Research Repository UCD

Title	Irish child sexual abuse victims attending a specialist centre
Authors(s)	O'Riordan, Beth, Carr, Alan, Turner, Rhonda
Publication date	2003-05
Publication information	O'Riordan, Beth, Alan Carr, and Rhonda Turner. "Irish Child Sexual Abuse Victims Attending a Specialist Centre." Wiley, May 2003. https://doi.org/10.1002/car.788.
Publisher	Wiley
Item record/more information	http://hdl.handle.net/10197/5132
Publisher's statement	This is the author's version of the following article: O'Riordan, B., Carr, A. and Turner, R. (2003), Irish child sexual abuse victims attending a specialist centre. Child Abuse Rev., 12: 190–204 which has been published in final form at http://dx.doi.org/10.1002/car.788
Publisher's version (DOI)	10.1002/car.788

Downloaded 2026-05-02 01:14:55

The UCD community has made this article openly available. Please share how this access benefits you. Your story matters! (@ucd_oa)

© Some rights reserved. For more information

O'Riordan, B., Carr, A. & Turner, R. (2003). Irish child sexual abuse victims attending a specialist centre. *Child Abuse Review,* 12, 190-204.

Irish Child Sexual Abuse Victims Attending a Specialist Centre

Beth O'Riordan

Midland Health Board

Alan Carr

University College Dublin

Rhonda Turner

St. Louise's Unit, Our Lady's Hospital for Sick Children, Crumlin, Dublin

Running head: Irish Child Sexual Abuse Victims

Keywords: CSA victims' psychosocial characteristics

Correspondence address: Dr Alan Carr, Director of the Clinical Psychology Training Programme, Dept of Psychology, Science Building, University College Dublin, Belfield, Dublin 4, Ireland.

email: alan.carr@.ucd.ie. **Phone:** +353-1-7162390. **FAX:** +353-1-7162846

Paper submitted in April 2002, revised and resubmitted in November 2002, further revised and resubmitted January 2003, final revisions completed in March 2003: Prof Margaret A Lynch, Editor Child Abuse Review, Optimum Health Services, Newcomen Centre, Guys Hospital, St Thomas Street , London, SE19RT, UK.

Ph: 0044-207-955 4651. Email<margaret.lynch@chsltr.sthames.nhs.uk>

Julia Walsh, Editorial Assistant, Child Abuse Review, Email: julia.walsh@southwarkpct.nhs.uk

Acknowledgements: This project was partially funded by the Midland Health Board. Thanks to all clinicians who contributed to the study at St. Louise's Unit, Our Lady's Hospital for Sick Children, Crumlin Dublin and to Dr Barbara Dooley at the Department of Psychology, University College Dublin for statistical advice.

ABSTRACT

We profiled a cohort of CSA cases referred for assessment to a specialist Child Sexual Abuse (CSA) centre in a national paediatric hospital in Ireland. Historical and clinical data were drawn from records of 171 cases. The majority of cases were referred by social workers following purposeful disclosure of CSA. Three quarters of the cases were female with a mean age of 9 years. They were from a wide spectrum of socio-economic groups and many had suffered a range of family adversities. In most cases the abuse involved masturbation of the child by the abuser. Almost all of the perpetrators were male with a mean age of 28 years and in 60% of cases extra-familial abuse had occurred. In 23% of cases the perpetrator had a history of previous sexual offending. Anxiety was the most common emotional problem before disclosure and after disclosure the most common emotional problem was guilt. Before disclosure school refusal was the most common behavioural problem and after disclosure fighting was the most prevalent behavioural difficulty. The most common factors supporting the credibility of CSA allegations were labile mood, the child's ability to differentiate fact from fantasy and a detailed disclosure of contextual details. More adolescents showed deterioration in schoolwork after disclosure and for more pre-school children clinginess following disclosure was a significant emotional problem. More primary school aged children were abused by perpetrators who had abused a number of children. For children abused by such perpetrators vaginal intercourse was less common. Vaginal intercourse was more common in 6-11 year old victims and those who were abused on a daily basis. The threat that disclosure posed to the integrity of the family structure was more often a factor hindering disclosure in victims abused by father figures and abused very frequently.

