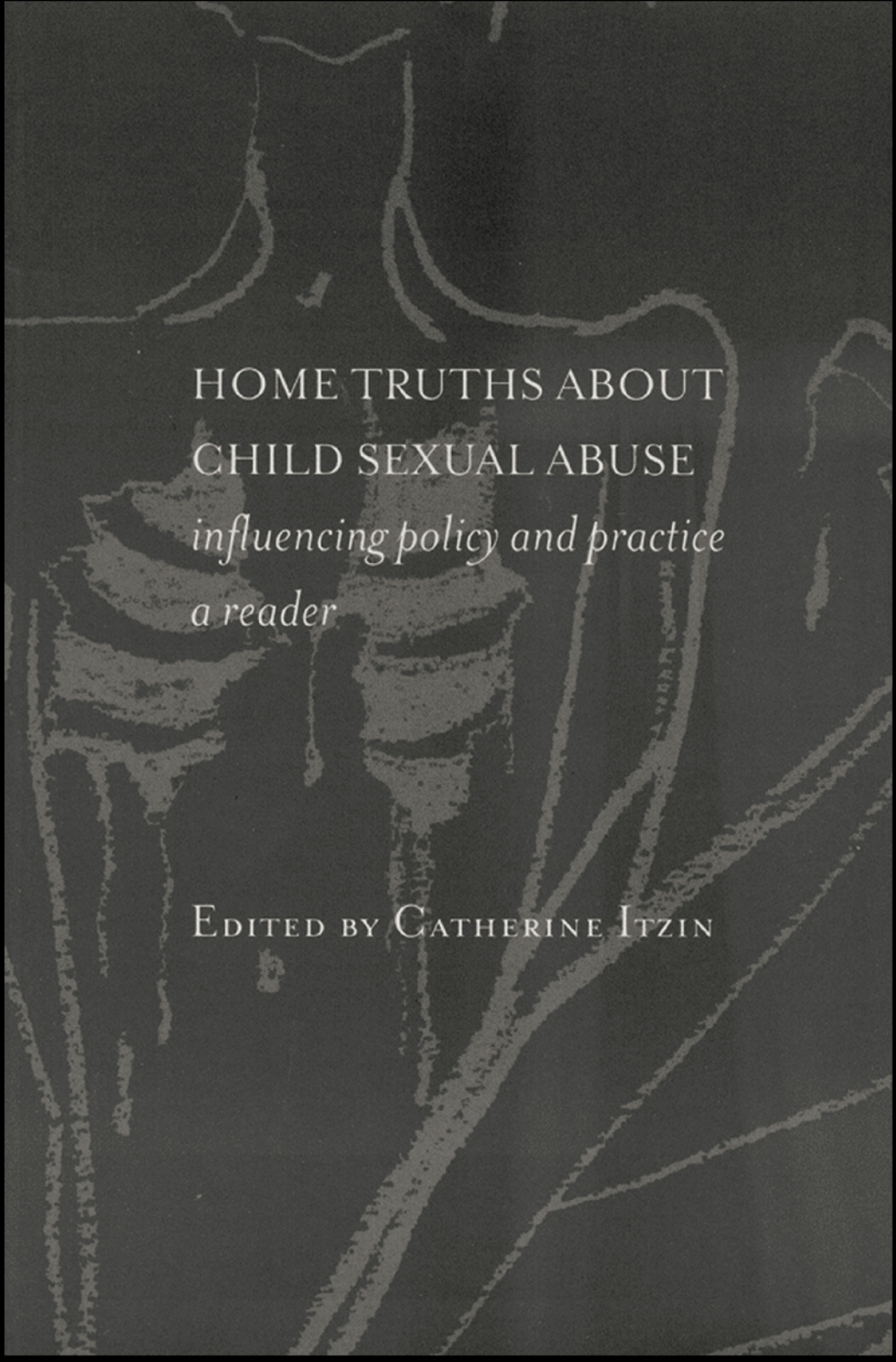

Home Truths About Child Sexual Abuse

Home Truths About Child Sexual Abuse brings together the findings of research and clinical work by leading figures in the UK and USA. It makes visible the prevalence of sexual abuse and exploitation of children by normal, ordinary, heterosexual family men, both within and outside the family. Comprehensive and multidisciplinary in approach, it covers the many different aspects of child sexual abuse including:

- phenomenology
- definitions and terminology
- epidemiology
- explanatory frameworks
- concepts and theory
- the contribution of radical feminism
- constructs, classifications and typologies
- policy
- treatments
- multi-disciplinary and multi-agency work
- medical evidence
- gender and epistemology
- criminal justice issues.

Home Truths About Child Sexual Abuse provides the evidence and knowledge base necessary to begin to achieve effective prevention. It offers professionals, researchers and policy makers an invaluable source of reference and an informed basis for action.

Catherine Itzin is Research Professor in Social Work and Social Policy and Co-Director of the International Centre for the Study of Violence and Abuse, University of Sunderland.

Home Truths About Child Sexual Abuse

Influencing policy and practice
A reader

Edited by Catherine Itzin

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For these many children
From JA with thanks
A gift
For my beloved husband

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Chapters

Children and the Media', *Psychiatric Bulletin* 21: 371–2; and S. Bailey (1993) 'Fast Forward to Violence', *Criminal Justice Matters* pp. 6–7.

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Figures

Figure 15.1, 'Causal factors contributing to child sexual abuse', pp. 299–300, is taken from M. O'Brien and W. Bera (1986) 'Adolescent Sexual Offenders: A Descriptive Typology', *Preventing Sexual Abuse* (1)3. Copyright © John Wiley and Sons Ltd. Reprinted with permission.

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Introduction

Every paper in this edited volume is here for one purpose only: that is, for what it contributes to the objective of child protection and child sexual abuse prevention conceptualised as 'stopping abusers abusing'. With that in mind it brings together material from many different sources and people from the UK and USA, most of whose paths would be unlikely to cross except in the pages of this book, but whose work contains insights or knowledge that, joined together, covers what needs to be known in order to prevent the sexual abuse of children.

Contributors to this book represent a wide range of professional and academic disciplines. Professions include: paediatric medicine (Marietta Higgs and Geoffrey Wyatt), social work (Hilary Eldridge, Tony Morrison, Bobbie Print, Sue Richardson and Sara Swann), probation (Ray Wyre), child and adolescent forensic psychiatry (Susan Bailey), clinical psychology (Heather Bacon) and psychotherapy (Alice Miller and Joan Woodward). Academic disciplines include sociology (Sheila Burton, Liz Kelly, Sarah Nelson, Linda Regan and Diana E. H. Russell), social work (Rebecca Bolen and Maria Scannapieco) and social policy (Elaine Farmer, Morag Owen and myself). Louise Armstrong is an independent scholar and author.

The research team which produced the paper on 'Risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys' in chapter twelve also includes a range of professional and academic disciplines. These are behavioural sciences (David Skuse), child psychiatry (Arnon Bentovim), child psychotherapy (Jill Hodges, Chriso Andreou and Monica Lanyado), clinical pscyhology (Michelle New) and research psychology (Jim Stevenson, Bryn Williams and Dean McMillan). Information about the contributors' institutional and organisational affiliations can be found on pages xii to xviii.

I call this book 'a reader'. Reflecting this there is considerable diversity of source and genre, style and length. The material also differs in nature and kind, from a chapter consisting of drawings with captions, to tape recorded interviews edited into narratives, together with scientific papers reporting findings from research, and analytical and theoretical papers involving the re-analysis of data from qualitative and quantitative research studies, and the extrapolation of policy implications from clinical work. Some chapters are original to the book.

Others are straightforward reprints of material previously published elsewhere. In some cases, contributors have constructed their contributions from the contents of a number of their previous publications, drawing together relevant themes and issues from a body of existing work for the purposes of this book.

Each chapter has its own intrinsic coherence and integrity, and I think readers will find each one interesting in its own right. At the same time, each chapter is part of a larger picture, which taken as a whole, provides what I hope will be, for many people, a new perspective on child protection and child sexual abuse prevention. The material in each chapter has been published with this purpose in mind. In the first and last chapters I have drafted a commentary developing an analysis which draws from and builds on the material in each chapter, using it epistemologically: that is, in the construction of knowledge from what is empirically evidenced and already conceptualised and theorised in different fields and disciplines, and the practice of various professions. This analysis draws in particular from the phenomenology of victim/survivor and perpetrator experience, and the ethnography of clinical work as well as from the findings of research.

