CHILD SEXUAL ABUSE: AN INVESTIGATION OF ASPECTS OF POLICY, PRACTICE AND PREVALENCE IN GREATER MANCHESTER

BY

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ABSTRACT

Title: Child sexual abuse: an investigation of aspects of policy, practice and prevalence in Greater Manchester

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This study is exploratory in nature with the central aim of increasing understanding and adding to the body of information relating to the management of child sexual abuse. Its primary focus is on issues of practice as seen from the perspectives of key professionals from social services, police, health authorities, NSPCC and voluntary societies who work in this field. Three major aspects are explored: investigation, interprofessional collaboration and continuing care after it has been established a child has been sexually abused.

A qualitative research methodology is used based on 42 indepth interviews with key informants ranging from managers through to front line practitioners selected from the County of Greater Manchester.

The study demonstrates the complexity and emotiveness of the issues involved in the management of child sexual abuse and the resulting impact on professionals and the effects of the impact on practice and interprofessional relationships. It highlights the influence of the present legal system on many aspects of practice. It points to the need for an increase in resources to deal with every stage of intervention but especially therapy.

The study concludes with a discussion of the aspects that would benefit from further research. It is suggested that closer consideration of the place of specialism in child sexual abuse, the appropriate skills and training, the coordination of care and the emphasis of care would help improve practice and set priorities within a climate of scarce resources.

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The main debt of gratitude is due to the many respondents interviewed for this project. They include those working in Greater Manchester for Social Services, Health Authorities, the Police, NSPCC, Childwatch and BAAF. Also contributing were members of the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN), The Standing

Committee on Sexually Abused Children (SCOSAC), the Training Advisory Group on Sexual Abuse of Children (TAGOSAC), the National Children's Home (NCH), The Children's Society, and the Tavistock Clinic. Help was also given by Michelle Elliott, founder of Kidscape. All were under much pressure because of the nature of the work and scarcity of time available yet they gave generously answering many questions and often recalling painful experiences.

CONTENTS

INTRODUCTION

The origins of the taboo concerning incest and sexual deviance in relation to children are lost in antiquity but to this day ignorance, prejudice and lack of understanding attend these subjects (Storr 1964) from which professionals are not divorced. Even Freud who achieved much in increasing our understanding of human sexuality failed to recognise the extent of child sexual abuse so powerful are the dynamics of suppression, concealment and taboo (Vizard 1984). For these reasons any explanation of child sexual abuse is both difficult and important. It is difficult because of its hidden nature. It is important because as Mead (1950) has pointed out, whilst regulations such as those related to incest, which have underpinned the development of family life as we know it, exist in every known human society there is still the problem of the protection of the sexually immature. This she believes is at the core of the problem of incest and an issue that every society needs to solve. One need hardly add that the sexually immature need protection not only from incestuous behaviour but also from sexual abuse outside the family context.

Evidence that the extent of child sexual abuse was considerably greater than previously thought began to increase dramatically in the mid 1980's both nationally and locally in the Greater Manchester area. It was also becoming abundantly clear that resources were inadequate to deal with the rising referrals.

Many problems were emerging. The new awareness of its extent found agencies and professionals uncertain about matters of policy and practice to cope with the new challenge. Extremes of approach occurred. On the

one hand Doctor Jane Wynne, a consultant paediatrician, said that professionals tended to minimise the facts to keep families together (1987). On the other hand Doctor Marietta Higgs in Cleveland appeared to find abundant evidence to justify the removal of children. Uniquely child sexual abuse evokes the most powerful personal feelings in everyone who is confronted by its reality (McFarlane 1986) - a factor which has serious implications for practice in terms of recognition and appropriate intervention and in terms of staff support. Sydney Brandon, Chairman of the Training and Advisory Group on the sexual abuse of children (TAGOSAC) said:

> "there is buck passing, scapegoating and boundary disputes... with some outstanding exceptions the professions and services [are], failing to cope with the challenge of child sexual abuse". (Community Care 17.9.87 p.2)

Inadequacies in the law and recommended changes in legislation aimed at protecting victims of abuse from further harm during the processes of identification and proof were identified by John Spencer and others also in 1987.

Clearly there was confusion, uncertainty, even a loss of perspective in aspects of policy, practice, interprofessional relationships and the law. But an understandable loss, for what is the evidence? What damage is done to children and how is it incurred? How can professionals serve the best interests of both child and family? How can the needs of all their clients be met and who should provide for them? This study set out not to answer these questions but with these objectives: to explore the issues through the

individual perspective of key professionals with experience in working in child sexual abuse with the aim of presenting individual commentary and analysis of them. This in turn it was hoped would illuminate individual beliefs and attitudes, communicate experience and needs, clarify strategies and processes and perhaps help to identify those practices believed to be 'outstanding'.

These objectives seemed all the more relevant at a time when child sexual abuse was under scrutiny from the general public, the media and central government. Whilst its position in the spotlight heightened awareness of the complexities and the need for investigation at the same time it was evident, particularly in the popular press, that the issues became distorted and sensationalized.

Another factor strengthening the need to explore this territory is the changing nature of 'the family'. There has been a rise in the number of marriages which break up resulting in many more single parent families and many more step parents and step children. Family relationships are increasingly complex and single parents face problems of what to do with their children whilst out at work or entertainment. (Jones et al 1987). Finkelhor (1986) states that the background factors which show the strongest connection to sexual abuse identified by recent research studies are those relating to parents and family. The children most at risk are those subject to parental absence and unavailability, poor relationship with parents, parental conflicts and the presence of a stepfather. Social trends, it seems are moving in a direction which can provide fertile conditions for sexual abuse to flourish.

Clearly the increase in referrals, the lack of resources, the confusion and debate about appropriate management, the emotional impact on those who have to handle it and the direction of social trends in relation to the family all point to the urgent need for a close examination of the management of this immensely disturbing problem.

Background to the Study

The sponsoring agency The Boys and Girls Welfare Society (BGWS) has a long and distinguished history of providing direct help and care for children in need in Greater Manchester and the North West. The Society became increasingly concerned with the problem of child sexual abuse since the early 1980's prompted by the growing number of cases where there was suspicion of sexual abuse being referred to them. A research project was initiated in 1986 which has been funded in part by the European Social Fund.

The objectives of the preliminary research (not conducted by the writer) were to:

* establish the extent of identified and suspected cases of child sexual abuse in the ten metropolitan borough councils comprising Greater Manchester
* investigate current policy and practice in each of the ten metropolitan districts with regard to child sexual abuse
* examine the level of multidisciplinary/agency co-operation relating to policy, decision and practice.

Two aspects emerged from the initial work which changed the focus of this subsequent study. Firstly it was found that the extent of child sexual abuse in the Greater Manchester area was considerable; referrals were increasing but exact figures were difficult to obtain for a number of reasons: lack of proof, denial that it happens, estimates based on different definitions of sexual abuse, signs and symptoms recognized as indicators disputed, and criteria for placing a child on the child protection register from which estimates are made varying from district to district and often no differentiation made between sexual and physical abuse.

Secondly there was a great deal of diversity in policy and practice and the spirit of change everywhere evident. Clearly if the research concentrated on what was happening much would soon be out of date. The focus of this study therefore shifted to the second and third of the above objectives and focussed in particular on the how and why of practice and the exploration of the diversity of opinion and attitude discovered in the preliminary research (BGWS 1987).

Three major aspects in relation to child sexual abuse in Greater Manchester are addressed in this study:

* Investigation
* Interprofessional collaboration
* Care and management after disclosure

Although the geographical area of this study is restricted to the County of Greater Manchester and it is recognized that each area has its own unique features nevertheless similar issues are being raised throughout the country (see Appendix i: Chronology

taken from Community Care 11.4.91 charting the areas where ritual abuse has been investigated since the end of 1990). It is hoped therefore that the findings presented will be of use and interest in a wider context than the focus of exploration.

Terminology

Two related terms used frequently in references to child sexual abuse need extra comment. These are Definition and Diagnosis.

Definition

There are many definitions of child sexual abuse. The one most commonly quoted in the literature and referred to by respondents is that of Schechter and Roberge (1976):

> "Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, to which they are unable to give informed consent or which violate social taboos of family roles".

Formulating a definition is necessary to describe a type of deviant behaviour to reflect society's attitudes and beliefs, to establish approximate incidence and to give planners, managers and practitioners a notional framework to build upon. The process of defining is however, inherently limiting. In the case of child sexual abuse the above definition fails to reflect the enormous range of activities which constitute sexual abuse. Whilst the terms used are sufficiently imprecise to encompass many activities they do not convey the huge differences

between, for example, fondling and sexual assault or between photographing for pornographic purposes and exploiting children for prostitution. Part of the difficulty in defining child sexual abuse is where to place the boundary between what is abusive behaviour and what is not. Perceptions of what is normal and what is not vary between individuals and cultures further complicating the issue. Pointing out differences and variations is not to claim that one activity is worse than another. Indeed there is a danger in categorizing in such a way as to suggest there is a spectrum of abuse ranging from the least to the most severe forms. Such a concept is devised by adults and tends to give primacy to physical effects. It bypasses the child's feelings and the child's capacity to define what has happened. The significance of underlining differences is rather to counteract the effect that an all embracing, over-simplified definition might have on practice: to respond to a 'case of sexual abuse' according to a pre-ordained process instead of considering each as having uniquely individual characteristics requiring an individual approach.

For the purposes of this study a definition of child sexual abuse was useful in so far as it differentiated the activities under discussion from other kinds of abuse categorized in Working Together (DHSS 1988) as Neglect, Physical Abuse, Emotional Abuse and Grave Concern. Whilst it was understood that those children believed to be at risk of sexual abuse were likely to be suffering abuse of other kinds - sexual abuse is often also physical abuse and can surely never be separated from emotional abuse - it was important to try and identify issues specific to sexual abuse since it was the overwhelming opinion of respondents that

these posed different problems which were greater in number and more stressful in quality.

As far as this study is concerned what each respondent meant by child sexual abuse emerged gradually through personal opinions, attitudes and illustrations. This chronicle of their perceptions charts a dynamic process of defining - a process which constantly challenges, modifies, creates anew and exceeds the boundaries laid down by others. Each carved out another facet in the growing body of knowledge concerning what we understand as child sexual abuse.

Diagnosis

The term diagnosis can be interpreted in different ways. The Oxford English Dictionary defines it as:

> "Identification of a disease by investigation of its symptoms and history"

This places the process firmly but inappropriately in the realm of medical practice - child sexual abuse is not a disease. Websters New International Dictionary gives it a wider scope:

> "Investigation or analysis of the cause and nature of condition, situation or problem".

The latter definition more accurately conveys the accepted sense of the word for this context.

The medical connotation of the first definition may, however linger in the mind, particularly following events in Cleveland where the inquiry centred on diagnostic procedures as performed by medical

practitioners. Butler-Sloss in her report considered it necessary to elaborate on how the term diagnosis should be interpreted:

> "Child sexual abuse describes aberrant adult behaviour; it causes physical and emotional damage to the child. Thus it is the cause of the child's symptoms and signs and in that limited sense child sexual abuse is the diagnosis of the child's problem". (Report of the Inquiry into Child Abuse in Cleveland, 1987).

It is important to eliminate medical connotations because viewing the term in this light underplays three vital aspects of investigation. Firstly it elevates clinical/medical evidence to an inappropriately high status when considering the question of whether a child has been sexually abused. Such evidence is now believed to contribute only in part to the final conclusions concerning the cause of damage to the child; psychological, emotional and social aspects are considered equally important (ibid, Peace and McMaster 1989). The second point, related to the first, is that investigation should be based on a multi-disciplinary approach. Use of the term 'diagnosis' may reinforce in people's minds the idea that child sexual abuse is a medical problem. Peace and McMaster (1989) found that some professionals particularly from schools, referred cases of suspected sexual abuse to the school Clinical Medical Officer or hospital paediatrician rather than to Social Services as recommended in the local authority guidelines.

Thirdly the medical connotation inherent in the term conveniently and comfortably conceals the fact that

child sexual abuse is not a disease nor accidental - there is a perpetrator.

Thus in addition to affecting practice concerning investigation use of the term diagnosis could be said to distort our view of the dynamics of child sexual abuse, assisting the understandable but dangerous tendency to deny that there are people who exist in our society who cause such damage to children.

CHAPTER 1 LITERATURE REVIEW

The Development of Concern: an emerging issue

Concern about the problem of child sexual abuse is relatively new. Interest in the subject began slowly in America in the early 1970's and in England ten years later in the 1980's (Helfer and Kempe 1976, Sgroi 1982, Vizard 1984a, Frosh 1988, O'Hagen 1989).

Incest and sexual exploitation have existed since early civilisation. As Beezley-Mrazek (1981) has noted their incidence and nature have been studied from the persepectives of anthropology, history and religion, but comment from those concerned with health and welfare has been almost absent until the last two decades. Even Freud it seems chose to misinterpret the recollections of his female patients of childhood seduction relegating them to fantasy (Vizard 1984).

The reason why awareness of sexual abuse as a problem has been slow to emerge according to Sgroi (1975) is that the 'willingness' to believe that it exists has been lacking. Kempe (1979) too has described growing awareness in terms of stages beginning with denial and ending in acceptance (cited in CIBA 1984).

Two routes to greater recognition and identification have been through the work of feminists such as that of Herman and Hirschman (1977), Strucker (1977) and Weber (1977) and through work on physical child abuse initiated by Kempe with his seminal paper on 'The Battered Child Syndrome' (1962). A continuum of gradual recognition of types of abuse characterized by less evidence than battering is reflected in a sequence of text books he wrote ranging from battering

(1968) to neglect (1976) and finally sexual abuse (1984).

In Britain the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN) was instrumental in disseminating more information in response to growing concern with the publication of a brief booklet (1981). NSPCC (1984) prompted by concern that response to the problem was not always in the best interests of the child raised questions about how management could become more child centered. In 1985 and 1987 the horrific deaths of Jasmine Beckford, Tyra Henry and Kimberley Carlile occurred and subsequent government inquiries underlined once more the problems of protecting children from neglect and violent physical abuse. In October 1986 the work of Hobbs and Wynne concerning diagnosis of buggery using the anal dialation technique became known. In 1987 referral rates of cases of suspicion of sexual abuse rose substantially in many parts of the country, due, in Bentovim's view, to an increasing awareness of the problem of sexual abuse (cited in Butler-Sloss 1988). During the summer of 1987 there was extensive reporting concerning the mismanagement of over a hundred children diagnosed as sexually abused in Cleveland. A government inquiry and report ensued conducted and written by Justice Butler-Sloss (1988). The Cleveland inquiry and its aftermath has been compared to the Maria Colwell inquiry in 1974 in the sense that they are turning points in the history of child abuse influencing future policy and practice (Dunning 1987).

A Changing Focus

Despite the increase in volume of the literature in recent years however, many writers have said that our knowledge remains limited (Sgroi 1982, Jones et al 1982, O'Hagen 1989). This is in part because awareness is recent, but also because of the many problems associated with research in this field (Finkelhor 1986).

Once resistance to believing that child sexual abuse exists lessened the focus of research turned to key questions:

* what is its extent?
* what is the nature of child sexual abuse and its cause?
* what are its effects? - is it harmful?

Extent of Child Sexual Abuse

There have been studies of incidence (new cases) in America and latterly statistics collected in Britain but the majority and most influential studies have been of prevalence (retrospective) such as Finkelhor (1979) and in Britain the first national prevalence study was conducted by Baker and Duncan (1985). Ten per cent of those interviewed reported they had been sexually abused before the age of sixteen. Overall the result of the studies and statistics show considerable variation. Butler-Sloss (1988) states:

> "It has been impossible...to arrive at any consensus or to obtain any reliable figures of the general prevalence of sexual abuse of children in the country". (p.4)

The reasons for this are that there are conflicting definitions of child sexual abuse, different methodologies and different prevalence rates among the various segments of population (Finkelhor 1986). Precision is further thwarted by probable underreporting due to the sensitivity of the subject and attitudes about the family (Beezly-Mrazek, Lynch and Bentovim 1981). Refusals to answer (12% in Baker and Duncan 1985) may mask positive responses.

Higher rates are reported by the Department of Health, The National Society for the prevention of Cruelty to Children and Child Line. However it is important not to confuse the rate of referrals with incidence of abuse (Davie 1987) and to recognise that up to 1987 (the start of this study) some areas had not differentiated between sexual and other types of abuse, nor were there standard criteria for placing a child on the child protection register from which estimates of incidence are drawn (Vizard 1984, Peace and McMaster 1989). Whatever the inaccuracies however the scope is generally accepted as extensive and warrants serious concern.

Nature and Cause of Child Sexual Abuse

Finklehor (1986) in his review of a decade of research on child sexual abuse points out that many researchers examining the characteristics of victim and abuser have tried to explain all child molesting with single factor theories - for example - all children who find difficulty making friends and who have working mothers are at risk, or all child abusers are immature. He concludes:

"So far research has shown that no single factor can explain fully all sexual abuse" (p.119)

Despite this, single factor theories derived from studies on characteristics have furnished opposing perspectives with data to support on the one hand the family systems perspective who see child sexual abuse as a failure of family functioning (Kempe and Kempe 1984, Dale et al 1986 a) and on the other the feminist perspective which views it as men's abuse of power over children and women (Hadley 1987, Macleod and Saraga 1987).

To combat the limitations of single factor theories Finkelhor (1984) developed the 'Four Preconditions Model of Sexual Abuse'. It postulates that four preconditions must be present for sexual abuse to occur:

"* there must be an offender with motivation to sexually abuse
* the offender must overcome internal inhibitions against abusing
* the offender must overcome external inhibitions against abusing
* the offender must overcome resistance by the child."

(cited in Finkelhor 1986 pp86-87)

Whilst the focus on offender responsiblity finds approval with feminists there are still matters of contention arising from this broader conceptual model. How for example, should motivation be interpreted? Is it socially, psychologically, emotionally, genetically or organically based?

Effects of Child Sexual Abuse

Studies of effects, both short and long term again show great variation (Finkelhor 1986, Frude 1980). Some claim that incest does no harm (Weiner 1962, Henderson 1975, Nelson 1979). Though such claims have not been noted by this researcher since the end of the 1970's. Indeed incest of longstanding is regarded by many as worse than abuse by a stranger (Groth 1978a) Steele and Alexander 1981, Chandler 1982). However great the variation of effects, received wisdom currently is that sexual abuse of any type is harmful to some extent (Finkelhor 1986). Simmons (1986) has argued the case for intervention on this ground with authority and conviction.

One of the main problems regarding effects is what Gelinas (1983) describes as 'disguised presentation' where incest victims present for treatment without disclosing sexual abuse. She claims that unless a clinician recognizes when a patient is an undisclosed victim treatment tends to be unsuccessful. This has obvious implications for the need for thorough assessment of effects.

The humanist approach pioneered by Giarretto in the 1970's and continued by Groth in the 1980's in America appears to attach more importance to effects of sexual abuse than to its causes. In view of the variation found in research on the subject the strength of the approach lies in the fact that it focusses on the self as a unique entity, attempting to understand the subjective meaning of a client's experience (Giarretto 1976). There are critics of the humanist approach - it cannot operate without a humanistic society (Anderson and Mayes 1982), it is preoccupied with

'self' ignoring the broader social environment (Butler 1986 cited in Bagley and King 1990). However as O'Hagen (1989 p.29) has observed, Giarretto's focus on effects led to a realisation that the most punitive response to child sexual abuse was also the most damaging for the child. In this sense he is one of the first to address the problems of intervention and to entertain the idea that professional practice could cause more damage than the abuse itself.

Since the mid 1980's the literature on child sexual abuse has increased rapidly. It is arguable, however, how useful much of it has been to professionals engaged in the management of such a complex and distressing social problem. It is 'top heavy' with procedure and guidelines (Weightman 1988). Little derives from research into practice and intervention issues. Several writers have commented on the urgent need for research which is more practice oriented (Jones 1982, Frosh 1988, Weightman 1988, O'Hagen 1989). The remaining review of literature therefore examines five key aspects of practice in relation to the management of child sexual abuse. Where there is little or no literature specifically on sexual abuse related areas are drawn on. The public debate that took place during the 'Cleveland affair' in the national newspapers is also referred to. Mainly British literature is examined in this section since there are differences in practice relating to law, organisation and administration of agencies, and cultural, historical and environmental differences with America and other countries.

Aspects of Practice

Five key aspects of practice are examined:

* Investigation
* Interprofessional Relationships
* Legal Aspects
* Therapy
* Impact on Professionals

Investigation

Suspicion of sexual abuse creates more problems than other types of abuse primarily because in most cases there is a lack of clear evidence (NSPCC 1984, Glaser and Frosh 1988). Secrecy, confusion and taboo surround the subject so that unless faced with concrete evidence some professionals respond by denial (Causby et al 1987). Also many of the signs and symptoms which suggest sexual abuse are not specific to it (NSPCC 1984). The two questions for practitioners arising out of these typical circumstances are:

* is the child in need of immediate protection?
* how best can the evidence be collected?

Is the child in need of immediate protection?

This question has been addressed more frequently in the media than in academic literature in the form of criticism of social workers for failing to intervene in the cases of physical abuse (Colwell, Henry and Beckford) and for overzealous intervention in cases of suspected sexual abuse in Cleveland. The task for social workers is to evaluate the risk to the child

whilst investigation takes place which Glaser and Frosh (1988) see as a major difficulty. Which approach will cause least damage, removing the child immediately or taking more time to think, discuss and plan? The extremes in terms of outcome are trauma to the child from sudden removal from home and death through non-intervention. The social worker has a statutory duty to protect children if it is judged there is imminent danger of sexual abuse (DHSS 1986). Yet the agencies in Cleveland were criticized for causing harm to children by removing them precipitately from their homes 'whatever may or may not have happened to them previously' (Butler-Sloss 1988 p.145). Butler-Sloss (ibid p.213) recommends that investigation should instead be 'planned and considered' and is supported by Causby et al (1987) who have developed a response to referrals of suspicion which incorporates a 'strategy meeting' as soon after referral as possible including all relevant multidisciplinary personnel to determine subsequent action. Dunning (1987) also, in his concern for the potential for damaging children by intervening with the intention of preventing abuse, recommends weighing up the different courses of action with more care. Given another tragedy attitudes may change. At present most professionals appear to believe with Butler-Sloss that responding to a suspicion of sexual abuse on an emergency basis is rarely required (1988 p.213).

How best can the evidence be collected?

The main issues addressed in the literature concerning this question are the development of policy for joint investigation, interviewing children and the medical examination.

Joint Investigation

It is generally agreed that it is essential for both police and social workers to collaborate in the investigation of child sexual abuse, a consensus endorsed by government guidelines (DHSS 1986 and 1988). Social workers have a legal responsiblity to protect children, the police to investigate crime (CIBA 1984, Glaser and Frosh 1988). The debate continues however as to how closely they should work together.

From the evidence of guidance published by BASPCAN (1981) and a discussion paper by NSPCC (1984) much collaboration until later in the 1980's was on parallel lines with only points of consultation at key stages. Simmons (1986) acknowledges a state of tension between social work and law, but describes social work as a bridge between the legal process and family distress. A joint interview of the family he sees as showing the social worker as allied to both the police and the family. The advantages are that it obviates the need for repeated interviews and maximum information is gained at an early stage of the crisis. The disadvantage is that the roles of police and soical worker conflict. As Simmons points out cases are subjudice and there are problems in achieving goals of provision of therapy and protection at the same time as obtaining evidence for the purpose of prosecution of the abuser. Retraction can occur if the abuser has the opportunity of putting his or her version to the child.

In 1984 the Metropolitan Police set up a working party following concern about the method of interviewing children who were alleged victims of sexual assault. In conjunction with Bexley London Borough a pilot

project introducing a policy of joint investigation involving joint training and interviewing was started with the aim of improving interviewing techniques. The emphasis was on "the welfare and protection of the child/victim ...arrest and/or prosecution, although important are secondary" (Bexley Experiment 1987 p.9). Problems concerning conflicting roles were not wholly resolved. It was perceived that such a policy might be a considerable drain on resources, both human and financial. However awareness and communication between agencies was thought to have increased. And while it was not possible to determine objectively whether the project was successful in reducing trauma for children, those taking part felt it was a success and continuation of the approach was recommended and adopted as permanent policy with a view to possible modification in the light of further experience.

Interviewing Children

The investigatory interview has come under the spotlight because of new techniques which have been developed to cope with an increasing number of younger children (under seven and even under three) presenting as possibly sexually abused (Vizard, Bentovim and Tranter 1987).

Berliner et al (1983) stress the importance of understanding the different developmental stages of children in relation to obtaining information from suspected victims of sexual abuse. The stage of development reached dictates what impact the abuse has had on the child and the ability to tell what has happened. In the experience of Vizard et al (1987) very young children cannot formulate abstract concepts and are frequently inhibited, terrified and coerced into silence. New techniques to elicit information

were gradually developed by this team at Great Ormond Street Hospital to try to help these disturbed and inarticulate children to express themselves using play methods and series of questioning. A number of aspects concerning these methods have proved controversial and raise ethical questions regarding practice.

The line of questioning used by the team, particularly the use of 'leading questions' was criticized by the legal profession - the responses to such questions are considered directed rather than spontaneous and are inadmissable as evidence in court (Justice Waite cited in Vizard et al 1987). The dilemma for clinicians say Vizard et al (1987 p.21) is this:

> "should [we] continue to develop our skills in overcoming this resistance to talking and thereby weaken the evidential value of the communications on disclosures which follow."

Glaser and Frosh (1988 p.94) conclude that it is a matter for professional judgement at the time of interview as to whether:

> "relief gained from the opportunity of talking and evidential requirements outweigh emotional discomfort for the child."

One of the methods used for eliciting information from young children is play with anatomically correct dolls. This too is contentious. Some critics are concerned about untrained practitioners harming children through misuse (Hobbs and Wynne 1986, McWhinnie 1987, O'Hagen 1989). Harm can be caused by stimulating children inappropriately (James 1987 in

Bagley and King 1990). O'Hagen also questions their value when used with male victims. Part of the problem is that there is little data about how children who have not been sexually abused react to these dolls. However two studies, admittedly using small samples, agree that sexually related behaviour is rare in non-abused children when presented with the dolls (White et al 1986, Glaser and Collins 1987).

