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Child sexual abuse

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INTRODUCTION

Over the two last decades sexual abuse of children has now come to be seen as one of the new 'epidemics' of childhood and yet previously it must have been present in communities; the question arises, why was it not viewed as pathological behaviour and a serious problem affecting children's physical and psychological health. It would seem that multiple factors must have contributed to what appears to be a suppression of the facts, or perhaps it was a reluctance to acknowledge the presence of sexual abuse. For instance, it might have been seen as having little to do with the wider community, but rather attributable to social or psychiatric deviance (R. S. Kempe and C. H. Kempe 1978). Recent reviews suggest a multiplicity of factors as contributing to the apparent increase of prevalence—a greater ease of disclosure, a greater sensitivity by professionals to the possibility of abuse, more knowledge about the relevant suspicious signs and symptoms, and the greater openness about sexuality (Smith and Bentovim 1994).

DEFINITION

The definition of what constitutes child sexual abuse varies widely according to the discipline of the defining professional. However, definitional differences reflect conceptual differences (Haugaard and Reppucci 1988). An older general definition which still has wide currency is that of Schechter and Roberge (1976); 'the involvement of dependent developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to and that violate the social taboos of family roles'. A tighter pragmatic descriptive definition was provided by D. Mrazek and P. Mrazek (1985) who suggested that sexual abuse could be conceptualized as one of four types: (1) exposure (viewing of sexual acts, pornography, and exhibitionism); (2) molestation (fondling of either the child's or adult's genitals); (3) sexual intercourse (oral, vaginal, or anal on a non-assaultive and chronic basis); and (4) rape (acute assaultive forced intercourse). Such a typology has high credibility in forensic situations.

Another useful typology is that developed by Jones and colleagues in Oxfordshire (OACPC 1992). They maintain that the key issue in assessing whether sexual abuse has occurred is that of exploitation. They classify sexual acts *first* as *direct*, for

instance, where there is genital, or anal sexual contact between a child and adult; penetration—anal, vaginal, or oral; or other acts where the child is the object of the adult's sexual gratification (e.g., bondage, ejaculation on the child, etc). *Second*, as *indirect*, which includes genital exposure and exposure to pornographic materials. *Third*, there is *exploitation*, this refers to the balance of power between the child and other person at the time the sexual activity first occurred. Thus, exploitation is considered to have occurred if the activity was unwanted when it first began, and/or involved a misuse of conventional age, authority, or gender differential. In the above definitions the key considerations concern questions of consent and the issue of exploitation. The last definition takes into consideration abuse by adolescents or peers and this is particularly important as recent work has demonstrated that a substantial minority of abuse is perpetrated by adolescents. Yet others, Finkelhor and Hotaling (1984), chose to emphasize a definition that includes any sexual contact that occurs as a result of force, threat, or deceit, etc., or through exploitation of an authority relationship, irrespective of the age of the partner.

PREVALENCE

Estimates of prevalence are bedevilled by differences of definition and methods of study, and are closely tied to the population source of the information. In his original study, Finkelhor (1979) reported rates of 19 per cent of female and 9 per cent of male college students who had been sexually abused as children. In the United Kingdom, Baker and Duncan (1985), using a MORI poll of those aged 15 years and older, calculated that 12 per cent of women and 8 per cent of men had abusive experiences in childhood. Unfortunately, even these population surveys are open to criticism of either flawed method, and/or not being representative of the general population (Markowe 1988). For example, few of the earlier studies distinguished between the four types of abuse, described by D. Mrazek and P. Mrazek (1985). In a review of four studies, Wyatt and Peters (1986) investigating methodological differences, demonstrate that the lower rates tended to be based on questionnaire surveys using broad questions. Higher rates were obtained from direct interview techniques. Other studies have demonstrated that where less restrictive definitions are used, mainly referring to exhibitionism and/or touching, very high rates of abuse were reported in women (59 per cent) and less than half of this in men (27 per cent). However, when more restrictive definitions are used these rates fall dramatically (Kelly *et al.* 1991). Rates of abuse also differ according to whether the information concerning biological father or step-father is explored—only 2 per cent of women raised by biological fathers report sexual abuse, as against 17 per cent raised by step-fathers. Higher rates are reported by younger respondents (Russell 1984). However, even when such studies have no such methodological flaws, it is not easy to identify those children who have been abused, as often there is no witness and no clear-cut physical evidence. Sexual abuse only emerges in about 15 per cent of girls at any point in time (Kerns 1981). Finally, it is accepted that official statistics will always

underestimate the size of the problem as there is an unwillingness by victims to report abuse (Markowe 1988).

PRESENTATION

Information about sexual abuse can present in different ways—the various forms of presentation can be summarized as follows: based on *accounts* by the *child*; based on *disturbed behaviour* or *changes* in behaviour; with *physical symptoms* or *signs* associated with *other forms of maltreatment*; with *allegations by parents, relatives* or other adults (Jones and McQuiston 1986; Kolvin *et al.* 1988). Some presentations have an established association with child sexual abuse whilst others are more tentatively linked in terms of having a low or only possible association (Kolvin *et al.* 1988). Irrespective of the source of information, it is evident that the most common form of presentation is through *accounts* by the child (Conte and Berliner 1988). Nevertheless, subjects who have been sexually abused often delay reporting what has transpired (Meiselman 1978, Conte *et al.* 1989). However, there is apparently less delay in reporting incidents by a stranger (Jones 1992). Accounts by children may be given to friends and less often to parents. Telephone help-lines are currently a common form of anonymous presentation (Smith and Bentovim 1994). Jones (1992) points out that disclosure happens at a variable time after the abuse has been initiated; and there are differing patterns according to the age and stage of development at which abuse occurs. For instance, some begin in infancy, whereas for others the start is in the teenage years.