The book is structured in two parts: Part One headed 'Child sexual abuse and exploitation' and Part Two on 'Interventions'. Part One includes four sections. The first, on 'Adolescent and adult male child rapists by many other names', considers the connections between incest, paedophilia, pornography and prostitution and looks behind the language, the categories, the typologies and classifications to see who is doing what to whom. The second section, on 'The victim experience of child sexual abuse and its effects', is precisely that: described by three women in their own words and pictures, together with a twelve-point analytical framework provided by Alice Miller specifically for inclusion in this book, synthesising the core messages of her work on the shattering effects of child abuse. The third section, on the 'Nature and extent of child sexual abuse,' features a chapter written specifically for this book, based on two new meta-analyses of all the major representative sample child sexual abuse prevalence studies over the past twenty-two years. The fourth section, on 'Contributing and causal factors', brings together current findings from research in progress by leading figures in the child abuse field in the UK working with adolescent male perpetrators of child sexual abuse.

In Part Two on 'Interventions' there are two sections: the first on the 'Treatment of victims and abusers', and the second on 'Child protection policy'. The treatment section includes five chapters commissioned from professionals whose work has been, in different ways, at the leading edge of developing effective practice of working with sexually abused children and the adolescent and adult males who abuse them. Their work is based on understanding the complexities of the inner world of child sexual abuse victims and perpetrators, and using that knowledge for the purposes of harm minimisation and harm prevention. The three chapters in the child protection policy section are included for the radical perspective they bring to controversial aspects of child protection policy in the context of the issues and focus of this book, and in

particular to: first, gender bias in the child protection process; second, the status of the medical evidence of child sexual abuse 'post-Cleveland'; and third, the systemic failure of child protection policy to protect children from sexual abuse.

From the mosaic of this material emerges a picture which makes it possible to see men as primarily the sexual abusers of their own and other people's children in the wider context of men's physical and sexual violence and abuse of women and children. In particular it is ordinary heterosexual family men who become visible as the perpetrators of both intrafamilial and extrafamilial child sexual abuse and child sexual exploitation. This focus on child sexual abuse as something that primarily men do – because they want to, because they can, and because largely they can get away with it – provides a perspective on child sexual abuse prevention as being something that men do that men have to stop doing: that is, it's a 'men-thing' (notwithstanding the small minority of women who do it too, an important issue I address in chapters one and twenty-three, helpfully, I hope). Moreover, not only is it something that men do that men have to stop doing, the men who don't have to stop the men who do.

I owe a debt to the rigour of radical feminism as an intellectual discipline and to its analytical and epistemological power. I will be curious to see, from how this book is received, whether it is possible yet for 'society' and its 'powers that be' – in government, in the policy making of the civil service, in the professions and their associations – to accept the fact that this 'men-thing' is not a 'feminist anti-men-thing', but a problem evidenced unequivocally, both empirically and analytically; and to recognise it as a problem that has to be addressed and resolved if child sexual abuse is to be ended.

Catherine Itzin
January 2000

1 Child sexual abuse and the radical feminist endeavour

An overview

Catherine Itzin

Introduction

In this chapter, I introduce some of the key themes in this book, drawing on the work of contributors. The first is to question the utility, in terms of reducing the incidence and prevalence of child sexual abuse, of the vast volume of academic and professional work on the subject produced since 1978 (when feminist scholarship started to identify incest as a major social problem), and to question the efficacy – in the radical feminist terms of 'stopping abusers abusing' – of current policy on child protection and child sexual abuse prevention. I use the findings of official inquiries into child abuse in the UK, and in particular the *Report of the Inquiry into Child Abuse in Cleveland in 1987*, to illustrate the size of the problem, and the lack of impact inquiries have had on solving it. I discuss the usefulness of 'cycle of violence' theory in explaining the aetiology of child sexual abuse and focus on feminist concerns about the way it is being used against the interests of sexually abused children and their non-abusing or protective mothers. This leads on to looking at the impact of gender-neutral language on what is seen, known and done about child protection and child sexual abuse prevention, and in particular, how it makes men invisible as primarily the sexual abusers of children and protects their sexual access to children.

The incest industry

There is a huge academic and professional interest in the issue of child sexual abuse. This is represented graphically in Bagley and Thurston's two-volume compilation of critical summaries of 500 key studies on the subject of *Understanding and Preventing Child Sexual Abus*e published in 1996. Volume one covered *Children, Assessment, Social Work, Clinical Issues, and Prevention Education*; volume two *Male Victims, Adolescents, Adult Outcomes and Offender Treatment*. It included a subject index of 153 headings; it was based on a literature review of '3000 journal articles, reports, book chapters and monographs'; and this was 'many more articles, book chapters and books on child sexual abuse' than the authors selected as being 'directly relevant to the issues of prevention' (Bagley and Thurston 1996: 2). Bagley observed that 'virtually no important studies on CSA

existed prior to 1978' (ibid.: 2) and 'by 1995 there had been a huge explosion of articles' (ibid.: 10). A survey of books on child sexual abuse being advertised by publishers in the UK in the spring of 1999 found 175 titles of books solely or primarily on child sexual abuse and a further 123 titles related to child sexual abuse. This did not include journal articles.

It would not be inaccurate, I don't think, to say that child sexual abuse has become very big business: for academics, for publishing, for mental health (treatment and recovery) services, and, in the USA, big media (talk show) business. It pays a lot of mortgages and makes careers for many people. The single most important issue, however, must be whether this immense industry has had any impact on reducing the incidence and prevalence of child sexual abuse. There is no evidence that I can find that it has done, and there is evidence to suggest that it probably has not. Research studies from the 1970s to the 1990s, based on community samples, consistently identify prevalence rates of 5 per cent to 10 per cent for men and at least 20 per cent for women (Finkelhor 1994a). These are at the lower end of the range of findings and they are regarded by most experts in the field as under-estimates (Watkins and Bentovim 1992).

Bolen and Scannapieco (1999) have identified, in a 'corrective metanalysis' of all relevant studies, a prevalence of at least 30 per cent and more likely 40 per cent for women and 13 per cent for men (Bolen, Russell and Scannapieco, chapter ten; Itzin chapter twenty-one). Utting cites Home Office statistics on the trend in relation to offences of gross indecency with children under fourteen which showed that recorded offences doubled between 1985 and 1995 from 633 to 1,287, but that there was a four fold decrease in convictions from 266 in 1985 (a rate of 42 per cent) to 155 convictions in 1995 (a rate of just 12 per cent) (Utting 1997: 190). Most child sexual abuse is not reported: of that which is, only a very small proportion is prosecuted; and only a small proportion of the prosecutions result in convictions (Finkelhor 1994a; Siddall 1997).

If there is no evidence that this huge explosion of work has had any impact on reducing the incidence and prevalence of child sexual abuse, then what, we should be asking, is its purpose? This book aims to develop some understanding of why all of this activity associated with child sexual abuse may have failed to impact on its frequency of occurrence and to consider what, in the form of public policy and professional practice, might be done about it. In the context of the voluminous literature, it has been important to consider whether there was anything in the form of another academic book which might actually contribute to bringing to an end the sexual abuse of children. I feel it is ethically uncertain to continue appropriating the pain of childhood sexual abuse unless there is some likelihood of it not only benefiting the already victimised, but also contributing meaningfully to the prevention of further abuse. I think the material collected in this book may have some potential to do so, because it draws from and builds very significantly on the already very substantial influence of feminism on what is known and done about child sexual abuse, and its focus is the radical feminist objective conceptualised as 'stopping abusers abusing' (Kelly, Regan and Burton 1991; Nelson chapter twenty).

It was in 1978, precisely the year prior to which Bagley and Thurston found 'virtually no important studies on CSA,' that *Kiss Daddy Goodnight*, Louise Armstrong's early and now classic feminist text on incest was first published. In chapter two of this book she describes how it was 'second wave' feminism, in the form of women's movement activism and the scholarship of feminist academics in the 1970s and 1980s such as Rush (1980) and Russell (1983, 1986) which uncovered incest as 'a widespread, universally permitted' practice. Kelly, Regan and Burton (chapter four) describe how this combined with advocacy by and on behalf of survivors – the 'courageous and passionate testimony of countless women' – to 'make child sexual abuse a mainstream social issue.'

In that tradition, one of the purposes of this book is to use scholarship in the service of those who are silenced, to give those who have been victimised a voice in the academic and professional discourses about them, and an opportunity through the forum of academic publication to influence public policy and professional practice relating to child sexual abuse. In this case, it is not just the child victims and adult survivors – represented in this book by 'Rachel Pearce' (chapter six), 'Alice Edwards' (chapter seven), and 'Nancy E' (1988, and chapter eight) – who have been silenced. It is also often professionals working with and advocating for them. They are represented in this book by Geoffrey Wyatt and Marietta Higgs (1991, and chapter nineteen, this volume), the paediatricians whose diagnoses of child sexual abuse at Middlesbrough Hospital precipitated the 'crisis' in Cleveland (in the north-east of England) in 1987; and also by Heather Bacon, the health service child psychologist, and Sue Richardson, the child abuse consultant employed by the local authority social services department to work with child abuse at that time in Cleveland (Bacon and Richardson 1991, and chapter thirteen, this volume).

