CHILD SEXUAL ABUSE—I

Frank Bamford, Raine Roberts

What is child sexual abuse?

Child sexual abuse is any use of children for the sexual gratification of adults.

Who abuses and who is abused?

The abuser is almost always a male known to the child: a relative (father, grandfather, uncle, or older brother); a member of the household (stepfather or mother's cohabitants); or a temporary carer—for example, teenage male babysitters. Note that abusing males may move after the discovery of abuse to another household of similar composition.

Child sexual abuse may occur in any part of society but is discovered more commonly in poor families.

Children of all ages and either sex may be sexually abused.

What happens?

Sexual abuse entails all types of sexual activity often with escalating intrusiveness.

Children may be exposed to indecent acts, pornographic photography, or external genital contact in the form of being fondled, masturbating an adult, or being used for intercrural intercourse. Finally, they may be penetrated orally, vaginally, or anally.

How often does sexual abuse occur?

Nobody knows how often sexual abuse occurs. It is certain that a lot of abuse is undiagnosed and equally certain that false diagnoses may be catastrophic.

Five main risk factors predispose to child sexual abuse.

- Previous incest or sexual deviance in the family
- New male member of the household with a record of sexual offences
- Loss of inhibition due to alcohol
- Loss of maternal libido or sexual rejection of father
- A paedophilic sexual orientation, especially in relation to sex rings and pornography.

Do children tell?

Sometimes children tell other people, but many are threatened to stop them telling. They may receive compensatory treats or presents.

Disclosure after a long period of abuse is common and may be followed by retraction. The statements of young children about sexual abuse should be taken seriously and, if possible, written down verbatim. Repeated questioning is potentially harmful and may evoke less truthful answers. Care is needed in understanding exactly what the child is saying—for example, "Daddy hurt my bum" may be interpreted in several ways, whereas "Daddy put his willie in my mouth" can hardly be anything other than abuse.

Does the non-abusing parent tell?

Sometimes the parent who is not sexually abusing the child will tell someone about the abuse, but collusion within families may occur, as in physical abuse. Beware of allegations made by parents in disputes about access or custody. Do not dismiss them but treat them with great caution.

What are the presenting symptoms?

Sexual abuse has three main types of presentation.

(1) Symptoms due to local trauma or infection—for example, perineal soreness, vaginal discharge, and anal pain or bleeding.

(2) Symptoms attributable to emotional effects—for example, loss of concentration, enuresis, encopresis, anorexia, and parasuicide. A change in behaviour is important.

(3) Sexualised conduct or inappropriate sexual knowledge of young children. Remember that such conduct or knowledge may be derived from observing others or from pornographic videos, but if a child describes pain or the quality of semen physical interference is probable.

Make careful notes at the time—they may be needed later as legal evidence.

What should be recorded?

Doctors dealing with child sexual abuse should keep a record of who asked them to see the child, who accompanied him or her, who raised the question of sexual abuse, who gave the history, and who was present at the examination.

The history should include details of the incident(s) causing suspicion; a full paediatric history, with particular emphasis on genitourinary or bowel symptoms; and details of previous abuse or sexual offences within the family or household.

Dr Frank Bamford, FRCP, is reader in developmental paediatrics, University of Manchester, and Dr Raine Roberts, FRCP, is forensic physician, Greater Manchester Police.

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Should the child be examined and where?

The child should be examined but not without the knowledge and agreement of a parent (or the order of a court). Mothers of preadolescent children should always be invited to be present, except in the most exceptional circumstances. Adolescent patients should be asked whether they wish a parent to be present.

It is usually counterproductive to examine a resistant child, and if his or her cooperation cannot be obtained the examination should be deferred unless there are urgent medical reasons to proceed.

The child should be examined as soon as optimal arrangements can be made. Few children require urgent examination.

Repetitive examination is usually abusive and should be avoided.

The examination should be conducted in absolute privacy and in an environment where the child can be comfortable—not behind screens in open wards or in police stations.

There should be adequate equipment for any necessary diagnostic tests. Recording and photographic facilities are an advantage but their value is outweighed if they cause distress to the child or mean that another examination has to be conducted.

Who should examine?

A person with skill in paediatric examination who is familiar with normal genital and anal appearances of children should conduct the examination. When physical abnormalities are expected from the history a forensic physician should be invited to examine or to be present during the examination so that it need not be repeated and a second opinion is available in doubtful cases.

Who should be present?

The only people present at the examination should be the child, his or her parent, and the examiner(s)—no one else—except, with the agreement of the parents, an occasional observer in training.

What about acute sexual abuse?

When abuse is thought to have been recent (within 72 hours) or there is serious genital injury forensic evidence must not be compromised. Examination should be deferred, if consistent with safety, until a forensic physician can be present. Nobody should remove clothing or attempt to clean or bath the child. Junior medical staff should not examine suspected victims unless the child urgently needs medical attention.

For Debate

Patient preferences and randomised clinical trials

C R Brewin, C Bradley

Allocating patients to different treatments by randomisation in a controlled trial is now accepted almost without question in accounts of trial design.¹ Randomisation may reasonably be supposed to play a large part in evaluating proposed studies for grant support. The virtue of randomisation is that it reduces some types of systematic error that may interfere with the interpretation of the results of a trial. Allocating patients to treatments in a systematic non-randomised way may introduce bias which destroys comparability. We argue here that despite this advantage random allocation is not always suitable. Though patients play an active part in the outcome of all treatments, we suggest that clinical trials in which they are required to sustain an effortful and demanding role and those in which they are likely to have strong preferences for one treatment need to be considered and conducted differently.

Motivation

Patients' motivation to follow treatment regimens is likely to be influenced by any preference before treatment is begun for one particular course of action. The greater the need for participation the greater is the scope for motivation to influence outcome. Such "participative" interventions include self monitoring, diet, and self medication regimens for patients with diabetes; rehabilitation programmes for patients recovering from a myocardial infarction; counselling for patients with cancer or those at high risk of passing disorders to their offspring; behavioural and

cognitive treatments for anxiety and depression; and deinstitutionalisation programmes for chronically mentally ill and mentally handicapped patients.

The success of many, but particularly participative, interventions depends further on the patients' perceptions of their suitability and on patients' willingness to help to make them succeed.^{2,3} If effectiveness is evaluated after random administration to patients who may or may not desire the treatment it will be difficult to distinguish between a treatment that failed because it was not inherently effective and one that failed because it was not targeted towards patients who understood why that treatment was given or who were suitably motivated. Traditionally, motivation was seen as a characteristic of the patient which, it was assumed, did not change with the nature of the treatment offered. If this is the case then conventional randomisation ensures that different groups contain equal numbers of those who are "well" motivated and "poorly" motivated. With participative interventions, however, it seems more realistic to view motivation in terms of the "fit" between the nature of the treatment and the patient's wishes and perceptions. If an attempt is not made to achieve a good fit misleading underestimates of effectiveness are likely to result.

Information

Consider the case where the investigator wishes to compare two treatments of which at least one is participative. If patients are randomly allocated to treatments the investigator may draw conclusions

**MRC Social Psychiatry
Unit, Institute of
Psychiatry, London
SE5 8AF**
C R Brewin, PHD, *research
clinical psychologist*

**Department of Psychology,
University of Sheffield**
C Bradley, PHD, *lecturer in
psychology applied to medicine*

Correspondence to:
Dr Brewin.

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