

*ACSSA Wrap* is the new approach taken by the Australian Centre for the Study of Sexual Assault (ACSSA) to keeping those who work in the field of sexual assault prevention abreast of the latest practice and policy information. Each *ACSSA Wrap* will offer a concise and easy-to-read overview of current information on issues and practice in relation to sexual assault. Each will include summaries of reliable statistics as evidenced by current research on the topic area, as well as list major resources, including books, articles, on-line documents and, if appropriate, organisations to contact for further information. *ACSSA Wrap* will be distributed bi-annually to ACSSA subscribers.

## Adult victim/survivors of childhood sexual assault

Childhood sexual assault is a common, yet largely hidden crime. Though estimates of the number of Australian women and men sexually assaulted in childhood vary, as shall be seen below, there is no doubt that childhood sexual assault is one of the most prevalent abuses in our society. The negative impact that childhood sexual assault may have on victim/survivors in adulthood, including an increased risk of revictimisation, indicates the abuse carries an enormous social, as well as individual cost, and must give a sense of urgency to our responses.

There are many gaps in our knowledge and understanding of the experiences of adult victim/survivors of childhood sexual assault. Nevertheless, from the research and knowledge which does exist, it is possible to identify three main lines along which responses are hampered: a socio-familial climate which hinders disclosure of abuse, the failings of the criminal justice system, and insufficient resourcing of service provision.

### What is childhood sexual assault?

The different state and territory governments use their own legal definitions, but child sexual assault is commonly considered to be any sexual activity between a child and an adult, or older person. This can include fondling genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism and exposing or involving the child in pornography.

Many definitions of child sexual assault specify the age difference between the perpetrator and the child or young adult, as it is considered that young people are not able to make a free and informed decision (that is, consent) to engage in such sexual activities because of their lack of relative knowledge and power. However, concerns have been raised that definitions that specify age difference between the perpetrator and child or young person fail to take into account non-consensual sexual activity between peers (such as sibling sexual assault, and sexual assault and date-rape perpetrated by adolescents).

### Who sexually assaults children, and how common is it?

Despite the widespread view that children are sexually assaulted mainly by strangers, the reality is that most sexual assault is perpetrated by someone who is known to the child, such as a family member, family friend, or person with whom the child comes into contact (Richardson and Bromfield 2005).



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The Australian Centre for the Study of Sexual Assault aims to improve access to current information on sexual assault in order to assist policy makers, service providers, and others interested in this area to develop evidence-based strategies to prevent, respond to, and ultimately reduce the incidence of sexual assault.

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## ACSSA Wrap No. 1 Adult victim/survivors of childhood sexual assault

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Information on prevalence of childhood sexual assault and the relationship of the perpetrator to the child comes largely from national population surveys, and of these the Australian component of the *International Violence Against Women Survey*, known as IVAWS (Mouzos and Makkai 2004), is the most recent and entails the largest survey population. It was conducted across Australia between December 2002 and June 2003, on a total of 6,677 women aged between 18 and 69 years. Eighteen per cent of women surveyed had experienced sexual violence before the age of 16 years (2 per cent by a parent and 16 per cent by someone other than a parent). The overwhelming majority of those abused by a parent were abused by fathers (only two women in the sample had been sexually abused by their mothers). Of those abused by someone other than a parent, 20 per cent of the perpetrators were friends or friends of the family, 17 per cent were acquaintances or neighbours, 13 per cent were strangers, 13 per cent were "someone else known". Uncles, brothers, grandfathers, cousins, other relatives and other children/students comprised less than 10 per cent of perpetrators each.

In a smaller national random survey of 710 women (Fleming 1997), 144 women (20 per cent) had been sexually assaulted in childhood. In 14 of these cases, the assault involved either vaginal or anal intercourse (that is, 2 per cent of the sample population experienced such abuse). The mean age at first assault was ten years, and most (71 per cent) of the women were aged under 12 years at the time. Ninety-eight per cent of the perpetrators were male, mostly known to the child, with 41 per cent being relatives. The mean age of abusers was 34 years, with a median age difference of 24 years from that of the abused individual.

To date, there has been no large-scale national population survey that includes childhood violence against males. This means information on the incidence of childhood sexual assault of boys comes mostly from reports of suspected child abuse made to statutory child protection departments. However, such data must be interpreted more conservatively than the population surveys, as it is well known that only a tiny fraction of cases of abuse are reported. In the latest report of the Australian Institute of Health and Welfare (AIHW 2004), 4,137 substantiated cases of sexual abuse were reported nationally over the year 2002-2003. Sexual abuse accounted for between 7 per cent (in South Australia and the Australian Capital Territory) and 27 per cent (in Western Australia) of substantiated cases of child abuse and neglect reported to child protection departments. In all jurisdictions (except the Australian Capital Territory) girls were approximately three times more likely than boys to be the subject of a substantiation of sexual abuse.

