Special report

Child sexual abuse: principles of good practice

Prepared by the Independent Second Opinion Panel*, Northern Regional Health Authority (1 October 1987), and submitted to the Cleveland Child Abuse Judicial Inquiry†

1. INTRODUCTION

Although sexual abuse is properly considered to be part of the spectrum of problems affecting the health, growth and development of children, its very nature calls for an especially careful and considered approach when it is suspected. On the basis of our extensive clinical and academic experience as paediatricians and child psychiatrists, we propound some principles of good practice. Our ideas have been amplified by our recent experience in providing clinical second opinions in Cleveland.

2. DEFINITION

Definitions of what constitutes child sexual abuse vary widely. A general definition would be that given by Schechter and Roberge (1976): "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles." A tighter descriptive and pragmatic definition is provided by Mrazek and Mrazek (1985) who suggest that sexual abuse can be envisaged as one of four types: exposure (viewing of sexual acts, pornography, and exhibitionism); molestation (fondling of genitals — child's or adult's); sexual intercourse (oral, vaginal or anal on a non-assaultive and chronic basis) and rape (acute assaultive forced intercourse).

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†Minor stylistic modifications have been made since the submission of this report to the Judicial Inquiry.

3. THE MODE OF PRESENTATION

Studies of populations of children who have been sexually abused, as well as clinical experience, reveal that the results of sexual abuse of children and young people may be manifested in one of five main ways (Jones and McQuiston, 1986):

1. an account by the child
2. disturbed behaviour or changes of behaviour
3. physical symptoms or signs
4. association with other forms of maltreatment
5. allegations by parents, relatives, or other adults.

Within these broad categories there are different degrees of likelihood that a particular presentation is linked to child sexual abuse. At this stage in our knowledge, it is not possible to place specific symptoms and signs in an accurate rank order, and to be able thereby to ascribe degrees of association with child sexual abuse. We can, however, note that certain signs and symptoms have an established association with child sexual abuse, whereas others are less clearly linked. For ease of reference, we present a preliminary grouping of presentation by degree of likelihood of child sexual abuse in *Table 1*.

Some presentations have an established association with child sexual abuse (association with CSA); others are more tentatively linked (low or possible association). It is hoped that future longitudinal studies of samples of abused children will allow these associations to be clarified, taking into account such factors as age and sex differences, and variables relating to type and circumstances of abuse, as well as the victim's understanding and method of coping with the experiences.

Groups of abused children have been studied (DeFrancis, 1969; Burgess and Holmstrom, 1975; Gomez-Schwartz et al, 1985; Conte et al, 1986; Friedrich et al, 1986) and this work has enabled us to construct *Table 1*, albeit tentatively. Other work which is relevant includes the study of young people, who, when surveyed, report that they were abused as children

(Finkelhor, 1979; Runtz and Briere, 1986). Additionally, there have been studies of children with specific signs and symptoms (e.g. prostitution (James and Meyerding, 1977) and self-harming behaviour (Sedney and Brooks, 1984)) that have investigated how many were previously sexually abused.

Table 1. Mode of presentation*

Likelihood of child sexual abuse (CSA)	Behaviour/ emotional disorders	Child's account	Physical signs and symptoms	Other conditions
Association with CSA	Sexualized behaviour Post-traumatic stress symptoms with sexual preoccupations Prostitution Promiscuity Self-mutilation Drug and alcohol abuse Runaway behaviour Acute anxiety syndrome Psychosomatic complaints	Clear by child, substantially or in response to open-ended enquiry	Overt chronic signs (anogenital) Signs of acute trauma (anogenital) Gonorrhoea/ syphilis/AIDS Incest pregnancy Unexplained anogenital bruising, scratches	Neglect Physical abuse
Low or Possible Association with CSA	Acute behaviour change (unexplained) Enuresis and encopresis Para-suicide Anorexia nervosa	Vague by child or no response to highly facilitative method	Marginal anogenital signs Teenage pregnancy Recurrent urinary infection Recurrent vaginal discharge Recurrent abdominal pain Other infections, e.g. Chlamydia	

*This table constitutes an aid to clinical judgement rather than a set of inflexible criteria

From comprehensive review of the literature (e.g. Browne and Finkelhor, 1986) it is noted that few presentations are likely to be conclusively diagnostic of child sexual abuse. Some cases may have multiple modes of presentation, e.g. behavioural and physical, as well as an account by the child. If such presentations are unequivocal, then the probability of a history of previous sexual abuse is likely to be high. At the other end of the spectrum, a presentation at the less severe pole will give rise only to a suspicion that sexual abuse has occurred.