Armstrong describes in chapter two how, by the mid-1980s in the USA, she was 'witnessing the birth of an incest industry' with a 'staggering array of clinicians and counsellors and therapists and researchers and authorities and experts, all with their careers sighted on one aspect or another of incest and its aftermath'. She thinks that this has ironically had the effect of normalising child sexual abuse and describes incest as 'what ordinary men do routinely and regularly in their own homes as a matter of right'. In the USA, she argues, there were too many men found to be doing it to criminalise them, so instead it was 'medicalised' and 'professionalised' and the concept of 'incest families' was constructed as a societal cover-up for what she describes as the 'dreadful actuality of paternal child rape'. Armstrong thinks incest as a feminist issue has 'all but disappeared' and she asks:

> How, in just two decades, did we go from total silence – from what was said to be a 'dread taboo' – from enforced secrecy, the suppression of children's experiences, women's experiences, such that they were not even heard – to a level of cacophony such that children's voices, women's voices, are once more not, in any purposeful sense, being heard?
>
> (Armstrong chapter two)

She concludes that all this 'noise has effectively functioned to silence victims, leaving men to continue committing incest with impunity'. One purpose of this book is to make these men visible as primarily the sexual abusers of children: and to see them not just as 'sickos' and 'weirdos' (Russell 1997), but as ordinary men from all walks of life, and in particular the middle class men whom Nelson writes about in chapter twenty, and the 'nice men' as Wyre (chapter three) describes how many of the 'paedophiles' with whom he has worked are perceived.[1]

The radical feminist endeavour

The subject of the radical feminist endeavour is male power, and men's violence and sexual abuse of children. Foremost, therefore, the purpose of this book is to bring into focus men as primarily the sexual abusers of their own and other people's children, and in particular the overlap between intrafamilial and extrafamilial child sexual abuse and child sexual exploitation. there is evidence in this book to suggest that, notwithstanding how otherwise systemically sound, intelligent and well intentioned it may be, child protection policy and professional practice will fail ultimately, inevitably to stop abusers abusing, unless it addresses the sexual abuse of children as an issue of men's violence: the fact that it is predominantly men who are the perpetrators of domestic violence and sexual violence; that it is largely males who are the child sexual abusers; that it is a 'menthing' and needs to be dealt with as what men do, and what men therefore have to stop doing.

Research findings support the view that there is a high level of sexual interest in children amongst normal, ordinary heterosexual young men. Briere and Runtz found, in a sample of 193 USA undergraduate male students, a significant minority – 7 per cent – who 'indicated some likelihood of having sex with a child if they could avoid detection and punishment'. The authors concluded that between 5 per cent and 20 per cent of this sample were 'paedophiles' depending on the definition used (Briere and Runtz 1989: 71). Russell (1988, 1992, 1993) cites research which shows that 10–15 per cent of ordinary young adult males report they would sexually abuse a child if they thought they could get away with it. Williams and Finkelhor found, in a sample of 116 fathers specifically selected to meet the criterion of not having sexually abused their children (as a matched control group in a study of 118 incestuous fathers who had), that 11 per cent of these non-abusing fathers nevertheless 'reported experiencing . . . sexual arousal to, or interest in their daughter' (Williams and Finkelhor 1995: 110).

Armstrong's notion – with respect to incest – of normalising what normal men do is also illustrated in the wider context of child sexual exploitation by the local businessman in Bradford described by Swann (chapter fourteen), found by the police in his car with his pants down and his penis in the mouth of a thirteen-year-old girl, who for a few pounds was 'masturbating him orally': this being regarded by the 'punter' and the police alike as 'prostitution', not even 'child prostitution', and most definitely not 'child sexual abuse'. Law which responds to child prostitution as a criminal justice system rather than a child protection issue,

which criminalises the children (and women) who 'sell sex' rather than the men who buy it, contributes materially to protecting ordinary heterosexual family men's sexual access not just to their own children (incest), but to other people's (in child prostitution and child pornography).[2]

This book aims to make, and to try to keep, visible this maintaining of men's sexual access to children as essential to the formulation of an effective public policy response to child sexual abuse (see also MacLeod and Saraga 1988). The radical feminist contribution to child protection is the identification of child sexual abuse as being what ordinary men want and what ordinary men do. What this book does, I hope, is to make it clear that this is nothing to do with a 'feminist anti-men thing', but a fact for which there is a substantial body of empirical evidence. This is what men do because they want to; because they can; and because, largely, they can get away with it.

The findings of official inquiries

This is evidenced in the UK in the findings of a long history of official inquiries, reviews and inspections of the sexual (and physical) abuse of children in children's homes (Department of Health 1991; Levy and Kahan 1991; Kirkwood 1993; Calouste Gulbenkien Foundation 1995; NSPCC 1996). There is no evidence that, as a result of these investigations over the past decade and more, child sexual abuse and exploitation by nonfamilial or extrafamilial males has diminished. On the contrary. Both the Utting *Review of the Safeguards for Children Living Away from Home* (1997) and the North Wales Child Abuse Tribunal Inquiry (into 250 allegations of abuse against 148 care workers in thirty-nine of the eighty-two children's homes in North Wales over a period of twenty years) were taking place during the period of researching this book (Davies 1997a, 1997b). Furthermore, during the period of the North Wales Inquiry , it was reported that major new 'additional investigations were launched by South Wales police into 250 allegations of physical and sexual abuse in thirty-three residential childcare homes, bringing the total number of children's homes in Wales that were being investigated for abuse to 101 and the number of allegations of abuse to 900' (Dobson 1997). In February 1998 it was reported that 'thirteen police forces were currently checking allegations of sexual abuse of children in care in Britain' (Dobson 1998).

Clearly, child sexual abuse by nonfamilial males is not a problem that has been solved. The truth is that there is evidence continually, week by week in the national press and in the social services professional journal *Community Care*, of 'paedophiles' locating themselves in key organisational and institutional positions to protect their own and other men's sexual access to children (Nelson chapter twenty). Moreover, the children who have been the subject of most of these inquiries and reviews – those subject to extrafamilial abuse in the care or protection of local authorities – represent a very important, but none the less only a small proportion of the total number of children who are sexually abused in childhood. Only one of the major inquiries in the last dozen years was concerned with intrafamilial child sexual abuse: this was the *Inquiry into Child Abuse in Cleveland in 1987*.

In the autumn of 1997, I attended a conference entitled 'Cleveland Ten Years On' which included papers presented by the paediatricians Geoffrey Wyatt and Marietta Higgs, the child psychologist Heather Bacon and the social worker Sue Richardson about their part in what happened in Cleveland. There was also a presentation by Beatrix Campbell who has campaigned without surcease as author and journalist about what she calls the *Unofficial Secrets*, the title of her book published in 1988 (revised in 1997), and the 'official cover-up' by the Cleveland Inquiry of the child sexual abuse that was uncovered by the paediatricians and their medical diagnoses, and by the child psychologist working with the diagnosed children and their disclosures of abuse.

All of these professionals were demonised and monsterised in the public mind (including mine) by the media during and in the aftermath of the 'crisis' in Cleveland in 1987, and they had been discredited by the public inquiry. I wanted, therefore, to see them as well as to hear them present their papers in order to form my own view. I think most observers would have found them modest (not 'monsters', not 'ideologically motivated'), impeccably professional and dedicated to the care of children, and what they had to say seemed sound in every respect. It is published here (in chapters thirteen and nineteen) so that readers can judge for themselves the merits of the doctors' diagnoses and the diagnosed children's disclosures which became subject to dispute about what constitutes medical evidence and children's evidence of sexual abuse.

Publication here also provides an opportunity to consider these accounts of the evidence of child sexual abuse in Cleveland in the context of the 'opinion' provided by Ralph Underwager, a consulting psychologist from the USA who was produced as an 'expert witness' by the Director of PAIN (Parents Against Injustice), an organisation which came forward to support the Cleveland parents who claimed to be 'falsely accused' (Butler-Sloss 1988: 162; La Fontaine 1990: 11). Underwager's 'expert opinion' can best be judged by the fact that he went on from Cleveland to become a founder member in the USA of the False Memory Syndrome Foundation, set up to propagate the view that children's and adult survivors' memories of sexual abuse are *inter alia* false and cannot be relied upon as evidence of sexual abuse having occurred: and by the interview he gave in 1991 to a quasi-academic journal published in the Netherlands called *Paidika: The Journal of Paedophilia*, claiming his belief that 'paedophilia is something good' and that 'paedophiles should boldly and courageously affirm what they choose'. PAIN continues to promote the work of Underwager by including his books in their literature list and disseminating material from his books amongst PAIN publications.