From a comprehensive review of the literature, it has been reported that few presentations are likely to be conclusively diagnostic of a child's sexual abuse (Browne and Finkelhor 1986). Some cases have multiple modes of presentation, such as behaviour and physical signs or symptoms, as well as accounts by the child. Often, accounts by the child are not welcomed by caretakers. There is continuing evidence that some children report being disbelieved when they make their first disclosure (Burgess and Holmstrom 1975; Jones 1992). Furthermore, children, especially younger children, may disclose only a part of what has occurred, perhaps waiting to see the caretaker's response and if they receive a (an accepting or supportive) response they may feel secure enough to give more (Jones 1992).

Some children may present with a change in behaviour and this will be discussed later. Changes in behaviour, or other behavioural or psychological warnings may constitute crucial evidence as only a minority of children (under 14 per cent) who have been abused show physical signs (Royal College of Physicians 1991).

Behavioural associations of 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. Whilst this is a useful exercise such patterns are not necessarily specific and only a minority of children who have shown these behaviours will actually have been abused. Some of these symptoms have an established association with sexual abuse, whilst others only have low or possible associations.

CLASSIFICATION OF BEHAVIOURAL FEATURES

Behavioural features associated with abuse may be categorized under a number of headings (Jones and McQuiston 1986).

1. Early warnings

Jones (1992) developed a concept of early warnings which occur in the field of physical abuse (Ounsted and Lynch 1976). In sexual abuse some behaviours are tantamount to early warnings in which the child tries to alert the world to his or her plight. For instance, the child may make an ambiguous statement ascribing his or her own experience to another mythical child or else, the child may simulate sexual behaviour, or even intercourse, with a friend in order to alert parents or professionals. In a similar vein Jones points out that older more verbal children may offer hints about their unwanted sexual experiences to either peers, or significant others in their family or social environment.

2. Social relationships

These may consist of a disturbance in relationships and attachments. There may be phobic avoidance of males (Sgroi 1982), the child may show mistrust of adults in general (Herman *et al.* 1986), or show impaired peer relationship (Adams-Tucker 1982). Some children may also not trust their mothers, presumably because of their failure to protect them. Some children may become over and inappropriately friendly with adults seeking close physical contact indiscriminately, some may seek and touch body parts or expose themselves as a means of initiating a relationship.

3. Disturbed behaviour

Post-traumatic stress disorder syndromes

Many children may develop post-traumatic stress disorder (Conte and Berliner 1988). This disorder consists of a sense of unexplained arousal or distress, often with numbed emotional affect, anticipation of future attacks, fears of helplessness, and re-experiencing of the traumatic events which may be 'flashbacks'. There are also memory problems (psychogenic amnesia) and some children may show a degree of hyper-awareness, sleep problems, night terrors, nightmares, and dissociative episodes.

Other behaviours

Regressive behaviour has 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 a sense of general fearfulness. In others, features representative of antisocial behaviour may be found. Somatic symptoms and eating problems, or even anorexia, have been reported (Browning and Boatman 1977; Oppenheimer *et al.* 1985). Symptoms of depression and parasuicidal behaviour are common.

Self-harming behaviour and drug and alcohol abuse are not uncommon. (James and

Meyerding 1977; Conte 1985). School and academic problems consisting of deterioration in behaviour in school and with school work has been reported (Goodwin 1982). This may be because the children's anxiety and distress impedes their concentration and, hence, their ability to achieve.

Some of the above occur more frequently in younger children, whilst others more frequently in older children, and some are found across the age range. When they occur after the abuse may be significant but the picture is not a simple or clear one. For instance, some behavioural features may reflect recent abuse, whereas others may be seen as longer-term affects (Green 1986). However, these behavioural features are often similar to those occurring in children attending child guidance, or child psychiatry clinics, and cover almost the total spectrum of child psychiatric disorders. Thus, the presence of disturbed behaviour is not diagnostic of sexual abuse (Jones and McQuiston 1986). Looked at from the other end of the telescope it is estimated that a minority of disturbed children attending child psychiatric clinics have been sexually abused (Kolvin *et al.* 1988). There is evidence that whilst many behaviours may be commonplace in sexually abused children, they are not specific; that is, only a minority of children with such behaviours would have been abused (Kolvin *et al.* 1988). Finally, a minority of sexually abused children do not show behavioural features, at least in the short term (Jones 1992), whilst others may present with behaviours and other responses which constitute 'accommodations to sexual abuse' (Summit 1983)—the latter constitutes a syndrome which is described more fully in a later section.

4. Attitudinal problems

Some sexually abused children may report feelings of worthlessness and poor self-esteem (Sgroi 1982), which may become enduring personality traits. They may blame themselves or feel irrevocably damaged by their experiences. Some may also experience shame and self-disgust if their bodies responded to the sexual excitement.