The issue of the child's age has given rise to complex accounts in the literature (Conte, 1985; Browne and Finkelhor, 1986). There is conflicting evidence as to whether an older age of the child is associated with greater or lesser ill-effects. In addition, clinical reports have suggested that the symptoms displayed by the child are different at different ages and developmental stages (Goodwin and Owen, 1982). Thus, there has been variable support for the notion that severity of impact is related to age (Tufts New England Medical Centre, 1984).

In summary, it seems that children can respond with a wide variety of symptoms to the specific trauma of sexual abuse. Nevertheless, there are some symptoms that occur relatively frequently in populations of sexually abused children at different ages: e.g. the child aged 6 years or under may display sexualized behaviour (Tufts New England Medical Centre, 1984; Friedrich et al, 1986; Mian et al, 1986); in the child 7–12 years, anxiety-related symptoms are seen, sometimes with sexual preoccupations (DeFrancis, 1969; Tufts New England Medical Centre, 1984), and in the teenager, acting out behaviour (Runtz and Briere, 1986), self harming (Herman, 1981; Sedney and Brooks, 1984; Browne and Finkelhor, 1986), drug and alcohol abuse (Herman, 1981; Browne and Finkelhor, 1986) and prostitution (James and Meyerding, 1977) are all symptoms resulting from sexual abuse. However, although these behaviour patterns may be common in abused children, they are not specific, i.e. only a minority of children with such behaviours will have been abused.

From the physician's point of view it is worth noting that children may present as an emergency or in the course of routine clinical practice.

4. THE BASIS FOR SUSPICION

Although some presentations are more indicative of child sexual abuse than others, few presentations are specific in and of themselves. Thus while professional suspicion may be justified, professional certainty must be based on appropriate investigation. Having noted the mode of presentation, the basis of suspicion should be considered and the nature and extent of the ensuing assessment, if any, should be determined by this. Who has been suspicious, and for what reasons? What is the capacity for objectivity and what is the quality of the source of the information? Other crucial considerations include the presence of vested interest or prejudgement of issues by any person, whether professional or lay, in the sequence of events associated with a suspicion of sexual abuse. These considerations constitute an argument for a system of checks and balances. We emphasize that the basis of suspicion is a step which enables the professional to proceed to the next stage of evaluation but is not tantamount to diagnosis itself. Once the basis of suspicion has been adequately examined, the professional response must be geared to the individual circumstances.

5. TAILORING THE ASSESSMENT

It is necessary to match the intrusiveness and extensiveness of the professional evaluation with the level of suspicion that exists in the individual case. As this is a complex and relatively new field, it would be inappropriate to attempt to offer a rigid prescription concerning the extensiveness of the evaluation. However, general guidelines can be given: for example, where there is a genuinely strong basis for suspicion, a full psychiatric and paediatric examination would be justified. In deciding the precise method of evaluation preferable in the individual case, the professional's own level of suspicion is an important factor. If the level of suspicion is set too high and the net is cast widely, then not only will a large number of genuine cases be picked up, but also a significant number of false positives. Thus, only in cases where the basis for suspicion has reasonable substance will psychological and paediatric assessment be indicated and justifiable. Conversely, in cases where there is a less strong basis, less intrusive psychological and physical investigations are called for. In such circumstances, it may be considered appropriate for the child to be asked some screening questions by the paediatrician, and/or for the parent to be presented with the facts which include sexual abuse as one of the possibilities in a differential diagnosis. The response to such screening measures can then indicate whether further psychological evaluation and/or paediatric assessment should be considered.

To sum up, we recommend that the level of suspicion by the professional should be based on a judicious consideration of the mode of presentation, any prior history of sexual abuse, and the source of the information, as well as the screening assessment of the individual child. By this filtering process we consider that overenthusiastic approaches with an excess of false positive cases can be avoided. Similarly, the other extreme, of profes-

sionals averting their gaze from suspicious evidence and thus giving rise to an excess of false negatives, can also be avoided. The presumption that abuse has taken place before the evidence is available has particularly damaging repercussions for the child and family. Equally, an abnormally low level of alertness to the possibility of child sexual abuse may deter children subsequently from trusting the adult world sufficiently to enable them to disclose their unfortunate secret.

