10. Sex abuse in childhood

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INTRODUCTION

The sexual abuse of children is one of the 'new' epidemics of the last decade. In the light of the recent public debate about this topic, which is an area fraught with difficulty and controversy, it is interesting to review Kempe & Kempe's (1978) description of the sequence in which child abuse has been recognised in the community.

First, it was seen as having little to do with the wider community but, rather attributable to social or psychiatric deviants. *Second*, attention was paid to more lurid forms of physical abuse. *Third*, the focus turns to physical neglect, infants who fail to thrive and more subtle forms of abuse such as poisoning. *Fourth*, emotional abuse, emotional deprivation and rejection are recognised. *Fifth*, sexual abuse is recognised. However, in the 1970s it would have been difficult to anticipate the recent legal backlash in the USA and in the UK from those parents who consider themselves wrongfully accused.

Definition

Definitions of what constitutes child sexual abuse vary widely. A general definition would be that given by Schechter & 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 & Mrazek (1985), who suggest 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).

Incidence

Estimates of incidence are bedevilled by differences of definition and are closely tied to the source of the information. Unfortunately, in many ways the available population surveys of prevalence and incidence are open to criticism of either flawed method and/or as not being representative of the general population (Markowe 1988). For instance, few studies distinguish between the four types described by Mrazek & Mrazek (1985). Rates derived from criminal or social service statistics are likely to give a gross underestimate. In an attempt to overcome such distortions, Mrazek et al (1981) screened professional groups in Britain and obtained a figure suggesting that an absolute minimum figure of three children per thousand could be recognised by a professional as having been abused at some point in their lives. While retrospective

studies of non-clinic populations are likely to give a more valid estimate, such estimates will be influenced by culture and selectivity, for instance, Finkelhor (1979) in the USA gives the figure of 19% of female and 9% of male college students who reported that they had been sexually abused as children. However, some might consider these rates inflated by inclusion of incidents where the child has observed an exhibitionist. In addition, Russell (1984) gives a figure of 2% of women raised by biological fathers who report sexual abuse by them, as against 17% of those raised by stepfathers. Higher rates are reported by younger respondents. Of those reporting abuse 44% involved physical contact but not sexual intercourse, and a minority (5%) involved sexual intercourse. The rates reduce considerably if we focus on incest alone: a conservative estimate is that up to 5% of adult women and 2% of adult men have been sexually abused within the family (Finkelhor 1979). One of the best of the national population studies is the Baker and Duncan survey (1985) which used a MORI poll but even their findings have to be viewed with caution (Markowe 1988). In their UK national survey of those aged 15 years and older, they calculate that 12% of women and 8% of men have had abusive experiences in childhood, giving a conservative estimate of one in ten over the first 15 years of life. If we accept the rate of 12% of women and assume that the abuse occurs at an even rate over the 12 years from 3–15, the cumulative incidence would be 1% at 3 years, 2% at 4 years, 3% at 5 years, and 4% at 6 years, etc, some of which would be single episodes, some repeated and some chronic abuse.

It is not easy to identify those children who have been abused, as often there is no witness and clear-cut physical evidence is present in only about 15% of cases at any point in time (Kerns 1981). Thus, of 1000 girls aged 6, 4% are likely to have been abused but only about 0.6% would present with demonstrable physical evidence. The latter figure may also be inflated because it is based on the assumption that all abuse is chronic; if it is not, the incidence could range from 0.2–0.6%.

Finally, much of the Child Sexual Abuse reported in surveys is abuse without physical contact (e.g. indecent exposure). On the other hand it is accepted that official statistics will always under estimate the size of the problem as there is an unwillingness to report abuse (Markowe 1988).

PRESENTATION

The various forms of presentation are described in the document submitted to the Cleveland Judicial Inquiry—*Child Sexual Abuse: Some Principles of Good Practice* (Kolvin et al 1988a). The presentation may be in the form of accounts from children or allegations by adults; it may be associated with other forms of neglect, deprivation or physical abuse, or it may be associated with behavioural change or disturbance and physical symptoms or signs (Jones & McQuiston 1986). Clinical reports suggest that the form of presentation is related broadly to the child's age and, in addition to this, some cases may have multiple and complex forms of presentation. However, it is still a matter of debate whether the child's age or the complexity of presentation have prognostic significance.

The psychology of child sexual abuse is the study of clinical patterns, stereotypes and explanatory models. However, only a minority of children and their families show behaviour and family functioning which coincide 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 evidence. In this chapter we focus mainly on behavioural presentation but, throughout, we emphasise that while child sexual abuse may present in many different ways, few presentations will be conclusively diagnostic.

Alerting signs and symptoms

Children can respond with a wide variety of symptoms to the specific trauma of sexual abuse. There have been a number of attempts to define patterns of behaviour that should alert professionals to the possibility that a 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. Few presentations are conclusively diagnostic of child sexual abuse and in all cases clinical judgement and good sense must be exercised.

The behavioural picture

The behavioural features may be categorised into a number of different groups (Jones & McQuiston 1986). It may be useful to view them as follows: (1) social interactions, relationships and attachments; (2) other forms of disturbed behaviour; (3) some unusual personal and attitude problems; (4) psychosexual; (5) academic (Jones & McQuiston 1986). Some sequelae occur more frequently in younger children, some in older children, and some are found across the age range. Some behavioural features reflect recent abuse, whereas others may be seen as longer term effects (Green 1986). Certain behaviours occur individually or in various combinations in up to three-quarters of abused children (Jones & McQuiston 1986). When looked at from the other end of the telescope, we estimate that a minority of disturbed children attending the university-based child psychiatric clinic in Newcastle have been sexually abused. There are suspicions in about a quarter but in only 50% of the latter are these suspicions substantiated (Kolvin et al 1988b). Furthermore, although each of these individual behaviours may be common in abused children, they are not specific, i.e. only a minority of children with such behaviours will have been abused (Kolvin et al 1988b).