Medical Examination

The purpose of the medical examination is to help establish whether or not sexual abuse has occurred. However it can also have a therapeutic effect in allaying the fear some victims have of the physical consequences of sexual abuse (Goodwin 1982, Simmons 1986, Bentovim et al 1988, Glaser and Frosh 1988).

Much of the literature emphasizes that the physical evidence usually neither supports nor contradicts a diagnosis of sexual abuse (British Paediatric Association and Association of Police Surgeons of Great Britian 1987). Negative findings at the time of medical examination do not exclude sexual abuse (Bentovim 1988). In fewer than half the children who have been sexually abused is there any physical evidence, partly because of the nature of sexual abuse, partly because the abuser is often known by the victim, so no force is needed, and partly because disclosure is usually sometime after the abuse has occurred and no medical findings remain (Paul 1987, Glaser and Frosh 1988).

There is much dispute about what constitutes evidence of sexual abuse. The widely publicized technique of anal dilation described by Hobbs and Wynne (1986) came under scrutiny during the Cleveland Inquiry (1987)

since it was their work which influenced the paediatricians at the centre of the controversy, Higgs and Wyatt, in their diagnoses. A number of medical practitioners disagreed with their interpretation including Doctor Paul. As early as 1977 Paul cautioned clinicians about the interpretation of genital and anal signs recommending that they be 'no more than a guide' (1977 p.258).

Despite this the legal profession and in some cases the police place much emphasis on the medical examination to determine whether or not sexual abuse has occurred without sufficient consideration of the child's personal account (Appleyard 1987, Peace and McMaster 1989).

There are other areas of dispute concerning the medical examination. It has been stated that in cases of sexual abuse there is no urgency for a child to be examined physically in contrast to cases of physical abuse (CIBA 1984). However if the history suggests the possibility that the abuse has been recent there is some urgency to examine as forensic evidence vanishes (Bentovim et al 1988). Also Paul (1977) and Hobbs and Wynne (1986) point out that even gross physical signs can regress quickly once the abuse has stopped even in cases of longstanding abuse.

Who should conduct the medical examination? CIBA (1984) in a description of various professional roles suggest a number of possible contenders: the school medical officer, general practitioner, police surgeon and hospital paediatrician. While warning that efforts should be made to avoid subjecting the child to repeated examination (endorsed by Butler-Sloss 1988 and DHSS 1988) the danger of identifying several

practitioners is that the child may be passed from one to another for what Bentovim et al (1988) call a 'look-see'.

During the Summer of 1987 there was a debate in The Times letter columns reflecting the differences of opinion between doctors giving evidence in the Cleveland inquiry, concerning who was the most competent in the medical field to diagnose sexual abuse in children. Davies put the case for the police surgeons arguing that they had the appropriate training and skills in forensic medicine. Hobbs and Wynne argued that paediatricians had training and experience in child abuse, that they assessed the whole child and offered treatment and that police surgeons were not trained in child abuse nor were they in a position to follow up cases.

The NSPCC (1984) and Simmons (1986) favour paediatricians rather than police surgeons since the latter are mainly male and more likely to be identified with the abuser by the victim. Also the setting of a children's hospital or ward is considered more therapeutic. They add that examinations should not take place in police stations (which is more likely if conducted by a police surgeon) since it increases the child's sense of guilt. Glaser and Frosh (1988) comment that many doctors are unfamiliar with the appearances of children's genitalia and anus and that the critical factors in deciding who is the most competent are specific training, knowledge and experience of sexual abuse, collection of evidence and giving evidence in court.

The British Paediatric Association and Association of Police Surgeons of Great Britain issued an Agreed

Joint Statement in 1987 stating that joint medical consultation could be advantageous. However Peace and McMaster (1989 p.102) found that this could become "examination by committee", be insensitive to the child's needs and might cause delay in locating the appropriate colleague in cases where swift action was necessary.

Overall there is a consistancy of view about the sensitive nature of the medical examination, that it should be conducted with great patience and gentleness and awareness that the child could interpret it as further assault, that consent should be obtained from a parent and whenever possible the child should be allowed to choose between a male and female doctor (Paul 1977, and 1987, CIBA 1984, Simmons 1986, Bentovim et al 1988, Glaser and Frosh 1988).

Interprofessional Relationships

The Seebohm committee stated in 1968 that the most serious problems of the day were dealt with by teams rather than individuals. Ten years later the DHSS, concerned about evidence of poor collaboration in community care published a discussion document which commented:

> "we consider [community care] to be a philosophy in which the starting point of service is the patient/client and his needs rather than administrative boundaries and the needs of organisations". (1978)

Despite the wish to provide a unifying principle of commitment to a common purpose essential for effective multidisciplinary practice (Brill 1976, Bruce 1980)

professionals continue to jeopardize the fulfillment of that purpose through poor communication, inflexible attitudes and administrative structures and power struggles resulting frequently in competition rather than co-operation. (Kane 1975, Tibbit 1975, Brill 1976, Bruce 1980, Lonsdale et al 1980).

Given these difficulties plus the fact that collaboration is costly and time consuming (DHSS 1978) is it essential? Several authors are wary of accepting uncritically that it is (Dingwall, Webb and Hobdell in Lonsdale et al 1980). Indeed Byles (1985) says he can find no evidence to support the view that improving interagency co-ordination reduces child abuse. Stevenson (1981) however, argues convincingly that to meet the diverse needs of clients it is crucial. Pringle (cited in Bruce 1980) supports this view in her identification of the risk factors to children which she claims are themselves multidisciplinary: physical, pyschological, psychosomatic, emotional, social and environmental. Furthermore many public inquiries and government circulars to various professions have recognized its importance in dealing with child abuse.

The problems in relation to sexual abuse are general and specific. In general terms its management requires expertise which does not fall clearly within the boundary of any one profession. Nor has there been a set framework to guide professional practice (BASPCAN 1981, CIBA 1984, Finkelhor 1986). The lack of boundaries Stevenson (1981) argues, poses problems of differentiation of roles, defining tasks and "the enthusiasm or lack of it which one group shows for a particular aspect", reflecting different ideologies, values and assumptions. The lack of a framework for

Stevenson appears to be a pivotal factor tipping professionals either towards closer collaboration or towards building "higher fences" round the boundaries (ibid p.112). Interprofessional cooperation is further threatened by the powerful emotions evoked by this work (Dunning 1987, Glaser and Frosh 1988).

The problems relating more specifically to child abuse and collaboration are these. Furniss (1983) and Dale et al (1986) show that mirroring processes whereby individual family dynamics influence professional intervention can produce "conflict by proxy" in the professional network. This is particularly evident in cases of sexual abuse. In America Byles (1985) describes a project of interagency collaboration which failed due to problems of power - who should be in overall control - differences in perceptions of what constitutes credibility and good practice and disputes concerning confidentiality.

There is some consensus about the ways in which multi-disciplinary practice could improve. To achieve better communication there needs to be more clarity regarding work boundaries (Dingwall in Lonsdale et al 1980), definition of roles (Kane in ibid),specific goals and objectives (Webb and Hobdell in ibid) and a clear structure and aims agreed between professionals and family (Furniss 1984). Dingwall, however, comments that social workers have a particular problem with their legislative burden. He describes them as an "underdeveloped" profession with lack of clarity about what they are trying to achieve.

The perceptions and expectations of certain professions about their own and each others' roles are clearly significant in relation to working together

(Lonsdale et al 1980). Kane (1975 cited in Stevenson 1980) has noted that little research exists on this subject. Tibbit (1975) compared the social work and medical professions showing an inequality between them in terms of power and status . Weightman (1988, p.17) identified how this inequality has affected practice. Social workers require the co-operation of other agencies to fulfill their statutory responsiblities of investigation and child protection in cases of child abuse, but are frequently met with "professional conflict, refusal to share information and mistrust,"largely due in Weightman's view, to adverse attitudes about social workers. He argues that social workers have to 'manage from below' and that procedure guidelines in their idealized picture of what exists fail to address the reality of the varying levels of interprofessional co-operation. From Weightman's anecdotal evidence there is clearly still a degree of ignorance that Stevenson (in Lonsdale et al 1980) found concerning the training, role and perspectives of other professions sufficient to adversely affect communication and collaboration.

Legal Aspects

The law relating to children and sex offenders is complex and appears to change through the years in tune with contemporary attitudes about the family's right to autonomy against state intervention (Dingwall et al 1983) and about sexual deviance in terms of whether it should be treated as pathological or criminal behaviour (Mrazek and Kempe 1981). In the last few years it has been subject to much debate culminating in the new Children Act 1989 (for the position current at the time of this study and subsequent changes see Appendix ii).

The two aspects of law relevant to the mangement of child sexual abuse concern protection of children (civil law) and prosecution of the offender (criminal law). In both aspects the literature suggests that achieving balance within the legal framework so that the rights of all concerned are protected is immensely difficult.

In the context of protecting children in relation to child abuse in general Dingwall et al (1983) show that whoever's rights in the view of the professional, take precedence, tragedy may be the outcome and public censure levelled at professional practice. In considering an appropriate statutory framework they suggest that parental rights are different to other rights in that they have some characteristics of duties which parents are not free to abandon. They cite Beck et al (1978) who draw an analogy of the relationship between child and parent with the legal position of a trustee - an analogy which is reflected in the Children Act 1989 through the notion of parental responsibility:

> "In the case of parents, the object of trust is the promotion of children's welfare. Where they prove deficient, for whatever reason, the beneficiaries have a ground for legal action in respect of the negligent discharge of their trustees duties." (Dingwall et al 1983, p.224)

Whilst this line of thought clarifies the question of rights whereby primacy is given to the child's welfare, the problems remain as to what course of action is in the child's best interests, who is the best judge as to his/her welfare - the child, parents or professional agencies, and in what ways can the

legal framework best promote those interests. Kellmer Pringle (1981) considered children have the right to more say in decisions affecting their lives - a right which if denied can cause sadness and resentment (Gardner 1987).

Parents Against Injustice (PAIN), a pressure group founded in response to what was seen as excessive power of statutory agencies, consider their voice too should carry more weight. Clearly debate and change are endemic. The Children Act 1989 is unlikely to be the last legislative word in the effort to find the right balance.

In the context of prosecution of the offender there is a different but equally difficult balance that is sought. Problems lie in the conflicting principles of justice - the right of the accused to be judged innocent unless proven guilty 'beyond all reasonable doubt' and the right of the child to be protected from the damange of abuse and the ordeal of giving evidence - 'professional abuse' (Children's Legal Centre 1988) or 'system induced trauma' (Berliner and Stevens 1980 cited in Colby and Colby 1987) - contingent on a less strict standard of proof; 'on the balance of probabilities' (Justice Waite in Vizard et al 1987, Smith 1987).

Much of the debate has taken place in the public arena of newspaper articles and letter columns. This is not surprising since English law is dependent on precedent and thus in a sense is evolving case by case. The debate has also related specifically to sexual abuse. The main issues have concerned aspects of criminal law in relation to children giving evidence. The law both frustrates the telling (Chesterman 1985) and adds

unnecessarily to the trauma of the child (Henshaw 1982, Mason 1987, Gilmour 1987, Spencer 1988). For these reasons the majority of cases, even clear cut cases, never reach court - confirming the view of many victims they are not believed (Simmons 1986, Gilmour 1987).

The telling is frustrated in a number of ways. It maybe impossible for younger children to repeat accurately details of the abuse months later in court (Vizard 1987). Once in court young children (under eight) are regarded as unreliable witnesses, incompetent of understanding the concept of truth.'Hearsay' evidence is not permitted and corroboration required. In the view of Spencer (1988) these rules severely limit the use a criminal court can make of a child's evidence. Both he and Vizard et al (1987) point out that such restrictions whilst favourable to the guilty, can mean that the innocent too are denied justice.

The received wisdom in England is that children rarely lie (Vizard et al 1987, Gilmour 1987). However this view has been contested in America where some believe that children can be pressurized or manipulated into false allegations or deliberately lie (Underwager cited in Gold 1987). Uncritical views on children's reliablity, the relaxation of the 'hearsay' rule in some states in America, and the use of video links, it is suggested, could tilt the balance too far resulting in the conviction of innocent offenders (ibid, Deer 1987). It is likely this will continue to be a subject of much concern with its implications for legal policy and practice.

The recognition that appearing in court can be exceptionally traumatic for a child is widespread although Underwager (cited in Gold 1987) insists that there is no evidence to support this view. However reports in newspapers of cases collapsing because young children broke down or were struck dumb with fright and of older children experiencing shame, humilation and guilt were numerous throughout 1987.

As a result efforts were made to reduce the trauma through the use of screens and live video links to prevent children having to confront the accused and through the removal of wigs and gowns to appear less formal. These measures were not radical enough in the view of many however (The Police Federation cited in Barwick 1987, Davies ibid, Spencer 1988). Davies argued that a video-link does not prevent a child from having to relive a past horrific experience. Because of financial constraints it is only available in the Crown Court not in magistrates courts (Spencer). Nor does it permit the court to hear the child's original story (ibid).

Spencer goes on to argue that a much fuller and more accurate record can be provided by videotaping the original investigatory interview and allowing it as evidence in the same way tapes of police interviews with suspects are at present. He claims he is supported in this view by many including The Council of Circuit Judges, The Police Federation, The British Medical Association and NSPCC (ibid).

The arguments against their use are firstly that it is unfair to the defence if the child is questioned in a suggestive or leading fashion. But this is the failure of the interviewer not the technique Spencer

argues. Moreover the judge can reject the tapes considered unsatisfactory in this repect. Secondly the defendant might be deprived the right to cross-examine if an earlier interview is accepted as evidence. In Spencer's view this too can be answered by allowing the tape as evidence only on the condition the child is made available at the trial for this purpose (ibid).

In some states of America videotapes of the initial investigatory interview are admissable as evidence. Colby and Colby (1987) describe what they see as successful and humane changes in the law in Texas. Emphasis is laid on the key role of the interviewer and the need for specific training in skills and expertise for the task, echoed by Vizard (1987) Davies (1987) and Spencer (1988). Vizard also comments on the lack of concern throughout the debate for the need for barristers required to cross-examine child witnesses to be given adequate training. Creating such changes it is suggested would provide a more sensitive judicial process for child victims whilst protecting the civil liberties of the accused (Colby and Colby 1987).

Clearly legislation regarding both civil and criminal aspects is in a transitional state. Also there appears to be a degree of flexibility in the way the judiciary interpret the letter of the law. This means that practice varies throughout the country. Both these factors must create additional difficulties for professionals in terms of judging which way forward is in the best interests of their clients and for children, families and perpetrators in terms of uncertain outcome.

Therapy

Literature on therapy is sparse and what little there is is largely based on clinical experience and case studies rather than systematic study (McFarlane et al 1986). There is practically none within the social work context (Bradbury 1987). There are a number of reasons for this state of affairs. Firstly recognition that sexual abuse has traumatic effects both short and longterm, and therefore requires treatment, is relatively recent as can be seen from the various studies addressing the subject such as Burgess and Holmstrom (1975), Groth (1978) and Mrazek and Kempe (1981). Secondly, deriving from the former, few treatment resources are available (Sgroi 1982, MacFarlane et al 1986) - possibly also because the initial focus in practice has been on recognition and investigation and not on what to do afterwards (Roberts 1987) or because of the realisation that treatment is costly in terms of the number of practitioners required and the time taken (McDonough and Love 1987). Thirdly there are difficulties in evaluating treatment programmes partly because they are in the early stages of evolution (Sgroi 1982 and Bentovim et al 1988), partly relating to the problems concerning how and when to measure outcomes (Bander in Sgroi 1982) and partly because they are complex and multifaceted in response to a wide range of client circumstances and sometimes complicated by legal activity (Sgroi 1982, CIBA 1984, MacFarlane 1986).

Therapeutic initiatives began in America notably with the pioneering work of Giarretto characterized by a humanistic approach, community involvement and an emphasis on self-help (Giarretto 1976 and Giarrettos and Sgroi 1978). Thereafter there is a picture of

lack of uniformity (McDonough and Love 1987) evident in the literature from the numerous descriptions of approach such as Lutz and Medway (contextual family therapy 1984), Jones (individual psychotherapy 1986) and Oppenheimer (cognitive restructuring approach) reflecting the clinical orientation of the writer. Four main groups can be identified from the literature deriving from psychoanalysis such as Pincus and Dare (1978), family systems theory such as Jorne (1979) and Dale et al (1986a), humanism such as Giarretto (1976) and feminism such as Meiselman (1978) and Herman and Hirschman (1981). Each places a different emphasis on explanations of how and why sexual abuse occurs which guides the therapeutic approach. This is a contentious area causing conflict (McDonough and Love 1987),and a polorization of views, particularly between adherents of family systems and feminist theory, which can be destructive to the therapeutic process (Dale et al 1986) and can hinder progress of developing effective intervention (Bannister 1986).

There is evidence from publications since 1987 that communication of knowledge and experience of previously isolated teams of therapists is increasing. Approaches to treatment in Britain more commonly involve multidisciplinary teams which draw on a variety of models and techniques such as described by Elton (in Bentovim et al 1988) and Glaser and Frosh (1988).

Inevitably such a multifaceted approach demands much emphasis on thorough assessment and co-ordination (Simmons 1986). Indeed in a response to findings of the Social Services Inspectorate that assessments in social work practice, particularly for long term planning have been sometimes 'absent, incomplete and

unco-ordinated' (DoH 1988 p.iii) the Department of Health published a detailed guide to assessment.

Despite the general acceptance of a multifaceted approach issues of debate remain. Possibly the most contentious of these is that of combining therapy with statutory control. This sometimes involves separation within the family, of the child in alternative care or the offender in prison (Glaser and Frosh 1988). Most of the literature relates to the latter. Giarretto (1981) contended that conviction was an essential prerequisite for treatment. Many writers since have advocated the 'marriage' of legal and therapeutic services (CIBA 1984, Dale et al 1986, Simmons 1986, Bentovim 1988). This is more straightforward in America where the legal system is more flexible for example in allowing deferment of prosecution. In Britain there are few alternatives to prison for sex offenders.

The arguments for a strong authoratative structure to therapy reflect the view that sexual abuse is a crime as well as a symptom (Groth in Sgroi 1982), and an abuse of power within the family (Sgroi 1982). It is considered a key to intervention to deal with clients who are poorly motivated, who do not seek treatment and who frequently default if it is offered on a voluntary basis (ibid, McDonough and Love 1987). Also Summit (1983), Simmons (1986) and Dale (1986), argue that the abuser and family's primary defence is denial and withdrawal. The combination of fear of authority and 'heightening of therapeutic tension' helps maintain the momentum of the therapeutic process (Simmons 1986 p.7). These views are based mainly on clinical experience.

McDonough and Love (1987) in their description of treatment within the family context on this basis, report that some clinicians were reluctant to work in this way, (no reasons were given). Simmons too suggests people might feel 'uncomfortable' with the apparent reduction of rights of those involved. Certainly the fact that the whole family are affected by the legal control seems to implicate them in the 'crime' of sexual abuse. In Holland the general approach is less punitive; court action is less likely as sexual abuse is seen as family failure rather than a crime - the cause rather than the effect is of prime concern (King 1988). In Israel too the approach is to minimize legal action because of its potential to harm the child (Perkins 1987). Fawcett (1988) suggests that there maybe cultural differences between countries. She comments that the reported success of the combined approach in America might not be translated to England since the English are less likely to accept imposed authority.

Underlying this debate are many questions as yet unanswered. Which approach to therapy is the most successful? Does intervention, with or without authoratative measures stop sexual abuse? What are the predictive factors for good/poor prognosis regarding ability to change? Is it sufficient to attempt to heal individuals involved or are there wider social policy implications?

Some of these aspects are being explored. Giarretto (1978) claimed that 90% of families treated under his programme for a minimum of ten hours were reunited with low rates of recurrance. But the degree to which this 'success' was sustained over time and the quality of family life were not examined. Bentovim et al

(1987) have addressed the question of prognosis and report that the largest group of families studied fall into the category of doubtful outcome. They state that it is essential for more work to be done in this area as at that time categories were crude and more information being discovered. Several writers suggest that there are families and offenders who are untreatable (Groth in Sgroi 1982, Perkins 1987, Bentovim et al 1987).

The focus of the literature has been on treatment of incest and on children of school age and adolescents. Keschet-Orr (in King 1988) has said that it is vitally important to examine the pathology of the offender. Sexual abuse will not be reduced until the perpetrators are effectively treated. This is difficult at present in England since the majority remain unidentified partly because of the legal system which imprisons rather than treats known offenders providing little incentive to suspects to confess. Such measures do nothing to heal those who perpetrate sexual abuse (King 1988) and may add to the damage suffered by children (Perkins 1987). Perkins, alarmed by the escalating figures for sexual offences advises that action to help victims and provide treatment and/or control of offenders should be linked with changes in social policy to achieve more equality and to 'redress inaccurate and distorted media depiction of the sexes' (ibid).

Impact on Professionals

It is widely accepted that working with child abuse and sexual abuse in particular evokes powerful emotions and is as a result disturbing, perplexing, and stressful for the professionals involved (Helfer and Kempe 1976, Giarretto 1981, Sgroi 1982, Dale et al 1986b, Dunning 1987). For social workers in particular their additional statutory burden makes this work 'among the hardest that can be envisaged' (Glaser and Frosh 1988 p.162).

The feelings evoked appear to be in response to four factors:

* the nature of child sexual abuse
* the sense that it is a 'new' field of work
* the complex and conflicting aspects of intervention
* the image and expectations of social work practice fostered by public and media attention.

Firstly, as Glaser and Frosh point out, each of the words 'child sexual abuse' evokes strong feelings. A sense of protectiveness and a desire to rescue victims are common (James 1986, Cooper and Ball 1987). The exploitation of children - the abuse of power by the strong over the weak can arouse intense anger, (Bradbury 1987, Dunning 1987) even hatred (Giarretto 1981) and guilt (Glaser and Frosh 1988). All such feelings are complicated by issues of gender since the

perpetrator is predominantly male and the victim female. Glaser and Frosh regard this concept of division as a potentially dangerous over-simplification, as it can distort assessment and subsequent management of child and family (ibid).

The sexual nature of the abuse is the aspect which is most taboo. Several writers comment on the problem for professionals of unearthing painful and repressed feelings when faced with the reality of child sexual abuse (CIBA 1984, Dunning 1987, Glaser and Frosh 1988) and the need to 'come to terms with their own sexuality' (CIBA 1984 p.77). It is unclear however what this means and how it may be achieved. Feelings can range from horror and revulsion to sadness and distress, to curiosity and excitement, depending, Cooper and Ball (1987) suggest, on whether or not we can contemplate doing whatever it is the child has been subjected to. In addition the profound distress and in many cases hostility of the family, are projected onto professionals (Walker 1987).

Secondly the field of child sexual abuse is regarded by many as new and the body of knowledge small(Sgroi 1982). In any area of work perceived as new professionals are likely to feel anxious, lacking in confidence and question what is the 'right' way of doing things (ibid, Dunning 1987). For social workers, uncertainty and self doubt about their own competence are added to the anxiety of trying to make correct decisions about whether or not children are at risk of abuse (Cooper and Ball 1987) - decisions which in the making can cause further frustration and disagreement (Glaser and Frosh 1988).

Thirdly the complexity of intervention and the time consuming nature of the work are obvious from the many detailed accounts of what needs to be done throughout the different stages of management. These factors, together with the rise in referrals throughout the country (Butler-Sloss 1988), increase pressure on professionals, yet acknowledgement of its degree and impact on frontline workers in particular is rarely addressed. In the field of social work in general Walker (1987 p.12) has demonstrated that workers feel under great pressure, they invariably feel guilty and 'utterly personally responsible' as they contemplate the possibility of failure to keep up with their work load. Her conclusion is that many social workers will suffer 'burn out' or will 'opt out' unless additional resources, particularly the employment of more staff are provided.

Finally it is believed that the level of anxiety among professionals, particularly social workers, has increased as a consequence of adverse public attitudes and media reporting concerning social work practice, beginning after the Maria Colwell inquiry in 1974 and sustained throughout subsequent tragedies of child abuse, and reaching a peak during the extensive coverage of events in Cleveland in 1987 (Cooper and Ball 1987, Dunning 1987). Much of the reporting was 'biased, hyperbolic and blatantly unfair and damaging' (Dunning 1987 p.28). Clearly sexual abuse evokes strong feelings in all who confront it, professionals and public and media reporters. As Dunning comments it is a matter of concern that some reporting exploits this fact rather than seeking to broaden understanding of the subject.

What effects do these feelings have on practice? Many agree they can be damaging, clouding objectivity (Dunning 987) inducing a sense of paralysis fuelled by the complexity of operating the bureaucratic machine (Farson 1987) and influencing whether or not professionals intervene depending on their 'willingness' to accept sexual abuse happens (Sgroi 1981). Disbelief and denial are not uncommon (Hallett and Stevenson 1980).

Emotions can distort perceptions. Anger for example can hinder the understanding of the pathology of the abuser (Giarretto 1981, Bradbury 1987) or the ambivalence of the victim (Glaser and Frosh 1988) or be redirected inappropriately onto the victim, the non-abusing parent, colleagues or oneself (Bradbury 1987).

Most writers and government guidelines advise that to combat these effects work with child sexual abuse should not be attempted by a single worker but in the context of a team and on a multidisciplinary basis. Even then the emotive nature of the work can have destructive effects. Furniss (1983) describes the dynamics of confrontation of the professional system with the family system in cases of intra-family sexual abuse - a confrontation which can be used creatively, but has the danger of generating 'conflicts by proxy' (ibid p.213) with the professional system through the process of 'mirroring'. Dale et al (1986a) p.6) develop the theme of professional/family interaction in their notion of 'professional dangerousness'. They consider that professionals can easily become over-involved and over-identified with members of the family under treatment and fail to recognize the manipulative power exerted upon them. Equally teams

can become 'hooked' on the power and influence they enjoy over the family and lose touch with their therapeutic aim (Dale et al 1986b).

Both the formulation of firm guidelines and consultation with known experts have been recommeded by government circulars and public inquiries as a safeguard against the effects of powerful feelings evoked by this work. Yet with both measures there appears to be some problems in practice. Dunning (1987) has suggested that professionals can be misled by an over-concentration on process. Guidelines 'cannot guide professional judgement in terms of assessment of abuse or risk of abuse but can only guide the process whereby such judgements are made and decisions reached (p.27). And where the 'judgement' is sought in 'experts', firstly there are few in the field of sexual abuse (Sgroi 1982) and with those few there are dangers. Robert Harris (1987) in a letter to the Times draws a lesson from the case of Kimberley Carlile and events in Cleveland (occuring simultaneously). From the evidence of the two inquiries he concludes 'there are dangers in abrogating responsiblity to the experts. They may as with Kimberley do too little, as in Cleveland do too much.'