6. THE EVALUATION — GENERAL COMMENTS

- The parents should be given the same courtesy as the family of any other referred child. It is important for professionals to allow parents to talk about their problems and concerns freely, and within a helping or enabling context, and without a display of emotive overtones by the professionals. Furthermore, the existence of bias or prejudgement on the part of the professionals may act as a considerable barrier to such a constructive context being developed in any particular case.
- All assessments should be carried out within a multidisciplinary framework. The key professionals involved are likely to be social workers, paediatricians, child psychiatrists, psychologists and police. Other professionals that may have knowledge of the family or can make a contribution should be involved; they include general practitioners, police surgeons, health visitors, community child health doctors, school nurses and education staff. A case conference will be convened by the social services department to collate available information.
- Each health district needs to devise a formula which minimizes the number of general and special physical examinations, as well as interviews, of children. For this to be achieved, examinations and assessments should be carried out only by suitably qualified experienced senior staff. Joint planning may be necessary to elicit information required by each assessor and to make it available to all relevant parties despite limited opportunities for personal interviews.
- As any short- or long-term sequelae are likely to be mainly in the form of psychological disturbance, child psychiatry and psychology services have a crucial role in the assessment and therapy of abused children: early consultation and/or referral to such services should therefore be considered.
- The child's and family's general practitioner should be contacted and involved at an early stage.

7. CONSENT TO CLINICAL ASSESSMENT

The usual arrangements apply when the examination is a standard physical, psychiatric and psychological assessment, and in that sense parental consent is implicit. This would include routine physical inspection and screening questions. In such circumstances, physical examination should not go beyond an external inspection of the anogenital area. Consent for more detailed anogenital assessment should be obtained when appropriate. The assent of the child should also be obtained. This also holds for any facilitative (enabling and encouraging) psychiatric and psychological approaches. Similarly, there should be consent and assent concerning the mode of recording (photography, one-way mirrors, audio taping, video taping).

The question of written permission from parents needs to be considered carefully. It should always be obtained when:

1. disclosures or allegations have been made
2. further physical internal examinations have to be done under sedation or general anaesthesia.

When consent for examination is not forthcoming, it will be necessary to discuss appropriate action for the protection and assessment of the child with the social services/police. It should be noted that if a child is a Ward of Court, he/she should not be submitted to an examination or treatment without the permission of the court (except in an emergency). The publication of any reports or sharing of information relating to proceedings before the High Court is a contempt of court: no information can therefore be passed to anyone who is not a party to the proceedings, without the permission of the court.

8. TALKING TO PARENTS OR CARETAKERS

The findings should be communicated to the parents, the differential diagnosis discussed, and the need for further investigation explained. It is good practice to give parents detailed feedback. An accusatory stance by the physician is inappropriate.

9. DOCUMENTATION AND REPORTS

Detailed records should be made of all interviews and examinations.

There should be two reports — from medical and from social services — specifying the information available, the assessments undertaken, the conclusions, the alternative explanations and the reasons for the proposed course of action. They should also give an account of the corroborative evidence — medical, social, family and psychological.

Statements to the police should be prepared as promptly as possible, and concise reports made available for case conferences and/or court hearings.

10. THE PHYSICAL EXAMINATION IN CHILD SEXUAL ABUSE

- *The clinical approach to the child and family* should follow the established principles of good paediatric practice (Meadow, 1987) and includes:

1. a comprehensive history of health, growth, development, illness and behaviour;
2. an appropriate family and social history;
3. a comprehensive physical examination including appropriate developmental assessment and investigations.

- *The environmental ambience.* A paediatric environment is desirable. The interviews and examinations should take place in quiet comfortable surroundings away from the general clinical bustle. Sufficient time should be allocated and as few people as possible should be present. The mother can often help with the examination, which can be done on her lap in the case of young children.
- *The physical assessment* should always begin with a systematic general examination.

The forensic examination should be part of the physical examination. A joint examination between a paediatrician or other children's doctor and an experienced police surgeon may be the most appropriate arrangement. Only one such examination should be done, and that by appropriately trained doctors. In the event of a difference of opinion, which we hope would occur very seldom, we would suggest that consideration be given to referral to a Regional Specialist Panel. Repeated physical examinations are to be avoided unless there are overwhelming medical indications; the permission of the parents must be obtained for each examination. Doctors should bear in mind that it is not wise to rely exclusively on physical examination, except in the clearest cases.

