

1



Paedophilia: The Public Health Problem of the Decade

BILL GLASER

Imagine a society afflicted by a scourge which struck down a quarter of its daughters and up to one in eight of its sons. Imagine also that this plague, while not immediately fatal, lurked in the bodies and minds of these young children for decades, making them up to sixteen times more likely to experience its disastrous long-term effects. Finally, imagine the nature of these effects: life-threatening starvation, suicide, persistent nightmares, drug and alcohol abuse and a whole host of intractable psychiatric disorders requiring life-long treatment. What should that society's response be?

The scourge that we are speaking of is child sexual abuse. It has accounted for probably more misery and suffering than any of the great plagues of history, including the bubonic plague, tuberculosis and syphilis. Its effects are certainly more devastating and widespread than those of the modern-day epidemics which currently take up so much community attention and resources: motor vehicle accidents, heart disease and, now, AIDS. Yet the public response to child sexual abuse, even now, is fragmented, poorly coordinated and generally ill-informed. Its victims have no National AIDS Council to advise governments on policy and research issues. They have no National Heart Foundation to promote public education as to the risks of smoking and unhealthy lifestyles. They do not have a Transport Accident Commission to provide comprehensive treatment and rehabilitation services for them.

A massive public health problem like child sexual abuse demands a massive societal response. This conference is hopefully about formulating such a response. But firstly, we need to acknowledge and understand the problem itself, and this is, sadly enough, a task which both professionals and the community have been reluctant to undertake, despite the glaringly obvious evidence in front of us.

How have we responded until now?

Until very recently, our professional ignorance regarding child sexual abuse was profound. Yet the data we needed has never been hard to find. Early nineteenth-century Londoners were well aware that in three of the city's hospitals during eight years there had been 2700 cases of venereal disease among girls aged between eleven and sixteen years (Pearsall 1981). In the 1890s, "minors" constituted over half of the prostitutes in Vienna and Paris (Rush 1980). A parliamentary committee in New South Wales, reporting between 1859 and 1860, found evidence that girls as young as seven were being prostituted in Sydney (Finch 1991).

Furthermore, there was extensive knowledge about the identity of the abusers, the nature of the abuse and the effects of this upon a vulnerable child. In a remarkably prescient paper given in 1896, no less a figure than Sigmund Freud addressed all of these issues. The most "numerous" of his eighteen cases of "pure hysteria and of hysteria combined with obsessions" resulted from abuse by an adult, including, "all too often, a close relative". There was no doubt in Freud's mind that the relationship was exploitative;

...on the one hand the adult who cannot escape his share in the mutual dependence necessarily entailed by a sexual relationship, and who is yet armed with

complete authority and the right to punish, and can exchange the one role for the other to the uninhibited satisfaction of his moods, and on the other hand the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility and exposure to every sort of disappointment and whose performance of the sexual activities assigned to him is often interrupted by his imperfect control of his nature needs — all these grotesque and yet tragic incongruities reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects... (Freud 1896, reprinted in Masson 1985).

Even the great sexologist, Krafft-Ebing, who labelled Freud's observations a "fairy-tale", nonetheless was well aware of the dangerousness and deviousness of child molesters. In his book on sexual perversions, which ran to twelve German editions alone and was widely translated, he pointed out the "inexhaustible" range of types of sexual assault committed by child molesters and also emphasised that, despite the "monstrosity" of their deeds, many abusers were "psychically normal" (Krafft-Ebing 1965, page 370).

Less than nine years after his initial observations, however, Freud had retracted them. In 1905, he admitted that he "overestimated" the frequency of childhood sexual abuse and placed a "higher value" than was necessary, on its effect on later development. Ten years later, the retraction had gone further and he was able to state that if a victim's "father figures fairly regularly as the seducer, there can be no doubt either of the imaginary nature of the accusation, or of the motive that has led to it". Indeed, there was no great difference in the consequences of the victim's memories "whether fantasy or reality has had the greater share in these events of childhood". (Freud 1905, 1915).

The effects of extra-familial child sexual abuse were similarly downplayed or ignored. A text book which was recommended reading for medical students as recently as twenty years ago declared that:

... various authorities who have examined children who have been seduced have concluded that the emotional as opposed to the physical

damage which is done to children is more the result of adult horror than of anything intrinsically dreadful in the sexual contact itself (Storr 1974, p. 105).

