Child sexual abuse: diagnostic thresholds

Les abus sexuels chez l'enfant: les obstacles au diagnostic

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Abstract

The term 'diagnosis' as applied to child sexual abuse is a misnomer; nevertheless, it is a useful 'shorthand' way of describing the roles and central tasks of the psycho-social professionals. Some consider the term 'assessment' to be a more apt description of such tasks.

This paper touches on some recent accounts of principles of good practice in relation to assessment, and the potential danger when such broad principles are not adhered to. It goes on to describe interpretation of findings during the assessment. It ends with a brief commentary on second opinions and also on the concept of children and parents as victims of bureaucratic procedures.

Key-words

Child
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Good practice
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Victimology

Introduction

In his psychoanalytical work in Vienna, Freud found that a number of middle class female patients reported some form of intimate sexual contact with their fathers. Freud apparently came to believe that these incidents constituted psychological fantasies rather than incest. His case material has since been reviewed and it has now been suggested that, although some allegations may have had a basis in the psychopathology of father-daughter relationships, in others Freud's judgement may well have been erroneous (1). It is possible that he perceived the accounts as unpalatable and incredible and thus may have ignored some genuine accounts or true incidents of incest. Thus, with Freud, the pendulum appeared to be indicating spurious accusations with a psychological basis; there was, therefore, a danger of under-diagnosis of child sexual abuse.

This tendency seemed to continue until the mid-seventies, after which there was a swing of the pendulum, as exemplified by a statement in the United Kingdom Department of Health and Social Security Paper "*Child Abuse—Working Together*" "*Any child who has claimed they have been sexually abused has to be believed*". Contemporaneously, the 1980s has seen an escalating enthusiasm for identifying perpetrators of intra-familial sexual abuse, possibly before the investigative procedures have been founded on a substantial, reliable and validated basis.

Two American authors Jensen and Garfinkel (2), in their paper entitled Sexual Abuse Investigations Gone Awry, have attempted to draw parallels between crisis in Scott County in the United States and in Cleveland County in the United Kingdom. In Scott County during 1983/84, initially one known paedophile was involved in an allegation of sexual abuse, but such allegations spread quickly; subsequently his extended family, friends and even adults who were said only to be tenuously connected with him, were arrested. A key figure in the Scott County legal procedures was the Scott County attorney, Kathleen Morris. Initially, allegation was made against the paedophile by a former girlfriend; subsequently she, too, was charged, as well as the mother of one of the children who had allegedly been abused. In due course, the paedophile's parents were arrested. Events moved swiftly, with 69 adults being suspected of child abuse; there were suspicions that 60 children were victims and there were simultaneous investigations of murder and of orgies involving multiple sexual acts between adults and children.

Eventually, 24 adults were charged with sexual abuse and 26 children were removed from their homes, some for as long as a year. Access by parents was often denied, with their letters being screened or withheld. In the course of time most of the charges against the adults were dropped because of inconsistencies of adult evidence and because of potential emotional distress of child witnesses. However, the verdicts appeared to be resented by the Chief Prosecuting Attorney who, in an account of her personal philosophy, criticised the jury, saying that the verdict indicated that society did not believe children. She also questioned the principal tenet of American justice, namely, that Government has the burden of proving that a person is guilty. One newspaper reviewer went on to state: 'For her, prosecuting child sex cases is not a job, it is a crusade' (3). It was noted that the children had been exposed to multiple interviews; some had given investigators bizzare but inconsistent account of experiences which included orgies and sadistic homicides; none of these so-called murders were substantiated.

A Commission was established which concluded that the Chief Prosecuting Attorney had handled the cases improperly, but that her inadequacies did not warrant her removal from office. The inadequacies identified included multiple, often coercive interviewing, inadequate reports, children being left in foster care for months and an absence of corroborating evidence. However, the Commission did accept that some of the children had been sexually abused. Equally, there were some unjust accusations which had led to long separations of children from their families.

In the Cleveland County crisis in 1987 there was a sudden rise in the number of allegations of sexual abuse. It proved difficult to obtain precise numbers. However, the report of the Judicial Inquiry (4) states that (two paediatricians)

> 'Dr. Higgs and Dr. Wyatt became the centre point of recognition of the problem. Between them in 5 months they diagnosed 121 children as being sexually abused — 78 by Dr. Higgs, 43 by Dr. Wyatt. Children were referred to them in various ways: some were brought by social workers because of a suspicion of sexual abuse or allegations or complaints; others were referred by family practitioners, health visitors, or community medical officers because of a suspicion of sexual abuse; a few from within the hospital were referred by junior medical staff or by nurses. In some the diagnosis arose on children attending outpatient clinics with medical conditions in which the possibility of sexual abuse had not been previously raised. Many were siblins of, or connected with, these children'.