Finally, in all of the above, special attention should be given to *changes* in behaviour, attitudes and achievements.

(1) *Social interactions, relationships and attachments*

One of the early effects of an abusive experience may be a phobic avoidance of males (Sgroi 1982) and subsequently the child may show a mistrust of adults in general (Herman et al 1986). The child may also show impaired peer relations (Adams-Tucker 1982).

There may be relational difficulties within the family and the child may not trust his or her mother, possibly because of her failure to protect them. Some younger children, however, may show an anxious attachment to their mothers.

(2) *Disturbed behaviour and psychiatric features*

Immediately after an abusive incident a child may present with the dramatic features of a *post-traumatic stress disorder*. The child has a distressed and numbed affect, is filled with fears of future abusive attacks and feelings of helplessness. He or she may show hyper-awareness, with everyday objects and occurrences acting as reminders

of the incident and having the potential to give rise to panic attacks. There is often difficulty in sleeping and the child may have night terrors (Jones & McQuiston, 1986).

Other psychiatric features are widespread and yet non-specific. In younger children *regressive behaviour* has been reported and includes bedwetting, thumbsucking and a tendency to cling. The child may show a reduced interest in their environment as represented by poor exploration and a reduction in creative play. A host of features representative of a *neurotic disorder* may be present, such as anxiety and agitation, nightmares, night terrors or other sleep disturbances (Lewis & Sorrel 1969).

Some children may develop phobias or general fearfulness (Kempe & Kempe 1978); others may show hysterical symptoms (Goodwin & Owen 1982). *Acting out* and *testing out* behaviour may occur in younger children, and features representative of a conduct disorder may be found in older children, consisting of petty delinquency, running away, promiscuous behaviour and drug involvement. Somatic symptoms and eating problems or even anorexia have been reported (Browning & Boatmen 1977). Symptoms of *depression* and para-suicidal behaviour are not uncommon.

(3) *Personal and attitudinal problems*

Classic analytic theory suggests that children must progress through normal developmental stages in order to achieve an appropriate adult sexuality, and therefore, on theoretical grounds, child sexual abuse may seriously harm such development. It is therefore not surprising that sexually abused children may display feelings of worthlessness and poor self-esteem, together with a sense of shame (Sgroi 1982). They may see themselves as irrevocably damaged and may also blame themselves for precipitating a crisis in the family (Anderson 1981). These reactions and attitudes may become enduring traits of the child's personality. Their worthless view of themselves may be confirmed by others with whom they fail to form lasting relationships.

(4) *Psychosexual and allied problems*

Younger children may present with what can be described as sexualised behaviour, being precociously preoccupied with more adult types of sexual behaviour (Friedrich et al 1986, Mian et al 1986). This behaviour may distinguish them from their peer groups, who often react adversely.

In adolescence, disturbance in sexual behaviour is not uncommon. These youngsters may become sexually disinhibited and behave provocatively (Browning & Boatman 1977, Sedney & Brooks 1984). Occasionally they may turn to prostitution (James & Meyerding 1977) or self-harming behaviour and drug and alcohol abuse are not uncommon (Conte 1985). Teenage pregnancy may occur.

(5) *School academic problems*

Deterioration in school work is reported (Goodwin 1982), but for some children the school becomes a haven and their scholastic achievements are remarkably good. Some may be reluctant to participate in physical activities and may even avoid school medical examination (Porter 1984).

PSYCHOLOGY OF CHILD SEXUAL ABUSE

Factors promoting abuse

It is useful to draw a picture of the factors which have the potential for promoting sex abuse and this is provided by Finkelhor (1984) who has conceptualised four basic

'preconditions'. *First*, an adult who has the motivation of being sexually aroused by children, together with the ability to fantasise a sexual interaction with the child; there may also be an impaired capacity for normal and sexual relationships and there may have been previous sexual abuse as a child. Not all these features necessarily coexist in an individual. *Second*, there may be the relative lack of internal restraints, determined by inadequate acquisition of socially appropriate norms, compounded by poor personal controls or other personality problems; in addition, alcohol and/or drugs may reduce normal inhibitions. *Third*, there may be inadequate external inhibitions in the shape of social and family forces which constrain the predisposition to sexual abuse, particularly the protection afforded to the child by the mother. The *final* factor is the ability of the child to resist abuse, which is enhanced by parental teachings and educational programmes; however, some children have a poor sense of danger. While the above stereotype allows a better understanding of factors which have the potential of promoting sexual abuse, it can give rise to a wide expectation set which can seriously mislead the inexpert.

Adaptation to abuse

Jones & McQuiston (1986) provide a convincing account of the processes by which the child and family may adapt to abuse. Often, the potential abuser becomes the most available care-giver, so the child and the care-giver become mutually absorbed and closer together. The non-involved spouse becomes aloof and excluded. The relationship between the abuser and the victim gradually becomes sexualised, starting with closer physical contact and culminating in inappropriate sexual contact. In the process, children become very confused and while they may suspect that such behaviour is wrong, they do not wish to lose the close emotional ties and may even begin to wonder if this is a normal process which happens to all children. The abuser abuses the care-giving relationship of the child and asks the child to keep their 'special secret', misusing parental authority to maintain control. Alternatively, gifts or threats of break-up of the family are used to ensure secrecy.

