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PROFILES OF CHILD SEXUAL ABUSE CASES IN IRELAND: AN ARCHIVAL STUDY

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ABSTRACT

Objective. This study aimed to profile subgroups of CSA cases referred for assessment at two national CSA assessment centres in Ireland.

Method. Historical and clinical data for 150 CSA cases were drawn from records of two Dublin based national specialist sexual abuse assessment and therapeutic centres. Three main comparisons were made involving (1) 113 confirmed CSA cases and 37 unconfirmed CSA cases; (2) 55 confirmed CSA cases who displayed clinically significant behaviour problems and the 56 confirmed CSA cases without significant adjustment difficulties; and (3) 19 confirmed CSA cases in which violence was a central feature and 79 confirmed cases in which violence was not a central feature.

Results. There were three main findings. (1) More unconfirmed cases were male; had single or separated parents; and a father with a criminal history. As a group, the confirmed cases 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. (2) Poorly adjusted CSA victims had a history of coercive violent abuse while better-adjusted children were victims of non-violent abuse. (3) Victims of violent CSA were more likely to have experienced penetrative abuse and to display more externalizing behaviour problems.

Conclusions. Confirmed and unconfirmed CSA cases; well and poorly adjusted CSA cases; and victims of violent and non-violent CSA referred for assessment at two national CSA assessment centre in Ireland had distinctive clinical profiles.

INTRODUCTION

In Ireland child sexual abuse (CSA) is a widespread problem (Kennedy, Manwell, Vincent, McKenzie and Blaney, 1990; MacIntyre & Carr, 1999a; MacIntyre & Carr, 2000a; McKeown & Gilligan, 1991; O'Reilly & Carr, 1999). Only a minority of CSA victims are referred for assessment and CSA is only confirmed in a proportion of these cases (MacIntyre & Carr, 1999c, 2000a). CSA has short and long-term effects on psychological functioning. About two thirds of sexually abused children develop transient psychological problems and a fifth of cases show clinically significant long-term problems which persist into adulthood (Kendall-Tackett, Meyer-Williams, & Finklehor, 1993). Psychological problems shown by children who have experienced CSA include sexualized behaviour, excessive internalizing or externalizing behaviour problems, school based attainment problems and relationship difficulties (Berliner & Elliott, 1996; Browne & Finklehor, 1986; Wolfe & Birt, 1995).

A wide range of factors may mediate the impact of abuse on 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 & Carr, 1999b; Carr, 1999; Spaccarelli, 1994). Aspects of the abuse such as the relationship between the victim and the perpetrator (Fischer & McDonald, 1998); the invasiveness and chronicity of the abuse (Black, Dubowitz, & Harrington, 1994); and the amount of physical violence involved (Gomes-Schawrtz, Horowitz, & Cardarelli, 1990) all have a potential impact on the level of abuse-related stress experienced by the child. 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 (Romans, Martin, Anderson, O'Shea, & Mullen, 1995; Spaccarelli & Kim, 1995; Toth & Cicchetti, 1996; Tremblay, Hebert, & Piche, 1999).

Little research on the behavioural effects of CSA and factors that mediate these effects has been conducted in Ireland. The objective of this archival study was to describe the characteristics and psychosocial circumstances of children and adolescents referred for CSA assessment at two national specialist centres in Ireland.

We were interested in profiling cases where there was considerable certainty that CSA had occurred. Thus, initially we wished to identify factors that distinguished these cases from those where multidisciplinary clinical teams decided that the results of their comprehensive assessment did not permit them to conclude with

confidence that CSA had occurred. Our hypothesis was that in unconfirmed cases, in addition to the absence of a purposeful disclosure, there would be other factors such as greater family disorganization or more non-sexual child behaviour problems which would distinguish these cases from confirmed cases of sexual abuse. With respect to the confirmed cases we wished to profile youngsters with and without significant behavioural problems. Our hypothesis was that youngsters with clinically significant behavioural problems would have a history of more severe or chronic abuse or multiple forms of abuse. Finally we wished to profile confirmed cases in which violent and non-violent abuse had occurred. Our hypothesis was that more significant adjustment problems would occur in cases where violent sexual abuse had occurred. In summary, this study addressed three questions:

1. How do confirmed and unconfirmed CSA cases differ on demographic variables; CBCL profiles; abuse-related characteristics; and disclosure-related characteristics?
2. How do CSA cases who do and do not display serious adjustment problems on the CBCL differ on demographic variables; abuse-related characteristics; and disclosure-related characteristics?
3. How do CSA cases who reported violent and non-violent CSA experiences differ on demographic variables; CBCL profiles; abuse-related characteristics; and disclosure-related characteristics?