The report goes on to state 'By reaching a firm conclusion on the basis of physical signs and acting as they would for non-accidental injury or physical abuse, by separating children from their parents and by admitting most of the children to hospital, they compromised the work of the social workers and the Police. The medical diagnosis assumed a central and determining role in the management of the child and the family. It was entirely proper for the two paediatricians to play their part in the identification of sexual abuse in children referred to them. They were responsible for the care of their patients. None the less they had a responsibility to examine their own actions; to consider whether their practice was always correct and whether it was in the best interests of the children and their parents. They are to be criticised for not doing so and for the certainty and over-confidence with which they perused the detection of sexual abuse in children referred to them'. Most of the children were separated from their parents and their homes; however, in due course, after further medical and social service assessments and court reviews, 98 were at home one year later.

In their conclusions, Jensen and Garfinkel (2), look for parallels in the way in which the two investigations went awry. They highlight the following: first, a unitary source of information by one discipline; second, assumed special expertise without sufficient corroboratory evidence to validate suspicions; third, parents were often assumed to be guilty until proven innocent; fourth, repeated and often coercive interviews; fifth, the exclusion of 'outsiders', whose differing opinions were often discounted; sixth, undue haste in removing children from their homes and schools.

Some principles of good practice

Indubitably, the scene in child sexual abuse has changed over the last decade. There has been an emergence of new ideas and, indeed, new techniques utilized in assessment and diagnosis such as the reflex anal dilatation test (RAD), and the use of anatomatically correct dolls. There has also been an enthusiasm for attractive psycho-social theories about origins, balanced by empirical research, with attempts to identify harder data. Another factor in the balancing equation is that society has placed this matter high on the politico-social agenda and the legal system has begun to apply legal logic in examining the issues. In the course of time, principles of good practice have been identified; some were set out in 1988 (5).

However, those principles promulgated before the publication of the Report of the Inquiry into Child Abuse in Cleveland in 1987 (4) are unlikely to be similar to those in 1988 and it is difficult to predict the extent to which the latter will change over the next 5 years. Furthermore, as these principles in their explicit form were established only post-hoc rather than propter-hoc in relation to the Cleveland County crisis, they were unavailable as guides to good clinical practice to the main actors in the Cleveland drama.

Thus, in no way do these principles or this lecture constitute a criticism at the professionals working in Cleveland or indeed in Scott County. The merits and demerits of these two cases are irrelevant to this lecture, but they did constitute an opportunity of looking at issues more clearly and thus provided the basis of establishing principles. What I am saying is that ultimately diagnosis is a question of professional clinical judgement. What distinguishes it from guesswork is that there are a number of indicators potentially available to the professional. It is only after an account has been taken of all the indicators and these placed in context of modern clinical thought that a professional judgement can be made. As time passes and expertise grows, even more powerful indicators may emerge. Nevertheless, professional judgements can be challenged:

First, if a particular indicator thought present is not present, or an account is not taken of a relevant indicator.

Second, taken together the indicators do not lead to the conclusion arrived at by the clinician on the basis of contemporary clinical thought. Thus the professional judgement can be challenged.

Third, in the course of time retrospective analysis may lead to a difference of interpretation or clinical judgement.

Types of abuse

A descriptive pragmatic definition of abuse is provided by Mrazek and Mrazek (6) which suggests that sexual abuse can be conceptualised as one of four types: exposure (viewing of sexual acts, pornography and exhibitionism); molestation (fondling of either the child's or adult's genitals); sexual intercourse (oral, vaginal or anal on a non-assaultative and chronic basis) and rape (acute assaultative forced intercourse). The importance of these types is that a distinction is made between abuse of a non-contact and contact variety.

Presentations

These have been described previously (5, 7). The presentations of child sexual abuse may be in the form of accounts by children or allegations by adults; such abuse may be associated with other forms of neglect, deprivation of physical abuse, or it may be associated with behavioural change or disturbance and physical symptoms or signs. Some cases may have multiple and complex forms of presentation.