5. Psychosexual disturbances and allied problems

Some younger children may present with what can be described as sexualized behaviour in which they are precociously preoccupied with adult types of sexual behaviour (Mian *et al.* 1986; Friedrich *et al.* 1986). Some older children may show disturbances of sexual behaviour—becoming sexually disinhibited, or may behave provocatively, or occasionally turn to prostitution. Some young people become sexually inhibited, avoiding peer sexual contact, and others are confused about their sexual orientation.

Presentations in adulthood

Not all sexually abused children present with disturbed behaviour in childhood and many do not do so until adulthood. Those behavioural symptoms presenting in adulthood have been summarized by Cotgrove and Kolvin (1994) who conclude that there are four main long-term associations with child sexual abuse.

1. Psychological symptoms consisting of depression, anxiety, low self-esteem, guilt, sleep disturbance, and dissociative phenomena.

2. Problem behaviours including self-harm, drug use, prostitution, and running away.
3. Relationship and sexual abuse problems: social withdrawal, sexual promiscuity, and victimization.
4. Psychiatric disorders, particularly eating disorders, sexualization, post-traumatic stress disorders, and borderline personality disorders. (See Chapter 15.)

MULTI-FACTORIAL ORIGINS OF DISTURBED BEHAVIOUR IN SEXUALLY ABUSED CHILDREN

It is commonplace to assert that all disturbed behaviour with which sexually abused children present is a consequence of the abuse. It is very important that this assumption is *not* made—due weight must be given to the effect of the level of dysfunction in the family and the environmental pathology. It is essential that the literature on child sexual abuse is studied with care and rigour. The data on which the main body of knowledge derives is often rather flawed, this is because of the nature of the study and sample and, generally, the absence of comparison groups. Perhaps the most cogent criticism of the search for behavioural association of child sexual abuse is provided by Jones (1992). He concludes that child sexual abuse is not a unitary phenomenon, but covers a wide variety of activities and situations. For instance, children may have been assaulted by strangers, or have been the victims of incest for many years. Furthermore, there are a diversity of environmental factors; such as accompanying neglect, emotional abuse, deprivation, or physical abuse. Available research does not necessarily specify whether there has been any pre-existing maladjustment. Other workers have sought evidence of a relationship between age of the child when first abused and evidence of disturbed behaviour as an indicator of more serious disturbance in younger children, but the evidence is contradictory. However, there does seem to be positive evidence of more serious disturbance when the abuse is coercive, or when it includes the use of physical force or violence (Finkelhor 1979; Fromuth 1986). In a similar vein, abuse which includes penetration appears to be associated with greater degrees of disturbance (Russell 1984; Mannarino *et al.* 1992). The nature of the relationship with the abuser seems significant—abuse by biological parents and step-parents, is associated with the greater severity of disturbance occurring where the abuser is a step-parent (Gomes-Schwartz *et al.* 1990). These authors also demonstrated that when mother showed negative responses to the disclosure of abuse, this was associated with an increased severity of disturbance in the child.

Psychology of child sexual abuse

A number of different theories have been advanced in an attempt to explain the psychology of sexually abuse: factors in the perpetrator; factors within the child; and family factors.

Factors promoting abuse

Finkelhor (1984) has conceptualized four basic 'preconditions' which may promote abuse. First, an adult who is sexually aroused by children, together with the ability to

fantasize a sexual interaction with the child. There may also be an impaired capacity to have normal and sexual relationships with adults and the potential abuser may have been sexually abused as a child. Not all these features necessarily coexist in the one individual. Second, there may be a 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. Fourth, the ability of the child to resist abuse, which is enhanced by parental teachings and educational programmes; in addition, some children have a poor sense of danger perhaps linked to vulnerability factors. While the above stereotypes allow a better understanding of factors which have the potential for promoting or preventing sexual abuse, it can give rise to a too high expectation of the prevalence of child sexual abuse which can seriously mislead the inexperienced.

Adaptation to abuse

A number of authors (e.g., Summit 1983; Jones and McQuiston 1986) provide convincing accounts of the psychological processes by which the child and family may adapt to abuse. Often, the potential abuser has become the most available care giver some time before the abuse occurs, 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 sexualized by what appears to be a growing process, 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 younger children may even begin to wonder if this is a normal process which happens to all children. The abuser abuses the care giving relationship with the child and asks the child to keep their 'special secret', misusing adult or parental authority to maintain control. Alternatively, gifts or threats of break-up of the family or threats to a beloved relative (Lister 1982) 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 (Conte *et al.* 1989), compounded by a desire to be loved and for some children some sexual pleasure. A child whose personal security and that of their 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, indeed a sense of learned helplessness (Seligman and Peterson 1986) as any action he or she may take may be seen as having dreadful personal and family repercussions.