INTRODUCTION

That child sexual abuse (CSA) is a significant problem in Ireland is now undisputed (Kennedy et al., 1990; MacIntyre and Carr, 1999a; McKeown and Gilligan, 1991; O'Reilly and Carr, 1999). However, only a small proportion of CSA survivors come into contact with assessment and treatment services (MacIntyre and Carr, 1999c, Nolan et al., 2002b; Nolan et al., 2002a). The effects, both short and long-term, of CSA on psychological functioning have been well documented. Up to two thirds of sexually abused children develop transient psychological problems and a fifth of cases show clinically salient long-term problems (Kendall-Tackett et al., 1993). In a previous Irish study it was found that 50% of referrals to two national CSA assessment and treatment centres showed significant short-term psychological difficulties on the Child Behaviour Checklist (Nolan et al., 2002b). Sexualized behaviour, excessive internalizing or externalizing behaviour problems, school based attainment problems and relationship difficulties are some of the more common psychological problems shown by children who have experienced CSA (Berliner and Elliott, 1996; Browne and Finklehor, 1986; Wolf and Brit, 1995; MacIntyre and Carr, 1999b).

A number of factors mediate the impact of abuse on psychological and social adjustment. These include stresses associated with the abuse itself, stresses associated with the disclosure process, and the balance of risk and protective factors associated with the child as an individual and his or her social network (McIntyre and Carr, 1999b; Carr, 1999, 2000; Spacarelli, 1994). Aspects of the abuse such as the relationship between the victim and the perpetrator (Fischer and McDonald, 1998); the invasiveness and chronicity of the abuse (Black et al., 1994); and the amount of physical violence involved (Gomes-Schawrtz et al., 1990) all have a potential impact on the level of abuse-related stress experienced by the child. In a previous Irish study it was found that poorly adjusted CSA victims had a history of coercive violent penetrative abuse while better-adjusted children were victims of non-violent abuse (Nolan et al., 2002b).

Following CSA disclosure, the degree to which children are supported by non-abusing parents, the degree to which the perpetrator denies the abuse, and the amount of disruption in the child's living arrangements (including changing residence) may all impact on psychological adjustment (Carr, 2000, Romans et al., 1995; Spaccarelli and Kim, 1995; Tremblay et al., 1999).

In a previous Irish study we found that cases attending two national assessment centres were largely youngsters who had been abused by male adults or adolescents outside their nuclear family and who subsequently were well supported by one or two parents (Nolan et al., 2002b). They were predominantly

from one-father families and only a minority had suffered adversities such as being taken into care, involvement in custody and access disputes, and having significant educational difficulties.

The present study aimed to build on the findings of other Irish studies by profiling a cohort of cases in which CSA had occurred or where there was a high probability that it had occurred on a wider range of variables than used in previous studies. Of particular interest was the status of the cohort on variables in the following domains: circumstances of referral, demographic characteristics, family adversity, characteristics of abusive experiences, perpetrator characteristics, strategies to achieve compliance and factors hindering disclosure, emotional and behavioural problems before and after disclosure, and factors supporting credibility of allegations. We also wished to examine the associations between variables in these domains.

METHOD

Setting

The study was conducted in St. Louise's Unit (SLU) a specialist child sexual abuse unit, based in a national Paediatric Teaching Hospital, Our Lady's Hospital for Sick Children in Crumlin, Dublin. SLU is staffed by a multidisciplinary team and provides a comprehensive CSA assessment and treatment service to a catchment area with a population of approximately 500,000 people in south Dublin, county Kildare and county Wicklow.