The same author stated that sexual intercourse in paedophilic activities was "extremely rare" and that they occurred "not from a superfluity of lust, but rather because of a timid inability to make contact with contemporaries" (Storr 1974, pp. 100, 102).

In many cases, professionals often resorted to victim-blaming in order to explain the laying of criminal charges against an apparently respectable member of society. Writing only thirty years ago, a prominent Sydney psychiatrist expressed his indignation regarding

... a powdered and painted thirteen year old who looked at least eighteen and haunted low class hotels or picked up drunks and offered them her favours for a small reward; or the garage man who was visited by a ten year old eleven times for sexual purposes before she decided the recompense was inadequate and informed the police; ... these can hardly be called examples of seduction of the innocent (McGeorge 1966).

Our response to child sexual abuse over the last century, therefore, has been largely that of denial. If we do not deny the offences, then we refuse to recognise the victims. If we do not deny that there are victims, then we refuse to recognise their suffering. The reasons for this state of affairs are complex and arise from a combination of entrenched patriarchal values, child (and woman) hatred disguised as pseudo-science and misguided "sexual liberationism" (Rush 1980; Masson 1985). However, the denial cannot continue. We must now not only define the problem but define paedophilia as a problem in order to deal with it effectively.

What is paedophilia?

Given this deliberate and widespread ignorance, it is not surprising that misleading stereotypes of child sexual abuse still prevail. The term "paedophilia" unfortunately has two grossly misleading connotations. Firstly, despite the implications of its Greek

etymology, paedophilia is not a love of children but a lust for them. The sole aim of the paedophile is to sexually abuse children. Any display of care, affection or friendship towards the victim is always secondary to this.

The second problem with the term “paedophilia” is that it is associated with crude caricatures which are often fostered by paedophiles themselves. “I don’t pounce on small children in public parks, I don’t play around with choir boys and I don’t kidnap babies in prams; therefore I can’t be a paedophile,” they might say. Their partners and friends, and the general community willingly accept these protestations, without realising that there is no such thing as the typical paedophile and that paedophilic behaviours can occur in virtually any sort of circumstance.

For these reasons, the terms “child sexual abuse”, or even better, “child sexual assault”, are preferable. Nevertheless, the word “paedophilia” is used widely and there should be agreement on an appropriate definition. The one that I would suggest is that given by the fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. There, the diagnostic criteria for paedophilia are:

A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges or behaviours involving sexual activity with a prepubescent child or children (generally aged thirteen years or younger).

B. The fantasies, sexual urges or behaviours cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The person is at least sixteen years and at least five years older than the child or children in criteria A.

There are exclusionary criteria for relationships between older teenagers and under-aged partners and one can specify the sex of the preferred victim, whether the relationship is incestuous or not and whether the perpetrator is solely attracted to children or not.

This definition is not entirely satisfactory. Its major drawback is that it implies that paedophiles are psychiatrically abnormal in some way, whereas this is nearly always not the case. Its advantages, however, are that it stresses that paedophilic

fantasies and behaviours are rarely one-off events, that the central motivator for paedophiles is always that of deviant sexual interest and that the paedophile is the cause of his own problems. This last point is very important: it is the paedophile’s sexual deviance which has to be dealt with, not family dysfunction or victim seductiveness or any one of a range of explanations for child sexual assault which have been postulated in the professional literature throughout the years.

Who are paedophiles?

As recent events in Australia have shown, they can be anyone. They can be politicians, priests, diplomats, football heroes, financial advisers, teachers, social workers, doctors and judges (James 1996). There have been a number of attempts to try and delineate the characteristics of paedophiles and to separate them out into sub-groups (*see*, for example, Knight 1988; Knight & Prentky 1990) but these are marred by their ignorance of “normal” male sexual behaviour and by their skewed selection of subjects for study (usually imprisoned offenders). A number of surveys have shown that the majority of “normal” men fantasise about sexually initiating a young girl; between 4 and 17 per cent acknowledge that they have molested a child. Tertiary students in both the US and Australia self-report a wide range of deviant fantasies and activities including voyeurism, obscene telephone calls, sex with animals, rape and child abuse (Crepault & Couture 1980; Finkelhor & Lewis 1988; Malamuth 1988; McConaghy & Zamir 1992a, 1992b). It is thus likely that (for example) the poor social skills said to characterise paedophiles are probably more an indicator of why they get caught, rather than why they offend. “Socially skilled” paedophiles are better at intimidating their victims or seeking them offshore in Thailand or the Philippines (O’Grady 1992).