METHOD

DATABASE

Archival records of 150 Irish youngsters aged 4 to 18 years referred over a 24 month period in the late 1990s to two national specialist sexual abuse assessment and therapeutic centres constituted the database for this study.

INSTRUMENTS

An extensive clinical information protocol, completed by clinicians, and the Child Behaviour Checklist (CBCL, Achenbach, 1991), completed by parents, were the two main instruments used in this study.

Clinical information protocol

This protocol was routinely completed by clinical teams involved in the assessment of cases and information was obtained from multiple sources including interviews with parents, children and other involved professionals.

The protocol included items in a number of domains and allowed demographic information, abuse-specific variables and disclosure-related information to be routinely and reliably coded. With respect to demographic information, data on the following variables were coded: age, gender, social class, birth order, family composition, unresolved custody and access issues, child's legal status, parents marital status, maternal and paternal criminal record, maternal and paternal history of violence, child's history of previous psychological treatment, child's history of completing the Stay Safe CSA prevention programme, child's school attendance, child's involvement with remedial educational services, child's history of repeating school grades, and the child's history of other school problems. With respect to abuse-specific variables the following information was coded: relationship of the child to the perpetrator, whether the perpetrator was living in same home as the child, age and gender of perpetrator, type of abuse, chronicity of abuse, strategies used by the perpetrator to achieve compliance, results of medical examination, child's sexualised behaviour problems, child's history of previous abuse, and maternal and paternal history of abuse. With respect to disclosure-related information the following data were coded: reason for referral, the person to whom the initial disclosure was made, the gender of the person to whom the child made the initial disclosure, whether each of the parents were supportive of child, whether each of the parents were non-supportive of the perpetrator, the perpetrators denial of the abuse, whether the perpetrator had other CSA victims, any changes in the composition of the child's household following disclosure, and the number of changes of residence for the child following disclosure.

In addition to this factual information a judgement about whether CSA had occurred or not was coded. This judgement was the outcome of a comprehensive assessment conducted by a clinical team. Cases in which it was judged with considerable certainty that 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 multidisciplinary teams following comprehensive multidisciplinary assessments 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 & Gentile, 1992). Sexualized 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 the view that sexual abuse has occurred included sexual

knowledge that was not age-appropriate; the use of age-appropriate 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 sympathized 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.

The Child Behaviour Checklist (CBCL)

This 113 item inventory was completed by parents so as to give a description of their children's behaviour problems (Achenbach, 1991). The CBCL yields scores on 3 broad band scales and 8 narrow band scales. The total problem scale, the externalizing behaviour problem scale and the internalizing behaviour scale are broad band dimensions. The narrow band scales are: withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour. CBCL items describe problem behaviours that children between 4 and 18 years may exhibit. A 3 point response format is used for each item: 0=not a problem, 1=sometimes a problem, 2=often a problem. Raw scores are converted to T-scores with a mean of 50 and a standard deviation of 10. T-scores above a clinical cut-off of 63 on the broad band scales are indicative of clinically significant problems. The CBCL scales have high internal consistency and test-retest reliability (Achenbach, 1991) and good discriminative validity (Kasius, Ferdinand, Van Den Berg, & Verhulst, 1997). In a recent epidemiological study of psychopathology in Irish children and adolescents as measured by the CBCL, 13-15 year olds did not differ from their American counterparts on the total problem score (Fitzpatrick & Deehan, 1999).

PROCEDURE

In both centres, it was routine practice for parents to be invited to give consent for their archival records to be used in studies such as that reported here. For the present study, data were abstracted from the archives and checked for completeness. Where records were incomplete clinicians involved in those cases were asked to provide missing data. For all items included in this study, missing data were present in no more than 10% of cases.