Perpetrator and victim

Intra-familial abuse is common in clinical studies and stranger abuse is relatively common in non-clinical studies (Finkelhor *et al.* 1986; Baker and Duncan 1985). Furthermore, abuse by siblings occurs relatively frequently in population studies,

perhaps even as common as abuse by fathers (Finkelhor 1979; Anderson *et al.* 1993). There are a number of other important patterns reported in the literature. For instance, girls with step-fathers are at much higher risk of being abused than those with biological fathers. And abuse by step-fathers tends to be associated with more serious disturbance (Russell 1984). Another pattern is that girls are more likely to be abused within the family and boys more so by strangers (Kelly *et al.* 1991; Haugaard and Reppucci 1988). Finally, a minority of the abuse occurring while still inside the home, is by caretakers who are not related to the family, mainly by female perpetrators who are mostly in their teenage years. Much of this abuse had taken place whilst the caretaker was functioning in a baby-sitting capacity (Margolin 1991).

Reliability and validity of alerting symptoms

Although the above-mentioned alerting or warning 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 screening measures, always bearing in mind that such 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 screening measures increases according to the number that coexist, 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 screening 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 screening 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 negatives 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 child sexual abuse. How much uncertainty we are willing to accept as a society and which way we prefer to err currently fluctuates.

The basis of suspicion

Professional suspicion may be justified but professional opinion about probability must be based on appropriate assessment. Jones (1992) clearly points out that when approaching assessment the over riding general principle is that the interview is not of a sexually abused child, but rather a child who may have been abused. 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 (Kolvin *et al.* 1988). It is essential that pre-judgement of issues is 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 (Kolvin *et al.* 1988). If clinicians are

overly 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 inquiry (Butler-Sloss 1988), a sensible policy of seeking parental consent for assessment of the child, and the consent of the older child, must be established. It is suggested that parental consent is implicit for 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 beyond the routine. Complementary to consent is the necessity for openness and honesty and the avoidance of misguided attempts at reassurance that 'all will be well'. Both child and parents should be kept informed about the possible consequences of the assessment (Jones 1992). Just occasionally, where suspicion is high that the parent is the abuser, after debate at a case conference, it may be decided that for the child's safety consent should not be sought and the parent be informed after an investigative interview.

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 (Kolvin *et al.* 1988). 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. The extent of assessment will also be guided by careful scrutiny and evaluation of the prior history and any social, psychological, school, and medical records (Jones 1992).

Principles in relation to evaluation and examination

The professional should avoid bias, pre-judgement, emotional overtones, and an accusatory stance, and should display an open-minded reaction to their accounts (Goodwin 1982). The clinician must provide a comprehensive, sensitive, and multi-disciplinary approach. The findings should be communicated to the parents and the need for further investigations explained.

In the examination of the child a number of principles or practices appear to be sensible: children should not be subjected unnecessarily to repeated examinations or disclosure interviews; the examiner must be cautious about the use of facilitatory questions and leading questions; it is helpful to interview the child in a sensitive atmosphere, always ensuring that the child is as comfortable as possible; finally,

investigations need to be child-focused rather than attempting to fit the child into the system. The child needs to be allowed to proceed at his or her own pace.

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 understand the child's past history, developmental level, and family context. An abuse history is then needed to allow information about the psychological background of sexual abuse to emerge, together with the gathering of 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 regarding the reliability of the accounts by the child and 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 any evidence of disorders of behaviour, including sexual behaviour (Kolvin and Kaplan 1988).

In the above, a distinction should be drawn between the standard clinical psychiatric assessment and the disclosure interview. An investigative interview may occur within the psychiatric assessment but may well be a separate interview arranged in the light of the information discovered during the initial interview. The basis of the investigative interview is that skilled, sensitive interviewing will allow children to confide (disclose) their secrets. Unfortunately, this has become questionable as it incorporates the preconception that non-disclosure is tantamount to denial. This can preclude the possibility that sexual abuse has not occurred (Kolvin *et al.* 1988; Jones and McQuiston 1986).

Disclosure techniques include the use of drawings and 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 sexualizing and abusive.

Many authorities take the view that evaluative assessment is preferable to an investigative 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 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 the psychology of child sexual abuse (Kolvin and Kaplan 1988). The interviewer needs to build a supportive and honest relationship with the child, while recognizing 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, it is certainly important to ensure the investigative process is time-limited. Other facilitating techniques, such as the use of hypothetical questions, have been seriously

questioned by some authorities. 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 avoid 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 (1986). 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. However, 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 (Jones and McQuiston 1986). The dolls can also be useful when interviewing children with learning difficulties who may lack the language and, rarely, some very shy inhibited children and young people. 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; sexualized behaviour; and possibilities of fabrication. A second stage of facilitative interviewing requires experience and skilled interviewing.

FAMILIES AS VICTIMS OF PROCEDURES

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 unnecesarily be removed from their families and familiar environments. Another aspect of this is the induction of an expectation 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 what is in the child's best interest and whether the needs and rights of children are being respected. Many questions remain as to 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. This is currently an area of considerable debate (Kolvin 1992).

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 interview, 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'.

MEMORY

It is only possible to touch on some salient aspects of the psychology of memory. This will be supplemented by sections covering psychodynamic understanding of memory, post-traumatic stress disorder, and the so-called 'false memory syndrome'.

