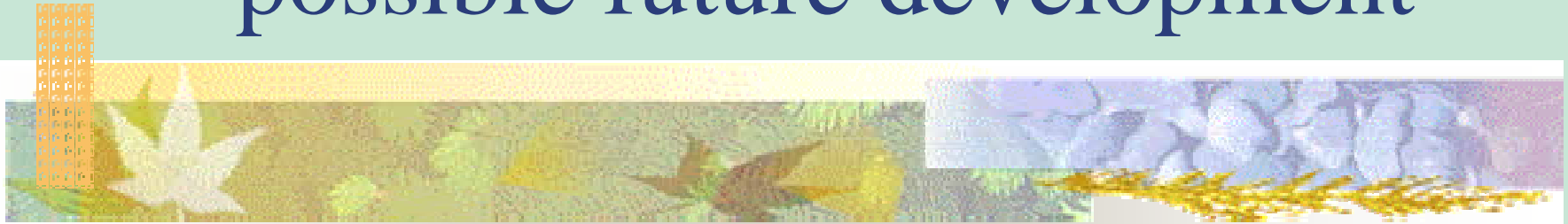


# Child sexual abuse: ‘Having a hunch’ – current practice & possible future development



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1.8% (43/2441) of 'determined' sexual abuse reports came from Community Health Centres in 2001/2002.

*Source: Client Information System, Annual Statistical Extract, 2001/02*

*Produced by: Information Management, NSW  
Department of Community Services*



**1. A report is made when there are  
'reasonable' grounds to suspect risk of harm**

*Reporting is required when one has 'reasonable' grounds to suspect risk of harm.*

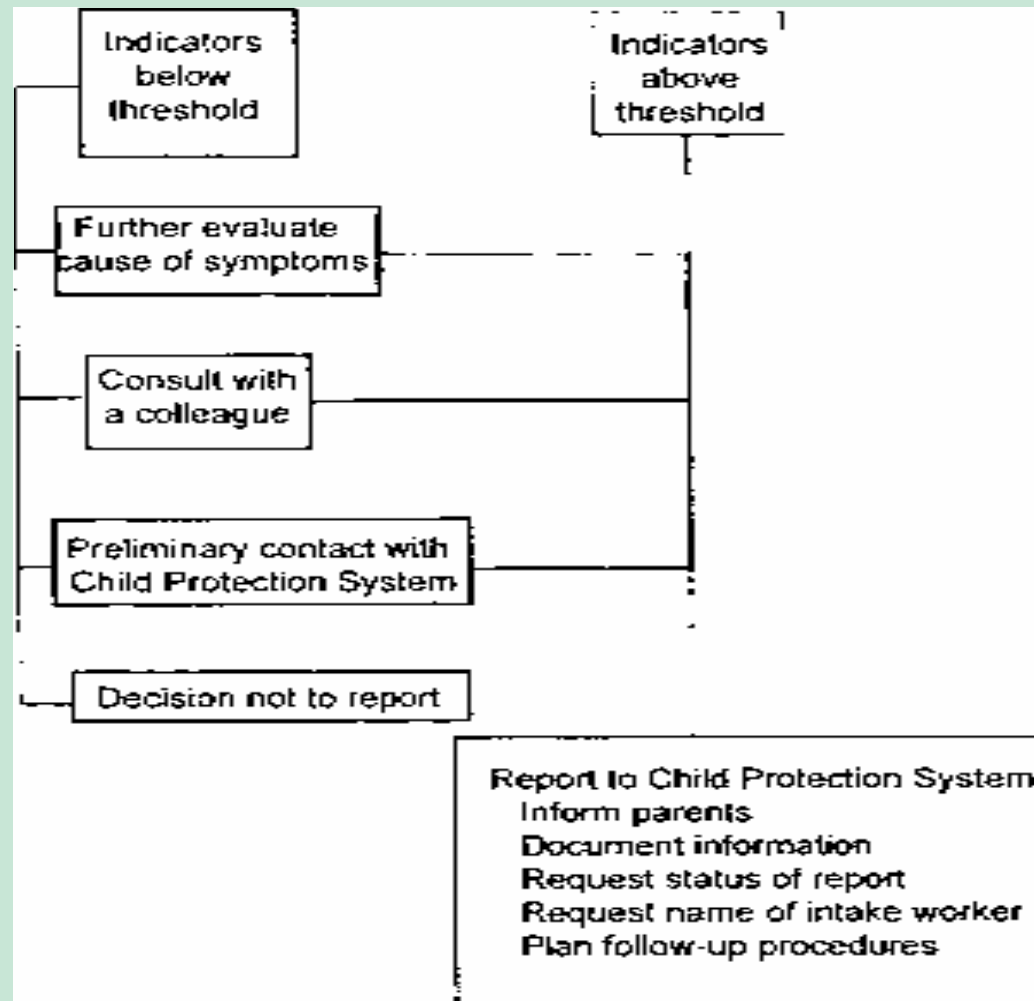
Mental health professionals frequently experience intuitions or '**hunches**' regarding abuse and engage in subsequent **decision-making processes** about whether or not to make a report (*Finkelhor & Zellman, 1991; Kalichman, 1999*).



