The Health Impacts on Adult Women of Childhood Sexual Violence Before the Age of Twelve Years

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Sharing their experience in the research context was, for them, a way of making their voices heard. This was important at a personal level but also carried with it the expectation that others would be helped in ways they were not; that others may not
need to experience what it is like not to be heard and to have no voice, (Darlington, 1997:vii).

The project was initiated by the Ipswich Sexual Assault Service.

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**Notes on Reading this Report**

Italicised script indicates direct quotations. Bordered italicised script indicates direct quotes from the survey respondents. Other text indicates comment.

It should be noted that the consultant, the counsellors and the survivors who made up the expert advisory group were all deeply affected by the contents of this research.

It may be distressing for you to read this report. The women’s retelling of stories touches that part of us that wants to look away. We recommend that you take a break and come back to the words later. The value of this report lies in breaking the silence of childhood sexual violence.

**Definitions**

*C childhood sexual violence or assault* Sexual violence perpetrated before the age of twelve years.

*Dissociation* A state in which emotional conflicts are dealt with by a temporary alteration in integrative functions of consciousness or identity in response to overwhelming grief, despair, anxiety, fear. (Darlington, 1997:7)
DSM-III-R Diagnostic & Statistical Manual of Mental Disorders 1987 - medical system of classifying mental illnesses.

"Flashbacks are generally reported as intrusive images of aspects of the sexual abuse." (Darlington, 1997:9).

Multiple personality disorder or MPD is the most severe form of dissociation when a woman creates other personalities to dissociate from the abuse. In one study (Ross et al., 1991), it was found that 90% respondents to survey of MPD cases reported childhood sexual abuse. (Darlington, 1997:8).

**Phobia** An overwhelming fear which interferes with effective adaptation to one's environment, (Al- lison, 1993:155).

**Repressed memory** "A related means of protection of the self from painful experience is complete or partial repression of memory of painful events." (Darlington, 1997:9).

Self-destructive behaviours include suicide attempts, self-mutilation, suicidal thoughts, self-cutting, (Darlington, 1997:10), risk taking.

**Sexual violence** Range of criminal behaviours which may include the perpetrator showing sexual parts of body, touching sexual parts of victim's body, making victim touch sexual parts of perpetrator's body, putting penis in mouth anus or vagina, putting fingers or objects into vagina anus or mouth, unwanted sexual attention, forced participation in pornography. (IWHCSAS pamphlet 1997).

Substance abuse of alcohol, nonlegal drugs, legal drugs, at hazardous levels, (Darlington, 1997:11).

**Violence against women** "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (United Nations Declaration on the Elimination of Violence against Women 1993).

Young 12-25 years (Zig Zag, 1998).

**Summary**

The purpose of this research project was to determine possible links between the health impact of childhood sexual violence before the age of twelve years and chronic ill-health in adult women who had experienced childhood sexual violence before the age of twelve years.

All of the respondents in this research had experienced childhood sexual violence before the age of 12 years. The majority were assaulted before six years of age. Respondents came from a range of backgrounds and experiences.

In all cases the perpetrator was well-known to the child, and most often a member of their own family. In most cases, there was more than one perpetrator. It is recognised that single incidents of
sexual violence against children are rare and that it is more likely that children will be subjected
to multiple assaults. The most significant perpetrator was commonly the biological father.

Most common acts of violence involved making the child touch parts of the perpetrator's body; the
perpetrator touching parts of the child's body; and the perpetrator showing the sexual parts of their
body to the child. The use of pornography was significantly high and most commonly within the
family unit. All women had experienced sexualised language and threats of violence to them or
those they love. Medication and/or alcohol was used on the child in the majority of assaults. Women
reported a high rate of rape (vaginal, anal, oral), digital rape, and rape with objects.

The majority of women reported injuries as a result of the sexual assault/s and that those injuries
were left untreated. Fathers injured their child to a high degree in the sexual assaults.

There was a high rate of reported physical impacts and emotional impacts from the assaults including
significantly high rates of illness across the broad spectrum of indicators, especially significantly
high rates of depression and dissociation.

There was a low rate of secondary school completion which may be attributed to inability to con-
centrated or life insecurity in violent households. The need to be financially independent as quickly
as possible in order to escape violent homes may drive women out of school earlier than those living
in secure home environments. In this current climate where adolescents are unable to receive inde-
pendent financial support, children are required to stay in violent homes with no means of escape.
There appears to be no policy analysis of the high rates of youth suicide and youth homelessness,
nor consideration that childhood sexual violence may be contributing to these sad futures for our
children.

For most of the women, they are still seeking assistance with recovery up to 25 years after the
event/s.

Women survivors of childhood sexual violence seek understanding and acceptance from other
people without fears of being judged or made different. Whilst most women did not tell anyone
when the assaults happened, their first telling was met with disbelief and rejection from those who
were supposed to protect them. The main reasons why the child did not tell someone included they
thought abuse was normal or didn't know otherwise; fear for others or themselves; fear that no-one
would believe them; blaming themselves or thinking that others would blame them.

It appears that children are not generally believed. Adults may have a better chance of being believed
but by then it is too late and the abuse and its impact has been ongoing for years. There is a clear
need for children's sexual assault services, based on a model of safety, support and control by the
child, listening to what the child wants and needs. Essentially, this research has given voice to
children. When a child is hurt, they need love, attention, care and reassurance. These children were
not just hurt repeatedly but violated in every way. Society has a duty to listen to children and to
believe them. Society has a duty to intervene in families where there is violence and to keep the
children safe. These researchers deliver this report in the hope that society will listen.
The respondents stated that the second time they confided in anyone which was for some many years later (for some up to 35 years later) was overwhelming negative.

*I was punished and called a liar and they tried to purify me. I was told it was all in my imagination and I was told I had a wicked imagination.*

Distrust of others is therefore an understandable long-term response to human interactions, or to be more specific, interactions with adults. Most women have good healthy relationships with their children. They are comfortable sharing their experiences with their children, but feel inadequate as parents, being overprotective and paranoid. Their desire to give their children what they did not have as a child makes the women as parents self-analytical and fearful of their doing the wrong thing with their children.

Most of the women lived on less that $20,000 per annum, spending more than one quarter of their income on accommodation and were dependent on loans which increased their indebtedness. Women on such low incomes require free counselling and support services to address their childhood traumas. Low incomes do not afford opportunities for healthy lifestyles with adequate diet and exercise regimens.

Women on such low incomes and with limited work opportunities require free, accessible, confidential and long-term support services where they can keep the one counsellor over the years necessary for their recovery.

Most women reported positive responses from women's services, whereas their experiences with 'mainstream' services (police, schools, doctors) were mostly negative. Counselling was by far the most popular option taken above and beyond consulting medical doctors. Counselling support from women-friendly services is vital to the women. The women report the profound benefits gained from such services in stark contrast to their experiences of 'mainstream' services such as doctors and police. The women are actively seeking to address the trauma of childhood, to heal and to move on, into healthy relationships with intimate partners, with children and with friends.

Relationships with their children and intimate partners were positive. The women are seeking honest and understanding partners whom they can trust in an intimate way. It may be said that this is what every person wants but for women survivors, the risks to their emotional well-being are so much greater. They have more obstacles to overcome personally with for instance high rates of depression, lack of self-esteem, guilt and shame, and distrust of others.

Early learnt responses to the violence experienced as a child would inevitably be a lack of trust of people and an inability to understand the unspoken rules of friendship. Friendships more than family relationships are built on trust, and if there is a decided distrust of people, there will be on-going difficulties in forming friendships. Most respondents have had difficulty making friends or have never made friends. The women commonly expressed feelings of being different in public worlds and their lack of feeling bonded. In effect, women have given up their public lives because of the overwhelming nature of these feelings. Relationships with people in a work environment appear very difficult.
For most women, their experiences of childhood sexual violence has a significant impact on daily life decisions including the type of housing chosen, transport used, and type of work performed.

Childhood sexual violence affects the whole person in thought, behaviour, feelings and daily living. The holistic impact on women requires a holistic response facilitated by a social view of health and well-being which is supported by a feminist counselling framework. Health is about the whole person - mind, body, soul, sociability. People who have not been subjected to childhood sexual violence may take these aspects of daily living for granted.

The women were very honest about what they perceive in themselves to be weaknesses but they did not acknowledge their strengths and courage in surviving the damage inflicted on them as children. To face and learn to deal with the trauma of their pasts and to actively seek to change their futures takes untold courage and strength that cannot go unrecognised.

As a society, we have a responsibility to all our children. Their basic human rights are food, shelter and clothing. Their basic emotional rights are love, protection and stability. If their needs are not met, then it is our responsibility to provide them. As a society, we are all aware that childhood sexual violence exists, but by its very nature, it lends itself to dark secrets and unspoken horror. It is only through research such as this that we can be made aware of its prevalence and the long-term effects on women, and thereby provide the means by which we can remove the secrecy, provide protection and openly discuss this issue.

This research gives us a significant insight into childhood sexual violence. Some women expressed difficulty in participating but recognised its need. One of the most powerful feelings generated by childhood sexual assault is helplessness. The helplessness of the child who cannot find the protection they need, the helplessness of the child grown into adult feeling lost in this world with a soul-wrenching desire to fit into society, unmarked and 'normal'. It takes only understanding and recognition to give these women the impetus to continue their recovery. Our children are the cornerstone of our future, and if, as a result of this research, we have empowered people to speak up, listen and change, then we have achieved much in the protection of our children and recovering adults.

This report echoes the voices of women from within the four walls of the counselling room. Women who participated have opened their hearts, told their stories with courage. This report challenges our society to open heart, ears and eyes to our children so that the violence stops.

Chapter 1.0 Project Background

1.1 Service Description

The Ipswich Women's Health Center and Sexual Assault Service is a feminist-based community organisation providing counselling, community education and development. The centre is a 'for women, by women' organisation and covers the Ipswich and West Moreton region in Queensland, Australia. The centre provides services for women aged fifteen and over. Funding is provided through Queensland Health from Commonwealth and State funds.
1.2 History of Project

Social research is the systematic collection of data, for whatever reason. Community research is social research conducted for a specific reason - clarification of community needs, to assist social change, to assist agency evaluation, to test the community acceptance of proposed changes(Ward, 1994:237).

The project was initiated by the sexual assault service as a result of the amount of information coming from women about the health impacts they were experiencing. It became clear over time that there were striking similarities and a dearth of information to provide for women as to these health issues. Women had also made connections between their health status and their histories of abuse but often found the medical field unsupportive or not interested.

I had been to numerous doctors with symptoms they thought were strange, often conveying the message that I was strange. There seemed to be a lack of understanding from practitioners in the medical community and often a lack of basic respect in their dealings with me. I developed a real fear of doctors and in the search for a doctor, I felt I could trust my counsellor to help me. Through counselling, I discovered many women could identify with these issues and symptoms. Something more had to be done with this information to reach the wider community so the research.

From this, the centre decided to produce a pamphlet to try and raise the awareness of the issues among GPs. This pamphlet was released in 1997. It was then decided to capture some of the information that women were providing and thus move a lot of the anecdotal information into something tangible. It was hoped that this information could be used to inform stakeholders such as funding bodies and the medical profession. By revealing the known long-term health impacts, it was considered that there would be a strong argument against service reduction from long-term counselling to brief intervention.

The research is innovative and one of the first in process and content for Australia. I am tremendously proud of it.

A research proposal was formulated, MIMS & Associates was approached and the stakeholders concurred on the final choice of consultant.

Chapter 2.0 Consultancy Terms of Reference

2.1 Consultancy Brief

The brief for the consultant was to facilitate the advisory group and assist with the research process. As an independent person with research skills, the consultant was also required to provide objectivity and focused outcomes.
2.2 Limitations

Limitations of the project for the consultant included the short time-frame and limited budget which did not allow for travel, catering, printing, and other usual additional project oncosts.

Chapter 3.0 Principles of Practice

The project commenced with a negotiated set of principles to guide the process and included the following:

1. Working with women who have experienced sexual violence as children requires sensitivity and respect by researchers.
2. Women who give their time and ideas about their experiences should be paid and acknowledged in the research, depending on their wish to be acknowledged publicly or to be co-authors to materials.
3. Women who give their ideas may experience concomitant distress when disclosing events or making links, and therefore, the counselling service must be prepared to provide long-term and back up support to them.
4. Principles of community development provide a framework for the research approach.
5. Research should not be voyeuristic but should empower the people interviewed.
6. All files and information should be kept confidential and reported information should not reveal identifying details of respondents.
7. The project will keep its focus small and realistic.

Chapter 4.0 Methodology

4.1 Implementation Stages Are as Follows:

Stage one

- Establishment of an expert advisory group (hereafter EAG) comprising women with a range of knowledge and skills and including women who have experienced sexual violence before the age of twelve years, centre workers and consultant.
- Consultant to advise workers who are to implement the survey.
- Workers to seek women who are willing to participate.
- Women will be contacted by consultant about confidentiality of research.
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- Literature review undertaken by consultant.
- Development of protocols for research boundaries and project roles.

Stage two

- Development of survey materials with EAG.
- Implementation of survey materials by centre workers.
- Collection and collation of materials by consultant.
- Working with women to be interviewed to go over the process.

Stage three

- Survey response analysis by consultant.
- Draft analysis to be checked by EAG.
- Final analysis provided by consultant.

4.2 Timeframe

The funded extent of the project was from June to September 1998, although unfunded work continued to mid December 1998.

4.3 Scope

The age limit of the assault was set as being at under the age of 12 years, following current service definitions of children being 12 years of age and under, and support services for youth setting the limits from 12 to 25 years of age.

The scope of the project was limited by funds and the short-time frame. The limitations restricted the scope to fifteen women being interviewed and three women survivors as part of the expert advisory group.

The scope of the survey extended to medical history profiles of each respondents in addition to demographic details and self-reported impacts.

Social research, both formal and informal, is needed to trace the particular path that leads to a deeper understanding of the causes and contexts of health issues at the local level. People's descriptions of their own experience are important not only for programme development and implementation, but also because they may offer new insights into the complex interaction of causes that give rise to health problems. They may also suggest new ways of thinking about old problems (Ward, 1994:247).
4.4 Expert Advisory Group

An expert advisory group was sought to guide the project and provide content input and data analysis.