Psychology of children's memory

Fundudis (1989) notes that a child who is alleged to have been sexually abused is likely to be interviewed by several professional including the police. Hence, the reliability of the child's memory has a central role in the credibility of the evidence. Further, there has been a tendency of some experts to doubt the ability of younger children to 'observe and recall events reliably' (Goodman *et al.* 1984), but later research has shown such doubts to be unfounded (Ceci *et al.* 1987). Jones (1992) concludes that the poorer ability of children than adults to remember events in detail is because of children's lesser experience, poorer grasp of language, conceptual level of development, and the inadequate assessment skills of professionals in assessing this memory (Loftus and Davies 1984). However, what children remember does not differ substantially from what adults remember—and in children it depends on language, conceptual level of development, and the style and manner in which their memory is assessed (Fundudis 1989). Furthermore, although children may have better recall in relation to certain aspects of memory, the development of memory is not linear, with some components becoming more reliable and others less reliable with age. An important theme is that some children may even be able to recall memorable events which occurred prior to them being able to speak (Todd and Perlmutter 1980). Children's *recognition memory*, for example, where a physical stimulus is present (e.g. a face in a picture, and the child must decide whether it is familiar or not) is better than in *free recall*, which involves recollection of past information or events and includes recounting rather than merely recognizing information or events from the past (Fundudis 1989). There are two other important factors: first, as in adults, memory does decay over time and, second, as the child grows older, the memories may be influenced by suggestion (Goodman and Clarke-Stewart 1990). It is important to note that salient events are often remembered well by children, and they also place them in an appropriate sequence (Gelman 1978). The salient events need to be emphasized as both children and adults are less likely to remember accurately events with less in the way of personal poignancy for the subject (Jones 1992). In addition, young children are particularly influenced by the authority of the interviewer, misleading questions, and suggestibility (Jones and Krugman 1986; Goodman and Clarke-Stewart 1990).

It also needs to be remembered that interviewer techniques can seriously distort

children's memories—in particular, leading questions combined with relentless probing for detail (Moston 1990), with a particular influence on the younger child (Jones 1992). Fundudis (1989) recommends that younger children need to be given opportunities to provide their accounts in their own way. For instance, allowing the child the freedom to report on personally relevant details (this constitutes script memory), rather than according to the expectations or demands of the interviewer. This can be followed by simple, unambiguous questions both as an aid to the child and to clarify any inconsistencies. Another factor in apparent forgetting is that the children may be exposed to circumstances where they are told not to tell or reveal information and thereby conceal information, fearing repercussions (Jones 1992). Much can be done to help the child to remember events by gentle open-ended questioning and the availability of appropriate historical props reminiscent of their everyday experiences, such as a dolls house, toy motor cars, etc. (Jones 1992).

A psychodynamic understanding of memory

In childhood sexual abuse, many processes are at work to try and enable the child to survive. These coping strategies are the usually intra-psychic mechanisms, but in addition the trauma provokes the use of other mechanisms. Normal events that cause anxiety or conflicts may be repressed, that is, removed from the conscious into the unconscious. The memory may at some later date re-emerge in the consciousness of the individual directly, or may emerge indirectly linked to some other event or stimuli. This process does not seem to be a mechanism that is capable of helping a child 'forget' sexual abuse, where the violation of the body produces very powerful emotions. Similarly, displacement cannot really help the child: this is where the affect and the surrounding conflicts are transferred from one event, or individual, on to another. Disavowal may be helpful—Freud defined it as 'a specific sense of a mode of defence which consists of the subject's refusing to recognize the reality of a traumatic perception'. It is seen as enabling the individual to deal with external reality by holding two incompatible ideas at the same time. In childhood sexual abuse, the child can simultaneously believe 'this is a kind caring father', 'this is a bad frightening person who hurts me'. Disavowal may sometimes enable a child to survive, but frequently it is not sufficiently robust to keep the terror from consciousness.

If the emotions are too painful the individual can resort to using earlier or infantile mechanisms: splitting-off and denial, or projection. An overwhelming or unbearable experience may be denied and split-off: this is not in the conscious mind but in the deep unconscious, the event having been such as to pass through the conscious and preconscious into the unconscious. The split-off and denied piece of experience remains encapsulated, unintegrated into the rest of the internal world. However, it has consequences for the individual, entrapping with it other areas of functioning, such as cognitive capacity or the capacity to distinguish fantasy from reality or the capacity to relate, empathize, be sensitive, and responsive. In some individuals this split-off and denied experience does not remain encapsulated but is projected outwards on to other individuals who are then seen as threatening and dangerous or very vulnerable. Mothers who may themselves have been abused but do not recall it, can present their daughters as sexual abuse victims and the child shows some symptoms. This can be understood as

the mother 'communicating' the abusive experince to the child, probably via projective identification. This process occurs at an unconscious level and needs to be distinguished from 'coaching' the child as happens in some divorce allegations.

These split-off experiences can re-emerge in consciousness and frequently this is very distressing. It can happen spontaneously, or during some form of therapy, perhaps for altogether other reasons. However, these memories once recalled do usually have some associated material detailing the abuse, or the environment. The memories can also re-emerge at specific points in the individual's lifecycle when married or pregnant or when their child reaches the age when they were abused.

Recently, there has been interesting corroboration of this hypothesis that certain very emotionally charged traumatic experiences can be split-off and denied. New psychological research has indicated that such experiences produced neurological responses that cannot be registered in the normal memory bank. They remain unprocessed, that is, they do not enter explicit memory but are presumed to be located in implicit memory. In addition, there is often a failure of development of normal object-relationships: each individual, as they develop, builds up an internal world, which contains, at an unconscious level, representations of themselves and significant others. In the unconscious this is thought to start as 'part objects', eyes, hands, body, etc., and then these come together as 'whole objects'. The child who is treated as a sexual object develops a model of themselves as 'part object', not a whole person, and this can give rise to difficulties in thinking, in remembering and making sense of experiences.