## 2. From professional hunches to reasonable grounds

The difficulty professionals experience in distinguishing between *clinical impressions (hunches)* and *reasonable grounds* of abuse accounts for many decisions not to report (*Jones & Welch, 1989*).

*Kalichman (1999)* proposed “*a hierarchical approach to managing ambiguous suspicions of abuse*”





### 3. Decision-making models

- **Utility models:** the perceived benefits & costs of reporting

#### *Reporting*

Costs – disrupting treatment; relying on CPS to handle situation; family must face CPS investigation.

Benefits – Stopping abuse/possible abuse; upholding law; maintaining trust.

#### *Not Reporting*

Costs – potential for further abuse; liability for failure to report.

Benefits – maintaining confidentiality; protecting child from system.

(from Kalichman, 1999)



## Decision-making models con't...

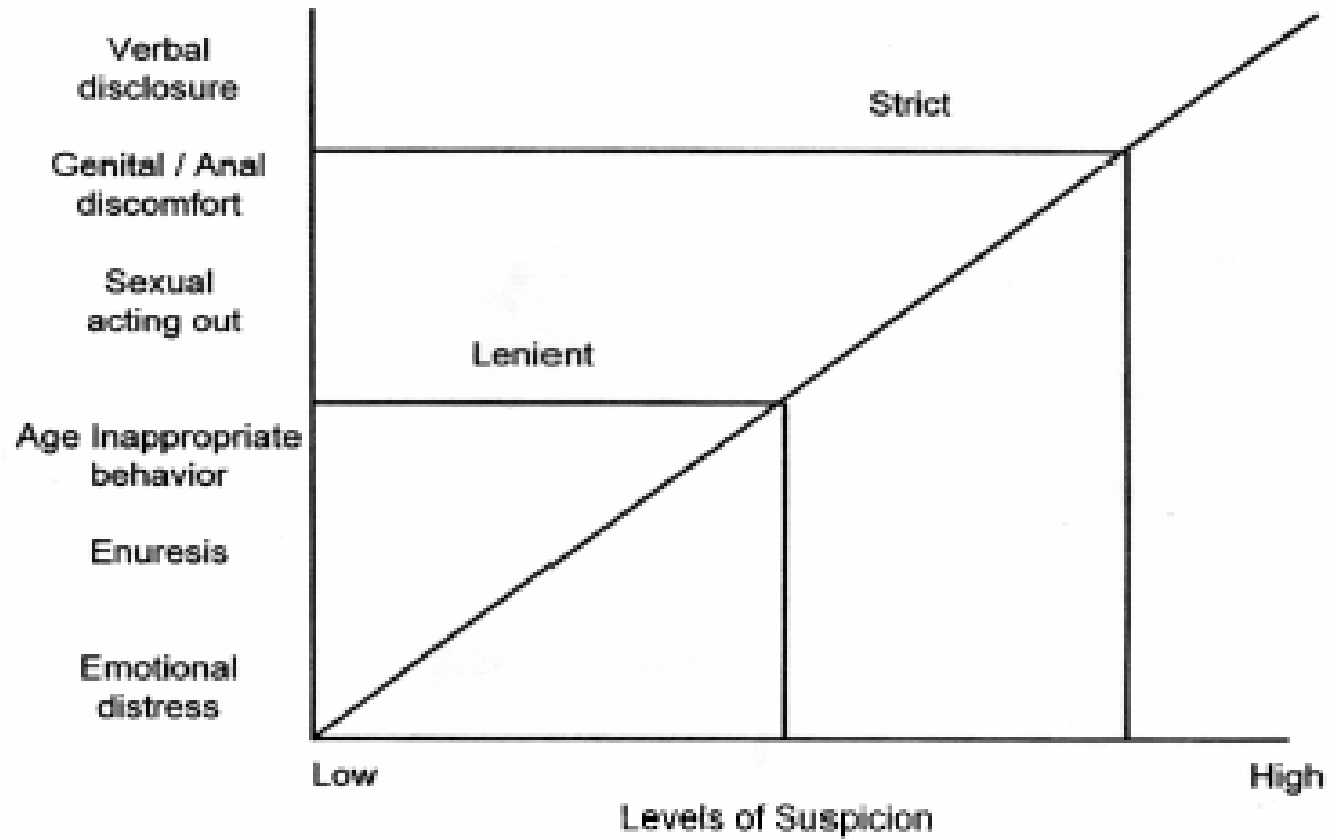
- **Evidence-based models:** indicators of abuse as reasonable suspicions
- **Threshold models:** a continuum of abuse indicators




