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Child Sexual Abuse in the Eastern Health Board Region of Ireland in 1988: An Analysis of 512 Confirmed Cases*

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Abstract: This paper reports some of the findings of a study of child sexual abuse in the Eastern Health Board region of Ireland. Data were supplied by Community Care Social Workers on all cases (990) known to them in 1988. By year end 512 of this total had been classified as confirmed on the basis of nationally agreed procedures; various findings for this group are presented. Three out of 4 victims were female; 1 in 4 male. The mean age of victims was 9.2 for girls and 7.0 for boys. In 60 per cent of cases the child was related to the abuser.

I INTRODUCTION

Child sexual abuse (CSA) is one aspect of a more general problem of child abuse and neglect which has received considerable public and professional attention in recent times. This attention has been stimulated by the increasing number and frequency of allegations of CSA by both adults and children. The effect of this has been to increase the demands on health care professionals responsible for the care and protection of children. In addition, the emergence of CSA has generated the need for research to establish some firm evidence on its nature, extent and correlates.

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This article is a contribution to the growing body of research literature on CSA. The article is divided into six sections. Following introductory remarks in Section I, Section II describes the context within which the research reported in the article was undertaken. This involves a brief review of the emergence of CSA in an international context as well as in Ireland. Section III describes the methodology used to collect and process the data. Data on 990 cases of alleged CSA which were known to the Community Care Teams of the Eastern Health Board (EHB) region of Ireland in 1988 were collected. Of these 990 cases, 429 (43%) were reported prior to 1988, the balance of 561 (57%) being reported in 1988. Of the 990 cases, 512 (52%) cases were classified as confirmed abuse at the end of 1988 following the assessment procedures of the Community Care Team. Section IV describes the main results of the study. Information on over 100 variables was collected for each case and a selection of the results is presented for all confirmed CSA cases. Section V of the article discusses the main results of the study in the context of some of the international findings on CSA. Section VI draws attention to some of the issues and implications raised by the research findings.

II CONTEXT

The International Background

Sexual abuse of children came to wide attention in the US in the 1970s, and in Europe in the 1980s. There is no immediately obvious explanation for this development. It may have been because the problem, through the work of women's groups, child protection lobbies and others, no longer remained hidden. Alternatively, or in addition, it may have been because the extent of the problem had grown in real terms. There can be no doubt, however, that CSA has now achieved a prominence, in the public and professional mind, on both sides of the Atlantic, never before reserved for incest or sexual offences against children. In this section, both the nature of this dramatic shift in the perception of sexual offences against children, and some of the possible reasons for the shift, are explored.

The term CSA seems to have been first used in the US in the [federal] Child Abuse Prevention and Treatment Act of 1974 (Haugaard and Reppucci, 1988, p. 3). It has been claimed that in the US since 1974, there has been an "explosion of interest in and concern about child sexual abuse of all types" (*ibid*). According to another authority, CSA "first began to appear on the agenda of mental health and child welfare professionals" in the mid-1970s (Finkelhor, *et al.*, 1986, p. 10). In 1976 there were 20 treatment programmes for offenders and their families in the US; by 1981 this figure had grown to 300 (Bulkley, 1985, cited in Haugaard and Reppucci, 1988).

The growth of interest by professionals in CSA appears to have been fuelled

by a number of large-scale research surveys, the results of which seemed to suggest that CSA experiences were much more common than had previously been thought (e.g., Finkelhor, 1979; Russell, 1983). Professional interest was also stimulated by professional opinion leaders who sought to spread a message of concern. In 1977, for instance, Henry Kempe, then a leading American paediatrician and Director of the US National Centre for Prevention and Treatment of Child Abuse and Neglect, described sexual abuse of children and adolescents in 1977 as "another hidden paediatric problem and a neglected area" (Kempe, 1978). He argued that it was just as common as the physical abuse of children to which he and his colleagues had alerted the western medical and social services worlds in a seminal article fifteen years earlier (Kempe, *et al.*, 1962). Whatever its precise sources, the growth of professional interest in the field in the US was soon to be reflected in the publication of a number of books on the topic (e.g., Finkelhor, 1979; Mrazek and Kempe, 1981; Giaretto, 1982; Sgroi, 1982).

For the US public, interest was prompted by media coverage of the issue, partly due to a scandal which broke in 1984 involving the alleged abuse of 125 children in a day-care centre in Manhattan Beach, California, over a ten year period.

Approaching the 1980s, the issue was beginning to receive attention in Europe. This was partly due to the influence of American professionals transmitting their preoccupations through the channels of international conferences and journals. In Britain, for instance, a book entitled *Child Abuse*, by two influential American paediatricians was published by Fontana and included a chapter on "Incest and Other Forms of Sexual Abuse" (Kempe and Kempe, 1978). The leading British *Journal of Child Psychology and Psychiatry* published an annotation on the topic of "Sexual Abuse of Children" by an American academic (Mrazek, 1980). The issue of sexual abuse surfaced in other European countries also, viz., Sweden in 1983 (Ronstrom, 1983, cited in Finkelhor, 1984); in Finland in 1984 (Peltoniemi and Korpilahti, 1986); in the Netherlands in 1985 (Wolters, Zwaan, Wagenaar-Schwencke and Deenen, 1985) and in Norway in 1986 (Lunde and Midre, 1988).

In Britain, CSA was a cause of growing concern among some professionals throughout the 1980s although it was not until the "Cleveland" episode in 1987 that the issue received widespread public attention. A major inquiry followed public and media controversy about the unprecedented rate of diagnosis and the style of management of alleged cases of child sexual abuse. Unlike many previous controversies surrounding the management of child abuse cases in Britain (see Parton, 1985), professionals were now being criticised for *excessive* rather than insufficient intervention. The recommendations of the inquiry team, led by a High Court Judge, Elizabeth Butler-Sloss, empha-

sised the importance of care for the child as a person, not just as an "object of concern" (Justice Butler-Sloss, 1988, p. 245). The inquiry team also emphasised the importance of: the same courtesy being shown towards parents in these as in all other types of cases; of attention to inter-professional and inter-agency co-operation and the structures for same; of training and of the need for legal reform. These recommendations prompted a major review of procedures nationally in the UK and gave an extra fillip to legal reform already in train which culminated in the passage of the Children Act 1989 for England and Wales.

The Irish Context

The first public expression of professional interest in CSA in Ireland can probably be traced to a multi-disciplinary seminar on *Incest* organised by the Irish Association of Social Workers (IASW) in January 1983. Earlier, reflecting presumably an emerging professional concern, the concept of CSA had figured in two separate sets of recommendations made about the legal and organisational framework surrounding child welfare. The first recommendation was made in 1981 by the two authors of the Supplementary Report attached to the Final Report of the Task Force on Child Care Services and involved citing sexual abuse as one of a small number of specific circumstances which, in their view, could justify compulsory intervention to protect the child (Task Force on Child Care Services, 1981, p. 344). The second recommendation was made by the Irish Association of Social Workers in 1982. This suggested that the Department of Health *Guidelines* for the management of non-accidental injury which were being revised at that time should include sexual abuse as a category of physical abuse (Irish Association of Social Workers, 1982).

The emerging awareness of the issue of child sexual abuse in Irish society in the 1980s was reflected in the activities of a variety of organisations and systems. The Department of Health, the central government department with a lead responsibility for policy and provision for deprived children, took a number of initiatives in relation to CSA during the decade. These were prompted partly by increases in confirmed and suspected cases of CSA in annual figures returned by the eight regional health boards to the Department. The Department's intervention was also probably due in part to the efforts of a number of mainly women's groups in the voluntary sector. These groups focused attention on CSA both at a policy level and at the level of public opinion. Towards the end of the 1980s, CSA had begun to impinge on the legal system. Cases were coming before the courts and raising questions about the possible need to change the law and legal procedures in relation to such cases.

Department of Health: During the 1980s the Department took a number of initiatives including the development of guidelines for professionals, the gathering of statistics, the development of new assessment services, the funding of research, and the inclusion of CSA in draft child care legislation.

In 1983, the Department of Health issued a revised edition of its *Guidelines*, re-titled *Guidelines on Procedures for the Identification, Investigation and Management of Non-accidental Injury to Children*. These guidelines included "injury resulting from sexual abuse" in the definition of non-accidental injury. The wording of this first such reference to sexual abuse in the *Guideline* series, which had begun in 1976, is signficant. It reflects a concern with *injury* arising from sexual abuse, rather than the psychological harm which only came to be more fully appreciated later. The Department of Health convened a Working Party on CSA in 1985 whose brief included advising on further revisions of the *Guidelines* so as to incorporate appropriate coverage of sexual abuse issues. The revised *Guidelines* were issued in 1987, this time with a separate section on sexual abuse, and a change in title: *Child Abuse Guidelines: Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse* (Department of Health, 1987).

In 1983, the Department of Health instituted the gathering of statistics from health boards on new cases of alleged non-accidental injury reported each year. The classification of findings included the sub-category of "confirmed cases involving sexual abuse". From 1985-86, the category of "alleged child sexual abuse" was added.