The group comprised the external consultant, three workers who are sexual assault counsellors from the centre, and three women who are survivors of childhood sexual assault and who offered their support to the project. These women were paid for their time at the same rate as the consultant although they gave more time to the project than the budget could allow.

The group met over six meetings between June and December 1998 to design survey schedules and set project parameters and to perform data analysis and observations.

4.5 Survey Design

Existing health and medical research has, by and large, done little to support women's health. Part of the problem is that some scientific methods have become reductionist and stress the collection of quantitative data as the only valid data source. (AHMAC, 1993:57).

The survey was designed by the expert advisory group in conjunction with the consultant over a series of three meetings and through other means of communication.

The first meeting examined group expectations of the research and devised some parameters, and listed possible symptoms and possible health impacts to be included in the survey.

The second meeting discussed staging of the research and interviews, definitions, feedback processes, and refinement of the survey.

Between this and the third meeting, a draft survey was designed and reviewed.

The idea of a sealed section of potentially intrusive and distressing questions was discussed, as it was felt that both interviewer and interviewee may be compromised by verbally asking such questions. It was considered that such questions about the type of violence perpetrated and the frequency of symptoms were essential to the credibility of such research. It was considered that inclusion of quantifying questions, if based on biomedical symptoms lists and actual types of violence, would provide a clearer picture of a possible correlation between the childhood sexual violence and adult health conditions.

The schedules in the sealed section, Illness or Disease Types 1-7, were modelled on The Australian Institute for Health & Welfare (1996) Burden of Disease Profile which listed symptoms by category of ill-health in groupings including injury, circulatory, digestive, respiratory, mental, infectious, musculoskeletal, nervous, genitourinary, skin, endocrine, and ill-defined. Into these categories were listed the ranges of conditions considered as relevant by the expert advisory group.
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The schedules in the sealed section, Types of violence I-III were wholly devised by the expert advisory group as a means of quantifying the type of violence perpetrated against the child and the type of perpetrator. It was considered that listing most to least significant perpetrators was relevant to determine any link between the level of violence perpetrated and the significance of the relationship with the perpetrator. It also allowed the women to decide the significance without pre-determination of significance by standard factors such as frequency of assault or severity of assault/s. What is significant to one woman may not be to the next, hence the intensity was left to the women to attribute.

The third meeting refined this schedule. The final schedule is to be found as Attachment 1.

Question order began with simple, less personal questions to overcome nervousness and progressed to more complex and intrusive questions, resulting in the final 'sealed' section which women had to fill in by themselves, and which asked questions about the specifics of their assaults and the specifics of their illness profiles.

To date, there has been little reframing of abuse research from the adult to the child perspective so that understanding of the physical and emotional dimensions of the assault are reconsidered from the child's perspective, (Trief, 1996).

4.6 Interviews with Women

Women self-selected after receiving an invitation to be interviewed. Only fifteen women could be interviewed due to budgetary limitations. An open invitation was extended to all women in contact with the service who met the basic requirement of experiencing sexual assault before the age of 12 years. Twenty five invitations were given out and all 25 women expressed an interest in this research. The first fifteen women who responded were given the opportunity to participate.

All five centre counsellors were involved in personally inviting women to become involved in the project.

Three counsellors offered their time to become involved in the project and to give assistance to the expert advisory group. These counsellors were given background notes to guide their interviewing processes with women and some interviewing guidelines such as "not prompting", "reading the question as written not elaborating", and "not leading interviewees with biased comments".

Guidelines for interviewers were based on the following precepts by Ward (1994:241-2).

Avoid these questions because of their low validity:

1. ambiguous - open to one or more interpretations;
2. vague - poor definition;
3. double barrelled - two distinct elements in question requiring simple yes/no answer;
4. leading - lead respondent to a particular wanted answer or biased;
The expert advisory group devised a preamble for the interviewer to read to the woman about the restrictions of the interview process; the differences between their role as interviewers and their role as counsellors, as per below:

**Preamble to the woman** We are trying to find out links between childhood sexual violence and long-term health impacts in adult women. We are doing this because there is not much information about the long-term health impacts of childhood sexual violence. Because you have kindly offered your ideas, we want to ask you a few questions. With ideas from you and other women survivors, we are going to use our findings to inform those who make decisions about sexual violence about the needs of women survivors of sexual violence. This is not a test. We are asking these questions because you have experienced violence and because you have kindly offered to give us your ideas. There are ** questions we are asking. It should take only ** minutes to do. We are also asking you to answer some questions in a sealed envelope by yourself. If you need help with this section, please ask. If you don't understand a question, we can come back to it later. At any time, you can choose not to answer a question or you can stop the interview. You can also take a break at any time. That's fine. Some of the questions may be confronting and direct. The questions are not intended to blame or judge. The questions have been designed by women survivors and workers who understand the impact of childhood sexual violence. The questions are designed to get a detailed picture of the impact of sexual violence in childhood on women without identifying individuals. The interview process is different from counselling. In this interview, I can only ask you the questions. I am not able to prompt you, or give you ideas, because that would be influencing the research or giving you my ideas rather than yours. Counselling is available to you after this interview if you request it. If you need any further information after this interview about health and well-being issues, please let a worker know and we will supply that information. All personal information and responses to this survey during this research project will be kept confidential and private. Any information provided will be cross-referenced to reduce identification of the person responding. Any information provided to the interviewer will be kept in a secure location. At the end of the process, information will be archived for one year. No
names, addresses or contacts will be provided to anyone other than the researcher, nor will the researcher discuss details of the responses with anyone other than those centre workers and the advisory group. Respondents will not be identified in any analysis of the surveys.

The fifteen women were interviewed over a period of three weeks. Interviews took between two and five hours and included some additional time allocated for support for the women who experienced difficulties with question content.

Feedback about the interview itself was returned by 14 of the 15 women and results are found in Attachment 2.

**4.7 Survey Analysis and Literature Review**

The fourth, fifth and sixth meetings of the Expert Advisory Group concentrated on analysing survey results and evaluations, in combination with refining the literature review. The results follow.

**Discussion of Findings and Literature**

**5.1 Respondent's Backgrounds**

**5.1.1 Demography**

Fifteen women were interviewed during September 1998, being clients of the sexual assault service at the Ipswich Women's Health Centre and Sexual Assault Service, Queensland.

Residential postcodes indicate that women reside in a broad area from suburban Brisbane to rural areas within the West Moreton shire, eight of which live within the Ipswich City Council region. Given the sensitivity of the issue for which counselling is being sought, it is not surprising that women move outside their locality to seek support, and away from where they work and live.

Ages range from 19 to 62 years, with a median age of 31 years.

All cultural backgrounds are from 'western cultures' including Australian, English, Anglosaxon, New Zealander and German. Most households (n=13) did not use other languages, but one used German and one Auslan (Deaf Sign).

More than 65% respondents have children, with the majority having children under 16 years of age, one respondent having 6 children, one having three adult children, with the average being 2-3 children of both sexes. All parents have resident children, with some shared parenting being non-residential.

**5.1.2 Educational Backgrounds**

The well documented difficulties that sexually abused children experience in the school situation with academic performance and behaviour might be expected to
negatively influence later educational attainments, and impair the development of
the skills and discipline necessary to sustain effective work roles, (Mullen and

All respondents (n=15) finished primary school. Two respondents did not finish high school to
Year 10, and the rest completed Year 10 before the age of 18. 86% finished year 10, 13% did not.
It may be a relevant factor that education departments rarely allow children to leave school before
Year 10. Eight respondents did not complete Year 12, and the rest completed it before the age of
22 years. 53% did not finish Year 12 leaving 46% who completed secondary education to Year 12.

Contributing factors to the low rate of secondary school completion may include inability to con-
centrate, low self-esteem whereby young women did not have the confidence to go on, or life in-
security in violent households. The need to be financially independent as quickly as possible in
order to escape violent homes may drive women out of school earlier than those living in secure
and safe home environments.

Seven (47%) respondents have not completed tertiary qualifications. Those who have completed
tertiary qualifications have opted for courses ranging from Office Administration at Skillshare,
TAFE, Receptionist, Certificate in Arts and a Diploma of Teaching. Eight (54%) respondents have
NOT completed more than one tertiary qualification, but those who have completed Bachelors of
Social Science, and Science.

In a recent phone-in survey of survivors of sexual assault in Victoria, 66% of participants identified
that their ability to pursue education had been affected, with the most common effects being inab-
ility to concentrate and early termination of education, (D'Arcy,1998).

5.1.3 Current Economic Status

For 60% respondents, they have an annual income of less than $10,000, 13% have an annual income
of between $10-20,000, 25% have an annual income of between $20-40,000, and no respondent
has an annual income of more than $40,000. With 60% on less than $10,000pa, it may be possible
that some of them are claimants of government benefits. It would be interesting to compare these
low incomes for women with male income levels within the same age ranges.

Most respondents (73%) have an income less than $20,000 which is below the poverty line. Later
in the survey, it is interesting to note that for 60% respondents, their earning capacity is reported
as affected by their childhood experiences.

The 'Poverty Line' income for the single parent with one child is $17,000 pa, for the single person
is $13,000pa, and combined income for the couple with two children is $24,140pa, (Brotherhood
of St Laurence,1997). This is not to say that women who are sexually assaulted as children come
from low income backgrounds but that they may experience disadvantages as a result of the violent
households in which they live. As discussed later, with 80% registering in the survey that they have
difficulty with work relations, it is not surprising that their capacity for work is damaged.
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The explanation for abused women being in less well paid and prestigious jobs could be that they underestimated their value and sought occupations below their capacities, (Mullen and Fleming, 1998:6)

Women on such low incomes require free counselling and support services to address their childhood traumas.

In a recent phone-in survey of survivors of sexual assault in Victoria (D'Arcy, 1998), with regard to their economic situations, 29% of participants identified that they had to take time off work without pay, 21% incurred costs due to changes in residence, 20% were paying for counselling, and 19% were continuing to spend money on seeking medical treatment. The survey noted that 33% experienced decreased work performance, 26% were unable to look for work, 19% have changed their career, 17% experienced loss of work, and 14% were using sick or recreation leave to stay away. Many respondents felt they could not work in an environment where there were men which obviously restricts their work opportunities.

In our research, in terms of domicile, more than 80% respondents do not own their own home. Those who rent are 46%, and those with a mortgage are 40%. For the respondents who do not own their own home, 25-50% of income for 46% respondents goes to payments, more than 50% of income goes to payments for 26% respondents, and less than 25% of income for payments for 20% respondents.

For 72% respondents, they pay more than a quarter of their income on payments for accommodation, meaning that a substantial amount of a very low income is being spent on rent or mortgage.

For the 80% respondents who own a car, the age of the car is more than 5 years old for 46% respondents, or more than 2 years old for 20% respondents. For the 20% respondents who do not own a car, most use the train.

The majority of respondents (80%) have current debts. Respondents on low incomes further lowered by high rates of indebtedness. Holidays are taken by 67% of respondents, of which 27% take holiday more than once a year, visiting family and friends, staying home, going to the coast, camping, with some travel. The majority of respondents (60%) eat out less than monthly. The most popular entertainment is home television or video (87%), reading for 67% respondents, and other forms of entertainment being cinema, theatre, radio, music, and football games. At least 20% respondents take no regular form of exercise, but walking is the most common form for 53% respondents, and other include cycling, swimming, teamsports, 'running around after the kids', rollerblading, yoga, and kickboxing.

With indicators of restricted mobility as per above, it is useful to reflect on the overall possible impact of sexual violence on women reaching their full life potential.
5.2 Outlines of Childhood Sexual Violence

5.2.1 Prevalence

Child abuse is found in all societies and is almost always a highly guarded secret, wherever it takes place, (WHO, 1997:1).

Trief (1996:599) reports that incidence of sexual violence against children in Australia is difficult to quantify and that estimates can range from 6-62% for females and 3-31% for males.

Pure quantitative data on the actual incidence of sexual assault does not exist, (Northern CASA, 1998:8).

CASA (1998) reports that by the time they are 18 years old, 38% girls and 9% boy have been sexually assaulted and that in one out of ten homes incest is taking place.

Three quarters of sexual assaults are not reported to the police, (Northern CASA, 1998:9). AHMAC (1993:41) reported that in Australia sexual assault is the largest single type of abuse against children aged under 16 years.

A survey of 600 women from middle and upper class in India found a staggering 76% reported sexual abuse under the age of 12 years, (Gibson, 1998) challenging the notion that abuse only occurs in low income households.

There is a growing body of evidence to suggest that different types of violence may occur simultaneously within a family, (Tomison, 1995:10).

Available national data constitutes a conservative estimate of maltreatment which is influenced by factors like professional labelling bias (doctors expect non-biological parents to maltreat more than biological) and the likelihood that non-offending family members being less likely to report the offending parent, (Tomison, 1996:3).

Tomison (1996:9) reports that statistics indicate 20% of children reported as being sexually abused came from female single parent families. He posits that literature shows that pederast offenders often target vulnerable families like families with a single female parent, and that those offenders may put themselves into a position of being a stepfather to the children. Similar statistics report that 20% stepfathers are known to be sexually abusive.

In the overwhelming majority of cases of childhood sexual assault, the perpetrator is the father, stepfather, mother's defacto partner, brother, uncle or grandfather of the victim, (Northern CASA, 1998:9).

5.2.2 Myths

Society is vulnerable to and eventually perpetuates a series of myths about social relations in order to maintain the status quo of power structures. For example, truths challenging the currently con-
structed notion of "family" (man married to a woman and their children in one household) are denied on a large scale.

My daughter was crying for her stolen childhood, I was crying for her pain. I was bewildered, devastated. This sort of thing didn't happen to happily married couples like us. A whole lot of things began to fall into place. It was like finishing a jigsaw puzzle. I had put it all down to adolescence. How dreadfully wrong I was (Fotchett, 1993).