In addition to the gathering of forensic evidence, screening for sexually transmitted diseases, AIDS, and pregnancy testing

should be undertaken when appropriate. The appropriate handling of specimen material is essential.

● *The sex of the examiner* is not usually a critical factor with young children. Older pubertal children should be given a choice if this is practicable.

● *Photography* is desirable as a record in itself and because it may reduce the need for subsequent examinations. It should take place only at the time of the initial examination, preferably by the examiner, and if not, by a photographer of the same sex as the child. It should be borne in mind that photography on separate or subsequent occasions constitutes further examinations of the child.

There is no substitute for accurate detailed accounts and diagrams of the physical appearances in the medical records, and an appropriate proforma can be very effective.

● *Every effort should be made to minimize any traumatic consequences* of the physical examination:

1. children should be asked, whenever possible, who they would prefer to be present, and should be helped to be at ease and comfortable
2. the examination should be deferred if there is any resistance
3. minimal touching by the examiner is desirable
4. junior medical staff should not examine suspected cases on admission or in casualty departments unless there is a life-threatening problem; preferably, the consultant or deputy should be contacted.

● *The differential diagnosis.* Alternative explanations should be considered. Abnormal physical signs are rarely unequivocally diagnostic, with the exception of the presence of semen, or blood of a different group to that of the child.

11. THE PSYCHIATRIC ASSESSMENT

The parents

An assessment of the family is essential, incorporating parental psychological problems, an explanation as to how the family functions, and the parents' parenting potential. Parents should be interviewed both jointly and individually.

The child

● *The concept of the disclosure interview.* The value of this concept is questionable, as traditionally it incorporates the preconception that non-disclosure is tantamount to denial. It also seems to preclude the possibility that sexual abuse has *not* occurred. Disclosure techniques include investigative play, the validity and utility of which may be hampered by suggestion, leading questions, and the possibility that the investigative procedure itself may be sexualizing and abusive.

● *Evaluative assessment:* This is preferable to a disclosure interview. It should follow the same principles as a general psychiatric examination, particularly bearing in mind the following points:

1. It is desirable to see the child on his or her own as well as with other members of the family.
2. Initially there should not be any leading or suggestive questions.
3. Essentially an open-ended questioning technique is used.
4. In the first stage, general evidence of the following are sought: traumatization, attachment problems, behaviour change, behavioural disturbance, social relational problems with peers or adults, unusual attitude, knowledge of sexuality in relation to family patterns, possibilities of fabrication.
5. If there is a sufficiently well established basis for suspicion, then the first stage may be followed by a facilitative second stage. Here great skill is required to avoid the extreme of being overtly leading during questioning or, on the other hand, being insufficiently enabling. The clinician also now faces a dilemma: on the one hand being aware that secrecy and an admonition not to tell are often an integral part of known cases of sexual abuse, and on the other, recognizing that at this stage there may only be a suspicion and no certainty of sexual abuse. Therefore to use leading questions may well confuse the issue both clinically as well as legally. Several methods of approach are available.

(a) The use of different degrees of facilitation in questioning, the use of cues and prompts to memory including anatomically correct dolls. Permission-giving and enabling questions may be described as providing a mild to moderate degree of facilitation for the child. Objective questions which require a "yes" or "no" answer may be considered as providing a moderate degree of facilitation. At the other end of the scale, questions which ask "did this happen or that?", the "either" "or" question, as well as the hypothetical question, for example "if daddy had touched you how would you have felt?", clearly represent a marked and unacceptable degree of facilitation. The extent to which facilitative questions may be considered to be leading takes into account not only the question itself, but also the persistence of the interviewers, the sequence of questions (i.e. whether facilitative or interspersed with other more open-ended approaches), the sensitivity of the examiner to the child's pace, emotions or responses, or the over-use of an authoritative or overbearing, driven style on the part of the interviewer with "rewards" given for the "right" answer. All these factors may be considered to be pointers to the degree to which this facilitative second stage may be considered as leading.

(b) Anatomically correct dolls are often used in the assessment of suspected sexual abuse. They are used by trained professionals as well as, unfortunately, those who are not trained to use them. They should not be used without an understanding of child development, play, fantasizing and psychopathology.

They should certainly not be used as the first stage method of evaluation. They may be a useful adjunct to the facilitative second stage, but in our view there are too many questions concerning the validity and reliability of anatomically correct dolls to recommend their use as a first stage diagnostic aid. They might be useful when a child has indicated sexual abuse at some level, but has then become stuck or wishes to describe a particular detail about sexual abuse and simply does not have the words and concepts, but might be able to show the evaluator. They can be useful with young, barely verbal children when other signs point to a strong likelihood of sexual abuse, e.g. physical findings.