Most child sex abusers start young; the median age of onset for same-sex paedophilic offenders is around seventeen years (Abel et

al. 1988). Clearly this has important implications for treatment and prevention programs (Vizard et al. 1996).

About the only generalisation that can be safely made about paedophiles is that most of them are males. Female child abusers do exist but most studies emphasise a picture of a woman who is suffering major social and economic disadvantages, psychiatric illness or intellectual disability and domination by a male partner who is the primary offender (O'Connor 1987; Faller 1987; Johnson & Schrier 1987).

Who are their victims?

Conservative estimates, using carefully designed random surveys of non-clinical community populations, have consistently shown that one in four women and one in eight men will have been subjected as children (*see* the summary in Salter 1988, ch. 1) to unwanted sexual touching, fondling, assaults or even rape, in North American communities. For women victims, these figures have now been verified by similar careful studies performed in New Zealand (Romans et al. 1996) and Australia (Fleming 1997). In the Australian study, the majority of women victims experienced "contact" abuse, 27 per cent of which involved actual or attempted vaginal or anal intercourse. Most abuse occurred before age twelve and the mean age at the first episode of abuse was ten years. The vast majority of the abusers were relatives (particularly fathers and stepfathers) or male family acquaintances.

This predominance of offenders who are known to the victim is important. Traditional stereotypes have provided a model of the "incestuous" family which seems to exculpate the offender — he has to cope with a passive "colluding" mother and a pseudo-mature "seductive" daughter (Cole 1992). However, there is no empirical evidence to support this explanation; in one survey, 66 per cent of one hundred and ninety-nine incest offenders had victimised non-family members (Abel et al. 1988). An incest offender is simply a paedophile who sometimes abuses his own children or young relatives. (It is a pity that most clinicians have little knowledge of criminological ideas — opportunity theory provides a better explanation of incest than family dysfunction ever did!)

While it has been thought until recently that the majority of child sexual abuse victims are female, it is now becoming increasingly obvious that a substantial minority, up to forty-five per cent, are

boys (Watkins & Bentovim 1992). Boys appear to be especially susceptible to offenders with multiple victims; incarcerated offenders themselves report that 62 per cent of their child victim contacts are with boys (Abel & Osborn 1992).

It is frightening to realise that children form the majority of the victims in *all* forms of sexual crime. During 1993-94 in Victoria, 62 per cent of sexual assault victims were aged less than seventeen years; 44 per cent were aged less than fourteen years (Victoria Police, quoted in Parliament of Victoria, 1995). Not only do sex offenders selectively victimise children, they also exploit the most vulnerable in an already vulnerable group: as recent experiences in Australia sadly demonstrate, child sexual abusers wreak the most havoc amongst children in institutional care, those from disrupted families and children with intellectual or other disabilities (*see*, for example, Hayes 1993).

What do paedophiles do?

It has taken us a long time to learn that perpetrators of child sexual abuse rarely commit only a single act with a single victim or a single type of abuse. Most offenders have multiple victims, often both boys and girls. Most offenders are long-term recidivists. The oldest offenders in the clinic where I consult are in their eighties; they are all paedophiles. Correspondingly, sex offenders always form the oldest group in prison populations both in Australia and overseas: burglars, car thieves and brawlers all appear to give up their criminal careers in their thirties, but paedophiles just keep on offending (Parliament of Victoria 1995, ch. 6).

The harm caused by child sexual abuse is immeasurable. As we have seen, for a large number of victims, there are the consequences of brutal and forced sexual penetration including bruising, tears to the perineal area, venereal disease and other infections and urinary tract problems. Immediate psychiatric concerns include a wide variety of behavioural

and emotional problems, such as sleep disturbance, nightmares, compulsive masturbation, precocious sex play, disturbed relationships with peer groups and parents and regression of behaviour such as loss of toilet training skills.