Tomison (1995:1-2) records the history of sexual exploitation of children which was not recognised in legislation until the 16th century in England which began the concept of protecting children from sexual abuse. A 17th century case in the United States of America reflects a contemporary attitude where the victim is blamed, when the father was executed and the daughter whipped for low morality. The 1920's saw a turning point in response to sexual violence against children under the influence of the growing field of psychoanalysis which characterised sexual violence against children as perpetrated by strangers and which represented victims as seductive.

Why wasn't child sexual abuse widely identified prior to the 1960's? While society could cope with 'stranger danger' and the threat of the stereotypical child molester assaulting children, it was much more threatening to acknowledge that sexual abuse was commonly occurring within the family, committed by family members upon whom children were dependent and should have been able to trust. The acknowledgement of sexual abuse was therefore a threat to the structure of the family. (Tomison, 1995:2).

Contrary to myths propounded in our society, Tomison (1995:7-9) notes that there are few studies about the incidence of child and adolescent sex offenders, no evidence from a range of studies of a link between homosexuality and pederasm, and little evidence of a significant incidence of female perpetrators.

Some of the myths perpetuated in our society (Northern CASA, 1998:2-8) follow.

1. Only strangers rape children.
2. Children forget easily.
3. Children don't need counselling.
4. The long-term impact on children is not significant.
5. Children are resilient and can take anything.
6. Sexual assault is an unusual occurrence.
7. Children lie about it.
8. Incest is not harmful.
9. If victim experiences sexual arousal during the assault, they consented to it.

10. Children can be provocative.

11. Mothers hide the abuse.

12. Perpetrators cannot control their sexual urges.

13. Perpetrators are sick people.

14. Incest only happens in poor or dysfunctional families.

The body mends soon enough. Only the scars remain. But the wounds inflicted upon the soul take much longer to heal. And each time I re-live these moments, they start bleeding all over again. The broken spirit has taken the longest to mend (WHO, 1996:2).

5.2.3 How Childhood Sexual Violence was Defined by Respondents

- Betrayal, degrading, kills the child inside. Seems like you're always running away from it but never getting further away.

- It's robbery first and foremost of my teenage years because I didn't have coming into puberty in the way that I understand as normal now. I felt I was labelled.

- An invasion. Innocence that is taken away. Concept of trust - not as straightforward as it should be.

- Any sexual activity with children including pornographic videos as well as physical contact because in no way can the child give consent.

- Any wrong doing to person/s that's not wanted.

- Probably violence of a sexual nature directed at kids, but it may not even appear to be violent.

- Where you've been sexually hurt, like abused when you were a kid.

- Anything that damages the child's perceptions of her body and that ranges from words to touch to rape.

- It's horrifying - takes away your identity. You're not the same as everybody else.

- Inappropriate behaviour or messages, not just physical hurt.

- Bad people hurt you.

- Betraying your child.
• Torture - to me it's more defined as loss of childhood.

These definitions by the women are not clinical definitions of violence, but very much focused on the impact of violence on personal well-being and identity. This reinforces the human face of the impact of childhood sexual violence.

### 5.2.4 Age When Violence was Experienced

All 15 respondents have experienced childhood sexual violence before the age of 12 years. 20% respondents were less than 2 years of age when the sexual violence started, 20% between 3 and 6 years of age (possibly up to 60%), 20% between 7 and 10 years of age, whilst 40% did not exactly know when the violence started but they knew it was in their early years before the age of six years.

Memories may return after a latent period, sometimes of many years, triggered by a significant life event like childbirth. Others, although retaining memories, may only feel able to speak about their abuse after many years, (Mammen & Olsen, 1996:519).

It appears that more than 80% of respondents were assaulted before the age of 6 years.

#### Table 1. Age of First Assault

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12 Years</td>
<td>100%</td>
</tr>
<tr>
<td>Under 6 Years</td>
<td>80%</td>
</tr>
<tr>
<td>7-10 Years</td>
<td>60%</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>40%</td>
</tr>
<tr>
<td>Under 2 Years of Age</td>
<td>20%</td>
</tr>
</tbody>
</table>

For those who remember childhood sexual violence before the age of 2 years, this is often questioned, yet we do not question 'good' memories before this age. Rape is often purported to be about misplaced sexual energies. How can rape of children have anything to do with sexuality? Such early sexual violence reaffirms the feminist belief that rape is about abuse of power where forced sexual acts are used as controlling 'weapons'.

For 80% respondents who experienced childhood sexual violence before the age of 6 years, they are still seeking assistance with recovery at an average age of 31 years. This highlights the reality that even 25 years down the track the impact is still intense and wide-reaching.

### 5.2.5 Types of Perpetrator

In the sealed schedule of the survey, women were asked to name the type of violence perpetrated and rate it according to the significance.
The Health Impacts on Adult Women of Childhood Sexual Violence Before the Age of Twelve Years

The most significant perpetrator of the violence was the biological father (33%), stepfather (20%), and others including brother, uncle, neighbour, mother and a combination.

In all cases the perpetrators were well-known to the child. No strangers perpetrated violence on the children. This debunks the myth of 'stranger danger' which is focused on by the media and social commentators. All perpetrators were in positions of care and trust of the child.

The common myth is that rapists are strangers or that assault is one off.

*Grandfather mainly had me do stuff to him.*

Assaults were multiple and by more than one perpetrator.

*There were others but I don't remember them very well.*

In most cases (73%), there was more than one perpetrator. Other than the most significant perpetrator, 73% respondents indicated that they were abused by others while under 12 years of age. These included brother, uncle, grandfather, family friend, stepfather, babysitter, brother's friends, father's friends, foster brother, cousins, mother, tradesmen, doctor or a combination. Friends of the family were also significant for 20% respondents. It is recognised that single incidents of sexual violence against children are rare. It is more likely that children will be subject to multiple assaults and that there is often more than one perpetrator.

Rather than the researchers scaling relationships under "Most significant to least significant", women were invited to place the name of those relationships in blank columns. For outsiders, it may appear that sexual violence perpetrated by a close "blood" relative is more profound than by a neighbour or other. However, it was the aim of these researchers to allow women to attribute the significance to perpetrator.

Mainstream definitions of significance of perpetrator are often confined to level of injury, frequency of assault and longevity of assaults over time. In contrast, as is shown below, when women have the opportunity to attribute the level of significance of the perpetrator, they will clearly indicate that the deciding factor involves none of these features and more often than not, involves the meaning of the relationship of the perpetrator to the victim.

Of the five women who identified their fathers as the most significant perpetrator to them, other perpetrators included older boys, brother's friends, uncles, grandfathers, father's friends and mother. Of the three women who identified their stepfathers as the most significant perpetrator to them, other perpetrators included doctor and grandfather. Of the two women who identified their brother as the most significant perpetrator to them, other perpetrators included cousin and mother. Of the two women who identified their mother as the most significant perpetrator to them, other perpetrators included foster brother, foster male child, father, grandfather, uncle, neighbour, church, teacher, stranger. One woman identified her uncle as the most significant perpetrator only. One woman identified the neighbour as the most significant perpetrator, and the next significant as her father. One woman identified older boys as the most significant perpetrator, with others including family friends, friends, and strangers.
Perpetrators were mostly men (95%), and 5% women. As perpetrators of sexual violence, fathers and step fathers were most common, then brothers and older boys. Medication was used mostly by fathers in the assaults.

Stepfather was really sly - made everyone believe that I was scared to sleep alone
- Mum worked night shifts so he would make me sleep in with him.

Male family members were most significant. Mothers do not appear as sexual abusers but are still significant perpetrators.

Significance may well be related to the feeling that the perpetrator is one who is supposed to protect you not assault you.

### 5.2.6 Types of Violence Experienced

All respondents said they were not currently experiencing violence of any kind.

Most common acts were making the child touch parts of the perpetrator's body, the perpetrator touching parts of the child's body, and the perpetrator showing the child sexual parts of their body. The use of pornography was significantly high. The notion of the pornographer being an outsider to the family unit is greatly challenged here.

The types of assault were described by respondents in the sealed schedule of the survey. All participants filled in this schedule.

All respondents (100%) experienced sexualised language, threats of violence to them or those they love, and the perpetrator making the child touch parts of the perpetrator's body, the perpetrator touching parts of the child's body, and the perpetrator showing the child sexual parts of their body.

For 60% respondents, they were forced as a child to participate in pornography and medication was used on them after the assault/s.

For 47% respondents, medication was used on them before the assault/s, and for 34% medication was used on them during the assault/s.

Didn't use medication a lot, mainly alcohol. "Other" making me watch while he/they did stuff to other kids - father's friends.

Respondents report a high rate of rape (vaginal, anal, oral), digital rape, and rape with objects. With regard to the type of assault, all respondents (100%) reported that objects were put into their vaginas, that the penis was put into their vaginas, that the penis was put into their mouth, and that fingers were put into their vaginas. For 64% respondents, objects were put into the mouth and for 54%
fingers were put into the anus. For 47%, the penis was put into the anus and for 40% objects were inserted into the anus.

The majority of respondents reported injuries as a result of the sexual assault/s. For 74%, injuries occurred after the sexual assault, for 60% injuries were perpetrated during the assault, and for 34% injuries were perpetrated on the child before the assault/s.

There is a considerable overlap between physical, emotional and sexual abuse, and children who are subject to one form of abuse are significantly more likely to suffer other forms of abuse, (Mullen and Fleming, 1998:4).

When injury was sustained, the majority (80%) of respondents reported that those injuries were untreated.

Why is it that a mother can tell her daughter that these things did not and cannot happen so therefore they must not happen? Is there not some way a person can open their eyes and see what is going on and seek treatment for the injuries after they are caused?

My injuries were mostly to my mind like scarring. It seems to never fade.

Fathers injured their child to a high degree during and after the sexual assaults (compared with the stranger where there was uncertainty about injury) and most injuries were left untreated (80%). Significance of perpetrator stayed the same despite injuries. The myth of the 'safety of family' is challenged by these statements.

There is also a high rate of reported physical impacts and emotional impacts from the assaults. Darlington (1997:4) reports that the most serious long-term health and psychological effects result from highly invasive sexual abuse such as oral, anal, vaginal penetration, violent, forceful, sadistic, long-term abuse, abuse by parent or step-parent or parent figure.

Fears, threats and punishment were used in 55% responses, and in 28% responses, when they told someone they were not believed.

In most cases I was told not to tell anyone like my parents by them saying no-one would believe me or people would think there was something wrong with me. There was also physical and emotional blackmail. By this time I believed I got myself into these situations and deserved it.

Threats of violence often did not have to be verbalised for the child to be frightened. It is indicated that the threat of violence is high, and is manipulated through fear. The fear is real and contributes to why women don't tell.

I can't remember if ever made any actual threats but I thought if I told anyone or try to run away be would kill me. Constantly told me not to tell anyone. I can't remember if he made me touch him but I've got very strong feelings that he did. And
I can't remember if he made me look at him but again I think he would of, but not really sure.

5.2.7 Talking About the Violence Experienced

More than 65% respondents did not tell someone about the sexual violence when it happened for the some of the following reasons:

- Because I thought it was normal. I was lead to believe it was a normal, secret, special thing. It was our special thing.

- I had a fear of my father hurting my sister and increasing the violence against me.

- Couldn't talk. I would be in serious trouble even if I mentioned it. The old scenario - no-one would believe - I didn't know what was happening at the time.

- I think first off I didn't know what was happening and then later on I didn't think people would believe me. They would think it was my fault and I thought it was all my fault.

- Too scared. I can remember I was going to tell my foster mum. I used to practice. I'd write it down and one time I went to do it. She was on the phone and when she got off I nearly did it. But I was too scared, I guess.

- Threats. I had a violent mother anyway so I couldn't speak to her.

- Up until I was about 14, I didn't recognise it as abuse. It was not overt. It wasn't until I was about 14 and becoming aware of my sexuality that I realised it was wrong. That was the most significant and traumatic time but I was still too scared to tell anyone. I started to avoid him. I wouldn't be alone with him and give him the opportunity for anything to happen. I thought that would be enough and 6 months went past and it happened again. That's when I told my mother because I realised I couldn't protect myself.

- I didn't know how and the doctor wouldn't understand me. I was used to it too. I thought it was the normal type of thing. I did tell in my own funny way I guess. I used to do things I suppose. I used to take stuff and hurt myself, black stuff to make you sick from the chemist (Ipecac). I wanted doctors to know but I didn't tell them in words.

- I was scared they wouldn't believe me. I was scared of him as well, what he'd do.

- I couldn't tell anyone. I didn't feel I had an opportunity to tell anyone. No-one wanted to know. I felt threatened that something more terrible would happen if I told. I felt it was my fault and others would blame me if I did tell. My mother walked in and caught him on two occasions when I was 12 or 14. On both occasions I had to go to the police station and I had to give a statement on both occasions but only about the incidents that my mother walked in on. They were vague, sketchy descriptions. I didn't tell anyone after that until I started going to counselling when I was 30.
Four main reasons why women did not tell someone were that they thought abuse was normal or didn't know otherwise; fear for others or themselves; fear that no-one would believe them; blaming themselves or thinking that others would blame them. This may indicate significant manipulation by perpetrators for such young children not to report for the mentioned reasons. This may reinforce that power via manipulation is greatly significant in perpetration of violence, a basic thesis of feminist analysis.

Child sexual abuse may, like child physical abuse, occur as a function of the misuse of personal power, and is another example of male attempts to control others through the use of violence,(Tomison,1995:10).

The first person who was told about the sexual violence was for most respondents their mothers (54%), pets, family friends, or grandmothers. Responses to this first telling were negative on the whole as below:

- Can't remember her initial reaction but not long after the police came to school and I assume she told them. She never told me she called the police but years after I put the connection.

- Four and a half to five years after the violence started it was still happening. She didn't respond to me in any way, shape or form. I can't remember if Dad was in the room when I told her but he found out and he did try to help me. If he heard my brother come into my room, he would make him go back to his own room.

- I got into trouble from mother.

- Mother - She told me I was making it up.

- Mother - No idea. I'm blank from there. I can remember telling her but can't remember the reactions. I remember being worried because mum told dad. I didn't want people to know. I was scared.

