

The College

'Child Sexual Abuse in practice after Cleveland' – A report on a day conference at the Royal College of Physicians, 10 November 1988

Joint Meeting of the Child and Adolescent Psychiatry Specialist Section and the Forensic Psychiatry Specialist Section

The morning session was chaired by Dr Ian Berg (Programme Secretary, Child and Adolescent Section), and the afternoon section by Dr Angus Campbell (Chairman, Forensic Section), who were jointly responsible for organising the meeting.

A large and expectant audience arrived at the Royal College of Physicians for this meeting. The timing, the venue, and the programme perhaps suggested to us that we could expect some authoritative guidance in an area which feels to many clinicians a potential minefield of clinical uncertainty, polarised attitudes, and the threat of legal or public exposure. Informal chats during coffee confirmed my impression that many clinicians fight shy of the whole field, leaving other "fools to rush in". Many seemed to feel they were on a reconnoitering trip, one said "I don't want anyone local to know I'm here in case I get swamped with referrals". It was interesting later to have this remark mirrored by Dr Bentovim's account of some of the counter-transference feelings that arose during interviews with abused children: "It's as if I want to find out but I'm afraid they're going to tell me".

Did the day respond to these expectations and anxieties? To answer this I shall consider some of the themes that emerged from the day, as they reflect clinical concerns.

What is the prevalence rate?

There was mercifully little bandying around of figures on this contentious issue: most speakers who touched on it were appropriately cautious. Professor Sydney Brandon (Leicester Royal Infirmary), in his trenchant review of the training implications of the Cleveland report, talked of one in five children having a sexual encounter with a male at some time, and a rate for substantiated sexual exploitation of 0.7 per 1,000 children per year (as against a figure of 3.4 for physical assault). Dr Bentovim (The Hospital for

Sick Children, London), talked of a prevalence of upto 25% for sexual contact broadly defined and a rate of 1% for serious abuse.

How do we attain accuracy in recognition?

One of the main themes of the day was the defence of clinical and research rigour against the confounding factors of passion and bias. Professor Brandon set the tone for many of the speakers when he deplored the sight in Cleveland of "medicine in disarray and zealots contradicting each other". Dr Zeitlin (Westminster Children's Hospital), talked of the anger that he now often experienced from other professionals if he questioned the reality of abuse on clinical grounds. He said that the profession had been "negligent in not applying the same scientific and clinical criteria to this problem as to others", and while not denying the high prevalence of abuse, he proceeded to cast a sceptical eye over some of the "myths" of the subject. He pointed out that CSA was not a diagnosis in the sense that it focused on an adult's behaviour rather than problems in the child. He talked of the lack of specificity of the indicators for CSA and the need for framing a differential diagnosis. Although the great majority of accusations were valid (perhaps 75%) this figure could fall in the context of marital separation or custody disputes (to perhaps 35%). This point was echoed by Dr David Jones (The Park Hospital for Children, Oxford), but he also added a caution. In his study looking at "unsubstantiated" cases of abuse (60% of allegations in his series), a quarter had been insufficiently investigated (e.g. absent or poor interviews), and in almost a fifth there was a strong suspicion despite inadequate legal evidence. Lack of criminal conviction clearly does not imply a false allegation.

Applying epidemiological thinking, both Dr Zeitlin and later Professor Kolvin (The Fleming

Nuffield Unit, Newcastle-Upon-Tyne), usefully pointed out the differing consequences of using high and low thresholds of suspicion for a “case”. Using a high threshold, most cases identified would be positive and there would be few false positives, but positive cases would be missed; using a low threshold, no cases would be missed but the cases identified would contain false positives. He pointed out that if the capacity to think clinically was lost, a “decisional drift” resulted in which there was either a paralysis of decision making or a tendency for impulsive decisions made on too few criteria.

Speaking from the floor in response, Dr Eileen Vizard (Great Ormond Street Group) felt that Dr Zeitlin’s approach was too narrowly focused and she wondered (rhetorically) “what model he was using”. She favoured an initial broad information gathering exercise from the whole network involved with the family and said that assessment in this context would be more reliable.

The implicit opposition here between the “medical” and “systems” perspective was carried out in the mildest way and was really the only frisson of argument in a day that concentrated on presentation rather than argumentation. But I thought that it was particularly good that both these broad trends within the discipline had a chance to show their understanding of the problem and presumably find sympathetic ears in various sections of the audience.

How should we assess the child?