RESULTS

Three main sets of analyses were conducted. First, 113 confirmed CSA cases were compared with 37 unconfirmed CSA cases. Cases were classified as confirmed or unconfirmed by highly experienced specialist multidisciplinary CSA assessment teams using best practice criteria (Heiman, 1992; Carr, 1999, p. 825-6; Wolfe & Gentile, 1992). Second, 55 confirmed CSA cases who displayed clinically significant behaviour problems were compared with 56 confirmed CSA cases who showed no clinically significant adjustment difficulties. Cases were classified as having clinically significant behaviour problems if they obtained a T-score of 63 or greater on the total problem scale of the CBCL. In two of the 113 confirmed cases, CBCL data were unavailable and so were omitted from this analysis. Third, 19 confirmed CSA cases in which there was clear evidence that violence was a central feature were compared with the 79 confirmed cases in which there was clear evidence that violence was not a central feature.

In all three sets of analyses, cases were compared on demographic variables. In the first and third set of analyses, CBCL profiles were compared. In the second and third set of analyses cases were compared on abuse-specific and disclosure-related variables. In each set of analyses independent t-tests were used to assess the statistical significance of intergroup differences on interval scale variables, while chi square tests were used for categorical data and Mann Whitney U test were used for ordinal data.

Because of the large number of comparisons involved in this study, there was an increase risk of Type 1 error (erroneously accepting the presence of an intergroup difference based on the results of a statistical test). To avoid Type I error, results significant at $p < .01$ were considered to be statistically significant. With multiple comparisons, the Bonferroni correction to control for Type I error was not used because it would greatly reduce the power of the tests used and inflated the chance of Type II error (Perneger, 1998). For CBCL scores, the

issue of Type 1 error was addressed by only analyzing intergroup differences on subscale scores if groups differed on the CBCL total problem score. This approach is an alternative strategy to conducting a preliminary MANOVA on all 13 CBCL scale scores.

Insert Tables 1,2,3 & 4 about here

CONFIRMED AND UNCONFIRMED CASES

From Table 1 it may be seen that the 113 confirmed and 37 unconfirmed CSA cases differed significantly ($p < .01$) on 4 out of 18 demographic variables: gender, parents marital status, fathers' criminal record, and father's history of violence. More unconfirmed cases were male (70% v 35%); had single or separated parents (72% v 35%); and a father with a criminal history (84% v 60%). For more confirmed cases there was no information on the father's history of violence compared with unconfirmed cases (66% v 38%).

On the remaining variables listed in Table 1 confirmed and unconfirmed cases did not differ significantly. Both groups of cases were from a range of social classes; had a range of birth orders and were predominantly from one-father families. Custody and access issues occurred in only a minority of cases. Care-orders and voluntary care were a rarity in both groups. Maternal criminality and violence was absent in about half of all cases and in a third to a half of all cases there was no information on these variables. Almost half of all cases had received previous psychological treatment. Just under a half of all cases had not completed the Stay Safe programme, a child abuse prevention programmes (MacIntyre, Carr, Lawlor, & Flattery, 2000). About a fifth of cases received remedial tuition. Between a tenth and a fifth had repeated grades. Less than a tenth of cases were not attending school. And just over a fifth reported other school problems.

Confirmed and unconfirmed cases did not differ significantly on any of the CBCL scales. From Table 2 it may be seen that mean scores for both groups on all scales fell below the clinical cut-off score of 63.

From Table 3 it may be seen that confirmed cases had a clear profile on abuse related characteristics. The four most frequent types of relationships with perpetrators were neighbours, cousins, uncles and friends. In under a fifth of cases the perpetrator lived in the child's home. Thus the bulk of confirmed cases were of abuse which occurred outside the nuclear family. Over 90% of perpetrators were male with 60% being adult and 30 %

being adolescents. About two fifth of cases involved contact-penetrative abuse and two fifths involved contact non-penetrative abuse. Just over half of confirmed cases had been abused for less than a year and about a third had been abused for 1-2 years. In almost a fifth of cases coercive-violence accompanied the sexual abuse. In over half of all confirmed cases no medical examination was conducted or it was refused. In just under a fifth of cases were there clear positive findings. Only a fifth of cases showed sexualised behaviour. In just under a tenth of cases, the child had previously been a victim of sexual abuse before the episode that led to the referral. In just over a third of cases the mother had a history of abuse whereas a paternal history of abuse was present in just under a tenth of cases.

The profile of confirmed cases on disclosure related characteristics is given in Table 4. Two thirds of cases made purposeful disclosures and in almost all of these the disclosure was made to a parent. In over four fifths of cases the disclosure was made to a female. In almost all cases the mother was supportive of the child while in two thirds of cases the father was also supportive. In over two thirds of cases both mother and father were non-supportive of the perpetrator. In about a third of cases the perpetrator denied abuse. In just over a quarter, perpetrators admitted to some aspect of the abuse and in two fifths of cases no information on this variable was available. In over a third of cases the perpetrator had abused other victims. In over four fifths of cases there had been no household changes following disclosure and the child had not been required to move household.