Table 1 summarises the statistics on child abuse for Ireland and for the EHB region collected by the Department of Health in the period 1984-1987, the latest year for which statistics are available. In the case of Ireland all child abuse referrals increased by 244 per cent over the period 1984-1987 while CSA referrals increased by 956 per cent over the same period. The pattern in the EHB area follows a similar trend with all child abuse referrals increasing by 208 per cent over the period 1984-1987 and CSA referrals increasing by a dramatic 1,458 per cent over the same period. In other words CSA became an increasing proportion of all child abuse referrals representing approximately 57 per cent of all referrals in both Ireland and the EHB region in 1987.

Not all referrals are subsequently confirmed as instances of child abuse. It is noteworthy in this context that the rate of increase in the number of confirmed child abuse cases was even faster than the number of child abuse referrals in the period 1984-1987, both in Ireland and in the EHB region. This suggests, other things being equal, that the upward trend in child abuse referrals reflected a growing reality of abuse of children. This conclusion suggests itself *a fortiori* in the case of CSA. In Ireland confirmed CSA cases increased by 1,282 per cent in the period 1984-1987 and in the EHB region the increase was

1,818 per cent over the same period. In other words, a growing proportion of all child abuse referrals, but especially CSA referrals, turned out to be confirmed cases thus indicating, other things being equal, a real upward trend in the abuse of children in the period. In 1987, CSA cases represented 60 per cent of all confirmed child abuse cases in both Ireland and in the EHB region.

Table 1: *Number of New Cases of Alleged and Confirmed Child Abuse in Ireland and the Eastern Health Board (EHB) Region 1984-1987*

Category	*Year*				*% increase*
	1984	*1985*	*1986*	*1987*	*1984-1987*
Ireland					
All child abuse referrals	479	767	1,015	1,646	243.6
CSA referrals	88	234	475	929	955.7
CSA as % of all referrals	*18.4*	*30.5*	*46.8*	*56.4*	
All confirmed child abuse	182	304	495	763	319.2
CSA confirmed	33	133	274	456	1,281.8
CSA confirmed as % of all confirmed	*18.1*	*43.8*	*55.4*	*59.8*	
EHB					
All child abuse referrals	257	353	504	793	208.6
CSA referrals	29*	81	201	452	1,458.6
CSA as % of all referrals	*11.3*	*22.9*	*39.9*	*57.0*	
All confirmed child abuse	100	137	273	350	250.0
CSA confirmed	11	42	134	211	1,818.2
CSA confirmed as % of all confirmed	*11.0*	*30.7*	*49.5*	*60.3*	

*Estimated

Source: Statistics on Child Abuse, 1984, 1985, 1986, 1987, Department of Health, Hawkins House, Dublin 2.

As indicated above, the first public expression of professional concern in Ireland with the problem of CSA only emerged in the early 1980s and this, in itself, may have led to a rise in the detection of CSA in the period 1984-1987. As professionals became more aware of some of the possible indicators of CSA they increasingly found evidence of those indicators in their work. The converse of this would also seem to apply, namely, that the existence of CSA on a significant scale in Ireland prior to 1984 cannot be discounted since it may have gone undetected because it fell outside the diagnostic frame of reference of Health Board professionals.

In January 1988, two Child Sexual Abuse Assessment Units were opened in Dublin to serve the Eastern Health Board region, one in The Children's Hospital, Temple Street, Dublin 1 and one in Our Lady's Hospital for Sick Children, Crumlin, Dublin 12. They were launched with Department of Health funding. Also in 1988, IR£500,000 was allocated to the seven other health boards "to enable them to improve their capacity for the assessment and investigation of alleged cases of child abuse including child sexual abuse" (Minister for Health, 1988).

In the field of research, the Department gave a grant in 1985 towards the preparation of a report by the Irish Council for Civil Liberties Working Party on child sexual abuse on laws, services and policies concerning CSA (Cooney and Torode, 1989). It also commissioned, in 1988, the research on which this article reports.

The Voluntary Sector: Activists in the women's movement and concerned professionals were among those developing responses to CSA in the voluntary sector in the 1980s. In some cases, such as the Incest Crisis Service, these ventures had a relatively low public profile. In others, for example the Sanctuary Trust or Childline, the initiatives had extensive media coverage. In addition, the Dublin Rape Crisis Centre which also had a high media profile drew public attention to the numbers of adults coming to the Centre who were reporting experiences of CSA in their childhood.

The Incest Crisis Service, a Dublin based voluntary counselling service, grew from the IASW conference in 1983 but, despite demand for its services, had to close in 1988 due to lack of funding and personnel. The Sanctuary Trust emerged briefly in 1986 with what proved to be short-lived plans to offer a crisis resource centre for children in the immediate aftermath of disclosure (Corcoran, 1990). Funds raised to assist Sanctuary Trust were finally used to commission a pilot study on the extent of sexual abuse experiences in the population (Market Research Bureau of Ireland, 1987). Despite certain professional opposition (see for instance O'Rourke, 1988, p. 15), the Irish Society for the Prevention of Cruelty to Children established Childline, a telephone crisis line, in Ireland in 1988, emulating the charity of the same name launched earlier in Britain by TV personality Esther Rantzen. Publicity for Childline made clear to the public and to potential child callers that child sexual abuse was to be one of its major concerns.

The Legal System: The Child (Care and Protection) Bill 1985, sponsored by the Minister for Health, included sexual abuse as a ground for the court-ordered protection of a child. This draft legislation lapsed with a change of government and was succeeded by the Child Care Bill 1988 which deals with CSA in broadly the same way. The Child Care Bill 1988 was passed by Dáil Éireann on 13th December 1990 and at the time of writing, March 1991, awaits its passage through Seanad Éireann.

There were other legal developments in the late 1980s. In March 1987, the Attorney General requested the Law Reform Commission to suggest reforms in the law on, *inter alia*, "sexual offences generally, including in particular the law relating to rape and the sexual abuse of children" (Law Reform Commission, 1990, p. 1). The Commission published its report, *Child Sexual Abuse*, in September 1990. It contains proposals for a variety of changes in the civil law, the criminal law, and in the law of evidence, including: a duty on professional workers in specific categories to report suspected cases of CSA (mandatory reporting); immunity from civil and criminal proceedings for any person reporting a suspicion of CSA who acts in good faith and with due care; specific obligations on health boards and their officers in relation to cases of suspected/confirmed CSA; new powers and procedures to be available to the District Court in cases of CSA; a new offence of "child sexual abuse" to replace the present offence of "indecent assault"; new measures to facilitate the hearing of children's evidence by the courts in cases of CSA.

The level of litigation involving CSA cases also appeared to be on the increase in the 1980s (Working Group on Child and Adolescent Psychiatric Services in the Eastern Health Board Area, 1989, p. 26). In 1989 the Supreme Court gave its judgment in a CSA case on appeal (The Supreme Court 343 and 369/88 "The State (D) v G, and Others"). The judgment led to a review of current practices in child protection proceedings and the passage of emergency legislation, the Children's Act 1989, to secure the continuing validity of pre-existing care orders (Fit Person Orders under Section 58, Children Act 1908) made by courts in favour of health boards.

III METHODOLOGY

The data presented in this article were collected through a census of all CSA cases known to the Community Care Teams of the EHB and open at any time in 1988. The cases were of children and young people aged 18 years or less who came to the attention of the Community Care Teams because they were alleged victims of CSA. In order to understand how this census was undertaken it is necessary to describe briefly the structure of the Health Boards particularly as they relate to the management of CSA cases.

The EHB is one of eight Health Boards in the Republic of Ireland which were established by the Health Act (1970) to provide health and social services on a regionalised basis. The EHB area covers the city and county of Dublin and counties Kildare and Wicklow. Each Health Board in the Republic of Ireland provides services in three broad areas: general hospital care, special hospital care and community care. Community Care, in turn, covers a wide range of services in the area of public health, dental care, general practice,

and personal social services. In the EHB region there are 10 Community Care Areas, each with its own Community Care Team headed by the Director of Community Care and Medical Officer of Health (DCC/MOH).

In relation to CSA, the management of these cases is the responsibility of the Community Care Teams and, specifically, of the DCC/MOH. The *Child Abuse Guidelines: Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse*, published by the Department of Health in July 1987 state:

> Responsibility for monitoring such cases [child abuse cases] rests with the Health Boards as part of the child care services provided within the community care programme. The Director of Community Care and Medical Officer of Health (DCC/MOH) or person delegated by him, or where the post is vacant, an officer designated by the Chief Executive Officer of the Health Boards, has overall responsibility for the monitoring and coordination of cases of child abuse occurring in his area (Department of Health, 1987, p. 8).

In practice, the main responsibility for the day-to-day management of CSA cases in each Community Care Area rests with the Area Social Work Team which usually works in collaboration with other professionals in the Community Care Team. However, the "key worker", as defined by the *Child Abuse Guidelines*, tends to be a Community Care Social Worker. For this reason the Social Work Teams are the main source of information on all CSA cases in the Community Care system. They thus played a crucial role in completing the census of CSA cases reported in this article.