In this way the child's feelings are harnessed and exploited by the abuser. In the course of time the child develops a sense of fear and guilt, compounded by a desire to be loved and perhaps even some sexual pleasure. A child whose personal security and that of the family is threatened by the abuser may find it hard to escape from this situation or to prevent a recurrence of the abuse. A child thus trapped is under a great deal of stress and develops a sense of helplessness, as any action he or she may take may be seen as having dreadful personal and family repercussions.

Memory

Academic psychologists are beginning to address the crucial subject of memory in childhood (Jones & McQuiston 1986). This is a matter of particular importance in child sexual abuse as it has been suggested that a young child's memory is unreliable. A number of points merit emphasis: first, the information available suggests that the forgetting curves in children and adults are broadly similar (Jones & McQuiston 1986). Second, it has been shown that the memories of both adults and children are susceptible to stress and to leading questions posed by authority figures. Third,

younger children's memories do seem to differ from those of older children and adults in that they recall less detail, possibly as a result of language limitations and a more limited understanding of the world in general; but the amount of detail recalled tends to increase with age (Davies & Flin 1986). It can be facilitated by the use of neutral prompts or cues using dolls' houses, cars and other toys as props to memory (Marin et al 1979). Fourth, the younger child's memory for repetitive events, such as repeated assaults, is likely to be accurate. Fifth, children may not recall events in the past in as accurate a sequence as adults, but they can be assisted in this by highlighting important events such as birthdays and relating incidents to them. Sixth, it is widely accepted that a child's recall will be as good as an adult's for salient events (Maecham 1977) and, indeed, may be less distorted by prejudice than an adult. Finally, it has been suggested that younger children may be inclined to confuse reality and fantasy but the evidence in support of this notion is tenuous (Jones & McQuiston 1986, Johnson & Foley 1984).

The above suggests that the young child's recall of detail may be improved. This can be achieved by prompts and cues, as indicated above. Experienced interviewers can also help to improve recall: the technique consists of eliciting information about incidents occurring before the critical event and then allowing the child to proceed at his or her own pace, with little in the way of prompting (Dent 1982).

THE ROLE OF THE CHILD PSYCHIATRIST

In most cases, physical examination of the child will have preceded psychiatric assessment, the exception being in those cases involving children already in the care of the Social Services. In all cases a careful history is essential, to allow information about the psychology of sexual abuse to emerge and to gather other information about immediate and long term sequelae and any changes in the child after the experience. In addition, the history may provide clues about the reliability of the accounts, both the child's and the parents'. Family's systems need to be examined and a full history taken from each parent, which includes sexual functioning and any parental childhood experiences of physical and sexual abuse.

The interview with the child

The psychiatric examination addresses itself to the child's psychiatric status, including mood, capacity for relationships, personal strengths, defence mechanisms, extent of fantasising, and evidence of disorders of behaviour, including sexual behaviour. The exercise of diagnostic labelling is far less useful than advancing an individualized psychological theory to explain the behaviour that a particular child exhibits (Kolvin 1978).

Although it may be helpful to observe a child's reactions to his or her parents the child may not be able to talk freely if they are present: it is therefore desirable to see the child alone. Green (1986) has advocated the inclusion of other members of the family, including the alleged abusing parent. However, this is a contentious area and is not widely agreed (Corwin et al 1987): can children confront an adult with an emotionally loaded event; how does the expert interpret loving interactions between father and child, which are not uncommon in incestuous families (Brant & Sink 1984)?

Some authorities suggest that children's responses are elicited best by indirect methods such as play, fantasy and dreams (Green 1986). If insufficient information is obtained using this approach, some clinicians have used enabling or facilitative approaches employing varying degrees of pressurising questions. A current fashion is the use of anatomically correct dolls in investigative play with younger children, but questions have been raised concerning the reliability of this technique. It may be useful when there are some indications from the child that sexual abuse has taken place and when the child has difficulty in describing the experiences (Kolvin et al 1988a, Jones & McQuiston 1986). However, this technique should not be used without an understanding of child deveopment, play, fantasy and child psychopathology. There are also always additional problems in interpreting what the child demonstrates.

The interviewer

Interviewers or assessors need to be senior, knowledgeable and experienced as there are potential civil and criminal legal implications. They require traditional interviewing skills and a background knowledge of children's play, language and memory, as well as knowledge of normal and abnormal sexual development and psychology of child sexual abuse. The interviewer must build up a supportive and honest relationship with the child, and must recognise that no guarantees can be offered about confidentiality. The child should feel that he or she has consented to the interview, as well as the interviewer having obtained the consent of the parent.

The initial questioning approach should be a flexible open-ended one, with little in the way of leading questions and suggestions. The child needs to be encouraged to talk spontaneously and this will be helped by the interviewer reducing tension in the interviews by interspersing general or neutral topics with more specific emotive themes. Probes should be brief and open-ended in order to allow the children to give their own spontaneous accounts. A major problem is that some abused children are often reticent or secretive, but this is not necessarily evidence of abuse.

There is also the question of the pace of the interview. Some authorities recommend a relatively slow pace and frequent contacts over a longer period (Green 1986), whereas others are concerned lest the interview process, if prolonged and focusing on 'disclosure', may become 'abusive' in itself. Furthermore, Corwin et al (1987) point out that contamination of data is likely to increase with the prolonging of time of the evaluation, and also the opportunities for coercion and recantation. In these circumstances some interviewers shorten the process by utilising facilitating techniques. It should be stressed that there is no place for threatening, lecturing or telling the child what he or she should do.

The foundation upon which the clinician bases his conclusions must be examined. His theoretical viewpoint and the extent and nature of clinical experience is important as, clearly, if the experience is not based on a representative sample, the conclusions reached may not be valid generally.