CONFIRMED CASES WITH AND WITHOUT BEHAVIOUR PROBLEMS

Confirmed cases with, and without behaviour problems did not differ significantly on any demographic or disclosure-related variables. With respect to abuse-related characteristics, cases with behaviour problems differed significantly from those without behavioural problems on only one variable: strategies used by the perpetrator to gain compliance (Chi Square (df = 2, N=111) = 8.56, p <.01). 31% of children with behaviour problems had experienced violent-coercive sexual abuse whereas only 8% of cases without behaviour problems had not experienced such violence.

CONFIRMED CASES WHO DISCLOSED VIOLENT AND NON-VIOLENT SEXUAL ABUSE

Confirmed cases who had experienced violent-coercive abuse and those who had experienced non-violent sexual abuse did not differ on demographic or disclosure related variables. However, significantly more of those who had experienced violent-coercive abuse had experienced penetrative abuse (68%) compared with those who had experienced non-violent CSA (37%) (Chi Square (df = 3, N=98) = 17.61, $p < .01$). Mean T scores for cases who had experienced violent-coercive abuse and those who had experienced non-violent sexual abuse differed significantly on 4 CBCL scales: total behaviour problems ($t(97)=2.31, p < .01$); externalizing behaviour problems ($t(97)=3.05, p < .01$); delinquent behaviour ($t(97)=3.04, p < .01$); and aggressive behaviour ($t(97)=3.15, p < .01$). For all four variables, the mean score for cases who had experienced violent-coercive abuse was greater than that for those who had not. For total behaviour problems, the mean for cases who had experienced violent-coercive abuse was 68 (SD=13.3) and the mean for those who had experienced non-violent sexual abuse was 61 (12.5). For externalizing behaviour problems, the mean for cases who had experienced violent-coercive abuse was 67 (SD=13.1) and the mean for those who had experienced non-violent sexual abuse was 58 (12.1). For delinquent behaviour, the mean for cases who had experienced violent-coercive abuse was 67 (SD=10.1) and the mean for those who had experienced non-violent sexual abuse was 60 (9.7). For aggressive behaviour, the mean for cases who had experienced violent-coercive abuse was 68 (SD=12.5) and the mean for those who had experienced non-violent sexual abuse was 60 (10.8).

DISCUSSION

In answer to the three questions addressed in this study the following conclusions were reached. With respect to the first question concerning differences between confirmed and unconfirmed CSA cases, more unconfirmed cases were male; had single or separated parents; and a father with a criminal history. For more confirmed cases there was no information on the father's history of violence compared with unconfirmed cases. On other demographic and behavioural variables these two groups of cases were indistinguishable. With respect to the second question concerning differences between cases with and without behaviour problems, more cases with clinically significant behaviour problems had experienced coercive-violent sexual abuse. On demographic or disclosure related variables these two groups of cases were indistinguishable. With respect to the third question

concerning differences between cases who reported violent and non-violent CSA, more of those who had experienced violence had been victims of penetrative sexual abuse and they had more externalizing behaviour problems such as delinquent and aggressive behaviour. On demographic or disclosure related variables these two groups of cases were indistinguishable.

This study had a number of limitations. First, the group studied was only representative of typical referrals to the two centres who completed assessment procedures, not of CSA cases within the wider community. So the results of the study cannot be generalized to referred cases who do not complete assessment procedures or cases within the community. It is noteworthy, in this respect, that the perpetrator was a parental figure in under 5% of cases, while community based epidemiological studies indicate that the level of incestuous intrafamilial CSA is far higher than this (MacIntyre & Carr, 1999a, 2000a). Second, only parent reported behaviour problems (on the CBCL) were evaluated and self-reports of behavioural difficulties from the children themselves were not included in the study. Thus, our results concerning behaviour problems reflect a parental perspective only. Third, no data were available on the time interval between the cessation of the CSA and the parents completing the CBCL. So in some cases, CBCL scores may reflect the immediate effects of CSA, whereas in others they may reflect effects of CSA that had ceased some time ago. Thus, we cannot be sure to what post-CSA period our results may validly be generalized.