Hopefully, these problems can be dealt with as soon as they are discovered. More problematic, however, are the long-term effects of abuse. Using fairly conservative definitions of “disorder”, a comprehensive New Zealand study of randomly-selected community participants found that the rate of current psychiatric disorder in women reporting childhood sexual abuse was three times that of a non-abused control group (Mullen et al. 1993). Psychiatric and social problems can take virtually any form including depression, anorexia nervosa, substance abuse, multiple personality disorder, suicide attempts, sexual difficulties, general relationship problems and difficulties in acquiring appropriate parenting skills. There may also be long-term physical problems such as chronic pelvic pain and irritable bowel disorder. There is now incontrovertible evidence of a firm link between childhood sexual assault and the development of many of these problems in later life, even after factors such as social disadvantage, family dysfunction and other forms of abuse are taken into account (Finkelhor & Brown 1988; Asher 1988; Conte & Berliner 1988; Oats 1990; Jakobson & Herald 1990; Bifulco et al 1991; Mullen et al. 1993; Fry 1993).

Why do paedophiles do what they do?

Although this is a question often asked by courts, governments and community agencies, it is one which is least likely to receive, or need, an answer. Various theories suggest specific biological, social, developmental and psychological factors, or a combination of any or all of them (*see*, for example, Marshall 1989). It is doubtful whether an ultimate “cause” for paedophilia will be discovered; this is regrettable but, pragmatically speaking, it is not necessary. As will be described later, there are already effective ways of dealing with the problem which only require appropriate resourcing and coordination to achieve a massive decrease in the number of current and potential victims.

From the point of view of the therapist, it is positively dangerous to ask an offender to contemplate why he has offended. Such questions inevitably produce a long list of excuses for his behaviour rather than any effective plans to do something about it (Glaser 1996).

How do paedophiles do what they do?

By contrast, this is a question which is least often asked by courts, governments, community agencies and other decision-makers. It is difficult for most people to understand that a paedophile’s offending activities are only the end-stage of a long and complex process often called “grooming”, which begin with the nurturing of deviant fantasies, proceeds through the long-term planning and rehearsal of the abuse and culminates in a complex relationship that, for the child, is both exploitative and loving, cruel and kind, perverted and normal, all at the same time. When a barrister interrogates a victim in court as to why they repeatedly returned to an offender’s house, why they invited him to their wedding, why they continued sexual activity with him, despite their disgust, shame and humiliation, they are often unable to answer. This is no reflection on the victim’s credibility, rather, it is a tribute to the paedophile’s deviousness and his ability to convince both himself and his victims that black is white and white is black.

The hallmark of child sexual abuse is the use of denial, not only by the offender but by his friends, his family, his employers, therapists, criminal justice personnel, the media and the wider community. That denial can occur at many levels: denial of the behaviour itself (“it didn’t happen”), denial of responsibility for it (“it was the grog”), denial of the harm caused to the victim (“she never complained”) or denial of the need for interventions (“I will never do it again”) (Salter 1988). This, combined with the bribery, threats and intimidation practised by all paedophiles, not only secures the compliance of the victim but makes them poor witnesses of the truth.

It has often been said that paedophiles tend to be “good with children”. That is

precisely what makes them so dangerous; this “goodness” is difficult to differentiate from (say) “good” parenting. One has to talk with many victims at length to realise how insidious and how overwhelming has been the influence of an offender on all aspects of their lives. One must listen to the woman who continues to mourn her deceased abuser, because she had always been his “special” child after he commenced sexual intercourse with her at the age of eight and her sisters refused him. One must see the young man who was praised as being one of the “good lads” by his sporting coach whenever he indecently assaulted him and who is now bewildered and angry because the offender has suddenly lost interest in him, having told him that “good lads” don’t do these things past a certain age. One must understand the woman sexually assaulted as a child by her father, who has struggled successfully with a mental illness for many years but who has now relapsed because the offender’s own serious illness makes her feel guilty about telling her aged mother about the abuse. These are not just soap opera stories; they are the devastating effects of cleverly-planned and executed assaults on the mind and body of a child.

What do we do now?

Currently, the major challenge in dealing with child sexual abuse is to understand the big picture. Even though the myths and stereotypes are being slowly replaced by empirical knowledge, the social response is fragmented and uncoordinated, seemingly dictated more by arbitrary bureaucratic and administrative boundaries than by any comprehensive and effective strategies.