- I told the school counsellor when I was 16 years. The counsellor said it was confidential but then went and told the principal who rang the family doctor. The family doctor worked closely with my mother and immediately told her. Interview with my parents, counsellor and principal chose not to believe me. I was sent to a psychologist with my parents in the room and couldn't say anything. I took another four years before I could tell anyone - a sexual assault worker.

- Grandmother - she said don't be stupid, in German, of course.

Most of the people told were women possibly because they could be seen as safer or less threatening to tell.

However, responses were very negative for three main reasons:

1. It was suddenly taken out of their control,

2. They were not believed and ended up in trouble, or
3. There was no or little reaction.

The majority of respondents told their mothers and received negative or no responses. This may have had a devastating effect, and may well have entrenched the abuse by maintaining the violence and not protecting the child.

Due to the negative first responses, periods of time passed before they told another person about the sexual violence in childhood, from six months later to 35 years later, with a median time of 17 years to retell their experiences. If women have taken this long to tell and retell, it appears that their apparent lack of trust of others (as discussed later) is well-founded.

Those who were told for the second time included the police, family members (20%), women's worker, school counsellor, auntie, best friend, sexual assault worker, nurse, husband, boyfriend, and mother. The responses at this point vary as below:

- Can't remember but I know no action was taken beyond that.
- Upset - didn't say much.
- Auntie - she was appalled that mother kept making me go back. As far as a positive action, I don't think she took anything.
- Shocked - she was upset, surprised it had happened to me.
- Still talking.
- Not surprised and got me out of the country real quick.
- I get a bit confused about how long it was or whether it was the feeling of wanting to tell. But I remember when I actually told was in hospital. I told a nurse who I got on with but she told the psychiatrist. He didn't believe me and treated me with more medication. Family services officer was really good. I didn't think she'd believe but she did. Really understanding and she took me into another room. I spilt it, patient, understanding, believed me, and didn't blame me. Really good through whole thing. When FSO told foster mum, foster mum said "my son wouldn't do it and who cares if he has.
- Husband - Initially he felt hurt for me and then over the next few years I felt he despised me somehow.
- Boyfriend and sexual assault service were fabulous, good response, warm.
- Mother - I felt as if she didn't believe me. She confronted him. She wanted to know exact details from me. She confronted him in the bedroom and then he came into the kitchen and said, "See, I told you you'd just cause trouble." And nothing happened. It wasn't spoken of again. The abuse stopped. I left home not long after.
Don't remember. Everything is all in boxes and my memories are all mixed up. It's probably something to do with the tablets I'm on because they bomb you out.

My middle sister didn't really want to believe it and my oldest sister had been abused by him too so she knew. She left home when I was really young and that was the reason. I think Mum always knew. I think there were enough signs given to her that she knew what he was like.

The Police - they were very cold like they didn't really care anyway. I remember feeling like I was in trouble because I was just sitting there nodding and not saying the things they wanted me to say but I couldn't say the things they wanted me to say.

It is imperative that all professionals develop clear protocols to ensure the safety of their clients as a high priority in the case of disclosure of sexual violence.

In a phone-in survey of women conducted in Brisbane in 1980 (Women's House:24), reasons for the childhood assault not being reported included the following responses:

- 23% fear of assault
- 18% guilt and shame
- 15% expected disbelief
- 18% protecting family and relatives
- 9% expected blame
- and being too young, incest did not continue, did not know who to report to.

Some women took up to 35 years before they told anyone again and then to those they had built some trust with. Median time taken was 17 years between first and second telling. For all respondents the responses were negative and included a range of responses from no response to being despised. With a majority of responses to the second telling (57%) being negative, it is not surprising that victims have difficulties with trust and perceptions that they will not be believed. It appears that children are not generally believed. Adults may have a better chance of being believed but by then it is too late and the abuse and its impact has been ongoing for years.

There is a clear need for children's sexual assault services, based on a model of safety, support and control by the child, listening to what the child wants and needs.

5.2.8 Use of Services for Support

Contact had been made with the following services as a result of the violence, including a combination of these: 87% used counsellors (mainly in women's services), 80% used women's services, 60% used sexual assault services, 46% used doctors, 33% used telephone counselling services including Lifeline, and other services included police, court, legal, neighbourhood centre, clergy,
refuge, childcare, school, psychiatric unit, child health worker, alternative therapist, psychologist and psychiatrist, a girl at work, deaf women's service, and Brisbane Rape and Incest Crisis Centre.

### Table 2. Women's Service Use

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Percentage of Participants Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Services (incl SAS)</td>
<td>87%</td>
</tr>
<tr>
<td>Sexual Assault Services</td>
<td>60%</td>
</tr>
<tr>
<td>Doctors</td>
<td>46%</td>
</tr>
<tr>
<td>Telephone Counseling</td>
<td>33%</td>
</tr>
</tbody>
</table>

More than 80% respondents reported positive responses from women's services, whereas their experiences with 'mainstream' services (police, schools, doctors) were mostly negative (69% respondents). Counselling was by far the most popular option taken above and beyond consulting medical doctors.

### Table 3. Satisfaction with Services Used

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Percentage of Participants Satisfied with Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women's Services</td>
<td>80%</td>
</tr>
<tr>
<td>Police</td>
<td>31%</td>
</tr>
<tr>
<td>Schools</td>
<td>31%</td>
</tr>
<tr>
<td>Doctors</td>
<td>31%</td>
</tr>
</tbody>
</table>

Positive or good experiences of these services included the following:

- Only the counsellors, women's services and sexual assault support services were good. I felt safe. I was able to open up. I felt like I was believed. I gained an awareness of abuse and violence. The support group helped me to accept it and begin dealing with it.

- Police were great because I'm here now. This centre is the most positive I've felt in all my counselling experiences and I've been to seven different counsellors in as many years.

- I'm getting somewhere. Improving my life but it takes ages.

- Release.

- Previous counselling didn't help. But current counselling is good, it's helping. Alternative therapist very helpful. Some doctors helpful, other not.

- To help me understand what I was going through, that I'm not crazy and I can slowly deal with what's been going on without being rushed.
• Being believed, being able to tell or not tell, being able to choose how much I tell, being able to remember, feeling safe that I've told and with what I've told.

• They were all good. Everyone listened, patient, took time, all tried to help. If they couldn't they find someone who would. Didn't directly say they'd tell perpetrator or force me to go to the cops. It was always my choice.

• Counsellors and psychologist were both listening, somewhere to come and offload. Don't feel victimised, the atmosphere is comfortable.

• The support. Having someone to believe me and finding practical ways to deal with what happened. Learning not to blame myself.

• They're pretty cool. They helped me. I had a lot to learn I guess. Even how to look after myself properly and I can do a few things myself.

• It made me feel more confident and made me believe in myself. Most of all that it wasn't my fault that I didn't do anything to deserve what he did. I enjoyed group. It was hard to talk in front of people but it was good.

• Positive experiences - Counsellor, Ipswich Women's Health Centre, Brisbane Rape and Incest Crisis Centre and Deaf Women's Service, doctor, - Acceptance of me and my experiences. There wasn't any judgement. There wasn't any time pressure, pressure to disclose, pressure to do anything. They didn't take control of anything. There was plenty of scope for reassurance and confirmation of my feelings - where I was at and what I was going through. They had experience in the area which reassured me to trust them. It was personal. It was people centred. It wasn't "a system".

• Ipswich Women Health Centre - group of people I was lucky enough to be with in survivors' group and the understanding counsellors. The continued friendship of the group has always been helpful.

Women clearly identified the basic components of an appropriate response and effective service as involving understanding, listening, going at their pace, being believed, feeling safe and being given choice.

Negative or bad experiences of the services utilized included the following:

• School counsellor brushed me off because nothing ever happened for me. Police didn't get my brother out and I thought that was unfair on his behalf. All sources of help that I went to were unsuccessful because nothing eventuated from it to get me out until I was 15.

• Psychiatric unit had no-one experienced in sexual assault to help.

• Child health worker made me feel inadequate as a parent. They made me feel bad and made me feel uncomfortable.
• Previous counsellor asked if I was pleasured by the experience!

• Housing people were not very helpful as my small wage was above their cut-off. One doctor was helpful but stitched me badly, needing surgery later, but did refer me to a sexual assault service.

• Setting off flashbacks. Mind you, I had 20 a day anyway. Didn't make much difference anyway I guess.

• Probably the only negative was early on, not being able to get in touch with people when I needed to.

• Haven't had any really.

• It's difficult to word. The clergy and the doctors were male, and I felt a sense of disdain, the impact of their words. I felt like they perpetuating it and with the doctor I felt like I was being assaulted all over again. The clergy, I felt like I was being punished again.

• At the beginning I felt very depressed, worse, when I left a session but that got better as it went on.

• Negative experiences - Counsellor, women's services, doctor. It's difficult to understand communication sometimes, primarily because of my hearing difficulties. It was only as my hearing got better that I was able to seek assistance from any of these groups. Prior to that I didn't feel I had any option to seek assistance.

• Negative experiences with police, courts and legal systems: Can I swear? Everything is just a system to them. It's a system that they never ever explain to you. For every step of the process, they are all cold. They work in dingy little offices that have hundreds of marks on the walls or holes that someone may have punched. Everything about their premises looks destructive, destroyed and broken. That makes you uncomfortable right from the start. It's like that at the police, at the court and when you meet the prosecutor. It's like that at every step. Everything is on facts. Everything always feels so pressured. You have to remember this and that; what you were thinking, what colour the floor was. It's like everyone in the system knows that but the police don't tell you that. When you go to court, they don't ask what you told the police. Everything is mismatched. Everything is based on irrelevant facts and what happens doesn't matter. It get lost. There is no support. Even if you bring your own support, you're bringing someone who doesn't understand the mismatch of the whole system. In the end they say "Well, that's just the legal system." It's a cop out.

• It's like when I was a kid. They didn't say "The more you tell us the more we can help make it stop." They didn't see that I was only 12. There was no explanation of why I was there. I felt I was the one in trouble. They didn't care that I was there from 11pm to 7am. Even then there was no. It was just awful. They just wanted to know what he did. They didn't want to know how I felt about it. It was almost like it was OK. They just wanted to know what he did and then "off you go." That night I had to go through a police medical as well. I'd never had an in-
ternal examination and they just did it. They stood around talking about me while I was still up on the examination bed. They made comments like "That girl is really messed up inside. She'll never have kids." They didn't talk to me, just about me while I was there. The only thing they said to me was come along and we'll do a medical. I didn't even know what a medical was until they started doing it. With police officers and the whole legal end of it, there is no connection a people side, to help or support. You give a statement but what do you do after that? The people there don't understand that when you give facts, it triggers a lot of other things. It's not just facts. There needs to be a people connection that's just not there. Even when you do get as many facts out that you can, it's not going to do anything. Even the people who are supposed to be on your side reduce the facts so they can bring it to something that can be convictable. So again it's brought to something that is secret again. The system keeps the secret like when rape is dropped and all that gets talked about is indecent assault. The perpetrator gets some kind of justification that what he's done is not all that bad. And the hardest thing about this is the people the legal system think that's fine and you have no right to get upset about that. The police and legal system have no time. You can't take your time, eg: "I've got finish my shift soon." "I'm tied up for a few weeks." They have no time to make things easier. Prosecutors are so busy you're lucky if she comes to court on time to say hello. They don't realise the extra stress this puts on us. They don't return phonecalls. They just want to hand a file on and get on with the next thing.

Women clearly identified the inadequacies of mainstream systems, including police, doctors and legal workers, in responding to their disclosures as being the lack of belief, lack of confidentiality, lack of respect, lack of concern for the child/woman, lack of willingness to assist with other referrals.

5.3 Impacts on Life as Adults

5.3.1 Impact of Childhood Sexual Violence on Relations with Family/ies

More than 73% respondents had contact with the family/ies with whom they lived when the violence happened.

The respondents gave the following descriptions of the impact of the sexual violence experienced as a child on their relationships with this family/these families:

- I have no relationship with them. As soon as I let the cat out of the bag, they basically wanted nothing to do with me.

- I don't think my brother knows about it but my sisters do. I get understanding from my elder sister but I don't get anything from my younger sister. She says "You could have got out of it." At ten years of age, how could I? I don't think she realises it was such an early age.

- With mum and dad - Mum gets upset when I talk about it because she blames herself. She doesn't get angry, just upset.

- I have no trust with these people. I still have a fear of being hurt.
• I don't have a relationship with them, I guess that's the impact.

• Destroyed - not my brother and sister but with my mum it's totally broken down, like a volcano. Hasn't just erupted, it's destroyed everything on the way down. If I didn't have a brother and sister, I probably wouldn't see my mum.

• While I have a very strong emotional bond with them on my part I feel the family relationship is one of control, putting me in my place, not wanting to know and minimising or ignoring the abuse. At the moment It's a very distant relationship.

• Tears the family apart emotionally. No-one knows how you are feeling. A lot of anger at everybody.

• I'm not close to my mother. As an adult, I've come to understand her but I'm not close to her at all. For a long time, I was angry that she couldn't give me support.

• Seeing my mother is not too good. I become a sad girl.

• It has made it very strained. I talk to my mother once a month but it's always hard. She still lives with him. I've got a really great relationship with both my sisters.

• Disastrous. It has put walls up between us. It is still something we cannot talk about. The relationships are extremely dysfunctional and often destructive.

It appears that most respondents continue to try to have some meaningful contact with their family/ies despite the strain. Why do women persist in trying to maintain strained relationships with family? Is it pertinent to query the social construction of 'family' as something to be gained and maintained at all costs? This social construction may reinforce the notion that "a bad family is better than none".

They appear to have better relationships with their siblings even though there is less contact with them. There is no mention of fathers. There are very negative responses to family interactions. These statements highlight how siblings (non-offenders) are a positive influence for women and how this may have been used against them as children.

A 1980 phone-in survey of women survivors (Women's House:27) reports effects on relationships with father include blame, hatred, estrangement, understanding, and closer relationship. This survey of women survivors (Women's House,1970:26-28) reports effects on relationships with other close family members including closer family ties, did not inform family of incest, strain, tension, and estrangement. This survey of women survivors reports effects on relationships with mother includes estrangement, blame, hatred, understanding, forgiveness, closer relationship. A similar phone-in survey of survivors (D'Arcy,1998) reports effects on family relationships including rejection, isolation, denial, deterioration, disbelief and family splits.

