsession
- overly compliant behaviour; often young people who have been abused have experienced extensive grooming/conditioning
- parentified or adultified behaviour e.g. acting like a parent or spouse
- delinquent or aggressive behaviour
- arriving late at school or leaving early
- poor or deteriorating relationships with peers
- increased inability to concentrate in school and/or sudden deterioration in school performance
- non-participation in school and social activities, e.g. withdrawal

- unwillingness to participate in physical/recreational activities, especially if this is due to symptoms of physical discomfort
- truancy/running away from home
- excessively seductive behaviour and/or sexual activity. This is an effect of the sexual abuse rather than a cause
- substance abuse; drug/alcohol abuse
- prostitution: there is a strong correlation between child sexual abuse and late teenage prostitution
- self-mutilation i.e. cutting of arms, legs, burning, home made tattoos.
- suicidal feelings and suicide attempts.
- fear of adults of the same sex as the abuser.
- unexplained accumulation of money
- eating disorders.

Physical indicators of child sexual abuse: Some sexually abused children also come to attention because of physical indicators:

- bruises, bleeding or other physical trauma in genital or rectal area. There may be pain or problems with urination/defecation or blood-stained and/or torn underwear. The physical discomfort may cause the child to limp, perform poorly at sport, drop out of strenuous play activities or perhaps even have difficulty in sitting still
- foreign bodies in genital, rectal or urethral openings
- abnormal dilation of the urethral, vaginal or rectal openings
- itching, inflammation or infection of urethral, vaginal or rectal openings
- presence of semen
- traumas to breasts, buttocks, lower abdomen or thighs
- unusual odours from the vaginal area
- sexually transmitted diseases e.g. HSV- 2 (genital herpes)
- pregnancy, especially when the child refuses to reveal any information about the father of the baby and/or complete denial of the pregnancy by the child and/or her family
- psychosomatic illness e.g. abdominal pain, nightmares.

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Alaggia, R. (2004) Many ways of telling: expanding conceptualizations of child sexual abuse disclosure, *Child Abuse & Neglect*, 28, pp. 1213-1227.

South Eastern Centre Against Sexual Assault (2013) Indicators of Child Abuse, retrieved from http://www.secasa.com.au/pages/indicators-of-child-sexual-abuse/

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THE EFFECTS OF CHILDHOOD SEXUAL ABUSE

The following factors are involved in assessing the effect of sexual abuse upon a child or young person:

- age of the child at the onset of the abuse, e.g. developmental factors relating to inability to disclose, due to cognitive factors and limited social experience of young children such as forgetting the abuse, no language to communicate the abuse, and limited understanding of the abuse. The child may only realise later in life due to triggers and cues of childhood sexual abuse
- the seriousness of the abuse
- whether there were multiple abusers
- whether or not force was used
- the age of the offender
- the relationship of the offender to the victim, e.g. the more closely the victim is related to the offender the less likely they are to disclose
- the response to the disclosure e.g. supportive and protective non-offending parental response
- the period of time//length of time the abuse occurred.

The possible short and long term effects of child sexual abuse on social, emotional and cognitive development:
Note there is considerable overlap with the indicators of sexual abuse.

- repressed, recovered, or delayed memories. Delayed memories are a term which includes a range of mechanisms involved in the loss of traumatic memory through repression, psychological blocking and forgetting. Traumatic abuse can be stored and is accessed by triggers and cues later in life.
- poor self esteem
- feeling guilty about ‘causing trouble’
- self concept as a helpless victim
- re-victimisation
- passivity, withdrawal, detachment, apathy
- sadness, depression, impaired sense of enjoyment, listlessness, lethargy
- aggressiveness, violent defensiveness or self-protectiveness
- hyper-vigilance
- sexual acting out - inappropriate for chronological age
- fear (expressed in various ways, e.g. exaggerated startle reflex, persistent nightmares, etc.)
- learning difficulties
- regressive behaviours e.g. bed-wetting

- self-destructive behaviours
- impaired sexual responsiveness in puberty and adulthood
- difficulty with intimate relationships in adulthood
- higher rates of self harm, suicide, accidental death by overdose and serious mental illness

The greater the means that are used to prevent information i.e. delayed disclosure, the greater the probability of stress-related physical and psychological problems.