The Social Work Teams in each of the 10 Community Care Areas in the EHB had a crucial input into the data collection process in two ways. First of all they were extensively involved in piloting the census form that was used to collect the data contained in the file of each case. This census form was designed to transfer the data on each CSA case from the Social Workers' files to the census form so that a computerised data base of all cases known to the Community Care Social Work teams and open at any time in 1988 could be created. The final census form was a 32 page booklet of pre-coded and open-ended questions on the following themes:

* general charactistics of child and family
* socio-economic characteristics of the child and family
* changes in child's normal place of residence since CSA came to the attention of Community Care
* disposition of parents/guardians to CSA case
* victims of CSA among parents/guardians
* disclosure of alleged abuse by child

* involvement of Community Care in each case
* characteristics of the alleged abuse
* characteristics of the alleged abuser(s)
* assessment of the case
* involvement of the General Practitioner in each case
* criminal proceedings in each case
* civil proceedings in each case
* interventions recommended for the child
* interventions recommended for the mother
* interventions recommended for the father, if not an alleged abuser
* interventions recommended for the family
* interventions recommended for the alleged abuser
* case work on each case by Community Care Social Workers
* inter-professional work on each case by Community Care Social Workers
* case conferences on each case
* office work on each case by Community Care Social Workers
* allocation of time on CSA cases by Community Care Social Workers.

The second input of the Social Work Teams into the data collection process involved the completion of the census form. The procedure adopted was that the census form for each case was completed by the Social Worker with responsibility for that case. The Senior Social Worker in each Community Care Area organised the completion of the census within their team and made final checks on the completed census forms to ensure that for every CSA case on their records there was a corresponding completed census form. It is a tribute to the level of co-operation given to the researchers by the Social Workers that completed census forms were returned on all known suspected and confirmed CSA cases for the relevant period.

The major involvement of the Social Work Teams in the construction and completion of the census form coupled with their detailed knowledge of the CSA cases and their families means that the accuracy and the overall standard of the information produced by the study is likely to be extremely high. Notwithstanding this, it is worth emphasising that the data are based on CSA cases which are known to Community Care Social Workers and, given the geographical concentration of their work in relatively deprived communities and the pressure to keep CSA cases hidden in all social strata, it cannot be taken as a reliable indicator of the actual prevalence of CSA throughout the EHB region.

The data in the census forms were checked and coded and prepared for computer analysis. Further checks were carried out at this stage to ensure that no errors had been introduced in the course of inputting the data.

IV THE FINDINGS

This article summarises some of the main findings of the study. A complete statistical digest of the findings of the study is contained in McKeown, Gilligan, Brannick, McGuane and Riordan (1989). The findings described in this article focus on the overall incidence and prevalence of confirmed CSA cases, the general characteristics of confirmed CSA cases, the disclosure of abuse in confirmed CSA cases, the characteristics of the abuse in confirmed CSA cases, the characteristics of the abusers in confirmed CSA cases, and civil proceedings in confirmed CSA cases.

The Incidence and Prevalence of Confirmed CSA Cases

The census produced extensive information on 990 alleged CSA cases which were known to the Community Care Teams of the Eastern Health Board and were open at some time in 1988. Each alleged CSA case was carefully assessed by the Community Care Teams. Typically this involved interviews with the victim, the parents/guardians, the referral agent and, in some cases, the alleged abuser. In 65 per cent of cases a specialised assessment of the case was undertaken by an agency other than the Community Care Teams and in 55 per cent of cases a physical examination was undertaken. The results of these assessment procedures were used by the Community Care Teams to classify each case into one of the following categories:

* confirmed abuse
* unconfirmed abuse/case still under review
* unconfirmed abuse/case closed
* confirmed non-abuse.

Table 2 summarises the breakdown of cases into these categories. This table reveals that just over half of the cases (52%) were assessed as confirmed abuse. By contrast only 5 per cent of all cases were assessed as confirmed non-abuse. In between these two ends of the spectrum lies 40 per cent of cases which remained unconfirmed. The majority of these were still under review at the time of the census and will ultimately be re-classified into one of the other categories. If it is assumed that these cases will be distributed proportionately between the other categories (and excluding those for which there is no information) the final outcome would produce 72 per cent of cases assessed as confirmed abuse, 22 per cent of cases assessed as unconfirmed abuse/case closed and 6 per cent assessed as confirmed non-abuse.

The results in Table 2 serve to underline one of the most difficult aspects of managing CSA cases, namely assessing the validity of allegations. It is clear that the majority of CSA cases are assessed as confirmed abuse although the adjusted figures reveal that over one-fifth of CSA cases remained unconfirmed.

Table 2: *Outcome of Assessment of each Case by Community Care, area EHB, 1988*

Outcome of Assessment of Child	*Area 1*		*Area 2*		*Area 3*		*Area 4*		*Area 5*		*Area 6*		*Area 7*		*Area 8*		*Area 9*		*Area 10*		*Total*	
	N	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*	%
Confirmed abuse[1]	37	54.4	45	52.3	25	71.4	53	50.0	47	47.5	60	69.8	69	52.7	51	41.8	48	45.7	77	50.7	512	51.7
Unconfirmed abuse/ case still under review[2]	9	13.2	16	18.6	3	8.6	35	33.0	22	22.2	10	11.6	43	32.8	28	23.0	34	32.4	41	27.0	241	24.3
Unconfirmed abuse/ case closed[3]	18	26.5	15	17.4	5	14.3	8	7.5	16	16.2	12	14.0	15	11.5	24	19.7	18	17.1	27	17.8	158	16.0
Confirmed non-abuse[4]	1	1.5	7	8.1	1	2.9	5	4.7	9	9.1	4	4.7	2	1.5	11	9.0	2	1.9	4	2.6	46	4.6
No information	3	4.4	3	3.5	1	2.9	5	4.7	5	5.1	0	0.0	2	1.5	8	6.6	3	2.9	3	2.0	33	3.3
Total cases	68	100	86	100	35	100	106	100	99	100	86	100	131	100	122	100	105	100	152	100	990	100
Total Number of children in each area[5]	40,224	9.2	29,801	6.8	24,619	5.6	58,630	13.4	41,129	9.4	48,521	11.1	35,560	8.1	77,307	17.6	47,217	10.8	35.998	8.2	439,006	100
Confirmed cases per 1,000 children		0.9		1.5		1.0		0.9		1.1		1.2		1.9		0.7		1.0		2.1		1.2

[1] A case is classified in this category if, after multidisciplinary assessment, it fulfills the criteria of CSA (child sexual abuse) set down by Schechter and Roberge (1976): "Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give informed consent, or that violate the social taboos of family roles".

[2] A case is classified in this category if the child's presentation does not fulfil the criteria of Schechter and Roberge and a thorough assessment has not yet been completed.

[3] A case is classified in this category if, following multidisciplinary assessment, the child's presentation does not fulfil the criteria of Schechter and Roberge and further assessment would not be in the best interests of the child.

[4] A case is classified in this category if, following the multidisciplinary assessment, there is a more plausible, acceptable and convincing explanation of the child's physical and psychological presentation than CSA.

[5] The source of this information is the Eastern Health Board Information Unit, Dr Steeven's Hospital, Steeven's Lane, Dublin 8. Based on an analysis of the 1986 Census of Population.

It is now recognised among health care professionals that assessing the validity of CSA allegations is a highly complex and specialised task and the dangers of incorrectly assessing an allegation have been amply demonstrated in the *Report of the Inquiry into Child Abuse in Cleveland* (Justice Butler-Sloss, 1988). The importance of the assessment procedure in the management of CSA cases was recognised by the Department of Health in 1987 with the decision to set up two specialised assessment units to deal with CSA cases in the EHB area: St Clare's CSA Assessment Unit, The Children's Hospital, Temple Street, Dublin 1 and St Louise's CSA Assessment Unit, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.

The results in Table 2 also provide a baseline against which to estimate the minimum extent of CSA in the EHB region and, possibly, in the country as a whole. It is generally accepted that the true extent of CSA in society is impossible to establish. As with other crimes, concealment by the perpetrator is an intrinsic part of the act. Table 2 shows that the known rate of confirmed CSA cases in the EHB region in 1988 was 1.2 per 1,000 children. This rate includes cases carried into 1988 from previous years as well as new cases in 1988. It is quite possible that many CSA cases do not come to the attention of the Community Care Teams so that the actual rate of confirmed CSA may be higher than this minimum.

There are no comparable data in the Republic of Ireland on the prevalence of confirmed CSA cases for any other period or Health Board region. The only evidence that is available was based on a pilot sample survey of 500 adults carried out in March 1987 by the Market Research Bureau of Ireland for the Sanctuary Trust and Radio Telefís Éireann (Market Research Bureau of Ireland, 1987). The results of this survey showed that 6 per cent of the sampled population admitted to having been sexually abused as a child. There is however, a number of difficulties with the methodology used in that study which, moreover, relates to past abuse and cannot be used to indicate current prevalence or the proportion of children who may be at risk at any time.

The remainder of this article focuses specifically on the 512 confirmed CSA cases since these are likely to provide a reasonably firm indication of some of the salient characteristics of CSA cases in general. However this does not imply that the other cases are unimportant and, from the perspective of the Community Care Team, an analysis of those cases which remained unconfirmed may indeed be of comparable interest. Every CSA case which comes to the attention of the Community Care Team typically represents a demand for services which must be provided, irrespective of how the case is finally assessed. Thus the focus on the confirmed cases for the purposes of this article should not be interpreted as an indication that the information collected on the other categories of cases is less valuable.