Post-traumatic stress disorder

This provides another conceptual framework to try and understand the response to a traumatic event or events. Where the individual experiences a stress outside the range of usual human experience, there can be re-experiencing of traumatic experiences shown by recurrent and intrusive recollections, recurrent distressing dreams, sudden feelings as though the event is recurring ('flashback'). In these manifestations the memory could be viewed as stuck, repetitive, and out of control. Or individuals may show persistent avoidance of thoughts and feelings of situations or activities that might provoke memories, or 'forgetting' of important aspects of the trauma (psychogenic amnesia). They may also show diminished interest in activities, feel detached, and have a restricted range of affect. In these manifestations memory is limited or lost and this mechanism is labelled dissociation.

Dissociation describes how memories are pushed away, out of consciousness but, as indicated, they can break through as flashbacks or re-experiencing. Where the trauma has been extensive and prolonged the dissociation can appear as lapses which may be mistaken for *petit mal*. The child briefly appears to be detached and unavailable. More frequently, this manifests as a flatness, an absence of liveliness, warmth, and spontaneity; this is because with the avoided memories go feelings and thoughts. Dissociation does not include a description of where the memories go other than out of awareness. Dissociation is described as a numbing process or distancing strategy (B. Justice and R. Justice 1979; Sgroi 1989). Dissociation can become a life-long coping mechanism that the survivor repeatedly invokes when triggered by minimal cues—perhaps a means of autohypnosis (Sgroi 1989).

False memory syndrome

In the 1990s a new syndrome has emerged—false memory syndrome—largely identified by parents who have been the subjects of allegations of sexual abuse. They maintain that in some cases where sexual abuse is alleged, particularly where the 'survivor' is in therapy, the allegations arise through the over-zealous attitude of the therapist in searching for repressed memories of sexual abuse in childhood. The therapist is believed to have suggested to their patient, with great conviction, their understanding that their patient's problems and difficulties arise because he or she must have been sexually abused. The therapist and patient then explore together the abusive experience the patient must have had. The patient becomes convinced of the reality of the abuse and blames the alleged abuser. This has occurred most frequently where the patients are young women and where they 'recall' sexual abuse in their early childhood. The parents argue that the young women are suggestible and vulnerable and easily believe what therapists tell them, particularly if this is conveyed with insistence. They claim these memories are not corroborated by independent evidence nor supported by other members of the family.

The question arises of whether this syndrome exists or whether it is a defensive manoeuvre developed by alleged abusers joining together. The nature and basis of the syndrome and of limited concepts are being debated strongly in the literature (Mersky 1995). The validity of the syndrome is dependent on three main factors: first, whether there is scientific evidence that memories can be repressed; second, whether earlier life forgotten memories can be recovered; third, whether there is independent corroborative evidence of sexual abuse. So far, research by academic psychologists has failed to support the notion of widespread repression of early life memories (Holmes 1990). As to clinical research, Loftus *et al.* (1994) revealed that one in five sexually abused women had had episodes of forgetfulness but, unfortunately, the nature of the amnesia was not clarified at interview. However, such findings cannot be discounted totally because of lack of clarification.

An important study by Femina *et al.* (1990) throws new light on relevant processes. They studied some 70 adults whose serious abusive experiences had been recorded during adolescence. However, only about 60 per cent reported this abuse at subsequent interview. About half of those who did not report abuse were re-interviewed and all revealed that they remembered abuse but *consciously* wanted to *forget* the painful experience or wanted it *to be private*, or wanted *to minimize it*. A worrying development in some recent reviews is a tendency by 'purist' researchers to want to underplay the fear and terror in sexually abused children that causes them to suppress their memories (Russell 1986). Nevertheless, so far there is neither definitive evidence that early-life forgotten memories cannot be recovered, nor definitive evidence that painful memories cannot be repressed. However, it is clear that any *demonstrated repression* will not prove to be a widespread phenomenon. But in one case study where a woman in her early thirties was in therapy for relationship problems, the patient and her therapist insisted she had been sexually abused but there was no confirmatory details of any abusive incident. There was only a conviction that the patient and her therapist believed it had happened and the traumatic experience explained her problems. A second-opinion interviewer found it impossible to discover any more information to

question or doubt the above conviction. Perhaps the main support for repressed memory phenomena derive from clinical anecdotes. And it is these case anecdotes, where forgotten memories appear to have re-arisen spontaneously, which cannot be discounted.

SOME DYNAMICS SURROUNDING THE MANAGEMENT OF SEXUAL ABUSE

Once sexual abuse has been suspected or disclosed powerful feelings may arise in carers or attendants such as shock, horror, fear, anxiety, rage, revulsion, distress, and sadness. But at the same time there may be both a denial—it cannot be true, these things do not happen, and not in this family that I know quite well. Or a wish not to know, a desire to walk away and not become involved. At every stage with cases of child sexual abuse, there may be the same conflict, the wish to rescue and protect and the wish to ignore in the hope it will go away. Child sexual abuse can be understood as the abuser psychically 'raping' the child's mind, that is, a piece of madness is forced into the child's mind so that the child can no longer make sense of their experiences, thoughts, and feelings. This same process can happen to those who then become involved.