The psychology of child sexual abuse is a study of clinical patterns, stereotypes and explanatory models (8). However, only a minority of children and their families show behavioural or family functioning which coincides closely with such patterns; the more they do, the greater the probability that the child has been abused, but sound clinical judgement and open-mindedness are essential when evaluating the evidence.

Association of presentations with child sexual abuse

Children can respond with a wide variety of symptoms to specific forms of sexual abuse. These can be viewed as signs or symptoms which alert professionals to the possibility that the child may have been sexually abused. However, although this is a useful exercise, these patterns are not specific and only a minority of children who show these behaviours actually will have been abused. Some of these symptoms have an established association with sexual abuse whilst others only have a low or possible association. The behavioural features may be categorised under a number of different headings (7).

Social relationships: These may consist of disturbance in relationships and attachment. There may be a phobic avoidance of males (9) the child may show a mistrust of adults in general (10), the child may show impaired peer relationships (11). The child may also not trust the mother, presumably because of her failure as a protector.

Disturbed behaviour: Often after abusive incidents a child may present with the post-traumatic stress disorder syndrome compounded of a sense of distress and numbed affect, fears of future attacks and feelings of helplessness. Such a child may show a degree of hyperawareness, sleep problems and night terros (7). Regressive behaviours have been reported and features representative of neurotic disorder have been found, such as, anxiety and agitation and again, nightmares and night terrors. Some children may develop phobias or

general fearfulness (12). In others, features representative of antisocial behaviour may be found. Somatic symptoms and eating problems or even anorexia have been reported (13). Symptoms of depression and para-suicidal behaviour are not uncommon.

Attitudinal problems: Some sexually abused children show feelings of worthlessness and poor self-esteem (9) which may become an enduring personality trait; they may blame themselves or feel irrevocably damaged.

Psychosexual and allied problems: Younger children may present with what can be described as sexualised behaviour (14). Older children may have disturbances in sexual behaviour, becoming sexually disinhibited and may behave provocatively or occasionally turn to prostitution, self-harming behaviour and drug and alcohol abuse (15, 16).

Academic problems: Deterioration in school work has been reported (17) but for some children the school may become a haven and their scholastic achievements may be surprisingly good.

Reliability and validity of alerting symptoms

Although the above alerting symptoms and behaviour patterns may be common in abused children, they are not specific: i.e. only a minority of children with such behaviours will be found to have been abused. Thus, these features should be seen as screen measures, always bearing in mind that such screen measures are of limited diagnostic utility and the data must be interpreted cautiously. A single feature must be seen as an indicator, and not necessarily as definitive evidence of sexual abuse. The validity of these screen measures increases according to the number that co-exist, the sources of information, and where this is supplemented by corroborative evidence from further careful assessment.

Two concepts derived from epidemiology — sensitivity and specificity — are particularly useful in validation of screen criteria. In this respect, sensitivity can be defined as the capacity of a measure to select a child who has been abused; it represents the proportion of true cases out of all possible cases selected by that particular screen measure. In contrast, specificity is the capacity of a screen measure to identify children who are truly free of sexual abuse by keeping the number of false negative to a minimum. Such validation exercises need to be complemented by reliability checks.

It is crucial that the judicial system, the professions and society must give attention to the twin issues of which is worse or which is better — more false positives and to have an excess of families under question; or more false negatives and to have more missed cases of CSA. And how much uncertainty we are willing to accept.

The basis of suspicion

Professional suspicion may be justified but professional opinion about probability must be based on appropriate assessment. The clinician has to consider a number of factors, including the source of the suspicion and the quality and objectivity of the information that is offered (5) as pre-judgement of issues must be avoided. It should be emphasized 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 confirmation of that suspicion (5). If clinicians are overly or enthusiastically suspicious, they are likely to identify an excess of false positive cases; in contrast, if the threshold of suspicion is too low, there will not only be a reduction in true positive cases but a simultaneous excess of false negatives.

Consent to assessment

In the wake of the Cleveland affair, a sensible policy of seeking parental consent to assessment of the child, and child consent in older children, must be established. It is suggested that parental consent is implicit in standard clinical assessments which include routine physical inspection of the child and screening questions. However, for more detailed assessment parental consent should be obtained and, when appropriate, agreement of the child as well. It is thought that such consent should apply as well to special methods of recording. It is also wise to obtain written consent if the assessment is going to be more than routine.