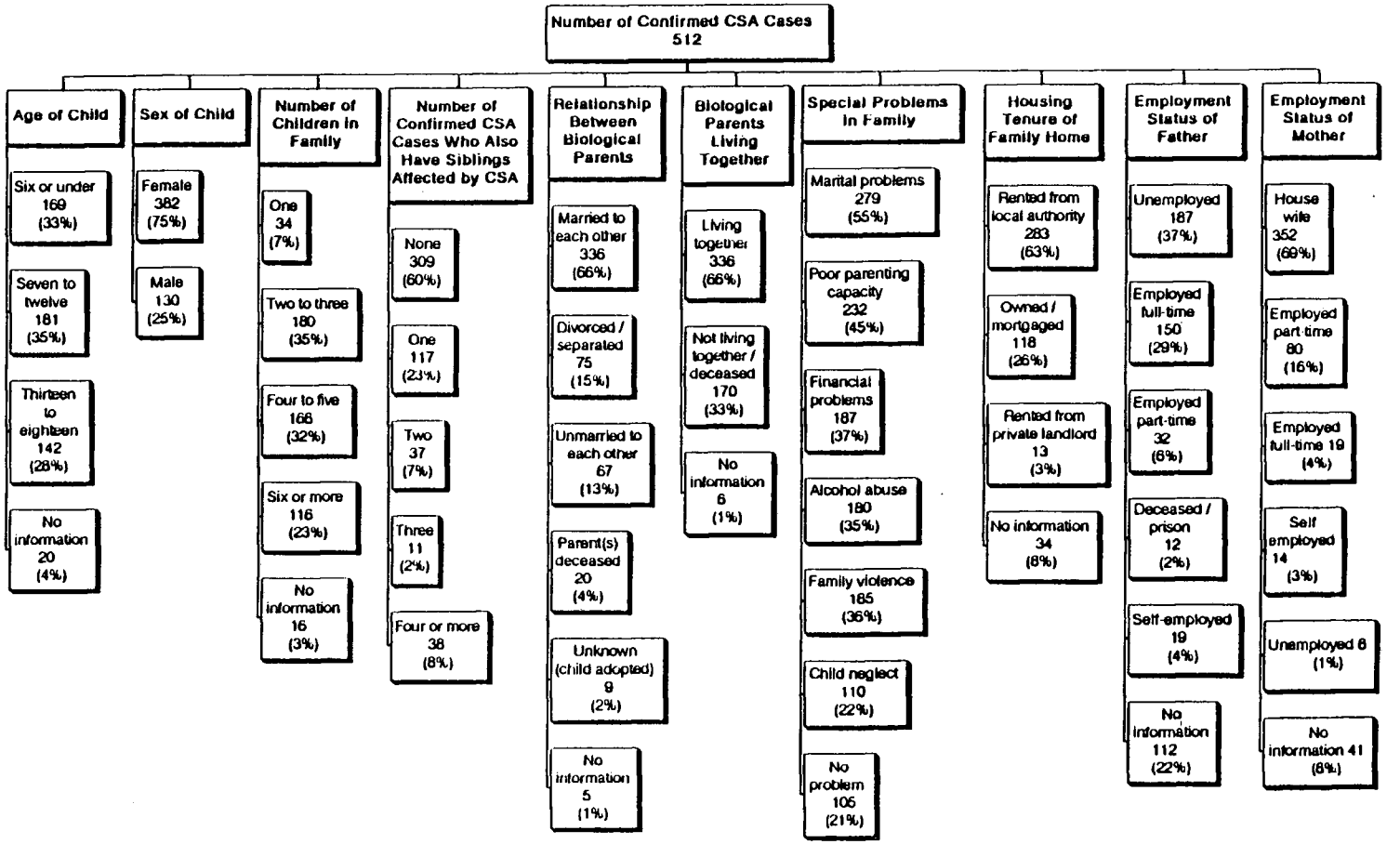
General Characteristics of Confirmed CSA Cases

The general characteristics of confirmed CSA cases are summarised in Figure 1. The results show that three-quarters of confirmed CSA cases are female and one-quarter are male. The age profile of confirmed CSA cases reveals that one-third are 6 or under and slightly more than one-third were aged between 7 and 12. Further analysis of sex by age reveals that the mean age for females is 9.2 years while for boys it is 7.9 years. More than two-thirds of confirmed CSA cases come from families of between 2 and 5 children with approximately one-quarter coming from families of 6 or more children. In a small proportion of cases, 7 per cent, there is only 1 child in the family. The extent of CSA within the same family was examined by collecting information on the number of siblings who were also suspected or confirmed CSA cases. The data reveals that 60 per cent of confirmed cases had no other siblings affected by CSA. However more than one-third of all confirmed cases had at least 1 sibling who was also a suspected or confirmed CSA case. The parents of two-thirds of all confirmed cases were married to each other. By contrast 28 per cent were divorced/separated or not married to each other. From the perspective of the child a more important indicator of family circumstances may be whether the biological parents are living together. The data on this variable reveal that approximately two-thirds of all biological parents of confirmed CSA cases were living together; one-third were not.

Further information on the nature of the families of confirmed CSA cases was collected by asking the Social Worker responsible for each case to indicate if, in her/his professional opinion, there was any evidence that "special problems" were being experienced by the child's family at the time CSA first came to the attention of the Community Care Social Work Team. The evidence presented in Figure 1 indicates that over three-quarters of all families showed evidence of special problems. More than half of the families were perceived to have marital problems, 45 per cent were described as having poor parenting capacity and more than one-third were regarded as having financial problems, problems with alcohol abuse and/or family violence. Child neglect was identified in 22 per cent of the families. Further evidence (not presented here) indicates that these problems were particularly concentrated in those families where the abuse was intrafamilial. However, 21 per cent of the families showed no evidence of any special problems according to the Social Workers.

Information on the class characteristics of confirmed CSA cases was collected in terms of the occupation, employment and housing tenure of the biological parents. The most useful of these indicators, and the ones on which Social Workers collected most information, was the housing tenure of the family home and the employment status of the father and mother.

Figure 1: *General Characteristics of Confirmed CSA Cases, EHB, 1988*



The results in relation to housing tenure reveal that two-thirds of the children live in rented, mainly local authority, accommodation. Slightly over a quarter live in a house which is owned or mortgaged. This contrasts with the pattern of housing tenure in Ireland where more than three-quarters live in a dwelling which is owned or mortgaged (Blackwell, 1988, p. 95).

The employment status of the fathers was relatively evenly divided between 37 per cent who were unemployed and 39 per cent who were either employed full-time, part-time or self-employed. Given that the unemployment rate in Ireland in 1988 was 17 per cent of the labour force, the unemployment rate among fathers was more than twice the national average (Labour Force Survey, 1988). However, it is noteworthy that no information was collected by Social Workers on the employment status of the father in 22 per cent of confirmed CSA cases.

The data on the employment status of mothers revealed that 69 per cent were classified as housewives while slightly more than one-fifth were either employed full-time, part-time or self-employed.

Overall the evidence pertaining to the general characteristics of confirmed CSA cases suggests that the victims are predominantly female with an average age of 9 years and come from families of between 2 and 5 children. Two-thirds of the children live in what appear to be conventional nuclear families where the parents are married and living together. By contrast, one-third of the children live in families where the parents are not living together. More than one-third of confirmed CSA cases have other siblings in the family allegedly affected by CSA. More than three-quarters of all the families showed evidence of special problems according to the Social Workers. Two-thirds of the children live in rented, mainly local authority, accommodation, while the father is equally likely to be employed as unemployed.

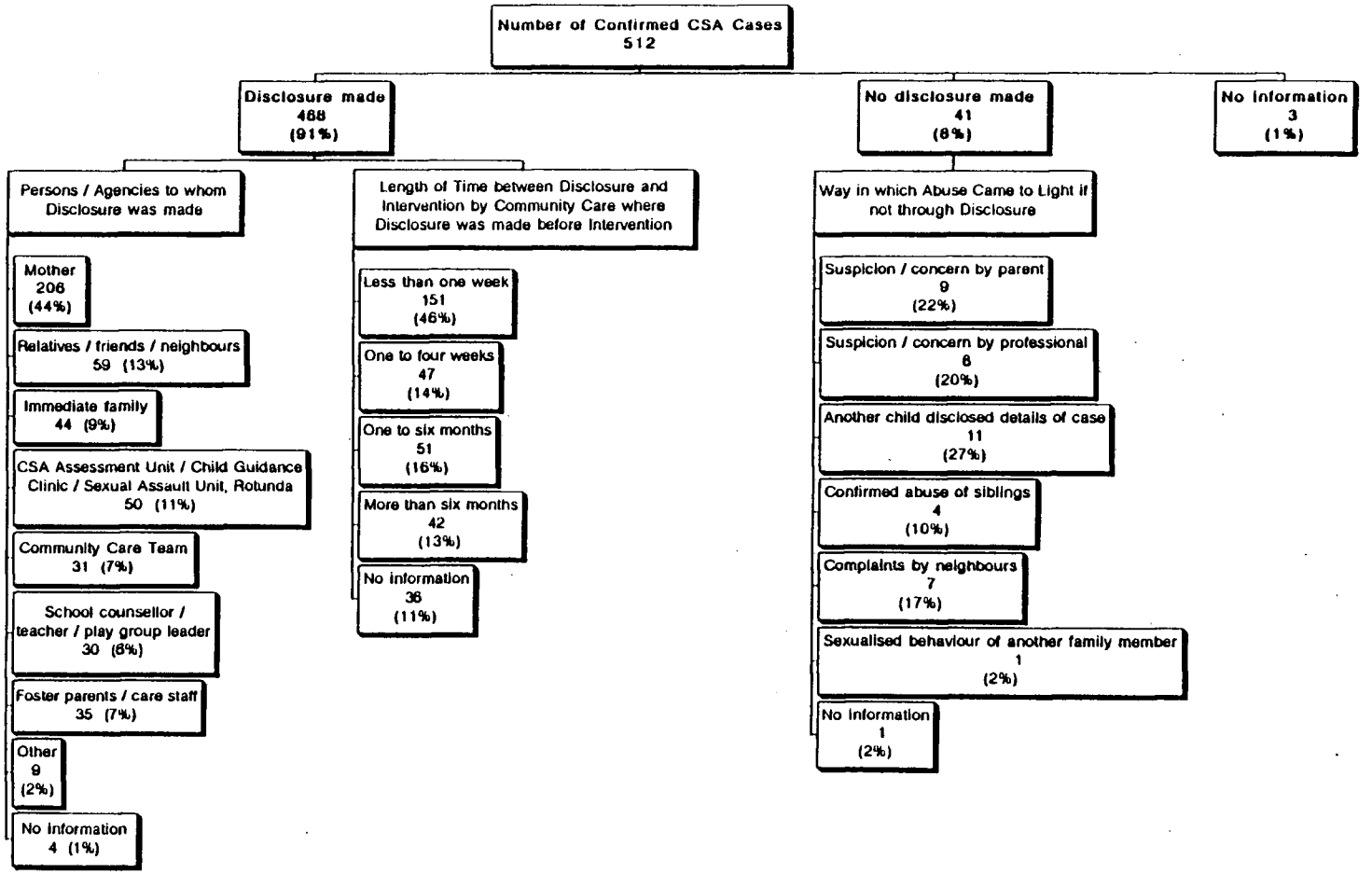
Disclosure of the Abuse in Confirmed CSA Cases