The 'Cleveland Ten Years On' conference also included presentations by survivors. A mother spoke, and her daughter, now a young adult and mother herself, with a story to tell of sexual abuse by her father (not unlike that of 'Rachel Pearce' in chapter six), except the mother in this case did not collude in her husband's abuse, but rather was 'groomed' by him, in the ways described by Wyre (chapter three) and Eldridge (chapter sixteen) to keep her in ignorance. Another mother spoke whose husband, and the father of their three sons, was convicted of child sexual abuse, served an eighteen-month prison sentence, and

subsequently committed suicide. This mother – also ignorant at the time of the abuse – mourned the loss of her husband as she grieved the abuse of her children: he needed help she said, but he didn't get any. In this book (chapters fifteen, sixteen and seventeen) are examples of the kind of help that might have saved this man's life and stopped him abusing. There was much pain in the stories told by these three women and in the lives of their children.

If there was, as Campbell (1997) argues, a 'cover up' of child sexual abuse in Cleveland, what was covered up was largely if not entirely intrafamilial (that is, incestuous) child sexual abuse. We know this because it was described as such unequivocally in the Cleveland Inquiry Report:

1 'The Inquiry was provided with evidence about Cleveland children primarily in respect of allegations of the most serious offences of incest, unlawful sexual intercourse and buggery of girls and buggery of boys and indecent assault, almost all within the family, including digital penetration, fondling, mutual masturbation, anal and oral/genital contact' (Butler-Sloss 1988: 6, para. 12); and
2 'There were examples in Cleveland of abuse by father, stepfather, [mother's] boyfriend, uncle, cousin, elder brother, babysitter and neighbour' (Butler-Sloss 1988: 7, para. 24).

One of the casualties in the UK of the 'crisis' in Cleveland in 1987, has been the status of the medical evidence of child sexual abuse, discredited through the processes of discrediting the paediatricians (see chapter nineteen). The other casualty of Cleveland has been the development of policy which appears to be child-centred, but which has – paradoxically – had a silencing affect on children and contributed materially to the protection of abusers rather than children.

How this has occurred can be seen first in guidance published by the Royal College of Physicians (1997: 2) 'stressing that a clear statement by the child is the single most important factor in making a diagnosis of sexual abuse'. Second, it can be seen in the guidance and protocols for police and social services on producing court-reliable evidence for criminal proceedings through the use of video recorded interviews, called the *Memorandum of Good Practice on Video Interviewing of Child Witnesses* (Department of Health 1992). Chapter thirteen by Bacon and Richardson, based on their work with children caught up in the 'crisis' in Cleveland, makes clear the limited capacity of many, perhaps most, sexually abused children to make any clear statement at all, least of all a disclosure that can be recorded in thirty minutes to a legal standard sufficient to support a successful prosecution.

The centrality of the role of paediatricians and the medical examination to the process of collecting evidence for civil and criminal prosecution; to taking protective measures; and to addressing the abused child's physical and mental health needs following abuse is evidenced by the findings of a study conducted at the Children's Assessment Center in Grand Rapids Michigan. Palusci *et al.* found,

in a sample of 497 children, that 'those with a positive examination finding were 2.5 times more likely to result in a criminal prosecution with a finding of perpetrator guilt [and that] disclosure of child sexual abuse during medical assessment was significantly associated with a positive physical examination finding' (Palusci *et al. 1999:* 388). The authors of this study concluded that:

> By relating legal outcomes to the medical evaluation of CSA, our study highlights the importance of the medical assessment in the overall community response beyond meeting the medical needs of the child. A medical assessment is more than just a physical examination. It begins a community response in which cases can move to CPS substantiation, issuance of a warrant, finding of guilt and criminal penalty. This process is aided by disclosure and positive physical findings that are significantly related to criminal outcome. Clinicians can play an important role in helping our community to protect children and prevent further abuse by carefully recording any disclosures of child sexual abuse, performing a thorough physical examination and working with other professionals who respond to identify, treat and prevent CSA.
>
> (Palusci *et al. 1999:* 392)

The role of medical examination in responding to child sexual abuse reflected in the findings of this study and in the way the Grand Rapids Michigan model operates does not, regrettably, as a result of the silencing effects of Cleveland, represent current policy and practice in the UK (see Itzin chapter twenty-one for information about the Children's Assessment Center). Nelson (chapter twenty) discusses the issue of protecting abusers through the silencing of professionals working with sexually abused children, and in particular the silencing of the professionals who were identifying child sexual abuse in Cleveland in 1987.

Gender and 'cycle of violence' theory

Another purpose of this book is to bring into focus the connections between men's 'domestic' violence and men's sexual violence against women, and their physical and sexual abuse of children of both sexes evidenced in the contributions by Kelly, Regan and Burton (chapter four), 'Rachel Pearce' (chapter six), Farmer and Owen (chapter eighteen) and Itzin (chapter twenty-one). Recognising these connections is important for professionals in identifying and responding appropriately to cases of physical and sexual child abuse in child protection contexts (see Farmer and Owen 1998, and chapter nineteen, this volume; Hester and Pearson 1998; Hester, Pearson and Harwin 1998; Kelly 1994). These connections are also important to understanding the aetiology of violence and abuse, and in particular the impact on boys of child sexual abuse in combination with physical abuse and domestic violence. A number of authors in this book (Bailey 1997a, and chapter eleven, this volume; Print and Morrison in chapter fifteen; Skuse, Bentovim *et al.* 1998, and chapter twelve, this volume) identify these as some of the contributing factors for boys, between childhood experiences of violence and

abuse and predispositions to becoming adolescent and adult sexual abusers, and there is a particular emphasis in the chapters by these authors on adolescent males as sex offenders.

These contributors refer in different ways to the relationship between having been abused as a child and becoming an abuser, or being vulnerable to revictimisation and to self harm. This is described by some as a 'cycle of violence' and they refer to the need to 'break it'.[3] Although she does not use the precise terminology, these compulsive repetitions and the need to stop them are at the core of Alice Miller's twelve-point analytical framework on 'the shattering effects of child sexual abuse' (chapter nine).

In order to acquire a better understanding of how child sexual abuse is perpetrated and experienced, and in particular to consider its effects, this book is very substantially based on research and clinical work with victims (Swann, chapter fourteen; Woodward 1988, and chapter seventeen, this volume); with abusers (Wyre, chapter three; Print and Morrison, chapter fifteen; Eldridge, chapter sixteen); and with abusers as victims (Bailey, chapter eleven; Skuse, Bentovim *et al*. 1998, and chapter twelve, this volume). Using the phenomenology of victim and abuser experience and what I think of as the ethnography of clinical practice, this book draws from those domains both data and knowledge which lend support to the view that, as a theory, 'cycle of violence' is relevant and helpful to understanding the aetiology of child sexual abuse and to making effective child protection and child sexual abuse prevention interventions.

However, there are serious and warranted concerns about 'cycle of violence' theory. Kelly, Regan and Burton (chapter four) consider it to be over deterministic and to imply an inevitability that permits men to absolve themselves of responsibility for their abusing. Armstrong (chapter two) also sees it being used to 'exonerate' men: as in 'I was sexually abused as a child and therefore I can't help being a sexual abuser.' Similar arguments have been advanced to exonerate men's domestic violence. However, Dobash *et al*. (2000) point out that 'seeking to increase men's insight into their own behaviour' is important to effective domestic violence treatment programmes. Likewise knowledge and understanding about childhood abuse and its effects, and the insights it offers men into their attitudes, beliefs and behaviour, can be used by them to assist themselves in their efforts to stop sexually abusing children if they choose to do so.

Finkelhor (1986) also expressed concerns that the implication of inevitability in 'cycle of violence' theory might 'strike terror into the hearts of boys who have been abused' or become a 'self-fulfiling prophecy' (Itzin, chapter twenty-one). Certainly it is the case that not every sexually abused boy becomes an adolescent or adult child sexual abuser. Using the concept of 'developmental pathways' may, therefore, be more accurate and helpful than 'cycle of violence' as a theory for explaining and understanding the contributing factors and causal relationships that connect childhood abuse with adolescent and adult male perpetration. Thus there may be dispositions conditioned by childhood abuse, but subject for each individual to many different kinds and combinations of 'motivating' and 'mediating' factors that determine whether or not, and in what circumstances,

having been abused can lead on to abusing (see Skuse, Bentovim *et al.*1998, and chapter twelve, this volume; Itzin, chapter twenty-one).