Dr David Jones usefully separated out the concept of “disclosure” as a process occurring over time, from the “disclosure interview” (unanimously criticised by the speakers as a deeply biased notion containing an *a priori* assumption of material to disclose), and the idea of “disclosure work” that is “therapy” planned over time with the implicit aim of disclosure or “seeing what comes out”, which Dr Jones abhorred. He emphasised Lord Butler-Sloss’s injunction to “listen to the child” by describing a child-centred and paced, open-ended, non-directive (at least initially) interview not repeated more than once with someone with the training and *aptitude* for the job. He stressed the importance of a style which was relaxed, confident, not overly intensely eager and which accepted the possibility of uncertain outcomes. Dr Arnon Bentovim is well-known for his more active approach to interviewing but I thought that he was more tentative about this in his presentation than he used to be. He said he was glad that the new, modified, Great Ormond Street semi-structured interview was finding more favour with the courts than the old one.

The use of anatomically explicit dolls was commented upon rather sceptically by both Dr Jones and Dr Zeitlin, although they did agree on research

evidence suggesting that non-sexually abused young children do use the dolls in a different way to children following sexual abuse and that the former tend not to produce false positive interviews. Dr Zeitlin, however, warned against an overly sexualised interpretation of some normal young children’s play. Dr Jones also presented evidence indicating 3 year-olds have less accurate recall than 5 year-olds and that they are more susceptible to being misled by direct or leading questioning from adults.

Talking on second opinions, Professor Kolvin was insistent that they should be *truly* independent and not “clone opinions” which depended for their assumptions and starting points on work already done by others. He was against the “cosy collusion” of professionals of similar view acting together, and felt that better provision should be made for parents to have access to independent specialists.

Who should do the interviewing?

The skills of child psychiatrists, Dr Jones argued, were well suited to the kind of interviewing he advocated, although they were often deficient in their knowledge of sexual abuse literature. In view of the numbers, Dr Bentovim argued that it was inevitable that trained social workers would carry the burden of the interviewing tasks with child psychiatrists seeing more complex cases, perhaps those involving custody disputes or mental health issues (but how, then, are psychiatrists to gain experience?). The issue of training in the field generally was tackled by Professor Brandon in describing the recommendations of the training advisory group on the sexual abuse of children (TAGSAC). The training implications are massive: over 1,000,000 people need some form of training and Professor Brandon described different phases of education across discipline and according to degree of specialisation. A particularly interesting addition common to all levels was the provision to examine the learners’ attitude towards sexuality and abuse (something that is certainly not part of the medical curriculum at present).

How reliable is the physical exam?

Not very, according to Dr Raine Roberts (Manchester) who, like Dr Zeitlin, wanted to apply basic principles of medicine and surgery to this field. She pointed to “sloppy and inconsistent” examination techniques, the lack of knowledge of normal variation of anatomy, and the ambiguity of much of the evidence. She called for standardised assessment procedures (including standard-view photographs), and minimising the need for second examinations by, whenever possible, doing joint examinations with an independently appointed doctor. Her procedure

stressed the child's control of the pace of the exam (by holding probes etc.), and her policy that "reassurance is always possible" to child and parents about the potential normal functioning of the abused sexual organs.

How can the law be changed?

Many people stressed how divisive the legal processes could be. Professor Brenda Hoggett (Law Commission) reviewed the use (or abuse) of Place of Safety Orders in Cleveland and outlined proposed changes to the law recommended by the Law Commission and the subject of a Government White Paper. The POS would be replaced by "an Emergency Protection Order" normally valid for eight days with right of parental challenge after three days and the court controlling access to the child. The criterion would be that the child was "likely to suffer harm if no order was made".

She also outlined recommended changes in the criteria for care proceedings and pointed out what to her were significant anomalies in the current use of wardship, particularly that its processes were biased against parents since an application for wardship by parents when local authority had care was impossible. She also quoted evidence showing how wardship applications often grew directly out of Place of Safety Orders, resulting in huge delays averaging 38 weeks before cases came to full hearing. The European Court of Human Rights have objected to this practice.

Comments on the legal issues were also made by Professor Bluglass (Reaside Clinic, Birmingham). He wondered why forensic psychiatrists had in the past not realised the enormity and seriousness of CSA and pointed out that he could only see 14 forensic psychiatrists in the audience! He had been worried, however, by what he had seen of the performance of child health professionals in court: the vague standards of proof, the implications of prior guilt in parents, and the poor use of rules of evidence. From his perspective, abusing adults were rarely mentally ill and there was rarely an issue of diminished responsibility, although they could often be described negatively in personality terms. He was not optimistic about the efficacy of psychological treatments for sexual offenders (although contrarily Dr Angus Campbell [Manchester], said that a research project with better results had just been published from his team).

Referring to Lord Butler-Sloss's concern for alternatives to prison, Dr Vizard encouraged the forensic psychiatrists to help the children's service plan treatments for adult offenders; but there was a contrast here between the enthusiasm of the group-orientated workers and the more pessimistic view of forensic colleagues.

What are the consequences of CSA and how can we organise treatment?