● *Investigative play interviews.* In general, extended investigative play interviews with the express purpose of attempting to get a child to disclose sexual abuse should be avoided. There may be a place for a small predetermined number of play-orientated interviews with a child with whom there is good reason to suspect sexual abuse, but even in this situation the interviewer must exercise particular care to avoid excessive or inappropriate facilitation. Clinical experience suggests that sometimes such an approach, in itself, may become abusive. By contrast, a period of free play for the young child in the context of a facilitative second stage may be a useful component of an evaluative assessment.

● *Video tape technology:* Video tapes are now seen as medical records and as such are subject to conditions similar to those for any other records that may be produced in evidence. Thus,

tapes have evidential qualities in addition to their clinical utility. For evidential purposes, detailed and careful recording of all interview material is essential and video taping is one means of achieving this. Closed-circuit television with video recording can reduce the overall number of interviews by allowing the professionals to view the session unobtrusively. However, there are disadvantages: the unavailability of reliable high quality equipment with reproducible sound; the possible interference with the relationship with the child or even the reduction of spontaneity of accounts.

12. CONCLUSIONS ABOUT SEXUAL ABUSE — INTERPRETATION OF FINDINGS

● *Interpretation and explanations.* The information gathered must be interpreted; this requires experience and also knowledge of psychological aspects of child development, children's play and fantasy, the accuracy of memory of young children and older children, and the extent of their suggestibility and the degree of facilitation employed. Alternative explanations of findings should be considered and a degree of open-mindedness must be maintained.

● *Feedback to parents and other adults.* The paediatrician or child psychiatrist should discuss and explain findings, differential diagnosis and conclusions without being accusatory. It can be useful to invite adults to see matters from the child's perspective when reviewing the situation with adults involved in the case.

● *The conclusions.* The same principles apply as outlined in the physical and psychiatric examination sections. The assessor should be open-minded and consider multiple explanations. Conclusions should be based on findings derived from full assessment of both the child and the family and not merely on one piece of evidence. Psychological abnormalities, unless sexually explicit, may also have alternative explanations. The diagnosis of sexual abuse is a composite one which does not rely on the finding in one particular area, but upon the adding together of information from facets of the child's and family's life. Unlike physical abuse of children, proportionately more weight derives from the statement of the child. Finally, it is essential that the assessors be reasonably expeditious so that early decisions can be made about the child's future.

● *Fabrication.* It is important to consider the possibility that children may fabricate or that spurious allegations may be made by parents or caretakers, as for example in matrimonial disputes in order to deny access (Green, 1986). However, this is not a common phenomenon (under 10%) and it occurs across the age band (Jones and McGraw, 1987). In younger children ideas may be put into their minds. Some manipulative fabrication may occur, particularly in older girls.

● *Open-mindedness.* This is important, as abuse may or may not have occurred; there may be fabrication or we simply may not know or never know. It is for this reason that we have to depend on the balance of probabilities which, in turn, is dependent on physical, family, social and psychological evidence. For these reasons, family assessment is essential. Where there are doubts or disputes, it is helpful to ascertain whether information at interview tallies with information from other sources.

● *Balance of probabilities.* Practitioners should try to assess whether child sexual abuse has taken place on the basis of balance of probabilities. This term is not necessarily used in its legal technical sense, but rather it connotes a process whereby all factors have been taken into account, both those in favour and those against the hypothesis, and these factors have been weighed against each other. On this basis the practitioner comes to a judgement as to whether it is *probable* that abuse has taken place.

13. CONFIDENTIALITY

● With any work with children, the principles of confidentiality are the same. However, in cases of alleged sexual abuse, complex questions of confidentiality inevitably arise because of the conflict between professional ethics and public interest in the detection of child sexual abuse.

Much depends on who is the patient and to whom the confidentiality is extended. Nevertheless, the doctor has to reconcile the extent to which confidentiality can be maintained, in the face of best interests of the child. In practice, the welfare and best interests of the child come first even though this may conflict with the best interests of the parents. In child sexual abuse confidential material may be shared with other professionals helping the patient (social workers), with the understanding that confidentiality extends to them as well. Doctors have been encouraged to share information with the police who, over and above protection, have a detection and prosecution role; they will be more willing to share this information when they have concluded that child sexual abuse is probable rather than merely possible, and particularly so whenever any risk to the child is involved.