What is needed is an approach which will link what we know to what we can do. The comparison of paedophilia to a plague is more than just a vivid metaphor. It suggests that lessons can be learned from the other great scourges and pestilences of human history. In particular, there have always been three major components to public health problems of this magnitude (Foege 1991).

Definition of the problem

As we have already seen, child sexual abuse needs to be defined as a problem. It has taken us a long time to recognise that child sexual abuse carries with it a high morbidity (particularly long-term physical and psychiatric disorders) and probably a high mortality in the form of premature deaths due drug and alcohol abuse, suicide and chronic physical disease. Even now, however, our knowledge is still

limited. There is still no good national child sexual abuse database and different sources — the police, courts, correctional services, protective services, health care providers, victim services and community agencies — provide incomplete and conflicting accounts of what is actually happening. There are still enormous gaps in our knowledge about the nature and prevalence of child sexual abuse and the needs for services; it is probable that we do not even know that the gaps exist (Parliament of Victoria 1995, ch. 3).

Perception of risk

There are some who say that we are becoming unnecessarily panicky about child sexual abuse. The evidence is that we have not panicked enough. We are still like the village-dwellers in certain parts of India whose culture has encouraged them to fatalistically accept the ravages of smallpox, year after year, despite the existence of vaccination and other control methods (Foege 1991). Even though we can see the damage being done to the vulnerable and needy members of our society, we remain reluctant to act.

The New South Wales Royal Commission is simply the most recent in a long line of enquiries into child sexual abuse which have been conducted in most Australian jurisdictions over the last ten years. The Commission’s findings that police repeatedly failed to investigate paedophile activity (*Sydney Morning Herald*, 21 March 1996) or that the education department allowed suspected paedophiles to continue teaching in schools (*Herald-Sun*, 17 March 1997) are just more spectacular examples of a widespread malaise. Protective services workers still assume that they can assess notifications of child sexual abuse by only making a couple of phone calls or that they do not need to report a crime involving child sexual assault if there are no current protective issues. Courts and legislatures still seem to be reluctant to

contemplate changes in legal procedures or rules of evidence which would (for example) permit hearsay evidence in special circumstances, give broader judicial discretion to allow the hearing of joined charges where multiple victims are involved, eliminate delays in bringing child sexual assault offences to trial and provide suitable facilities (including the presentation of video evidence and closed circuit television monitoring) for child witnesses. There are still too many doctors, psychologists and psychiatrists who, through greed or ignorance, are only too happy to provide one-sided reports about offenders to not only the criminal courts but those having jurisdiction over children and families (Parliament of Victoria 1995, ch. 5 and 8).

But the most important influences on our perceptions of the dangerousness of child sexual abusers are the media and popular culture. A great deal has been written about the effects of pornography on the way sex offenders behave and on how we view them (see, for example, Goldsmith 1993). Kiddie-porn on the Internet, however, is far less sinister than images of models looking like schoolgirls, coyly displaying their sexuality as they parade next year's fashions. The makers of Calvin Klein jeans were recently forced to withdraw advertisements which showed a young teenage boy being encouraged to "rip that shirt off" by an obviously older male who was interested in his "real nice body" (*Canberra Times*, 9 September 1995). Clearly, protective behaviours programs in schools are not going to be of much help if the advertisements for the brand-name fashions so much sought after by the young continue to associate style with adult exploitation of children's bodies.

The social response.

As with most public health problems of this magnitude, the response needs to be at the community level. The identification, assessment and treatment of individual victims (and offenders) is not enough. Indeed, as has been shown with the modern plagues of heart disease, AIDS and road accidents, the response needs to be institutionalised. There must be a well-planned, highly coordinated and effective bureaucracy that can provide national or at least state-wide surveillance and monitoring of the problem, a useful analysis of the data received and prompt communication of the results of that analysis to all concerned government departments, professionals and agencies. In many cases this centralised bureaucracy will also coordinate or even operate treatment and rehabilitation services, policy

development units, public education campaigns, research facilities and programs evaluating outcomes and costs of these various interventions.