The basis of suspicion and the extent of the assessment

Given the mode of presentation, the clinician has to ask a number of questions, particularly what is the *basis of suspicion*? This includes the source of the suspicion and the quality and objectivity of information that is offered (Kolvin et al 1988a). Such questions also apply to any persons contributing to information which gives

rise to the suspicion. Special attention should be given to avoiding prejudgement of issues.

The extent of professional assessment should be based on a judicious consideration of the mode of presentation, the source of information, prior history of sexual abuse and a screening assessment of the individual child. Thus, where there is a strong basis for suspicion, a full paediatric and psychiatric examination would be justified. However, where a level of suspicion of sexual abuse is set too high, professionals are likely to cast their nets too widely and will not only pick up a large number of genuine cases but also a significant number of false positive ones (Zeitlin 1987). It is important that the presumption of abuse does not precede the gathering evidence, as this will be damaging for the child and the family; conversely, a low level of alertness to the possibility of sexual abuse will deter the child from trusting the adults with whom he comes into contact, even those from caring or helping agencies. It is suggested that the clinical filtering process described above will moderate both trends (Kolvin et al 1988a).

The disclosure interview versus clinical psychiatric assessment

The basis of the disclosure interview is the assumption that skilled sensitive interviewing will allow children to try to confide their secret. Unfortunately this has become a questionable concept as it incorporates the preconception that a denial constitutes a reluctance to admit to abuse. It therefore seems to preclude the possibility that sexual abuse has not occurred (Kolvin et al 1988a, Jones & McQuiston 1986).

In younger children the interview includes investigative play but this must be conducted with caution; otherwise the validity and utility may be hampered by suggestion and leading questions; if unwisely conducted or prolonged, the interview may itself become sexualising and abusive.

Seldom are any signs or symptoms *diagnostic* of a prior history of child sexual abuse, and further physical or psychological abnormalities in the child may have alternative explanations. Hence, the interviewers must approach the task with an *open mind*.

Family and child assessment is essential but the interviewer should also be receptive to other historical and current information about the family in order to provide a global picture. In this way the practitioner will be able to take into consideration the balance of probabilities — a process whereby all factors, both in favour and against the hypothesis, are weighed against each other. This allows a judgement as to the degree of probability that abuse has taken place (Kolvin et al 1988a).

Substantiation of suspicion

A distinction needs to be made between *unfounded* or *unsubstantiated* and *false* allegations. The former merely suggest that the 'null' findings are inconclusive and cannot support a theory of sexual abuse, but neither can they disprove it (Corwin et al 1987). However, labelling an accusation as unsubstantiated does not necessarily mean that it is false, rather that there is insufficient or inconsistent evidence. Jones & McGraw (1987) prefer the term fictitious to false as it allows for both misperceptions and deliberate falsifications.

The crucial theme in child sexual abuse is the extent to which suspicion is validated. Research based in the UK has so far not addressed itself widely to this problem.

As already indicated, half of suspected cases of sexual abuse seen at a psychiatric clinic are substantiated (Kolvin et al 1988b) but this was a rather selected sample. More rigorous research has been undertaken by Jones & McGraw (1987) in the USA, where the reporting of suspected sexual abuse is legally mandatory. They studied 576 cases reported to the Denver Social Service Department by neighbours, relatives, day-care providers and professionals providing a wider and more representative data base. After investigation, the sexual abuse team of the Denver Social Services designated the cases as 'founded' or 'unfounded'. Convincing accounts numbered 309 (53%), which included 25 (4%) in which the children retracted their statements; however, often this retraction was considered to be false and to have been made under duress (Summit 1983). The conclusion must be that one in two of the reports going to social services were not substantiated.

Jones & McGraw (1987) classified those which were considered as unfounded as follows: insufficient information to allow definitive conclusion (25%); appropriate suspicion unsubstantiated by further investigation (17%). They then subtracted those cases in which there was insufficient information, and regarded the remainder as suspicious of possible sexual abuse. In these circumstances 70% of the total of 439 turned out to be substantiated and the rates of fictitious reports by adults rose to 6% and by children to 2%, thus representing only a small proportion of the cases categorised as unfounded.

Much attention has been given to the notion that children do not falsify their accounts of sexual abuse, and the above statistics demonstrate that this is an uncommon phenomenon. However, in the above account a crucial piece of information is lacking, which constitutes the sum of children reporting sexual abuse. If one-third of the cases which Jones & McGraw consider reliable were child-initiated reports and the rest adult, then we estimate a 5% fictitious rate in children and 9% by adults, i.e. 1 in 20 and 1 in 10. Similar rates of fictitious accounts (6%) are reported by Goodwin (1982) and Peters (1976).

Much higher rates of lack of substantiation are reported in access disputes following parental separation or divorce—up to 55% by Benedek & Schetky (1985). Here again, Corwin et al (1987) suggest there is an artifically high rate influenced by referral bias; they commend as base samples all cases reported to a social service agency or to a medical emergency centre. However, as the most complex and ambiguous cases may be referred to a child psychiatric clinic, the rates of fictitious accounts in such centres are likely to be much higher. Referral bias means that there are hazards in generalising from clinic samples but, equally, there are hazards of 'expectation set' when applying conclusions derived from more representative samples to clinic samples. However, the higher rates of lack of substantiation in access disputes need to be balanced by the possibility of more evidence being forthcoming following separation or divorce. For instance, after separation there is less opportunity for an abusing parent to enforce secrecy and there is greater willingness of the non-abusing parent to view accounts by the child as credible (Corwin et al 1987).

Attempts have been made to identify the features of cases where fictitious accounts are given (Green 1986) but this is a major area of contention (Corwin et al 1987).