The consequences of suspecting abuse or hearing a child disclose inevitably means there needs to be action. The person told must inform the responsible statutory agencies (e.g., the social services). It will also be necessary to have strategy meetings, investigative interviews, and case conferences. The child and his or her family are likely to be split up one way or another; the alleged abuser may leave, or the child may be removed, with consequent further emotions of shame, confusion, guilt, doubts, and disbelief.

If the abuser is the father, or step-father, the mother is precipitously placed in a conflict of loyalty situation between her partner—her emotional support and bread-winner, or her vulnerable child who is in need of protection. If the mother's relationship with her child has previously been poor, the decision to believe and support the child may be difficult or impossible. If the child has a disability or exhibits antisocial behaviour the mother may find it very hard to decide between her partner and her child, particularly if the child reminds her of someone in her own background. Extended families usually become drawn in, in one way or other way—taking sides with 'their daughter', or 'their son', or the grand-child. Ripples spread into the community, the school is likely to be involved, also neighbours, the family doctor, the community, and the legal system. Inevitably, child sexual abuse, especially associated with obvious uncontrolled sexuality and probably aggression, and also the abuse of power, provoke very powerful feelings (Furniss 1991; Glaser and Frosh 1991; King and Trowell 1992).

The inter-agency professional network that must assess the case and then carry through any legal action is always subjected to this emotional barrage—their capacity to hold on to clear rational objective thinking is imperative, but is all too frequently lost. Often, there may be revulsion, disgust, and outrage. Different agencies and different professionals easily become identified with different members of the family (Hay *et al.* 1991). This process is known as mirroring, and if not expected and

anticipated can lead to inter-professional and inter-agency conflict. Police are likely to want evidence for a criminal prosecution, social workers will want to protect the child and to keep the child's world child-centred and not cause too much disruption, and health workers will want to care and treat the child. All too frequently, these different professional aims can lead to conflict and fragmentation of the network. Often, professionals will not want to work with or have dealings with the alleged abuser, except to convict. All the professionals ostensibly want to 'help' the child but may compete for this role. However, the social worker may become very involved in supporting the mother and may lose sight of her parenting inadequacies. It is frequently the case that mothers have been physically and/or sexually abused themselves and need much help and support (the abusers have also, many of them, been physically or sexually abused). The child's needs, once the abuse has stopped and the child is safe, can be lost sight of because of the greater needs of the mother. It may well be that the health visitor, the family doctor, or the school are the professionals that are in touch with the child's pain and distress after the initial tasks of child protection have been implemented.

In case discussions and conferences these divergent views about needs can lead to rather heated, and at times, acrimonious discussions. The professionals speaking for the child may feel ignored, put down, or attacked; the professionals speaking for the mother may feel misunderstood; any thought or plan for the abuser may be lost other than punishment. With good professional skills based on appropriate training, many of these difficulties can be anticipated and dealt with so that the decisions made are not too biased or distorted by these identifications. If the decision is to go for Court action, civil and/or criminal, sadly all too often the conscious conflicts and unconscious dynamics can be reactivated and dominate the legal process unless this phase is handled with awareness, sensitivity, and care. Once decisions in Court are made, the dynamics can again be acted out. Where is the emphasis to be—the need for help, treatment, or the need for punishment? Whose need in a time of limited resources? Moreover, agreeing a treatment plan for parents, abuser, abused child, and siblings can be skewed unless there is constant vigilance and a monitoring of the process of decision-making because, again, the identifications with the different family members and their needs is so powerful.

Therapy

All members of the family system are likely to need treatment from the following menu:

Adults

Abuser

- individual psychotherapy (focused or long-term); group therapy; cognitive-behavioural therapy.

Non-abusing parents

- help with parenting issues; individual psychotherapy; group therapy; marital therapy; parent/child work.

Foster/substitute carers

- support and management help.

Children

Abuse survivor (victim)

- individual psychotherapy (focused or open-ended); group therapy (to reduce isolation); cognitive-behavioural (to enhance self-esteem); group psychotherapy (psychodynamic, psycho educational); parent/child work; educational therapy.

Siblings

- individual psychotherapy; group psychotherapy.

Family

Family work

- re-establishing family structuring.

Family therapy

- rehabilitation of abuser, or rehabilitation of child survivor.

In addition, there may be a need for work with the school and the community. As all the work is likely to be very stressful and demanding, therapists need regular supervision if they are to retain their capacity to function effectively. It bears remembering that all the dynamics present within the family may be repeated in the treatment.

The child

The child may have difficulty in talking about the abuse, or may talk of nothing else. It is important to work with the whole child—not to see the child only as a victim of abuse. However, the child by oscillating between projection, projective identification, introjection, and introjective identification can from moment to moment change from, for example, an abused victim, being rather vulnerable and distressed, to an excited sexualized being, to an autocratic sadistic abuser, or to a depressed or ignoring preoccupied indifferent carer. The therapist has to deal simultaneously with all these different experiences, in addition to helping the child make sense of his or her life experiences as well as the other traumatic or depressing experiences he or she may have had. This requires considerable skill and sensitivity. Part of the initial assessment is to decide whether the child would be more likely to benefit, from group or individual therapy as well as all the support and management work listed above.