Child sexual abuse is typically carried out in secret and often the secret can be concealed by the abuser and the victim for months or even years. In some cases the secret may never be disclosed. In view of this it is important to examine how confirmed CSA cases come to light in the first place. The data on this issue are contained in Figure 2.

The results show that 91 per cent of confirmed CSA cases came to the attention of the Community Care Team through disclosure by the child. Only 8 per cent of confirmed CSA cases came to light without a disclosure by the child.

The person to whom the child disclosed is usually the mother or other family member. In two-thirds of confirmed CSA cases the child made the disclosure to someone in or close to her/his family. By contrast, disclosures by

Figure 2: *Disclosure of the Abuse by Child in Confirmed CSA Cases, EHB, 1988*



the child to one of the statutory agencies involved in the assessment, treatment or overall management of CSA cases occurred in only 18 per cent of cases. This is not unexpected given that the statutory agencies are often not in a position to intervene unless the child has already made a disclosure since this is often the only indication that CSA may have occurred. In a further 13 per cent of cases disclosures were made to school counsellors, teachers, play group leaders, foster parents and care staff.

The *Child Abuse Guidelines* of the Department of Health describe the initial steps that should be taken following the disclosure of CSA:

> Any person who knows or suspects that a child is being harmed, or is at risk of harm, has a duty to convey his concern to the local health board. Allegations made by close relatives, friends or neighbours or by children or parents referring themselves for help should be regarded as serious and investigated urgently. All reports of child abuse (including anonymous calls) should be investigated (Department of Health, 1987, p. 9).

The evidence in Figure 2 reveals that, in 46 per cent of confirmed CSA cases, intervention by Community Care occurred less than one week following disclosure by the child. This is probably due to the fact that the Community Care Team was immediately informed of the child's disclosure. In the other cases the length of time between disclosure and intervention was considerably longer and may reflect the fact that Community Care were not informed of the disclosure. In 16 per cent of confirmed CSA cases the period between disclosure and intervention varied from 1 to 6 months while in 13 per cent of confirmed CSA cases the period was more than 6 months. This strongly suggests that, in a significant minority of cases, disclosures by children of CSA may not be routinely communicated to the Community Care Teams.

Given the centrality of disclosure in the identification of CSA, the question arises as to how cases can be identified without disclosure. The evidence presented above in Figure 1 indicates that one-third of confirmed CSA cases were 6 years of age or less and it is most unlikely that all of these children would be capable of making a disclosure. At the same time, as Table 3 indicates, there is no statistically significant relationship between the age of the child and his/her disclosure of the abuse. Figure 2 reveals that 42 per cent of those cases which came to the attention of Community Care without a disclosure by the child did so through suspicion/concern by either a parent or a professional. In a quarter of non-disclosure cases the information emerged through the disclosure of another child while, in a further 17 per cent of cases, intervention was precipitated by complaints from neighbours.

The evidence in this section reveals that most confirmed CSA cases are identified through the disclosure of the child. In turn the persons in and around

Table 3: *Disclosure/Non Disclosure of Abuse by Age of Child in Each Confirmed Case, EHB, 1988*

Disclosure/Non Disclosure	*Age of Child*								
	Six or Under		*Seven to Twelve*		*Thirteen to Eighteen*		*No Information*		*Total*
	N	%	*N*	%	*N*	%	*N*	%	*N*
Disclosure made	149	88.2	170	93.9	130	91.5	19	95.0	468
No disclosure made	20	11.8	8	4.4	12	8.5	1	5.0	41
No information	0	0.0	3	1.7	0	0.0	0	0.0	3
Total	160	100	181	100	142	100	20	100	512

The relationship between disclosure and age is not statistically significant using the Chi-Square test. (Chi = 12.1; df,6; p 0.05)

the child's family are the ones most likely to first hear the disclosure. In almost half of the cases involving disclosure by the child intervention by the Community Care Team followed within the week. However, in a significant minority of cases there is a considerable delay between the child's disclosure and intervention by Community Care, possibly because the child's disclosure was not reported to them.

Characteristics of the Abuse in Confirmed CSA Cases

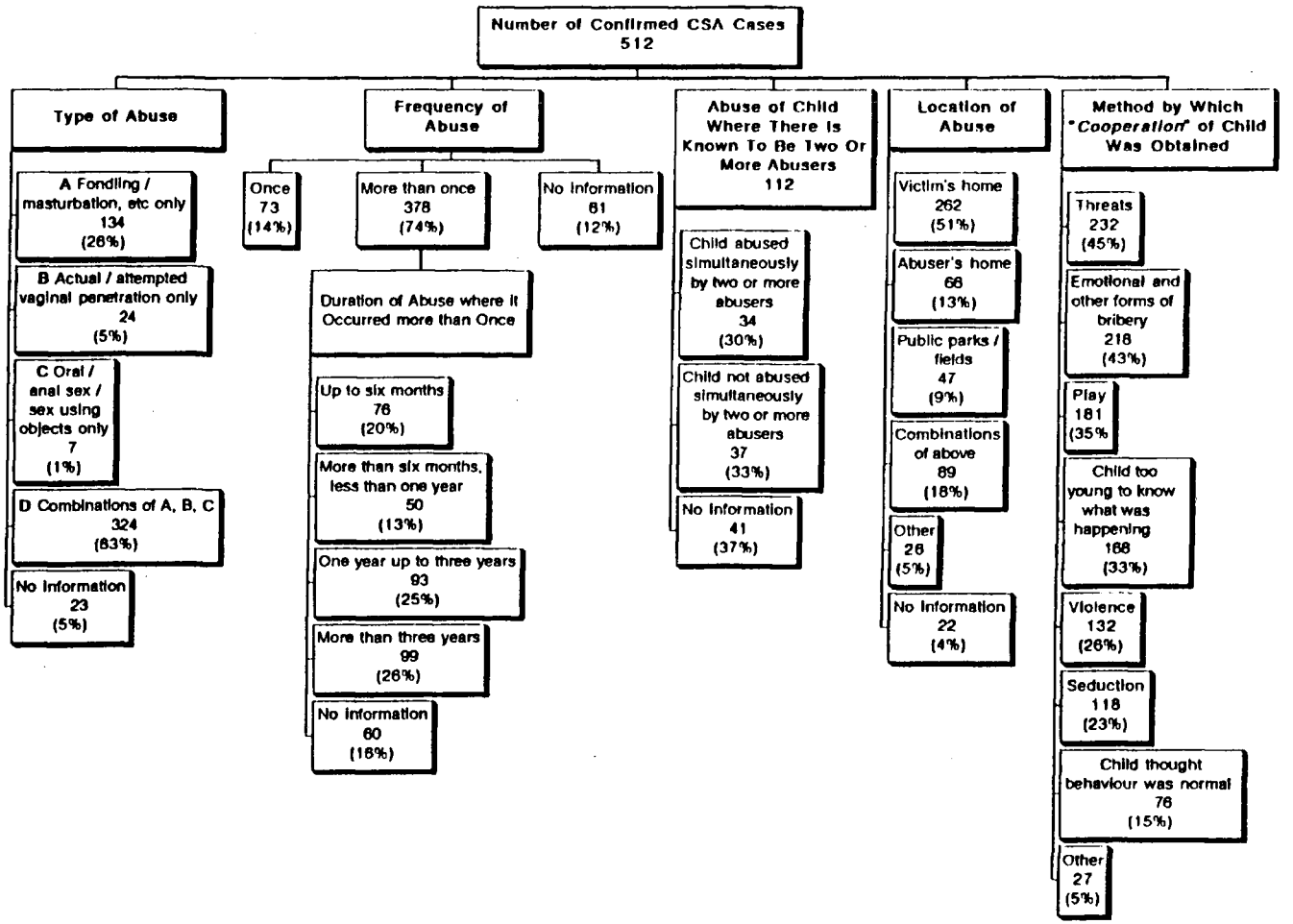
Child sexual abuse can have very traumatic effects on children. Moreover, the nature and extent of the trauma can vary independently of the characteristics of the abuse. Thus the characteristics of the abuse described in this section provide only an indication of the possible trauma caused to children by CSA. The full extent of the trauma would require more detailed clinical information on each case.