Reference:
Alaggia, R. (2004) Many ways of telling: expanding conceptualizations of child sexual abuse disclosure, *Child Abuse & Neglect*, 28, pp. 1213-1227.
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THE DYNAMICS OF INTRA-FAMILIAL CHILD SEXUAL ABUSE

'Intra-familial sexual abuse is abuse perpetrated by a parent, step-parent, grandparent, uncle, mother's boyfriend or other relative. Extra familial abuse is abuse perpetrated by a stranger, teacher, babysitter, clergy or other religious leader' (T.B. Goodman-Brown et. al.2003)

The Dynamics of intra-familial child sexual abuse
To understand the experience of child and adult survivors of child sexual abuse, it can be helpful to explore four key areas that relate to the way the offender interacts with the victim to trap and silence the child about the abuse.

Common ideas operating at a societal level serve to reinforce the beliefs, which the victim develops as a consequence of the offender's behaviour. Understanding this process of interaction between the offender and victim can assist in understanding the context of many common presenting problems.

1. Responsibility
There is an imbalance in the way in which responsibility is handled. The offender commonly denies responsibility for the abuse, for its impact, and for the consequences to the rest of the family of disclosure. When the offender is a parent or carer then attachment issues, traumatic bonding, and the child's need to protect the family are reasons children and young people withhold disclosure or delay disclosure.

The offender gives the child the message (either overtly or covertly) that the abuse is the child's fault. He may say, for example, things like:

- 'You're a slut, you asked for this!'
- 'You let me do it for so long; who'll believe you didn't want it?'

The shifting of responsibility for the sexual abuse is reinforced by the victim-blaming messages which the child receives from the wider society:

- 'Women who are raped must have led the man on.' Or 'What do you expect if you wear that?'

As the offender shifts responsibility onto the child, the child is left with a burden of guilt. Often, the offender also shifts responsibility onto the child's mother, by saying things like:

- 'I wouldn't have to do this if your mother treated me properly!'
- 'Your mother knows and she doesn't mind.'

An offender may say to authorities and others - 'She came onto me'.
This trickery is reinforced by societal beliefs, such as the idea that mothers always know and collude with the abuse.
As a consequence of this pattern of behaviour by the offender to avoid taking responsibility, the child is left with a legacy of blame.

Vicious cycles of guilt and blame between mothers and children following sexual abuse are common and can be understood given the way the offender creates a context in which responsibility for the abuse is shifted onto others. The pervasiveness of guilt as an issue for sexual abuse survivors is not surprising when it is seen in the

context of the offender's manipulation of the child to avoid taking responsibility. The longer sexual abuse occurs the more complicit the child feels they were in the abuse.

2. Secrecy

Enforcing secrecy is necessary for the offender to continue to have access to his victim, and to avoid having to take responsibility for his behaviour. He uses a variety of methods to enforce secrecy, usually carefully chosen to match the child's developmental level and/or a particular area of the child's vulnerability (e.g. threats that the family will break up or that the mother will not believe the child if she tells). The secrecy imposed by the offender is reinforced by societal and cultural factors that influence silence about child sexual abuse.

Secrecy divides the offender and the victim from the rest of the family and creates a context in which the child is isolated and the offender has the power to create for the child whatever reality he chooses, for example:

- 'All fathers do this'
- 'Your mother wouldn't believe you if you told'
- **'**This doesn't hurt'

The child is powerless to check out her perceptions of the situation because of the offender has enforced secrecy. The legacies for the child are isolation and ongoing doubt about her own reality.

These consequences and 'side effects' of being forced to live with secrecy are seen often in work with adults who were sexually abused as children. Many adult survivors of child sexual abuse present with issues around isolation, often experience intense self-doubt and lack confidence in their own ideas and perceptions, and often describe a feeling of not being 'real' or not connecting with others.

3. Protection/Loyalty

The child is charged with protecting the abuse secret. The child is also given the impression from the offender's threats and tricks that they are protecting the family. This may be overt (e.g. 'if you tell, your mother will have a breakdown', 'I will go to gaol') or implied less directly.

The child's experience is that protection is not something that she is entitled to expect from the adults in her life, but something that she must provide for others at her own expense. This is reinforced for women by ideas at the societal level about the role of women as caring for others, even at the expense of their own needs.

