

The Diagnosis of Child Sexual Abuse

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Why is it important to diagnose child sexual abuse?

Kempe, in an address to the International Association for Child Abuse and Neglect in 1979, drew the professional communities' attention to 'the serious plight of sexually abused children'. He described this as the final stage in the communities' recognition of patterns of child abuse. This cycle had commenced with his recognition of 'The Battered Child Syndrome' in the early 60s.

The sexuality of children has long been a recognised 'fact of life'. But children's descriptions of sexual activities with adults—particularly parents—has been considered a form of wish fulfilment, and therefore a fantasy, rather than having a basis in reality. Children's tendency to withdraw their statements and to be inconsistent in reporting confirmed such a view. It is, however, now recognised that such behaviour may be more in the nature of an 'accommodation' to a family demand to maintain 'secrecy', than because of there being no abuse.¹

A gradually accumulating body of evidence indicates that sexual abuse of children is not only far more prevalent than was previously thought, but also far more traumatic in its short and long-term effects, including:

- (i) direct physical effects
- (ii) effects on sexual functioning
- (iii) effects on emotional well-being and ways of relating
- (iv) sexual abuse is implicated as a contributory factor to a variety of adult problems including sexual dysfunction, marital problems and parenting disorders.

It is therefore important:

- (i) to be able to make a diagnosis of sexual abuse
- (ii) to ensure that the child is protected from further abuse
- (iii) to prevent long-term effects and to define the most effective ways of treatment for the family.

How large is the problem?

Initially, sexual abuse was thought of principally as a problem of abuse by strangers with paedophilic tendencies. Incest was seen as a more rare occurrence between fathers and teenage girls. A survey of professionals in the United Kingdom² revealed that, by contrast, reported abuse occurred within the family context in three quarters of cases, and children were abused across the age span. Boys were abused as well as girls, and it was estimated at least 3 in 1000 children would come to professional attention during childhood. Surveys of various populations have indicated that the 'true' prevalence is far higher than this and that as many as 20% of girls and 10% of boys experience some form of inappropriate sexual contact during childhood. At least 1% of girls report a serious form of 'incestuous' abuse.

Such surveys give a consistent account of the sense of 'victimisation' of individuals who have experienced such inappropriate sexual experiences, a traumatisation which can last into adulthood.

Since there has been increased awareness of sexual abuse among professionals and the public, the taboo of secrecy has been broken. Many more cases are now reported; a doubling of referrals each year over a five year period to a sexual abuse treatment project (children are currently being referred in equal numbers from 5–16, with a significant number of under fives being referred and girls to boys abused to a proportion of 3.1) has been described.³

Definition of sexual abuse

The most widely accepted definition of sexual abuse is 'The involvement of dependent developmentally immature children and young people in activities which they cannot fully comprehend, to which they cannot give informed consent, and which violate the social taboos of the culture and *are against the law*' (added by DHSS Draft Guidelines, 1986).⁴ This includes the following categories:

Incest as 'sexual intercourse between close relatives within a defined relationship who cannot marry'. The concept of incest has been extended to other relationships in the family where there is dependency, an authority relationship and where informed consent is not possible. Stepfathers, stepmothers, non-related half siblings, other relatives and friends who are not permanent residents of the family are included in this definition.

Other forms of sexual contact are covered by the notion of 'The sexual use of a child by an adult for his or her sexual gratification without considering the child's consent' e.g. anal contact, mutual masturbation, oral-anal-genital contact, battered children with injuries primarily in the genital area may also be included.

Child pornography is the arranging, photographing by still, video or film production of any material involving children or young people in sexual acts including other children, adults or animals regardless of consent given by the child's guardian.

Child prostitution involves children in sex acts for profit, and generally with frequently changing partners. Boys and girls are used, although sometimes acting alone, and parents may manage their activities and receive the profits, e.g. sex rings.

What are the problems associated with diagnosing sexual abuse?

One of the major problems in making a diagnosis of sexual abuse is that:

- (i) the diagnosis is based on interviews, statements of children and observation of their behaviour

- (ii) such statements are often not corroborated by the adult implicated through a process of denial and fear of the consequences of accepting responsibility
- (iii) there are few physical signs of sexual abuse although there may be a variety of physical symptoms. Not more than 30% of children show confirmatory features on examination even with the most thorough investigations.