Despite these limitations, our results are valuable because of a number of 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 fact that unconfirmed cases were, broadly speaking, more disadvantaged than confirmed cases is a particularly important finding from this study and partially supports our first hypothesis. These males from single parent families with antisocial fathers may have been referred because the level of disorganization within their families may have prompted concern in teachers or others which was misattributed to CSA. It is noteworthy, in this regard, that the rates for completion of the Stay Safe child abuse prevention programme (MacIntyre, & Carr, Lawlor & Flattery, 2000) were similar for both confirmed and unconfirmed cases. In a previous study we found that participation in the programme was associated with a higher rate of confirmed disclosures (MacIntyre & Carr, 1999c, 2000a), a finding that would be expected in light of the results of outcome research on CSA

prevention programmes (MacIntyre & Carr, 2000b). The unconfirmed cases in this study were therefore, most likely youngsters who had not experienced CSA but whose family circumstances had prompted referral.

The association between violent CSA and behavioural problems in Irish CSA victims found in the present study is supportive of our second and third hypotheses and consistent with similar findings from international studies where sexual abuse involving violence has been found to lead to more profound psychological difficulties (e.g. Conte & Schuerman, 1987; Cohen & Mannarino, 1988; Gomes-Schawrtz, Horowitz, & Cardarelli, 1990).

Future research in this area is required to clarify the referral processes associated with unconfirmed cases, the psychological mechanisms by which violent CSA and behavioural difficulties are linked, and the most appropriate way of treating youngsters who have experienced violent CSA.

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Table 1. Comparison of demographic characteristics of confirmed and unconfirmed CSA cases

Variable	Confirmed CSA Cases (N=113)	Unconfirmed CSA Cases (N=37)	t or Chi Square or Z
Age			
M	10.6 y	9.0y	t 2.33
SD	3.7y	3.7y	
Range			
4-5 yrs	10.6%	24.3%	
6-11 yrs	40.7%	45.9%	
12-17 yrs	48.7%	29.8%	
Gender			
male	34.5%	70.3%	X 14.51 **
female	65.5%	29.7%	
Social Class			
1	4.4%	2.7%	Z 0.95
2	7.1%	10.8%	
3	10.6%	13.5%	
4	23.9%	27.0%	
5	23.9%	24.3%	
6	15.0%	10.8%	
7	15.0%	10.8%	
Birth Order			
eldest	31.1%	44.4%	X 10.13
2 nd	29.1%	18.9%	
3 rd	18.4%	11.1%	
4 th	5.8%	13.9%	
5 th	10.7%	5.6%	
6 th	1.9%	2.8%	
<7 th	3.0%	2.8%	
No. of fathers in family			
1	74.7%	75.9%	X 2.13
2	18.9%	24.1%	
3	4.2%	0.0%	
4	1.1%	0.0%	
Custody/ Access Issues	6.1%	25.0%	X 1.89
Child's Legal Status			
family care	97.0%	100.0%	X 1.81
care order	1.0%		
voluntary care	1.9%		
Marital Status			
married	62.4%	27.8%	X 14.64 **
single/separated	34.7%	72.3%	
widowed	1.0%	0.0%	
divorced	2.0%	0.0%	
Criminal record (father)			
none	59.5%	83.8%	X 28.61 **
yes	10.8%	2.7%	
unknown	29.7%	13.5%	
Criminal record (mother)			
none	73%	58.9%	X 5.99
yes	0%	1.8%	
unknown	27%	39.3%	
History of violence (father)			
none	41.8%	50.0%	X 30.27 **
marital violence	5.5%	7.1%	
multiple	3.6%	0.0%	
anti-social behaviour	1.8%	0.0%	
violence towards children	0%	5.4%	
unknown	65.5%	37.5%	
History of violence (mother)			
none	49.1%	50.0%	X 7.92
marital violence	0%	1.8%	
violence towards children	0%	1.8%	
unknown	50.9%	39.3%	
Previous psychological treatment	41.7%	50.0%	X 0.74
Did not complete Stay Safe Programme	43%	48.6%	X 3.83
Not attending School	9.8%	8.1%	X 0.10
Remedial Services	20.2%	17.1%	X 0.42
Repeated Grades	16.2%	8.6%	X 1.24
Other School Problems	31.1%	20.6%	X 1.40

Note:**p<0.01. X = chi square. z = z derived from Mann Whitney U test. Cases were assigned to socio-economic groups on the basis of occupation with O'Hare, Whelan & Cummins (1991) scale.