The parents and school

Parents may need help in their own right. The abuse of their child may have stirred up memories of their own childhood difficulties and they may need help to work through these, so as not to repeat earlier experiences with their children. Parents may need to be seen individually or as a couple if there are parenting or marital difficulties. Many of the mothers are vulnerable, traumatized, and depressed individuals. The guilt for them is very painful. Helping mothers to see that the abuser must take responsibility for his or her own actions is very important. It is a delicate exercise because many mothers are aware, with hindsight, of noticing something different, but at the time they did not realize they should be suspecting abuse. The mother must believe she is not responsible for the abuse, and yet she also has to think about how to protect her child in the future.

Whilst this emotional maelstrom is being worked through with the child in therapy,

there are practical management and educational issues. Many of the children are depressed and under-functioning academically. Many of them will be presenting behavioural problems. Hence, teachers are likely to need support and help in order to educate and manage the child. In addition, carers may need support as they attempt to provide for these children's physical, emotional, and psychological needs.

The abuser

Abusers need advice and help from highly skilled and very dedicated professionals. The work is difficult and demanding and keeping hope alive is particularly difficult. We now know that abusers have often been having sexual fantasies about children for long periods and that it is very difficult to change these. What can be done – it is hoped – is to reduce their intensity and help the abuser find coping strategies.

Rehabilitation

The child

A crucial question is whether a child, who has been removed from his or her family, can ever return? Equally, if an abuser has been excluded from the home can he or she ever return? Most sexually abused children remain in their families and there are very few criminal prosecutions (30 per cent of cases), and very few of these result in convictions. Thus, in reality most children remain in their families or return to them. Court proceedings to protect the child are becoming more common and the child may be received into the care of the local Authority. Most of such children eventually re-establish contact with their families or at least by the age of 16 or 18 years when they leave care. In some families, where the abuse is completely denied but the child has clearly been abused, the child may be permanently removed and freed for adoption. However, in most cases where the child has been sexually abused, they remain or return to their home with at least one natural parent.

The abuser

There are differing views on rehabilitation of abusers. One set of experts considers it imperative that the abuser admit their guilt and take full responsibility. Another view is that if the alleged abuser and the non-abusing parent can agree that the child has been abused, and what needs to be in place to protect the child, and they take responsibility for the protection, then it may be possible to consider rehabilitating the child.

If the abuser has been excluded it is not easy to judge when, or if, they may return. Many abusers move away and find new families, and only a few are willing to undertake the long-term commitment to treatment that is required. However, even at the end of treatment professional anxieties remain.

Racial, cultural, and gender issues

In order to understand the significance of the abuse to the child and family there must be adequate knowledge of the child's heritage and culture. If therapists are of

the same heritage and culture this is ideal, but usually these are not available. Access to suitable consultation and advice then becomes important. It is also sensible to talk to the child and family about cultural issues and to be honest about the limits of one's knowledge.

Some experts advise that male and female children require male and female therapists, respectively. However, a child or young person may have a very strong preferences and this should be respected. In reality, because there are many more female therapists and as most children prefer a woman there is no problem. A small number of girls ask for a male therapist and if this can be provided, then it makes sense to do so. There is, however, an issue about male therapists and many experts question whether men should undertake this work at all. Another view is that it is important that men are involved, in order to provide a good male role model. However, perhaps much more important are the qualities of the therapist rather than their gender as the outcome of therapy is likely to depend on whether the therapist is skilled, competent, sensitive, and thoughtful. In long-term work it appears doubtful that the gender of the therapist determines the outcome. It is definitely not the same experience with a man or a woman—it is different, but, it is hoped equal.

Disabilities

Disproportionately more disabled children are abused than the able-bodied. Seriously disabled children, particularly deaf children are a high-risk group; children with learning difficulties who may have speech and language problems, or may be viewed as too cognitively impaired to be believed (Sinason 1992) and children with physical disabilities or those that are temporarily or permanently immobilized, are the most vulnerable groups. Offering treatment to these children and young people requires special communication skills and awareness (Sinason 1992) and ideally some professionals will require training such as *Signing* or *Maketon*. But in reality such skills will only occasionally be available.

Many sexually abused children have been unable to concentrate, learn, and think, and so present as learning disabled. Thus, assessment of these individuals is important so as to be sure about the basis or extent of their disability. Other disabilities may have been exacerbated by the abuse or threats of violence. Again, it is important to ascertain what is due to the disability and what is the secondary disability due to the trauma, shock, and disassociation of the abuse.

CONCLUSION

Child sexual abuse is a complex and distressing issue for society and professionals. We do not fully understand the impact on the children, but we do know it is a major mental health problem in countries where basic physical needs—food, warmth, and clothing are not met. Inter-generational abuse is a frequent occurrence alongside inadequate parenting. Considerable resources have now been used and abused children are being identified. The pressing need now is to have treatment available when the child is ready to work through any of their worries or distress. The children need to be allowed to

remember in their own time so that they can forget in a healthy way, letting go, so that they can rediscover their humanity and get on with their lives.

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