5.3.2 Impact of Childhood Sexual Violence on Relations with Children

Those respondents who are parents (65%) described their relationships with their children as follows:
Most (89%) have a good relationship with their children although they feel overprotective, paranoid about other people and lacking bonding. They desperately do not want the pattern repeated, give the children what they did not have as children, are loving towards children, and have not reported that they have abused or are abusing their children in any way.

There is a myth that abusers will abuse their children. Victims of sexual violence do not necessarily go on to perpetrate violence against those close to them. Women survivors appear to turn the experience of sexual violence back on themselves through self-harm and depression.

Survivors of childhood sexual violence may have difficulty setting limits and rational control strategies for young children and may become indulgent of their children, (Cole & Woolger, 1989). A phone-in survey of survivors (D'Arcy, 1998) reports effects on relationships with children including general concerns about their own parenting for 38% respondents. A 1980 phone-in survey of women survivors (Women's House:27) reports effects on relationships with own children include more open relationship, overprotective, difficulties in relating to them, adopted kids out, and concerned about child's sexuality.

For those respondents who are parents they felt the impact of the sexual violence on their relationships with their children as a combination of feeling overprotective and loving.
I get angry a lot. I'm overprotective. My partner says I "pamper or smother them with love".

I am going to be a complete opposite from what I came from - I'm not going to mess up their lives - I'm secretly making promises to this person - anyone who touches them is history.

I always have to be aware to not be so overprotective - to let him grow up and grow away.

Overall it's been a loving, protective relationship but there have been incidences where I feel I have abused them. For my part, it has probably prevented me from fully enjoying motherhood. I have been so over-conscious of my actions or behaviours, maybe the word is over-anxious. That I haven't really relaxed as a mother.

It's made me more determined to always check and ensure that what I'm doing is right. That my relationship with my kids is one that would encourage us to be as open as we can so that the same pattern doesn't repeat.

5.3.3 Impact of Childhood Sexual Violence on Relations with Sexual Partners

A recent phone-in survey of Victorian survivors (D'Arcy, 1998) reports effects on intimate relationships including problems with touch (63%), fear of intimacy (59%), fear of sex (51%), sexual problems (49%), isolation (40%), lack of sexual satisfaction (34%), impaired sexual arousal (33%), and guilt during sexual contact (30%).

In our study, the majority of respondents (80%) currently have a sexually intimate relationship. 10 of them with a man (66%), and 2 of them with a woman (13%), 3 of total living in (20%), 3 of total defacto (20%), 2 of total married (13%), 1 living separately (6%), 1 boyfriend (6%), 1 engaged (6%), and one casual (6%).

Their descriptions of these current relationships are as follows:

- Difficult. It's hard to trust anyone. My past constantly hounds me, so I try and make things perfect but I can't.

- We are extremely close.

- Amazing - I've found someone I can really trust. I feel really lucky at the moment because all my other relationships have been shit.

- Too good. It's really hard to describe. Unreal! I guess I now can't live without him. It's too good. He's grown on me.

- I think I need to clarify I'm still married. I feel that in a marriage there ought to be a sexual relationship but in the last four years, I have been unable to give that and nor do I desire resuming it with my husband.
• Fairly close but since I broke up with my husband I find it difficult to trust somebody. He tells me I'm a lot closer to him than I realise. I find it difficult to relax and believe it's too good to be true. I'm always looking for something to be wrong.

• Excellent. He's very understanding and we have a very easy going relationship.

• It is an intimate relationship but it is casual. I tend more to protect my independence and control.

Given that 80% respondents are in intimate relationships of which 66% are with men, this may challenge the myth that women who have experienced violence stay alone because they become 'man haters'.

85% respondents make links between childhood sexual violence and difficulties in their relationships.

Descriptions of the impact of the sexual violence on these relationships included:

• It took me a long time to be sexually comfortable with him. Sometimes I think I haven't yet reached it. I feel insecure. I feel abandoned almost because if P leaves me, that's the end of my family. It just feels like another family's failed because of me.

• Paranoid and mistrusting. Fear of unknown. Don't know what's going to happen in the next few years. Analytical because I don't want any more violent relationships.

• Sometimes I can't stand him touching me. At times, it tends to become very overpowering.

• Again I feel lucky to have found this person who is so amazingly patient and understanding, who knows me well enough to know my past, recognise my triggers and support me through these.

• It's a 24 hour job to make this work.

• I think I'm suspicious of motives sometimes and sometimes I'm not as honest as I'd like to be or she'd like me to be. I guess I'm very closed about some things and I feel very guilty about that.

• I didn't know how to care for my feelings. I gave the other person so much love and attention. This made me happy for a long time until my own needs began surfacing. I think I confused sex with love.

• I have flashbacks sometimes so that puts a bit of a strain on it.

• At the beginning it was hard to have sex with T. It was hard to be intimate in certain situations because of what my stepfather did. My stepfather used to take me into the shower so when T first tried to shower with me I freaked out. I didn't like to have my back to T when were sleeping and when he started sexual contact with me because that's the way my stepfather would do it.
• It's affected more my previous relationships in the sense that there was a high degree of sexual dysfunction and that made relationships difficult if not destroyed them.

Seven spoke of sexual difficulties and flashbacks during sex, three spoke of mistrust, two talked of having support from partners and two do not know how to care for their feelings, and feel like a failure.

62% respondents are in 'good' close relationships with 38% in 'poor' relationships. Even though the majority are in 'good' relationships there feel they are unworthy of having a 'good' relationship. This may be linked with poor self esteem. Sex and trust issues are mentioned. Dreams of the 'perfect' relationship are mentioned. There are expressed extremes of independence ranging from 'can't live without him' to a need to protect their independence and control.

These statements highlight the long-term impact on sexuality and intimacy, and the need for skills and information for workers to support women. The women expressed an obvious desire for intimate and fulfilling relationships.

When linked with the reported low rate of sexual promiscuity, and high rate of sexual desire, women appear to be seeking long-term, positive, trusting, honest and understanding relationships with others. As discussed later, all respondents reported difficulties with intimacy, being physically sexual, fear of sex (87%), discomfort during sex (94%) and distrust of sex (94%). It appears that women are wanting to be sexual (only 6% reported lack of sexual desire), but fears around the act of sex and intimacy are high. They are not actively seeking platonic relationships (as per below rate 94% difficulty with friendships) but they are hoping for and working for intimate sexual relationships over the long-term.

The women are seeking honest and understanding partners whom they can trust in an intimate way. It may be said that this is what every person wants but for women survivors, the risks to their emotional well-being are so much greater. They have more obstacles to overcome personally, as discussed below, with high rates of depression, lack of self-esteem, guilt and shame, and distrust of others.

5.3.4 Impact of Childhood Sexual Violence on Friendships

A recent phone-in survey of Victorian survivors (D'Arcy, 1998) reports effects on social relationships including distancing, distrust, withdrawal, sense of waiting for life to begin, fear of being close and fear of being out of control.

In our study, descriptions of the impact of the sexual violence on forming and maintaining past and current relationships with friends included:

• Sometimes when a friend finds out they treat me differently. Sometimes they don't want anything to do with me because they don't know how to deal with it. Some friends think they have some magic words to fix it and it doesn't.
The Health Impacts on Adult Women of Childhood Sexual Violence Before the Age of Twelve Years

- I believe that my circumstances are related to the abuse that I had. Some of my friends think it's too difficult to be my friend. They don't know what to say. So there's just one friend who sympathises and encourages me.

- I have very few friends, mainly because I find it hard to trust people coming into my house.

- A huge impact - friendships I have made in the more negative times of my life I no longer keep. It takes a long time, sometimes even years for me to trust new people and I tend to keep them at a distance.

- Well, I tell them honestly where I've come from and let them deal with it in their own way. Honesty's the best way. They may find out accidentally in another way.

- Any close and lasting friendships have been with people who have had a similar background and are therefore warm and understanding. In casual friendships, I don't let people close and I don't find it easy to form such friendships.

- When I was at school I used to get picked on. I didn't have many friends and kids can be cruel I guess. Because I'm shy I don't make many friends now.

- It's made it extremely difficult to make and maintain friends. As a child I never had friends. I always feel that there is something, this big dark secret, that you can't share. At the same time you just feel like it is written all over you like a freak anyway. You just feel so different. It takes longer to trust, to get to know people. A spin-off is that when you do put the effort in you end up with a really good friendship. So friendship is just casual.

Most respondents have had difficulty making friends or have never made friends. Concerns are that it is hard to trust people, they don't know what to say or do, they might be treated differently, they might be thought of as dirty, lack of understanding, and they might find out or triggers might occur. If they have friends it is with people of similar backgrounds.

The women commonly expressed feelings of being different in public worlds and their lack of feeling bonded. In effect, women have given up their public lives because of the overwhelming nature of these feelings.

5.3.5 Impact of Childhood Sexual Violence on Work Relationships

Descriptions of the impact of the sexual violence on relationships with people with whom they work or have worked (paid and unpaid work) included:

- I'm always sensitive - I'm very sensitive. I tend to stick to myself. I've never made a close relationship with a fellow worker.

- I think over the years if I'm having a bad day at work I haven't been able to say I was having a bad day. And there's been lots of them. It's not always been easy to put on a happy front. It's still not easy. Damned hard sometimes.
The Health Impacts on Adult Women of Childhood Sexual Violence Before the Age of Twelve Years

- I'm really sensitive to people who are abusive. I can pick them a mile off from past experience. So if there's someone like that then I refuse to get along with them unless I absolutely have to.

- It's hard if you're upset and they don't know. But just as difficult if they know. They don't understand child sexual abuse.

- The people at my work know a "pretend" me. I've hidden myself and my past. I put on a false facade every morning when I talk through the door which makes my relationships with these people feel false.

- I don't trust anyone in the work-like environment. I'm a darned good worker but I've gone through so much at work.

- I feel I was open to sexual harassment at work and while it feels wrong and you know it's wrong, you're somehow stuck. You can't speak out. In order to protect myself I often left work positions. In unpaid work, I tend to give, give, give and exhaust myself.

- People at work have had to help me more because I wouldn't speak out because I had no confidence because of the way I've been brought up.

- Previous employers - I never felt comfortable with them - men. Currently I work for two men and with two girls and it's a very close firm. We get on really well. I feel comfortable now if my bosses hug me if something good happens or pat me on the shoulder. I'm not paranoid.

Relationships with people in a work environment appear very difficult. Appears to be 100% negative experience with about 93% extreme difficulty with relationships in work environment. Women have told of their experiences of sexual harassment in the workplace which adds to their difficulties in working outside the home, and further complicates their fears resulting from childhood sexual violence.

**5.3.6 Impact of Childhood Sexual Violence on Relationships in General**

Relationships with their children for 89% respondents were positive. Relationships with intimate partners for 62% respondents were positive. Relationships with friends for 94% respondents were negative or difficult. Relationships with work colleagues for 87% respondents were negative or difficult.

Descriptions of the impact of the sexual violence on interactions with people in general included:

- I'm very cautious of who I associate with. I don't try to make it public record of what happened. I try to have a boundary. I don't like to have people too close. And if someone does happen to find out I'm scared of what they think of me or what I'm capable of. I don't trust anybody at all.

- I don't interact successfully. If I can help somebody I'm happy to but I can't ask for help because I always fear there's such a hidden agenda.
• I tend to be very stand-offish. I really find it hard to mix with people. I can talk to people on the phone but it's hard when it comes to one-to-one or face-to-face.

• I guess I'm always a bit guarded particularly with men. I think I'm a bit suspicious of all men really.

• It's made me very cautious, very cautious on the one had and then extremely vulnerable on the other hand.

• Confused with life. For someone who has been abused, I looked at things as if everything was bad, I was bad, I was a curse. I just grew up in a completely different world. I was present but not present.

• I'm very wary in mixed company. Around men. Especially if I'm on my own. If a man comes up and starts a conversation I feel very threatened. Like I have to be on my guard. I find it difficult to believe I can have a conversation with men without there being some sort of sexual connotation.

• I don't normally mix with people. If I can get out of it I will. It takes me a long time to trust people. Normally I feel scared, wondering why they are talking to me.

• So long as the interaction was not about me, it didn't have to be personal and I didn't have to relate. I have tended more towards not interacting. I didn't trust people. I always felt there was something wrong with me and they might find out so I kept my distance.

It appears that most respondents have ongoing difficulty relating to men in general.

Most respondents thought that people will think there is something wrong with them. Flashbacks make social association with people difficult.

Abuse affects interpersonal functioning, interfering with development of trust and intimacy, and producing feelings of isolation and alienation, (Bagley,1997:246).

SACSS (1990) reports that 32.3% women survivors of childhood sexual violence experience adult relationship problems.

Early learnt responses to the violence experienced as a child would inevitably be a lack of trust of people and an inability to understand or practice the unspoken rules of friendship. Friendships more than family relationships are built on trust, and if there is a decided distrust of people, there will be ongoing difficulties in forming friendships. If you have never had friends as a child, it is very hard to learn how to have friends when you are an adult.

Sexually abused children face a blow to their construction of the world as a safe enough environment and their developing sense of others as trustworthy, (Mullen and Fleming,1998:9).
More than 89% of respondents noted a positive relationship with their children, 62% noted a positive relationship with their intimate partners, 94% noted a negative relationship with friends and 87% noted a negative relationship with work colleagues. It appears that children, simply because they are not adults and therefore trustworthy, are no threats to women who have experienced childhood sexual violence.

### 5.3.7 Impact of Childhood Sexual Violence on Daily Decisions

There has been little attention paid to cognitive aspects of the impact of sexual abuse, such as the attitudes, beliefs and self-conceptions that develop as a result of the abuse and how people attempt to cope with the abuse, (Darlington, 1997:3).