Kelly, Regan and Burton argue in chapter four that 'if there is a cycle of violence, it is gendered, and that in turn requires explanation'. Inevitably 'cycles of violence' – or developmental pathways – will be gendered, and taking this into account is crucial to child protection and child sexual abuse prevention. It is also inevitable that these pathways will be gendered in ways that reflect the gendered power relations of male dominance and female subordination described by Dobash *et al.*(2000) with respect to domestic violence as 'one end of a continuum of male domination', how 'normal men establish and maintain control in their relationships with their women partners'. The sexual abuse of children by adolescent and adult males is, I think, part of this continuum and another sphere in which this control is exercised. There is, however, work still to be done in understanding the mechanisms and processes by which 'cycles' or pathways become gendered.

In chapter twenty-one, I attempt an analysis which undertakes to explain what Finkelhor has called 'the male monopoly of molestation' (Finkelhor 1979, 1986: 126) in terms of what I call 'the social and psychological construction of gendered power relations'. This has the merit of trying to take account of the many variables that have a bearing on developmental pathways. It is supported empirically by clinical and social research data, and builds on theories of aetiology and process from the different, but relevant fields of sociology and epidemiology (re: incidence and prevalence); from psychiatry, psychoanalysis, psychotherapy and psychology (re: replication and recapitulation); from social work and social psychology (re: social and psychological constructionism); and in particular from feminism (re: the structures and relations of gendered power). It is also radical, I think, in its potential to provide foundations for change at the only level that matters if the goal is, as Kelly, Regan and Burton argue it must be (chapter four), 'to change the structure of social relations': that is, at the level of the individual, so that, as they put it, 'Man A does not sexually abuse Girl B or Boy C', so that there is a reduction in the incidence and prevalence of child sexual abuse.

The issue of women who sexually abuse children is frequently raised as a refutation of the radical feminist analysis of gendered power, male violence and men's sexual abuse of children: that is, if women do it, too, then it cannot be a 'men-thing'. The answer is that it can be, and is, and indeed it is an understanding of gendered power relations that is likely to explain this. The research about, and clinical work with, women who sexually abuse, and in particular that of Saradjian (1996, 1997) is important for understanding and treating victims and abusers, and both 'Rachel Pearce' (chapter six) and 'Alice Edwards' (chapter seven) are strongly of the view that it is important to acknowledge their mothers' collusion in their sexual abuse by familial males. However, prevalence rates for female abusers remain consistently in the region of 5–10 per cent (Itzin, chapter twenty-one). Those who are, like Bagley and King (1990), seeking to find symmetry between sexual abuse perpetrated by women and by men will not, I don't think, find this and will not uncover sexual abuse by women on any substantial scale.

On the contrary, it is well known that the likeliest *sequelae* for girls who have

been sexually abused is to be predisposed to self harm, and that is entirely congruent with women's subordination and their vulnerability to victimisation. Saradjian is concerned to raise awareness and to increase recognition of sexual abuse perpetrated by females, and her book does this well. She makes it clear, however, that this is 'no attempt to suggest equivalence of numbers with male offenders' because 'socialisation of males . . . tends to reinforce sexually aggressive behaviour' and 'socialisation of women inhibits it' (Saradjian 1996: xiii). Indeed, the explanation of why the majority of abusers of girls and boys are male, why women who are sexually abused in childhood largely do not become child sexual abusers, but do instead go on to be vulnerable to revictimisation and self harm lies in understanding the ways in which the 'cycle of violence' is gendered in terms of the power relations of male dominance and female subordination (Itzin, chapter twenty-one).

My concern is with how the issue of women who sexually abuse is seized upon, often emotively and overstated, out of proportion to the size of this problem, and how this draws the focus of attention away from the problem of men as largely the sexual abusers of children. There is also the point made by Armstrong (chapter two) and Farmer and Owen (1998, and chapter eighteen, this volume), that when women do what men do, it is always regarded as much worse. With respect to women, the problem is actually the opposite: not that women are the sexual abusers of children, but that women – bizarrely – are blamed and held responsible for men's sexual abuse of children (MacLeod and Saraga 1988; Finkelhor 1984: 160). 'Home Truths' refer to what we would prefer not to know. The most concerning of the 'home truths' in this book are legal findings in the USA, cited by Armstrong (chapter two), of cases where children are given in custody to a sexually abusing father because the non-abusing mother failed to protect her children from him. Similarly in the UK Farmer and Owen (1998, and chapter eighteen, this volume) document the processes found in a Department of Health funded study, of children on child protection registers, whereby the violent and abusive males become invisible, and the protective mothers come to be treated as if they were responsible for the sexual abuse of their children. Most alarming is that this occurs apparently so routinely that really it is very visible, and at the same time (paradoxically) apparently so normalised and invisible that it occurs virtually unnoticed and passes without comment or concern. Moreover, Kelly, Regan and Burton (chapter four) and 'Rachel Pearce' (chapter six) provide examples of 'cycle of violence' theory taken to mean that women who were sexually abused by men in their childhoods are at risk of sexually abusing their own children when this is both theoretically unsound and evidentially not the case.

In this context, Kelly, Regan and Burton (chapter four), express the 'gravest misgivings' about 'cycle of violence' theory because of how it is being used inappropriately against women. I share these concerns and believe it is a theory that is dangerous to women in the ways that are evidenced in this book. At the same time, I think feminism needs to consider 'cycle of violence' theory, gendered in terms of power relations, for what it has to offer to stopping abusers abusing at the simplest of social learning levels, that is, what is learned can be unlearned through processes of re-education and resocialisation. Indeed this must be the

underpinning premise of sex offender 'treatment' programmes if they are to stand any chance of being effective.[4]

The relevance of 'cycle of violence' theory has also been challenged by Armstrong (chapter two) and Kelly, Regan and Burton (chapter four) for not making sense from the gender perspective that men are primarily the abusers and a 'cycle' would therefore require a reversal for males from victim to perpetrator. However, in chapter twenty-one I review research which suggests that boys are sexually abused on a substantial and previously unrecognised scale (see also Bolen, Russell and Scannapieco, chapter ten), and argue that if there is a 'cycle of violence', there are certainly sufficient sexually abused boys who are also victims of what have been identified as the additionally predisposing factors of physical abuse and domestic violence, to account for the level of child sexual abuse perpetrated by adolescent and adults males found in prevalence studies. However, what determines which boys in which circumstances become caught up in a 'cycle of violence' continues to require explanation.

The theory most frequently used to explain 'cycles of violence' (that is, the 'repetitions' and 'recapitulations' from the literature of psychoanalysis) needs to be developed so that more is known about the precise nature of the processes involved in repetition and recapitulation and how they can be influenced by motivating and mediating factors to break the cycle and to support non-abusing developmental pathways through the earliest possible interventions. Woodward (1988, and chapter seventeen, this volume) contributes from the theory of psychoanalysis explanations of the psychic processes involved in childhood victimisation and how these can influence subsequent revictimisation and victimisation of self and others in adolescence and adulthood. These processes can, I argue in chapter twenty-one, only be properly understood by bringing together key tenets from the psychoanalytic paradigm (for example, 'repression and its return' as Woodward describes this) with the key tenets of the radical feminist paradigm of power relations gendered in terms of male dominance and men's routine use of violence and abuse against women and children to maintain this (Dobash *et al.*2000).

Gendering the language of child sexual abuse

Part of the process of overlaying the psychoanalytic and radical feminist paradigms involves gendering the abusers. The findings, for example, of the study by Skuse, Bentovim *et al.* (1998; see chapter twelve, this volume) would be reframed in terms of effects on boys not of 'experiencing and witnessing intra-familial violence' (Skuse, Bentovim *et al.* 1998: 177), but rather of the effects on boys of 'witnessing' – that is, experiencing and being powerless to prevent – the abuse of their mothers by their fathers and other conjugal males (namely, 'domestic violence'), of being themselves physically abused by (largely) their fathers or father figures and sexually abused by (almost without exception) their fathers or father figures and other familial males. In other words, it is the effects on boys of men's violence and abuse against women and children of both sexes, in a societal environment which permits and encourages this in various ways and which takes no effective steps to

stop it. The use routinely by men of physical and sexual violence and abuse against women and children is evidenced frequently in the findings of research, but the 'men-thing' of it is not visible. One way in which this happens is that they are routinely edited out of the picture through the use of ungendered or gender-neutral language. Making male violence, and men as primarily the sexual abusers of children, become visible and conceptualised as causal in the aetiology of child sexual abuse is the radical feminist contribution to child protection and child sexual abuse prevention conceptualised in terms of 'stopping abusers abusing'.