● When social workers are involved in the assessment, it would seem sensible for medical confidentiality to be extended to them. Parents need to appreciate that there may be wider sharing of information by social workers with professionals from many other disciplines; the doctor must also realize this. In multidisciplinary settings, the doctor should clarify who has custody of the notes and the confidential information in them, and who has access to them.

● When the child is a patient, parents cannot expect to be accorded the benefits of confidentiality: it must therefore be made clear to them that all relevant information given by them to the doctor concerning the child and any information resulting from the subsequent assessments may need to be shared among professionals working on the case; this also applies to video recordings. The professional has an obligation to alert the family to the extent of this potential sharing of information.

● When all the members of the family are patients, confidentiality becomes even more complex; in court proceedings about welfare, the doctor is obliged to reveal all relevant material to the court. When the paediatrician or child psychiatrist feels that this is not in the best interests of the child, his view should be brought to the attention of the court. In civil cases it may be possible for the court to restrict dissemination of the records.

● Older children's permission or assent is required to disclose confidential information, provided that they have sufficient understanding and intelligence to do this. Although, in younger children, any necessary consent can be given by the person who is "in loco parentis", the parents' informed consent should be sought as well.

14. GENERAL MANAGEMENT

● Sexual abuse does not usually call for *an emergency medical response* unless: there are serious health risks to the child (e.g. bleeding, evidence of acute infection); samples are needed for forensic purposes when abuse is thought to have taken place in the preceding 72 hours (e.g. semen); or there is serious psychiatric disturbance.

● Sexual abuse does not usually call for *an immediate legal response* unless: there is a strong possibility that a perpetrator may commit further immediate sexual assaults on the child in

question or on other children; there is a risk of violence from the alleged perpetrator; or the non-abusive caretaker is incapable of protecting the child.

The presence of items listed in the former category may well necessitate admission of the child to a hospital for either paediatric or psychiatric reasons. The presence of items listed in the latter category need not normally result in an admission to hospital unless there is an accompanying medical reason, but do call for protection of the child. The multidisciplinary team can then decide how best to achieve this.

● *Admission to hospital* may be necessary under the following circumstances:

1. For the treatment of the child
2. To undertake further medical investigations
3. As indicated, at times admission may be arranged for *the protection of a child at immediate high risk of further abuse* or when the child is fearful of returning home. Under these circumstances admission to hospital should be considered as a stop-gap measure until alternative provisions are made.

It should be emphasized that hospitals cannot provide adequate substitute care for young children; therefore children should be admitted with a parent or other family member if at all possible. If this is not possible, free visiting of appropriate family members and friends should be encouraged. The admission of a child to hospital without a parent or familiar adult, and with the intention of isolating the child from the family in order to obtain further information about possible sexual abuse, should take place only after the most careful consideration of the likely benefits as opposed to the possible harm to the child. Generally speaking, hospitals do not provide the appropriate environment for this purpose. Nursing staff and junior medical staff must be fully informed of the circumstances of any admission, be appropriately involved in the care of the patient and be adequately supported in this role.

● *Place of Safety Orders* are primarily the responsibility of the social services department or the police. They should be sought only:

1. When there is a high risk of immediate further abuse to the child and no alternative methods are available to protect the child
2. When parents refuse all further assessment and there is a high probability that abuse has occurred. Under these circumstances a Place of Safety Order should be sought only after full consultation with social services, preferably at a case conference, even when convened in haste. Wardship proceedings may have a place, but this is an issue which is still under discussion.

When a strong suspicion arises, it would be sensible for the response by social services to be a considered exercise rather than an automatic one. This is a crucial time for the medical agencies and social services to collaborate in assessments which would give rise to a series of moderating checks and balances. If these are followed by full multidisciplinary consultation, it is probable that a sound conclusion will be reached in the best interests of the child and fairness to the family. It will be remembered that three conclusions are possible: on the balance of probabilities, "yes" and "no", and also the important category, "don't know".

Such a strategy should limit the overuse of the Place of Safety Order. A 28-day Place of Safety Order is a useful device when there is strong evidence of abuse, but it is a long time to separate children from their families when evidence is less certain. The other side of the coin is the effect of the two contrasting experiences. Known severe or persistent sexual abuse carries a psychological risk to the child that can justify separation. However, separation from parents and family disruption have potential for short- and long-term traumatic effects. Therefore, good judgement is needed in those cases where there are doubts and uncertainties about the existence of abuse.