The majority of respondents felt that their experiences of sexual violence as a child have an impact on their decisions about:

1. with whom they associate (100%),
2. their thinking (93%),
3. what is believed (87%),
4. what is worn (87%),
5. going out at night (87%),
6. type of self-care (80%),
7. with whom they live (80%),
8. what is read (80%),
9. where they live (75%),
10. types of entertainment (73%),
11. type of health care (73%),
12. future planning (67%),
13. their level of education (67%),
14. earning capacity (60%),
15. how they travel (60%),
16. what food is eaten (60%),
17. and types of exercise taken (60%).
More than 80% respondents considered that their experiences of childhood sexual violence had a major impact on other areas of their daily life including the following comments:

- Majority of abuse happened in a mobile home and my partner wants to get a mobile home when the kids grow up. I want nothing to do with one. I don't even like caravans. I lived on hamburgers, sausages, schnitzels and they are the last things you'll find in my freezer. My mother had us at the doctor for any scratch. I'm always having to ask my partner for reassurance if something is serious enough to go to the doctor. I always have to be reassured that what I'm thinking or my actions are right.

- Some days I'm reluctant to answer the phone or open the door. I find it difficult to walk into a room with other people. I can't take movement behind me. I can't sit and have someone behind me.

- People I associate with especially babysitters for the child.

- Most of my life habits were formed at such a crucial age. I grew up with violence and it changed how I grew. I have dissociation and this affects every decision I make.

- It's with you 24 hours a day, no matter what you do or say. I have to get used to what has happened but not let it stop my life otherwise I'll be a miserable person and have no life. And it will be me missing out and they've won.

- Sleep patterns. My capacity to believe in my sanity, the ability to express myself creatively, verbally, emotionally.

- You think of safety first, ie: house - look at the safety of it. To feel safe, I have to be in control of any situation.

- With my children, it affects how I am with them, eg: the children have gone to their father's this weekend and I am going to spend the whole weekend worrying about them.

- It affects everything really.

For about 50% respondents, their experiences of childhood sexual assault has an impact on the type of housing chosen, transport used, and type of work performed.

Childhood sexual violence affects the whole person in thought, behaviour, feelings and daily living. The holistic impact on women requires a holistic response facilitated by a social view of health and well-being which is supported by a feminist counselling framework. Health is about the whole person - mind, body, soul, social. People who have not been subjected to childhood sexual violence may take these aspects of daily living for granted.
5.4 Health Impacts

5.4.1 Definitions of Health

Health is important, a basic need for life. Impaired health reduces their ability to be effective social beings. Well being includes health, social wellbeing, economic wellbeing, environmental wellbeing, life satisfaction, spiritual wellbeing and other valued characteristics, (AIHW,1996:1).

Western medicine offers a powerful framework for describing and classifying much of the sickness afflicting individuals. Using this "biomedical model" ill health is treated as the mechanical failure of some part of one or more of these systems and the medical task is to repair the damage. Within this model, the complex relationship between mind and body is rarely explored and individuals are separated from both the social and cultural contexts of their lives, (Doyal,1995:15).

All respondents viewed being healthy as a whole state of well-being, physical and mental with no single focus on physical illness.

Definitions of health were sought and some of the perceptions follow.

Being healthy means:

- Well nurtured, well loved, nutritionally wise, being at ease with yourself and with your conscience. Being comfortable and confident in what you do and above all being happy. Able to cope with day to day living and all the unexpected things that crop up.

- It's rather broad. Being able to live life and live it to its fullest.

- Being happy. Healthy emotionally and physically.

- Not feeling sick physically or mentally, feeling good about yourself.

- Feeling alive, feeling happy with yourself, having steady energy patterns, being able to cope with normal stress and normal illness, being able to care for your body, feeling well.

- Well fed and well balanced and being able to live without heaps of pill, in your mind and body.

- I relate being health to how you think and feel about yourself and your state of mind relating to this.

It is interesting to note an increase in detail about conditions and frequency in the sealed schedule. As suspected, conditions which were not highlighted in the one-on-one interview were revealed in the sealed schedule which provided the respondent with anonymity and privacy.
5.4.2 Prevalence of Health Conditions in the General Population

The most common long-term conditions in Australia are sight disorders, arthritis, hayfever, asthma, hypertension, mental disorders, (ABS, 1998c:3). The prevalence of mental disorders in Australian with one in five Australians or 18% at some time during their lives, (ABS, 1997). The most common recent illness conditions experienced by women in Australia are headache (15%), arthritis (8.5%), hypertension (8.3%), and asthma (6.5%), (ABS, 1998a:1).

In 1998, 83.6% of Australian women over 15 years reported good to excellent health, (ABS, 1998b).

Apart from reproductive health problems, the main reason that women use health services more than men is for a lack of physical and emotional well-being which is translated into descriptions of symptoms such as headaches, tiredness, depression, sleeplessness and so on. (Kane, 1991:26).

Queensland has recorded self inflicted injuries by women as being 54% of the total, by drug poisoning, cutting or piercing. Self-harm constitutes 25% all injury, (QISU, 1998). It is pertinent to posit whether registers of injury collect information about the reasons behind self-harm.

5.4.3 Links between Childhood Sexual Violence and Adult Illness Experienced by Respondents

It is noteworthy that there is an increase in detail about conditions and frequency in the sealed schedule. As suspected, conditions which were not highlighted in the one-on-one interview were revealed in the sealed schedule which provided the respondent with anonymity and privacy. There is a significant difference in the details and extent of impact between responses to the interview schedule and the sealed schedules.

For further information about types of conditions reported in the interview schedule and age of onset, please refer to Attachment 4.

For survey template of sealed schedule questions for women, please refer to Attachment 5.

For full details of responses to these questions of sealed schedule, please refer to Attachment 3.

Research has consistently demonstrated that there are significant negative psychosocial consequences for adults who have been sexually abused as children, such as higher rates of substance abuse and disturbed interpersonal relationships, (Trief, 1996:599).

When compared with current Australian averages for illness conditions in women, it appears there is a significantly high rate of all major conditions being experienced simultaneously by women who were respondents to this research.

Women who have been sexually abused as children complain of significantly more physical problems including chronic headaches, muscle tension and pelvic pain when compared with women who have not been abused as children, (Briere and Runtz, 1987).
When such strong and negative feelings are repressed, the pain must manifest elsewhere. Physical complaints are often the only or most legitimate expression of the pain that women may allow themselves to feel. (SACSS, 1990:2).

In our surveys, all respondents have experienced physical or psychological ill-health.

Most respondents recorded the frequency of conditions as being chronic, current, or recurrent.

The most highly rated categories included self-harm, eating issues, respiratory, psychological, skeletal, emotional, gynaecological, urological, hormonal, and breast.

Depression, anxiety, psychosomatic symptoms, compulsive and obsessive disorders, low self-esteem, eating problems, sexual dysfunction and post-traumatic stress disorder (PTSD) are all common to victims of partner violence. Victims of violence are likely to develop behaviours that are self-injurious such as substance abuse and smoking. Violence has also been associated with greater sexual risk-taking among adolescents, and the development of sexual problems in adulthood. Women with a history of sexual assault were nearly twice as likely to have sought mental health care than women who had not been sexually assaulted, (WHO, 1996:2-3).

Psychological or Emotional Conditions

Under the subcategory of psychological or emotional conditions in the sealed schedule, DSMIII-defined psychiatric conditions were included. 100% experienced dissociation, feeling crazy, disturbing memories and stress.

A relationship may exist between having a history of abuse and the tendency to use dissociation as a coping mechanism. Dissociative mechanisms such as derealization, depersonalization, multiple personality, develop to protect the woman from the painful, traumatic memories and that the [woman] with chronic pelvic pain may experience pain as a partial memory of the abuse without being consciously aware of the full extent of the memory. During the abuse, the abused child learns to disconnect from the sensations of her body, to cope with the overwhelming physical and emotional pain by not allowing herself to really feel it. However, the defences of the child are often inappropriate for and detrimental to, the adult, (Trief, 1996:600-601).

In the sealed section, 94% experienced depression (53% in interview beginning as early as 12 years of age), 94% experienced phobias, 87% experienced agrophobia (7% in interview beginning as early as 8 years), 47% experienced fear of spiders and insects, and 34% experienced obsessive-compulsive disorder. In the interview, sleeping disorders are experienced by 20% respondents as early as 8 years of age, flashbacks for 14% respondents as early as 7 years of age, dissociation for 14% respondents as early as 5 years of age, post traumatic stress disorder for 14% respondents as early as can be remembered (less than 6 years of age), memory loss for 7% respondents after the assault, ADD for 7% respondents as early as 8 years of age, and anxiety attacks for 7% respondents as early as 12 years.
I have great problems at the moment of leaving the safety of my home and even when I am at home I need to have all the doors locked and security doors also locked. Windows by choice would not be kept wide open but the kids need to have a sense of space, air and freedom. At night I cannot go to bed or get to sleep until every door has been checked or rechecked to see if it is locked or not, this can go on sometimes for up to 5 hours after my husband has gone to sleep.

In the interview, eating disorders is experienced by 20% respondents beginning as early as 14 years of age. Waller (1994) reports that many women attending an eating disorders clinic reported childhood sexual assault. Laws (1993) reports that research links childhood sexual abuse with bulimic symptoms and eating disorders. Eating disorders are acknowledged by current feminist practitioners as a means of women or girls seizing control over themselves through their bodies, where that is the only control they have, (ISIS,1998).

I now eat because I have to not because I'm hungry.

In the interview, suicidal thoughts are experienced by 14% respondents as early as 7 years of age, and self harming for 14% respondents as early as 17 years of age.

In adult life, women who have been sexually abused as children report more mental health problems than those who have not had such experiences, especially depression and drug and alcohol abuse. (Doyal,1995:73).

There is now an established body of knowledge clearly linking a history of childhood sexual abuse with higher rates in adult life of depressive symptoms, anxiety symptoms, substance abuse disorders, eating disorders and post-traumatic stress disorders, (Mullen and Fleming,1998:10).

The 1987 DSM-III classification system recognised psychological disorder as a direct result of stressful events and entitled it Post Traumatic Stress Disorder or PTSD. PTSD includes rape or sexual assault. Two levels of primary symptoms are repeated experience of trauma (intrusive thoughts, emotions, recurrent nightmares) and psychic numbing or reduced responsiveness to environment. PTSD also includes additional experiences of at least two or more of these:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response
Most women who have survived childhood sexual violence have low self-esteem, depression, physical complaints (headaches, stomach ailments, skin disorders), self-destructive behaviours, relationship problems, dissociation from feelings, sexual problems, and nightmares, (SACSS, 1990).

Allison (1993:152-7) reports that some long-term reactions to childhood sexual violence in women include phobias, disturbances in general functioning such as eating or sleeping, and sexual problems.

A recent phone-in survey of Victorian survivors (D'Arcy, 1998) reports emotional effects including low self-esteem, anger and rage, depression, guilt, sense of vulnerability, confusion, sadness and grief, flashbacks, sense of helplessness, nightmares, generalised anxiety, emotional numbness, fear of men, panic attacks, dissociation, suicidal attempts, out of body experiences, fear of offending and self-mutilation.

**Self-Harm**

In our survey, under the self-harm subcategory, it is noted that 80% hurt themselves which included slashing (47%), scratching (60%), and suicide attempts (60%).

> Quite often I want to hurt myself. It usually stays in my thoughts but it's like a time bomb. The more often I get down the more often I think of better ways to get rid of myself to stop the way I feel. One day it may come to me. That's how I feel.

> It was diagnosed as attention seeking behaviour, so was made to feel even more guilty about what I had done.

Victims of sexual violence are likely to have symptoms of depression, anxiety, somatization, obsessive compulsive disorder and paranoia. Sexually abused girls are three times more likely to grow up depressed than other children, they are more likely to do deliberate physical harm to themselves, more likely to have sexual difficulties as adults and more likely to abuse drugs. According to WHO, in view of the abuse to which many girls and women are subjected, depression and anxiety are 'a totally understandable and realistic reaction'. (WHO, 1994:2).

Alcohol, drug abuse and heavy smoking is linked to childhood sexual violence, (Springs & Friedrich, 1992).

Briere and Runtz (1986) reported a survey of 195 women attending crisis counselling in Canada. The mean age is 17. There was a comparison between two groups of women, being those who were abused and women who were non-abused. Abuse started at 8 and continued to 14 with a mean average of two perpetrators. Oral, anal or vaginal intercourse occurred in 77% victims, 56% reported concomitant physical abuse and 61% experienced intrafamilial abuse. Previous suicide attempts were more common in victims, with first suicide attempt usually before 14 years of age and involving more than one attempt. Victims experienced massive loss of self-esteem and blamed themselves for abuse. Self-blame can motivate self-destructiveness and powerlessness.
In the minds of these researchers, there is an underutilisation of feminist analysis in the research of youth suicide including linking suicidality to childhood sexual violence. The strong association with adolescent suicidality suggests that all suicidal children and adolescents should be assessed for a history of sexual abuse, and that abused children in treatment should be monitored for suicidal thoughts, (Bagley, 1997:247). To date, there is little funding support for child survivors of sexual violence, and a great deal of recent funding support to suicide prevention. Suicide prevention work focuses on young men and look at the immediacy of prevention rather than asking the young people why they are attempting suicide.

We put energy into pulling young people off bridges, but not into asking why they’re there in the first place, (Sewell, 1998:22).

Gynaecological Conditions

Under the gynaecological conditions subcategory in the sealed schedule, 80% reported painful menstrual periods and PMT, 74% reported heavy periods, 67% reported irregular periods, and 60% reported pelvic pain.

This pelvic pain is all gone now as I have had a full hysterectomy.

Wouldn’t know about gynaecological conditions because I haven’t had a pap smear.

Have had hysterectomy, removed womb and ovaries due to constant bleeding which could not be controlled even after many curettes.

Fertility and Breast Conditions

Under the subcategory of fertility, 20% reported difficulties with pregnancies and with fertility. Under the subcategory of breast conditions, 47% reported mastitis (7% in the interview as early as 16 years of age) and breast cancer for 7% respondents as early as 29 years.