In this context gendering the language of child sexual abuse is crucial to child protection and child sexual abuse prevention, and is addressed in this book from several different perspectives. One is, as I have just illustrated, the gendering of abusers. There are a number of contributors to this volume who use ungendered or gender-neutral language, including Bailey, Eldridge, Print and Morrison and Skuse, Bentovim *et al*. I do, too, in chapter five. None the less, the 'sadistic, sexual and violent acts in the young' to which Bailey refers in her title, and the children and adolescents who are the subjects of her clinical work and research are almost without exception male children and adolescent males. In the chapter by Print and Morrison, the 'adolescents' of the title who abuse 'others' are primarily male, and the 'others' are male and female children. Given its purpose, at one point in the early stages of putting this book together I considered getting contributors to replace the gender-neutral language with words that were gender-specific. However, it proved to be actually impossible to address this at the level of language and it raised epistemological issues that are beyond the scope of this book to address. I do, however, devote a substantial section of chapter twenty-one to showing precisely how the use of ungendered language functions to protect ordinary heterosexual men's sexual access to their own and other people's children, and how endemic this is.

Another language issue addressed in this book is the use of the word 'paedophilia'. Kelly (1996a) describes it as a 'weasel word', which Kelly, Regan and Burton (chapter four) argue prevents 'recognition of abusers as "ordinary men" – fathers, brothers, uncles, colleagues' and encourages the 'more comfortable view of them as "other", fundamentally different, not "normal" men'. They also argue, that it 'shifts attention from issues of power and control to notions of sexual deviance, obsession and "addiction"', and 'medicalises and individualises what', citing Liddle (1993), they identify as 'clearly a social issue concerning the construction of masculinity and male sexuality'. In chapter five, I develop models based on a combination of victim and abuser data which show incest, 'paedophilia' and child sexual exploitation as overlapping rather than discrete categories, which may involve the same perpetrators, the same victims, the same or similar activities and the same locations. Given the predominance of 'paedophilia' in the public and the public policy discourses in the UK at this time, I have concluded that the best one can do is to use both incest and 'paedophilia' as they are currently used – incest generally to mean what familial males do to children in their immediate and extended families, and 'paedophilia' to mean the sexual abuse of children to whom the abusing males are not familially related – in ways that highlight the epistemological

issues; that make the abusers most visible as both familial and nonfamilial males; and that enable the overlaps between men's intrafamilial and extrafamilial abuse and child sexual exploitation to become visible (Itzin, chapter twenty-one).

The whole of this book is about what was covered in two words in the Utting *Review of Safeguards for Children Living Away From Home* (1997). Those two words were 'predominantly males' and they were located bracketed subjunctively (like this, that is subordinately) between the words 'human' and 'wickedness' in a sentence that reads: 'The experience of the Review has seemed at times a crash course in human (predominantly male) wickedness and in the fallibility of social institutions' (Utting 1997: 7). This illustrates how literally, in the language, the key fact that it is predominantly men's abuse can become invisible in the use of generalised and ungendered or gender-neutral language, represented here in the attribution of the wickedness of child sexual abuse to being 'human'. How different the meaning, and more accurate the message, if the text had read 'the Review seemed at times a crash course in overwhelmingly male-perpetrated, male-inspired and male-led wickedness'. In the 'reports' of the findings of the Review by journalists this sentence was often quoted, but with the two superordinately key words which gender the abusers as men edited out.

Stopping abusers abusing

The problem of men's violence and abuse is so big, so invisible, so endemic in the wider societal context and so intractable at the level of the individual that effective prevention must be addressed from a number of perspectives. One must be criminal justice system sanctions that are sufficiently rigorous to act as some sort of deterrent. There are complex and difficult issues to be addressed in achieving this which are beyond the scope of this book to consider. However, finding ways to reverse the current trend identified by Utting of fewer and fewer successful prosecutions must be a priority. What is required is the root and branch reform recommended by Utting (1997: 189). At the time of writing, the Home Office was conducting a review of sex offences legislation, and it remained to be seen what proposals would emerge from this exercise. Certainly the Sex Offenders Act 1997 and the Sex Offender Orders in the Crime and Disorder Act 1998 are deeply flawed and limited in their scope to have any significant impact on stopping abusers abusing.

At the same time it has to be recognised that prison is not a form of effective child sexual abuse prevention (Laws 2000: 41), not even, as is often argued, in preventing abusers' access to children for the term of their imprisonment. At an institutional level, often, it actually brings child sex offenders together, segregated for *their* protection from other prisoners, in an environment where at the level of the individual distorted thinking can be reinforced, where fantasies and pornography (both adult and child), and 'intelligence' about locating and accessing actual children are shared: where, in effect, children are traded and 'trafficked', and 'paedophiles' can effectively plan and organise more 'paedophilia' on their release.

Without 'treatment', prison can increase the risk of re-offending, and if the objective is to prevent child sexual abuse, then 'treatment' has to be effective.

There is now a very substantial programme of sex offender 'treatment' provided by the prison and probation services in the UK, subject to a process of official accreditation. Some of this work with offenders has been evaluated, and there is evidence to suggest that prison programmes can reduce the rate of reconviction (Barker and Morgan 1993; Beckett *et al.* 1994; Thornton and Hogue 1993; Mann 1996; Home Office 1996; Allam and Browne 1998).

It is beyond the scope of this book to engage with the effectiveness of this 'treatment', and the criteria by which it is judged to be effective. Assessment of the risk of reconviction as high, medium or low is a component of the prison programmes, and used by police to target the higher risk offenders for monitoring on release. If prevention of child sexual abuse is the objective, then risk would be assessed against the absolute standard of stopping abusers abusing, and success would be defined as the certainty that an individual male would not continue to sexually abuse children. With this in mind, Nelson (1999) thinks there are only two relevant risk categories: high and very high.

It is essential in this endeavour, as Eldridge points out in chapter sixteen, to accept that men need 'treatment' as abusers and also as victims: for the victimisation they experienced as children and its contributing or causal relation to the abuse they perpetrate as adolescents and adults. In particular it is necessary, as I have argued, to address the 'construction of desire' and the conditioning of male sexual arousal and orgasm to the abuse they experienced in childhood; to the sexual abuse they perpetrate; to fantasy of child sexual abuse; and to child sexual abuse in pornography; and how these are reinforced through masturbation (see Bailey 1997a, 1997b, and chapter eleven, this volume; Itzin 1992a, 1992b, 1994, and chapter twenty-one, this volume). Helping men in this way must, as Bacon and Richardson point out (chapter thirteen) be regarded – and defined – as a child protection priority. At the same time, child protection itself must be conceptualised – and defined – in terms of stopping abusers abusing.

Ultimately, however, there is really only one certain way to end the sexual abuse of children: that is through the exercise of choice, and a decision made by each individual male to stop acting on his desire to abuse (Kelly, Regan and Burton, chapter four; Itzin, chapter twenty-one). It is possible, then, and almost certainly necessary, to provide men with 'help' in making this decision (in the form of effective 'treatment' programmes) and to provide them with 'help' in continuing to make this decision for the rest of their lives (in the form of relapse prevention programmes) in the ways described by Print and Morrison (chapter fifteen), Eldridge (chapter sixteen) and Woodward (1988, and chapter seventeen, this volume).[5] This is also true for women who sexually abuse children.

It follows from this that the only way to stop men's sexual abuse of children is a policy based on either effective 'treatment' or indefinite incarceration. Which of these two options prevails is subject to the exercise of choice at the level of each individual adolescent and adult male, so it cannot be said, from a civil liberties perspective, to be unfair. Relapse or failure to stop abusing would need, by way of being a deterrent with teeth, to be subject to something like the 'three strikes and you're out' policy adopted in the USA: the 'untreatable' and

the 'unsuccessfully treated' would be detained indeterminately, until such time it was certain that, through a combination of choice and effective 'treatment', they no longer posed a danger to children.

Crucially, as a 'third way', there must also be a route direct to 'treatment' and rehabilitation, as a criminal justice alternative for men who come forward and identify themselves as child sexual abusers seeking 'help' (see Laws 2000: 39–40). In both cases – of those caught and convicted, and those coming forward to confess – 'help' would be provided through a programme of rehabilitation involving re-education and resocialisation evaluated for its effectiveness in time and over time in the case of each individual. It would also involve reparation by the abusers to the children they have abused based on having acquired empathy for their victim: this being defined in terms of understanding and acknowledging the harm and the pain their abuse has caused, attributing blame entirely to the abuser, and exonerating the child from any responsibility for the abuse having taken place.