In summary the body of literature on child sexual abuse in the context of the health and welfare of children has existed for only twenty years. It increased rapidly in America in the 1970's and ten years later in Britain. The focus of the literature has changed over the years. The original unwillingess to believe that sexual abuse happens has to some extent been dispelled by the evidence of retrospective studies of widespread prevalence and annual statistics

showing rising referral rates. Studies of the characteristics and effects of child sexual abuse followed.

Little focus had been placed on the vital question of how the problem of child sexual abuse should be tackled until 1987. Then reports of mismanagement in Cleveland emerged. These events proved decisive. Throughout this and following years a plethora of guidelines were drafted by various professional bodies, government, local authorities' area review committees and working parties. Whilst knowledge of an agreed code of practice is vital to provide a basis for action, guidelines can only guide. They address practice issues in general terms which are open to different interpretations. They cannot address the detail and complexity of an individual case, nor obviate the need for professional judgement in assessment and risk of abuse.

Text books on the management of child sexual abuse can, and latterly have, fulfilled this role to some extent. But these are largely based on untested clinical experience and case studies. There has been virtually no research into the realities of practice as faced daily by front line workers. The urgent need for practice oriented research has been underlined by O'Hagen (1989 p.59):

> "Researchers must ask themselves whether their efforts are merely academic, the riskless pursuit of knowledge and understanding, or do they really want to contribute to the efforts of those engaged in the high risk task of responding to and combating child sexual abuse."

This study is an attempt to take that risk in its exploration of key practice issues.

CHAPTER 2 DESIGN AND METHOD

Choosing a method depends on what one wants to know, what the expected outcomes of the research will be, the constraints of the setting and to a lesser extent, on the resources available (Henry 1986). In this section the design and method used to conduct this study will be considered in the light of these factors and in relation to the following:

* nature of study and data to be collected
* scope of the study
* method of data collection
* means of analysis

Throughout it is the researcher's intention to convey an awareness of epistemological factors in relation to the limitations of what can be known.

Nature of Study and Data to be Collected

This study is exploratory in nature with the aim of increasing understanding and adding to the body of information relating to the management of child sexual abuse. The subject is characterized by a climate of a new awareness, change and development (Sgroi 1982, McFarlane 1986). It is a field of unknown parameters and intricate complexity (Finkelhor 1986) involving a diversity of professional disciplines and agencies where role boundaries are uncertain and controversial (CIBA 1984). The subject in itself is sensitive, in some circles taboo, and evokes strong personal feelings and views. Moreover many practice issues concerning its management are influenced by individual

attitudes and rely on personal judgement (Dunning 1987, Glaser and Frosh 1988).

For these reasons it is clear that a quantitative approach with its focus on uniformity to enhance comparability would be restrictive and fail to respond to the varied concerns of all interested parties or to the complex nature of relationships and attitudes (Walker 1985). The field of study is in the early stages of evolution where few features have been clearly identified let alone can be measured. Furthermore the emotional ingredient inherent in the data defies the control necessary to conduct reliable comparisons.

The qualitative approach, however, with its less structured format fits the task better. The seminal work of Glaser and Strauss (1967) on grounded theory which derives directly from the world experiences of people has been the foundation upon which qualitative research has risen to become well established currently as legitimate and appropriate for the study of the social sciences (Reason and Rowan 1981). Qualitative research has been likened to 'an exploration into unexplored territory' (Whyte, 1955, p.355). Social reality is seen as fluid and emerging about which researchers seek 'understanding' in the manner of 'verstehen sociologists' as described by Sjoberg and Nett (1968) or 'enlightenment' in the model developed by Weiss (in Bulmer 1982). In the latter more emphasis is placed on problem definition rather than problem resolution. The functions of englightenment in the view of Weiss are to present individual commentary, to analyse the problems identified, to illuminate individual beliefs and attitudes, to communicate experience and needs and to

clarify strategies and processes (Ritchie and Sykes 1986). The 'enlightenment' model therefore was chosen to attempt to gain a fuller understanding of the 'real world' of management of child sexual abuse - an understanding reached through an exploration and analysis of the views of key professionals working in the field.

The researcher adopting this model inevitably forms a close relationship with the data. As Clark (1975 in Punch 1986 p.12) puts it "the researcher is his own research instrument; his/her social and emotional reactions to and involvement with the phenomena he/she is studying tell us something of importance about those phenomena and thus constitute an additional source of data". In a sense it is the researcher's own understanding which tests the validity of what he/she discovers (Sjoberg and Nett 1968). As Kirk and Miller (1986) comment, perfect validity, that is the degree to which the finding is interpreted in a correct way, is not possible. The field of child sexual abuse illustrates this amply. The degree to which practice can be affected by the refraction of evidence through the feelings and attitudes of professionals has been well documented (Furniss 1983, Dale et al 1986a). The researcher too cannot escape these effects (Peace and McMaster 1989).

For this reason it is important that the researcher should "come clean...as to the nature of his relationships with the field setting and with the subjects of inquiry" (Punch 1986 p.15). The researcher of this study came from 'outside' the environment under scrutiny in geographical terms and in the sense that she had not been involved in practice in the management of child sexual abuse. The

advantages of 'insider' research are being accepted by the respondents and understanding the environment (Burgess 1980). The disadvantage is that the insider is more inclined to have preconceptions and cause bias.

In a field as contentious and emotive as child sexual abuse it was possibly easier to obtain a more balanced view by an 'outsider'. This was a view expressed by several respondents. Moreover whilst an 'insider' might sort out the complexity of the information more quickly he/she may make assumptions. An 'outsider' on the other hand has to have intricacies explained clearly and in detail due to unfamiliarity with the subject. A clearer picture may emerge as a result.

A nursing training and years of clinical practice in hospital and community settings gave this researcher a familiarity and understanding of issues that concern the 'caring' professions and her research experience in the last ten years concerning community care, terminal care and bereavement proved a useful background. There are some parallels between these fields of study and child sexual abuse. They are all complex, emotive and taboo subjects often featuring concealment, collusion and loss and difficulties of interprofessional communication which require sensitive handling and an awareness of the need for balance. Whilst a researcher can never claim absolute neutrality nor hope to understand the totality of the environment explored it is hoped that the optimum conditions as recommended by Kirk and Miller (1986 p.32) were achieved:

> "We have no technology for making [a] validity check other than long-run personal interaction.

> We can never be absolutely sure that we understand all the idiosyncratic cultural implications of anything, but the sensitive intelligent fieldworker armed with a good theoretical orientation and good rapport over a long period of time is the best check we can make".

The result of a qualitative approach then, dependent as it is on a close relationship between researcher and the data, is in the end an individual perception of the truth - a truth which is multilayered and in which paradox and contradiction inhere. As Jung has written (1933 p.96):

> "Whatever we look at and however we look at it we see only through our own eyes. For this reason a science is never made by one man but by many. The individual merely offers his contribution and in this sense only do I dare speak of my way of seeing things".

Scope of the Study

a) The Timing

The interviews took place between September 1987 and March 1989. It is significant that the timing inadvertently coincided with the development of the crisis concerning the management of child sexual abuse in Cleveland and the subsequent government inquiry. There is no doubt that the massive publicising of the details throughout the media had some effect on respondents. Many used the information that was emerging as a measure for comparison with their own working environment. Some, particularly managers, were eager to point out the differences between their methods and quality of interdisciplinary relationships

and those reported in Cleveland indicating that 'Cleveland' could not happen on their patch.

The disadvantage of the timing may be that the issues arising in Cleveland may have been given prominence producing a bias against local issues. The advantage may be that the whole subject of child sexual abuse was opened up, no longer taboo, even 'fashionable'. Respondents understood the need to arrive at a more balanced and considered picture of what was happening than was appearing in the media, and welcomed the chance to contribute to a study which attempted to explore the field. Many were already involved in a review of policy and practice regarding management of child sexual abuse and were currently thinking through the implications of certain ways of doing things. The key issues were thus in the forefront of their minds.

This climate of heightened awareness fluidity, change and development was further confirmed by the findings of preliminary research begun in 1986 by the Boys and Girls Welfare Society and influenced the choice of method. A qualitative approach is sufficiently flexible to take into account change occurring within the research period (Paulett 1981).

b) Population and Sample Studied

The geographical scope of the study was restricted to the County of Greater Manchester since the sponsoring organization, The Boys and Girls Welfare Society, served that area. One of the objectives of the research was to inform the society of the current local 'state of the art' of policy and practice with a view to responding according to the findings in a way that might help the growing number of children and families involved in this serious social problem.

Initially six interviews were conducted outside Greater Manchester with respondents selected for their nationally acclaimed knowledge and experience in this field. The reason for this was to generate ideas about the scope and nature of the issues involved and to provide a framework for interviewing further in Greater Manchester.

These initial interviews revealed that the number of agencies involved were many and included a variety of professional disciplines. Obviously the total population of all the agencies who played a role in the management of child sexual abuse in Greater Manchester could not be examined. Nor would it be useful to randomly select professionals since those emerging might have no experience of dealing with child sexual abuse. A purposive sample of key professionals all of whom had some experience in the field was therefore chosen. Social services have the main responsibility for the protection and welfare of children suspected of being sexually abused so the focus of the research was upon them and emanated outwards to those agencies which impinge upon social work practice: the health authority, police, NSPCC, and some voluntary organizations.

The social services respondents came from five out of the ten boroughs of Greater Manchester. They were selected by the Chief Executive of the sponsoring agency who knew the Directors of social services of the five boroughs to be interested in participating as key informants in the study. Within each of these boroughs the director or his/her deputy, a middle manager and/or coordinator at principal officer level, a team leader and an area fieldworker from the same team were interviewed. The rationale for this was to

see if there appeared to be differences of view relating to seniority of rank and management/practice functions and to examine aspects of intra-agency communication. Mainly recommendations were made by social services' respondents as to the most appropriate personnel from other agencies to include in the project. This may have caused some bias illustrated by the surprising omission of paediatricians recommended as appropriate to contribute. On the other hand this may reflect a regional difference. In Greater Manchester the medical examination of children suspected of being sexually abused was usually undertaken by a police surgeon.

Not all those recommended by initial respondents were interviewed. Further selection was necessary to restrict the amount of data due to available time and resources. In making that selection consideration was given to the relevance of the contribution of each potential respondent. This was difficult as the parameters of such a study are vague and assumptions had to be made. However the focus was restricted to the three key disciplines: social services, police and health professions, excluding for example the educational perspective. And duplication of perspectives was also partially avoided within the police and health authority - the aim being to explore these territories rather than evaluate different responses.

The total number of respodents was 42. No one approached refused to collaborate. For characteristics of the respondents see Table 1 below.

Table 1: Respondents

Total:		**42**
Professional background:	Social work	30
	Medical	7
	Police	3
	Counselling/telephone helpline	2
Agency:	Statutory & Health Authority including DHSS Inspectorate	30
	Voluntary, including NSPCC	12
Geographical situation	Outside Greater Manchester	6
	Greater Manchester	36

From this table it is clear that there is a bias towards the social work perspective. However the intention was not so much to gain a representative view of a particular profession. This would hardly be possible at this early stage of our understanding of the subject. But rather to gain insight from individual and personal perspectives.

Method of Data Collection

The method chosen was the semi-structured indepth interview which was recorded in note form and transcribed immediately after the interview. The transcription included field notes concerning ease of access to the respondent, the context of the interview, observations of non-verbal data and, as data collection progressed, aspects of analysis such as comment on recurring issues, emerging patterns, connections and contrasts. Each transcript was then discussed in depth with a number of professionals from different disciplines before a final analysis was made.

The objectives of an indepth interview are to generate factors which have a bearing on the issues being studied, explore the range of ideas and concepts raised and to penetrate beneath people's rationalisations or scripts (Keegan 1986). With a subject such as child sexual abuse where the boundaries of knowledge were largely unknown and relatively unexplored such objectives are appropriate for these reasons: The method allowed the researcher to learn from what people said without prior categorization or reliance on 'old knowledge' (Patton 1986). Probing beneath surface responses was possible yielding valuable insight into the more sensitive and emotive aspects of the subject. Furthermore it was a flexible tool adapting to the variety of contexts and constraints of the different respondents some of whom could give more time than others. It also allowed for the development of a slightly more structured interview as data collection progressed.

Topics generated by respondents of earlier interviews were incorporated into later ones by the researcher demonstrating the interactive nature of the qualitative approach (Keegan 1986). Glaser and Strauss (1967) have commented on the benefits of developing the method in this way during the course of the study so that the researcher can concentrate on the most useful and meaningful information emerging.

There are a number of limitations to this method. Firstly there is the danger of subjectivity partially discussed above. The method of note taking at the time of interview rather than audiotaping is particularly open to bias. Audiotaping might have helped identify areas of subjectivity and eliminated a degree of selectivity inevitable in the process of notetaking. However it has been suggested that this method can inhibit respondents when dealing with sensitive and/or contentious subjects (Bastin in Walker 1985). In the past experience of the researcher when taperecording, the most revealing data has been proffered after the tape recorder has been switched off. Moreover the large amount of data audiotaping yields is difficult to manage at the analysis stage and is costly to transcribe. To counterbalance the acknowledged subjective bias all transcriptions of the interviews with field notes were discussed in detail with a range of professional supervisors.

Secondly, the use of the indepth interview has a number of drawbacks and particularly if used exclusively. Schatzman and Strauss (1973) have suggested that it cannot be guaranteed that the respondents interviewed have the capacity to describe and explain aspects of their work. They also argue

that the interview situation influences how the interviewee responds and may not reflect accurately how they respond in practice. Becker and Geer (1970) suggest that combining participant observation with interviews helps to check any distortion of data. It was the intention originally to seek opportunities for observation of practice. However few openings were offered perhaps because of the high profile that management of sexual abuse cases had at the time which appeared to foster hostile attitudes towards practioners. It is also a time consuming process which neither the researcher nor possibly the practitioners concerned were able to afford. More importantly such was the state of change in the field it is questionable whether the data yielded would have added to the main thrust of the study.

Procedural guidelines were not analysed despite the focus on practice issues since the aim was not to evaluate practice. In the event few agencies had guidelines specific to sexual abuse. Existing child abuse procedures were under review. Rather the study focussed on individual and personal perspectives, not derived from existing policy, with the aim of exploring basic issues of a new area of research, how people conceptualize these issues and individual understanding of them. To achieve such data Sellitz, Wrightman and Cook (1976) confirm that the informal, indepth interview is the most useful tool.

Means of Analysis

The main concern of an analysis of indepth interviews is to understand the world of the respondents as they construct it (Jones in Walker 1985). Whilst disciplined measures to maintain as high a level of

objectivity as possible, as outlined above, are indispensible, in the end analysis is a "highly personal activity" (ibid p.56). Jones concludes that there is no "best method" and with other proponents of the qualitative approach such as Keegan (in Ritchie and Sykes 1986) and Stone and Harris (1984) she advises:

> "we all build and use the routines and tools with which we find, often through trial and error, we are most comfortable and which help us best make sense of the way other persons make sense of their realities". (in Walker 1985 p.96)

What follows is a personal account of the method of analysis.

Data from the interviews were prepared for analysis by transcription from note form to detailed typewritten accounts. Key issues were identified and coded in the margin of the transcripts and listed on a chart indicating which respondents raised which issues and on which page the comment could be found. All comments concerning an individual issue could then be identified. (Up to this stage the method resembles those described by a number of authors including Stone and Harris (1984)). The range of aspects, the degree of convergence and divergence of opinion and any linking with other issues were noted. This was achieved by modifying a technique devised by Buzan (1974).

Buzan argues that the brain works primarily with key concepts in an interlinked and integrated manner; that is in the form of a network or pattern rather than in a linear fashion. Information translated on paper

reflecting this pattern makes it easier for the brain to define, clarify, prioritise, contrast, compare and to make connections. Analysis was facilitated by placing each key issue in the centre of the page with individual aspects originating from respondents comments branching out to form a network around it (see Appendix iii for an example). From this 'picture' depicting all aspects of a particular issue or category a written analysis was made.

Three texts were written reflecting the professional and personal perspectives of the respondents concerning the management of child sexual abuse on aspects of investigation, interprofessional collaboration and continuing care, for publication by the The Boys and Girls Welfare Society. The findings and discussion of issues which forms the body of this thesis are a distillation of these texts:

Child Sexual Abuse: Professional and Personal Perspectives

Part 1 - Aspects of Investigation (1989)
Part 2 - Interprofessional Collaboration (1991)
Part 3 - Towards Healing (to be published)

They reflect the creative relationship achieved between the professional and personal perspective of the researcher and those of her respondents. In this sense the results of this study represent what Margaret Mead has called a partial truth - "[we] must wait upon the contribution of others for a fuller truth" (1950 p.43).

CHAPTER 3 FINDINGS

Aspects of Investigation

Whilst the phenomenon of child sexual abuse is not new the awareness of its extent and the subsequent concern about how to manage the increasing number of referrals is new. Respondents raised many aspects reflecting their concern to make sense of 'this new thing'. This chapter deals with those concerns related to the initial stages of management and includes the following:

* effects of new awareness
* lack of evidence
* time taken in investigation
* proctection issues
* processes involved in the collection of evidence: assessment

Effects of New Awareness

Many respondents said that there were no experts in this field that they were all learning and trying to discover the best ways of working. This made whatever they did wide open to criticism. The expression 'minefield' was used frequently to express the high risk involved and the awareness that mistakes would be made. A Child Psychologist was concerned that current thinking was that nobody had better do anything till everyone knows everything. She believed however, that imperfect intervention was better than nothing at all; in other words that risks had to be taken.

The general concern was to reach a balance between overreacting and underreacting - but opinions differed

as to how to reach that balance. For one Social Worker the only way was:

> "to think abuse and then elimnate it".

A Child Psychiatrist however believed that there were dangers in this approach:

> "What is going on in the whole family in particular the emotional damage gets lost or ignored".

A number of respondents pointed out that the different levels of experience and knowledge across the various agencies was reflected in inconsistent practice. There was concern about lack of knowledge as to when it was appropriate to refer and to whom. A Chief Inspector of police said "they fear to start off world war three" or in panic response "hit the emergency button".

A Child Psychologist was concerned about the lack of expertise in the ability of many professionals to recognize evidence of child sexual abuse and to respond appropriately. She said:

> "mismanagement [in the early stages] makes for most of my problems".

Thus whilst front-line practitioners were reassured that the climate of opinion was that everyone is feeling their way in this field, they were also aware that in practice expertise is perceived as all important in making what were called those "crunchy decisions".

It is understandable that in this ambivalent climate the degree of confidence in their skills should play some part in how they respond to referrals. A respondent from a service used for consultancy said that cliques had formed of so-called experts who undermined the skills of frontline workers, making them feel inadequate. The agency had anxious practitioners seeking reassurance about whether they had done the right thing when they had coped perfectly adequately.

One of the outcomes of this lack of confidence was that professionals perceived as 'experts' tended to be inundated with referrals both for advice and consultancy and for assessments in cases of suspicion of child sexual abuse. Not only did this put a lot of pressure on them but also it caused delays leaving cases 'in the air' with the obvious risk of children left unprotected and family relationships further damaged by uncertainty and mistrust.

Additional sources of anxiety to professionals were the adverse attitudes of society to social workers in general and the influence of the media oversimplifying the issues relating to the management of child sexual abuse. One respondent said:

> "they expect you can wave a magic wand and put it all right".

Another, a social services Team Leader, described this anxiety as a healthy rather than a disabling one. He believed that public expectations were ligitimately higher; that the profession (of social work) was much better than it used to be and that work in the field of child sexual abuse was a challenge to raise

standards still higher, to increase resources and equip social workers to cope with the additional demands.

What might help in meeting these challenges is the recognition that there are differences in dealing with sexual abuse as opposed to other types of abuse. The main differences were identified as follows:

* cases are more complex; they involve concealment, secrecy and taboo, there is little visible evidence and what is visible can have a number of differential diagnoses
* the subject is emotionally highly charged and volatile
* the consequences for the perpetrator and family are more severe
* the police are more likely to be involved with an accent on prosecution rather than therapy

Working in the field of child sexual abuse is clearly challenging even when a professional's experience and knowledge are considerable. But few can have these advantages at this early stage of awareness of the problem. The pressure and the risks involved, for social workers in particular, were not, it seems acknowledged widely, nor was the potential harm to children as victims of an investigative procedure which appeared to focus on prosecution rather than therapy. A Consultant Child Psychiatrist commented:

> "The whole country is at the stage of shock...this will change...when attitudes have changed and people have got beyond the urge to blame and prosecute."

Lack of Evidence

There was general agreement that the majority of referrals for suspected child abuse offered little or no concrete evidence and that they caused the most problems for professionals. It was suggested that "top-rate" skills were necessary for the assessment of such cases as most children will not tell and retractions are frequent.

Whilst in some areas liaison between police and social services was immediate after referral and recommended as providing the ideal combination of "caring and sensitivity and hard-headed commonsense" in others there was no set pattern. Some social services'respondents said the police were not interested if there was no definite allegation or clear evidence. This was refuted by a Chief Inspector of police however who said that information about suspected cases is best shared with the police so that records for the whole of Greater Manchester, kept centrally, could be consulted which might yield valuable clues.

The possibility of false allegations was said to be an area of particular complexity. In custody and access cases a parent's allegations might be "bitching between partners" or "a form of revenge". The frequently quoted statement "children never lie about sexual abuse" was also treated with scepticism particularly by police respondents. Some children in care had made allegations against their foster parent possibly "to get back at them" or "to make their social worker jump", or "simply for attention".

There is also the dilemma of what is sexual abuse and what isn't. A Social Worker described how one child accused her stepfather of abusing her because she wanted to be taken into care. It turned out he went in and out of the bathroom frequently with his dressing gown open. This case was not dropped as the social worker realised there was a problem needing attention, however in some instances respondents reported that borderline cases were. Several respondents pointed to the differences between their colleagues in their perception of what is normal sexual behaviour - differences which influenced whether or not action was taken.

There was some agreement about how cases with little evidence should be approached. The stance should be non-judgemental and focus on observation and accurate recording of the child's behaviour and words. Information should be sought from all the professionals and agencies who might know the child and family. Sometimes said one respondent:

> "it all slots together. There are times when you can see that if there had been no-one to put all the bits together you would never have known a child was a risk".

Even after accumulating bits of evidence there was often dissent about their interpretation. In such cases of strong suspicion but what has happened remains uncertain there appeared to be two dangers. Firstly that intensive intervention is initiated centring on questioning the child. One Social Worker said:

"we arranged three disclosure interviews but the child did not disclose".

And a Child Psychiatrist said that some children had been seen by Uncle Tom Cobley and all before they referred to her. Secondly it was said there is the the danger of a greater reliance on 'gut feelings' and on strongly held views, both of which can affect practice. A senior Social Worker recognized the role of feelings in clarifying some aspects of a case in conditions of uncertainty. He used them, however, with extreme caution in the decision making process - "that's fraught" he said "dealing with feelings".

The other course of action said a Woman Police Constable is that you just have to wait for something awful to happen before you can do anything. "Doing nothing" said a social services Team Leader could be viewed as in the best interests of the child.

A number of respondents suggested ways to help professionals improve the quality of their judgements and prevent idiosyncratic and unilateral responses in relation to diagnosis. Two were of particular importance. First it was suggested there is a need for a consistent framework to work within which ensures no worker deals with referrals in isolation. Second was the need for individual feelings and views about child sexual abuse to be brought to the surface, acknowledged, discussed and shared at all stages of working together. If time was not given to this activity it was believed methods of intervention and even the decision of whether to intervene or not could be flawed.

Time Taken in Investigation

There was agreement throughout the region that there had been a rise in referrals of child sexual abuse associated with an increase in public and professional awareness. There was also agreement that investigation of these referrals was a lengthy business. The implications for practice seem obvious. As a social services Leader of a generic team said with feeling:

> "A case of child sexual abuse can create havoc with the rest of the caseload".

Some respondents felt that their managers were unaware of this pressure on frontline workers. Managers were concerned about a broader spectrum of reponsibilities. For the police, murder and drugs were a priority, for social services' Directors resources for mental health and the elderly competed with those needed for child sexual abuse. Achieving a balance in the deployment of resources was an aim of both managers and frontline workers. A social services' Team Leader said:

> "...there are other awful things that happen [besides child sexual abuse]. Sometimes I feel we are giving it sole priority - but then sometimes you have to."

This comment reflects that personal perceptions can control not only <u>what</u> professionals do, but <u>how much</u> they do according to the significance they consider a case of child sexual abuse has as against other problems that contribute to the work load.

Trying to make sense of what is going on was considered time consuming for two reasons: because of the nature of the cases referred and because of the system of investigation.

Nature of Cases Referred

Many respondents said referrals of suspected child sexual abuse were more complicated than those involving other kinds of abuse. They may present with multiple clients, victims, siblings, caretakers and possibly multiple perpetrators. Because of the hidden nature of the evidence the investigator may have to search actively for clues to discover accurately the relationship between all the above individuals and to assess who may be at risk from whom. Each member of the family needs to be heard, and usually separately advised one Social Worker.

Thorough assessment of the child was considered the most time consuming but vital aspect of investigation. It needed to be conducted at the child's pace. Any pressure to speed up the process was believed to be counterproductive - "they will only say what they think you want to hear" was a view of several practitioners. More than one session is often needed to build up trust, to accomodate a child's shorter concentration span and a child's need to 'test' the investigator by allowing small amounts of information to emerge gradually to see if the investigator can 'take' the full account.

System of Investigation

All respondents agreed that management of child sexual abuse demands a multidisciplinary approach. Several pointed out that the number of agencies involved is usually greater in the investigation of sexual abuse

because of the legal focus. As a result communication takes longer and more delays are likely.

Some social workers reported delays in police investigation, despite the fact that the police preferred to approach suspected perpetrators before social services intervened. A Chief Inspector admitted this was bad practice and believed it was probably due to workload problems at local level. Delay in dealing with the courts was a frequent complaint. A Child Psychiatrist, perceived as an 'expert witness' was inundated by requests for assessments to establish whether or not sexual abuse had occurred. A six month delay in seeing clients was reported. Other resources offering consultancy and expertise in the field were said to be "snowed under" with a consequent backlog of cases.