Tailoring the assessment

It has been suggested that it is necessary to adjust the intrusiveness and breadth of the professional evaluation according to the level of suspicion that exists in the individual case (5). It is not possible to provide a rigid description of this tailoring: broadly, the stronger the

basis of suspicion the fuller the paediatric/psychiatric/social investigation. When the basis of suspicion is weaker, a further filtering/screening exercise would help to gauge the appropriate depth of the investigation. The response to such screening measures can then indicate whether further psychological evaluation should be considered.

Principles in relation to evaluation and examination

The professional should avoid bias, prejudgement, emotional overtones and an accusatory stance, and should display an open-minded reaction to their accounts. The clinician must provide a comprehensive, sensitive, multidisciplinary approach. The previous findings should be communicated to the parents and the need for further investigations explained.

In the examination of the children a number of principles or practices appear to be sensible: first, children should not be subjected unnecessarily to repeated examinations or disclosure interviews; the examiner must be cautious about the use of forceful (so called facilitatory) examination techniques; it is helpful to examine the child in a sensitive atmosphere, always ensuring that the child is as comfortable as possible; finally, investigations need to be child-focused ratehr than attempting to fit the child into the system.

Psychiatric assessment

There are a number of potential pitfalls in psychiatric assessment and the following approach will help the clinician to avoid them. In all cases a carefully taken history is essential to allow information about the psychological background of sexual abuse to emerge, together with gathering information about immediate and long-term possible sequelae and any changes in the child after the alleged experience. In addition, the history may provide clues as to the reliability of the accounts both of the child and of the parents. The child's psychiatric examination must, first and foremost, address itself to the child's psychiatric status, including mood, capacity for relationships, personal strengths, defence mechanisms, extent of fantasizing and evidence of disorders of behaviour, including sexual behaviour (8).

In the above, a distinction should be drawn between the standard clinical psychiatric assessment and the disclosure interview. The

basis of the disclosure interview is that skilled, sensitive interviewing will allow children to confide their secrets. Unfortunately, this has become questionable as it incorporates the preconception that non-disclosure is tantamount to denial. This seems to preclude the possibility that sexual abuse has not occurred (5, 7).

Disclosure techniques include investigative play, the validity and utility of which may be hampered by suggestions, leading questions and the possibility that the investigative procedure itself, when unwisely conducted or prolonged, may become sexualising and abusive.

Many authorities take the view that evaluative assessment is preferable to disclosure interview. Evaluative assessment follows the same principles as a general psychiatric examination, while bearing in mind the following points. Interviewers or assessors need to be senior, knowledgeable and experienced, as there are potential civil and criminal implications; they require traditional interviewing skills and a background knowledge of the child's play, language and memory, as well as knowledge of normal and abnormal sexual development and psychology of child sexual abuse (8). The interviewer needs to build a supportive and honest relationship with the child, while recognising that no guarantees can be offered about confidentiality. The initial questioning should be flexibly open-ended, with little or no leading questions or suggestions. The child should be encouraged to talk spontaneously. The pace of the interview is also a factor, with some authorities recommending a slower pace and frequent contact, whereas others are concerned that the interview process, when prolonged and focusing on 'disclosure', may become abusive in itself. Other facilitating techniques, such as the use of hypothetical questions, have been seriously questioned by some authorities. However, there is general agreement that facilitative techniques should not be used in the first stage of interviewing. When these techniques are used, great skill is required to avoide the extreme of being overtly leading during questioning, or insufficiently enabling. The use of different degrees of facilitation in questioning has been outlined by Jones and McQuiston (7). As part of this facilitating exercise, an anatomically correct doll may be used in the assessment of suspected sexual abuse. Unfortunately, such dolls are often used by those who are not trained to use them; they should not be used without an understanding of child development, play, fantasizing and psychopathology. They are thought to be particularly useful when a younger child has indicated sexual abuse at some level but then has

become stuck, or wishes to describe a particular detail about sexual abuse but does not have the words or concepts to do this (7). Any interviewer using anatomically correct dolls needs to bear in mind that many questions remain concerning their validity and reliability.

The stages of interviewing with a younger child consist of an introductory free period with open-ended questioning; seeking of evidence of traumatization; attachment problems; behaviour and social relational problems; unusual attitudes, sexualised behaviour and possibilities of fabrication. A second stage of facilitative interviewing requires experience and skilled interviewing.