Children need 'help' when they are victimised in childhood, both the girls and the boys, when their sexual abuse is discovered or suspected: what Macleod and Saraga call 'the emotional work to be done' following abuse (1988: 47). Mothers need 'help,' particularly in cases of incest where they are often the 'secondary' victims of the abusers (Eldridge chapter sixteen, Itzin chapter twenty-one), but also when they have participated either passively and collusively, or actively. All of these victims need the right 'help' at the right time if the objective is to prevent child sexual abuse; and if they don't get it, then child sexual abuse will continue much as it currently does. This is, I think, one of the key and overarching messages that comes from every chapter in this book.

The role of adult and child pornography in child sexual abuse is an issue addressed throughout the book. This includes the role of pornography in predisposing men to sexually abuse, in fantasy arousal, distorted thinking, overcoming internal and external inhibitors, targeting, initiating, overcoming victims' resistance and entrapment, reinterpreting victims' behaviour, and normalising and legitimising the sexual abuse of children (Wyre 1992: 237, and chapter three, this volume). Kelly, Regan and Burton (chapter four) locate the sexual exploitation of children in pornography in the continuum of sexual abuse in childhood, and, as I do in chapter five, conceptualise the connections between incest, paedophilia, pornography and prostitution, and the role of pornography in the organisation of child sexual abuse (see also Itzin 1996a, 1997a, 1997b). In chapter twenty-one, I consider how pornography conditions men's sexual arousal and orgasm to the sexual abuse of children, and Bailey (chapter eleven) discusses how pornography functions through its effects on fantasy to trigger sexual and violent acts in young males at risk of being influenced in this way. In chapter seven, 'Alice Edwards' describes some of the particular effects she has experienced as a result of sexual abuse involving adult and child pornography. Print and Morrison (chapter fifteen) and Eldridge (chapter sixteen) consider pornography as part of the 'cycle of offending' to be addressed in 'treatment' programmes for child sexual abusers.

Contributors to this book do not speak in one voice. Not all of them share the same views nor operate from the same perspectives. Certainly most of the

contributors are not, and would not regard themselves as feminists, radical or otherwise. For the majority, feminism may have had little or no direct impact in their lives or work. Everyone, however, will be aware of feminism's bad press, and the hostility and contempt of its detractors. Emphatically this book is not a feminist tract, nor does it seek to promote feminism or its theories. Rather, I use radical feminism analytically and methodologically for what it has to offer child protection and child sexual abuse prevention. The book deals with challenging and contentious issues, and within its pages issues are contested. There is a diversity of views, and disagreement. There are apparent contradictions and there is paradox, and, in my view as the one who has brought us together in this volume, there are, in each contribution, 'truths' which are essential to the endeavour of stopping abusers abusing.

Notes

1 I put the word 'paedophile' in quotes throughout my chapters in this book because I want to draw attention to its use and to question its usefulness. Kelly, Regan and Burton do this in chapter four and I do in chapter five.
2 At the time of writing, the Home Office and the Department of Health were engaged in consultation on draft guidance on working with children and young people involved in prostitution, based on principles in the Children Act 1989 (Home Office/Department of Health 1999). Although this represented a significant shift in policy in its recognition of these children as vulnerable and 'suffering or at risk of suffering significant harm' and in need of protection rather than prosecution, it did nothing to change the law to stop abusers abusing by criminalising the men who seek out and pay children (and women) to engage in sexual activity or by decriminalising the children (and women) who are victims of sexual exploitation in prostitution.
3 I have put 'cycle of violence' in quotes throughout the book to acknowledge that, as a concept, it is contested on grounds which are important and have to be properly addressed.
4 I put the word 'treatment' in quotes throughout the book to signal that 'treatment' does not mean 'cure,' only 'control' (see Eldridge, chapter sixteen).
5 'Help' is in quotes because it is beyond the scope of this book to consider what effective 'help' entails.

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Part 1

Child sexual abuse and exploitation

Part 1.1

Adolescent and adult male child rapists by many other names

2 What happened when women said 'incest'

Louise Armstrong

Introduction

It is now twenty years since I first spoke out on the issue of incest, with the book *Kiss Daddy Goodnight* (Armstrong 1978). Today that issue is all but buried under the rubble from a bombardment of rhetoric about False Memory Syndrome and its siblings, False Accusation Syndrome, and Parental Alienation Syndrome. The subject of incest has become entertainment. The topic of incest has become a selling point. But the issue of incest, the feminist political analysis, has all but disappeared.

Recovered memory, ritual abuse, healing this, and recovery that have all generated flak and the airwaves are filled with static. It is no wonder than an interested observer, coming fresh into the midst of all this after the mid-1980s, would see no coherence, no internal logic to the ongoing events, but only an apparently randomly generated series of dramatic (or melodramatic) occurrences constantly escalating in pitch. It is no wonder that, given the fundamentalist spin that's been overlaid on the issue – 'I believe!'; I don't believe!'; 'Infidel!' Heretic!' – great numbers of people throughout the land are simply praying for surcease.

As a political story, the history of this issue is a prime illustration of how it is now possible for the powers that be to use noise to achieve the same end that was once served by repression. It is a story of how readily the solid feminist concept that 'the personal is political' can alchemistically transformed into 'the personal is the public'. It is, alas, the story as well of the power of the promise of 'help' and the language of 'treatment' to infantilise massive numbers of women, emphasising their fragility, securing their helplessness, isolating them from the larger universe, so cementing their focus on the purely internal that it looms to fill their entire visual screen. All in the name of empowerment.

Consider this: Ellen Bass and Laura Davis co-authored the most promoted – and most vilified – book on incest, *The Courage to Heal*, a book dedicated to the validation of survivors' experience, and the endorsement of survivors' veracity (Bass and Davis 1988). Surely a worthy effort. But here is the catch. No matter how much one implicitly trusts that suppressed memories do emerge in adulthood, the charge used by those challenging the reality of claimed assault is correct. The book does not require real memory, offering instead the assurance

that if you think you were abused, if you feel you might have been abused, you probably were. Within this loose construction lurks the invitation to turn the dreadful actuality of paternal child rape into an experiential metaphor.

Consider this also: if you turn to any presentation by the mainstream media almost any week of the year, you will find assertions of ever greater pathology in ever greater variety ascribed to victims of childhood rape in the home, alongside men arguing that they have been falsely accused, alongside women who, having believed their children and tried to protect them, have in fact lost custody of the children to the alleged perpetrator. Oprah Winfrey has spoken of her own childhood sexual abuse, along with Roseanne Barr, Suzanne Somers, a former Miss America. We now have 'celebrity incest'.

How did we get here? How, in just two decades, did we go from total silence – from what was said to be a 'dread taboo' – to mothers gagged by the courts, mothers jailed, child credibility impugned? How did we get from enforced secrecy, the suppression of children's experiences, women's experiences, such that they were not even heard? Furthermore, how did we get to a level of cacophony such that children's voices, women's voices, are once more not being heard in any purposeful sense? It is all but forgotten in the current bedlam, but incest is a political issue that was born of the women's movement in both the USA and the UK.

Incest as a political issue born of the women's movement

In the 1970s, feminist literature boldly addressed the need for social change, as distinct from later emphasis on social and economic access, and it was a vibrant force, both in the market and in the marketplace of ideas. Women were speaking out forcefully on rape as a male crime of violence against women. Wife-battering, too, widely referred to as 'spousal assault' in the USA, was analysed as an issue of male prerogative, male right. A plethora of historical documentation was introduced as evidence. Women organised around these issues in grassroots efforts, starting rape crisis centres and shelters for battered women. The words patriarchy and patriarchal prerogative, quaint as they now sound, were spoken without apology.

Consciousness-raising groups were a vigorous tool of discovery. 'The personal is political' described the use of shared stories to extrapolate commonalities that fuelled analysis, which in turn led to activism for social change. First: remove the secrecy that had long protected the violences. Second: raise the issue and raise the kind of outcry that would force measures to reduce their incidence. It should be remembered here that consciousness-raising was conceptually antithetical to therapy. In fact, to view consciousness-raising as therapy was to express 'anti-woman sentiment by implying that when women get together to study and analyse their own experience, it means that they are sick, but when Chinese peasants or Guatemalan guerrillas get together and use the identical method they are revolutionaries' (Kitzinger and Perkins 1993). Radical feminist Kathy Sarachild said in 1978,

> The purpose of hearing people's feelings and experience was not therapy, was not to give someone a chance to get something off her chest. . . . It was to hear what she had to say. The importance of listening to a woman's feelings was collectively to analyse the situation of women, not to analyse her. The idea was not to change women, was not to make 'internal changes' except in the sense of knowing more. It was and is the conditions women face; it's male supremacy we want to change.
>
> (Kitzinger and Perkins 1993).