Another demand on time was the frequently expressed view that practitioners working in this field required a great deal of support and supervision. Some respondents believed that employees of voluntary agencies fared better in this respect. Not only were two and sometimes three workers allocated to one case, spreading the workload, but also more time and 'space' it was claimed, was given to plan discuss, share and support.

Protection Issues

This section deals with the problems related to protection of a child before a firm diagnosis of sexual abuse has been made. It considers the meaning of protection, which children are at risk, and how to protect children where there is suspicion but no evidence.

The meaning of protection

It is the statutory duty of social services "to take appropriate action to protect the child and to promote the welfare of the child" (Working Together DHSS 1988). A Social Services' Coordinator summed up a belief of many respondents that they performed this duty very well. There was also an awareness of the risks involved at the levels of both management and practice - on the one hand a team might decide a child needs protection and take action when it is not needed, on the other they may choose not to intervene and it turns out it is needed. Either way the result can be a traumatized child who may become even more vulnerable as a result of intervention.

What was not clear was what respondents meant by protection. A number of comments made suggested that protection had become separated from its therapeutic context. The maxim "protection before therapy" was often quoted. And a typical remark drawing attention to the differing roles of social workers and other agencies was:

> "it's a natural inclination for some professions not to want to do the messy bits, to do just the therapy, but you must not compromise protection".

A Police Surgeon believed that a social worker's idea of protection was "physical protection" in the sense of separating the child from the suspected abuser. This perception had evolved, she believed as a result of social workers opting for the lower risk of removing a child from its natural home. Whilst in some circumstances an "unsuitable home" could be made safe, she said there were many social

services'departments who were not happy to attempt it because:

> "they have been the whipping boy over the dead children who have been under their care".

Her view was confirmed by a number of respondents from all levels of social services who spoke of protection and safety in terms of removal of either the suspected perpetrator (the preferred approach) or of the child. How safe the child felt in a psychological and emotional sense did not seem to feature significantly in assessing the need for protection. That is not to say that social workers were unaware of the possibility of separation from the family causing trauma to the child, nor of the need to balance such effects against the severe psychological and emotional traumas resulting from sexual abuse itself. What seemed to need scrutiny and clarification was the objective of protective intervention and the basis upon which an assessment of the need for protection was made, so that protection is interpreted in a wider sense to encompass the emotional and psychological needs of children.

Which children are at risk?

> "The [child protection] register assumes there are two sorts of children; those at risk and those not. There are some mentalities that would put all the children in [our area] on it just in case...There is a feeling that if a child is put on the register something magical will happen. Some social workers see it as a way of protecting themselves".

This comment from a social services' Child Protection Coordinator suggests that there are degrees of risk rather than a clear line separating those at risk from those that are not. He went on to say that decisions about how much risk is too much before action is taken constituted major problems for social workers.

From the evidence of many comments of respondents it appeared that social workers need to cast the net wider rather than restrict their assessment to the suspected victim as presented by the referrer. The reasons for this are drawn from these views:

* boys are at least as likely to be victims as girls but do not disclose so often as girls
* there is an emerging trend for the whole family to be involved in the sexual abuse
* there is an increase in younger children who are victims of sexual abuse
* victims are too "petrified" to tell their siblings what is happening so a child saying her brother or sister is not involved cannot be taken at face value

An aspect which has a powerful bearing on the question of which child is at risk is the behaviour of offenders. It was the general view that little is known about them and more attention should be focussed on this issue.

Against this alarming picture which a Chief Inspector of police called:

> "a terrible tree with its branches spreading wider"

is the fact that in increasing the cast of the net more children who have not been abused are likely to come under scrutiny and thus subject to all the problems attendant on cases with no evidence. Sadly it seems there are no short-cuts to full assessment. As a senior Social Worker of many years experience said:

> "There are no foolproof systems, no potential abusers or victims. In one family the father sexually abused three of his daughters but not the fourth. When asked why he hadn't abused her he said, 'because she said no'".

How to protect where there is apparent need but no evidence

A typical case posing this regularly recurring problem was described as featuring:

* uncorroborated evidence from the child
* lack of medical evidence
* denial and hostility from the family
* the family withdrawing
* the child retracting
* barring of professional access

Is the only option left to wait "for something awful to happen"? Some respondents, notably from an NSPCC background, argued that it was unethical to attempt to work with a child whilst the suspected abuser was still in the household because the child comes under intolerable pressure. A Child Psychiatrist disagreed. He believed that not to intervene put the child at further risk of abuse and that he, as a psychiatrist, was less threatening and more likely to be accepted by a hostile family than a social worker. His main

concern was that families were frequently abandoned by professionals when insufficient evidence was found to support a positive diagnosis:

> "professionals are unaware of how shattered the family is by the experience [of investigation]".

This is a view which again points to the narrow interpretation of what protection means and the dangers of separating the concept of protection from therapy.

Some families it was agreed could not be helped and there were circumstances when protective measures amounted to communication with all the professionals who might be involved in a child's care and development: nursery workers, health visitors, general practitioners, school teachers and nurses, outpatients etc. It was then a matter of monitoring, watching and waiting. Seeing a child regularly said a respondent means that not only can one build up a relationship so that a climate appropriate for telling is cultivated, but also it provides the opportunity to observe and record changes in behaviour which may give diagnostic clues.

Each case it seems presents different circumstances, different histories of intervention in the context of different resources available. It remains a difficult task for practitioners to decide the priorities of protection. Evidently there can be no blueprint for action, no right or wrong way to try and protect a child.

Assessment

This section examines the processes involved in the collection of evidence for the purpose of establishing whether child sexual abuse has occurred which are: the investigatory or joint interview, the medical examination, assessment by 'expert witness'.

These headings have been selected for the purpose of clarity. In fact the terminology used by respondents was confusing. Terms such as interview, joint interview, joint investigation, assessment, disclosure interview, disclosure work, were used sometimes as though they were interchangeable. This confusion appeared to reflect a lack of clarity in the objectives and roles of the professionals involved which some respondents believed could lead to repetition of procedures causing additional trauma to the child.

Inherent in the term 'disclosure interview' is the danger of placing the onus on the child to provide evidence. It is a term which was repeatedly referred to in the context of investigating circumstances where it was not fully known either what had happened or what the condition of the child was. Its use assumes the child has something to disclose. One respondent said:

> "the workers get anxious, feel they haven't achieved anything if there is no disclosure".

The objective of these investigators does not appear to be to evaluate the condition of the <u>whole</u> child.

In terms of roles one would expect social workers to fulfil their role of child protection, police to fulfil their role as prosecutors of a criminal offence, health professionals to fulfil their role in diagnosis and healing. However, respondents indicated that in practice role boundaries are not so straightforward. Social workers for example said their role in investigation was protection, therapy and prosecution. Police surgeons represented both the police and health authority. Clinical psychologists sought evidence for diagnostic purposes, prosecution and therapy.

Compounding the problems and tensions of overlap between professional roles was the uncertainty about what constitutes evidence that sexual abuse has occurred. "You can never be confident that you know what's happened", said a number of respondents, whether assessing physical, emotional or behavioural effects in the child, or verbal evidence from the family.

To improve the conditions of confusion and uncertainty a NSPCC Team Leader recommended that a tighter protocol was needed to develop a more consistent approach. Other views were that practice should not become too rigid as cases of sexual abuse differed greatly and needed to be treated on an individual basis. A social services' Coordinator was hopeful that the current climate of learning, planning and discussion initiated by the review of child abuse guidelines, would be of great value in clarifying roles and objectives and in promoting good interdisciplinary relationships.

Investigatory or joint interview

The main benefits of joint investigation as described by a DSS inspector were:

* avoiding repetition (for the child)
* ensuring therapeutic input from the start.

A formal policy for joint investigation between police and social services existed in one borough only in Greater Manchester and this was at an experimental stage. In the other nine there was an informal policy for joint collaboration which some said lacked definition and impetus. The majority of respondents were in favour of extending the experimental scheme to the other nine boroughs. Many believed that a firm policy in place of the current informal basis of joint investigation would improve practice. There were many remarks however, that revealed a gap between acceptance of the theory and its translation into practice.

One of the most frequently mentioned deficiencies was the lack of a suitable setting and facilities in which joint investigations could take place. The ideal was described as:

* informal, non-threatening, homely atmosphere
* with medical facilities
* with bathing facilities
* comfortable interviewing rooms equipped with appropriate toys, video facilities, and one-way screen
* kitchen

Other factors mentioned affecting practice concerned the scarcity of trained and experienced professionals

and the uneven levels of co-operation and availability between different areas and different agencies. There was debate about many details of practice such as who should be present at the joint interview, of which professional discipline and gender should investigators be and how specialist should investigators become. There was also debate about what emphasis the focus of the investigation should have, prosecution or therapy. This was particularly interesting since there were signs of both police and social workers shifting from the traditional stance. A social services' Area Manager said:

> "The police have moved away from the arrest model because they see it leads to the destruction of evidence"

whereas a social services' Team Leader said:

> "the aim with sexual abuse is always for prosecution. It's always appropriate - I think so and the police do".

In fact a Chief Inspector of police disagreed. In his view it was wrong to generalise. He believed it was important to consider what was best for the individual child. The constructive conclusion to be drawn from this apparent shift in perceptions is that as more experience is gained in training and working together in this field social workers and police will move closer to a central position between the poles of punishment and therapy and develop common rather than separate aims.

Other differences in the perceptions of social workers and police of each other in relation to practice are

to be found in Appendix iv. Many of these perceptions were generated by a debate about who makes the better interviewer, police or social worker. That it should be an issue indicates an underlying rivalry between the disciplines. What was of value was the highlighting of those components considered necessary to conduct an effective interview. There were plentiful views about the appropriate knowledge base, skills and qualities (see Appendix v) but there was one aspect which respondents found hard to define yet seemed to influence views about the kind of person who was most appropriate to work in joint investigation.

It was to do with the emotiveness of sexual abuse, particularly the feelings engendered when a child discloses. An experienced social work Consultant said:

> "You live through that abuse. In physical abuse you are not replaying that abuse...they haven't the vocabulary. 'Daddy hit me' hasn't the same impact as 'Daddy stuck his dick up my bum'. It's to do with one's sexuality - its so precariously balanced. We are very rarely indifferent to sexual abuse whereas you can get indifferent to violence".

Methods of selection of appropriate professionals for joint investigation varied. The police tended to be selected by their managers. Social workers could choose not to be involved if they wished and were mainly self-selected. Whilst wanting to do the work was considered important some respondents advised caution concerning self selection believing that the "right, mature and rounded personality " and "being

able to handle your own agenda about sexuality" were of greater importance.

Problems in developing and integrating new policy and practice were evident. However the majority of respondents were confident that frontline social workers and police officers who wanted to do the work and were appropriately trained were capable of acquiring new skills and accomplishing the complex and stressful task of joint investigation.

Medical Examination

The general impression gained from all respondents, of whichever discipline, was that there were fewer problems associated with the medical examination in comparison to all other aspects of investigation. That is not to say that they underestimated their complexity. The difference seemed to be a greater clarity of thought about three major questions raised.

The first of these was: what status should medical/physical evidence have within the context of diagnosis? There was no doubt in the mind of a Police Surgeon as to her part in the provision of evidence:

> "it should be regarded as only a tiny bit of the mortar that holds the edifice together".

As few as one third of victims of sexual abuse she examined had positive genital findings and these were open to multiple interpretations. She pointed to deficiencies in knowledge about genital variance and the effects of masturbation - the latter being used frequently in defence of the alleged offender.

Whilst physical signs in the majority of cases could not prove that sexual abuse had occurred, equally it was said, the absence of physical signs did not indicate that it had not. This is not surprising when viewed in the light of a Chief Inspector's judgement that 80% of child sexual abuse is mutual touching not full sexual intercourse. What concerned the Police Surgeon was the discrepancy of view between herself and the legal profession concerning the status of physical evidence:

> "The system demands that there shall be medical, physical and forensic evidence".

It is as if the courts judge the severity of the offence by the severity of the physical signs - a judgement which bypasses the child when it is the child, said a Social Worker who should define how it has affected him/her.

The second question was: <u>In what circumstances is it appropriate to conduct a medical examination</u>? It was agreed by most respondents that there could be no set rules or criteria. Children alleging 'fondling' may not have told the whole story since they rarely disclose the worst aspects of the abuse at the beginning. So the dilemma is - is it ethical to subject a child to what was acknowledged could be felt by the child as a second assault if he or she has described abuse in terms of 'fondling'. The reason why this dilemma did not seem disabling to the respondents in Greater Manchester maybe because the decision whether to initiate a medical examination was more often than not taken by police and social worker together. Furthermore every respondent who spoke of the women police surgeons' work appeared to have a

high level of confidence in their experience, knowledge, skill, sensitivity and compassion.

The third question was: who should conduct the medical examination? The main body of respondents interviewed regarded the police surgeon as the most appropriate. This was probably partly due to their perceived credibility as effective professionals, partly due to the organizational aspect where immediate sharing of information with the police was encouraged on referral to a statutory agency. Other reasons given were that it was necessary to have specific relevant training and experience in the collection, interpretation and presentation in court of medical, physical and forensic evidence. A Police Surgeon also claimed that consultant paediatricians had seen on average far less female genitalia than other doctors and that interpretation of evidence depended on a thorough knowledge and experience of normal variants. In her view and others, problems occurred when the police were not involved early on. Children could suffer repeated examinations:

> "The GP takes a look, doesn't know what he's looking for, sends the child to hospital - the casualty doctor takes a look, he's a junior doctor and hasn't a clue - the registrar feels he ought to know - the consultant may have heard of one of us women police surgeons and he finally refers".

An examination performed by a known medical practitioner in the presence of a police surgeon might be less threatening to the child and yield more accurate information it was suggested. However a Police Surgeon warned that "examination by committee" could be insensitive to the child's needs. She also

pointed out that the colleague might not be available quickly and if there was the likelihood of forensic evidence there should be no delay.

The general consensus of opinion was that each area should have a designated professional to conduct the medical examination. Any doctor who had a serious concern about child sexual abuse should be ready to refer to the social services, NSPCC or the police, who could then decide whether to refer to the designated medical practitioner. If used properly they would then become increasingly expert.

Assessment by expert witness

Children who were strongly suspected of having been sexually abused but no clear evidence existed were often referred to an 'expert'; either staff of a NSPCC unit or a child psychologist. The reason for this explained a social services' Team Leader was:

> "because we...wanted someone with the reputation and status of an expert for court purposes".

The professional discipline of the assessor appeared to be less important to a number of respondents than their skill and availablity at the time of referral. The overload on those experts and subsequent delays in making assessments prompted a social sevices' Manager to comment:

> "we need to develop this expertise in disclosure work here in this team...If we could do it ourselves we could provide a more efficient service".

This poses the questions: what constitutes 'expertise' and is it feasible for social workers to attain such expertise both in terms of acquiring skills and taking on extra work?

What constitutes expertise?

Two aspects were highlighted. The first concerned legal requirements. A Child Psychologist much in demand as an expert witness said:

> "It is highly skilled...you need full notes or even better a video - you cannot have 'suggestive' questions - it is not so much 'leading' questions as 'suggestive' ones. You have to run a case in a way that will convince the court in order to achieve what is in the best interests of the child".

The second aspect concerned the importance of approaching assessment with full consideration of the child's perspective. A social work practitioner and trainer of long experience explained the complications inherent in a child 'telling' her story:

> "[Children] don't use language the way we do...instead they 'tell' through changes in behaviour. It's as if they are saying 'please listen to me, something is happening I don't understand', we need to learn to use all our senses to tune into the way the child is behaving - put all the information together to build up a picture of what the child is saying".

Expertise, however, is not only to do with skills and experience, as the respondent quoted above indicated it concerns 'reputation' and 'status'. The status of

'expert' was said to be accorded to few by the legal profession in Greater Manchester and appeared to favour child psychologists rather than those of social work disciplines, despite the degree of experience some of the latter had obtained. This has a bearing on the second question posed:

Is it feasible for social workers to take on the work of assessment?

With few exceptions respondents from social sevices proposed that such work should be their responsibility. Whilst their ability to acquire the skills necessary is not under question there were three factors raised which could hinder the implementation of such a proposal. The first concerned legal attitudes. One of the reasons social services had to refer on the bulk of assessment work was because the legal profession had put constraints both on the choice of person they perceived as 'expert' and on the kind of evidence they regarded as valid for diagnostic purposes. Their attitudes in these respects were said to be "entrenched". Several respondents from different professional backgrounds said the outlook that social workers would soon be regarded as expert witnesses was poor. However one social services' Team Leader believed the work of Guardians ad litem would have a positive effect on the way the courts perceive social work practice. A member of his team, herself a Guardian ad litem, put forward another perspective. She was reluctant to present evidence in court in cases of child sexual abuse because of the legal profession's adverse attitudes to social workers and because she felt it was in the interests of the child to have 'an expert'.

The second factor concerned financing training. A social services' middle manager responsible for training was prepared to use his budget for short courses for enhancing skills of recognition of child sexual abuse or for joint investigation training courses but was aware of the far greater costs of training for the skills necessary for this particularly specialized area of assessement.

The third factor concerned the time available. It appeared that the pressure on social workers in terms of their workload was already great. The facts as presented by respondents were these:

* the volume of referrals was increasing
* training programmes at this level of specialization were time consuming
* cover was necessary for those undertaking training increasing the caseload of front-line workers
* assessment itself was considered a lengthy procedure
* time set aside for supervision and support was considered essential

These factors raise further questions: how many experts are needed in each area? clearly there were not enough at the time of writing but were existing resources used to their fullest potential? Several respondents appeared reluctant to use psychiatric services. A Community Child Psychiatrist said there was "job hugging" among social services and wished they would refer more. From a social services' perspective it was said there were psychiatrists who didn't want to be involved in the "statutory bit". These views indicate a degree of interdisciplinary

confusion and rivalry - a subject examined more closely in the next chapter.

CHAPTER 4 FINDINGS

Aspects of Interprofessional Collaboration

This chapter is divided into five sections addressing the following:

* reasons why interprofessional collaboration appears to be more difficult in the field of sexual abuse than other forms of abuse
* reasons why it is so important
* aspects of collaboration concerning Area Child Protection Committees and case conferences: the formal forum
* aspects of collaboration concerning individual professionals and agencies: the informal forum
* aspects of improvement in interprofessional relationships.

1. Why so difficult?

All respondents from different agencies and professional backgrounds agreed that co-operation between professionals was a key component to effective practice. There was a general consensus however that it was one of the most difficult aspects of working in this complex field. The reasons why it was considered more difficult in cases of sexual abuse appeared to stem from conflicting perceptions of sexual abuse, the most pervasive at the time being that it was more 'criminal' in nature than other types of abuse. This conclusion was reached from the frequent reiteration of the following:

* in practice sexual abuse cases are dealt with differently - the police are more often involved
* the aim of referral is prosecution of the offender
* the dynamics of sexual abuse are different - "it is carefully planned, premeditated like murder, cold blooded"
* the effects of sexual abuse [on the child] are more serious and longlasting - "these children are appallingly damaged - their lives ruined."
* the emotional impact of sexual abuse - of horror, disgust, bewilderment on everyone is greater.

All these views suggest that the questions of which professional is involved, with what skills, knowledge and experience, for what purposes and with what result in terms of intervention, are intimately connected with their attitudes to a number of related conflicting factors. Among those raised by respondents were these:

Conflict between punishment and therapy

Is the perpetrator a criminal or a patient? A Community Child Psychiatrist believed there was too much emphasis on prosecution and not enough on therapy. Yet as many respondents remarked sexual abuse is a crime and for the child's sake in particular it has to be acknowledged as wrong. A NSPCC Team Manager believed a middle way could be found. His view was that prosecution and a legal mandate could be used constructively in therapy as a pivotal strategy marking the point of acknowledgement of responsibility and threshold for potential change.

However, as was pointed out, only a small percentage of perpetrators are prosecuted because of lack of evidence. There was much debate about whether it was ethical to offer therapy to a traumatized child where the alleged perpetrator denied responsibility and remained in the same household as the victim. Those who believed therapeutic intervention would be "immoral" or "ineffective" were all from a social work background (predominantly but not exlusively NSPCC). A Child Psychiatrist believed in treating the child's symptoms rather than naming the possible cause. For him the accent on diagnosis and subsequent prosecution could damage the child and cause professionals to ignore everything else that was going on in the family, effectively closing the door to therapy since the family would withdraw co-operation. Other child psychiatrists echoed this view. The difference between the social worker and psychiatric perspective possibly reflects their different roles and the nature and type of client they usually deal with. A Child Psychiatrist said:

> "[we] look at the whole family...social workers see their work in terms of protection rather than therapy".

A further aspect of this conflict is the child's perspective of the consequences of investigation. A social services' Principal Officer said:

> "we resolve the situation...by punishing [the child]. Children see removal into care as going into clink. [They] are doubly hurt by the abuse and by removal into care".

If on the other hand it is the alleged perpetrator who is removed the child may still feel guilt, be blamed by the family and feel implicated in the punishment meted out to the perpetrator for allowing the abuse to happen. Feelings of ambivalence, of love and hate for the perpetrator, are common it was said. "Doing the right thing for the child" was the aspect many respondents found the most difficult in dealing with child sexual abuse.

Conflict between the interests of the child and interests of the perpetrator

It was emphasized frequently that evidence of sexual abuse is mostly hidden. For this reason much detailed investigation is necessary focussing on interrogation and examination of the child. Several respondents were aware that these measures were in themselves potentially damaging and could jeopardize both short and long term interests of children. The consequences could result in the child experiencing multiple losses described as: temporary or longterm break-up of the family, loss of a loved member, the breadwinner, the affection and trust of the non-abusing parent and siblings, the friendship and respect of neighbours and peers and possibly home and school. The question some respondents asked was: how can such losses be weighed against the damage of abuse itself which can have similarly life affecting consequences?

To turn to the perpetrator - is a prison sentence likely to change their behaviour and allow for his/her return to the family without futher risk to the family? Most respondents believed not. Yet they were concerned that the lighter measures such as a caution, probation or fine did not convey to the offender and family the seriousness of the crime. Nor did these

measures validate for the child that the behaviour of the perpetrator was wrong and the child in no way to blame. Many believed that offenders should be offered a treatment programme either as an alternative to or in conjunction with incarceration. Even then, said a social services' Manager:

> "I do not know the answer to the child who does not want dad to go away, but the abuse has to stop, and men must face what they have done".

Role of agencies with statutory duties and those without

Agencies with statutory duties - social services, NSPCC, and the police - carry the brunt of the investigative process. They have the responsibility to make crucial decisions which if ill-judged, in the view of a Child Psychologist, can cause much damage. Many of these decisions it was said have to be made quickly and sometimes have to be based on assumptions. All agreed that there was inherent risk whatever the choice of action. Moreover the outcome more often than not aroused anger, resentment, withdrawal and sometimes violence in the family affected. It was hardly surprising to find that there were tensions between agencies which have to be involved and those which can choose.

Social work respondents spoke of the luxury of the role of professionals involved in therapy who do not have to do the "messy statutory bits" like removing a child from home. Yet a Child Psychiatrist said that social services did not refer enough to the community psychiatric services. He believed that once a referral was made to one of the three statutory agencies there was an assumption that the matter was

in hand and involvement of other agencies unnecessary. This was corroborated by a number of social services' respondents from managers to frontline practitioners who considered that cases of sexual abuse should be their responsibility throughout the various stages of management.

The differences in client/service relationship was another aspect raised. Medical services offer help instigated by the client and work is carried out with his or her approval and cooperation for which clients are usually grateful. Social services have statutory duties with powers to enforce them. One respondent was conscious of the media exacerbating such divisions and presenting a distorted picture: "They set professionals against each other" she said. Another said that social services and regional health authorities reached decisions in different ways radically affecting interprofessional collaboration - the former were more democratic, the latter imposed from the top.

A Child Psychologist was concerned that whilst there was a lot of talk about interprofessional collaboration little effective work was being done to break down what she called "the sense of fiefdom - this is my kingdom, my boundary".

Management of sexual abuse involves a complicated mixture of voluntary and involuntary clients, a mixture of professionals acting as carers and custodians and sometimes a choice of action between the use of a legal mandate or not. Combined with the differences in professions originating in different administrative structures and distribution of power evolved through diverse cultural and historical

backgrounds, and the conflicting pull of punishment and therapy and interests of child and perpetrator, collaboration is clearly never straightforward.

Compounding the problem is the fact that almost every aspect of the subject of child sexual abuse appears to be a matter for debate such is the recency of awareness, understanding and experience in relation to theory and practice. Moreover views change as more knowledge, experience and skills are gained. In such a climate of controversy and flux, agreement between professionals about the way forward cannot easily be achieved. Why then, attempt to overcome the problems when doing so might cause delays, or worse, damage children?

2. Why so important?

First it is necessary to place the principle of interprofessional co-operation in its historical context. Ever since the inquiry into the death of Maria Colwell (1974) which cited "lack of or ineffectiveness of communication and liaison" between agencies as a major factor, there has been agreement among professionals, corroborated by respondents interviewed for this study, about the importance of working together in the management of child abuse. As a result of the inquiry, Area Child Protection Committees and case conferences became prominent features encouraging more co-operation between professionals.

It was evident that despite this valuable framework the details of how to work together effectively were frequently debated. Furthermore the problems associated with personality clashes, whether perceived

as related to a particular profession or individual attitude, had not disappeared because an organizational framework existed compelling professionals to work together. Indeed the separate issues associated with sexual abuse seemed to bring debate and personality differences into sharper relief. At the same time, the realization had strengthened that with this type of abuse co-operation between agencies is even more essential - "you can't do it on your own" said many respondents.

One of the main reasons why collaboration was considered so important was the need for dissemination of knowledge and expertise because "we are all learning", "there are no experts". Several areas had created new posts of Child Protection Coordinators to facilitate this dissemination, although one said there were still "too many separate working parties reinventing the wheel".

A Child Psychologist confirmed this view in relation to the formulation of guidelines:

> "An effect of poor interdisciplinary relationships is that no-one learns from anyone else. Every single authority is issuing guidelines. There is need for <u>central</u> guidelines".