Green (1986) has produced a table in which he attempts to discriminate between true and fictitious allegations by child or parent. This work has been heavily criticised on the following grounds: that it consists of an over-simplified approach; that the

data are based on anecdotes, impressions and extrapolations from writings of other clinicians (e.g. Benedek & Schetky 1985, Peters 1976); that the small size of Green's sample may give rise to considerable distortions; that clinical experience may not be representative of the range of child sexual abuse cases and, finally, that Green's abbreviated case descriptions do not allow an appreciation of all the relevant factors. However, we doubt whether Green's themes should be rejected out of hand; rather, they should be viewed as providing useful clues from which a theory can be derived which gives rise to hypotheses which can be tested in clinical interview. They should be viewed as helpful rather than diagnostic and, further, no feature on its own should be seen as discriminating.

One suggested important feature included an easy and spontaenous account of the abuse by the child, which is not accompanied by any negative affect (Benedek & Schetky 1985, Jones & McGraw 1987, Goodman et al 1986, Green 1986); however, other workers (Corwin et al 1987) suggest that there is evidence from the literature that spontaneous easily elicited reports are likely to be more accurate than responses during repeated questioning (Loftus 1979) and, further, that in validated sexual abuse the child may also give a spontaneous account; the child may discuss the abuse when prompted by the mother, and seek maternal endorsement.

However, this needs care in interpretation — such social referencing (Shaver & Klinert 1982) is likely to occur when the child is in an ambiguous situation, being pressurised to make a false report or, when making an accurate report, challenged about what occurred (Corwin et al 1987). There is a discrepancy between the angry accusations made when the child confronts the father and the apparent comfort in his presence; there may be a lack of appropriate detail for the age of the child (Jones & McGraw 1987), and the language used may be full of personal pronouns and age-inappropriate words. But, again, this is not specific as children from 'intellectual' backgrounds may be comfortably familiar with adult-type sexual terminology. The child may be sexually preoccupied but not show signs and symptoms commonly described in studies of sexually abused children. A minority (1 in 5) of sexually abused children may show no behavioural signs (Conte & Berliner 1987).

When allegations are *not* fictitious talking about experiences of sexual abuse may not be easy: often such accounts may be delayed or conflicted and there may be retractions. They may be accompanied by a painful depressive affect. The younger child will tend to use age-appropriate terminology (as compared to adult sexual terminology in fictitious accounts). Initially the child may be diffident about discussing abuse, will rarely confront the father and is usually fearful in fathers presence unless the abuse has been gentle. He or she may illustrate other signs often found in children who have been sexually abused, tending to avoid symbolic play and seem more comfortable with repetitive and concrete play.

Green offers suggestions about the basis of fictitious allegations by older children: for instance, it may be based on a desire for revenge or retaliation for punitive management or deprivation by the parents (Green 1986) or based on sexual fantasy (where some incest accusations are concerned), but others see this as invoking controversial aspects of Freudian theory (Masson 1984, Corwin et al 1987). However, on rare occasions a child who exhibits hysterical personality traits may accuse a parent in a manipulative way or display opportunistic lying (Goodwin & Owen 1982). Although accusations may be without foundation they may have a basis in reality, e.g. the

application of cream to the child's genitalia for medical reason which is turned into accusations about sexual abuse by one of the parents due to relationship difficulties.

In addition, some mothers who are delusional may misperceive a relationship and bombard the children with incessant interrogation. In these circumstances an abnormal dependency may be fostered between the mother and child, which allow her to enforce and reinforce the child's compliance with her allegations.

OUTCOME

It is noteworthy that experts often anticipate the most dire outcomes of child sexual abuse, both in the short and long term; however, empirical evidence in support of such inevitable adverse prognostications is lacking. Where data are available, there are often serious methodological flaws with the samples which usually have a clinical base and thus are subject to selection bias. Nor has it always been possible to disentangle the effects of sexual abuse from that of associated family pathology (Mrazek & Mrazek 1985).

The careful literature review of Mrazek & Mrazek (1985) has provided some helpful clues. In the short term the psychological symptoms in adolescence were legion but those commonly mentioned were problems of sexual adjustment, especially promiscuity or prostitution in girls and molestation of young children by boys. Para-suicide is also reported, with Goodwin (1981) giving a figure of 4% of para-suicide in girls.

In the long term adult sexual dysfunction has been recorded, but again it is difficult to know the extent of this as there are few good long term follow-up investigations (Mrazek & Mrazek 1985). Superficial surveys may well underestimate the extent and severity of personal intrapsychiatric distress in victims in adulthood, which remains known to them alone. Further, little thought has been given so far to spontaneous reparative processes or even protective factors in children or their environment which could mitigate any long term effects.

MANAGEMENT AND TREATMENT OF CHILD SEXUAL ABUSE

The management and treatment of child sexual abuse should be multidisciplinary. It is crucial that social services, police and the health services (hospital, community and nursing) coordinate their efforts. It should be noted that child sexual abuse calls for an emergency medical response only in a limited number of circumstances, e.g. when there are serious health risks to the child, when samples are required for forensic purposes, when abuse is thought to have occurred within the previous three days, or when there is serious psychiatric disturbance (Kolvin et al 1988a). Furthermore, child sexual abuse calls for an immediate legal response only if there is a strong possibility of a repeat of sexual abuse or violence, or there is inadequate protection from the non-abusive parent. The treatment plan should be devised at a case conference and the formula evolved should be responsive to the needs of the individual child and family. Such needs will vary with age, kind of abuse and response of the caretakers and others to the allegation. Some of the therapeutic aims of dealing with such children will include the provision of sensible and empathic emotional support, helping the child to understand the experience in an appropriate way, a lifting of feelings of guilt or responsibility and help with deep feelings of depression; in addition, it is important to help the child to understand the difference between 'good' and 'bad' touching and 'good' and 'bad' secrets (Baker & Duncan 1985).