Table 2. Comparison of CBCL profiles of confirmed and unconfirmed CSA cases

Variable		Confirmed CSA Cases (N=113)	Unconfirmed CSA Cases (N=37)
CBCL Total Score	M	61.64	58.24
	SD	12.51	12.43
CBCL Internalising T	M	60.80	57.65
	SD	13.18	13.04
CBCL Externalising T	M	58.86	56.19
	SD	12.38	11.17
Withdrawn	M	60.01	58.70
	SD	10.24	9.09
Somatic Complaints	M	60.71	60.00
	SD	10.37	10.36
Anxious/Depressed	M	62.65	58.24
	SD	11.75	8.51
Social Problems	M	58.75	56.78
	SD	9.06	10.67
Thought Problems	M	59.63	56.89
	SD	9.38	7.90
Attention Problems	M	62.69	58.35
	SD	11.23	8.96
Delinquent Behaviour	M	60.81	57.30
	SD	10.09	8.04
Aggressive Behaviour	M	60.31	58.32
	SD	11.23	9.94

Table 3. Abuse-related characteristics of confirmed CSA cases

Variable		%
Relationship of Perpetrator	neighbour	21.7%
	cousin	14.2%
	uncle	13.2%
	child's own friend	13.2%
	sibling	5.7%
	family friend	5.7%
	biological parent	2.8%
	step-parent	2.8%
	babysitter	2.8%
	multiple	2.8%
	co-habitee parent	1.9%
	grandparent	1.9%
	lodger/frequent visitor	1.9%
	stranger	1.9%
	adoptive parent	.9%
other	6.6%	
Perpetrator living in same home	no	81.4%
	yes	18.6%
Gender of Perpetrator	male	93.2%
	adult	55.9%
Age of Perpetrator	adolescent	30.1%
	child	14%
Type of Abuse	contact-penetrative abuse	42.9%
	contact non penetrative	41.1%
	contact-attempted penetrative abuse	9.8%
	non-contact	6.3%
Chronicity of Abuse (months)	less than 1 year	57.3%
	1 to 2 years	32.9%
	2 to 3 years	5.2%
	more than 3 years	5.6%
	unknown	4.2%
Strategies to Achieve Compliance	coercive-violent	19%
	coercive-non violent	49%
	grooming/reward	32%
Physical Findings	medical refused	31%
	no medical done	24.8%
	definite positive	18.6%
	none	18.6%
	uncertain	7.1%
Sexualised Behaviour Exhibited	none/age appropriate	78.2%
	yes	20.8%
Child Previous Victim of Abuse	no	86.4%
	yes	9.7%
	unknown	3.9%
Mother History of Abuse	no	50.5%
	yes	36.9%
	unknown	12.6%
Father History of Abuse	no	67.6%
	yes	7.8%
	unknown	22.5%

Note: N=113

Table 4. Disclosure-related characteristics of confirmed CSA cases

Variable		%
Reason for Referral	purposeful disclosure by child	67%
	accidental disclosure by child	7.8%
	disclosure by other child	4.9%
	disclosure by sibling	3.9%
	contact with known abuser	3.9%
	behavioural/emotional signs	3.9%
	abuse overheard by third party	3.9%
	concern	1.9%
	contact with alleged abuser	1.0%
	other	2.0%
Initial disclosure to whom	parent	58.8%
	professional	10.7%
	sibling	7.8%
	Garda Siochana	5.9%
	relative	4.9%
	friend - child	4.9%
	friend - adult	2.9%
	babysitter/minder	2.0%
	No disclosure	2.0%
	Gender child initially disclosed to	female
male		15.1%
Parents supportive of child	Mother	93.3%
	Father	67.0%
Parents non-supportiveness of perpetrator	Mother	84.7%
	Father	67.0%
Perpetrators stance on abuse	unknown	40.0%
	denial	32.0%
	admits part of the abuse	13.0%
	admits abuse in full	10.0%
	admits abuse but not responsibility	5.0%
Other children victims	yes	39.2%
	no	39.2%
	unknown	21.6%
Household changes post disclosure	none	86.5%
	perpetrator left	7.7%
	child removed	3.8%
	other	1.9%
Number of moves of child post disclosure	none	86.5%
	1	9.6%
	2	2.9%
	3	1.0%

Note: N=113