Since this interview central guidelines have been published by the government (1988). Some respondents welcomed these in the hope they would establish more consistent practice. However, all respondents in management positions considered it essential to have local guidelines as well taking into account local resources.

Other reasons raised concerning the importance of collaboration related to the problem factors associated with managing sexual abuse. These were: hidden evidence, complexity and emotiveness. The correlation of these categories with the problem factors means that they stand for both the reasons why it is necessary to collaborate and the reasons why collaboration is so difficult.

Hidden evidence

Respondents offered many examples of how evidence is hidden. Typical conditions were these:

* lack of visible evidence, or where it is visible there are multiple explanations for it
* concealment and secrecy - the child under horrific threats not to tell, the perpetrator "calculating...no witnesses"
* the subject is taboo - "people don't want to think about it, so don't see it" or if suspecting it prefer to "hush it up" rather than open up "the can of worms".

Under such conditions where suspicion arises information has to be actively sought. Co-operation with different agencies and professionals was commonly sought on three levels.

Firstly it was considered that personal knowledge of the family, for example the medical history from the general practitioner or health visitor, or educational history from school teacher, might clarify the situation.

Secondly co-operation in consulting records such as the child protection register or police records often

proved invaluable. The Child Abuse Liaison Department serving the whole of Greater Manchester had records going back to 1974. The Chief Inspector said that they show children who were battered coming back as abusers and help monitor the "travelling offender" - perpetrators who travel from woman to woman in different areas.

Thirdly co-operation was sought from professionals with specialist knowledge, experience or skills which might help clarify the situation, for example concerning children, legal aspects, forensic and clinical evidence. Problems of co-operation seemed most prevalent at this third level possibly because the boundaries of professional responsibility appear to come under greater tension here.

Complexity

Part of the complexity professionals found in dealing with sexual abuse lay in the conflicts they faced as outlined above. There was widespread agreement also that the complicated dynamics of sexual abuse, the complex family relationships and the legal issues associated with its mangement all contribute to difficulties in collaboration. More agencies and professionals are involved, more transactions necessary and delays were said to be endemic in trying to contact the professional with the appropriate resources or the family member with critical information. Such delays aggravated relationships both with professionals and the family.

Three ways were suggested in which effective collaboration can alleviate problems caused by the complexity of dealing with child sexual abuse. Firstly, time and space given to sharing information

and planning an integrated approach among professionals with different perspectives helps to clarify what has happened, to sort out priorities and decide who should take on which role.

Secondly the sheer volume of work entailed can be shared among different agencies and professionals, with the proviso that each is appropriately equipped for the role undertaken. It appeared that psychiatric services and health visitors were underused in this respect.

Thirdly collaboration with a variety of agencies and professionals increases the breadth and depth of knowledge, experience and skills. The following comments illustrate this:

* "the police simplify matters with their commonsense, their tendency to see things in black and white, their knowledge of what is legally possible"
* "health visitors have excellent knowledge of the normal development of children and can help distentangle what is a deviant change from the normal pattern"
* "child psychiatrists have knowledge about normal family patterns and skills in exploring how the whole family functions and dealing with the deep undercurrents surrounding the issues of child sexual abuse"
* "NSPCC have unparalleled expertise in child abuse in general".

Emotiveness

There was agreement that the concept of sexual abuse has a strong emotional impact on everyone. This has

implications for collaboration for both professionals and the families invovled. A Child Protection Officer explained it from the professional's perspective:

> "it can effect practice right across the board. They either cannot cope emotionally, or they do not believe it has happened...or they handle it so badly the child withdraws...they can feel like giving in before they start".

Another aspect pointed out by several respondents was the danger of overreacting - the "overzealous" professional "sniffing out" every angle. A Child Psychiatrist believed every key issue concerning the subject was "clouded by strong feelings" affecting communication adversely. He said:

> "the more I see of professionals...the more I am aware of people adopting attitudes that are impervious to reason".

This pesimistic picture was offset by other respondents who had been helped by using outside consultation to achieve a balance and objectivity over some emotive issues emerging in practice.

Collaboration is also necessary, it was stressed, to deal with the consequences of the emotional impact on the family. The family is frequently distressed, angry, hostile and sometime violent. The power struggle that ensues is the most debilitating aspect of dealing with sexual abuse, said one respondent, and keeping the interests of the child to the forefront in such circumstances is difficult. Each member of the family needs to be heard yet the child too must have an advocate.

Many respondents spoke of the high risk of 'burnout'in workers dealing regularly with sexual abuse, mainly because of the emotional impact but also because of the pressure on them to deal with the high volume of referrals of a time consuming nature. There was a consensus that extra support was needed by these professionals in terms of supervision, support groups, and some said outside consultation. It was generally believed that effective collaboration was mutually supportive.

3. Aspects of Collaboration within the formal forum: Area Child Protection Committees and Case Conferences

It has been established that co-operation between professionals and agencies was considered necessary at all stages of dealing with child sexual abuse. The remaining sections examine the difficulties of translating principle into practice.

Area Child Proctection Committees (ACPC's)

The main activities of the ACPC (formerly known as the Area Review Committee (ARC)) are to establish, maintain and review local interagency policy, practice and training concerning all aspects of child abuse (Working Together DHSS 1988). The link between policy and practice inherent in these responsibilities was a focus of concern for respondents. A NSPCC Manager was concerned that the lack of clear guidelines in many areas was reflected in inconsistent practice. Field workers in some areas were said to be uncertain about how to respond and who to refer to, sometimes resulting in disagreement between professionals and repeated interviews or medical examinations for the child. There were frontline workers who felt that

managers had lost sight of the realities of practice and did not consult them when formulating guidelines. It was suggested that the representatives on the committee were frequently of too senior a level, a number of whom were not currently practitioners nor had been for some time.

Not surprisingly the quality of interprofessional relationships varied between committees. In some areas poor communication skills, biased and poor chairmanship and prejudice against professional disciplines and individual personalities were reported. Yet in one area the ACPC was said to work well in promoting multidisciplinary cooperation because it focussed on "the key decision makers" the social services' area officers.

The main priorities of ACPC's at the time of interviewing were reviewing the guidelines or in some cases formulating new ones to guide responses to child abuse and developing training programmes. The aim of these activities was to equip professionals to meet the new challenges of managing child sexual abuse. There was some debate about whether sexual abuse should be separated out from child abuse in general for particular attention. Most directors of social services seemed anxious to build on existing knowledge, experience, skills and resources already gained from working in the field of child abuse. There were specialists however who stressed the high degree of skills necessary to tackle certain tasks, particularly that of assessment of a child in cases of suspicion where little evidence was available. A social services' Principal Officer's concern was this:

"Getting the balance right and seeing child sexual abuse as separate from, but coming within the system of child abuse".

Views concerning the 'specialization' of child sexual abuse were varied and complex. It would not be possible to evaluate which was the best approach within the scope of this study. What seems relevant here is that the issue is potentially divisive at any stage of collaboration, not least in the policy making arena.

The climate of change and development was nowhere more evident than in the reported activities of ACPC's. Opinions as to what policies and practices were appropriate to enhance co-operation between professionals and agencies were clearly various and seemed sometimes uncertain. Reaching consensus was not straightforward and debates are likely to continue. For some respondents it was important that they should continue - that guidelines and policies should not be "sacrosanct" but allow for individual responses reflecting the infinite variety of different circumstances and to remain in tune with the development of experience and increasing knowledge in this field.

Case Conferences

"Case conferences provide a forum for the exchange of information between professionals involved with the child and family and allow for interagency, multidisciplinary discussion of allegations of suspicions of abuse" (Working Together DHSS 1988). From the evidence of this study case conferences can also be a fertile ground for unprofessional responses to flourish. When asked "what do you find the most

difficult aspect of working with child sexual abuse?" a Child Protection Coordinator said:

> "Chairing case conferences - getting information out of people - sharing and reaching a decision - making sure the right decision is made".

She was not alone. Incidents of interprofessional rivalry, 'mirroring' of problems between agency and family and power games of various kinds were reported.

The last seemed of particular significance, perhaps understandably since although in theory each person attending is equal in status, power is an active component in relationships between people of different sex, race, professional discipline, level of seniority, level of knowledge, experience and skills and degree of confidence. All these variables are likely to be present in people attending case conferences.

Professional discipline was the variable which featured most strongly particularly concerning the manipulation of opinion regarding available evidence. The clinical evidence of hospital consultants for example, it was believed by some, was frequently given too much weight as against the evidence of a social worker.

These power dynamics, present in all case conferences are particularly volatile in cases of sexual abuse because of "lack of clarity as to what has happened" and the sexual nature of the subject generating problems of prejudice, inhibition, titillation and not least uncertainty about "terminology...that is not pornographic but conveys accurate description". Much

of what goes on said a social services' Principal Officer is "opinion and conjecture". He added:

> "Some say that it is a weakness, but it is part of the reality of the work we have to do".

There were a number of issues which were under debate concerning case conferences. These concerned chairmanship, the keyworker, registration and parental participation.

Chairmanship

Respondents' main concerns were who is the most appropriate person within social services or NSPCC to take on the role, and whether specific training is necessary to perform it effectively. The focus of debate on the first was whether the chairman should be a person involved in area management, e.g. the Team Leader, or some "independent specialist". Both alternatives were in practice. The argument in favour of the latter tended to predominate because "you can be detached to some extent and more easily facilitate clear recommendations".

The majority of respondents who raised the chairmanship issue believed that special training is appropriate. However they pointed out that few who performed the role recognized the need nor was there much specific training available if they had.

Keyworker

There was little debate about the purpose or reponsibilities of a keyworker which are to "coordinate interagency activity in the case" (Working Together DHSS 1988). What was interesting was that one borough in Greater Manchester did not conform to

the usual acceptance that the role should fall exclusively on a social worker. The Assistant Director explained:

> "we as a department do not believe in the concept of a 'keyworker'. We believe in co-working - that is mainly through the work of a committed senior health visitor who has promoted the working together of social workers and health visitors. It's been successful over the last fourteen years"

The result of this collaboration appeared to be that links with the health authority in general were good.

There was surprisingly little comment on the role of health visitors. They were said to have easier access to families than social workers, that they were seen as friends. They were also said to have a thorough knowledge and much experience of normal development and behaviour of children - both valuable assets in the management of sexual abuse. This finding raises the question why more areas do not adopt co-working.

Registration

At the time of interviewing neither the criteria for registering a child on the child protection register nor the method of operation were standard. Differences of opinion abounded concerning who should be registered, whether all children in a family orjust the suspected victim should be registered and what should be done once they were on it. Such differences caused disagreements in case conferences which concerned once social services' Coordinator:

> "Research has shown that about 50% of the time at case conferences is spent agonizing whether to

register or not. What we should be concerned about is whether and how to protect the child".

One social services' Manager said that there was a belief prevalent among some professionals that registration by itself somehow offered protection to children at risk which, he said, was a "myth". Another suspected that the register was "pointless". Others, whilst agreeing it did not protect children, believed its function was to provide statistics to identify the extent of child abuse and to demonstrate belief in the child that he or she had been abused and demonstrate to the family the degree of concern about that abuse.

Parental Participation

The participation of parents in case conferences was the most frequently mentioned subject of debate in the context of the 'formal forum'. Possibly respondents were influenced by the media attention at the time which heightened the feeling of public censure of agencies disregarding parents' rights. Respondents were perhaps eager to redress the balance since their account reflects the problems of conflicting rights - many were conscious that the rights of children had had little media exposure. The debate however predated events in Cleveland and has provoked much fierce and emotional argument not least in the forum of the Area Child Protection Committee each of which appeared to have different policies and some of which were currently debating the issue.

First it has to be clarified what participation means - to what degree participate? It could range from the whole, to part of the conference, to after it has finished or not at all, and from influencing

decisions, to commenting or questioning them, to merely listening. The main arguments of those committed to full participation were these:

* better decisions are made through openness and honesty
* the civil rights issue cannot be ignored - parents need to be put in the picture as to what is happening and be allowed to have more say in the decision making process.

None of the respondents who raised the issue believed that full participation was appropriate in all cases,although one reported that there were proponents of this view actively working towards this end through a working party. None denied the importance of being open and honest with parents but they felt that information, explanation, parents putting their point of view and discussion could all take place outside the conference arena, both before and after and only exceptionally to be invited for part of it after professionals had fully discussed the issues.

Several respondents believed it was not the case that better decisions were made if parents were present. On the contrary it was thought they could inhibit discussion. One said:

> "A parent attending a case conference would cause a tremendous emotional charge and the child would be overlooked as they are again and again...at the case conference stage the <u>child</u> is the client."

Others said parents should attend <u>review</u> conferences where the objective was working out therapeutic issues but not <u>initial</u> conferences because the objective was

different and concerned intervention issues. One respondent believed there were two kinds of initial case conference:

> "those where the facts are more clear and acknowledged and it makes sense to have more involvement of the parents...but where there is denial and concealment it is inadvisable to have parents".

It was said that the police and NSPCC were the main opponents to full participation - the police because they were not happy about giving evidence such as revealing past offences, or the possibility of parents incriminating themselves if present - NSPCC because they were concerned about the child's needs being lost or ignored.

Clearly the issues of conflicting rights are complex. It seems unlikely that "one way" will fit all cases, as one respondent hoped would eventually emerge from the debate. In each, it seems, the circumstances, the degree of evidence, the people involved are all different. Each will surely have to be assessed individually as to whether and how much it is appropriate for parents to contribute. It will be another focus for argument, but if the issues are known and recognized the task should be easier and better decisions made.

4. Aspects of collaboration concerning individual professionals and agencies: the informal forum

The degree of interaction varies greatly depending on its objective. It can range from a phone call to ascertain details of a family background to joint

investigation between social worker and police to 'co-working'; a form of working together on agreed terms of partnership. Up to the case conference stage professionals have to work together even if in a limited sense. Thereafter choices can be made as to who and how much other professionals are involved. This section explores the factors which impinge on these choices focussing particularly on joint and co-working. Aspects of secondary referral and organizational and personality factors which encourage or militate against professional co-operation are examined.

Secondary referral

A powerful influence on the extent of secondary referrals is the perception of the role of specialists and specialism in the realm of child sexual abuse. A Director of social services expressed the view of many social services' respondents:

> "I hate the idea of specialists being involved in what should be integrated social work".

A Community Child Psychiatrist called this attitude "job hugging". He was concerned that not only were some social services' professionals unaware of the need to refer many families to his agency for help with psychological damage incurred by the consequences of investigation but also that they actively discouraged psychiatric intervention. He said:

> "It puts children at risk...social workers see their remit as dealing with most child sexual abuse cases but they are often not doing direct work with children".

A Child Protection Coordinator summed up the dilemma:

> "Realistically the local authority teams don't deliver the goods, they can't cover everything. So either we subcontract work to specialists or form a partnership."

Forming a partnership with approved specialists was considered by a number of respondents as a valuable way of spreading expertise and increasing learning. In practice however several practical factors prevented it from happening as frequently as was wished: some specialists were overwhelmed by the high volume of referrals and had to limit their caseload and there was a scarcity of facilities such as video equipment and one way screens which were said to enhance supervision and learning opportunities. Moreover an Assistant Director pointed out that in the case of voluntary organizations offering specialist resources it came down to "whether we could afford it".

Organizational factors which encourage or militate against professional collaboration

Below three factors raised by respondents are examined: availability in terms of access to a professional/agency, flexibility in terms of the adaptability of the 'package' offered by the professional/agency to the individual needs of the client/s and the collaborating professional, and control of management.

Availability

Collaboration cannot flourish where key posts remain unfilled or where there is a rapid turnover of staff. In one area the post of Community Child Psychiatrist

had been vacant for a year. In the years before no one stayed longer than one year. Government cuts in social services were blamed for a shortage of social workers in another area where police reported that,despite the policy for joint investigation, social workers were frequently unavailable at the time they were needed.

Common difficulties were reported of trying to contact people who were away on a course or off sick, but the most frequent complaint was the difficulty of tracking down general practitioners - a key professional in terms of collaboration. A social worker said:

> "In an ideal situation we would refer [to a psychiatrist] but...a lot won't take referrals from social workers who have to go through the GP, then there's a delay getting hold of the GP. You can't let the family drift".

Geographical proximity is another aspect of availability. Many respondents said they would use a certain resource such as groups set up to work with perpetrators, mothers or victims if they were local and it wasn't necessary to travel half way across Manchester.

A significant number also said it was vital to have access to facilities offered, such as premises appropriately equipped for investigation, twenty four hours a day, seven days a week. Some operated 9 to 5, Monday to Friday and this was considered a waste of a scarce and valuable resource.

Flexibility

Many of the units visited during this research study offered a range of facilities and services. Typically they were staffed on a multidisciplinary basis. The range of work undertaken could include consultative work on all aspects of management of sexual abuse, court work such as acting as an expert witness or Guardian at litem, investigatory interviews, assessments through to individual and group therapy and support groups for professionals. The kind of relationship referrers wanted was described as "flexible" in the sense of being able to use whatever aspects of the service seemed appropriate to the individual case and circumstances. Working together on this basis means that unit staff have to be willing to adapt the degree and type of collaboration according to the need of the referring agency. A Director of social services explained how he visualised this flexibility of organization:

> "We want someone who will firstly listen to our problems and secondly to help guide us; lead us jointly rather than take over management of the case".

Clearly flexibility is linked to control of management, a subject which generated much heated discussion.

Control of Management

Two dimensions of control were raised. The first concerned the selection of clients. The people who choose which clients to take on are in a position of considerable power. Both police and social workers were criticized for misuse of that power.

Some respondents, particularly social workers, expressed resentment that some agencies had the privilege of choice as to which client they took on. Unlike social services they were spared "the messy bits". Others were critical of agencies which they considered over-selective of clients as for example NSPCC who in some units showed strong preference for working with clients in conjunction with a legal mandate such as a care order.

Agencies offering resources it was advised should define their catchment area and be quite clear about the type of expertise and terms of reference on offer. The most frequent advice was "sell your service, spell out what you have to offer".

The second dimension was the question of who should be in overall control of management of the individual case. It was demonstrated often that social services want, as one of their managers put it "to be in the driving seat", chiefly because they have the statutory duty and power for the protection and welfare of children at risk.

The other protagonists mentioned in relation to the dynamics of control were medical practitioners who, one respondent said, "are used to giving orders and expecting others to obey", and voluntary societies who can be "independent, flexible, not weighed down by bureaucracy", and can bridge interprofessional boundaries more easily.

NSPCC has characteristics of both statutory and voluntary societies. Despite its acknowledged expertise in the field of child abuse it was stressed that this was no justification for cases referred

initially to other agencies to be taken over by NSPCC staff.

The fear expressed by many social services' respondents was that of control being taken over by "over zealous professionals" - an approach it was felt, that was often underpinned by a "fragile ideology" and rigid patterns of practice. Voluntary societies including NSPCC were considered the worst culprits. On the other hand, the positive side of collaboration with these agencies was characterized by flexibility, innovation and partnership.

It is in the area of co-working several respondents believed that most problems arise. For collaboration to be effective at this level it was advised:

> "There must be clarity, no misconceptions or false expectations. It is helpful to have written contracts between workers...with reviews built into it...Working together is about exchanging views, seeing things from a different perspective, not holding on to rigid options."

Despite such conditions, control of management often comes down to "force of personality", said a Social Services' Prinicipal Officer.

A children's Resource Centre run by a voluntary society seemed to have found an effective model of partnership. The principle of this model was that each worker had an equal part to play in planning and putting into practice tasks to improve and maintain the child's welfare. In practice the responsibility for management of each case rested in a planning group consisting of all relevant parties which was chaired

by the team leader of the children's resource centre. Such a model has a number of advantages when dealing with sexual abuse cases:

* it takes into account the different levels of skills and expertise as well as the different degrees of willingness to be involved in such work without diminishing the sense of value of each participant's role
* it provides an opportunity to learn and develop new skills with supervision and support within an open, honest, caring group
* roles are not rigid
* no one worker can put pressure on another to respond in a certain way without the planning group agreeing it is the appropriate intervention.

The characteristics of availability, flexibility and partnership in control of management were evident to this researcher in this centre's approach to co-working. Moreover the relationship between a statutory and voluntary agency appeared to have achieved an equilibrium whereby the statutory agency could choose whether to take the service on offer and influence the plan of action. At the same time, the voluntary agency could retain its independence and be assertive in its role when necessary.

People and personality factors

Typically when respondents were asked about the quality of interprofessional relationships in their area, the answer would be:

"it all comes down to personality" or
"if you get the right person it's fine"

In other words it was not that relationships were good or bad, depending on whether they were dealing with the police or a social worker but that there were some people it was easy to work with, others who were not. This section examines the kind of person/personality who respondents considered the ideal - the 'right' person with whom collaboration could be effective and rewarding.

There were four factors identified: elitism, credibility, flexibility and internal resources - these are respondents' own terms. Their meaning will become clear as they are considered in more detail.

Elitism

There was a concern that cliques of professionals had formed in the field of child sexual abuse. Two fears were expressed as a consequence of this. Firstly that such 'elitism' would nurture the development of "polished practitioners unable to hear the child's pain", secondly that elitist groups:

> "undermine skills of frontline workers ...sensationalising child sexual abuse, disseminating the idea that special skills are needed...making workers feel inadequate."

It was generally agreed that what was wanted was not "someone who sets himself up as an expert" but a person who builds on existing resources - a relationship where thoughts, ideas and feelings are flowing horizontally in both directions rather than vertically from expert above to referrer below.

Clearly if the specialist nature of the management of child sexual abuse is overemphasized, highly skilled

professionals such as child psychiatrists and psychologists may not accept referrals believing them to be out of their range of competence. Furthermore primary agencies would not refer if professionals were seen as non-specialist. There was some evidence that this was happening as referred to above. Confidence, it seems, plays a large part in interprofessional relationships in the field of child sexual abuse, perhaps largely because of this perception of it as new. The relationship is a delicate one between professionals with specific knowledge and experience which need to be widely disseminated and frontline practitioners who have some experience and skills but the levels of which can vary enormously.

Credibility

The kind of person who has credibility said a Director of Social Services is :

> "Someone as equally well informed theoretically as experienced in practice".

Several respondents agreed that achieving credibility was vital but difficult. It seemed to depend on establishing a reputation of competence over a long period of time. Any new service usually encounters criticism unless, said a Team Leader of a voluntary society telephone helpline, "it can prove outstanding practice."

Flexibility

This term was used to describe an attitude of mind. There were many comments to suggest that working together is more effective when those involved were free from rigid adherence to a certain way of seeing and doing things. It was also stressed that the range

of what is termed sexual abuse, the variety of circumstances in which it is perpetrated and the diverse effects on children and families are so great that no blueprint approach should be followed.

The advocates of the flexible approach, however, were not precluding the need for some consistency either in a shared ideology/philosophy/ethos (all three terms were used) or in policy or methodology. Indeed, it was said a framework of some kind is valuable to help bind together a team with a sense of common purpose. What can be dangerous is if that framework excludes other perspectives. In such an emotive and sensitive field as sexual abuse, it was suggested, there is a tendancy for professionals to adopt extreme positions.

Internal Resources

This expression covers a wide range of factors raised by respondents, many of which were qualities such as empathy and acceptance one would hope for in any member of a 'caring profession'. Additional qualities were considered of particular importance in dealing with sexual abuse.

One of the primary features of the work is the sense of uncertainty about what has happened and what intervention will be most appropriate. "You have to be able to live with never knowing the full answers" said one respondent - "not everyone can cope with that". It seems to require a certain inner strength and resolve to accept such conditions and explore what must seem an uncharted landscape.

There is a need, believed a Child Psychologist, for a particular sensitivity "about your role and your job in handling child sexual abuse [because] it's such an

emotive area". A sensitivity, it seems, that needs to be focussed both internally in the sense of awareness of oneself and one's strengths and weaknesses and externally to relationships with clients and professionals. It is necessary to combine this sensitivity with openness and honesty in communication with others. An effective team it was believed was one where members trusted each other and where respect for each others' contribution rather than rivalry is apparent.

5. Aspects of improvement in interprofessional relationships

Three key factors emerged which make relationships between agencies a complex matter. The first is the condition of incomplete knowledge about the subject which encourages myth, prejudice and uncertainty. The second is the climate of flux: policy and practice are developing, views changing adding to the uncertainty, many issues are under debate and disagreement frequent. The third is lack of resources: of skills and experience as well as facilities and equipment - there are different levels of skills within and among agencies, there is lack of confidence, reliance on 'experts' and consequent delays because they too are scarce. This section examines what respondents suggested could be done to lessen these effects.

Incomplete knowledge

Training to increase knowledge and skills was considered a priority by many respondents. Particular emphasis was placed on the importance of self knowledge - of being aware of the kind of feelings that working in this field evokes and of learning about the roles of different professions. A Child

Psychologist believed this was not as easy as it sounds:

> "How to establish better relationships? You force them together! You cannot just let them talk. They talk <u>at</u> each other and no understanding of each other ensues. You get them together and make them assume each other's roles. You then have to spend several hours de-roling them! But it works."

It was considered particularly important that any measures taken to increase understanding between different disciplines should be extended to those in the legal profession.

A NSPCC trainer was concerned that their agency dominated training. He believed it important that trainers from different units, different disciplines should be involved in training and in turn train their own staff.

Several respondents pointed out that improving communication and the building of good interdisciplinary relationships was not achieved by one exposure to a training programme but had to be a constant and continuing activity - learning through sharing thoughts, feelings, ideas, attitudes and experience. Only then would trust and respect for each others' roles flourish.

<u>Climate of flux</u>

There were some respondents who found the time of change and development in the field of sexual abuse disturbing, increasing their sense of insecurity and

uncertainty in their professional role. Others were challenged by the need to equip themselves to meet new problems. Several respondents spoke of the search for "a consistent framework" or "guiding philosophy". The process of reaching common ground on these matters was considered valuable in itself as it brought to the surface many aspects of debate. What was thought dangerous was the polarization of views that can ensue hindering interdisciplinary relationships.

In practice those who professed to have no specific code were consistent in one major aspect - the point from which all thought and action flowed was the child. The framework was underpinned by issues of practice: how best to assess this child and family in these circumstances. If it were accepted that a thorough assessment should be the starting point, personal agendas and professional competiveness, though not absent, would surely be pushed into the background.

Individually tailored contracts between professionals and between professionals and clients can also provide a framework for intervention. They establish terms of reference, confront issues of control and management, clarify roles, prevent argument and minimize manipulation whereby professional is set against professional or agency against agency.