Both individual and group therapy are considered appropriate models for dealing with the psychosocial trauma and subsequent disturbance or distress. Group therapy provides an invaluable opportunity for sharing experiences, deriving emotional support, practising of new behaviours and asking for help (Baker & Duncan 1985).

The mother's attitude is frequently a key to prognosis (Mrazek & Mrazek 1985). If she aligns herself with father and continues to disbelieve the child, the chance of the child receiving appropriate affection, care and protection is reduced, and the prognosis is likely to be poor. However, if her immediate response has been to protect her child and spontaneously to seek help, she is likely to achieve a satisfactory relationship with the child. Group therapy for mothers of abused children has been used frequently (Giaretto 1981) but there is no good evidence of wide improvement. It is customary for perpetrators (usually father) to be charged when there is sufficient evidence. When the case is proven, the court will deal with the offence according to its severity, the sentences ranging from caution to custody. Commonly, family breakdown occurs and the question of rehabilitation arises. Much depends on the attitude of the perpetrators — distinctions need to be made between merely preventing further sex abuse and the therapeutic rehabilitation. Irrespective of therapy, it is rare for perpetrators of incest to repeat the offence once the matter has been dealt with by the legal system (Kroth 1979); in addition, custodial sentences appear to be salutory experiences in relation to wider offending (Kroth 1979).

In the USA Sgroi (1982) claims that only half of perpetrators admit their guilt and accept responsibility but denial tends to continue despite intensive treatment endeavours. Nevertheless, admission of guilt does not necessarily lead to success of therapy. Some families drop out of treatment despite the perpetrator's admission of guilt.

Lack of success in treating offenders in isolation from the rest of the family has focused attention on the use of family approaches. Nevertheless, great caution must be exercised before a decision is taken to reunite the family. Server & Janzen (1982) have recommended a number of criteria in making such decisions, the main ones including the following: that the perpetrator acknowledge responsibility for the abuse; that family members and therapist all agree that the child is adequately protected; that the mother displays a willingness together with an ability to protect her children; that the daughter would call attention to her plight if abuse recurs; that intrafamilial relationships have improved; and that the family members have addressed themselves to resolving their own personal problems (such as alcoholism).

Increasingly, multiple forms of therapy are used as it is felt that this increases the potential for change. Thus multimodal approaches, consisting of combinations of individual treatment, dyadic treatment (which may include combinations of husband, and mother and child), group therapy and family therapy, have all been used (Mrazek & Kempe 1981). Giaretto (1981) has advised strongly that individual and couple therapy should precede any endeavours at family therapy. There are many management and administrative difficulties in arranging such a treatment approach and efficacy has as yet to be adequately demonstrated (Sgroi 1982). Nevertheless, a recent follow-up of a large series of sexually abused children suggests that multiple forms of therapy are effective (Bentovim et al 1987) and while this gives cause for optimism, there is equally cause for caution. The dropout rate was considerable and, further, as it was an uncontrolled study, there is no way of estimating the extent

of the effect of natural reparative processes in the child and other supportive and protective influences in the family.

LEGAL ASPECTS

Once the question of sexual abuse of a child has been raised, two legal issues must be dealt with—civil and criminal. First, there is the question of the care and custody of the child; second, the question of a criminal offence.

In the case of the *criminal proceedings* there is a legal dilemma. This has been clearly described by Waite (1987) and consists of the conflict of two fundamental principles. First, a basic requirement of justice is that the accused should have the opportunity to confront his accuser and to have an allegation against him clearly specified and cogently proved. The second consists of the effect on a child of having to give evidence in court which entails facing a possible abuser and coping with detailed cross-examination which may have serious and lasting emotional repercussions. It has been suggested that the conflict lies between the formal procedures required in legal proceedings (Latey 1987) and the clinical needs of abused children.

This may be exemplified in those circumstances where clinicians have used anatomically correct dolls to encourage the child to demonstrate behaviour which he/she was reluctant to or unable to describe in words (Vizard 1987). Originally this was a therapeutic technique employed where there was already firm evidence of abuse, but it has been used as well for evidential purposes. In the latter circumstances the technique often was associated with degrees of coaxing, leading and hypothetical questions, and questions with only two options which preclude a neutral answer or a spontaneous response from emerging. In such assessment the interviewer may have started with the presumption that sexual abuse had occurred, rather than seeking to explore the situation from an objective stance.

So far the technique has neither a proven therapeutic nor diagnostic utility. The reliability and validity of the technique has been questioned. A further problem has been the difference in the perception of denial: the courts may wish to treat this at its face value, whereas the clinicians may believe that the child is being defensive. It is not surprising that the initial judicial view has been that little evidential weight could be attached to such an assessment (Hollis 1987). Furthermore, any associated pressure on the child during the assessment carried the risk that he or she would say that something had occurred, which in fact had not, or that the child would think that things had occurred which in reality had not. Refinement of the technique has led to a modification of those judicial criticisms which seemed to be directed at the interviewer going beyond encouraging spontaneous responses and leaning towards promptings of the child.

However, facilitative techniques of interviewing may lead the child (1) to modify recall of events when questioned in the future and (2) to be less likely to produce accurate information than when he or she is giving a spontaneous account—fewer distortions will occur with free-flow interviews with open-ended questions. In addition, some clinicians consider it unethical to use such coercive techniques with non-abused children and advocate an attempt to generate an ambiance of trust which encourages spontaneity.

Careful recording of interviews is of course essential and videotaping or concurrent

notetaking is useful. Such notes should be available to the court in order to allow an evaluation of the interview (Douglas & Willmore 1987) and they may assist the court in deciding the degree of risk inherent in the family situation. The use of video for initial interviews should not be underestimated as any discussion with the child after that interview may become suspect—'the session has a high chance of influencing the child's behaviour in any subsequent session' (Hollis 1987).