Doyle Peters, Wyatt and Finkelhor (1985) carried out a review consolidating the evidence of several smaller-scale international surveys, and found a range of between 6 and 62 per cent of females and 3 and 31 per cent of males were victims of child sexual abuse, depending on definitions, measures and data collection methods used. Fergusson and Mullen (1999) confirmed this range in an updated review, and stressed that the *majority* of studies suggested prevalence somewhere in the interval of between 15 and 30 per cent for females, and between 3 and 15 per cent for males. This seems to be the origin of the often-quoted figures: "one in three women" and "one in six men" are victims of childhood sexual assault.

Acknowledgement that children and adolescents may commit acts of sexual assault has only occurred relatively recently (Vizard, Monck and Misch 1995). The National Children's Home (1992, as cited in Masson 1995) reported that it is estimated that between one-quarter to one-third of sexual abuse cases in the United Kingdom are perpetrated by a child or young person.

Finkelhor and Russell (1984) concluded that, although males clearly constitute the majority of perpetrators, females do abuse in a small proportion of cases: approximately 5 per cent of female victims, and 20 per cent of male victims experience sexual abuse perpetrated by a female.

Little data exists on adult victim/survivors of childhood sexual assault from Indigenous communities. Stanley (2003) details the even greater difficulties in understanding such abuse in Indigenous communities than in the non-Indigenous population. She refers to the contribution of past and present trauma experienced by Indigenous people to the present problem of child sexual assault, as well as cultural clashes in child protection. According to Lievore's (2003: 56) recent literature review of available statistics on reported and unreported sexual

assaults: “Anecdotal evidence, case studies and submissions to inquiries support the assumption that sexual violence in Indigenous communities occurs at rates that far exceed those for non-Indigenous Australians.”

In response to the frequently asked question of why perpetrators offend, Wurtele and Miller-Perrin (1993: 20) remark that “the only common denominators appear to be an offender’s lack of sensitivity to the child’s wishes and needs, along with a willingness to exploit the child’s trust for the abuser’s own gratification, profit or selfish purposes”. Tomison (1996) also notes that no single psychiatric disorder has been identified across the majority of offenders.

### How do we know what we know?

There are four major sources of knowledge and data on childhood sexual assault:

- **Population surveys.** These are probably the most accurate source of information on prevalence of childhood sexual assault, but they obscure the contexts and life experiences of individual victim/survivors.
- **Accounts by victim/survivors.** These detail experiences of childhood sexual assault and the effects on survivors’ lives. They do not, in themselves, reveal how prevalent such experiences are, nor the extent to which individual experiences are typical, although the latter may be theorised in accompanying socio-structural analyses.
- **Clinical studies.** These look for common features in cases of childhood sexual assault and, as such, lend themselves to generalisation, although this is limited by the medical and/or psychological focus of their frameworks.
- **Official data.** This includes reports to statutory child protection departments and police statistics. The limitations associated with these sources include gross levels of under-reporting; few cases being substantiated, because of lack of physical evidence (which is rare); and under-representation of the extent to which child abuse is committed by biological parents (Wallis 1992).

### What are the effects on victim/survivors?

In 1992 Judith Herman likened the effects of childhood sexual assault on survivors to the effects of war on combatants. Many studies since have documented correlations between childhood sexual assault and adverse psychological and social outcomes such as increased depression, anxiety disorders, antisocial behaviour, substance abuse, eating disorders, suicidal behaviour, and post-traumatic stress disorder (Dinwiddie et al. 2000; Fergusson, Lynskey and Horwood 1996; Mullen, Martin, Anderson, Romans and Herbison 1994). Fergusson and Mullen’s 1999 review cautions, however, that the influence of childhood sexual assault may be confounded by other factors such as the disturbed and disadvantageous family backgrounds in which abuse may occur. Mullen and Fleming (1998) advance the hypothesis that the fundamental damage inflicted by child sexual assault is to the child’s developing capacities for trust, intimacy, agency and sexuality, and that many of the mental health problems of adult life associated with histories of abuse are second-order effects. Fergusson and Mullen suggest that such correlations are by no means inevitable, and that a substantial minority (up to 40 per cent) of victim/survivors may not have any adverse psychological or social outcomes at all, as many of the negative outcomes may be lessened by appropriate social and emotional support immediately following the assault and later in life.