Dr Bentovim offered the day's only account of the developmental psychopathology in children following abuse. He did this using the concept of the post-traumatic stress disorder and its later manifestations. Using some of Finkelhor's concepts, he talked of the "traumatic sexualisation" following abuse leading to promiscuity and the compulsive re-enactment of abusive patterns, or an avoidant denial with impotence and frigidity. He talked of the sense of "powerlessness and betrayal" which could lead to social failure and behavioural problems, and the sense of "stigmatisation" which could lead to the use of drugs or self harm.

He developed a model of the way these processes could be expressed at various points in the life cycle and thus influence mental health. He noted no evidence to support this model but noted with concern a recent New Zealand study, which argued that the sex difference in the incidence of adult neurotic disorder could be explained by the prevalence of sexual abuse in girls. He conveyed well the rawness of the developmental tragedy that sexual abuse can be for many people.

Most usefully, Dr Bentovim described prognostic signs for therapy during the assessment phase (these largely centred around the presence of insight and lack of scapegoating as well as the supportiveness of the mother and other agencies), and then went onto describe the organisation of treatment at Great Ormond Street. This consists of a mixture of family therapy and group work, using homogeneous groups of similar aged children and others for parents. In general, he was cautious about rehabilitation of families (only 15% in his series) and found the work with children more successful than that with parents. He emphasised the close collaboration with a network of agencies in the referral and treatment process and did the immense service of making a comprehensive and well organised treatment service seem achievable.

Overall I thought this was a successful day, presenting clear models of good practice, particularly in the areas of interviewing children and organising a complex multi-agency treatment service. It was also good to listen to clear thinking within the framework of our discipline about this subject in which thinking can tend to get lost. I was strengthened in my feeling that child psychiatrists would be foolish to duck out of a central role in the debate and practice in this area. We had demonstrated to us schemes for assessment, interviewing, and therapy which are grounded in the mainstream of our training and experience; we should be able to make a vital contribution clinically and play our part in the raising of general standards. As for research, it struck me that the next need was

for a careful investigation of developmental psychopathology following abuse, which investigation will surely reveal the complexity of vulnerability and risk factors, age and personality influences, which have characterised research into the consequences of other severe stresses in childhood. As we streamed out into

London, I imagine that most of us felt somewhat reassured and empowered by the day.

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Psychiatry and Court procedures

This report was produced by the Irish Division in response to a request from the Medical Council. It has been approved by the Executive Committee and the general body of the Irish Division. It has also been submitted and approved by the Executive and Finance Committee of the Royal College of Psychiatrists.

There are two main areas of psychiatric involvement in the legal process:

(a) Psychiatrists may be asked to examine individuals and to formulate professional opinion for legal purposes.

(b) Psychiatrists may be asked to attend court as expert witnesses. Technically the evidence in court can be divided into the witnessing of facts and the delivery of expert opinion but such separation does not arise in practice. (The non-expert witness is simply a witness of fact).

Psychiatry can be of value in both criminal and civil cases.

Civil cases. Civil cases include personal injury and mal-practice actions. Psychiatric testimony is often requested in family law cases involving child custody and access following marital breakdown. Finally psychiatrists may be asked for advice on testamentary capacity.

Criminal issues. Advice may be sought on "fitness to plead". To satisfy the fitness criteria the accused must be able to understand the nature of the charges against him and to be able to co-operate in his own defence. This obviously includes a capacity to instruct his legal advisers and to assist, if necessary, in the selection of jurors and to understand the evidence produced in court.

Criminal responsibility. The psychiatrist may be asked to assist the court in determining whether the defendant was legally insane at the time of the criminal act. In Irish courts, McNaughton rules still operate although modified by recent decisions. For a defendant to be judged legally insane it must be shown that he failed to understand the nature and quality of the criminal act and the wrongfulness of the act. McNaughton is often quite unsatisfactory, depending almost entirely on cognitive functioning. Irish courts will now ask whether the accused was, by reason of mental illness, unable to refrain from committing the act complained of. That brings us close to the concept of diminished responsibility—a plea which is not acknowledged formally in this country. In practical terms, psychosis and more severe forms of mental handicap fit easily with the legal concept of insanity but psychiatric relevance can extend beyond such illness confines.

Disposition. A psychiatrist may be able to help the court towards appropriate disposition, particularly where there is identifiable illness or behaviours that may respond to treatment and supervision.

The psychiatrist as a witness. The court has right of access to all available evidence which will help it to reach the correct decision in each individual case. The psychiatrist is expected to attend and to tell the truth under oath. Like any other witness the psychiatrist can be subpoenaed.

Clinical files. Concern is frequently expressed about the subpoena of clinical files with all their confidential, sensitive material. As already stated, the court has a right to view and hear all the evidence and that can include the clinical records, but it also has an obligation to act in the best public interest and that