The characteristics of the abuse in confirmed CSA cases are summarised in Figure 3. For the purpose of this study four main types of abuse were identified. These are:

* Type A: Fondling/masturbation, etc. only
* Type B: Actual/attempted vaginal penetration only
* Type C: Oral/anal sex/sex using objects only
* Type D: Combinations of A, B, C.

The results show that the majority of confirmed CSA cases suffered from combinations of abuse rather than from one single type of abuse. The largest category of cases, 63 per cent, were of victims of a combination of Types A,

Figure 3: *Characteristics of the Abuse in Confirmed CSA Cases, EHB, 1988*



B and C. However, over a quarter were victims of Type A alone. It is noteworthy in this context, as Table 4 confirms, that the age of the child has no bearing on the type of abuse experienced.

Table 4: *Type of Abuse by Age of Child in Each Confirmed Case, EHB, 1988*

Type of Abuse	*Age of Child*								
	Six or Under		*Seven to Twelve*		*Thirteen to Eighteen*		*No Information*		*Total*
	N	%	*N*	%	*N*	%	*N*	%	*N*
Fondling/Masturbation, etc. (Type A)	36	21.3	56	30.9	35	24.6	7	35.0	134
Combinations of abuse (Type B+C+D)	124	73.4	116	64.1	102	71.8	13	65.0	355
No information	9	5.3	9	5.0	5	3.5	0	0.0	23
Total	169	100	181	100	142	100	20	100	512

The relationship between disclosure and age is not statistically significant using the Chi-Square test. (Chi = 6.7; df,6; p 0.05)

In relation to the frequency of the abuse, nearly three-quarters of confirmed CSA cases were abused more than once. In a quarter of these cases the abuse occurred for more than 3 years while in a further quarter the abuse lasted between 1 and 3 years. In one-fifth of the cases the abuse lasted up to 6 months.

Information was collected on whether the child was simultaneously abused by 2 or more abusers since this could be an important indicator of the gravity of the abuse. However, in 37 per cent of cases Social Workers did not collect information on this variable. Nevertheless, 30 per cent of the confirmed CSA cases were reported to have been simultaneously abused by 2 or more abusers.

Children were sexually abused in their own home in more than half of all cases, while a further 13 per cent were abused in the home of the abuser, where this was separate from the victim's home. Only 9 per cent of children were abused in public parks/fields. Nearly one-fifth were abused at a combination of these locations.

A variety of methods was used by the abuser to obtain the compliance of the child in the abuse. The most usual methods were threats, emotional and other forms of bribery, play and "the child was too young to know what was happening". Violence was used in over a quarter of all confirmed CSA cases to obtain the compliance of the victim.

The profile of the abuse which emerges from these data indicates that, in the main, children suffer from combinations of sexual abuse with a significant minority involving fondling/masturbation, etc., only. Most victims are abused more than once and many of them are abused for 1 year or more. Nearly one-third were abused simultaneously by 2 or more abusers while half of all children were abused in their own home by an abuser who also lived in the home. Often the abuse was accompanied by threats and bribery with a quarter of all confirmed CSA cases involving violence.

Characteristics of the Abuser(s) in Confirmed CSA Cases

The characteristics of abusers in confirmed CSA cases is summarised in Figure 4. The number of abusers in 76 per cent of confirmed CSA cases was one. However, in 22 per cent of cases there were 2 or more abusers involved.

In terms of age, the data reveals that child abusers are not confined to any particular age category. Looking at those cases which involved only 1 abuser the largest concentration (41%) is in the age category between 21 and 45 years. However, a notable feature of the results is the young age of many abusers: 37 per cent were 20 years or less. More than one-fifth of all confirmed abusers were aged 15 or under and were thus themselves children. Sixteen per cent of abusers were aged between 16 and 20 and a further 17 per cent were aged between 36 and 45.

The sex of the abusers in 90 per cent of confirmed cases is male. The abuser in 20 per cent of cases was female although females were also involved with males in 7 per cent of cases.

The relationship of the abuser to the child was examined to establish whether it was intrafamilial or extrafamilial. *Intrafamilial* abusers, for the purpose of this study, include: fathers, brothers, uncles, mother's cohabitee, mother, grandfather, cousins and other relatives. *Extrafamilial* abusers include: neighbours, family friends, strangers and others. The results of the study show that over 60 per cent of all confirmed CSA cases involve intrafamilial abuse. Extrafamilial abuse occurred in 31 per cent of cases while 8 per cent of cases involved both intrafamilial and extrafamilial abuse.

Further information on abusers is presented in Table 5. This shows that fathers constitute the single largest category of abusers at 28.6 per cent of the total. Neighbours are the next largest category at 15.6 per cent, followed by brothers and uncles at 11.8 per cent and 10.9 per cent, respectively. By contrast strangers constitute a relatively small percentage of abusers at 2.8 per cent of the total.

CSA is typically committed by persons who are known to the child and often in a position of trust. The evidence in relation to "baby-sitters" adds some credence to this. *Baby-sitters*, for the purpose of this study, refers to

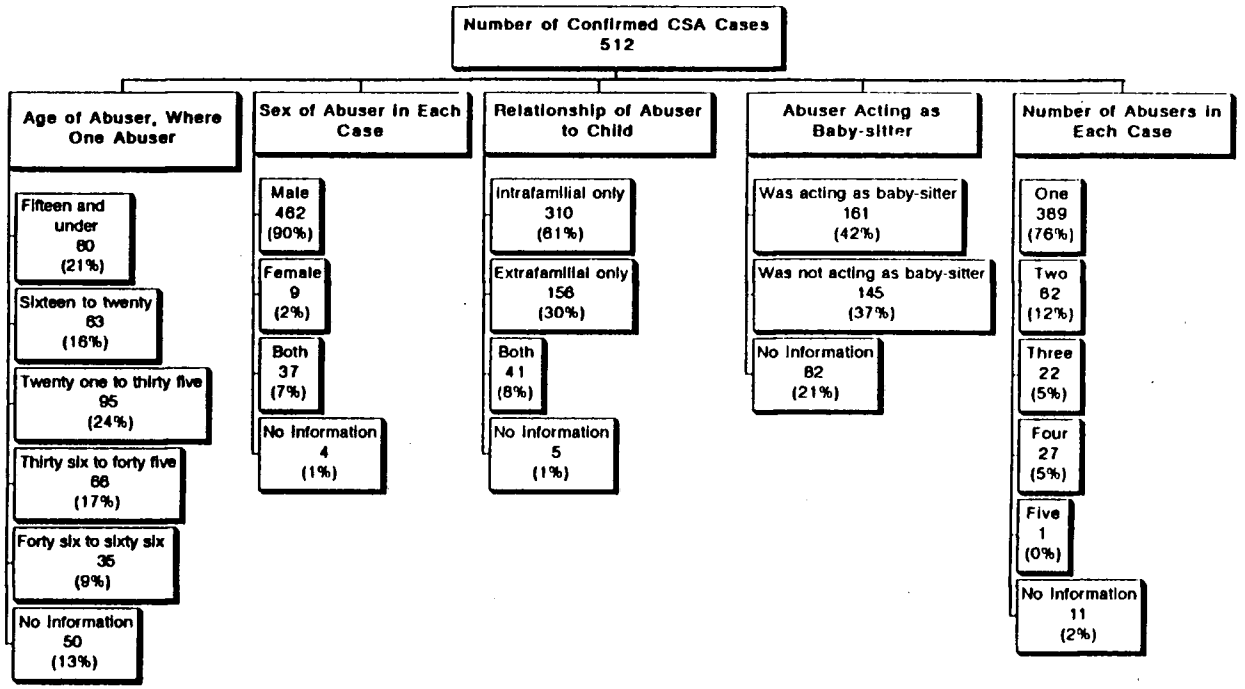

Number of Confirmed CSA Cases
512
Age of Abuser, Where One Abuser
Fifteen and under
80
(21%)
Sixteen to twenty
63
(16%)
Twenty one to thirty five
95
(24%)
Thirty six to forty five
66
(17%)
Forty six to sixty six
35
(9%)
No Information
50
(13%)
Sex of Abuser in Each Case
Male
462
(90%)
Female
9
(2%)
Both
37
(7%)
No Information
4
(1%)
Relationship of Abuser to Child
Intrafamilial only
310
(61%)
Extrafamilial only
156
(30%)
Both
41
(8%)
No Information
5
(1%)
Abuser Acting as Baby-sitter
Was acting as baby-sitter
161
(42%)
Was not acting as baby-sitter
145
(37%)
No Information
82
(21%)
Number of Abusers in Each Case
One
389
(76%)
Two
62
(12%)
Three
22
(5%)
Four
27
(5%)
Five
1
(0%)
No Information
11
(2%)

Table 5: *Number of Intrafamilial and Extrafamilial Abusers, EHB, 1988*

Category of Abuser	*Total*	
	N	%
Intrafamilial	431	67.8
Father	182	28.6
Brother	75	11.8
Uncle	69	10.9
Mother's cohabitee	35	5.5
Mother	17	2.7
Grandfather	16	2.5
Cousin	11	1.7
Sister	7	1.1
Step-father	7	1.1
Other[1]	12	1.9
Extrafamilial	205	32.2
Neighbour	99	15.6
Family friend	60	9.4
Stranger	18	2.8
Other[2]	28	4.4
Total[3]	636	100

[1] Other refers to grand-uncle, brother-in-law, adoptive brother, aunt, father's cohabitee, step mother, etc.