This type of organisation is almost totally lacking in the area of child sexual abuse and for that reason, there are still huge deficiencies in knowledge and service provision. In particular, there are two areas of need which, one suspects, can only be remedied by a comprehensive program coordinator at a national level. The first is that of services to victims. Currently, there are long waiting-lists at every Centre against Sexual Assault in the country. The professionals who are trained to help survivors with their problems remain pitifully few in number. Every day arbitrary and heartbreaking decisions must be made in order to prioritise the limited services available; in New South Wales, adult victims of child sexual abuse are seen as only a "third priority", even though the ongoing difficulties of a mature adult raped and abused as a child thirty years ago may be just as disabling as those of the child abused yesterday (New South Wales Parliament, ch. 8). It is indeed ironic that the child experiencing emotional distress following a horrifying motor vehicle accident will receive, without cost, special education facilities, help with career advice, salary benefits if they were working and years of treatment. The child experiencing the same sort of distress after a brutal sexual assault may well be entitled to nothing.

The second great area of need concerns the assessment, treatment and monitoring of the offenders themselves. There has been an ongoing debate as to whether perpetrators "deserve" the treatment resources which might otherwise be devoted to victims. This, however, arises from a serious misunderstanding. The "treatment" offered to paedophiles does not have the aim of comforting them or alleviating their distress. Modern treatment techniques, particularly cognitive-behaviour therapies, relapse prevention and pharmacological methods aim to make the offender take responsibility for his

actions, reduce the level of his deviant sexual arousal and develop strategies to deal with situations where he is at risk of re-offending. The measure of successful treatment is not that of a happy perpetrator but rather of a safe victim.

Modern treatment techniques are spectacularly successful. Carefully-designed studies now claim a long-term recidivism rate of 6 per cent, compared with the thirty-five per cent found in untreated control groups (New South Wales Parliament, ch. 12; see also Marshall et al. 1993, and Marshall & Pithers 1994).

The simple incarceration of offenders, however, has no, or even an adverse, effect. Harassed, abused and locked up in “protection” for their offences, they simply become more secretive about them, and invent ever more elaborate and cruel fantasies to occupy their time until they are released. One middle-aged offender, who had kidnapped and trapped his six-year-old victim in his bedroom, was asked what he had learned from his prison experience after he was burned badly when boiling water was thrown over him. He replied: “that will teach me not to tell the truth to the police next time”.

This is not a plea for mercy for these undoubtedly cunning and devious offenders. However, from the pragmatic point of view, we have to realise that nearly all child sex abusers will be released back into the community sooner or later, following which they can take the opportunity to offend again and again (you will recall that the oldest offenders I have encountered are in their eighties). Rather than locking them up for long periods of time, we must give them the skills and the incentives to keep themselves out of trouble.

These sorts of considerations merit a radical rethink of sentencing policy. We have to stop separating the culpable, who deserve tariffs, from the rehabilitable, who deserve treatment. Paedophiles probably deserve both, but if we are to protect the community on a long-term basis, then much of the average paedophile’s sentence may need to be spent in a non-custodial setting, in a supervised hostel environment with appropriate treatment conditions and restrictions on his movements. It might now be time to consider the imposition of long-term reviewable community-based sentences rather than lengthy or indeterminate terms of imprisonment.

Ultimately, however, to do all these things, we must radically rethink our attitudes as a community. We must understand child sexual abuse as a problem of national importance. We have to understand its devastating consequences for the victims, their families and the community at large. And most of all,

we have to understand the how and the why of paedophilia: the subtle, bizarre and cruel ways in which seemingly blameless and upright men insidiously cripple the most vulnerable members of our society. We have possessed that understanding for a long time; we have ignored it for too long. Shakespeare well understood sexual lust and he could well have been describing the lusts of a paedophile when he wrote these lines:

*Th’ expense of spirit in a waste of shame
Is lust in action; and till action, lust
Is perjured, murd’rous, bloody, full of
blame,
Savage, extreme, rude, cruel, not to trust;*

*Enjoyed no sooner but despised straight:
Past reason hunted; and no sooner had,
Past reason hated, as a swallowed bait,
On purpose laid to make the taker mad:*

*Mad in pursuit, and in possession so,
Had, having, and in quest to have,
extreme,
A bliss in proof, and proved, a very woe;
Before, a joy proposed; behind, a dream.*

*All this the world well knows, yet none
knows well
To shun the Heaven that leads men to
this Hell.*