## 4. Indicators of abuse: evidence-based & threshold decision-making models

- *Finlayson and Koocher (1991)* - clinicians view suspicions of abuse along a continuum, with a ‘mere hunch’ representing one end and ‘absolute knowledge’ representing the other.
- *Kalichman (1988) & Conte et al. (1991)* - many mental health professionals are more likely to report after they have observed a combination of child abuse indicators.
- *Kalichman (1999)* - vignette studies have consistently shown that professionals are more inclined to report specific and salient indicators of abuse than ambiguous clinical symptoms.


**Indicators  
of Sexual Abuse**





Because mental health professionals do not perform physical examinations, sexually descriptive statements by children are the single best indicator of sexual abuse (*Adams, 1991*).

However, only about one third of sexual abuse cases involve verbal accounts from children (*Herbert, 1987*) so suspected sexual abuse often results from indicators other than verbal disclosures such as behaviours and emotional reactions.



These indicators of child abuse are usually cumulatively evaluated through observation and perhaps through formal assessment measures.

Professionals rely on observations/informal assessment to identify abuse “*because of the lack of validated assessment tools relevant to detecting child abuse*” (Kalichman, 1999, p. 79).



## 5. What is currently out there that's been validated ?

- Because sexual acting-out is among the most frequent symptoms exhibited by sexually abused children *Friedrich (1991)* developed the **Child Sexual Behavior Inventory**. It provides a valuable device for indicating the need for assessment (*Dammeyer, 1998*).
- **Trauma Symptom Checklist for Children** (*Briere, 1996*). Self-report measure to evaluate children's responses to traumatic events. 'Sexual concerns' subscale.



## Questions...

- What signs have given clinicians a ‘hunch’ that a child may be being sexually abused?
- Do clinicians utilise interviews, drawings, dolls, standard tests etc to assist them in their decision-making process?
- Would clinicians find a brief self-report, validated, objective measure that used a range of behavioural/emotional sexual abuse indicators useful and would they be inclined to use it?



## What we did...

- Liaised with clinicians and district guidance officers in developing survey.
- Contacted Managers of CAFT in SWSAHS to inform them about the survey and gain permission to send survey to teams.
- Emailed survey to 56 clinicians on the CAFTs.
- Resent email 2 and a half weeks later.
- Response rate of 23% (13 clinicians).
- Contacted Dept. of Ed & Train.