[2] Other refers to child's employer, foster brother, foster cousin, father's homosexual clients, etc.

[3] The totals refer to the total number of confirmed abusers, not the total number of cases.

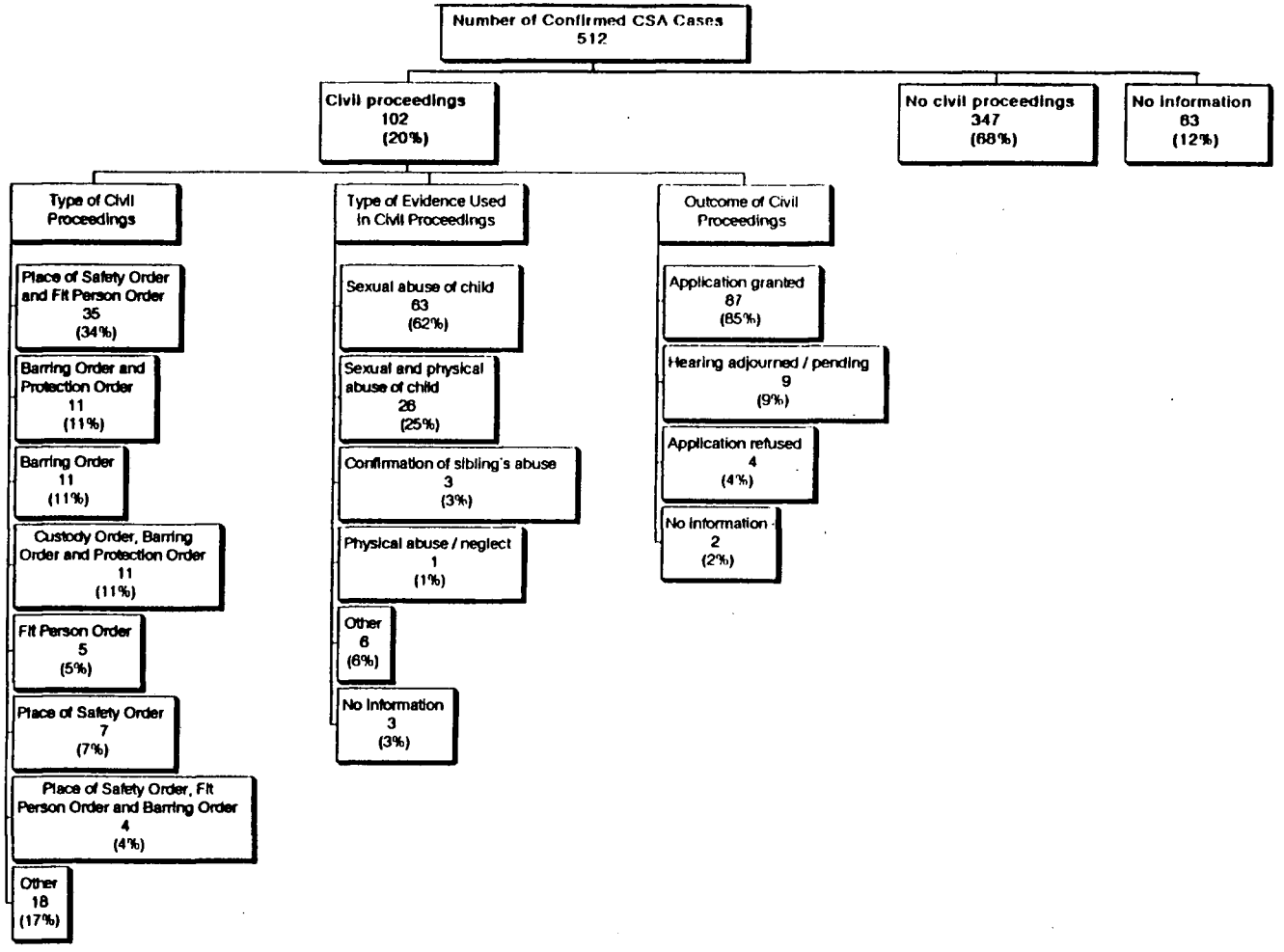
any person other than the child's parents or guardians, who looks after the child occasionally. The results show that 42 per cent of confirmed CSA cases are known to have been abused by a person who was acting as a baby-sitter at the time CSA is thought to have occurred.

The picture to emerge from these statistics is that child abusers are predominantly male, often come from the child's own family and may have acted as a baby-sitter to the child at the time CSA is thought to have occurred. Child abusers are not concentrated in any particular age category.

Civil Proceedings in Confirmed CSA Cases

Civil proceedings refer, in this context, to Court actions initiated by the Community Care Teams to protect children at risk. These actions typically involve applications to the Courts for one or more of the following Court Orders: Place of Safety Order, Fit Person Order, Barring Order, Protection Order, Custody Order. The extent to which these legal instruments were used is summarised in Figure 5.

Figure 5: *Civil Proceedings in Confirmed CSA Cases, EHB, 1988*



A noteworthy feature of the results is that only 20 per cent of confirmed CSA cases are known to involve civil proceedings. This would seem to reflect a reluctance by Community Care to take civil proceedings except as a last resort and, in practice, the possibility of civil proceedings may be sufficient to ensure the protection of the child on a voluntary basis.

The measures taken to ensure the protection of children in confirmed CSA cases is crucially dependent on whether the child and the abuser are known to live in the same home, the situation which obtained in 51 per cent of cases. Table 6 presents information on the changes in the home circumstances of children and abusers in confirmed CSA cases.

The data reveal that the number of children and abusers who left or were removed from the home was considerably in excess of the number of civil proceedings. This suggests that voluntary arrangements may have been used quite widely to secure the protection of the child. The evidence in Table 6 also suggests that the protection of the child may not always involve the removal of either the victim or the abuser from the family home where both live in the same home although no information was collected on the arrangements for child protection in these cases.

Table 6: *Changes in Occupancy of the Family Home by Child and Abuser in Confirmed CSA Cases, EHB, 1988*

Changes in Occupancy of Family Home	*N*	*%*
Child left/removed	55	21.0
Abuser left/removed	85	32.6
Both left / removed	40	15.3
Neither left/removed	62	23.8
No information	19	7.3
Total[1]	261	100

[1] The totals refer to those confirmed CSA cases where the abuser is known to have lived in the same family home as the child.

The type of civil proceedings involved in over three-quarters of the relevant cases consisted of a combination of the Orders listed above. The most frequent combination of Orders, involving 34 per cent of the relevant cases, consisted of a Place of Safety Order and a Fit Person Order. Barring Orders, Protection Orders and Custody Orders were also applied for in over one-fifth of cases.

The evidence presented by Community Care in support of its application for Court Orders was based, in nearly two-thirds of the relevant cases, on the

sexual abuse of the child. Evidence was based on both sexual and physical abuse in over a quarter of the cases.

Eighty-five per cent of all the applications were granted by the Court.

The picture which emerges in relation to civil proceedings is that Community Care makes application for Court Orders in only a minority of confirmed CSA cases and these tend to be granted by the Courts. However, voluntary arrangements for protecting the child appear to be the preferred practice.

V FINDINGS COMPARED TO SELECTED US, BRITISH AND IRISH STUDIES

The significance of the results reported in the previous section is made more salient by comparison with the results of studies carried out in other countries. However, despite the growing number of studies on CSA, the level of comparability between them is relatively limited because of the way in which the variables are defined and measured. In view of this, a selection of results from those US, British and Irish studies which are most strictly comparable to those reported here are discussed. The variables discussed in this section are: sex of victim, age of victim, relationship of the victim to the abuser, disclosure of the abuse, and characteristics of the abuser.

Sex of the Victim

All studies, whether of referrals, alleged cases or confirmed victims report that girls are much more likely to experience CSA. It is clear however that boys are also subjected to CSA, although the proportion reported varies in different studies. This study found that three-quarters of all confirmed CSA cases were female and one-quarter were male.

In a review of 1,152 suspected abuse cases referred to a CSA evaluation centre in Sacramento in the period 1983-85, 16.4 per cent were male (Reinhart, 1987). De Jong, Hervada and Emmett (1983) reported that 18.2 per cent of alleged victims under 16 were male in their review of 566 children under 16 seen over a 3 year period in a sexual assault crisis centre in Philadelphia. A lower rate of male victims (11.2%) was reported by Cupoli and Monaghan Sewell (1988) in their review of 1,059 patients aged 3 months to 16 years referred for medical evaluation of alleged CSA over a 44 month period from January 1982 to May 1985 in Tampa, Florida.