Lack of resources

The highest priority in terms of resources, most respondents believed, was more people with the appropriate knowledge, skills and experience. Assessment was considered the area of work where an increase in skills was most needed and the ability to communicate with children most essential. More

training and education is clearly needed in these areas with particular emphasis on collaborative initiatives such as co-working and live supervision so that expertise can be passed on from one professional to another. An additional dimension to increasing human resources is to widen the range of professionals who could be involved in the management of child sexual abuse, providing they are equipped with the appropriate skills. As noted above, health visitors and psychiatric services seemed to be underused.

Whilst the importance of increasing the number of people with the right skills overshadowed other considerations it was frequently mentioned that more facilities and equipment were needed, preferably in designated centres situated in every locality. Ideally such centres would have core staff of high calibre in terms of experience, practice skills, and ability in negotiating and communication. The Children's Resource Centre, referred to above, appeared to meet these criteria providing a focal point for collaborative initiatives of all kinds between different agencies. Within the scope of this study it was unique in it philosophy of partnership and its apparent success in the practice of interprofessional relationships.

CHAPTER 5 FINDINGS
Aspects of Continuing Care

This chapter is divided into two focussing firstly on the work and secondly on the worker involved in the care of a child after it is clear that an offence has been committed.

The Work

The three subjects of major concern to respondents were the legal aspects, the placement of children if their own home is unsafe and therapy.

Legal Aspects

Child law is notoriously complex and currently in a transitional state following the Children Act 1989. The situation pertaining at the time of interviewing and the subsequent changes are outlined in Appendix ii in table form devised by Mitchels (1989). The issues raised concerning prosecution and protection remain relevant despite these changes. These two aspects are linked since the best means of protecting a child (physically at least), it was believed, is by identification and prosecution of the offender. The context for each is different however. Prosecution relates to criminal law and takes place in the Crown Court where a child is called upon as a witness and is cross-examined; protection relates to civil law, takes place in the High Court or the Juvenile Court and the child is not called as a witness. The main causes for concern lay within the legislature for criminal cases.

Prosecution

The majority of cases, many respondents stressed, never

reach the courts for prosecution because of lack of evidence acceptable by the law. There are legal rules which combine to minimize the significance of a child's statement. These concern a child's competence to understand the meaning of truth, the requirement of corroboration and the unacceptable nature of 'hearsay' evidence. These rules were questioned as to their appropriateness. Most respondents believed very young children (the number of victims of three and under were considered by a Chief Inspector of police to be increasing) could be reliable witnesses. It was widely felt that these rules should be changed. The irony is, said the Chief Inspector, that some offenders have been convicted as much as seven years after the offence because the victims have become adults and their evidence is now believed.

A major concern of some respondents was that the focus on trying to find evidence substantial enough to bring a case to the criminal court could cause irreparable harm to the child victim. A Police Surgeon said:

> "Our present legal system...forces us to be investigative rather than therapeutic...[it] demands that there shall be medical, physical and forensic evidence...A child cannot make the distinction between the abuser who has assaulted her and my genital examination".

In the search for evidence a Child Psychiatrist also said that the child could be subjected to what could become "a rape of the mind" by investigating professionals anxious to extract a 'disclosure'. And yet, as a Child Psychologist pointed out, the legal aspects must be considered:

"you cannot have 'suggestive' questions...you have to run a case in a way that will convince the court in order to achieve what is in the best interests of the child."

The balance is clearly not easy to achieve between an assessment which is not abusive in itself and one which will allow the courts to judge fairly what has happened. It was not surprising that several respondents spoke of the need for more expertise and training of assessors for this task.

Many respondents spoke of the severe conflict a child often feels when the decision to prosecute is made (when the alleged offender is a member of the family). On the one hand they want the abuse to stop but not for the offender to be prosecuted. They believe "my daddy's been sent to prison because I told" said one respondent. Another said that the consequences of prosecution sometimes put the child in a worse situation than previously. The feeling of ambivalence towards the offender was common it was thought, and, in the view of a Police Surgeon, not always recognized by professionals caught up in the thrust towards prosecution.

Appearance in a criminal court was widely considered to be potentially very damaging for a child despite the modifications that were beginning to take place such as dispensing with legal dress and the use of screens or live video links. Reliving the abuse during proceedings, often after considerable delays, could undo much preparatory therapeutic work. A Police Surgeon was particularly concerned about a child hearing the medical evidence:

> "[They] pick up the words we use 'too big, broken, notched'. They are all perjorative, related in the child's eyes to it being her fault. That is the self image she takes away with her".

Several respondents while acknowledging the requirement of the law to cross-examine the child's evidence believed that this could be accomplished without the child having to attend the criminal court. Furthermore the quality of the evidence, in the view of a Chief Inspector of police, would be better firstly if the child was not intimidated by the surroundings and secondly if there were less delay.

The question of punishment of the offender proven guilty was another issue under debate. The majority of respondents agreed that prosecution for such an offence was right but most believed imprisonment did no good other than protect the child for a limited period. Yet lighter sentences - probation, a fine or a caution, were considered by some to convey the message to the child and society that the offence was not serious and hence invalidated the criminality of sexual abuse and the trauma to the child. Several pointed to the apparent success of the American system where offenders can opt for a treatment programme. A Chief Inspector of Police viewed this as offering "a huge carrot" in the sense that it was insufficiently punitive. An NSPCC Team Leader who had experience with offenders in America and the UK disagreed. To confront an offender with the damage done to an abused child he believed was no soft option. It seems that a range of options would be appropriate taking into account that some offenders, in the words of one respondent, "are beyond help".

What was widely agreed was that it was difficult to know what was best when so little is known about those who abuse. In order to construct a legal framework which attempts to balance the provision of justice for victim and offender it seems crucial to focus more on exploring the pathology of the perpetrator.

Protection

The document Working Together (DHSS 1988) states that child care legislation has as its main consideration the protection of children and places upon social services' departments statutory duties to take appropriate action where necessary to protect children at risk of abuse. Social services receive referrals from a wide number of agencies and concerned members of the public. At the present time reporting sexual abuse is voluntary. A Consultant Child Psychologist of national repute believed that mandatory reporting should be introduced in the UK as it is in America where suspicion of sexual abuse should be reported by law within six hours. This system "removes us from the position of judge and jury" she said, "and the system of protection and care...automatically goes into gear". Others were sceptical believing that it was not successful universally as people bypassed the system. It was suggested that possibly people would be more likely to report if they were convinced that the resources designated to deal with sexual abuse were at least adequate.

There are two alternative means of protecting a child thought to be at immediate risk of sexual abuse from a family member - removal of the alleged offender or removal of the child. The former was considered preferable by all respondents - the latter a last resort. Removal of alleged offenders however has to be

on a voluntary basis as the law stands. Several respondents wished for change so that they had the authority to compel them to leave. Reports about what happened in practice differed greatly. In one area it was said nearly every child was removed at least in the short term. In another it rarely happened. One respondent spoke of the shortage of men's hostels to accommodate alleged offenders. Another suggested a scheme whereby social services paid for bed and breakfast accommodation to overcome this deficiency - an idea one respondent classed as "rewarding the perpetrator".

At the time of interviewing, either a Place of Safety Order or Wardship could be sought in emergency to secure the protection of a child. The evidence required before the courts approve such measures is less stringent in the standard of proof than that required for prosecution in a criminal court. This difference accounts for the apparant paradox that whilst few cases were reported to come to prosecution many children were said to be removed from home after successful application for a Place of Safety Order or Wardship. The use of the latter, said an Assistant Director of social services had increased dramatically in the last year. One of the consequences, he said, was that judges were making more complex access demands which were costly in time and money and deflected social workers with skills in child care from the 'coalface', i.e. direct work with children.

The most frequently voiced complaint was that of delay in many aspects of court procedures but particularly in waiting for a hearing and in finding an available Guardian ad litem due to what was termed by several as "a chronic shortage". The danger is, said one

respondent in relation to Wardship, that you become "locked into the system" because of these delays. As regards Guardians ad litem, it was the view of one respondent that the problem of shortage was that the work was unpopular. Improvements were however under way. In several areas consortiums were hoping to appoint more Guardians and make them full-time rather than part-time appointments.

Again there seems to be a shortfall in resources. It was frequently stressed that the child's voice must be heard through his or her own representative in legal proceedings. Yet those skilled in childcare who act on a part-time basis as Guardians ad litem are deflected from the equally vital role of direct work with children in need of thorough assessment and therapy.

Placement

This section addresses aspects of decision making in relation to the child's safety and considers issues concerning short and long term care.

Making the decision

The question as to whether it was necessary to remove a child from his or her home was one that appeared to cause the greatest difficulty and distress to respondents. It is possible that events unfolding in Cleveland and the media response to them had some influence on opinions at the time. Several social worker respondents said as a result of 'Cleveland' that they believed that the expectations of many of their clients were that social services intentions were to take their children from them. One respondent when reviewing a number of recent cases equated good handling with minimum intervention. Whilst many would

agree with an Assistant Director who said that intensive intervention is dangerous, it is surely also 'dangerous' if the balance swings away from removal of children to taking more risks leaving them at home. This was the dilemma of which many respondents were aware - there is a high risk whatever decision is taken in this aspect of their work. It is compounded by the poor quality of existing resources in alternative care. A Social Services Area Officer said succinctly "it is no better than what we are protecting [children] from".

Whilst at the time of interviewing it was said that the majority of children were removed from home there appeared to be signs of change. If the alleged perpetrator was the father or stepfather agreement was first sought for him to live away from the family home. Some areas appeared to be more successful than others. Those that were successful put it down to thorough assessment of the family and good relationships with the police.

The other key factor in deciding the extent of risk to a child in the view of many was assessment of the non-abusing parent, usually the mother - a task which was said to be particularly difficult due to her extreme but understandable state of conflict:

> "one day she will say she believes the child and will protect her, the next she is supporting the perpetrator".

In one area where it was reported 99 per cent of children were removed from their home, it was said this gave a "breathing space" at a time of extreme crisis, time to work with the family and assess. The question as to who benefits should surely be asked - is it for

the investigating agencies sake at the expense of the child?

Yet it is clearly difficult to make home safe. One respondent spoke of cases of "low level" abuse where it was rarely necessary to remove children. Instead the work focussed on enabling the mother to protect her child. Others, however, pointed out that children often disclose the least abusive experience, keeping secret or suppressed the worst that has happened so "low level" is the interpretation of the professional not the child. Furthermore it was said perpetrator's behaviour invariably escalates from "low level" to more severe forms.

The important factor for many respondents was the need to treat each case individually based on thorough assessment rather than, as a Police Surgeon believed many social workers did, opt for removal because it seems the safest. She said:

> "Social Services' departments are not happy about leaving the child in the natural home because they have been the whipping boy over the dead children who have been under their care. They do not want it to happen on their patch".

She was not alone in believing that the effects of removing children from home could be more damaging than leaving them in an "unsuitable home". She was concerned that at times the professionals' perception of safety sometimes overrides the child's perception of it. It is not surprising that several respondents stressed the need for more attention to be given to the issues and skills of assessment of risk in training

programmes for those given the difficult responsibility of making decisions about the safety of children.

Short-term Placement

If the placement of children in alternative care is unavoidable what is the best choice for the child in the short term? Firstly many respondents said that in practice they were rarely able to make that choice - placement was a matter of "whereever there's a bed available". This was despite the fact that several departments had a policy to place all children under eight with foster parents. The following debate then is largely theoretical. It should be considered in the context of the ideal where the favoured environment, foster or residential care, is freely available at the time of need.

Arguments in favour of foster care were that it was a more 'normal', 'healthy', 'stable' environment where it was easier to control sexualized behaviour typical of sexually abused children and there was no stigma attached to the child. Those in favour of residential care stipulated they had to be small scale establishments not dealing with 'delinquent' children. The main advantage, they argued, was that a residential home is <u>not</u> a family - the child is therefore not subject to the same power structure, the sexualized behaviour is easier to control, there is less risk of reabuse (fostered children, it was reported, are at high risk of abuse by a foster father) and specialized individual care can be provided by resident staff.

When considering alternatives to care it is necessary to ask what are the child's needs and which alternative will best meet those needs. What many respondents

appeared to be saying was that children require both a sense of normality and stability and attention to special needs specific to victims of child sexual abuse. Whilst 'normality' was seen as a longterm goal by most respondents, attention to the 'special needs' i.e. the high level of trauma suffered by these children and handling the sexualized behaviour, was seen as the most important short-term goal by two experienced consultants in child sexual abuse. Both favoured a specialist residential home staffed by skillful therapists, providing for a small number of children on a short term basis.

Ideally then it seems a range of alternatives is necessary to meet the different needs of different children. For some whose need for a 'normal' home and family is paramount and whose 'special' needs are not so acute, fostering will be best. For others the structured framework and emotional neutrality of a residential home or a therapeutic community will be more beneficial.

Long-term Placement

Most respondents believed that foster care or adoption were the most appropriate options for long-term placement of sexually abused children who could not return to their 'natural' family or live independently as a young adult. The main benefits were cited as a normal environment and consistency. The strain on resources and difficulties involved in implementation were reported to be numerous however.

Many respondents emphasized that special training and additional support were essential for those taking on the care of these children. Underlying this widely held view were these concerns:

* the shortage of foster parents and associated recruitment problems
* availability and content of training programmes
* the special problems experienced by foster parents in caring for sexually abused children.

Shortage and recruitment of foster parents

Four areas reported attempts to develop a specialist foster parent scheme. One failed through "lack of commitment". In another it was said response was poor because "they were apprehensive and too fearful" to undertake the care of these children. In another where funding for eighteen foster parents was available only half were found. In another the scheme was under review "because its not working as well as we hoped". This reluctance was put down in part to the general climate of opinion about child sexual abuse. One respondent went so far as to say that some of those who did take on these children were unaware of what they were undertaking. A respondent working for a fostering organization believed this reflected poor social work practice. She said:

> "the social worker is there to define the task and only then can the family be asked 'have you the capacity to take this on?'".

In her view indepth assessment of families who offered to care for sexually abused children was a crucial but difficult and sensitive area of work. It is necessary to go to some lengths in assessing attitudes about sexuality in particular (these issues are considered in more detail in the last section of this chapter). In the opinion of one respondent foster parents are not used to having their own lifestyle questioned and get

defensive when a social worker investigates the more intimate details of their life.

Availability and content of training programmes for foster parents

Several respondents in a management position in social services said that training foster parents was a priority and practitioners reported that many of them were eager for more information. Yet availability of courses for these carers was sparse in every area. Moreover there was some debate about the content of them and uncertainty about the questions: how much do they need to know about sexual abuse? What do we want to train them to do? Do they have to be experts? In the light of such a shortage of foster parents it seems important to ensure that the complexity and detail of the subject matter do not on the one hand overwhelm prospective recruits and persuade capable people that they are not equipped to undertake the task, and on the other hand do not lead them into territory which is better tackled by skilled therapists.

Special problems of foster parents caring for sexually abuse children

The difficulties of looking after sexually abused children should not be underestimated in the view of most respondents. The sexualized behaviour appeared to cause the most problems for fosterparents. Additional concerns raised were the importance of understanding the different perceptions of 'normal' sexual behaviour and the recognition that such is the prevalence of sexual abuse it is likely that a number of foster parents were themselves abused in the past raising unresolved traumas. Though being an adult survivor it was said need not prevent foster parents from caring effectively.

Considering these difficulties it does not come as a surprise to hear from several respondents that the breakdown rate for long-term fostering for these children was "pretty horrendous". However the view was qualified by the remark from one respondent from a fostering agency that breakdown may not have been always due to sexual abuse. Another respondent working for a voluntary fostering organization was optimistic for the future - she was convinced that there were families capable and willing to give these children a second chance in life and that they would succeed given sufficient training, support and supervision.

The discrepancy in views highlights the need for more knowledge in this area - how many children are removed from home? Where are they placed? For what reasons? Does this choice of placement meet their needs?

Therapy

This section addresses the lack of therapy, aspects of its perceived aims and current approaches including consideration of combining therapy with the use of a legal mandate.

Lack of Therapy

The clearest finding this study produced was that in the Greater Manchester area resources providing therapy for sexually abused children, their families and especially for offenders are very scarce. The reasons given for this deficiency were not simply lack of financial commitment to increase manpower and expertise, though this was a significant factor. Part of the problem was felt to lie in the perception of sexual abuse as a new field of work for which many professionals felt ill-equipped, and felt should be

left to 'experts'. Secondly many respondents said the main emphasis in practice had been on issues of recognition and investigation absorbing the lion's share of both interest and time available to practitioners. Thirdly a Child Psychiatrist pointed out that therapeutic work is time consuming and emotionally draining. Certain agencies are compelled to investigate allegations of sexual abuse by statute, but they can choose whether or not to offer therapy and many choose not to: "they are wary of sexual matters ... and it's such awful work" she added. Lastly another Child Psychiatrist said, some professionals are unaware that therapy is necessary - they believe that if the child is protected "the danger is over, no need for more intervention". He believed that better communication between agencies and fostering good interdisciplinary relationships would help change some of these attitudes and open up opportunities for increasing provision of therapeutic services.

What is Therapy about?

It was stated by some respondents with experience in therapy that there is nothing "mysterious" about therapy for sexually abused children. Several agreed that there were many similarities with treating other problems. However it was said the age and stage of development of the child needs careful assessment and it was stressed that to promote healing the child needs more than protection from further abuse and more than 'streetproofing'. It was clear that those claiming some experience believed that one did not have to be an 'expert' to offer therapy. Indeed many stressed that the residential social worker or nursery nurse could be in the ideal position to give consistent and competent care given some preliminary training.

The main aims of therapy were said to be to heal, protect and prevent further abuse (for the child) and prepare for return to normality. When questioned about success in fulfilling these aims however the term was considered inappropriate by some respondents since the outcome was so often disruption to the whole family, often leading to permanent separation. Furthermore the prognosis of the abuser is poor, particularly, it was said, in this country where few alternatives to prison exist. This deficiency prompted a heartfelt plea from one respondent:

> "we have to do more for male victims and offenders because that is where it all starts."

A few resources for therapy were available at the time of interviewing. Several respondents were conscious that at this early stage of development it was difficult to say which approach was proving most successful - none had been evaluated or challenged. Several expressed fears that some therapists adhered too rigidly to a set theory. One social services Area Officer said there appeared to be two poles of opinion: "the family therapy view ... [which] attributes the causes to family disfunction" and "the view that child sexual abuse is a man's problem" - others called this the feminist view. Whichever view is held affects the approach and focus of treatment. However it was clear from many comments that opinion was changing to find a balance between these extremes - taking strengths from each theory. The strength of the feminist theory was thought to be the focus on power relationships and the pathology of the offender; the family therapist therapy was considered valuable in taking the whole family context as its focus.

Those therapists who might be considered the most experienced took the view that no one theory fitted every case. They stressed the most important aspect of therapy was thorough individual assessment and to ask the questions:

* how did this child come to be abused within this family?
* what are the effects on the child and other members of the family?
* has the family the capacity to change?

A social services' Inspector said that many social workers were not currently competent at assessment and that they needed more training on this aspect of practice. The government have recognized this deficit and recently published Protecting Children - A Guide for Social Workers Undertaking a Comprehensive Assessment HMSO 1988.

One of the major debates in this field concerned the appropriateness of using a legal mandate in conjunction with therapy. Most dicussion centred on a therapeutic model for families whose children have been taken into care on a compulsory child protection order developed by NSPCC based in the region of this study. Whilst much respect was expressed about their work there was also criticism. On both sides views appeared to be strongly held and deeply felt. It seemed as though the issues of crime and punishment, illness and healing were in conflict. There were, however, some who believed care and control could be combined, achieving healing within an authoritative framework. What seems to emerge from this debate is a need for a range of therapeutic models with different degrees of control. Not all families will require compulsory care orders

before they have access to therapy. Indeed as a Child Psychiatrist pointed out in the majority of cases there is insufficient evidence to obtain them. These families, he stressed, should not be abandoned by professionals because of the lack of a legal mandate.

One of the organizational factors concerning therapy which was reiterated often is its time consuming nature. This has significant implications on planning and developing new resources. The whole family is affected and needs attention. Therapists said that both individual and group therapy are used and sometimes a mixture of both. Group work led by a professional was preferred by most above self help groups especially for the following: teenage victims, adult survivors, offenders, and non-offending parents. However resources for all group work were said to be scarce.

Several respondents advised that therapy is more effective if given promptly after the incident of sexual abuse. If left untreated effects often take the form of unconscious coping mechanisms which are destructive to the victim and prove resistant to healing after long use. It was also said that many victims needed a 'top up' of therapy at later stages in their life, e.g. at puberty, adolescence, marriage or birth of a baby. The message from respondents on the subject of therapy was clear: the provision of more resources <u>now</u> is a matter of urgency.

<u>The Worker</u>

From the evidence of this study working with sexually abused children is complex and emotionally demanding. The people who take on the work need a high level of

commitment, competence and knowledge, and a management framework which promotes and sustains the high standards demanded of them. This final section examines what respondents thought about the workers and the existing framework. The main aspects raised concerned recruitment, issues of gender, power and sexuality, and aspects of stress, supervision and support. The focus applies mainly to social work practice.

Recruitment

There was little doubt among respondents that more practitioners are needed to deal with the rising referrals of child sexual abuse particularly in view of the time consuming nature of the work, its emotional impact and pressure from public expectations which, it was said, "demand 150 per cent attention" to sexual abuse cases.

The answer however does not appear to be as simple as increasing manpower although one respondent said "we are not training enough social workers in the first place". A Director of social services was concerned about too many resources being poured into child abuse "because of its current high profile " and mental health and the elderly being neglected. Another manager pointed out that in contrast to the past there is now difficulty in recruitment for child care because "social workers are aware that if you do something wrong ... it could be the end of your career."

A major factor affecting the deployment of manpower is the apparent confusion and debate about the system of provision of care in social services: whether it should be generic or specialist based. The majority of respondents felt that child abuse work should be

specialist, but were unclear how specialist. Recruiting more staff without researching the needs of the area and deciding for example whether teams should deal exclusively with child abuse or more broadly with child and family problems could lead to ineffective and inefficient practice.

The other crucial factor is the quality of interprofessional relationships. There was evidence, particularly in the realm of therapy that social services felt that they should be responsible for all care. This apparent reluctance to share the burden of care appeared to be based on such arguments as "child psychiatrists do not necessarily know anything about sexual abuse." Yet judging from the skills and qualities recommended which stressed the importance of knowledge and competence in communicating with children, they should be well equipped apart from the lack of knowledge base on sexual abuse. It is surely easier and more efficient to equip professionals with knowledge rather than skills - the latter, some respondents said take years to acquire. A change of attitudes within social services encouraging more interprofessional collaboration might increase resources particularly in the much needed area of therapy.

Gender power and sexuality

The consensus of opinion was that child sexual abuse is more difficult to manage than other types of abuse because of these interelated issues which impinge on all realtionships between adults and between adults and children. It was generally agreed that our understanding of child sexual abuse and subsequent response to it are linked closely with our individual personal experience and feelings, explaining the

"embarrassment, inhibitions and stereotyped ideas" which some respondents had noticed among their colleagues.

The taboo concerning child sexual abuse has been so prevalent it is only recently we have become aware of how widespread the problem is. Several respondents spoke of the difficulty they found in accepting the fact of rising figures. Some were critical that there were still professionals who chose not to believe that it happened and who did not believe children's evidence. Others stressed that people's perceptions of what is normal or abnormal, acceptable or non-acceptable sexual behaviour varies greatly and again influences responses at all stages of intervention including the provision of preventative measures. In the context of prevention, it was noted by a number of respondents, that headmasters of primary schools in particular, were often resistant to acknowledgeing the need to include prevention programmes such as those developed by Michelle Elliott of Kidscape in the school curriculum.

Gender and power issues were frequently linked. This is perhaps hardly surprising, since as it was frequently pointed out, the majority of abusers are male and the victims female, and the majority of professionals in management positions are male and practitioners are female. These imbalances caused numerous tensions arising from the gender of both client and professional.

Issues raised concerning the gender of clients included the fear that professionals underestimate the number of boys who are victims of sexual abuse. Some blame the mother for not protecting her child, some the child,

especially if a girl, for being provocative and minimize the role of the male abuser. The chief culprits of this attitude were said to be members of the legal profession. There is an underlying assumption, one respondent said, that men cannot help themselves; that they cannot control their sexuality nor change their behaviour. This is reflected in measures taken to intervene where the onus is put on the mother to protect her child and make the mother choose between losing her child (to local authority care) or her partner (into custody or prison).

Issues raised concerning the gender of professionals primarily focussed on whether it was better for the child to have a male or female practitioner. Since the majority of victims are girls it was generally considered important, particularly in the early stages of investigation where victims were acutely frightened, to have female practitioners. In the social services this presented few problems since the majority were women. In the police they were not always available and delays had been caused by social workers unwilling to go ahead without the required woman police constable. The police surgeons had anticipated the need for more skilled women in the field several years ago and recruited and trained sufficient to meet the growing need. The gender of the medical examiner was thought to be particularly critical. Despite the preference for female practitioners it was felt that a choice should be offered to the child victim.

In the case of management of the offender a major deficiency was underlined. Social workers, said a Child Protection Coordinator, are mainly women and the clients they ususally deal with are women and mothers. He added:

"They are not equipped to work with men let alone those who sexually abuse ... they get the abuser out of the picture as soon as possible".

There is clearly a need to address this deficiency both by the provision of specific training and the development of collaborative initiatives with professions who have the appropriate skills and experience such as probation officers or psycho-therapeutic services.

Many respondents said that one of the most important factors for anyone working as a therapist in the field of child sexual abuse was "being in touch with your own sexuality". It was often unclear what was meant by this and even more mysterious how one could tell whether it had been achieved.

For some it meant not being embarrassed, upset, shocked or emotionally 'thrown' by the words used and the experiences described by children, colleagues, or oneself. For others it meant acknowledging anger, disgust, titillation or whatever uncomfortable emotions were aroused. Admitting to these feelings, it was believed, allowed one to see more clearly how they can affect responses to child victims and other clients involved. Intellectual responses are then not overruled by the emotional impact.