## What we found...

### 1. What signs have given you a hunch that a child may be being sexually abused?

- Sexual preoccupations: language, behaviour (self/others), advanced knowledge 100% (12)
- Acting out/withdrawing behaviour 58% (7)
- Bedwetting 42% (5)
- Smearing of faeces/soiling 25% (3)
- Nightmares 25% (3)
- Fearful reactions towards adults; self-harming behaviour; anal/vaginal soreness; drop in grades; verbal references to family secrets; hypervigilance; anxiety



## 2. Have you found any useful procedures to assist in your decision-making process?

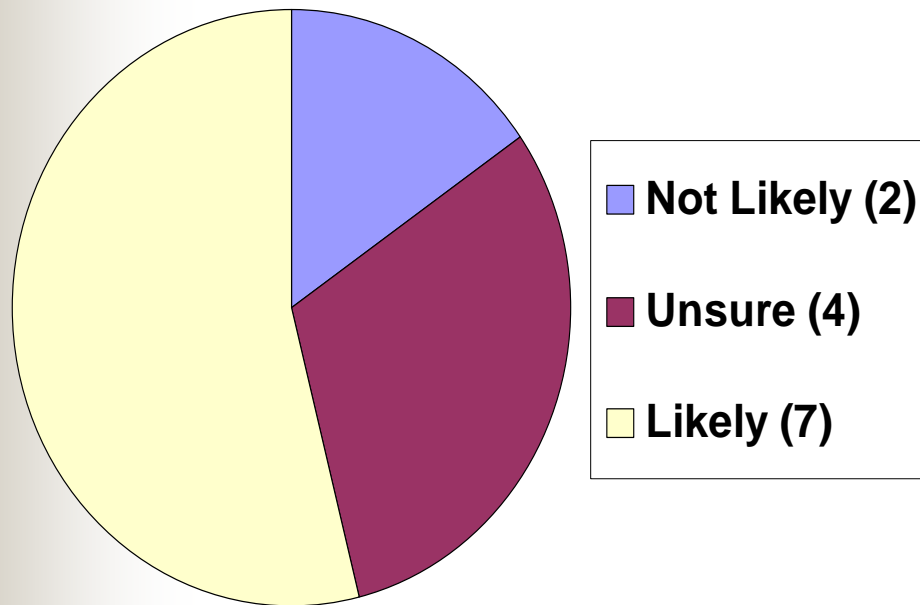
- Ask questions of the child 75% (9)
- Use drawings 75% (9)
- Ask questions of anyone else (e.g. other health professionals, school counsellors) 75% (9)
- Ask questions of other family members 75% (9)
- Using dolls 33% (4)
- Using sandplay 25% (3)
- Administering standard tests(CBCL;CDI;CMAS) 17% (2)

3. Would you find a brief self-report, validated measure that used a range of behavioural/emotional sexual abuse indicators useful?



85% of clinicians thought that such a measure would be useful.

## 4. How likely would you be to use it?



- Those clinicians **not likely** to use the measure had an average of **3 years clinical experience**.
- Clinicians who were **unsure** had an average of **10 years clinical experience**.
- Clinicians who were **likely** had an average of **15 years clinical experience**.



In the last 12 months...

Had a Hunch but did not report:  
24 children

Did make reports:  
24 children

Clinicians have hunches and are actively involved in a decision-making process about those hunches.



## Sum up & Considerations...

- **Signs of Sexual Abuse:** Sexual preoccupations; Acting out/withdrawing behaviour; Bedwetting
- **Useful procedures:** Ask questions of the child; Use drawings; Ask questions of anyone else (e.g. other health professionals, school counsellors); Ask questions of other family members
- **85% of clinicians** thought a brief self-report, validated measure that used a range of behavioural/emotional sexual abuse indicators would be useful



## Sum up & Considerations con't...

- Most clinicians stated they would be likely to use such a measure, with the more experienced clinicians providing the strongest endorsement.
- Clinicians have hunches and are actively engaged in a decision-making process about those hunches regarding whether or not they have 'reasonable' grounds to report.



## Sum up & Considerations con't...

- An *optimal reporting threshold* is one that catches a maximum number of cases while minimising the number of false reports. One way to assist in achieving this balance is through the use of evidence-based validated measures *in conjunction* with other information.
- Controversial topic...



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