(William Shakespeare Sonnet 129)

References

- Abel, G.G., Becker, J.V. & Cunningham-Rathner, J. et al. 1988, "Multiple paraphilic diagnoses among sex offenders", *Bulletin of the American Academy of Psychiatry and the Law*, vol. 16, p. 153.
- Abel, G.G. & Osborn, C. 1992, "The paraphilias: The extent and nature of sexually deviant and criminal behaviour", *Psychiatric Clinics of North America*, vol. 15, no. 3, p. 675.
- Asher, S.J. 1988, "The effects of childhood sexual abuse: A review of the issues and evidence" in *Handbook on Sexual Abuse of Children*, ed. L.E.W. Walker, Springer, New York.
- American Psychiatric Association 1994, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn, American Psychiatric Association, Washington.
- Bifulco, A., Brown, G. & Adler, Z. 1991, "Early sexual abuse and clinical depression in adult life", *British Journal of Psychiatry*, vol. 159, p. 115.
- Canberra Times* 9 September 1995, "Selling jeans by dubious means".
- Cole, W. 1992, "Incest perpetrators: Their assessment and treatment", *Psychiatric Clinics of North America*, vol. 15, no. 3, p. 689.
- Conte, J.R. & Berliner, L. 1988, "The impact of Sexual abuse on children: Empirical findings", in ed. L.E.A. Walker, *Handbook of Sexual Abuse of Children*, Springer, New York.
- Crepault, C. & Couture, M. 1980, "Men's erotic fantasies", *Archives of Sexual Behaviour*, vol. 9, p. 565.
- Faller, K.C. 1987, "Women who sexually abuse children", *Violence and Victims*, vol. 2, p. 263.
- Finch, L. 1991, "The nineteenth-century identification of incest as a working class crime: Implications for analysis", in *Incest and the Community: Australian Perspectives*, ed. P. Hetherington, University of Western Australia Centre for Western Australian History, Perth.
- Finkelhor, D. & Brown, A. 1988, "Assessing the long-term impact of child sexual abuse: A review and conceptualisation", in *Handbook on Sexual Abuse of Children*, ed. L.E.A. Walker, Springer, New York.
- Finkelhor, D. & Lewis, I.A. 1988, "An epidemiologic approach to the study of child molestation", *Annals of the New York Academy of Sciences*, vol. 528, p. 64.
- Fleming, J.M. 1997, "Prevalence of childhood sexual abuse in a community sample of Australian women", *Medical Journal of Australia*, vol. 166, pp. 65-8.
- Foege, W.H. 1991, "Plagues: Perception of risk and social responses in *In Time of Plague*, ed. A. Mack, NY University Press, New York.
- Freud, S. 1896, "The aetiology of hysteria", trans. James Strachey. Reprinted as Appendix B in *The Assault on Truth*, J.M. Masson 1984, Penguin, Harmondsworth.
- Freud, S. 1905, "Three contributions to the theory of sex" reprinted in *The Basic Writings of Sigmund Freud*, ed. A.A. Brill 1938, Modern Library, New York.
- Freud, S. 1915, *Introductory Lectures in Psychoanalysis*, 1973, Penguin Harmondsworth, 1973.
- Fry, R. 1993, Adult Physical Illness and Childhood Sexual Abuse, *J. Psychosom, Res*: vol. 37, pp. 89-103.
- Glaser, W.F. 1996, "Sex offenders", in *Psychiatry and the Law*, ed. W. Brookbanks, Brookers, Wellington.
- Goldsmith, M. 1993, "Sex offenders and pornography: A casual connection?" in *Without Consent: Confronting Adult Sexual Violence*, ed. P.W. Eastal, Australian Institute of Criminology, Canberra.
- Hayes, S. 1993, "Sexual violence against intellectually disabled victims", in ed. Eastal *ibid*.
- Jacobson, M. & Herald, C. 1990, "The relevance of childhood sexual abuse to adult psychiatric in-patient care", *Hospital and Community Psychiatry*, vol. 41, no. 2.
- James, M. 1996, *Paedophilia*, in Trends and Issues in Crime and Criminal Justice no. 57, Australian Institute of Criminology, Canberra.
- Johnson, R.L. & Shrier, D. 1987, "Past sexual victimisation by females of male patients in an adolescent medicine clinic population", *American Journal of Psychiatry*, vol. 5, p. 650.
- Knight, R.A. 1988, "A taxonomic analysis of child molesters" in *Human Sexual Aggression: Current Perspectives*, eds. R.A. Prentky & V. Quinsey, New York Academy of Sciences, New York.
- Knight, R.A. & Prentky, R.A. 1990, "Classifying sexual offenders: The development and corroboration of taxonomic models" in *Handbook of Sexual Assault*, eds. W.L. Marshall, D.R. Laws, H.E. Barabaree, et al., Plenum, New York.
- Kraft-Ebbing, R.V. 1965, *Psychopathia Sexualis*, trans. P.S. Klaf, Mayflower-Dell, London.
- McConaghy, N. & Zamir, R. 1992a, "Non-sexist sexual experiences survey and attraction to sexual aggression scale" manuscript cited in *Sexual Behaviour: Problems and Management*, McConaghy 1993, Plenum, New York.
- McConaghy, N. & Zamir, R. 1992b, "Heterosexual and homosexual coercion, sexual orientation