Laws (1993) reports that exemplary studies link childhood sexual abuse to bowel disorders, pelvic pain, and lifetime surgeries. Moeller et al (1993) reports that pelvic and genital problems is noted as 2.5 times higher for the group who experienced childhood sexual assault than for the control group. Springs & Friedrich (1992) reports that childhood sexual violence is seen as a contributory factor in breast problems. Walker et al (1998) discusses a study of 25 women with history of chronic pelvic pain of at least three months’ duration taken from hospital laparascopy surgery. More pain sufferers 64% experienced sexual abuse up to age of 14 than the women in the control group 23%. Childhood sexual abuse is associated with a ten-fold increase in chronic pelvic pain, (Walker & Stenchever, 1993).

In the interview, the following gynaecological conditions were reported:

1. Prolapse womb for 20% respondents as early as 25 years of age.

2. Miscarriage, abortion, pregnancy difficulties for 14% respondents as early as 14 years of age.
3. Endometriosis for 14% respondents as early as 12 years of age.
4. Pelvic pain for 14% respondents as early as can be remembered.
5. Ovarian cancer for 7% respondents as early as 30 years of age.
6. Erosion of cervix for 7% respondents as early as 18 years of age.
7. Pelvic inflammatory disorder for 7% respondents as early as 31.

If women are unable to self-care, especially with gynaecological conditions, their risk of preventable and fatal diseases such as cervical cancer is significantly increased.

**Digestive Disorders**

Under the digestive disorders subcategory in the sealed schedule, it is noted that 67% reported eating disorders including bulimia (34%), and anorexia (47%). This subcategory also included digestive complaints including irritable bowel syndrome (27%), nausea (60%), ulcers (34%), and prolapse of anus (7%).


In the interview schedule, digestive disorders were listed as below:

- Oesophagitis for 7% respondents as early as 10.
- Anus prolapse as early as five years of age.
- Gastric reflux for 7% respondents as early as 16 years and ongoing.
- Lump in throat for 7% respondents as early as 30 years.
- Nausea for 27% respondents as early as can be remembered.
- Appendicitis for 7% respondents as early as 12 years of age.
- Stomach ulcers, burning for 14% respondents as early as 12 years.

Scarinci et al (1994) report a study of 50 women patients with gastrointestinal disorders. The majority (68%) of women reported sexual abuse and 25% reported both sexual and physical abuse. The abused women were significantly more likely to report tobacco use, frequent headaches, back pain, joint pain, pelvic pain. They had lower pain thresholds and heightened vigilance for symptoms.
They reported an increased use of medical systems, seeking relief which cannot be provided or using coping strategies like smoking.

The Scarini study poses a few questions in the minds of these researchers. Most diagnoses of gastrointestinal disorders involve the use of invasive tools such as endoscopes. If women have experienced oral rape, they may avoid such procedures at all costs, and therefore, may leave seeking treatment until their conditions are advanced.

**Respiratory Conditions**

Under the respiratory conditions subcategory, chest infections constituted 80%, 67% reported asthma in the sealed schedule and 34% in the interview being as early as can be remembered, pneumonia for 7% respondents as early as 11 years, sinus problems for 14% respondents as early as 8 years of age, and bronchitis for 14% respondents as early as 12 years. The current ABS (1996) statistics peg asthma rates at 6.5% for the general population.

The Lechner et al (1993) study of 523 women with a history of childhood sexual abuse reported that they two times more respiratory disorders. Springs & Friedrich (1992) reports that childhood sexual violence is seen as a contributory factor in asthma.

**Infectious Conditions**

Under the infectious conditions subcategory, 87% reported influenza, 80% reported infectious diseases like measles, 54% reported glandular fever, and 47% reported sexually transmitted infections.

**Endocrine System Conditions**

Under the subcategory of endocrine system conditions, 74% reported hormonal imbalances. This appears a rather high percentage. Some current alternative health practice which is slowly being recognised by medical practice, notes the link between emotions and hormones, between how we feel under stress and how our immune system responds. In the interview, 7% respondents reported hormonal or endocrine problems as early as 15 years.

**Circulatory Conditions**

Under circulatory conditions in the interview, palpitating heart is reported for 20% respondents as early as 10 years of age and stroke for 14% respondents as early as 19 years.

**Urinary Conditions**

Under the subcategory of urinary conditions, 67% reported urinary tract infections, 47% reported bladder conditions (and 14% in the interview), and 47% reported cystitis. In the sealed schedule, 46% reported kidney infections and in the interview 14% as early as under 12 years of age.

**Skin Conditions**
Under the subcategory of skin conditions, 47% reported scarring, skin cancer for 14% respondents as early as 29 years, and urticaria for 7% respondents as early as 6 years.

Springs and Friedrich (1992) reports that childhood sexual violence is seen as a contributory factor in vocal cord dysfunction.

**Musculoskeletal Conditions**

Under the musculoskeletal conditions subcategory in the sealed schedule, 100% reported aches and pains, 74% reported muscle spasms, 60% reported posture problems, 54% reported arthritis (7% in interview as early as 16 years of age). Other conditions noted in the interview included back disorders for 7% respondents as early as teenage years and sciatic nerves for 7% respondents as early as 24 years.

Moeller et al (1993) reports that musculoskeletal pain and other chronic pain such as headaches is two times greater in the childhood sexual assault group when compared to the control group.

In the sealed schedule, surprisingly, 54% reported unattended fractures as children which were not diagnosed for between months to years later.

> My left arm was left broken for six weeks before I was taken to a doctor who was told that I had refused help. How does a seven year old do that? I was told to shut up, there was nothing wrong with me. I have not been able to write very well with that hand and arm since then.

With the high rate of injuries in childhood reported here, it is pertinent to ask why these were not identified by teachers or school nurses and others in the education system. It is imperative that such professionals receive training and skill development in this area to genuinely fulfill their duty of care of protecting children from violence.

**Ear, Nose, Throat Conditions**

In the interview schedule other conditions noted for ear, nose and throat subcategory include deafness for 7% respondents as early as 2 years, ear infections for 7% respondents as early as can be remembered, no sense of smell for 7% respondents as early as can be remembered, and balance difficulties for 7% respondents from very young.

**Sexual Relations**

Under the subcategory of sexual relations in the sealed schedule, 100% reported intimacy difficulties, difficulties with being physically sexual, discomfort during sexual acts, and distrust of sex, and 74% reported difficulty with expressing sexuality. It is interesting to note that only 7% reported a lack of sexual desire.

> How after being abused from a young age and not having anybody to protect you from it or stop it, do you express your opinions vocally? I have three children who I love with all that I am but cannot help disliking the act that gave them life.
In the interview schedule, intimacy issues are reported by 7% respondents. High risk sexual problems reported for 7% respondents as early as 15 years.

With 100% reporting difficulties with intimacy, and a low rate of high risk sexual behaviours, there may be a case against the myth that women who have been raped are promiscuous. There is also a case to be made of the high need for women who have experienced violence to receive support on redeveloping intimacy in their lives so that their relationships are strengthened.

SACSS reports (1990) that 24.2% women survivors experience sexuality problems and self image problems. Walker et al (1998) reports that more victims 74% suffered from adult sexual dysfunction than non-abused women 35%.

**Nervous Conditions**

Under the subcategory of nervous conditions in the sealed schedule, 100% reported sleeplessness, 100% reported headaches (migraines or headaches for 40% respondents as early as 10 years of age in the interview), 100% reported dizziness, 80% reported numbness, 80% reported tiredness (14% in interview), 80% reported vagueness, 74% reported strange body sensations, and 67% reported Tinnitus or ringing in the ears and in the interview, 14% reported this as early as 2 years of age.

**Ill-Defined Conditions**

Under the ill-defined category, 100% reported anger problems, self-esteem lack, body image problems, guilt or shame, nightmares, flashbacks, poor emotional feelings, relationship difficulties and distrust of others. These percentages are significantly high and it is suggested that comparison be made with women who have not experienced childhood sexual violence before the age of 12 years.

Moeller et al (1993) reports that sleep disturbance and fatigue are reported more by survivors of childhood sexual abuse than for the control group. Allison (1993:158) reports that women survivors experience changes in life-style such as showering a lot or re-checking doors.

A 1980 phone-in survey of women survivors (Women's House:25) reports long term emotional effects on victims as 39% guilt shame, 33% sexual problems, 27% distrust fear of men, 16% bitterness, 13% sexual problems, 12% failed marriage, 7% sought psychiatric help, and 4% unable to form stable sexual relationships.

Ellenson (1985,525-530) explores a mental status examination (MSE) which reveals a set of symptoms often associated with a history of incest including:

1. Thought content disturbances - recurring nightmares with catastrophes endangering woman, family or both; children being harmed; woman or family being chased by attackers; scenes of death or violence.
2. When awake, recurring unsettling obsessions like impulses to hurt their child or feeling their child is in danger; recurring dissociation from one’s past; sensations that their child is a stranger; persistent phobias of being alone or in physical danger.

3. Perceptual disturbances like recurring illusions of a malevolent entity or recurring auditory, tactile or visual hallucinations like shadowy figures in the home or feeling physically pushed.

Ellenson (1985) reports that survivors rarely reveal these ideas for fear of being thought crazy.

Under the ill-defined category in the sealed schedule, 87% reported weight problems, 80% reported addictions (7% alcoholism in interview), 74% reported smoking problems (7% in interview as a significant problem), 87% reported difficulties with feeling connected with people, and 67% reported parenting difficulties (27% in interview).

I often have problems directing my anger, it can be the smallest thing that can set me off but it is always directed to my husband. Never to the person it should be, my mother. The small hours of the night are the hardest to cope with. All the feelings of shame, guilt and all the ”whys” in the world seem to haunt me. I tend to be very judgemental of people and not terribly trusting of their feelings for me or my children.

I am too scared to be angry. I never go on the scales - too scared.

5.4.4 Comments on Conditions

Many conditions began early in life. Multiple health conditions are recorded for each woman and included a broad range of conditions. With such a small sample, it appears there is a significant number of complaints.

Long-term effects of child sexual abuse include depression, anxiety, low self-esteem, guilt and dissociation, sexual problems, self-destructive behaviour, substance abuse, vulnerability to re-victimisation, in that order of being commonly reported, repressed memory, flashbacks, disturbances in experience of self, (Ussher & Dewberry, 1995:5-9).

A history of childhood sexual abuse does not however mean that a woman will necessarily experience some or all of these symptoms. While common patterns can be identified in the impact of and recovery from childhood sexual abuse, people with a history of childhood sexual abuse are individuals whose backgrounds and current life situations differ,(Ussher & Dewberry, 1995:12).

There is a significant difference in the details and extent of impact between responses to the interview schedule and the sealed schedules. This may well be attributable to the extent of minimisation of women disclosing or seeking medical assistance. If women are disclosing a certain amount in the safety of a counselling room and withholding a certain amount, what are they then choosing not to disclose to doctors and mainstream services?
With a significant proportion of reportage of emotional conditions such as self-harm, dissociation and depression in the sealed schedule, was the privacy of this schedule conducive to women acknowledging what are seen as non-physical symptoms of assault? This may well challenge the notion that there is no long-term impact from childhood sexual violence, and that women lie or overreact or exaggerate their symptoms or life history. It appears that women underreport and actively minimise their symptoms and life history. Medical practitioners genuinely need to commit to active understanding of these issues, developing an appropriate process of identifying women at risk, and developing protocols and procedures for working with women who disclose childhood sexual violence.

5.4.5 Treatments Sought

For further information about treatments sought for conditions and negative or positive results from those treatments, please refer to Attachment 6. For details of general comments about treatment options, please refer to Attachment 7.

Unfortunately, doctors may focus mainly on symptom relief. Although symptoms remit, patients represent, often with different and varied symptoms, thus repeating a vicious cycle, (Mammen & Olsen,1996:522).

88% respondents sought help from GPs or specialist medical practitioners, 48% of which reported negative results, and 32% of which reported positive results.

Physical, emotional and behavioural sequelae have been reported in adults with childhood sexual abuse. Such patients may seek repeated appointments for single or multiple symptoms, and may attract the label of neurotic or attention seeking. International reports show significant association between childhood abuse and several problems commonly encountered in general practice settings, (Mammen & Olsen,1996:518).

52% respondents sought help from alternative practitioners, 69% of which reported positive results, and 14% of which reported negative responses.

It appears that survivors of childhood sexual assault disclose it more readily to allied health professionals than to doctors, (Mammen & Olsen,1996:518).

From the direct interview schedules, most women reported depression, eating disorders, self-harming, sleeping problems, anxiety and panic attacks. They sought help from traditional medical practitioners such as psychiatrists, and the majority reported negative results. They believed that medication responses were not the solutions they were seeking for emotional issues.

*I find medication is not the answer. It's only talking it out with an understanding person and learning to believe in yourself to have confidence.*

In contrast, the majority of respondents sought help from alternative or non-medical practitioners such as counsellors, herbalists, naturopaths, with the majority reporting positive results.
Understanding it as a natural consequence of abuse, I'm learning ways to cope with it.

In the sealed schedules, respondents reported much higher percentages of emotional and psychological issues. This may be attributable to the following reasons. These problems are not medically quantifiable as 'illness' such as bacterial chest infections. Women may not mention these issues to their medical practitioner if they are seeking medical help for something defined as medical, such as bronchitis. When confronted with these issues in list form as in the sealed schedule, they will naturally give them more credence. With high rates of depression, eating disorders, self-harming, agoraphobia, phobias, feeling crazy, aches and pains, sleeplessness, anger, lack of self-esteem and guilt or shame, it appears that these conditions are experienced as an entire package of being unwell. Women appear to become trapped for some time in this cycle of unwellness, with depression feeding eating disorders and vice versa.

Low energy levels so you always feel that you're pushing yourself, enjoying life but at the same time missing it. Feeling like a hypochondriac because you always have vague symptoms, never feeling on top of things, no matter how much you look after yourself with diet, exercise and sleep.

Medical practitioners appear to be in need of advice and support on how to treat women as a whole person, not just a list of symptoms, and to work actively with non-medical services which are achieving long-lasting positive changes in women.

5.4.6 Service Implications

General practitioners and other health professionals need to be aware that child sexual abuse is common, and that it leads to an increased rate of a wide range of problems in adult life, (Romans,1997:59).