Interpretation of findings

The information collected needs to be collated and interpreted. This exercise requires experience and extensive theoretical knowledge. In the process alternative explanations of findings should be considered and a degree of open-mindedness must be maintained (5), as abuse may not have occurred, or the truth may never come to light; thus the assessor must be able to live with uncertainty. During the above exercise it is important to bear in mind the possibility that the 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. In younger children, ideas may be put into their minds and in older children some manipulative fabrication may occur, particularly in adolescent girls.

In the final analysis, conclusions are usually drawn on the basis of clinical judgement of the balance of probabilities. The term is not necessarily used in its legal technical sense but rather it denotes a process whereby all information and evidence is taken into account, for and against the hypothesis, and these findings have been weighed against each other.

Finally, Royal College document (18) and the Cleveland report (4) (1988) suggest that the practice of treating a child with the primary intention of encouraging 'disclosure' is likely to be confusing, and possibly harmful, for all parties.

Conclusions

The assessor should be open-minded and should consider several explanations. Conclusions should be based on findings derived from a

comprehensive assessment of the child and family, and not merely on one piece of evidence, always bearing in mind that psychological abnormalities (unless sexually explicit) may also have alternative explanations. Thus the assessor needs to add together the information from various facets of the life and behaviour of the child and family. As already indicated, more weight should be given to the child's statement than is given in cases of physical abuse. Finally, it is essential that the assessment should be reasonably expeditious, so that early decisions can be made about the child's future.

Second opinions

This has now become an area of considerable concern because parents often request a second opinion and, indeed, in circumstances where there are such awesome consequences for the child and the family, parents are entitled to one. It is hoped that this second opinion will be skilled, objective and independent and thus parents need a degree of choice in this. The Social Services may wish to obtain a second opinion when there is doubt, or if the case is complex. In order to minimise the impact on the child, all available information from the initial enquiry should be made available to avoid unnecessary replications. With regard to a 'second opinion' by a close colleague, 'in-house' second opinions by consultants working together are unlikely to be acceptable in the future, as they will be seen as 'cosy chats' or sharing of information. These may even be viewed by cynics as clone second opinions, rather than objective or independent assessments.

The expert offering the second opinion should be aware that hypotheses are being advanced at different levels: the first is on the basis of their evidence alone that that expert gathered during assessment; and then according to whether there is corroborative evidence from other sources.

The fallacy of the spurious external criterion has to be borne in mind. In these circumstances, the expert from one discipline may make the presumption of abuse based on another expert's evidence, that is, each expert uses the others evidence as confirmation of sexual abuse. What is more questionable is when the new expert is informed that the child is 'starting to disclose', as this may unduly influence the implementation of full procedures of the second opinion.

The bedside manner in investigation of child sexual abuse

Parents should always be treated with the same courtesy as any other child's parents. Before proceeding with intrusive investigations, either of a psychological or physical nature, their informed consent should be sought and furthermore they need to be informed and consulted at every stage. In the current litigious climate all major decisions should be confirmed in writing to parents together with explanations and implications of those decisions. It has also been suggested that they should be given details of their rights, and avenues of complaints and appeals. When it is necessary for the children to be separated from their parents, and it is to be hoped that separation from mother will be a rare occurrence, arrangements for access should be agreed with the parents, if possible.

The fundamental principle is to listen carefully to, and to treat seriously, what the child says, and to take this into consideration in drawing any conclusions. Furthermore, it is essential that the child's views about experiences and wishes for the future are ascertained and taken into consideration. Most experts will offer the child appropriate explanations and counselling about any investigations and decisions. Furthermore, the consent of the child, particularly older children, should be obtained before any intrusive examinations, including medical examinations and photography. Qualifications about confidentiality remain: it is not possible in cases of child sexual abuse to offer absolute guarantees of confidentially to the child; similarly, it is not possible to enter into any collusive discussions with the child.

Management

Much has been written about management and the essence of management has been identified elsewhere (5): this includes the necessity of avoiding emergency care responses unless there are serious health risks to the child, or if samples are needed for forensic purposes, or if the child displays serious psychiatric disturbance. Similarly, an immediate legal response should be avoided unless there is a strong possibility of further assault or a risk of violence, or there is good evidence that the non-abusive guardian cannot protect the child.

In the Cleveland Inquiry, medical, social and legal agencies were criticised about their management. All have to act with skill and

wisdom, with the direct objectives of identifying the guilty and protecting the innocent, and of offering appropriate help for all. However, within this framework agencies have to establish effective and humane procedures for investigations. It is, therefore, essential to have appropriate training of all staff, with a system of checks and balances employed by the multidisciplinary team. All agencies have to bear in mind the need to seek corroborating evidence.