Cases

Archival data for a cohort of 479 children and adolescents who were referred to SLU in 1997 and 1998 were analysed in this study. In the 24 month period from 1.1.1997 to 31.12.1998 a total of 479 cases were referred to SLU. Of these, 271 attended preliminary assessment appointments. In 114 cases, for a variety of reasons, a decision was made not to proceed with assessment; in 58 cases consultation was offered to referring or involved professionals; and in 36 cases an assessment appointment was offered but not accepted.

Of the 271 who attended preliminary appointments 89 were excluded from this study. In 24 of these cases the multidisciplinary team concluded that CSA had not occurred; in 39 cases the team were unable to reach a conclusion about whether or not CSA had occurred; and in 26 cases the assessment process was not completed.

Of the 271 cases who attended preliminary appointments, 163 were classified after assessment as confirmed CSA cases and 19 were cases in which the multidisciplinary team concluded that there was a high probability that abuse had occurred. 171 of these 182 confirmed or high probability cases were the main focus of the present study. 11 cases were dropped because they were qualitatively different from the rest of the group. Six had been victims of a large number of multiple perpetrators and 5 had undergone multiple assessments at SLU.

In all of the 171 cases, which are the main focus of this study, the CSA was reported to statutory law enforcement or social services agencies.

Judgements about whether CSA had occurred or not was the outcome of a comprehensive assessment conducted by a clinical team. Cases in which it was judged with considerable certainty that CSA had occurred were clearly distinguished from those where uncertainty remained about whether or not abuse had occurred. These complex judgements were made by a multidisciplinary team following comprehensive multidisciplinary assessment and, in line with best practice, took account of factors concerning the child's behaviour; the child's account of the sexual abuse; the child's medical condition; and child's social context (Carr, 1999, Heiman, 1992; Wolfe and Gentile, 1992). Sexualised behaviour and avoidance of possible abuse related situations and stimuli occurring in conjunction with other difficulties such as conduct problems, emotional problems or attainment difficulties were the main features of children's behaviour considered to be consistent with child sexual abuse. Aspects of the content and form of the child's account which were considered to lend support to the view that sexual abuse has occurred included sexual knowledge that was not age-appropriate; the use of age-inappropriate language; an account given from the child's perspective; an account that was contextually detailed and internally consistent; an account given in an emotive way which described attempts by the abuser to silence the child through the use of coercion or bribery; accounts given spontaneously in response to open non-leading questions; accounts which did not sound like a rehearsed story; accounts consistent for major details with repeated telling but with different sentence structures; and verbal accounts which were consistent with those given using anatomically correct dolls or drawings. Increased confidence was placed in the truth of a child's allegations if his or her medical condition was consistent with the child’s verbal account. Features of the context of the disclosure which were considered to lend support to allegations of abuse included an account that was given against a history of allegations and retractions by the child; an account that contradicted accounts given by the alleged perpetrators and those who sympathised with them; accounts given by children who demonstrated the ability

to distinguish between fact and fantasy; and children's accounts of abuse or related events corroborated by witnesses. Where many of these features were present, cases were classified as confirmed and where few were present, cases were classified as unconfirmed. In cases where the multidisciplinary team concluded that there was a high probability that CSA had occurred, a significant number of the features were present, but not as many as in confirmed cases.

Instruments

The archival data were drawn from an extensive intake proforma which included items in the following domains: referral information, demographic characteristics, family adversity, characteristics of abusive experiences, perpetrator characteristics, perpetrators' strategies to achieve compliance and factors hindering victims' disclosure of abuse, emotional and behavioural problems before and after disclosure and factors supporting credibility of allegations.

Procedure

Data from parents, children and involved professionals were abstracted from case notes by members of the multidisciplinary assessment team during the assessment process and used to partially or fully complete proformas on all cases. This routine coding of information, however, led to much missing data. For the present study, a team of four trained raters reviewed proformas of all 171 cases involved in this study and completed sections where there were missing data. Missing data were found by systematically reviewing all reports, assessment and interview records contained in case files and by consulting with members of the multidisciplinary team who had initially completed the assessment and proformas. Information from completed proformas was entered into a computer data file and verified and analysed using the Statistical Package for the Social Sciences (SPSS).