A disturbing and yet common effect of childhood sexual assault is increased risk of revictimisation. Mouzos and Makkai (2004) found that the risk of sexual violence in adulthood doubles for women who were abused as a child (54 per cent versus 26 per cent). The 1996 survey, *Women’s Safety Australia* (ABS 1996), found that a history of violent victimisation, either as a child or adult, was a strong predictor of future victimisation regardless of age, educational attainment, employment status, income or marital status. Again, revictimisation is not inevitable. Mouzos and Makkai (2004) report that a minority of women (22 per cent) who were victimised as children stated that they had not experienced any physical and/or sexual victimisation since the age of 16. The authors contend that this may depend on the severity and frequency of the violence experienced as a child, and/or on the child’s resiliency and ability to cope with the situation. Lobmann, Greve, Wetzels and Bosold (2003) note that various coping mechanisms or “protective factors” (such as the child receiving support from teachers and friends) are able to buffer or palliate the negative impact of violence victimisation and/or assist in overcoming the after-effects.

In any discussion of the effects of childhood sexual assault on victim/survivors, it is important to remember Scott, Walker and Gilmore’s (1990) warning against “an over-emphasis on ‘individual-pathology’, which alternates between blaming the victim, the victim’s mother, dysfunctional families, or simply defines the offender as deviant”. Without minimising the enormous harm childhood sexual assault causes to individual victim/survivors, they suggest it remains imperative to focus on the social climate in which abuse occurs, and in which victim/survivors are largely denied support, if these harms are to be adequately addressed (Scott, Walker and Gilmore 1990).

### Service responses

Although the gaps in knowledge about how to respond to survivors of childhood sexual assault are significant, in recent years there have been several texts published that are designed to assist counsellor/advocates who work with victim/survivors (Bullen, Jacobs, Le Pont, Martin and Smith 2004; Holden 2002; Mann 2004; Rokvic 2002; Stojadinovic 2003). However, the effectiveness of many therapeutic responses to childhood sexual assault has not been evaluated. Fergusson and Mullen (1999) suggest that treatment is complicated by the fact that child sexual assault is not a disorder, but rather an assumed cause of disorder, making it difficult to determine treatment objectives, methods, and assessments. Furthermore, a gendered understanding of childhood sexual assault has not been widely incorporated into mainstream thinking in this area, and myths surrounding childhood sexual assault prevail within society and often impact on the delivery of services to survivors (Rokvic 2002).

In 2002, Women’s Health Statewide in South Australia conducted a research project that explored the current service needs of adults subjected to sexual assault during childhood, resulting in the report *It’s Still Not My Shame*. Findings of this report (Holden 2002: 21) highlighted the issues and needs for adult survivors and workers as follows:

- “The demand for counselling and group services by adult survivors continues to be high, with many services in the government and non-government sector reporting they are unable to respond to a large number of requests for services.”

- There is a lack of a coordinated approach to issues of childhood sexual abuse for adult survivors in relation to service provision, training and policy issues.
- Limited training opportunities exist for workers in this area, including basic and advanced childhood sexual abuse training.
- There is no specialist after hours crisis service.”

The report built on earlier research in 1994 by the South Australian Rape and Sexual Assault Service (now known as Yarrow Place), which culminated in the original *It's Not My Shame* report (Women's Health Statewide 1994), as well as the 1991 *Strategies for Change* report by Moira Carmody (1991). All three reports have identified the need for a lead agency/specialist service for adult victim/survivors of childhood sexual assault. Holden (2002: 22) notes that without such an agency there remains a continuing lack of coordination around service delivery, training and community education, resulting in:

- “ • Limited identification of the health cost associated with poor coordination between services dealing with childhood sexual abuse, mental health and other related issues such as domestic violence.
- The needs of adult survivors of childhood sexual abuse not being reflected in policy development, organisational strategic planning and subsequent service delivery.
- Limited encouragement of research and community education strategies, including prevention.
- Inadequate development of comprehensive training for allied health workers and limited opportunities to warehouse appropriate literature or amass a body of knowledge or expertise for workers to access.
- Lack of a systematic approach to informing health planners and purchasers of services about current service trends and issues for adult survivors of childhood sexual abuse.”