Control of the over-zealous

The final question regarding principles of good practice relates to control of the over-zealous: how do we recognise crusaders and how do we recognise doctrinaire attitudes? Personalities and attitudes should not be allowed to obscure the wider issues and principles of good practice outlined above. If these philosophies, personalities and attitudes are not controlled, both the children and their families may become procedural victims.

Children as procedural victims

When there is a presumption of abuse without adequate attempts at comprehensive assessment and validation, it becomes apparent that children may be exposed to traumatic procedures by professionals which may be extremely distressing and anxiety-provoking: for instance, children may be exposed to multiple coercive questioning and unnecessarily be removed from their families and familiar environments. Another aspect of this is the induction of an expectation set whereby children obtain the impression that they have to give the 'right response' to be allowed to go home. Children may be treated with inadequate sensitivity; there may be lengthy delays in the assessment and other procedures; there may be forceful separation of children from parents. Hence, foremost in the expert's mind must be the question of whether the needs and rights of children are being respected. The question remains of how the experiences and views of the children can best be ascertained and how investigative procedures can be controlled so that they are not misapplied.

A fundamental principle is the employment of senior knowledgeable and trained staff and skilled interviewers. Assessors or experts need to be supportive and honest in their approach and should avoid collusion and promises or guarantees which cannot be kept. They also

have to exercise maximum discretion in using 'encouraging' or 'facilitating' interviewing techniques. In the interviewing, they need to be guided by the level of suspicion, the level of the child's distress and the possible value of, and objectives met by, this information. However, they must also respect the child's persistent refusal to talk about their experiences. They have to ask themselves whether the investigatory processes are in the best interests of the child's psychosocial needs and whether the child's welfare is totally dependent on obtaining the truth.

Parents as procedural victims

This may occur when a parent is suspected and assumed to be guilty until proven innocent. This is more likely to occur when the parents are exposed to inexperienced professionals; or when validly independent and objective second opinions are not available; or when differing second opinions are discounted. Experts must consider whether the skills of experts in other disciplines are being utilised to the full, and must find ways and means of controlling unacceptable procedures involving parents. The interviewer must handle the exercise with sensitivity and honesty and parents need to be fully informed at all levels by those who are initially suspicious and by those who are conducting the assessment.

One other contentious area is the diagnostic case conference. It is in this setting that the evidence needs to be examined, as few presentations are conclusively diagnostic. Within the setting, one has to ask how the parents perceive the evidence and what are the parents' views. One must also remember that this should be an effective communicational informational process, rather than an ad hoc trial. Those attending the case conference must ask themselves how they can achieve good sense and clinical judgement, and how both the parents and children can best be kept informed and helped to contribute to being architects of their own destiny.

The role of the child psychiatrist in diagnosis and treatment

Recently the Royal College of Psychiatrists outlined their policy in relation to child psychiatry and child sexual abuse (18). First the child psychiatry perspective can complement that of other professionals.

Child psychiatrists see their primary orientation as the recognition, prevention and treatment of psychiatric disorder in children, and as such are primarily concerned with CSA as a factor which has an impact on a child's psychological development. Child psychiatrists do not see themselves as having the primary detection role of the Police, nor the primary protection role of social services. However, they are likely to be asked to help to clarify situations which are complex or where there is disagreement or dispute, and in these circumstances the child psychiatrist is likely to be the person with the appropriate assessment and diagnostic skills. As the College suggests, the boundaries between professional roles are not seen as being rigid but rather with inevitable overlap.

Résumé

Le concept « diagnostic » tel qu'il est appliqué aux abus sexuels envers l'enfant est inadéquat. Il offre néanmoins une manière simple et concise de définir les rôles et les principales tâches des professionnels psycho-sociaux. Certains (auteurs) considèrent que le terme anglais « assessment », c.à.d. mise au point (analyse) convient mieux.

Cet article présente quelques-uns des principes récemment développés en ce qui concerne cette mise au point ainsi que les dangers auxquels expose le non-respect des principes. Il montre ensuite comment on peut interpréter les découvertes faites au cours des mises au point. Il se termine par un bref commentaire sur les avis résultant d'une seconde analyse ainsi que sur le concept des enfants et parents en tant que victimes de procédures bureaucratiques.

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