RESULTS

Referral information

61% of cases were referred by social workers and the remainder were referred by a variety of other healthcare, educational and law enforcement professionals. In 73% of cases, referrals were made following

purposeful disclosure of CSA by the child and the remainder were made following an accidental disclosure or as a result of suspicions that abuse had occurred. 63% of disclosures were made to parents and the remainder to other family members, friends or professionals. 87% of disclosures were made to females.

" Insert Table 1 about here"

Demographic characteristics

From Table 1 it may be seen that cases were on average about 9 years old, in primary school, predominantly female, and from a wide range of socio-economic groups. They were almost equally divided between single and two parent families with most having 1-3 siblings and being either the eldest or second eldest child.

" Insert Table 2 about here"

Family adversity

From Table 2 it may be seen that this cohort of cases had endured a range of developmental adversities. In descending order of frequency these included separation from their fathers, separation from their mothers, peri-natal difficulties, developmental delays, involvement in custody and access disputes, abnormal pregnancies, death of their father, maternal post-natal depression, and death of their mother. Referred cases were not always the only members of their families who had experienced CSA. 26% of siblings, 23% of mothers and 8% of fathers had been victims of CSA. Involvement with other agencies and professionals prior to referral was common and 79% had attended social work agencies or child guidance clinics.

" Insert Table 3 about here"

Characteristics of abusive experience

From Table 3 it may be seen that most cases of abuse involved masturbation of the child by the abuser and penetrative abuse was relatively rare, occurring in less than a fifth of cases. There was considerable variability in the lifestyle stage during which the abuse started, with the onset being relatively evenly spread across the pre-school, primary school and adolescent years. There was also considerable variability in the frequency of abuse with very similar percentages of cases reporting abuse on one occasion only, up to10

times, and more than 10 times. Concurrent physical abuse, emotional abuse and neglect occurred in approximately a tenth of all cases.

" Insert Table 4 about here"

Perpetrator characteristics

From Table 4 it may be seen that perpetrators were predominantly male with a mean age of 28 years. The ratio of intra-familial to extra-familial abusers was 2:3 and for the intra-familial abusers a minority (10%) were father figures. Cases were classified as intra-familial if perpetrators were biological parents, step-parents, adoptive parents, grandparents, uncles, cousins, or siblings. Cases were classified as extra-familial abuse if the perpetrator was a residential care staff member, lodger, frequent visitor, family friend, neighbour, babysitter, teacher, authority figure or stranger. Neighbours (22%) was the most common subcategory of extra-familial perpetrators. About a quarter to a third of the abusers had a history of past sexual offending, had abused more than one victim and were questioned by police about CSA, but under 5% were charged or convicted.

" Insert Table 5 about here"

Strategies to achieve compliance and factors hindering disclosure

From Table 5 it may be seen that abusers used a range of coercive strategies, notably their authority as adults, to elicit compliance from victims. For victims, bribery, deception and embarrassment were the main factors that had hindered earlier disclosure.

" Insert Table 6 about here"

Emotional and behavioural problems before and after disclosure.

From Table 6 it may be seen that a wide range of emotional and behavioural problems characterised a significant proportion of the cohort before and after disclosure. Anxiety, moodiness and clinginess were the most common emotional problems prior to disclosure, and afterwards guilt, social withdrawal, clinginess and moodiness were the most prevalent emotional difficulties. Before disclosure, school refusal was the most common behavioural problem, while afterwards the most frequently reported behaviour problem was

fighting. Sexualised behaviour problems were rare. They were reported in fewer than 10% of cases both before and after disclosure.