On this side of the Atlantic, Creighton reported that boys made up 15 per cent of children recorded as sexually abused on local child abuse registers in England and Wales in the period 1977-84 inclusive. Her findings are based on the 10 per cent of registers maintained on behalf of local authorities by the NSPCC agency (Creighton, 1987, p. 28). Of 337 probable/confirmed cases seen by two Leeds paediatricians in the calendar years 1985 and 1986, 27.9

per cent involved boys (Hobbs and Wynne, 1989, pp. 195-210). At Great Ormond Street Children's Hospital in London, 411 abused children from 274 families were seen by the Sexual Abuse Team between 1980 and mid-1986 and in 22 per cent of these cases the abused child was male (Bentovim, *et al.*, 1988, p. 20).

The findings in this article that 25 per cent of confirmed CSA cases are male victims corresponds fairly closely to the Leeds and London findings but represent a higher proportion of boys than that reported in the NSPCC registers research in England and Wales, or the US studies referred to above. In terms of other Irish evidence, McKeown, Brannick, McGuane and Riordan (1989) also report a rate of 25 per cent for boys among all cases seen at two Child Sexual Abuse Assessment Units in the period December 1987 to October 1988. Similarly, Hynes and Jennings (1989, pp. 115-117) found that boys made up 22 per cent of confirmed/strongly suspected sexual abuse cases seen in a Dublin Community Care Area in 1986 and 1987. In a study of 408 confirmed CSA cases in Northern Ireland, boys made up 19.1 per cent of cases (Kennedy, *et al.*, 1990).

Age of Victim

In this study, the mean age of victims was 9.2 years for girls and 7.9 years for boys. In other studies this tendency for male victims to be younger is also found: in the Tampa study, the mean ages were 8.4 for girls and 7.4 for boys (Cupoli and Monaghan Sewell, 1988); and in the Philadelphia study 10.4 for girls and 8.6 for boys (De Jong, Hervada and Emmett, 1983). The tendency for a relatively low mean age is also reported in the Leeds study: 8.8 years for 1985 victims and 7.4 for 1986 victims (Hobbs and Wynne, 1989). In terms of age distribution, the Tampa study reported 42 per cent of children under 7 years (Cupoli and Monaghan Sewell, 1988); the Leeds study reported 34 per cent under 6 (Hobbs and Wynne, 1989); and the Dublin Community Care area study reported 32 per cent under 6 (Hynes and Jennings, 1989). In this study, 33 per cent of children were 6 years or under.

Disclosure and Discovery

This study found that 91 per cent of confirmed CSA cases came to the attention of the Community Care Teams through disclosure by the child. By comparison with the Leeds study where 39 per cent of the confirmed/probable cases came to light through disclosure by the child (Hobbs and Wynne, 1989), this is a remarkably high figure. It is also significantly higher than that reported in the Sacramento study where 60 per cent of male cases and 61 per cent of female cases came to attention through spontaneous and prompted disclosure (Reinhart, 1987).

Intrafamilial/Extrafamilial Abuse

This study found that 61 per cent of all confirmed CSA cases involved intrafamilial abuse. Extrafamilial abuse occurred in 31 per cent of confirmed cases while 8 per cent of cases involved both intrafamilial and extrafamilial abuse. This result is broadly in line with the Leeds study where 63.5 per cent of the probable/confirmed cases were intrafamilial (Hobbs and Wynne, 1989). In the Great Ormond Street study 75 per cent of perpetrators were household members (Bentovim, *et al.*, 1988). In the Dublin Community Care Area study 44 per cent of children were abused by a family member (Hynes and Jennings, 1989) while in the Northern Ireland study 31.4 per cent of children in confirmed cases were abused by a relative (Kennedy, *et al.*, 1990). In the US, the proportions of cases involving intrafamilial abuse seem lower, viz., in the Philadelphia study 23.7 per cent of children were abused by relatives (De Jong, Hervada and Emmett, 1983); in the Tampa study in Florida, incest occurred in 32.8 per cent of cases (Cupoli and Monaghan Sewell, 1988); in the Sacramento study 38 per cent of male victims and 43 per cent of female victims were related to the perpetrator (Reinhart, 1987). The proportion of intrafamilial abuse in this study is more in line with British results and higher than US studies cited here.

Characteristics of the Abuser

This study found that the abuser in 90 per cent of confirmed CSA cases was male. The abuser in 2 per cent of cases was female although females were also involved with males in 7 per cent of cases. This is not dissimilar to other studies which show that only a tiny proportion of abusers are female, whether they are acting alone or with a male. Some studies report substantial minorities of relatively young abusers. Almost half of the children were abused by persons under 20 years in the Philadelphia study (De Jong, Hervada and Emmett, 1983). In the Dublin Community Care Area study almost 1 in 4 perpetrators (23%) were under 16 years of age (Hynes and Jennings, 1989) compared to 19.9 per cent in the Northern Ireland study (Kennedy, *et al.*, 1990). In this study, 20 per cent of abusers were under 16. A clear message from the Irish evidence is that total strangers account for a very small proportion of child sexual abuse: 6 per cent in the Dublin Community Care Area study (Hynes and Jennings, 1989), 4.7 per cent in the Northern Ireland study (Kennedy, *et al.*, 1990) and less than 3 per cent in this study. In Irish cases of CSA it seems most perpetrators are known to their victims.

VI ISSUES

Researching a field such as child sexual abuse can scarcely leave researchers untouched not only by the great trauma endured by its hapless victims but

also by the energy and dedication of professionals seeking to respond to the needs of children and their families. But the issue is intellectually as well as emotionally challenging. As in the best research traditions, the findings of this study raise or re-echo many more questions than they answer.

What are the short and long-term effects of CSA? Our study did not answer this question but clearly it is of great importance. Professional understanding is evolving. One research study found mood disturbances, self-damaging behaviour, interpersonal problems, stress disorders and sexual difficulties among 51 participants in a therapy programme for adult women who had been CSA victims in their childhood (Jehu, 1988).

The impact of CSA on the individual seems to be mediated by a variety of factors. Browne and Finkelhor in Finkelhor, *et al.* (1986) summarised what appears to be some converging evidence from research on those factors associated with more severe effects of abuse, viz., longer lasting abuse; separate episodes of abuse with different perpetrators; abuse by a father or step-father; abuse involving the use of force; abuse by males and adults, (rather than females or teenagers); an unsupportive reaction by the child's family and/or the victim being removed from home (*ibid.*, p. 175). Research evidence is equivocal on the effect of other factors such as the child's age at the onset of abuse, or the nature of the abuse activities (*ibid.*; Haugaard and Reppucci, 1988, pp. 76-80). Overall there seems to be much further work for researchers based not only on censual-type data reported here but also on longitudinal studies where the longer-term impacts of CSA could be examined.

It seems clear that children may be traumatised not only by the abuse experience itself but also by the type of response they receive from family or professional networks after disclosure. At the level of social care, a child will need not only prompt and authoritative investigation of their circumstances but also arrangements which guarantee the non-recurrence of the abuse. Children should also have ready access, as needed, to ongoing counselling and therapy for themselves, for their mothers and siblings where necessary, and for their fathers where relevant. While structures for the speedy investigation of reported cases seem to be in place throughout the country, the availability of long-term help to victims is less developed in some parts of the country.

Some child victims of CSA may suffer in three ways, viz., the original experience of abuse, removal from home, and absence of sufficient ongoing professional therapy where it is required. Providing adequate care to children depends not only on more resources but on resolving problems such as the common delay between disclosure to a significant adult and reporting to professional services, and on finding the most effective techniques for helping each particular child.

The criminal and civil law have an important part to play in the management

of CSA cases. CSA poses special challenges for the criminal justice system: the issues raised by the evidence of child victims, the formulation of an appropriate sentencing policy which manages to graft on some element of treatment onto the necessary core of curtailing the freedom of abusers; and the relatively low ratio of cases which finally end in conviction. In the civil law there is a need to evolve measures which secure the child's protection against further abuse while balancing the rights of the other parties involved. The final report from the Law Reform Commission on *Child Sexual Abuse* should serve as a guide and stimulus to action, not only in relation to the criminal and civil law, but also in terms of streamlining the capacity of the different elements of the criminal justice system to deal with CSA (Law Reform Commission, 1990). When enacted and operative, the Child Care Bill 1988, which was passed by Dáil Éireann on 13th December 1990 and at the time of writing awaits its passage through Seanad Éireann, will also extend the range of possibilities for assisting actual or suspected CSA victims under the civil law.

Child sexual abuse is a criminal offence and should properly remain so. However, the risk of recidivism renders urgent the support of treatment programmes inside and outside the criminal justice system. The group work with abusers initiated by the EHB at the Central Mental Hospital in Dublin is greatly to be commended as are the programmes for offenders developed by the North Western Health Board and by the Probation and Welfare Service of the Department of Justice in Arbour Hill Prison. The support given by the Department of Health for the development of a *Child Abuse Prevention Programme* for use in primary schools is also to be welcomed.

VII CONCLUSION

The study reported here is the most comprehensive yet undertaken on the problem of CSA in the Republic of Ireland. The results provide a picture of some of the salient features of CSA and draw attention to some of the key issues involved in the management of these cases. Further analysis of other variables in the data-base have yet to be undertaken and this could throw valuable light on the response of the different health and personal social service agencies to CSA. Such research is essential if effective policies and practices are to be developed to protect children from CSA and to treat those already affected by it.

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