Some consequences for the child and the adult survivor can be seen in patterns of 'self-erasure' (e.g. suicide attempts, anorexia) and super-responsibility for others.

4. Power/Powerlessness

The child's relationship with the offender is characterised by his use of power over tactics, which discount her/his experience and create a climate of fear and intimidation. The legacy for the child is one of fear, a sense of violation and powerlessness.

Adults and children who have been abused commonly present with issues around fear/anxiety and with problems in establishing a sense of control in their lives and relationships.

The child/adult survivor has been conditioned by the offender in particular beliefs around these key issues. By focussing on these it is possible to move from a position of seeing presenting problems in the context of individual dysfunction, to a wider view in which the key role of the offender is exposed, and the broad socio-political context is included.

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Alaggia, R. (2004) Many ways of telling: expanding conceptualizations of child sexual abuse disclosure, *Child Abuse & Neglect*, 28, pp. 1213-1227.

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UNDERSTANDING PROBLEM SEXUAL BEHAVIOURS IN CHILDREN

This reading is a summary from: Supporting Children's Disclosure. Responding to children and young people's disclosure of abuse' by C. Hunter, NCPC Practice Brief – September 2011

An adult's response to a child or young person's disclosure of abuse can be central to a child or young person's ongoing safety and their recovery from the trauma of abuse. If an adult does not take action when there are suspicions that a child is being abused, it may place the child at serious risk of ongoing abuse and prevent the child's family from receiving the help they need.

This document aims to assist professionals and non-professionals (family and friends) to respond to a child's initial disclosure of abuse.

At the point of disclosure

When a child discloses that he or she has been abused, it is an opportunity for an adult to provide immediate support and comfort and to assist in protecting the child from the abuse. It is also a chance to help the child connect to professional services that can keep them safe, provide support and facilitate their recovery from trauma.

When might a child or young person disclose?

Children and young people can disclose abuse at any time. If the abuse is ongoing over a period of weeks, months or years, they may disclose while the abuse is happening. Others might disclose either immediately after the abuse has ended or years later. Many children do not disclose abuse at all during childhood (London, Bruck, Ceci, & Shuman, 2005; Ullman, 2003).

Delays in disclosure may be linked to a range of factors including concerns regarding the consequences of disclosing. For example, one study found that many children expected negative consequences for themselves and/or another person (usually their mother or sibling) if they disclosed (Malloy, Brubacher, & Lamb, 2011). These expected consequences included physical harm and/or death.

Supporting the importance of the initial, informal disclosure, Keary and Fitzpatrick (1994) found that once a child had disclosed abuse to a family member or another adult they were more likely to disclose again during formal investigations by child welfare workers.

How children and young people disclose abuse

A child or young person's disclosure is seldom straightforward because they can disclose abuse in several ways. Many of the ways children and young people disclose abuse are indirect or accidental.

Children sometimes attempt to alert adults they trust to the fact they are being, or have been abused, by their behaviour or by making ambiguous verbal statements (Collings, Griffiths, & Kumalo, 2005; Shackel, 2009; Ungar, Barter, McConnell, Tutty, & Fairholm, 2009). For example, a child or young person might suddenly refuse to attend the house of a previously loved relative, or could begin saying and doing sexual things that are inappropriate for their age. Older children may indirectly attempt to disclose or cope with their abuse through risk taking behaviours such as self-harming, suicidal behaviour, disordered eating and other sorts of risk exposure (Ungar et al., 2009).

The child or young person might say he or she made a mistake, lied, or that the abuse actually happened to another child. Some children and young people may disclose when asked or after participating in an intervention or education program (Shackel, 2009).

Children may disclose spontaneously (disclosure as an event) or indirectly and slowly (disclosure as a process).

Understanding disclosure of abuse as a **process** may help adults to be patient and allow the child or young person to speak in their own way and their own time (Sorensen & Snow, 1991) while maintaining an awareness of any changes in behaviour or emotions that may indicate abuse is occurring or increasing.

There are a number of reasons for children and young people to retract or delay their disclosure, including:

- Pressure or threats from the perpetrator
- Relationship to the perpetrator
- Expected consequences of telling (eg, physical injury/death, family separation, parental distress)
- Pressure from the child's family
- Fear of negative reactions from parents or family
- Fear of not being believed
- Feelings of embarrassment, shame and self-blame; and/ or
- For males specifically: fear of stigmatisation, being labelled a victim or being labelled homosexual (Allaggia 2004; Alaggia 2005; Hershkowitz et al 2007; Malloy et all 2011; Ullman 2003)

If you are a family member or friend

Research shows that children and young people are most likely to initially disclose abuse to either a parent or same-aged friend (Priebe & Svedin, 2008; Shackel, 2009).