Factors supporting credibility of allegations

In 90% of cases the multidisciplinary team concluded that child sexual abuse had occurred. In 10% of cases, the team concluded that it was highly probable that CSA had occurred. The most common factors considered by the multidisciplinary assessment team as supporting the credibility of CSA allegations were labile mood (50%), the victim's ability to differentiate fact from fantasy (22%), a disclosure statement containing contextual details (17%), a disclosure statement containing idiosyncratic detail (17%), sleep disturbance (15%), depression (14%), a disclosure statement made in the child's own language (without adult phrases or sentences) (13%), a disclosure statement containing a detailed account of abusive events (12%), post-traumatic play in which non-sexual aspects of the abusive episodes were re-enacted (12%), nightmares (10%) and inappropriate sexual activity (8%). Medical examinations occurred in 65 cases. Out of this group of 65 cases, the results of 66% were consistent with the child's disclosure and 77% were consistent with other information on the case.

" Insert Table 7 about here"

Significant associations between variables

A number of statistically significant and clinically meaningful associations were found between variables evaluated in this study. The statistical significance of associations was assessed using chi square tests. Given the large number of tests conducted, to reduce the probability of Type I error (detecting spurious inter-group differences), only chi square tests significant at .01 were interpreted as statistically significant. Standardised residuals were calculated to interpret contingency tables that yielded statistically significant chi squares. Where the standardised residual in a contingency table cell exceeded an absolute value of 2, this was interpreted as indicating that there was a significant difference between the observed and expected values in that cell and so it contributed significantly to the value of the observed chi square. The most clinically meaningful results from these analyses are presented in Table 7. From this table it is clear that

more adolescents (than children of other ages) showed a deterioration in school work after disclosure and, for more pre-school children (compared with victims of other ages), clinginess following disclosure was a significant emotional problem. More children abused between 6 and 11 years of age (compared with younger or older children) were abused by perpetrators who had abused a number of children, but for victims of such perpetrators vaginal intercourse was relatively uncommon (4%). However, vaginal intercourse was most common in 6-11 year old victims (rather than younger children or adolescents) and in victims who were abused on a daily basis. The threat that disclosure posed to the integrity of the family structure was more often a factor hindering disclosure in victims abused by father figures and in those abused more frequently (10-100 times).

DISCUSSION

The present study aimed to profile a cohort of cases in which CSA had occurred or where there was a high probability that it had occurred in terms of circumstances of referral, demographic characteristics, family adversity, characteristics of abusive experience, perpetrator characteristics, strategies to achieve compliance and factors hindering disclosure, emotional and behavioural problems before and after disclosure, and factors supporting credibility of allegations. The results showed that the majority of cases were referred by social workers following purposeful disclosure of CSA. Three quarters of the cases were female with a mean age of 9 years. They were from a wide spectrum of socio-economic groups and many had suffered a range of family adversities. In most cases the abuse involved masturbation of the child by the abuser. Almost all of the perpetrators were male with a mean age was 28 years and in almost two thirds of cases extra-familial abuse occurred. In almost a quarter of cases the perpetrator had a history of previous sexual offending. Anxiety was the most common emotional problem before disclosure and after disclosure the most common emotional problem was guilt. Before disclosure school refusal was the most common behavioural problem and after disclosure the most prevalent behavioural difficulty was fighting. The most common factors supporting the credibility of CSA allegations were labile mood, the ability to differentiate fact from fantasy and a detailed disclosure of contextual details

A number of important associations were found between variables in this study. Following disclosure, a deterioration in school work was typical of adolescents while clinginess was a distinctive feature of pre-schoolers. More primary school aged children were abused by multi-victim perpetrators and for children

abused by such perpetrators, vaginal intercourse was less common. In contrast vaginal intercourse was more common in 6-11 year old victims and victims who reported daily abuse. The threat that disclosure posed to the integrity of the family structure was more often a factor hindering disclosure in victims abused by father figures and victims who had been abused more than 10 times.