● It is desirable that an attempt be made to arrange *case conferences* at a time convenient to all senior staff, both from the hospital and the community services. This is because personal attendance by key hospital staff is essential, and if at all possible a written report should be made available by that time. Some case conferences appear to be rather large and we suggest that they be limited to those directly concerned with the case.

● All management should be planned in the context of the procedures devised by the local multidisciplinary child protection committee.

● In each region there should be a core group of highly skilled professionals who can provide an assessment of the most contentious cases. However, not all cases will require the comprehensive and time-consuming assessments indicated above (such as those undertaken by the Second Opinion Panel in Cleveland). Thus, while a core group will be invaluable, the resource would need to be utilized selectively. Such a resource should be available not only for clinical assessment, but also for consultation, training and research.

15. INVESTIGATION AND TREATMENT OF COEXISTING ILLNESSES

These will need to be undertaken.

16. THE ASSESSMENT OF SIBLINGS

This should be arranged whenever there is a high probability of sexual abuse in the index case. It should include a physical examination if this is thought to be indicated. Parental consent should be obtained, but if refused a Place of Safety Order or Wardship proceedings may have to be instituted by the social services department after appropriate consultation. The physical assessment should be a planned exercise ensuring the minimum of discomfort, with the timing of assessments geared to the individual circumstances.

17. SECOND OPINIONS

Parents who request a second opinion should be advised to consult their general practitioner in order to obtain an opinion from someone of their own choice. Doctors and social workers would be wise to consider obtaining a second opinion in cases of doubt and difficulty. The objectives should be carefully defined and ways of minimizing trauma to the child and family should be considered. If a second opinion is being obtained, then those professionals who carried out the initial assessment should make all information available to those carrying out the second assessment to avoid, as far as possible, unnecessary replications of interviews and examinations. In child care proceedings, all second opinions regardless of their favourability or otherwise to any party should be available to the court. If this is not done, in our opinion the best interests of the child may not be served.

18. INDIVIDUAL AND FAMILY THERAPY

A normal family environment should always be sought. Therapeutic intervention, although not denying the importance of abuse, should aim at avoiding further sexualization or undue emphasis on the original abuse.

19. FOSTER PARENTS

Foster parents require careful preparation and continued guidance and help.

20. FOLLOW-UP

Appropriate arrangements should include monitoring of health, growth and development.

21. NATIONAL STATISTICS

National statistics should be gathered of all substantiated cases in order to provide a picture of the size of the problem both within and across regions.

22. CONCLUSIONS

Medical experts should be aware of the weight and influence their conclusions carry with respect to other professional groups. They need to be cautious in the manner in which they couch their conclusions. This is necessary because not only is medical practice based upon a specialized sphere of knowledge and experience, but there is also a traditional degree of trust which is invested in this practice by public and other professional groups.

Medical experts should present their conclusions with the level of confidence or degree of certainty appropriate to their findings. In child sexual abuse, where there may be a range of opinion, it seems appropriate to let other professional groups know of this potential variation in opinion.

The range and interpretation of anal and genital findings is a good example. Norms for different ages and population groups with or without the presence of other potentially complicating anogenital or generalized medical conditions have not yet been clearly established. There has been some well-conducted descriptive work (Paul, 1977; Cantwell, 1981; Hobbs and Wyne, 1986; Emans et al, 1987). These and similar papers should enable the practitioner to draw qualified conclusions in the individual case, especially when these physical findings are in keeping with the account given by the child and/or the family dynamics.

Categorical conclusions are seldom in order when physical findings are considered in isolation. Similar considerations apply to findings from psychiatric or psychological assessment alone, such as in relation to assessment using anatomically correct dolls, or any other single sign or symptom.

It is essential to keep an open mind, to listen to the child and family and to collate all available information before formulating a view. It may not be possible to be certain about a diagnosis even when a great deal of information is available. The practitioner should come to a judgement about the balance of probabilities on the basis of the processes described earlier.

We suggest that rarely should any one individual have the power to weigh, sift and filter all the clinical evidence, to diagnose, and to decide the implications of that diagnosis. Social services departments, paediatricians and/or police surgeons and child psychiatrists will all have major roles, different but related, in the assessment of child sexual abuse at a clinical level. Such a system of checks and balances does not indicate any form of group diagnosis or diagnosis by committee — on the contrary, it calls for a recognition of the necessity for multidisciplinary approaches involving professionals with different bases of knowledge, expertise, experience, and for the sharing of the results of their assessment.