For others it was necessary to go deeper into "personal sexual agendas" - to establish whether potential foster parents for example "have confidence in their sexual roles and are secure in their relationships sexually". Apart from the difficulty of assessing such dynamic relationships it is questionable how useful it would be to go to such depths of analysis. A social

services'Area Managers's comment helped elucidate the point:

> "[being in touch with your sexuality] ... is about understanding agendas that the child will hang on you but don't originate with you."

The important point it seems, from this comment is that practitioners (or foster parents) need to have insight and understanding of their own 'agenda' sufficient to be able to separate it from that of the child's to enable them to see the child's problems and needs more clearly. To the writer it seemed that too much preoccupation with our own sexuality could have the opposite of the required effect hindering the effort to share the child's perception of what has happened and restricting the imaginative leap necessary to enter his or her world.

Stress, support and supervision

Every respondent raised some aspect of the stress experienced when working with child sexual abuse. This was often in response to questioning about the difference for workers in its management as opposed to other forms of abuse. All agreed that the provision of adequate support and supervision for practitioners was vital if standards were to be maintained and 'burn-out' prevented.

The reasons given as to why the work is so stressful were various:

* it's a "new" area of work, no "model" to work on
* public expectations and pressure "not to get it wrong"

* increase in referrals and volume of work
* the lack of evidence, "helplessness", "you have to wait for something awful to happen"
* "power struggle" between professionals and alleged abuser and family
* the nature of sexual abuse, its effects on the child and the consequences of intervention are severe and distressing "you cannot be indifferent to it - it gets to your innermost feelings".

In the experience of several respondents 'burn-out' is a constant risk particularly for those who work in isolation or exclusively with sexual abuse. Those who worked within a supportive team and with a mixed case load were said to fare better.

Several respondents from different professional backgrounds believed that social workers had the most stressful job. A Woman Police Officer said that it was social workers who bore the brunt of confronting families, coping with denial and had to carry on working with the family after the initial investigation.

Voluntary societies in general felt they were under less pressure than statutory agencies, that they had better and more resources and were supported by their management more adequately. Two had outside consultants to give additional team building advice and individual counselling to professionals on a regular basis. They were the only services which considered the level of support received was adequate. There was evidence that a NSPCC team had suffered considerably from the stressful nature of the work and lack of direction. NSPCC are possibly at higher risk of burn

out than other agencies since they deal exclusively with child abuse and are often involved in investigatory work as well as other stages of intervention unlike other voluntary societies.

Provision of support among statutory agencies differed in amount and kind between disciplines and departments. It was mostly provided on an ad hoc basis, sometimes initiated by individuals wanting back-up from colleagues and developing their own self-help groups, often starting up with great enthusiasm but not always sustained for more than a few months. A Woman Police Constable laughed at the unlikely idea of anyone taking up a new service of stress counselling provided by her police department because, she said, there was a widely held view among police that only the young and inexperienced should feel stress. Admitting a need she added, could damage promotion prospects.

There was some confusion about the terms support and supervision. Good supervision was felt to be supportive but it was clear that respondents believed it was not enough on its own. Good supervision was described broadly in terms of three functions:

* communication between supervisor and practioner on the same level of knowledge, awareness and understanding of issues relating to child sexual abuse
* controlling the caseload
* monitoring the caseload

It was widely held that setting controls both on the number of cases and assessing severity of cases was vital because of the emotionally demanding nature of this work. The responsibility for unallocated cases

should be taken on by senior management it was suggested.

Monitoring the management of a case, it was said, should include particular vigilance in relation to the common phenomena of families 'sucking in' professionals from many different agencies, often setting one against another and generating 'mirroring effects' - a term used to describe what happens when a professional reflects the stance of the client/s.

Other suggestions were made as to how professionals can be supported besides ensuring access to good supervision. These included the provision of the following:

* validation in terms of recognition and acknowledgement of the risk, complexity and emotiveness of the work involved
* a 'safe' climate to express emotions freely - to give vent to anger, helplessness, sadness, fear or uncertainty
* a structure to work within; a team or network of professionals - "not all responsibility bearing down on one individual".

To endorse recognition of the reality of the work involved it was recommended that 'time out' from the pressure of practice be given. Sometimes this could be in terms of time off or change to a different type of work for a period of time, or attending a training course to improve skills and competence which in turn increases confidence and lessens anxiety about the ability to cope. Training courses also increase communication between professionals and help diminish the sense of isolation felt by some in the field.

The expectations of society and of managers of professionals who work in this field that they will function effectively and efficiently are legitimately high. Those who are prepared to take on the responsibilities of this exceptionally demanding work should equally expect high standards of support. From the picture drawn by respondents they do not feel sufficiently supported. If resources in this aspect of management are deficient then many professionals will, as reported, adopt coping mechanisms damaging to practice or 'burn out' altogether and leave their jobs. As a consequence there will be no opportunity to build up experience and skills. In a field where it seems there will never be sufficient resources to meet demands it is surely vital not to lose the most important of all to the child and family - the commitment and skill of the practitioner.

CHAPTER 6 DISCUSSION AND CONCLUSIONS

In the last ten years in Britain the subject of child sexual abuse has been increasingly a focus of attention. This is evident from the literature, the media, government inquiries (notably Cleveland 1987, Rochdale and Orkney 1991), DSS and regional working parties, publication of new procedural guidelines throughout 1988 by both central government and local authorities, training initiatives and government funding to increase training in 1989 and proposed changes in child law embodied in the Children Act 1989 to be implemented in October 1991.

Despite this spotlight and these changes the management of child sexual abuse is clearly still a major problem for professionals. Since the start of this study in 1987 which was conducted in the shadow of the crisis in Cleveland, there has been criticism of the handling of cases throughout the country - as far a field as Kent, Nottingham and Orkney and within the region of this study in Manchester and Rochdale. New aspects concerning ritual and satanic abuse have emerged. Procedural issues are currently being re-examined and yet more guidelines proposed by the government.

The issues are clearly immensely complex. In this final chapter an attempt is made to illuminate four areas. They have been selected from the many aspects which emerged during this explorative study for a specific reason. On the basis of the findings of this study it is the writer's opinion that the recent and proposed changes in procedural guidelines and child law and the modest financial investment offered to local authorities for training purposes may not in themselves be enough to improve the management of child sexual

abuse cases without a close consideration of the following areas:

* the place of specialism in the management of child sexual abuse
* appropriate skills and training
* coordination of care
* emphasis of care

The Place of Specialism

Two fundamental questions are raised by any discussion concerning the place of specialism in the management of child sexual abuse - the first is contingent upon the second:

* is child sexual abuse different to other family problems and so requires specialist management?
* are specialists needed to carry out the work required?

This study suggests that the answer to the first is yes, it is different, and to the second, predictably with this complex subject, yes and no.

This is a field where "the willingness to believe that it exists" (Sgroi 1975) is at an early stage of development as this study confirms. Moreover respondents perceived it as new - "we are all learning". Knowledge and experience in how to handle it are therefore still scarce resources so yes specialists are clearly needed to disseminate their expertise as widely as possible to equip practitioners to cope with increasing referrals. And yes child sexual abuse was seen by respondents as different to other family problems, requiring specialist skills to

cope with the additional complexity of both its dynamics and management, particularly in relation to the conditions of secrecy and lack of evidence, the legal implications of prosecution and protection, the severity of effects on child victims and the personal and emotional impact on professionals dealing with it arising primarily out of the sexual nature of the problem.

The evidence of this study confirms much of the literature in emphasizing the need at the stage of investigation for a specialist to assess alleged child victims for psychological, emotional and behavioural signs and symptons who is also competent at giving evidence in court (Vizard, Bentovim, Tranter 1987) and for a medical practitioner to be qualified in forensic medicine (Davies 1987). In this context however, this study stressed the importance of additional expertise in knowledge and experience of anatomical variation in the genital area and awareness that the status of medical evidence is small in relation to other factors. It was also confirmed that such projects as the Bexley experiment (1987) where social workers and police were given specific specialist training in joint interviewing were of vital importance. Neate and Sone (1991) support this view. They comment that criticism of social work investigative practice in Rochdale and Nottingham should not cause social workers to be silenced. On the contrary they must demand more information, training and guidance. An area which this study suggested might also need specialist care was in therapy in cases where the effects of sexual abuse on a child were particularly profound.

This affirmation of specialism in the field was however qualified by the counter argument expressed mainly by

those working in social services that child sexual abuse is their remit and that investigation, assessment and therapy should be integrated, not split up between different professionals and agencies. In practice it was reported that specialists were overwhelmed by ever increasing referrals causing lengthy delays and placing more pressure on social services as a result. If specialists cannot provide an effective service "we'll do it ourselves" is an understandable response. The dangers though, as seen by several child psychiatrists, were that when specialist intervention was necessary it was not recognized or acted upon.

This clash of views between professionals from different backgrounds illustrates the problems caused by differences of perception of who is 'specialist' or 'expert' at what. Respondents regarded as specialists came from a variety of backgrounds including social workers, child psychologists/psychiatrists, paediatricians, police surgeons or more unusually nurses or educational psychologists. This can create confusion and sometimes bitter debate concerning who is best qualified to do what, adversely affecting practice. In this study it was found that the status of 'expert witness' was accorded to few and tended to favour child psychologists rather than those of social work background. Interestingly the judge presiding over the Rochdale Inquiry (1991) mirrored this perspective. He criticized social workers for not having an independent appraisal of the material gathered and said that expert advice from a psychologist or psychiatrist should be sought before any intervention in the family occurs (Cervi 1991).

In the context of the medical examination there was no debate as in the letter columns of the newspapers in

1987 between paediatricians and police surgeons - in Greater Manchester it was perceived the latter were the most competent. And in court a medical practitioner offering physical evidence appeared to have more status as a specialist than either social worker or psychologist - this was despite a police surgeon insisting that medical evidence should be regarded as "only a tiny bit of the mortar that holds the edifice together".

Thus whilst there is little disagreement that specialists are needed sometimes, at certain stages, and for certain aspects of management, there is disagreement about who is and who is not a specialist and what expertise is appropriate in relation to professional background. There is also disagreement at what level within an agency specialists should be deployed and how a specialist service should be organized. In some areas multidisciplinary specialist teams have been developed who deal only with child abuse or even more exclusively only with sexual abuse. The advantages were said by some respondents to be that a core of knowledge, expertise and competence is built up, liaison with other agencies is simplified and more effective and the team framework provides support and enhances confidence. Others pointed to disadvantages. Operating in a narrow field which is exceptionally emotive and stressful causes practitioners to become "burnt out, blunted and blinkered".

These findings reflect the ambivalence of the literature. On the one hand the multidisciplinary team approach is endorsed by government recommendations in response to agency failure and public criticism and supported by Pringle (in Bruce 1980) and Stevenson (1981) whose analysis of the problem of child abuse is

that it is multifaceted and therefore demands a multidisciplinary approach. On the other hand the scepticism of Dingwall, Webb and Hobdell (in Lonsdale et al 1980) and of Byles (1985) concerning the effectiveness of the team approach in child abuse is also born out. The tendency of specialist teams dealing exclusively with child abuse this study suggests, is to provide a 'package' deal which can be insensitive to individual need.

In the wave of criticism recently expressed in the media concerning agency handling of investigatory procedures in suspected sexual and ritual abuse in various parts of the country it is possible to pick out illustrations supporting both the advantages and disadvantages of multidisciplinary specialist teams. Clearly practice varies greatly. It would perhaps prove fruitful to examine more closely those areas where it is claimed agencies work well together such as the domestic and child abuse units set up in West Yorkshire by Detective Inspector Vasey and Leeds Director of Social Services Norman Tutt in 1988 as a response to 'Cleveland' and Working Together 1988 (Sone 1990). A focus on good practice would not only help to identify goals to achieve in terms of improving practice and training but also enhance the image of the social worker as a credible 'specialist' in this field.

Because there are disadvantages in relation to specialist services it does not mean they have no place in the provision of care. At certain stages and with certain clients they will always be necessary. Furthermore this study suggests that collaborative initiatives betwen a specialist service and other agencies can be valuable both to clients and professionals where participants are aware of and put

into practice a number of principles of partnership. What it does mean however is that there needs to be more clarification of the following aspects:

* which tasks, which clients and what circumstances require specialist handling?
* what specific knowledge and skills are necessary?
* what services/professionals are available in the immediate locality which are equipped and able to provide this knowledge and skills?
* how many clients out of the total referred in a specific locality require specialist handling?
* how many specialists are required for each locality?

Only when these answers are provided can decisions be made about the following:

* how specialist should intervention into child sexual abuse become?
* how many specialists are needed?
* at what level (for example within social services, police) should they be deployed?
* at which stage of intervention?
* at whom should training be targeted to fill the gaps?

A case could be made for pouring money into extra resources for almost every aspect of child sexual abuse. There have to be priorities more specific than more manpower or more training. Specialist care is clearly needed but surely hard data about who, what, where and how is the most pressing priority.

Skills and Training

It is generally accepted that management of child sexual abuse should be approached on a multidisciplinary basis but that social services with their statutory responsibility and powers to investigate reports of children at risk, to protect them and promote their welfare (DHSS 1988), should take a leading role. How should they be equipped to accomplish these tasks? In terms of skills and training a number of factors emerged.

Firstly how one interprets a role has a direct bearing on the question of how one approaches a task and what skills are considered appropriate. Analysis of investigatory practices in this study suggests that social workers sometimes interpret their role of protecting children too narrowly and consider protection only in terms of a child's physical safety. Over-hasty separation of the child can result. This may be due to the influence of public and media pressure that highlights mistakes in a high risk business. It may be due to the wave of awareness of the prevalence of the sexual abuse of children and the very necessary and proper surge of training programmes, study days, conferences and publications aimed at helping practitioners recognize and respond to it. It was an interpretation which disturbed a number of respondents including a Child Psychiatrist who spoke of the dangerous focus on "this new thing child sexual abuse", a focus she believed could exclude so much else that may be going on.

The researcher's impression in this study was that some social workers, because of this 'new' focus, because of their statutory responsibilities and because of public pressure, based their assessment of children suspected

of being sexually abused on less than neutral ground. The term 'disclosure work' or 'disclosure interview' was repeatedly referred to in the context of investigating circumstances where it was not fully known either what had happened or what the condition of the child was. Its use assumes the child has something to disclose and puts an additional onus on the child to provide access to evidence with possible damaging consequences. One respondent described some professionals response to a hint of sexual abuse as a homing in, "like iron filings to a magnet". It is this kind of 'attraction' to a certain aspect that can add weight to certain signs and symptoms without adequate justification. To be truly open minded one has surely to base an assessment as much on the fact that the child has not been sexually abused as that he or she has. In which case the starting point is the health of the whole child. It was perhaps not unwarrented that the judge in the Rochdale inquiry (1991) accused the social workers involved of "being obsessed in their own belief" in what the children were saying (writer's emphasis) (Cervi 1991).

A further factor emerging from this study (not widely evident in the literature) in relation to the investigation and assessment of children was the emphasis placed on the need for practitioners in this field to have considerable training, experience and skills specific to childcare. The ability to communicate with children was most prized. It was suggested that only a limited number of social workers have specific training such as those who started their careers as child care officers. Furthermore only few have experience of direct work with children.

To increase expertise more training is undoubtedly necessary. However a three day course cannot realistically correct this deficit. In fact too superficial a coverage could cause harm - there was no lack of criticism about some training programmes. Longer more intensive courses are time consuming and expensive. Social services are short of both resources. It does seem vital that the pool of expertise is extended by increasing collaboration with professionals and agencies who already have experience and skills in child care. These could include health visitors, nursery and school nurses, child psychologists, psychiatrists and psychotherapists.

A significant finding of this study was that the role nurses played at any stage of intervention appeared very limited, yet where they were involved they were held in high esteem for their initiative in creating opportunities for interprofessional collaboration, for their skills as trainers, for the specific knowledge of health visitors of child development and for their ability to form close relationships with families in their care - all aspects of vital importance in the management of child sexual abuse. Greater efforts made towards collaborating with agencies outside social services would surely be more effective and efficient than trying to equip large numbers of social workers, already hard pressed, to do all the work. Social services can still remain 'in the driving seat' and maintain its role ensuring children are protected and their welfare supervised.

Collaboration between social workers and nurses and child psychiatric services was not unknown in Greater Manchester but it was rare. The literature too suggests that it is more common to find social workers

working together with police (Bexley experiment 1987) or medical practitioners (Cleveland Inquiry 1987) or other professionals whose skills are used to elicit information from children which satisfy legal requirements of proof of guilt (Vizard, Bentovim and Tranter 1987). While it is not the intention to diminish the importance of acquiring and using these skills this researcher shares the sentiments of a Child Psychiatrist interviewed who looked forward to a time when the whole country had got over the initial stage of shock and desire to blame and prosecute perpetrators of sexual abuse and concentrated effort towards healing. A step on the way would be to change the present legal system in its approach to criminal law from one which is adversarial based on defending the accused against evidence of guilt, to one that is inquisitorial (as in France) based on discovery of the truth. Establishing such a system could result in a shift of balance in emphasis from prosecution to therapy affecting practice in two ways. Firstly assessment objectives, which at present appear to be aimed at meeting legal and public demands for prosecution more than the needs of the child or family, might be eased. Secondly the way forward towards increasing skills, training and collaborative initiatives aimed at reaching therapeutic goals from the beginning of investigation might be made clearer.

Coordination of Care

This study suggests that the management of child sexual abuse usually involves more agencies and professionals than dealing with other family problems. It confirms the necessity for interagency liaison and cooperation underlined by Stevenson (1981) Butler-Sloss (1987) and DHSS (1988) but also confirms the findings of Dingwall,

Webb and Hobdell (in Lonsdale et al 1980) and Byles (1985) that in practice there are many aspects which militate against effective coordination of care. Events in relation to the handling of sexual abuse in Nottingham, Kent, Manchester, Rochdale and Orkney subsequent to the end of the data collection for this study demonstrate the stark reality of these difficulties.

In addition to the poor communication, inflexible attitudes and power struggles commonly found in relation to interprofessional coordination identified by many writers, and to the specific problems in relation to sexual abuse concerning interprofessional 'mirroring' (Furniss 1983) and 'professional dangerousness' (Dale et al 1986) this study identified two other aspects both of which related to professionals' perceptions of child sexual abuse as a 'new' area of work. The first was that many frontline practitioners were said to feel ill-equipped and lacking in confidence. Linked to this an increased reliance on 'experts' was reported - a trend with its own dangers as identified by Harris in 1987 who wrote "they may, as with Kimberley do too little, or as in Cleveland do too much." More recently, as yet more 'new' aspects of sexual abuse emerge in so called ritual or satantic form, practitioners have been criticised for seeking advice from quasi 'experts' such as Pamela Klein whose status as satanic abuse therapist has been questioned (Waterhouse 1991). Practioners have also been criticised for using Satanic Indicators written by Catherine Gould and distributed to a number of social services' departments but since denounced as "exceedingly dangerous½" (Bannister in Neate and Sone 1991). This sense of inexperience was compounded by the typical conditions of uncertainty concerning the

evidence and establishing what has happened (conditions amply illustrated by events reported throughout the country).

The second aspect is related to the first. The combination of uncertainty and feelings of inexperience not surprisingly generates a climate of debate whereby every aspect of handling child sexual abuse cases is subject to criticism - a factor the media are not slow to exploit and sensationalize adding to the problems of interprofessional/agency co-operation.

The first aspect - the sense of inexperience - it is hoped will diminish with increased discussion and knowledge about each others' roles and objectives encouraged through joint and multidisciplinary training programmes. The second - debate - is likely to continue and surely should continue in the realms of lierature, policy making and practice, as learning the best way forward can only be discovered by exchanging and sharing different perspectives - a process to which this study contributes. Where debate is not constructive is where it is fuelled by interprofessional rivalry or distorted reporting in the media. All these aspects militate against effective interprofessional/agency practice particularly it seems where there has been a breakdown in communication and lack of a framework, albeit a flexible one, within which to operate.

Two factors which could help improve communication and provide a framework to improve interprofessional agency co-operation this study suggests are:

* a person designated as coordinator
* a place - a central unit - for use by all involved.

Coordination is needed on several levels. A number of social services' departments had recently appointed child protection coordinators to improve communication between management and field staff. How widely these coordinators liaised beyond their borough and professional discipline varied. Some reported very close relationships with members of the police, health authority, NSPCC and schools. Some pointed out the importance of communicating across district boundaries in an attempt to pool ideas and develop more consistent practice. They are in a pivotal position to influence both Area Child Protection Committees and field workers.

Their role seems to differ from the vague concept of "officers with experience to act as central points of advice and contact between and with agencies" which the DHSS in Working Together (1988 p.32) recommends for facilitating interagency cooperation. It would perhaps be fruitful to clarify the role since this study suggests that, despite the apparent increased reliance on experts in some quarters, those who set themselves up as consultants or experts in child sexual abuse dispensing 'advice' are treated with some suspicion. Rather the function of keeping open channels of communication between agencies was considered more appropriate as each has its own perspective to offer which needs to be shared, recognized and respected. Such conditions were apparently absent between the police and social workers involved in the cases reported in Nottingham at the inquiry in 1989, but present in the case of allegations against masters of

Crookham Court School, 1990, which, professionals involved reported on news programmes, greatly facilitated investigatory procedures.

At another level, again usually a social services' responsibility, is the keyworker who coordinates care in individual cases. It was at this level that there was some confusion between the role of coordination and that of control, particularly when specialist help was sought, such as child psychiatric services. In effective teamwork it appeared that common principles and aims were sought and views openly and continually shared - a factor Brill (1976) and Bruce (1980) predicted should enhance co-operative initiatives. The keyworker's role this study suggests should include having a say as part of the team in the planning of individual care, carrying out his or her specific statutory duties in relation to the child's protection and being responsible for communicating about the progress of care between the different agencies involved. Overall control of individual cases, however, should reside in the collective body of the team which should, in policy and practice, reflect the spirit of partnership. The use of contracts between professionals/agencies (which have no legal status) it was believed, could provide a useful framework to facilitate such a partnership providing they were reviewed regularly and changed if appropriate.

The second factor - a place or central unit designated in each locality - does not guarantee better coordination (Bruce 1980) but judging by the evidence of this study it could help. There was considerable criticism concerning the lack of ideal premises available to investigate child sexual abuse cases as recommended in central and local guidelines. The ideal

was described as specifically planned with the needs of children in mind - comfortable and unthreatening - and with facilities such as video equipment and one way mirror to enhance the opportunity for multiprofessional learning, supervision and co-working. A centre, whoever it is funded by, which is not obviously part of a hospital, social services' department or police station, would carry less stigma for clients and be more neutral ground for collaborating professionals, particularly if its remit covers a range of family problems rather than exclusively sexual abuse. Such a centre, ideally with its own core staff trained in child and family care, could also provide the services of information base, consultation and support.

These ideals were found in practice in one centre only - and not in the Greater Manchester area. Whilst it was not within the scope of this study to evaluate this resource the impression gained by the researcher through comparison with over twenty centres was that the levels of interprofessional collaboration and coordination were of the highest order. In view of recent criticism of the handling of suspected ritual and satanic sexual abuse it seems that a focus on provision of adequate resources and evaluation of what appears to be <u>good</u> practice to identify what helps support professionals in what will always be an immensely difficult task, would be of more value than the present focus on procedural guidelines which cannot address the complex and individual nature of the issues involved.

<u>Emphasis of Care</u>

The emphasis of care in the field of child sexual abuse in Greater Manchester and it seems throughout the

country, in both policy and practice, has been on matters concerning investigation. Most would agree that this is right since mistakes made at this crucial stage can have serious and irreversible effects causing much pain and harm to children and families and extra work for professionals when resources are already inadequate. Many respondents believed however that the handling of this stage was now better than in the past. The problems are not solved and new aspects underlining the complexity of the issues such as the phenomena of ritual and satanic abuse are continually emerging. But professionals are more aware of what needs to be done and who should do it. Policies and a framework for practice in many areas have been developed on a multiprofessional basis.

Working against this growing experience in handling the investigative stage, it seems, is adverse public opinion, exacerbated by media coverage of the more sensational aspects of investigation such as reporting of 'dawn raids', in relation to professional and in particular social work practice. It seems that few people recognise the high risk of making mistakes due to the immense complexity of dealing with suspected sexual abuse and the lack of resources and experienced professionals to deal with it. Nor, it seems, do many realise the profoundly damaging and irreversible effects suffered by victims which professionals witness and seek to prevent happening through what appears, to the ill-informed, as precipitate intervention. It is such attitudes that will be slow to change and will perhaps perpetuate the focus on investigative issues, even influence some social workers to take the safest route for them in terms of job protection rather than for the child. The overwhelming opinion voiced by respondents in this study, however, was that the focus

should move on towards aspects of therapy for which there is little provision either for victims, parents, siblings or for perpetrators. Nor has there been much critical evaluation of therapy that is available.

A number of factors besides the current preoccupation with investigative issues suggest that the movement towards healing will not be straightforward. Firstly an increase in resources is unlikely in the present climate of government cutbacks of local authority expenditure and NHS changes.

Secondly our current legal system is not geared to the goal of therapy in a number of aspects. As referred to above it "forces us to be investigative rather than therapeutic". It places the onus on the child to provide evidence and thereby jeopardizes his or her emotional and psychological health through intensive assessment and accent on disclosure.

Furthermore the present criminal law offers few alternatives to a custodial sentence for offenders. Incarceration, fining, a police caution - any of these alternatives - without therapy will not stop abusers offending. This was the opinion of the few professionals in this study who had experience in this aspect of the work, and is beginning to be confirmed by others (Wyre, 1989, Furniss 1991). The pathology of the offender is an area many believed needs much greater attention with particular focus on 14 to 15 year old boys, since it is then that patterns of abuse seem to begin. From this point, as a Chief Inspector of Police aptly put it, springs "the terrible tree with its branches spreading wider". To extend the metaphor further - new trees are propagated from the old - the abused become abusers and the cycle continues. Without

increasing our understanding of abuser pathology, changing our laws to provide more options in non-custodial treatment and increasing resources to treat more offenders to attempt to control if not cure their behaviour, the branches will continue to spread. The outlook that such changes will take place seem poor, largely because society, whether in the private, professional or political sphere, does not appear to support the philosophy behind the treatment of offenders. The offence is either minimised and prosecution not sought, with the intention of saving children from a potentially harmful court appearance, or imprisonment is seen as deserved punishment, a fitting deterrent and an appropriate means of protecting children by removing the abuser from society. Given this climate of opinion it seems that efforts towards prevention in terms of educating children should also be increased.