Laws (1993) recommends that doctors should routinely ask questions about prior abuse of patients who present with these symptoms.

Some adult survivors who present to their doctors seeking help primarily for childhood sexual abuse are acutely distressed, anxious, depressed, suicidal and/or experiencing flashbacks. Many in this group fulfil diagnostic criterion for post traumatic stress disorder (PTSD) syndrome. Thus a wide variety of features may alert the doctor to the possibility of childhood abuse, (Mammen & Olsen,1996:519).

A female doctor (Radomsky,1995) conducted survey of women presenting to her medical practice. She describes the transformation of her clinical practice as she began routinely to discuss abuse histories with patients.

It is important that the diversionary debate about false memory and recovered memory, fuelled by adversarial court cases, does not deflect practitioners from accepting what patients report, (Romans,1997:60).
Mammen and Olsen (1996) discuss the likelihood of general practitioners having women survivors of childhood sexual abuse in their practices and offers sound advice about learning to recognise the signs. They acknowledge that survivors of abuse are resilient but remind practitioners of their duty of care to prevent self-harm and chronicity by addressing the core reason for the woman attending a clinic.

The foremost principle is that the survivor must feel heard. The doctor's listening should be non-judgmental, gentle and sympathetic. Professionals must not be perceived to minimise or negate the experience of abuse. The doctor should be prepared to cope with intense emotions, and sensitively assess the patient's capacity to cope at each session. Symptoms of anxiety, or depression may occur. However, it would be inadvisable to replace psychological work with pharmacological methods, (Mammen & Olsen,1996:519-521).

Walker et al (1998) raises the possibility that sexual abuse of children results in demands on physical as well as psychological medical care when victims become adults, and suggests that not addressing the history of sexual abuse underlying certain symptoms may result in faulty diagnoses and treatment.

Another negative is the financial cost of psychiatrists. It's a lot. There's been times in the four years when I've had to cut back groceries and other basic budgets just to afford to pay for a visit.

Women on such low incomes and with limited work opportunities require free, accessible, confidential and long-term support services where they can keep the one counsellor over the years necessary for their recovery.

Chapter 6.0 Conclusions

Is there a causal link between the health profiles of women interviewed and their experiences of sexual violence as children under the age of twelve? Can we make causal links between these factors and our propositions which framed the research methodology?

The first phase of modern research into child sexual abuse was not triggered by observations on child victims, but by the self-disclosures of adults who had the courage to publicly give witness to their abuse as children,(Mullen and Fleming,1998:2).

Strictly speaking, and using the methodology described, we cannot make firm causal links. Without a methodology which incorporates control cohorts and a longitudinal approach, it is difficult to draw firm causalities.

Even among sexual abuse survivors who experience negative long-term consequences, it is impossible to say absolutely whether the negative consequences were caused by the sexual abuse or whether both may actually be a function of some third variable, such as dysfunctional family dynamics, (Darlington,1997:4).
We can however, make observations and propositions about the possible links between types of ill-health experienced as adult women and their experiences of sexual violence as children under the age of twelve years. We can also attribute determinants to health conditions for consideration by professionals who are consulted by women in their work.

It is observed from the findings that:

1. The most significant perpetrator is known to the child. The most significant perpetrator of the violence was the biological father and others including stepfather, brother, uncle, neighbour, mother and a combination. In all cases the perpetrators were well-known to the child. No strangers perpetrated violence on the children. This debunks the myth of 'stranger danger' which is focussed on by the media and social commentators. All perpetrators were in positions of care and trust of the child.

2. Sexual violence happens more than once.

3. Survivors of childhood sexual violence will experience difficulties with intimacy and physical contact despite their desire to be intimate.

4. Survivors put a great deal of effort in making their close relationships with partners and children work.

5. Survivors of childhood sexual violence will experience difficulties with friendships and work relations.

6. Survivors of childhood sexual violence attempt to maintain relations with their families even though this involves considerable strain.

7. Despite the extent, chronicity and range of illness reported, women did not focus on illness. They are not 'hypochondriacs' and on the contrary often underrated the seriousness of their conditions.

8. Women pay a third of their income on rent or mortgage. Survivors do not go out often because they are fearful of crowds and socialising.

9. Low rates of sexually transmitted infections and high risk sexual behaviours challenge the myth of sexual promiscuity by survivors of sexual abuse.

10. There were significant differences between the responses to interview schedules and to sealed schedules, highlighting the necessity of well-contrived processes to provide survivors with opportunities to discuss the full extent of health impacts on their lives.

11. The average time between first and second telling about their childhood sexual violence was 17 years.

12. Children may be taken to traditional services like doctors and hospitals for persistent illness or injury. Childhood sexual violence is not being picked up by these professionals. There is
an assumption by professionals that if the parent is seen as 'caring' (by bringing the child along for medical help), a secondary assumption is then that childhood sexual violence could not possibly be occurring. Children are required to disclose in the presence of adults who may be perpetrators of violence. Children are taken into alienating medical and legal systems for determination of their truthfulness. The onus is on the medical and nurse practitioners within their duty of care to be more vigilant.

13. No-one questions a child having good memories but if the memory involves childhood sexual violence, suddenly there is disbelief as evinced by the persistent rejection of 'repressed memory syndrome'.

14. With increased likelihood of working with men in a work environment (increased fear of sexual harassment) and the traditionally male dominated routes for redress through police and doctors, the reported positive results from alternative services may be attributable to that sector being more frequently female dominated.

Questions Raised

Questions that are raised by the findings of this research follow:

1. Is the age of abuse a contributing factor to long term health impacts?

2. What determines the significance of the perpetrator? Is it the age of the victim, level of injury, gender of perpetrator or age of perpetrator, closeness in family relations, nature of being family or non-family, actual type of violence perpetrated, or position of trust held by perpetrator and then betrayed?

3. If majority of respondents have achieved positive results from using women's services, why are there persistent funding problems for these community services? Why is so much going into hospitals when preventative services struggle for finances?

4. With mothers as survivors of childhood sexual violence being overprotective of their children, what impact does this have on their children?

5. With the majority of respondents being assaulted before the age of 6 years, they must have been displaying behaviours to indicate this violence. Why did no-one appear to pick up on this?

6. With the majority of respondents having persistent illnesses as child, including unattended fractures, why was no-one questioning this? If it were questioned, why was no action taken? What does it mean for our current 'interventions' on suspected childhood sexual violence.

7. It is important to note that services contacted are for adult use and not children focussed. How can children find out about services which can help them at the time?
8. How do women relax on such low incomes? There is a new push in our society to relax, to reduce stress, and to be healthy individuals. Health costs money.

9. Is there a link between low education levels and the childhood sexual violence?

10. Current strenuous independent study financial support systems require applicants to reveal all the reasons why they need the money to study and live independently of their natal homes. Such strenuous conditions may limit young women's freedom to leave violent homes. How does this impact on long-term prospects for these women?

11. Is there a link between the low self esteem arising from the childhood sexual violence and subsequent adult substance abuse?

12. Anger appears high for these women and is it comparable with averages in the general population?

13. Depression rates appear high for these women and are they comparable with averages in the general population?

14. Dissociation is abnormally high. Is this comparable with averages in the general population? Does every woman who has experienced sexual violence as a child experience adult dissociation? If dissociation is diagnosed by a psychiatrist, is it a psychiatric disorder or coping strategy?

15. Is the endocrine system affected by emotions?

16. Can it be posited that the high rates of tinnitus, bodily aches and pains and unattended fractures may be attributable to early physical injuries which were left untreated?

17. Are gynaecological conditions affected by emotions?

18. There appears to be no policy analysis of the high rates of youth suicide and youth homelessness, nor consideration that childhood sexual violence may be contributing to these sad futures for children. There is a high rate of self-harm and suicidal thoughts in this research. Is there room for policy redirection about primary causes of youth suicide and self-harm?

Outcomes

8.1 Outcomes of Research Framework

The methodology of employing both open (one to one interview) and discrete (sealed, private section) schedules for obtaining information has clearly been a useful one.

The woman clearly disclosed many more incidents of abuse in this setting which highlights the complexity of abuse. I had had a long counselling relationship previously so it did highlight how often things are not disclosed. Contact next day also
revealed the women had experienced a hard night with quite a few flashbacks but she also told me she felt less weird, that it affirmed that she wasn't just 'sick' for no reason, that it was one of the first times it wasn't minimised. She also said she hadn't told all the abuse before because some of it seemed unimportant.

It is recommended that this model of framework be replicated in further or similar research.

### 8.2 Outcomes of Research Process

The greatest asset of this research was compliance with our working principles - respect by researchers, financial recompense for all women participating, provision of additional counselling, promise of long-term support by the service, and collaboration.

Responses from women who were interviewed, members of the advisory group and the counsellors reflect the genuine appreciation of the research process.

Some of the responses from the women interviewed follow:

- I feel honoured to be part of a research which has been longed for, especially for us "the victims".
- I hope that any research you do helps sufferers of child sexual abuse. I wish only more people cared.
- I didn't really want to do the interview. I needed to. Thank you.
- I still don't really understand why you gave us money even if it is to show your appreciation. I would've done it for free coz it is to help people!! I'm glad I did this interview. It was heavy. It was hard and parts of it made me feel awful but in the end, it was more than worth it. I hope you get the results that will help you in your research. Best wishes.
- I hope my information helps someone else because it has helped me to get out some of those things that I could never say or write to be able to just tick a box and not have to put it into words was so much easier and I did release some held-in or hidden events.
- Thanks for the opportunity to participate, to share my 'story' however freely I could. Because so many other avenues (legal/medical) do have confined boundaries for sharing.

Some of the responses from the expert advisory group members follow:

- I feel incredibly honoured to be involved in the research project. I've felt that the process has been very important and crucial in designing and analysing the research material. I've also felt very supported throughout the process. I especially like the composition of the advisory group including women and workers. I'd like to also say that the participants were told about the composition of the advisory group and expressed that they felt reassured that women survivors were a part of the design of project and saw this as a strength of the research project.
• I am very grateful for the opportunity. On one hand I feel very empowered to be able to be a 'voice' and maybe make a different but on the other hand it has emphasised the enormity of how insidious sexual abuse is and this had led to feelings of helplessness, anger and frustration. We are talking about children, who NEED protection from big people and if I could make my arms big enough to encompass them all, I would.

• Incredibly proud of being part of EAG. It has been a truly wonderful experience of women working together that not only has an outcome of valuing women's experiences and knowledge, but has a process to match. I believe it will help bring about change, it already has!

• It has been an honour to be a part of this research. I think we truly did justice to what we were entrusted with by women. Our process modelled how women's experiences and knowledge should be treated. I felt always equal, always respected and always valued by EAG.

It is recommended that the acknowledged success of this model may prove a valuable guide for further research projects in this field, by community or government agencies.

8.3 Outcomes from Feedback

Feedback was sought from the women interviewed within 7 days of their interview. 14 of the 15 women interviewed returned their feedback on the process.

Feedback was also sought from members of the expert advisory group on the process of the research. All six members returned their forms.

Feedback was sought from the interviewers/counsellors about the interview process. All three interviewers returned their forms.

Chapter 9.0 Recommendations

It is essential to support the provision of appropriate support services [for women victims of violence] with 24 hour availability of well-trained counsellors and female medical practitioners. There is also the need to provide accessible and appropriate long term counselling services, (Doctors' Reform Society,1998:1).

Following discussion of the findings, the researchers make the following recommendations for agencies to consider as viable within Queensland. Such recommendations certainly have a wider application to other jurisdictions.

We recommend that:

1. An 'eyes wide open' campaign is devised and commenced combining community education and training of educators, child care workers, police, lawyers, doctors, alternative health practitioners and other 'front-line' workers. This campaign should include policy redirections, support to children, support to professionals, research and reemphasis in medical systems.
2. This research process and methodology is replicated throughout Queensland within rural and remote services and in other states. This research should not be replicated without utilisation of the process as described. Trial this research with control cohorts of women who have not experienced childhood sexual violence. There should be a centralised research collation and analysis point which has an understanding of long-term impacts of childhood sexual violence. A potential option for this central point could be a collaborative study between a tertiary institution and a community counselling service.

3. Children specialist centres are established.

4. Violence support centres are established in schools to provide information and support to children, teachers, and significant others.

5. Self-esteem classes are provided for children in primary and secondary schools.

6. Sexual assault workers are provided for children under the age of twelve years based at schools and preschools.

7. Sexual assault workers inform P&C Associations about the facts of childhood sexual violence.

8. Core protective behaviours programs are available in childcare centres, schools and medical practices, and provided to health care workers such as paediatricians and school health nurses.

9. All human relations education curricula should include protective behaviours programs.

10. In any further research, schedules should include dental health. Some women become compulsive about cleaning their teeth and some are frightened of cleaning their teeth because of childhood experiences of oral rape. This may also be linked with bulimia.

11. In any further research, schedules should include proactive health strategies such as vitamin supplements and pap smears which women are likely to pursue.

12. In any further research, consideration of inclusion of a cohort study of male victims of childhood sexual violence to facilitate gender comparisons.

13. All professionals develop clear protocols to ensure the safety of their clients as a high priority in the case of disclosure of sexual violence.

14. Given that it takes so long for women to report and get a positive response, there are services which provide long-term support. If funding constraints prevent counselling to survivors beyond six weeks, the long term health impacts will not be redressed and the subsequent costs of health burden will be greater.

15. State and hospital registers of injury should collect information about the reasons behind self-harm.
16. Core training components for workers to include those outlined by participants in this research: appropriate response to disclosure of childhood sexual violence includes to be believed; safety; go at their own pace; choice; how to care for themselves; to be listened to; no controlling them; awareness or understanding; learn not to blame self; more confidence; believe in self; no judgement; trust; no pressure to disclose; confirmation of feelings. Such practices are supported by current feminist counselling frameworks.


18. Government recognise the introduction of brief intervention strategies for sexual violence in place of long-term counselling services may be detrimental to survivors.

19. Youth suicide prevention programs recognise primary causes for suicide and self-harm include childhood sexual violence and make policy redirections to compensate.

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