- and sexual roles” manuscript cited in McConaghy 1993, op cit.
- McGeorge, J. 1966, *Reflections of a Psychiatrist*, Hodder and Stoughton, Sydney.
- Malamuth, N.M. 1988, “A multidimensional approach to sexual aggression: Combining measures of past behaviour and present likelihood”, *Annals of the New York Academy of Sciences*, vol. 528, p. 123.
- Marshall, W.L. & Barbaree, H.E. 1988, “The long-term evaluation of a behavioural treatment program for child molesters”, *Behaviour Research and Therapy*, vol. 26, no. 6, p. 499.
- Marshall, W.L. & Pithers, W.D. 1994, “A reconsideration of treatment outcome with sex offenders”, *Criminal Justice Behaviour*, vol. 21, no. 1, p. 10.
- Masson, J.M. 1985, *The Assault on Truth*, Harmondsworth: Penguin.
- Mullen, P.E., Martin, J.L. Anderson, J.C., et al. 1993, “Child sexual abuse and mental health in adult life”, *British Journal of Psychiatry*, vol. 163, pp. 721-32.
- Oates, R.K. 1990, “Understanding the problem” in *Understanding and Managing Child Sexual Abuse*, ed. R.K. Oates, Saunders/Tindall, Sydney.
- Ó'Connor, A.A. 1987, “Female sex offenders” *British Journal of Psychiatry*, pp. 150-615.
- O’Grady, R. 1992, “*The Child and the Tourist: The Story Behind the Escalation of Child Prostitution in Asia*”, Campaign to End Child Prostitution in Asian Tourism, Bangkok.
- Parliament of NSW, Standing Committee on Social Issues 1996, “Sexual violence: Addressing the crime”, *Inquiry into the Incidence of Sexual Offences in NSW Part II*.
- Parliament of Victoria, Crime Prevention Committee 1995, “Combating child sexual assault”, *First Report of Inquiry into Sexual Offences Against Children and Adults*, Government Printer, Melbourne.
- Pearsall, R. 1983, *The Worm in the Bud*, Penguin, Harmondsworth.
- Romans, S.W., Martin, J.L., Anderson, J.C., O’Shea, M.L. & Mullen P.E. 1996, “The anatomy of female child sexual abuse: Who does what to young girls?”, *ANZ Journal of Psychiatry*, vol. 30, no. 3, pp. 319-25.
- Rush, F. 1980, *The Best Kept Secret*, Prentice-Hall, New Jersey.
- Salter, A.C. 1988, *Treating Child Sex Offenders and Victims: A Practical Guide*, Sage, Newbury Park.
- Storr, A. 1974., *Sexual Deviation*, Penguin, Harmondsworth.
- Vizard, E., Wynick, S., Hawkes, C., Woods, J., & Jenkins, J. 1996, “Juvenile sexual offenders”, *British Journal of Psychiatry*, vol. 168, pp. 259-62.
- Watkins, W.G. & Bentovim, A. 1992, “The sexual abuse of male children and adolescents: A review of current research” *Journal of Child Psychology and Psychiatry and Allied Disciplines*, vol. 33, no. 1, p. 197.