While victim/survivor accounts have assisted in raising awareness of childhood sexual assault, reports like *It's Still Not My Shame*, as well as testimonies from organisations around the country (Basham 2005; Lawson 2004), indicate that further funding by state governments is needed to provide more dedicated and appropriate services. While there is a small number of organisations around Australia that provide counselling support for childhood sexual assault survivors, broadly speaking, the service needs of adult survivors are overlooked. Those seeking help from specialist sexual assault services are likely to be faced with long waiting periods before a counsellor is able to see them, or in some circumstances, may be advised that the service is unable to extend to victims of past assaults. This is largely due the nature of service agreements that restrict the core funding of services to areas that predominantly address the needs of recent victims of sexual assault, where crisis-care (including forensic care) and short-term counselling models are prioritised.

### Service provision for victim/survivors of childhood sexual assault

The Australian Centre for the Study of Sexual Assault is aware that national service provision for adult victim/survivors of childhood sexual assault is yet to be adequately mapped, and that there are

significant gaps in our knowledge. To this end, ACSSA will be compiling information and resources on service provision for adult victim/survivors. The information, to be reported through a later publication, will be sought via a survey to sexual assault, community and health services, building on state-based research such as *It's Still Not My Shame* (Holden 2002). The topics to be explored include the type of services organisations offer victim/survivors, the framework from which they work and the difficulties they face in providing assistance to victim/survivors. We look forward to being in contact with many of you over the coming months.

## Barriers to reporting

Research shows that the majority of victim/survivors encounter a range of obstacles to reporting childhood sexual assault. Fleming's 1997 survey found that only 10 per cent of such experiences were ever reported to the police, a doctor or a helping agency (for example, community organisations, such as sexual assault services). Patricia Eastal's (1992) national survey of 2,852 self-selected victim/survivors of sexual assault found that a staggering 52.6 per cent of male respondents, and 37 per cent of female respondents, had not only *not* reported their abuse to police, but had never disclosed their abuse to *anyone at all* prior to the survey.

Neame and Heenan summarise from the testimonies of adult victim/survivors as to why, as children, they often felt unable to disclose: “fear of family breakdown, a sense of ongoing responsibility for the safety of other children or family members, and fears for their own personal safety were all major reasons” (2003: 3, citing Rush 1980; Eastal 1994; Mullinar and Hunt 1997; Russell 1986). They also note the pervasive fear that if survivors do tell, they will not be believed (Neame and Heenan 2003). Evidence suggests the closer the relationship between an abused child and a perpetrator, the less likely it is that the abuse will be formally reported (Wallis 1992). According to Neame and Heenan, male victim/survivors of child sexual assault may be particularly reluctant to disclose their experiences “because of community assumptions that have often labelled them as future perpetrators; as homosexual; or, because they fear being treated as social outcasts, liars, or as emotionally weak” (Neame and Heenan 2003: 4, citing Mezey and King 1989; Stott 2001).

## Criminal justice responses

For many of the above reasons, official reports of rape and other sexual assault to police reflect a minority of all those victimised (ABS 1996; ABS 2002). However, Neame and Heenan (2003) note that reporting trends for victims of *past* sexual assault have increased considerably in the last eight years. According to the Victorian Law Reform Commission, for offences such as incest and other penetrative offences against children, almost one-third of reports (30.6 per cent) were in relation to assaults that occurred more than five years ago (VLRC 2003), compared with a mere 1.7 per cent ten years ago (Victorian Community Council Against Violence 1991). Most victims of incest and other penetrative offences who are involved in court proceedings are now adults, or nearing adulthood (VLRC 2003). An increase in rape prosecutions involving close family members was noted by Heenan and McKelvie in 1997, though the proportion of cases resulting in prosecution remained low. Almost one-fifth

of the 282 incidents they examined in case files involved immediate family members as offenders, including fathers and stepfathers (Heenan and McKelvie 1997).

The fact that only a small proportion of childhood sexual assault cases will ever result in prosecution has been blamed, at least partially, on structures within law that continue to prejudice the outcomes of sexual offence cases (Mack 1998; Taylor 2004). Neame and Heenan (2003: 4-5) note that proponents of law reform have particularly criticised: "the continued use of corroboration warnings, where judges routinely caution juries against convicting unless other evidence can independently support the victim's version of events. This substantially impacts on cases involving adult survivors who in recounting . . . childhood sexual assault often have nothing more than their sworn testimonies to convince juries of the accused's guilt."

In other criminal proceedings where the prosecution must establish the accused's guilt through the oral evidence of a single witness, corroboration warnings are nevertheless usually considered unnecessary in the face of the high standard of proof ("beyond reasonable doubt"), and the standards of testing the evidence through cross-examination. Feminist legal scholars and other advocates of abolishing the corroboration warning have suggested that judges' use of the warning in childhood sexual assault cases is a reflection of the systemic prejudice that "women and children, especially girl-children, possess a seemingly natural propensity to lie about sexual abuse and to fabricate allegations" (Taylor 2004: 5).