Interviews and their validity

A diagnosis based on interview, and therefore on the child's memory and perceptions of traumatic events, is likely to be less convincing than one corroborated by the adult involved and the presence of physical findings. In fact children are no less accurate in their memory for 'central' events in their lives than adults, and in some respects they can be more accurate. When events are traumatic there may be a variety of pressures both external or internal to remove painful experiences out of memory. Forms of interviewing, therefore, need to be adopted to overcome such resistance and props need to be used such as drawing and the use of anatomically correct dolls for younger children. The form of questioning in interviews also has to enable children to speak. These range from 'open' questions, with minimal prompting, to more leading forms of questioning when suspicion is high and children are frozen and unable to speak. Interpretation is straightforward if a child can make a spontaneous unprompted statement about his experiences. If responses are reluctant, however, and through agreement to suggestion, with little additional material, this may convince the clinicians, but a legal view may see the interview as biased, and confirming the expectations of the examiner. Therefore the interview may be discounted and the child may be unprotected.

It is essential to validate interviewing methods and the responses of children to dolls with anatomically correct features. Work in progress indicates that children who have been abused do play with such dolls in more sexualised ways compared to non-abused children.

True and false accusation of abuse

If the professional is convinced of the 'spontaneity' of the child's description, what are the chances that the statement may have been suggested or fantasised? In some contexts, e.g. where there are major custody and access disputes in divorce, there is a higher incidence of false allegations and statements. In these cases the language of the statement is often more adult in form than expected, unusually consistent and lacking in spontaneous distressed affect. It has been calculated that about 5% of parents or 2% of children give fictitious accounts about the occurrence of abuse.⁵ A parent who is convinced that a non-custodial parent is abusing a child on access visits can confirm suspicion by pressuring the child following his or her return and convince the child that he remembers inappropriate contact when there was only appropriate contact. Distorted memories may then persist.

Dilemmas for clinicians

The dilemma for the clinician in interviewing is thus considerable since:

- (1) A child may make 'spontaneous' statements which represent 'true' experiences. Other children may resist all attempts to prompt them to describe their experiences even when there are suggestions of physical findings.
- (2) The context with the higher likelihood for 'false' allegations, e.g. in divorce and separation, is also one of risk for actual abuse, e.g. care of a child by a single male parent.
- (3) If a probability of abuse is established on interview and if protection is felt necessary, an interview with parents under these circumstances will inevitably provoke a crisis. There may be considerable difficulties in making a diagnosis, ascertaining responsibility, enabling parents to acknowledge long-standing problems and assessing the capacity for change. Fear of the consequences of taking responsibility for abuse may then outweigh the needs of the child and prevent a proper assessment being carried out.
- (4) Talking to the family without ascertaining whether abuse is a probability through interview with the child alone may leave the child dangerously exposed if abuse is asked about in a context where silence is demanded.
- (5) The ethical issues of reporting a child who describes abuse or has possibly been abused are considerable. Clinicians may feel a responsibility to all members of the family. They may be concerned that reporting abuse may lead to a far more destructive effect on the family through separation and punishment than maintaining medical confidentiality and working with this. The burden of protecting an abused child without using protective services in the community is, however, considerable.

Overcoming dilemmas in diagnostic work with sexually abused children

There is no substitute in making a diagnosis of child sexual abuse for:

- (i) an individual interview with the child by an experienced professional
- (ii) A physical examination of the child—again carried out by a skilled professional
- (iii) an assessment of the family to help make the diagnosis and to assess protective and therapeutic possibilities.

This implies that reliable diagnosis requires a team of professionals who have experience of carrying out these tasks and of assessing them jointly. The DHSS draft Guidelines⁴ advise that 'police, social work and medical professionals need to work together in the early stages of the diagnostic process' so that the tasks can be carried out in a way which:

- (i) will maximise the possibilities of making a diagnosis, thus protecting the child
- (ii) will ensure that the needs for 'services' i.e. treatment will be recognised and offered at the earliest times.