This study had its limitations. The group studied was only representative of typical referrals to the centre who completed the assessment process, not of CSA cases within the wider community. So the results of the study cannot be generalised to referred cases who do not complete assessment procedures or non-referred cases. Despite this limitation, our results are valuable because of two main strengths of the study. First, there were a large number of cases; and second, archival data on the cases were relatively complete and accurate. Thus a fair degree of confidence may be placed in the conclusions drawn from the study.

The results of this study concerning demographic characteristics, family adversity, characteristics of abusive experience, perpetrator characteristics, strategies to achieve compliance and factors hindering disclosure, and emotional and behavioural problems before and after disclosure are broadly consistent with those reported in the Irish (Kennedy et al., 1990; MacIntyre and Carr, 1999a; McKeown and Gilligan, 1991; Nolan, et al., 2002b; O'Reilly and Carr, 1999) and international literature (Berliner and Elliott, 1996; Browne and Finklehor, 1986; Kendall-Tackett, et al, 1993; Wolf and Birt, 1995). Our findings on factors supporting credibility of allegations are consistent with guidelines for best practice when assessing children who make allegations that CSA has occurred (Heiman,1992). The results of this study require replication.

REFERENCES

Berliner, L., Elliot, D. (1996). Sexual abuse of children. In J. Briere, L. Berliner, J. Bulkley, C. Jenny, T. Reid (Eds.) *The APSAC Handbook on Child Maltreatment* (pp.104-118). Thousand Oaks, CA: Sage.

Black, M., Dubowtz, H., Harrington, D. (1994). Sexual abuse: Developmental differences in children's behavior and self-perception. *Child Abuse & Neglect* 18, 85-95.

Browne, A., Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin* 99: 66-77.

Carr, A. (1999). *Handbook of Clinical Chid and Adolescent Psychology: A Contextual Approach.* London: Routledge.

Carr, A. (2000). *Family Therapy: Concepts, Process and Practice.* Chichester: Wiley.

Fischer, D., McDonald, W. (1998). Characteristics of intrafamilial and extrafamilial child sexual abuse. *Child Abuse & Neglect* 22: 915-929.

Gomes-Schawrtz, B., Horowitz, J., Cardarelli, A. (1990). *Child Sexual Abuse: The Initial Effects.* Newbury Park, CA: Sage Publications.

Heiman, M. (1992). Annotation: Putting the puzzle together: Validating allegations of child sexual abuse. *Journal of Child Psychology and Psychiatry* 33: 311-329.

Kendall-Tackett, K., Meyer-Williams, L., Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin* 113: 164-180.

Kennedy, M., Manwell, M., Vincent, O., Mackensie, G., Blaney, R. (1990). *Child Abuse In Northern Ireland: A Research Study Of Incidence.* Antrim: Greystone Books.

MacIntyre, D., Carr, A. (1999a).The epidemiology of child sexual abuse. *Journal of Child Centred Practice* 6: 57-86.

MacIntyre, D., Carr, A. (1999b).The effects of child sexual abuse. *Journal of Child Centred Practice* 6: 87-126.

MacIntyre, D., Carr, A. (1999c). Helping children to the other side of silence: A study of the impact of the stay safe programme on Irish children's disclosures of sexual victimisation. *Child Abuse & Neglect* 23: 1327-1340.

McKeown, K., Gilligan, R. (1991). Child sexual abuse in the Eastern Health Board region of Ireland: An analysis of 512 confirmed cases. *Economic and Social Review* 22: 101-134.

Nolan, M., Carr, A., Fitzpatrick, C., O'Flaherty, A., Keary, K., O'Shea, D., Smyth, P., Tobin, J. (2002a). A comparison of two programmes for victims of Child sexual abuse: A treatment Outcome Study. *Child Abuse Review* 11:103-123.