Then there is the new Children Act to be implemented in October 1991. Will it improve the situation and enchance the opportunity of managing child protection with a more therapeutic emphasis? Harris (1990) considers it in a historical context and believes it represents a resistance to professional power and invasion of privacy of the family at a time (the 1980's) when professions were under polticial attack (supported by opinions offered in this study) and the ideological benefits of the family promoted. Legislature regarding the welfare of children, he believes, has swung between the poles of privacy demanded by parents and powers of intervention demanded by professionals. His view, and he is not alone (Smith 1991) is that the new act will shift the balance in the direction of the former. In its emphasis on "parental responsibility" and the "near exclusion of partnership

between parents and authority" (Smith 1991 p.24) this certainly could be the case.

Disconcertingly the issue of parental rights was rarely referred to by respondents in this study. The issues that preoccupied them concerned the child. There may be several reasons for this ommission. The focus of this study was intentionally placed on discovering the needs of children. Also events in Cleveland massively publicized at the time could have been a further powerful influence. The message many professionals were receiving was that they were under attack for inventing child sexual abuse where it did not exist. They were made aware of the discrepancy of power between articulate adults, including parents protesting their innocence and infringement of rights and the vulnerability of the children caught up in the affair - their voices apparently seldom sought or heard.

Social workers gave cogent reasons for their focus on the rights and needs of children. Sexual abuse is an abuse of power and the child in a position of powerlessness within the family unit and in society. Sexual abuse has been hidden for so long; its perpetration relies on conspiracy and taboo. The shift of legislation to the right of privacy and responsiblity of parents for the child may well support the perpetuation of this climate of silence and concealment at a time when it is believed that society is at last beginning to recognize the prevalence of child sexual abuse and its devastating effects and child victims are at last beginning to receive professional validation and advocacy which is their need and right.

Nevertheless parents do also have rights and to ignore them, as many respondents reported, results in hostility, withdrawal of co-operation and denial of access, at the worst sexual abuse continues, at the best therapy is jeopardized. Improvement of skills and attention to the needs and interests of parents as an integral part of investigation, assessment and therapy is surely vital. Whether the new legislation will encourage more of a partnership between parents and authority in the interests of better care and support for both child and family has yet to be seen. The evidence of this study sows seeds of doubt on this particular patch of ground.

Finally there is a need for more emphasis of provision of care and support for the professionals - as one respondent put it "therapy brought into the process of management of a professional team". It is widely held in the literature and supported by the evidence of this study that the work is complex, stressful and emotionally draining. Many practitioners did not feel valued yet those who are qualified and experienced in this field were said to be "like goldust". There was also difficulty reported in recruiting for child care work in social services. If social workers continue to come under pressure from the nature of the work without adequate support they will 'burn out'. If they continue to suffer public and political censure supported by the media they will resign as did the social workers and Director of Social Services in Rochdale recently (1991).

Caring for the professionals should be demonstrated in a number of ways:

* attitudes of society, professionals (especially those of the legal profession) and managers need to change - to recognize the problems involved in dealing with sexual abuse and diminish the sense of being under attack felt by many
* resources need to increase to reduce the pressure on practitioners undertaking time consuming work and to facilitate interprofessional collaboration and co-operation and prevent delays. The new Children Act 1989 increases demands on social workers in terms of work to be done within a set time limit, but the money and resources to implement these demands are considered inadequate. The development of Family Centres, also recommended in the act, are expensive to establish and run and not within the means particularly of the smaller local authorities in the present climate of cuts
* policies and guidelines need to be developed which provide a framework to authorise and validate professional practice but are flexible enough to accommodate the fact that sexual abuse covers a wide range of aberrant behaviour and requires attention to the individual nature and circumstances of each case
* opportunities for multidisciplinary training programmes and interprofessional collaboration need to increase and focus on improving knowledge and respect for each others perspectives to generate mutual support and diminish 'scapegoating' of individuals or professions
* more research is needed focussing on practice issues so that priorities can be identified

particularly concerning aspects of specialised care and what happens to children after it has been confirmed that an offence has been committed.

The aim of this study has been to throw some light on the issues faced by professionals from different disciplines who work together in the field of child sexual abuse. Sadly the problems perceived at the start of the study and which provided the impetus for exploration into the field seem hardly to have lessened despite the attention focussed upon them during the last four years. It is clear from this study, from the literature and media, that the diversity of experience, opinion, attitude and background among professionals and society in general is very great. It would be unrealistic to expect that a greater understanding of each others' perspective will lead to everyone thinking in unison. Indeed, this would be a stultifying outcome. It is hoped instead that what understanding this study may have generated will increase respect for those who undertake this necessary and valuable work and be put to creative use in the general debate about the subject, so that we can learn to value each others' strengths and complement each others' weaknesses and in so doing care more effectively for the children and families involved in this immensely distressing social problem.

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Appendix i **CHRONOLOGY**

taken from Community Care 11.4.91, p.15

ORKNEY

November 1990: South Ronaldsay, Orkney. Eight children from one family taken from into care on mainland on place of safety orders.

January 1991: residential care orders confirmed on eight children to remain on mainland. Evidence of penetrative abuse on at least one young child.

27 February: social work and police operation removes nine children from four families into care on mainland on place of safety orders. Families claim police remove variety of items from homes: cloaks, graduate hoods, shepherds crook, book with goat on cover, crucifix, family photos' videos.

5 March: Orkney children's panel extends place of safety orders for 21 days. Allegations that say each child 'fell into bad associations and exposed to moral danger' and that 'lewd and libidinous practices had been committed in respect of him or a member of the same household'. Allegations of sexual intercourse or simulated intercourse, with 'the use of ritualistic music, dance and

dress'. Basis believed to be statements to police by children in care since November 1990.

6 March: parents' lawyer fails in appeal against legal grounds for hearing decision.

15 March: Parents Against Injustice issue detailed claims that Orkney SWD did not properly follow child abuse procedures and guidelines.

17 March: some newspapers claim that evangelicals in Orkney may have influenced at least one Orkney social worker.

25 March: Orkney children's panel extends nine place of safety orders for a further 21 days.

4 April: Sheriff David Kelbie dismisses case because 'proceedings fundamentally flawed'; recommends children return to parents; accuses social workers of 'coaching' children in interviews and children's panel of at least seven breaches of social work law.

LIVERPOOL

In Liverpool the police arrested 17 adults following a seven month investigation in to ritual abuse allegations but they were later released. Knowsley SSD still has five children in care.

NOTTINGHAM

October 1987: Children of an extended family removed from their homes on suspicion of sexual abuse by relatives. February 1989: ten adults charged and prosecuted for gross sexual abuse of 23 children.

August 1988: police set up a separate investigation into the revelations. Social services staff not included. Police deny ritual abuse, witchcraft or any other perpetrators involved.

July 1989: joint inquiry team established and presents detailed report in late December 1989. Joint team concludes: no evidence of Satanic abuse in Broxtowe, no evidence of any other organised abuse, no evidence of ritual abuse in satellite cases.

White and chief constable accept main recommendations including that techniques for listening to children be reviewed.

White says: 'I find it difficult to believe that staff and foster parents could have imprinted the stories in their minds'. Team 4 believe there are further 17 cases involving 29 children.

MANCHESTER

September 1989: social services begin investigation following a pediatrician's referral. NSPCC disclosure work suggests 13 children from one family were 'Satanically abused'.

17 December: Mr Justice Hollings rules five children should be in care, but remaining eight should not. Accuses social workers obsession with satanic child abuse. Manchester reviews child protection procedures after SSI visit.

ROCHDALE

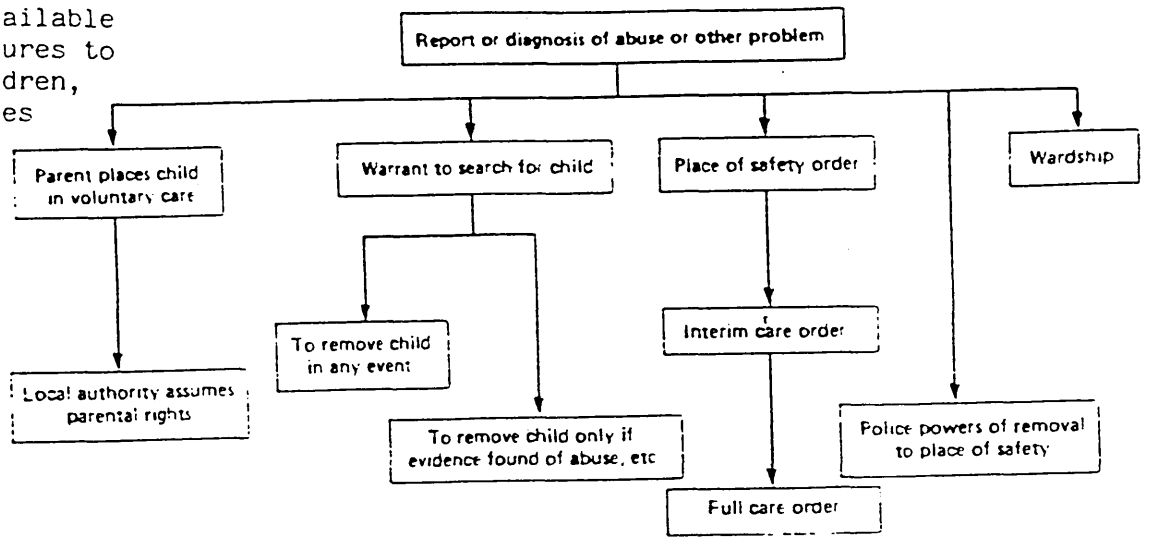
29 March 1990: four children taken into care from one family on Langley council estate. 13 more children taken in June.

March 1991: Mr Justice Brown orders ten children to be returned to parents. Four children stay in care. SSI report, October 1990, criticises social workers for not following Cleveland guidelines.

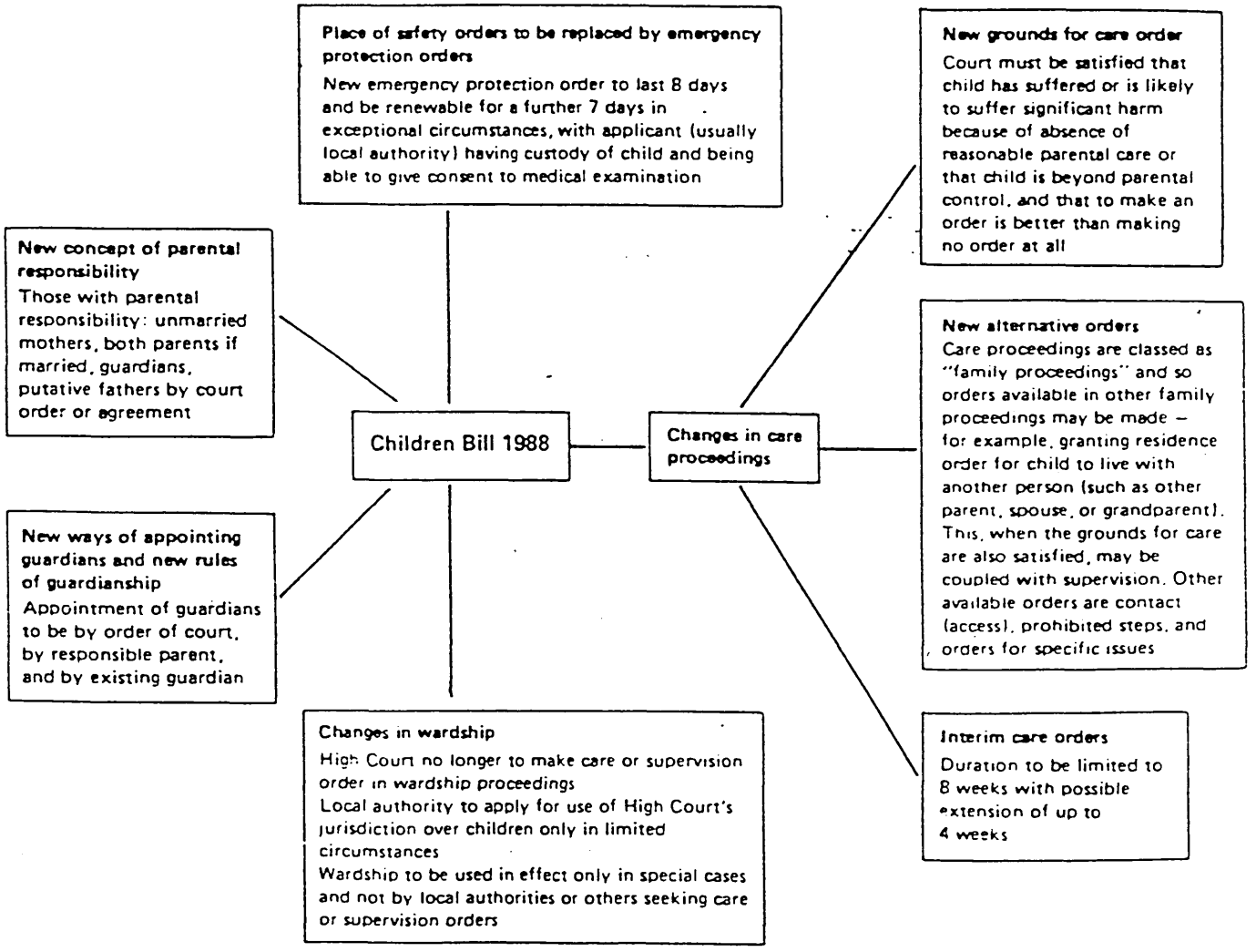
After 47 day hearing Mr Justice Douglas Brown says social workers involved were obsessed with their own belief that ritual abuses were being described. Among the catalogue of errors: leading

questions asked; interviewing techniques used resulted in exaggeration and fabrication.

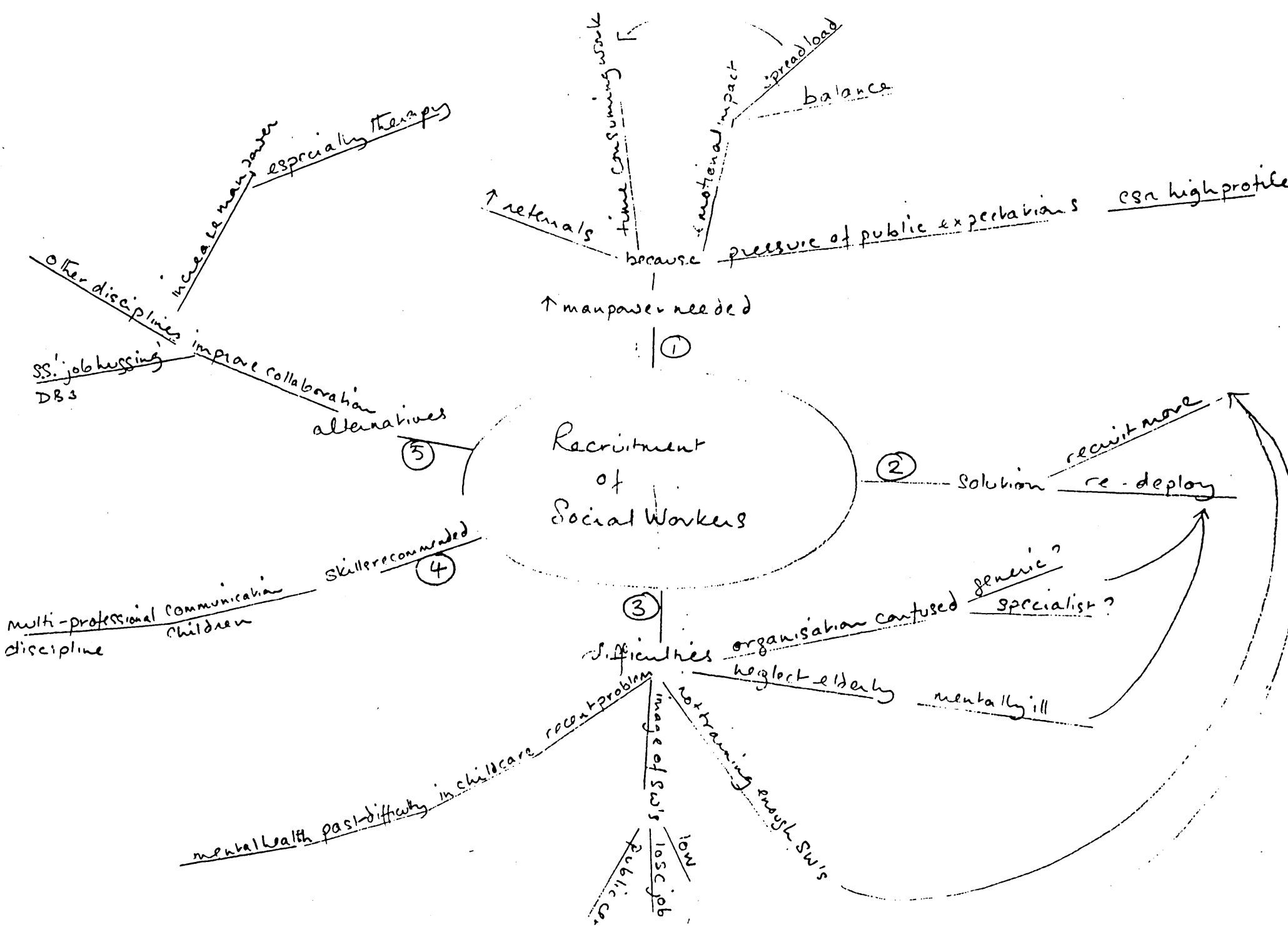
Currently available legal procedures to protect children, with sequences of action



Changes in child care law



Some of the proposed changes in child care legislation: Children Bill 1988


↑ referrals
time consuming work
emotional impact
spread load
balance
because
pressure of public expectations
CSA high profile
↑ manpower needed
1
other disciplines
increase manpower
especially therapy
SS' job hussing
DBS
improve collaboration
alternatives
3
Recruitment of Social Workers
2
solution
recruit more
re-deploy
skills recommended
4
multi-professional communication
discipline
children
3
difficulties
organisation confused
generic?
specialist?
neglect elderly
mentally ill
mental health past difficulty in childcare recent problem
image of SW's
low
job satisfaction
public
no training enough SW's

Appendix iv

DIFFERENCES OF PERCEPTION OF SOCIAL WORKERS AND POLICE IN RELATION TO JOINT INVESTIGATION

Some Social Workers' Views of Police Practice

1) Availability

* There are delays before police respond to a referral
* The "right" officer in not always available ("right" meaning a Police Officer known and worked with well in the past)
* The Officer is frequently diverted from the case to cases perceived as more important by their managers.

2) Competence

Police are not qualified to interview young children.

3) General Perspective

Police see things in black and white.

4) Stance in relation to the child

Police Officers don't believe the child, or think they are exaggerating.

5) Management Support

Police lack support from their managers to help cope with the emotional stress of the work.

Some Police Views on Social Work Practice

1) Availability

Social workers are not always available to conduct an interview (in one area where cutbacks have been particularly severe).

2) Competence

Social workers don't interview so well. Police are better trained. We know better how to phrase things, what the legal profession requires. We have had more experience in investigatory work, interviewed more often.

3) General Perspective

Social workers are not so practical - you need a lot of common sense.

4) Stance in relation to the child

Social workers always believe the child.

5) Management Support

No opinion was offered by the police respondents concerning social work support compared with their own. A WPC had a low opinion of their own provision. On the other hand she qualified this by suggesting that the police perhaps did not have as great a need for support as social workers whose responsibilities continued after the investigatroy stage. One social worker involved in running joint training programmes, when asked

where she received most of her support, said from her police colleagues. A health visitor when she heard this said:

> "I'm not surprised - the police are more fatalistic - they accept people as they are - not like social workers looking for causes and wanting to change things".

This mixture of views in no way relfects what all respondents of these disciplines felt about all members of each other's profession. Many stressed that what it came down to was individual personalities:

"There are good and bad police officers, good and bad social workers".

Appendix v

KNOWLEDGE BASE, SKILLS AND QUALITIES RECOMMENDED IN RELATION TO JOINT INVESTIGATION

Knowledge Base

* Specific knowledge concerning child sexual abuse including the range of offences under the definition of child sexual abuse, the possible behavioural, psychological and emotional indicators, the dynamics of child sexual abuse including an understanding of the issues of threat and power involved in sexual abuse.

* Knowledge of the law relating to child sexual abuse including what questions are admissable by the legal profession, what types of offence there are and their implications for child and perpetrator.

* Knowledge of normal child development though not necessarily to the extent of an "expert" assessor. Sufficient to estimate the child's current stage of development, how best to elicit information from children at different stages and how to interpret that information in the light of the estimated stage of development.

Skills

* The ability to communciate with children. This skill respondents found difficult to describe in detail. Some said it was not being patronising, others said it was the ability to come down to the age of the child, to be sensitive to the different

and preferred ways in which they might communicate through play. To discover and use the words the child uses for parts and functions of the body without embarrassment.

* The ability to go at the child's pace and if that means he/she withdraws, to accept that and not to pressurise.

* To recognise and accept that if the child does not like you to get out and let someone else take over.

* To recognise and accept the complexity of every aspect of child sexual abuse.

* The ability to work jointly; to feel comfortable about your own role, authority and power, and to be able to communicate with other workers.

Qualities

* Above all to care and be committed to bring about what is best for the child.

* Sensitivity needed for all the above skills to operate.

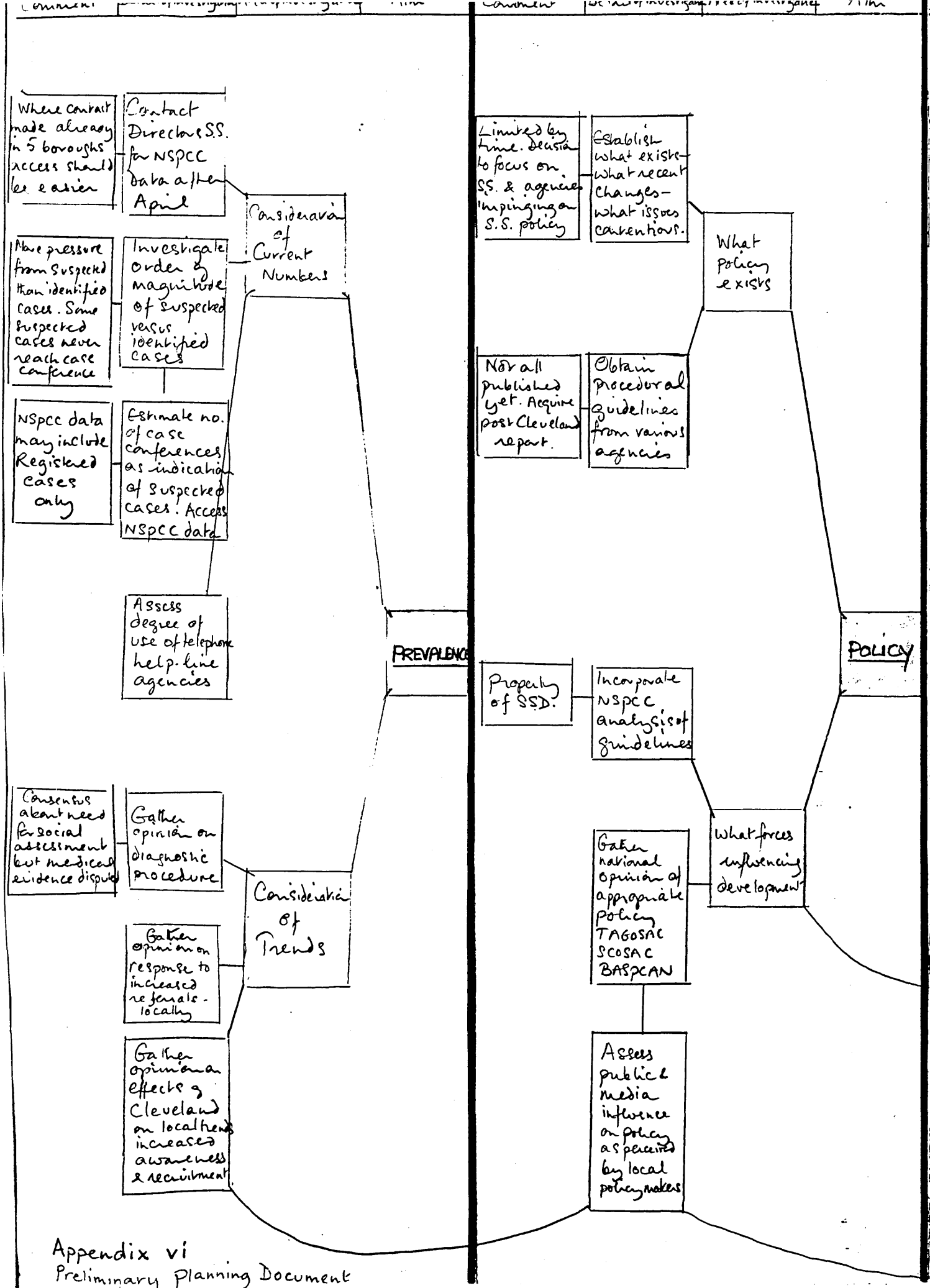
* Patience, particularly to avoid pressurizing or bullying the child for information - a temptation espeically if the child appears close to disclosing. An experienced voluntary worker used as an advisor to the police said that investigators who try to bully children to get at the truth will only encourage them to withdraw.

She also advised that they should not correct children as that would increase guilt feelings.

* Common sense. A WPC described this by saying "You have to be a bit of an actor and put over that you believe all they say, but at the back of your mind you must be award they could be lying".

* The ability to act might also be helpful in the following bit of advice which is part skill and perhaps part quality - being unshockable. However horrifying and distressing the information offered investigators should not show anxiety or register disgust on their faces or by their manner. This would increase feelings of guilt and cause the child to withdraw. They frequently test out their interviewers to see if they can 'take' what they have to say. This raises the question what should an interviewer register on his/her face? Presumably not total impassiveness as this hardly validates what the child is trying to express. It would seem that the quality of sensitivity will help guide the response in each individual case and the last quality mentioned which to some was most important, will largely dictate non-verbal responses.

* "You have to like kids, to have sympathy for the victim". (WPC) "You have to be able to <u>show</u> that sympathy, to show you care by the sound of your voice and by treating the child as special". (A hospital social worker).



Appendix vi
Preliminary Planning Document