The CIBA Foundation working party⁶ recommends the following principles to assist professionals in this work:

- (1) The General Medical Council Guidelines on professional conduct state that 'confidential' information may be shared with other persons who are assisting and

collaborating with the doctor in his professional relationship with the patient. (GMC 1983:19 (2) (6).

(2) Rarely, disclosure (of confidential information) may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence. (GMC 1983:20 (2) (9)).

(3) Case conferences are vital to handle cases of children, injured, neglected or at risk. Senior members of each profession should be designated to meet regularly and advise on practice to help develop good local inter-professional relationships.

(4) The DHSS Guidelines⁷ on confidentiality state 'the safety of the child must in all circumstances be of paramount importance and must override all other considerations'. The sharing of information is, therefore, on a 'need to know' and for those directly concerned with the family and who have the duty legitimately to perform a service on its behalf and taking action in the light of all relevant facts.

(5) The CIBA group emphasised that 'A punitive attitude towards child sexual abuse does not serve aggressor, victim or the community. All professionals need to accept that, although cases involving violence, seduction of very young children, or multiple offending will require imprisonment, most sexual abuse offenders within the family are not dangerous criminals and what needs to be developed is a 'shared professionals' view to aim for the exploration of the possibilities for treatment and rehabilitation in a context of safety for the child'.

This implies that satisfactory diagnostic work can only occur where rehabilitation approaches are actively being pursued. Given acceptance of these views it should be possible for professionals to exercise their skills to a maximum in deciding what is the best diagnostic procedure.

A psychiatrist and his colleagues can play a role depending on:

- (i) working context, hospital and clinic—i.e. whether acute diagnostic work is carried out or longer term work
- (ii) interests and skills, e.g. direct examinations of children, consultation, and training functions; family assessment
- (iii) the development of treatment resources with other community professionals and self help groups.³

Making a diagnosis

- (i) alerting symptoms and signs
- (ii) the family context
- (iii) interviews with the child

ALERTING SIGNS AND SYMPTOMS OF SEXUAL ABUSE

Attention of professionals to a child is drawn either through:

- (i) direct allegation
- (ii) suspicions through a variety of symptoms suggestive of trauma.

(1) *Direct physical consequences, e.g.*

- (a) genital and anal damage
- (b) bleeding per vagina or anus
- (c) infections
- (d) pregnancy
- (e) association with other forms of physical abuse.

(2) *Direct psychological consequences*

- (a) Signs of post-traumatic stress disorder (acute, chronic, delayed); flashbacks—re-experiencing; psychic numbing; reduced response; detachment and estrangement; frozen watchfulness; hyper-alertness; sleeplessness; nightmares; memory impairment; guilt; depression; anxiety and irritability.
- (b) Specific patterns seen in sexual abuse:
 - (i) school failure; withdrawal; general unhappiness. Regressive patterns
 - (ii) depressed mood
 - (iii) psychosomatic responses—headaches; abdominal pains; anorexia nervosa
 - (iv) signs of poor self esteem—'Cinderella syndrome'; failure of self care; overdosing; self mutilation
 - (v) sexualisation of behaviour—actions which seem to suggest an unusual degree of awareness of adult sexual patterns
 - (vi) victim behaviour—(more frequently in girls). Identification with the aggressor—(more frequently in boys)
 - (vii) allegations of abuse and confusion of ordinary affectionate contact with abuse; the making of 'unbelievable' allegations and withdrawal—'Sexual Abuse Accommodation Syndrome'.¹
- (c) The patterns in particular children depend on: the age, sex and stage of development, e.g.
 - (i) the pre-school children show direct physical responses; sexualisation of behaviour and regressive signs and symptoms
 - (ii) school age children show schooling failures; loss of self esteem patterns
 - (iii) adolescents—overdosing; running away; self mutilation patterns; pregnancy; promiscuity; sexual abuse of younger children; regression; anorexia
 - (iv) adults with delayed responses—sexual inhibitions and failures; parenting difficulties; physical abuse; pervasive loss of self esteem; marital failure.