Nolan, M., O'Flaherty, A., Turner, R., Keary, K., Fitzpatrick, C., Carr, A. (2002b). Profiles of child sexual abuse cases in Ireland: An archival study. *Child Abuse & Neglect* 26: 333-348.

O'Hare, A., Whelan, C.T., Commins, P. (1991). The development of an Irish census-based social class scale. *The Economic and Social Review*, 22: 135-156.

O'Reilly, G., Carr, A. (1999). Child sexual abuse in Ireland: A synthesis of two studies. *Irish Journal of Psychology* 20: 1-14.

Romans, S., Martin, J., Anderson, J., O'Shea, M., Mullen, P. E. (1995). Factors that mediate between child sexual abuse and adult psychological outcome. *Psychological Medicine* 25: 127-142.

Spaccarelli, S. (1994). Stress, appraisal and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin* 116: 240-362.

Spaccarelli, S., Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect* 19: 1171-1182.

Tremblay, C., Hebert, M., Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse &, Neglect* 23: 929-945.

Wolfe, V., Birt, J. (1995). The psychological sequelae of child sexual abuse. *Advances in Child Clinical Psychology* 17: 233-263.

Wolfe, V., Gentile, C. (1992). Psychological assessment of sexually abused children. In W. O'Donaghue & J. Geer (eds.), *The Sexual Abuse of Children: Clinical Issues* (pp. 143-187). Hillsdale, NJ: Erlbaum.

_____

Table 1. Demographic characteristics

Variable		% Cases (N=171)	N
Age	Mean	9.2y	
	SD	4y	
	Range	14y	
	2-5 y	26%	45
	6-11 y	40%	68
	12-16 y	34%	58
Gender	Male	28%	48
	Female	72%	123
Socio-Economic Status	1	5%	8
	2	9%	15
	3	8%	13
	4	14%	24
	5	21%	36
	6	5%	8
	7	8%	13
	8	1%	2
	unknown	31%	52
Family type	Two parent families	42%	72
	Single parent families	39%	67
	Other or unknown	19%	32
Number of siblings	Only child	12%	21
	1-3 siblings	57%	97
	4 or more siblings	31%	53
Sibling position	Eldest	33%	56
	Second eldest	25%	43
	Other	42%	72
School	Preschool	10%	17
	Primary school	54%	92
	Secondary School	28%	48
	Unknown	8%	14

Note: SD=standard deviation. y=years. Cases were assigned to socio-Economic groups based on occupation with O'Hare et al., 1991 scale.

Table 2. Family adversity

Adversity	% Cases (N=171)	N
Separation from father	50%	86
Separation from mother	18%	31
Perinatal difficulties	13%	22
Developmental delay	9%	15
Involvement in custody and access disputes	9%	15
Abnormal pregnancy	8%	14
Father deceased	7%	12
Maternal post-natal depression	6%	10
Mother deceased	2%	3

Table 3. Characteristics of abusive experience

Domain		% Cases (N=171)	N
Sexually abusive behaviour	Masturbation of victim	71%	121
	Fondling	36%	62
	Genital to genital contact	22%	38
	Attempted anal intercourse	19%	32
	Tongue kissing	16%	27
	Vaginal intercourse	12%	21
	Attempted vaginal intercourse	6%	10
Lifecycle stage when abused	Began during preschool	37%	63
	Began during primary school	39%	67
	Began during adolescence	24%	41
Frequency of abuse	One occasion only	30%	51
	Up to 10 times	40%	69
	More than 10 times	30%	51
Other types of concurrent abuse	Physical abuse	11%	19
	Emotional abuse	8%	14
	Neglect	9%	15

Table 4. Perpetrator characteristics

Domain		% Cases (N=171)	N
Gender	Male	94%	161
	Female	6%	10
Age	Mean	28y	
	SD	15y	
	Under 16y	28%	48
	17-39y	30%	51
	Over 40	42%	72
Relationship to family	Intrafamilial abuse	40%	69
	Extrafamilial abuse	60%	102
Family role	Father figure	15%	26
	Other family member	25%	43
Historical characteristics	History of past sexual offending	23%	39
	More than one victim	33%	56
Legal involvement	Questioned by police	24%	41
	Charged	3%	5
	Convicted	2%	3