Taylor also highlights what she perceives as the failure of the criminal justice system to understand delayed disclosure of sexual assault and its association with so-called victim acquiescence – "especially in long-term sexual abuse cases, these responses occur as a consequence of the offender's conduct and trauma-induced suffering of the victim. Very often complex and perhaps counter-intuitive behaviours manifested by traumatised children are simply interpreted as evidence of the falsity of the alleged charge(s)" (Taylor 2004: 292). The access of adult victim/survivors to the variously-structured systems of "compensation" (whether monetary or in terms of counselling and other support) is also hindered by this dismissal of delayed disclosure. Reporting to police within specified timeframes is a requirement of many "compensation" systems, meaning that only a tiny proportion of adult victim/survivors are eligible for the benefits of such schemes. Indeed, a small number of counselling sessions may be the only compensation most adult victim/survivors can ever expect to be granted by the criminal justice system (Cumberland, Heenan and Gwynne 1998).

## Where to now?

There are several gaps in our knowledge of childhood sexual assault, its effects on victim/survivors, and the effectiveness of various responses. In order to meet the needs of victim/survivors, a better understanding of the causal effects of such abuse on mental health and other health and social problems is required, along with a fuller knowledge of what factors act as buffers or exacerbate the impact of childhood sexual assault. There is also an urgent need for evaluations of the therapeutic responses to the abuse for both children and adults so that appropriate services can be developed. A better understanding of the health costs to victim/survivors, such as that developed for the VicHealth report, *The Health Costs of Violence: Measuring the Burden of Disease Caused by*

*Intimate Partner Violence* (Victorian Health Promotion Foundation 2004), and of the costs of childhood sexual assault to society as a whole, along the lines of the Access Economics report, *The Cost of Domestic Violence to the Australian Economy* (2004), would be invaluable in documenting the wider health and social impacts of childhood sexual assault, and allow us to frame our responses accordingly.

Fear of not being believed and/or "being responsible" for family breakdown are predominant in adult victim/survivors testimonies as to why they do not report or, in many cases, even disclose, sexual assault in childhood. These fears are linked to pervasive social myths about sexual assault, especially that women and children often lie about rape, and that their right to live free from such abuse can be sacrificed for the sake of "keeping the family together". As Easta (1994: 1) notes: "One of the only means available to reduce sexual assault and to enhance the probability that its victims will report it to authorities is through knocking down the false images of rape that act to perpetuate it in society."

According to feminist legal theorists, not only do these myths act as barriers to disclosure, they are likely to be perpetuated by criminal justice responses following the reporting of childhood sexual assault (Taylor 2004). Low prosecution rates, unnecessary and misleading corroboration warnings, misunderstandings of delayed disclosure, and the silencing and revictimisation of complainants within the trial system have all been criticised as examples of the system's failure to deliver justice to sexual assault victim/survivors, especially those abused as children. Furthermore, the barriers to accessing the variously-structured systems of "compensation" mean that few adult victim/survivors are likely to benefit from them. Recommendations for reform are plentiful (Heenan and McKelvie 1997; Taylor 2004; Mack 1998; VLRC 2003), but in most cases are yet to be implemented.

Indeed, the collective experiences of adult victim/survivors of childhood sexual assault indicate they are subject to consistent, systematic discrimination. Many fear disclosing the abuse out of fear they will not be believed, and, of those who do disclose, many report disbelief on the part of family and friends (Easta 1994). Those who somehow find the courage to seek help from services are unlikely to receive the long-term support they need because of discriminatory funding guidelines. With all evidence indicating that significant numbers of Australian women and men are dealing with the physical, psychological and emotional after-effects of childhood sexual assault, it is essential that response measures to adult victim/survivors be considerably expanded. Reports on service provision which do exist have consistently identified the need for a lead agency/specialist service for adult victim/survivors of childhood sexual assault (Carmody 1991; Holden 2002; Women's Health Statewide 1994). Over the coming year, ACSSA will be mapping existing service provision in this area throughout the country, with the aim of identifying good practice, along with the difficulties services face and the consequent gaps in current levels of provision.

The ACSSA Wrap papers will be regularly updated online. Go to <http://www.aifs.gov.au/acssa/pubs/pubsmenu.html> for the latest resources, statistics and information on service provision. For specialist advice and information, including activating and compiling comprehensive literature searches, on issues relevant to childhood sexual assault, contact our Research Advisory Service: phone (03) 9214 7888; or email [acssa@aifs.gov.au](mailto:acssa@aifs.gov.au)

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