The interests of the child and family will best be served by a sensitive multidisciplinary approach which makes use of all the resources, professional experience and skills available in the local community.

Browne, A, Finkelhor, D (1986) Initial and long-term effects. A review of the research. *In* A Sourcebook on Child Sexual Abuse (edited by Finkelhor, D) Sage, Beverley Hills, 143–179

Burgess, AW, Holmstrom, LL (1975) Sexual trauma of children and adolescents: sex, pressure and secrecy. *Nursing Clinics of North America,* **10,** 551–563

Cantwell, H (1981) Vaginal inspection as it relates to child sexual abuse in girls under thirteen. *Child Abuse and Neglect,* **7,** 171–176

Conte, JR (1985) The effects of sexual abuse in children: a critique and suggestion for future research. *Victimology,* **10,** 110–130

Conte, JR, Berliner, L, Schuerman, JR (1986) The impact of sexual abuse in children; final technical report. NIMH, Bethesda, Maryland

DeFrancis, V (1969) Protecting the Child Victims of Sex Crimes Committed by Adults. American Humane Association, Denver, Colorado

Emans, SJ, Woods, ER, Flagg, NT, Freeman, A (1987) Genital findings in sexually abused symptomatic and asymptomatic girls. *Pediatrics,* **79,** 778–785

Finkelhor, D (1979) Sexually Victimized Children. New York Free Press

Friedrich, W, Urguiza, A, Berike, R (1986) Behaviour problems in sexually abused young children. *Journal of Pediatric Psychology,* **11,** 47–57

Gomez-Schwartz, B, Horowitz, J, Sauzier, M (1985) Severity of emotional distress among sexually abused pre-school, school aged and adolescent children. *Hospital and Community Psychiatry,* **36,** 503–508

Goodwin, J, Owen, J (1982) Incest from infancy to adulthood: a developmental approach to victims and families. *In* Sexual Abuse: Incest Victims and Their Families (edited by Goodwin, J). John Wright, London. pp. 71–91

Green, AH (1986) True and false allegations of sexual abuse in child custody disputes. *Journal of the American Academy of Child Psychiatry,* **25,** 449–456

Herman, J (1981) Father-daughter incest. Cambridge MA. Harvard University Press

Hobbs, CJ, Wynne, JM (1986) Buggery in childhood — a common symptom of child abuse. *The Lancet,* ii, 792–796

James, J, Meyerding, J (1977) Early sexual experiences and prostitution. *American Journal of Psychiatry,* **134,** 1381–1385

Jones, DPH, McQuiston, M (1986) Interviewing the sexually abused child. The C Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect: Volume 6. Republished (1988) *British Journal of Psychiatry,* special publication, Gaskell Press, London

Jones, DPH, McGraw, JM (1987) Reliable and fictitious accounts of sexual abuse to children. *Journal of Interpersonal Violence,* **2,** 27–45

Meadow, R (1987) Staying cool on child abuse. *British Medical Journal,* **295,** 345–346

Mian, M, Wehrspann, W, Diamond, HK, Lebaron, D, Winder, C (1986) Review of 125 children, 6 years of age and under who were sexually abused. *Child Abuse and Neglect,* **10,** 223–229

Mrazek, D, Mrazek, P (1985) Child maltreatment. *In* Child and Adolescent Psychiatry — Modern Approaches (edited by Rutter, M, Hersov, L). Blackwell, London

Paul, DM (1977) Medical examination in sexual offences against children. *Medical Science and the Law,* **17,** 251–258

Runtz, M, Briere, J (1986) Adolescent acting out and childhood history of sexual abuse. *Journal of Interpersonal Violence,* **1,** 326–334

Schechter, MD, and Roberge, L (1976) Sexual exploitation. *In* Child Abuse and Neglect: The Family and the Community (edited by Helfer, RE, Kempe, CH). Ballinger, Cambridge, Massachusetts. pp. 127–142

Sedney, MA, Brooks, B (1984) Factors associated with a history of childhood sexual experience in a non clinical female population. *Journal of the American Academy of Child Psychiatry,* **23,** 215–218

Tufts New England Medical Centre, Division of Child Psychiatry (1984) Sexually exploited children; Service Research Project, Final Report Washington DC, US Department of Justice