Rules of evidence

The rules of evidence are strictly applied in the *criminal courts*. Here guilt must be proven 'beyond reasonable doubt' and the unsworn testimony of minors needs to be corroborated. Psychiatrists can be summoned to give evidence in criminal proceedings, in which circumstances they must bear the rules of evidence in mind. As has already been indicated, the accused has the right to confront a child accuser. This may be harmful or distressing to the child (Goodman & Jones 1986), representations may be made to the court about ways of attenuating such an impact. The courts themselves have experimented with the use of screens as a means of overcoming such distressing direct confrontations of the abused and the alleged abuser.

In *civil proceedings* the case must be judged 'on balance of probabilities'. Further, in custody, care and wardship proceedings, there may be a degree of relaxation of the rules of evidence in the best interest of the child. Moreover, it is left to the court to give appropriate weight to hearsay evidence (Munday 1986). It has been suggested that the best interests of children lie in the courts responding to possibilities of risk, even when the chance of the evidence being right is less than probable, on the grounds that while it is grave for parents to be wrongfully accused of abuse, it is graver still for the child to be left at risk of further abuse.

A civil court may either accept or refuse video recordings and also has the discretion of not revealing reports to parents, when such a revelation would be harmful to the best interests of the child. In any event, the court also has the power to compel those who have information relevant to the court to testify or to produce appropriate documents.

Emergency removal of the child

This is the responsibility of social services or police. It is usually effected through a Place of Safety Order. More recent professional opinion advises that the response by social services to suspicion should be a considered, rather than a reflex one. In addition, Place of Safety Orders should be confined to circumstances of high risk of immediate further abuse with no alternative methods of protecting the child; and when there is a high probability that abuse has occurred but parents refuse all further assessment (Kolvin et al 1988a). Nevertheless, some workers commend the collaboration in assessment before this draconian step is embarked on, so that a series of moderating checks and balances become operational which allow a sound conclusion to be achieved. Such an approach would limit the overuse of the 25 day Place of Safety Order and its potential for damaging secondary psychological effects in situations of doubt (Kolvin et al 1988a).

Confidentiality

One of the problematic issues which has confronted child psychiatrists with regard to child sexual abuse is the conflict between their professional ethics and the public and legal interest in detection. However, recent documents have helped to clarify the position about the extent to which confidentiality can be maintained in the face of the best interests of the child. A wider concept of confidentiality has emerged, encouraging the sharing of material with other professionals working with the family, such as social workers. However, a recent document suggests that doctors will be more willing to share information when child sexual abuse is probable rather than merely possible (Kolvin et al 1988a.) When the child is the patient, parents cannot be accorded the benefits of confidentiality and this potential sharing of information with other disciplines needs to be clarified with them. Doctors also need to be aware that in court proceedings the privilege of confidentiality no longer applies. Nevertheless, in civil cases the doctor can appeal to the court not to bring into open court views which are not in the best interests of the child, and also to restrict dissemination of records.

REFERENCES

Adams-Tucker C 1982 Proximate effects of sexual abuse in childhood: a report on 28 children. American Journal of Psychiatry 139: 1252–1256

Anderson L 1981 Notes on the linkage between the sexually abused child and the suicidal adolescent. Journal of Adolescence 4: 157–162

Baker A, Duncan S 1985 Child Sexual Abuse: A study of prevalence in Great Britain. Child Abuse and Neglect 9(4): 259–280

Bentovim A, Boston P, van Elburg A 1987 Child sexual abuse — children and families referred to a treatment project and the effects of intervention. British Medical Journal 295: 1435–1457

Benedek E P, Schetky D H 1985 Allegations of sexual abuse in child custody and visitation disputes. In: Shetky D H, Benedek E P (eds) Emerging Issues in Child Psychiatry and the Law. Brunner/Mazel, New York

Brant R, Sink F 1984 Dilemmas on court ordered evaluation of sexual abuse charges during custody and visitation proceedings. Paper presented at the annual meeting of the American and Canadian Academies of Child Psychiatry, Toronto, Ontario

Browning D H, Boatman B 1977 Incest: children at risk. American Journal of Psychiatry 134: 69–72

Conte J R 1985 The effects of sexual abuse in children and suggestions for future research. Victimology 10: 110–130

Conte J R, Berliner L 1987 The impact of sexual abuse on children: clinical findings. In: Walker L (ed) Handbook on Sexual Abuse of Children. Springer, New York

Corwin D L, Berliner L, Goodman G, Goodwin J, White S 1987 Child sexual abuse and custody disputes. Journal of Interpersonal Violence 2 (Suppl) 1: 95–105

Davies G, Flin R 1986 The accuracy and suggestibility of child witnesses. Paper to British Psychological Society, Wolfson College, Oxford

Douglas G, Wilmore C 1987 Diagnostic interviews as evidence in cases of child sexual abuse. Family Law 17: 151–154

Finkelhor D 1979 Sexually Victimised Children. Free Press, New York

Finkelhor D 1984 Child Sexual Abuse. New Theory and Research. Collier Macmillan, London

Friedrich W, Urguizon A, Berlke R 1986 Behaviour problems in sexually abused young children. Journal of Paediatric Psychology 11: 47–57

Giaretto H 1981 A comprehensive child sexual treatment program. In: Mrazek P B, Kempe C H (eds) Sexually Abused Children and their Families. Oxford, Pergamon Press.