Hearing that a child or young person has been abused is distressing, and this will be felt even more acutely if you are a friend or relative. It is also possible that the perpetrator is known to you and may even be a family member. Services that are available for children can also help support family members and friends of victims and guide you through the next steps.

It is important to remember that whilst it is your role to be a supportive listener, it is not your role to counsel the child or investigate his or her claims. Child protection workers will undertake investigations and professional counsellors may be accessed to provide counselling.

If you work for an organisation

Organisations should ideally have in place a set of protocols to respond quickly and effectively to disclosures of abuse (Irenyi, Bromfield, Beyer, & Higgins, 2006). If you work for an organisation and a child or young person in the care of that organisation discloses abuse that has been perpetrated by someone associated with that organisation, it is imperative to follow the organisation's protocols as well as make a report to the relevant statutory child protection department in your state/territory.

If a child or young person discloses abuse that is occurring, or has occurred, outside the organisation, you should support the child or young person by believing him or

her and reassuring them that telling was the right thing to do. Finally, keep information confidential. Only those people who must know should be informed of the disclosure.

Summary

If a child has decided to speak to you, then there is a good chance they trust you. Simply by calmly and empathically listening and offering support, you are helping the child or young person. There are some general tips for responding to disclosure (Bussey, 1996; Office for Children Youth and Family Support, 2006; Queensland Department of Communities, 2004; Victorian Department of Human Services, 2006):

- Always listen to and support the child or young person and thank them for helping you to understand.
- Don't make promises you can't keep.
- Reassure the child or young person it is right to tell.
- Don't be afraid of saying the 'wrong' thing.
- Maintain a calm appearance.
- Give the child or young person your full attention.
- Let the child or young person take his or her time.
- Let the child or young person use his or her own words.
- Accept the child or young person will disclose only what is comfortable and recognise the bravery/strength of the child for talking about something that is difficult.
- Tell the child or young person what you plan to do next.
- Do not confront the perpetrator.

VICARIOUS TRAUMA

Vicarious Traumatisation: Simply put, vicarious trauma can occur when we open our hearts to hear someone's story of devastation or betrayal, and our cherished beliefs are challenged and we are changed. A worker/ helper's vulnerability to vicarious traumatisation is unavoidable if their work involves listening empathically to traumatised people with the goal of helping them. Taken together, their desire to help and their empathic engagement with traumatised clients create the conditions for vicarious traumatisation.

STRESS SYMPTOMS VS BURNOUT SYMPTOMS	
STRESS	**BURNOUT**
• Characterised by over-engagement	• Characterised by disengagement
• Emotions are over-reactive	• Emotions are blunted
• Produces urgency and hyperactivity	• Produces helplessness and hopelessness
• Loss of energy	• Loss of motivation, ideals and hope
• Leads to anxiety disorders	• Leads to detachment and depression
• Primary damage is physical	• Primary damage is emotional
• May kill you prematurely	• May make life seem not worth living

SIGNS AND SYMPTOMS OF VICARIOUS TRAUMA	
GENERAL CHANGES	**SPECIFIC CHANGES**
• No time or energy for oneself	• Disrupted frame of reference
• Disconnection from loved ones	• Changes in identity, world view,
• Social withdrawal	• Diminished self capacities
• Increased sensitivity to violence	• Impaired ego resources
• Cynicism	• Disrupted psychological needs and cognitive schemata
• Nightmares	• Alterations in sensory experiences

The ABC of addressing vicarious trauma:

Awareness – Being attuned to one's limits, emotions and resources. Heed all levels of awareness and sources of information, cognitive, intuitive and somatic. Practice mindfulness and acceptance.

Balance – Maintaining balance among activities, especially work, play and rest. Inner balance allows attention to all aspects of oneself.

Connection – Connections to oneself, to others and to something larger. Communication is part of connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope.

References:
Saakvitne, K.W., Pearlman, L.A., (1995) Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients, 1996 New York: W.W. Norton.