ABC of 1 to 7 (Revised)

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CHILD ABUSE

The ABC of 1 to 7 was first published in the "BMJ" in 1981 and then in book form in June 1982. Dr Bernard Valman has now substantially revised the book, and we are publishing six of the revised chapters in the "BMJ." The revised edition of the book will be published in the late spring.

100 deaths

Sexual abuse:

1 in 10 girls

1 in 15 boys

In Britain as many as a hundred children may die each year from inflicted injuries. Before the age of 16 years at least one in ten girls and one in fifteen boys will have been sexually assaulted. The peak incidence of the first sexual assault is about the age of 8 years, although disclosure by the child is later—usually in early adolescence. About 80% of the children are sexually abused by persons known to them, often a father, stepfather, male relation, or co-habitee of the mother. A borough of about a quarter of a million population can expect 500 new cases of sexual abuse a year but probably only one in five of them will come forward.

Definitions

Physical injury

Neglect

Emotional neglect

Sexual abuse

Potential abuse

A parent or another supervisor can harm a child by a deliberate act or failure to provide adequate care. The types of abuse have been divided into the following groups:

- Physical injury*, which may have been inflicted deliberately or by failure to provide a safe environment.
- Neglect* in providing food and warmth may impair physical health and development.
- Emotional neglect* or rejection may impair normal emotional development.
- Sexual abuse* (see next page).
- There may be a high risk of *potential abuse* where another child in the household has been harmed or a large number of risk factors are present.

Recognition

Child abuse should be suspected, especially in a child aged under 3 years, if any of the following features are present:

- There has been delay between an injury occurring and the parent seeking medical help.
- The explanation of the injury is inadequate, discrepant, or too plausible.
- The child or sibling has a history of non-accidental or suspicious injury.
- There is evidence of earlier injury.
- The child has often been brought to the family doctor or accident department for little apparent reason.
- The parents show disturbed behaviour or unusual reactions to the child's injuries or have a history of psychiatric illness.
- The child shows obvious neglect or failure to thrive.

Injuries may be similar to those encountered after a genuine accident, but certain injuries are typical of abuse:

- Burns, abrasions, or small bruises on the face.
- Injuries to the mouth or torn frenulum of the lip.
- Finger-shaped bruises.
- Subconjunctival or retinal haemorrhages.
- Bruises of different ages.

If non-accidental injury is suspected the child should be undressed completely, examined fully, and careful notes made of all findings using drawings. If suspicions are not allayed the child should be admitted immediately to hospital under the care of a consultant paediatrician. If possible the suspicions should not be communicated to the parents at this stage as they may refuse to allow admission.

If the parents refuse to agree to the child being admitted or want to remove him from hospital too soon the social services department may seek a Place of Safety Order, which allows a child to be kept in hospital for 28 days. In an emergency the police can secure an immediate Place of Safety Order but this lasts only 8 days. The fact that children with genuinely accidental injuries will occasionally be admitted unnecessarily should not deter any doctor from admitting a child when there is reasonable doubt about the cause of an injury. Within a few days a case conference is convened to try to determine whether an injury was accidental and whether the child should be allowed home, taken into care voluntarily, or taken into care through court proceedings.

Sexual abuse

Sexual abuse is the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, and which violate the social taboos of family roles or are against the law. In the past few years the number of cases identified has increased as the public has become more aware of the problem and professional staff have become more skilled at recognising sexual abuse. A child's statement that he or she is being abused should be accepted as true until proved otherwise. Children rarely lie about sexual abuse. False allegations are, in any event, a sign of a disturbed family environment and an indication that a child may need help.

Presentation

Injuries to genitalia or anus
Recurrent urinary infection
Sexual explicitness
Sudden changes in behaviour

Sexual abuse presents in three main ways:

- allegations by the child or an adult;
- injuries to the genitalia or anus;
- suspicious features.

Suspicious features include unexplained recurrent urinary tract infections, or sexual explicitness in play, drawing, language, or behaviour. There may be sudden or unexplained changes in behaviour—for example, sleep disturbance with nightmares, fear of men, or loss of trust in those near them. Self-destructive behaviour may occur, including the taking of overdoses of drugs or running away from home. Most of these physical or behavioural signs have other explanations and should do no more than raise the possibility of child sexual abuse for professionals puzzled by a child's behaviour.

Investigation

Long-term effects

Post-traumatic syndrome

Suicidal behaviour

Psychiatric illness

Problems with relationships
and sexual adjustment

Quick, highly co-ordinated work by doctors, social workers, and the police is required and they may meet informally to plan the investigations. If the abuse has occurred within the previous 48 hours the investigation may need to include the collection of forensic evidence by a suitably qualified doctor. The child should not be subjected to repeated medical examinations but referred initially to a suitably experienced doctor who is sensitive to the needs of children and the issues involved and who is experienced at giving medical evidence in court. This doctor could be a paediatrician, police surgeon, or other doctor. Social workers, police, and doctors should not subject the child to unnecessary repeated interviewing. The medical examination should be conducted in a suitable clinical setting in the paediatric department of the local hospital.

The first formal case conference involving other agencies is likely to be called only when the outcome of the investigation is known and further assessment and planning are needed. Admission to hospital allows the initial investigations to be carried out, as well as providing a place of safety until the risks can be assessed at the formal case conference. Initial management should provide care for acute medical, emotional, and social problems, ensure that the abuse stops, and encourage the formulation of plans for treatment while complying with legal requirements. Court sentences with a requirement to undertake treatment without a prison sentence have been effective in some cases.

Sexual abuse, particularly where a person known to the child was involved and where the abuse continued over a long period, can be followed by serious long-term effects. These include the post-traumatic syndrome, suicidal behaviour, psychiatric illness, and problems with relationships and sexual adjustment.

Prevention

Increasing the knowledge and awareness of the public and all professionals involved with children will result in the earlier reporting of sexual abuse. Clear local guidelines on procedure and good co-operation between investigating agencies will improve the management of these very difficult problems. Voluntary organisations and self-help groups offering informal counselling through drop-in centres or telephone lines enable some children or families to seek help.

Teaching children how to protect themselves offers the greatest potential for prevention. The prime responsibility lies with the parents, but some schools have started work in this subject within the broad context of health and safety education. Some children have confided experiences to their teachers as a result of these programmes.

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