Table 5. Strategies to achieve compliance and factors hindering disclosure

Domain		% Cases (N=171)	N
Coercive strategy	Adult authority	52%	89
	Bribery	19%	32
	Exploiting child's fear of disciplinary consequences	19%	32
	Non-violent threats against the child	15%	26
	Threats of violence to others	10%	17
	Threats of violence to the child	5%	9
Factor hindering disclosure	Bribery	21%	36
	Deception	21%	36
	Embarrassment	20%	34
	Threats of violence	15%	26
	Fear of disciplinary consequence	14%	24
	Fear of disbelief	10%	17
	Fear that disclosure would threaten structure of family	9%	16
	Silencing by abuser	8%	14
	Violence to victims	3%	5
	Victims' fears of rejection by their families	3%	5

Table 6. Emotional and behavioural problems before and after disclosure.

Timing of problems	Problem types	Problem	% Cases (N=171)	N
Before disclosure	**Emotional**	Anxiety	19%	32
		Moodiness	16%	27
		Clinginess	16%	27
		Loss of ability to trust	12%	21
		Being argumentative	16%	27
		Restlessness	9%	15
		Shyness or isolation	9%	15
		Deterioration in schoolwork	6%	10
		Regressive behaviour	5%	9
	Behavioural	School refusal	28%	48
		Sexualized behaviour	6%	10
		Angry outbursts	5%	9
		Truanting	4%	7
		Destruction of property	4%	7
After disclosure	**Emotional**	Guilt	22%	38
		Social withdrawal	19%	32
		Clingy	18%	30
		Moodiness	18%	31
		Loss of ability to trust	15%	26
		Regressive behaviour	10%	17
		Being argumentative	10%	17
		Poor school work	9%	15
		Shyness or isolation	5%	9
		Anxiety	5%	9
	Behavioural	Fighting	20%	34
		Lying	6%	10
		Sexualized behaviour	5%	9

Table 7. Significant associations between variables

Variable 1.	Variable 2.	Categories	%	n/N	Chi Square
Clingy after disclosure (n=30)	Age	**2-5y** (n=45)	**33%**	15/45	11.38*
		6-11y (n=68)	16%	11/68	
		>12y (n=58)	7%	4/58	
Poor school work after disclosure (n=15)	Age	**>12y** (n=58)	**19%**	11/58	13.84*
		6-11y (n=68)	6%	4/68	
		2-5y (n=45)	0%	0/45	
Multiple child victims (n=56)	Age	**6-11y** (n=68)	**53%**	36/68	9.87*
		2-5y (n=45)	36%	16/45	
		>12Y (n=58)	7%	4/58	
Multiple child victims (n=56)	**Vaginal Intercourse**		**4%**	2/56	8.74*
Vaginal intercourse (n=21)	Age	**6-11y** (n=68)	**18%**	12/68	8.54*
		>12y (n=58)	12%	7/58	
		2-5y (n=45)	4%	2/45	
Vaginal intercourse (n=21)	Frequency of abuse	**Daily** (n=21)	**29%**	6/21	10.00*
		Weekly or monthly (n=26)	8%	2/26	
		One or a few times (n=124)	10%	13/124	
Threat to family structure hindered disclosure (n=16)	Relationship to victim	**Father figures** (n=26)	**23%**	6/26	9.09*
		Family members (n=43)	16%	7/43	
		Others (n=102)	3%	3/102	
Threat to family structure hindered disclosure (n=16)	No. of times abused	**>10 times** (n=51)	**18%**	9/51	8.51*
		1-10 times (n=120)	6%	7/120	

Note: *p<.01.