Goodman G, Jones D P H 1986 The child witness in court. Paper presented at British Psychological Society, Criminal and Legal Division, Annual Conference, Oxford

Goodman G S, Hepps D, Reed R E 1986 The child victim's testimony. In: Haralambie A (ed) New Issues for Child Advocates. Arizona Council of Attorneys for Children, Arizona

Goodwin J 1981 Suicide attempts in sexual abuse victims and their mothers. Child Abuse and Neglect 5: 217–221

Goodwin J 1982 Sexual Abuse: Incest Victims and their Families. John Wright, Boston

Goodwin J, Owen J 1982 Incest from infancy to adulthood. A developmental approach to victim and families. In: Goodwin J (ed) Sexual Abuse: Incest Victims and their Families. John Wright, Boston
Goodwin J, McCarthy T, Divasto P 1981 Prior incest in mothers of abused children. Child Abuse and Neglect 5: 87–96
Green A H 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, Russell D, Trocki K 1986 Long term effects of incestuous abuse in childhood. American Journal of Psychiatry 143 No. 10: 1293–1296
Hollis J 1987 In C vs C (child abuse evidence). Family Law Reports 321
Johnson M K, Foley M A 1984 Differentiating fact from fantasy: the reliability of children's memory. Journal of Social Issues 40: 33–50
Jones D P H, McGraw J M 1987 Reliable and fictitious accounts of sexual abuse to children. Journal of Interpersonal Violence 2 No. 1: 27–45
Jones D P H, McQuiston M 1986 Interviewing the sexually abused child. The C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect. Vol 6. Kempe Center Publications, University of Colorado Medical School, Denver
James J, Meyerding J 1977 Early sexual experience and prostitution. American Journal of Psychiatry 134: 1381–1385
Kempe R S, Kempe C H 1978 Child Abuse. Fontana/Open Books, London
Kerns D L 1981 Medical assessment of child sexual abuse. In: Mrazek P B, Kempe C H (eds) Sexually Abused Children and their Families. Pergamon, Oxford
Kolvin I, Steiner H, Bamford F, Taylor M, Wynne J, Jones D, Zeitlin H 1988a Child Sexual Abuse: Some Principles of Good Practice. Independent Second Opinion. Panel: Northern Regional Health Authority. British Journal of Hospital Medicine 39: 54–62
Kolvin I, Kaplan C A, Wressell S 1988b Child Sexual Abuse: Performance Indicators (in preparation)
Kolvin I 1978 Psychiatric factors and the abused child. In: Carver V (ed) Child Abuse—a study text. Open University, Milton Keynes.
Kroth J A 1979 Family therapy: impact on child sexual abuse. Journal of Child Abuse and Neglect 3: 297–302
Lewis M, Sorrel P 1969 Some psychological aspects of seduction, incest and rape in childhood. Journal of the American Academy of Child Psychiatry 8: 606–619
Latey J 1987 Child abuse Evidence. Family Law Reports 293
Loftus E F 1979 The malleability of human memory. American Scientist 67: 312–320
Maccham J A 1977 Soviet investigation of memory development. In: Kail R V, Hagen J W (eds) Perspectives on the development of memory and cognition. Earlbaum Associates, Hillsdale, New Jersey
Markowe H L J (1988) The frequency of childhood sexual abuse in the UK. Health Trends 20: 2–6
Masson J M 1984 The assault on truth. Freud's suppression of the seduction theory. Farrar, Strauss and Giroux, New York
Mian M, Wehrspann W, Diamond H K, Le Baron 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
Marin B V, Holmes D L, Guth M, Kovac P 1979 The potential of children as eye witnesses. Law and Human Behaviour 3: 295–305
Mrazek P B, Kempe C H 1981 Sexually Abused Children and their Families. Pergamon, Oxford
Mrazek D, Mrazek P 1985 Child maltreatment. In: Rutter N, Hersov L (eds) Child and Adolescent Psychiatry. Modern Approaches. Blackwell Scientific Publications, Oxford
Mrazek P B, Lynch M, Bentovim A 1981 Recognition of child sexual abuse in the United Kingdom. In: Mrazek P B, Kempe C H (eds) Sexually Abused Children and their Families. Pergamon, Oxford, pp 35–50
Munday R 1986 The rules of evidence and the law of the family. Law Society Gazette 29 Oct: 3219–3221
Peters J 1976 Children who are victims of sexual assault and the psychology of offenders. American Journal of Psychotherapy 30: 398–421
Porter R (ed) 1984 Child Sexual Abuse within the Family. Ciba Foundation Symposium. Tavistock, London
Russell D E H 1984 Sexual exploitation. Rape, Child Sexual Abuse, and Work Place Harrassment. Sage, California
Schechter M D, Roberge L 1976 Sexual exploitation. In: Helfer R E, Kempe C H (eds) Child Abuse and Neglect: The Family and the Community. Ballinger, Cambridge, Massachusetts, pp 127–142
Sedney M A, 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
Sgroi S M 1982 Handbook of Clinical Intervention in Child Sexual Abuse. DC Health, Lexington, Massachusetts

Shaver P, Klinnert M 1982 Schachter's theories of affiliation and emotion. Implications of developmental research. In: Wheeler L (ed) Review of Personality and Social Psychology, vol 3. Sage, California
Server J H, Janzen C 1982 Contraindications to reconstitution of sexually abusive families. Child Welfare LX15: 279–288
Summit R C 1983 The child sexual abuse accommodation syndrome. Child Abuse and Neglect 7: 177–193
Vizard E 1987 Interviewing young sexually abused children — assessment of techniques. Family Law 17: 1–36
Waite J 1987 In Re W (Minors) (child abuse evidence) 1. Family Law Reports 297
Zeitlin H 1987 Investigations of the sexually abused child. Lancet 2: 842–845