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Commentary

Eileen Vizard

The key messages emerging from this paper are the need for early intervention in all cases of known or suspected child abuse, and the necessity for practitioners to remain alert to the possible early traumatic origins of adult symptomatology. These clear messages are amply supported by research (Lindberg & Distad, 1985; Browne & Finklehor, 1986; Briere, 1992; Mendel, 1995; Styron & Janoff-Bulman, 1997). The paper suggests that services for both victims and perpetrators could be identified and provided much sooner if the process is started with an 'overall statement of risk' or risk assessment. Given the connections between child abuse, family violence and various physical, psychosomatic and emotional problems presenting to doctors in all specialities, it is clear that "The likelihood of a clinician encountering past or current abuse is overwhelming" (p. 109). The message here is that all doctors, not just psychiatrists, should be alert to the possibility of abuse in the past history or present symptomatology of their patients.

The generations

A familiar pattern of neglect and physical and emotional abuse across generations is described in the family backgrounds of the people who subsequently became John's mother and father. The absence of any known or documented sexual abuse in the parental or grandparental generations may be because none occurred, or because specific questions about a past history of sexual abuse were not asked. Lack of specific enquiry is an important omission, since research (Kaplan *et al*, 1988) has shown that parents of adolescent incest perpetrators have high levels of victimisation in their own childhoods. Was specific enquiry made among adult family members for any convictions for 'schedule one' offences (sexual or physical) against children inside or outside the family? Follow-up studies

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https://doi.org/10.1192/apt.4.2.116 Published online by Cambridge University Press

of generations of maltreatment (Oliver, 1985) show a high prevalence of general criminality and antisocial behaviour in the parents of the maltreated children, with only 61 of the 278 parents studied between 1960 and 1980 not having criminal convictions (unrelated to the abuse of their own children) and 36 parents having criminal convictions (including sexual offences) against their own children. A major difficulty reported by Oliver (1985) lay in gathering the vital "uncollated information" about these families which was distributed among a large number of local agencies.

An important message from this case history is the need for a full, developmental and family history to be taken in relation to the whole family in cases of child abuse and neglect. Separate histories in relation to individual family members presenting to different medical agencies are important but must be collated and brought together as part of a holistic picture about family functioning if a coherent and informed plan of action is to be made.

The victim

The vulnerable stepsister of this young sexual abuser is at increased risk of being abused for a number of reasons. In particular, her communication difficulties act as a magnet for the abuser because she is likely to be perceived as an incompetent witness in any subsequent court proceedings. Such child witnesses are in great need of psychiatric assessment, treatment and support services before and after court proceedings (Hollins *et al*, 1994; Ryan, 1994).

It is of serious ethical concern that the defence solicitors "raised strong objection to Dawn being given any treatment that might influence her subsequent reporting of events in criminal proceedings" (p. 111), given the child's documented need for treatment. A carefully undertaken investigative interview in line with Government guidance (Department of Health, 1992) does not detract from the need to put the best interests of the child first and to offer pre-trial therapy when needed, even if this is before an investigative interview rather than afterwards as recommended (Department of Health, 1992). In the case of an adult witness/victim with medically diagnosed physical or psychiatric symptoms there would be no question of withholding essential medical treatment which, it would be assumed, could only assist in giving evidence later in court.

The perpetrator

John's early history is characterised by very disturbed patterns of attachment to his mother, father and new stepfather, with some predictable consequences for his later emotional relationships (Styron & Janoff-Bulman, 1997). The case study shows clearly the over-determined nature of sexual offending against young children, with the roots of John's sexual violence towards his stepsister arising from a number of personal, family, peer and societal sources (Hawkes *et al*, 1996) including his own resentment towards a new sibling. John's long-standing conduct disorder, bullying and involvement with the criminal justice system is in line with current descriptions of the characteristics of young abusers in the UK and the USA (Becker *et al*, 1986; Vizard *et al*, 1996).