Factors associated with sexual abuse

A second stage in the diagnosis once alerting signs and symptoms have been noted is the examination of the child to assess the level of probability of abuse and assessment of the family to see whether any of the factors are present in the family which could be associated with sexual abuse. There may need to be individual interviews, interviews with parents together, parent(s) and child(ren), whole family

interviews, interviews with social workers, police, etc., interviews with children separately or with families.

None of the following factors in themselves are diagnostic of sexual abuse but some are strongly associated. Finkelhor⁸ describes four basic pre-conditions in the family which he feels need to be met for abuse of a child to occur.

First precondition. Are factors present which may be motivating the individual towards sexual abuse?

(a) Is sexual abuse of a child emotionally congruent to either the individual's beliefs and views, or the families' experiences, e.g. confusion of roles within the family, children expected to take on parental roles, parents functioning at an arrested emotional level so that sexual contact with a child is emotionally appropriate to them?

(b) Is there sexual arousal towards children through either the perpetrator or other parent having had traumatic experiences in childhood, e.g. sexual abuse, are partners sought who would perpetuate previous patterns in victim or perpetrator roles?

(c) Is there a blockage of normal sexual outlets because of excessive sexual anxiety on the part of the adult, traumatic experiences with adults, long-standing sexual failures?

Second precondition. Are factors present which predispose to overcoming internal inhibitions on the part of the abuser? For instance, is there evidence of alcoholism, drug abuse, psychotic illness, impulse disorders, senility, limited intellectual factors or a family with a tradition of very poor boundaries?

Third precondition. Are factors present which predispose to the overcoming of external inhibition to abuse? For instance, is there illness or absence of a protective parent through illness, death or handicap? Is there a distant rejecting relationship between parent and the child through anomalous family structures, stepparenting, social isolation?

Fourth precondition. Are there factors present which will help overcome the particular child's resistance? For instance, is a child handicapped physically or intellectually, is he the scapegoat or has he a particular role as one parent's favourite?

FAMILY PATTERNS

There are a number of family patterns which seem predisposed to abuse. One is a pattern of high secrecy, almost total absence of conflict or avoidance of conflict between marital partners, with intense fears of the results of separation, separateness and breakdown. In these families the child is called on to take on a self-sacrificial role to maintain the marriage and family togetherness at the expense of the child's needs.

This contrasts with a group of families with far higher levels of conflict, physical violence and neglect. Here poor boundaries between family members mean that there may be a high level of physical or sexual abuse which may involve more than one family member. Such family patterns often have their origin in the childhood and the family life of parents as children.

INTERVIEW WITH THE CHILD

The form of interview depends on the age of the child and whether the interview is basically a verbal one or focused around drawing and dolls with explicit anatomical features. These are particularly useful in young children who have a limited language for sexual parts and activities, and are also very useful with older children as a way of communicating about matters which are very difficult to articulate. Pointing to the parts of a doll, indicating possible activities or asking an older child or young person to show patterns and experiences through the dolls can be helpful.

It is important, therefore, to have interviews which explore what children have alleged, and getting other professionals or neutral individuals who may have been talked to in the session can be a very helpful means of enabling a child to pick up from his previous comments. Parents, if present, are often caught in the same family patterns of secrecy so that even when they want to help the child speak they may obstruct. Individual interviews are essential in order to provide a neutral context in which children may feel relatively free to speak.

There are advantages with younger children to videotape interviews so that there is an accurate record of the non-verbal responses of the child and the child will not have to repeat the interviews. Videotapes are available to other professionals and to legal representatives in child-care and possibly criminal contexts. The police have used video records to confront a potential perpetrator as part of their investigations and parents have been shown videos to indicate what their children have experienced.

With older children the aim is to elaborate what has already been alleged and in particular to explore the fears of the consequences of disclosure to the child, to parents, both perpetrators and other parental figures and to the siblings.

Exploration of the traumatic consequences, dreams, nightmares, sleeping problems, feeding problems, fears of revealing secrets and the consequences for others are particularly important. Also attention should be paid to the responses to the interviewer, if the same sex as the alleged perpetrator, or different. The use of supportive statements such as 'other girls/boys tell me they have troubles with sleeping etc. Do you?' or are cross with mother/father, or are worried about talking for fear of, for example, parental breakdown, suicide, gives the young person a 'language' to communicate. A silent interviewer stance can, in a sense, recreate abuse.