The medical findings in relation to Dawn confirm physical force (bruising on the lower back) and a degree of rapaciousness (vaginal bruising and anal tears) which do not suggest the common pattern of 'grooming' or seductive preparation for abuse, but indicate aggressive penetrative assaults committed recklessly with the conscious or unconscious intent to inflict pain. This hypothesis is borne out by recent research (Allard-Dansereau *et al*, 1997) looking at 235 alleged sexual aggressors against children, of whom 54 were younger than 19 years old with 39 of these being less than 16 years old. It was shown that "adolescent aggressors appear to engage in more genital/genital and genital/anal sexual abuse than older aggressors" and that "another important characteristic of young aggressors is that they perpetrated more penetrative acts such as genital/genital and genital/anal contact". John's guilty plea to rape and buggery charges and the emergence of aggressive and sadistic material during his subsequent six-session assessment by the forensic team seems to confirm his willingness to inflict pain on his victim and would suggest that he poses a very high level of risk to any vulnerable child inside or outside his family.

Developmental factors are clearly relevant in the choice of sexual (as opposed to non-sexual) offending behaviour. For instance, with a well-developed conduct disorder and patterns of fighting and bullying, why did this young sexual abuser not become just an ordinary thug? Early exposure to sexualised influences in the home and environment (such as John witnessing parental intercourse at the age of seven, his father's violence towards his mother and the presence of sexually explicit and violent videos in the home) may have helped to predispose John to the later development of sexualised

https://doi.org/10.1192/apt.4.2.116 Published online by Cambridge University Press

behaviour. However, it is more likely that when his own history of insecure attachment and inconsistent parenting (amounting to emotional abuse) is taken in the context of his failure to settle at school and coupled with his resentment of Dawn, these factors may have combined to suggest sexual assault as a way of humiliating and getting even with his stepsister.

No history of John having been sexually abused has been given. However, the aggressive and belligerent attitude of John's biological father, and his father's significant history of violence and many years in care at possible risk of abuse himself, coupled with his day-to-day care of John as a young boy must raise at least the possibility that John may have been sexually abused by his father. A review of research studies (Watkins & Bentovim, 1992) confirms that only between 30 and 70% of juvenile sexual offenders report their own sexual victimis-ation. However, links with physical victimisation (Awad & Saunders, 1991) and emotional abuse (81% of a sample of 70 juvenile sexual abusers were emotionally abused) are also reported, so it would be sensible to enquire about all types of childhood trauma when interviewing sexual abusers of all ages.

The investigation

Although it is encouraging to note that there was a case conference on both Dawn and John, it was not clear from the case study whether John was being dealt with as an alleged young abuser, in line with Government guidance (Home Office *et al*, 1991) or as a child in need in terms of the Children Act 1989. John's sullen 'no comment' responses to his PACE interview bring into sharp relief the conflict between the 'rights' of a juvenile suspect under the Criminal Justice Act 1991 to remain silent, and the 'best interests' of the same juvenile as a child in need (which John certainly was) in terms of the Children Act 1989. Put bluntly, the defence advice to a young sexual abuser to 'clam up' during the police interview was not in his best interests if specialist assessment and treatment resources were to be made available. This conflict of interest may present an ethical dilemma for the forensic child psychiatric team subsequently asked to assess a 'no comment' boy such as John and to elicit relevant facts from him prior to his criminal court case. In such cases, the clinical response must balance the child care and Children Act 1989 issues against the evidential needs of the criminal courts, bearing in mind the age and developmental status of the young abuser. Very young criminals of less than 13 years or so (and many older, learning-disabled adolescents) should always be considered as a children in need, regardless of the nature of their crimes. If child care professionals including child psychiatrists are not free to ask the necessary assessment questions of 'young sex fiends' like John at these crucial stages in their criminal careers, then it is clear that they run the risk of repeating their sexual abuse of children and of perpetuating further cycles of abuse with new victims in years to come.

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