The interview *with younger children (up to 9 or 10 years of age)* relies on the use of the anatomically correct dolls to assist the child to enact and facilitate the interview. It is important, therefore, for children to be able to play freely and to have opportunities to play with dolls clothed and unclothed. It is also important to give the child as much opportunity as possible to speak 'spontaneously' without prompting their experiences and to use open questions to enable them to describe their experiences. Courts are more impressed by the spontaneous acts and comments of children, and it is helpful to delay more direct exploration of the possibility of abuse, hypothetical, multiple choice questions

to the latter part of the interview. A structured interview has been developed⁹ which progresses through:

- (i) a free play period
- (ii) undressing the dolls and naming body parts
- (iii) types of touching, and physical and emotional relationships
- (iv) naming the dolls who it has been alleged have been involved in abuse
- (v) re-enactment of the abuse
- (vi) recapping, reassurance and relief.

Integrating findings

Because of the high degree of secrecy, retraction, intense loyalty within families and demands on children, it is often possible only to give a level of probability in making diagnosis of sexual abuse. It is helpful to distinguish between:

- (i) a definite occurrence of sexual abuse
- (ii) a probable diagnosis of sexual abuse
- (iii) a possible diagnosis of sexual abuse
- (iv) sexual abuse is unlikely
- (v) sexual abuse has not occurred.

The factors to be considered in differentiating the diagnosis are:

- (1) Whether specific allegations have been made in a spontaneous, consistent way, or there have been observations of inappropriate sexualised contacts, sexual play, intensive masturbatory behaviour or allegations, vague, inconsistent age-appropriate behaviour.
- (2) The presence or absence of physical symptoms, e.g. genital/anal bleeding, discharges, infections, soreness.
- (3) Physical examination, evidence or not of trauma, enlargement of vaginal/anal opening, ruptured hymen, infections, sexually transmitted diseases.
- (4) Spontaneous descriptions of or demonstrations of inappropriate knowledge of sexual activities, responding to open questions, or responses to multiple choice, hypothetical or leading questions which may be consistent, or may be random.
- (5) Evidence of frozen, sexualised, angry or distressed behaviour, an 'identification' with the feeling component, or is the child's play free, with appropriate curiosity and interest, or 'automatic' response without appropriate feeling component?

(6) Symptoms consistent with traumatic experiences or not, regression pattern, sleeping, wetting, soiling, poor self esteem, in school contacts, depressive self-mutilating, running away.

(7) Evidence of a family context consistent with sexual abusive patterns, e.g. the 'preconditions' of abuse, or rigid 'conflict avoiding' patterns, secretiveness, protectiveness or high 'levels of conflict', neglect or poor care.

The factors can only be seen as general guidance to clinical practice. It is likely that diagnosis is going to focus on medical findings and the interview with the child rather than alerting factors and family factors which can be seen as corroboration. This is an indication of the importance of the interviews and the examinations since they are often the only way in which suspicions and concerns can be confirmed. The dilemma which arises is how to manage the 'possible' and the 'likely' cases, how to protect the child where there is doubt. Sharing the decision with the court and other professionals may help in this process but it is essential that the basis of the approach to the diagnosis is shared.

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A Psychoanalytic Perspective on Child Abuse

A half day conference entitled 'A Psychoanalytic Perspective on Child Abuse' will take place on Wednesday, 25 November 1987 from 1.00-4.00 p.m. The workshop (to be held at Springfields Health Education Centre, Raddlebarn Road, Selly Oak, Birmingham) is open to professionals working with children and would be suitable for teachers, psychologists, clinical medical officers, nurses, social

workers, occupational therapists and others interested in this area. Dr Judith Trowell will speak on 'A Psychoanalytic Perspective on Child Abuse'. The conference fee will be £5.00. Application forms are obtainable from the Workshop Organiser, Child & Adolescent Department, Selly Oak Hospital, Raddlebarn Road, Selly Oak, Birmingham B29 6JD. (Closing date 30 September 1987).