As I set out on my journey in the mid-1970s, I found the literature cupboard on incest all but bare. There was some anthropological musing on the 'incest taboo', sombre dialogues about tribal exogamy, the pragmatics of marrying outside the family or clan in order to solidify relations and support with outside peoples. The rest of what one could find was mainly secreted in psychiatric and sociological works. On the whole, it was remarkably uncharitable towards children. Much focused on children who had otherwise come to the attention of the courts, prostitutes, or what were termed 'sex delinquents'. Since the greatest number of children thus caught and spotlighted were from socially deprived circumstances, the abiding presumption was that this type of behaviour was exclusive to children of the lower class, who were both morally defective and inherently untrustworthy. Psychiatrists Loretta Bender and Abram Blau wrote in the 1930s that

> the most remarkable feature presented by these children who have experienced sexual relations with adults was that they showed less evidence of fear, anxiety, guilt or psychic trauma than might be expected. . . . The probation reports from the court frequently remarked about their brazen poise, which was interpreted as an especially inexcusable and deplorable attitude and one indicating their fundamental incorrigibility.
>
> (Bender and Blau 1937)

Other works suggested that the sexual assault by fathers was benign and the normal result of the child's need for affection (Burton 1968).

The ages of permitted and denied abuse

As Florence Rush was even then documenting, contrary to presumptions of shock and horror suggested by the word 'taboo', there was, historically, what I call an 'age of permitted abuse'. Fathers wielded absolute power over their children's lives: they could be bartered, sold, mutilated, thrashed, starved (and raped) without recourse. Talmudic law decreed that betrothal and marriage could not take place before three years and one day of age. That was not, however, a magnanimous protection of two-year-olds. This simply meant that the female under three had no sexual validity, and therefore had no virginity to lose. Copulation with one so young was not illegal but invalid.

Maimonides assures us that the rape of one under three was no cause for alarm, for once past three, 'she will recover her virginity and be like other virgins' (Rush 1980). Under Christianity, sex with children under seven was invalid (ibid.). Invalid meant it didn't count; it didn't happen. Sixteenth-century jurists decided that ten was the legal age of consent and twelve was the legal age for marriage. From this historical record, one thing is clear: it is unlikely in the extreme that all this fussing with technicalities would have been of such compelling ongoing interest had there not been widespread sexual abuse of children.

And then, in the late 1800s came Freud, and his by now well-rehearsed graduation from listening to women tell of sexual abuse by fathers, and believing them, to listening to himself, and finding the women's stories incredible. Reality, in his revised opinion, was not actual abuse, but rather the child's wish for, the child's fantasy of, abuse. As his disciples would later intone, the girl's shame and disgust were due not to the actual violation, but to the girl's deep, unconscious wish for her father, her fantasies. Thus:

> Any attempt on the part of the child or her family to expose the violator also exposes her own alleged innate sexual motives and shames her more than the offender; concealment is her only recourse. The dilemma of the sexual abuse of children has provided a system of foolproof emotional blackmail: if the victim incriminates the abusers, she also incriminates herself.
>
> (Rush 1980)

So we entered what I call the 'age of denied abuse'.

What is evident throughout this history is that it was not that women or girls held their silence out of self-generated feelings of shame or guilt. This is often alleged, alongside the presumptive 'because they knew it was wrong', presupposing a child's innate sense of sexual sin. This, in my opinion, is not only specious, but entirely unnecessary. Kids know they are being degraded, exploited, terrified, isolated, and enslaved. They also know they are being told not to tell. That should be enough. Their silence was enforced, sometimes by direct threat, as with the legal rule declaring the complaining girl an 'accomplice-witness'. Other times it was enforced by pre-emptive and codified disbelief. The venerable legal scholar John Henry Wigmore in his *Evidence in Trials at Common Law* relied on Freud's work to summarily declare that young female complainants were not to be believed. His over-riding concern was 'to protect innocent young men from false charges' (Bienen 1983). Other notable personages openly stated that they did not see what the problem was. Alfred Kinsey wrote in the 1950s: 'It is difficult to understand why a child, except for its cultural conditioning, should be disturbed by having its genitalia touched, or disturbed by seeing the genitalia of another person' (Kinsey 1953).

So there it was, clearly stated and explained in the most professional terms, what pundits thought when they thought about child sexual abuse/incest. Either the girl was the real offender, or she was a liar (fantasist), or else it was no big deal.

Most impressive, perhaps, was that they thought about it a lot: that such a great amount of professional and juridical attention was directed to forestalling disclosure, when over and over again experts assured the public that such misbehaviour was calculated to be one in a million. It would later come to seem incredible that – even in the USA, where historical memory can be stretched to two weeks – both the historically gendered nature of the issue and the societal tolerance for the behaviour could be so efficiently vanished.

With the discovery in the 1960s of the 'battered child syndrome' and the 1974 codification in US civil law of social disapproval, overt avowals of the harmlessness of a man's deliberate sexual aggressions against his own child, and the willingness to see children as the architects of their abuse at the hands of adults, began to fall out of fashion. However, and here was the dilemma, as it began to be strongly suspected that rape of one's own child was not entirely rare, how could you suddenly start making open charges against thousands of upstanding male citizens; charges of something that overnight and by fiat was being labelled 'abuse'? So those early professionals who addressed the issue of incest were increasingly driven to find an alternative focus, one that would continue to avoid spotlighting respectable male citizens (who until this minute had believed incest to be within their rights). They visited the Oracle (who'd been around for a while and knew what worked) and the Oracle said 'Mom'. The following extract from *The Mother, Anxiety, and Death: The Catastrophic Death Complex* by Dr. Joseph Rheingold (written in 1967), is illustrative of the tendency towards 'mother blaming' in many professional explanations of incest:

> It is acknowledged as more or less relevant to certain neurotic trends and personality problems and to certain clinical syndromes, but its pertinency to the whole sweep of psychiatric and psychosomatic disorders is not conceptualised. We may not say that maternal destructiveness is the prime factor in all pathological states, but the total evidence at hand seems to permit one to say that it enters causatively into a greater range of disorders than any other factor, and that it is the predominant determinant in more individual cases.
>
> Even the nurturant mother is not without destructive effect. It is her mutilative impulse in its castrative form which cannot be separated from the mother's sexual seduction of the child. Here, as in the case of cruelty, one deals with behaviour that is more frequent and more obtrusive than we have allowed ourselves to believe. The father is seductive too (of the daughter, very rarely the son), but the clinical evidence indicates that seduction of the girl is without significant pathogenic effect, even where it involves actual incest and in the presence of the father's reactive guilt and punitiveness. It is the father's indifference to her femininity or his surreptitious interest that is detrimental to the girl's self concept and the reason for strong protests against him later in life. But even a nonsensual relationship between father and daughter may become pathogenic if the mother is jealous and intervenes threateningly.
>
> (Rheingold 1967, cited in Armstrong 1983: 35)

What followed was the development of a list of mothers' multiple and pervasive failures, inadequacies, and sexual shortcomings which were seen as driving their husbands into the beds of their five-year-olds.

I look back in wonder. Even as I noticed, in 1976 and 1977, bits and pieces of stereotyping and scapegoating and unsupported conjecture that would prove to have the sticking power of crazy glue, I was unperturbed. For example:

> After examining the character of the incest family . . . the unavoidable conclusion seems to be that the failure of the mother to protect the child against the contingency of incestuous victimisation is a crucial and fruitful area of study. . . . Considering the father offender as a possible source of control of incest behaviour seems . . . like considering the fox . . . as guard in the hen-house. . . . The mother is the only possible agent of incest control within the family group.
>
> (Tormes, undated)

> Typically, the father and daughter become incestuously involved after the mother has rejected the sexual role with her husband and the maternal role with her daughter. The mother is infantile and dependent, reverses the mother-daughter role, and assumes with her daughter the relationship she wished she had had with her own rejecting mother.
>
> (Pitman 1976)

> In a typical traumatic case, an authoritarian father, unhappily married in a sexually repressed household and probably unemployed, drunkenly imposes himself on his young daughter. . . . Since the father otherwise extends very little attention to his daughter, his sexual advances may be one of the few pleasant experiences she has with him. If she is unaware of society's taboo and if the mother does not intervene, she has no reason to suspect the enormity of the aberration but when she grows up and learns of the taboo, she will feel cheapened.
>
> (Nobile 1977)

> The father is a basically inadequate man who drinks a lot. The mother is a very powerful, controlling person, but because of illness, has not been able to function as well as she should and the father has often had to take over the mother's role. As in most of these cases, the mother gave her tacit consent by ignoring what was going on.
>
> (Cole 1977)

Over and over and over. But I was (I repeat, incredulously) unperturbed. After all, these folks just had the wrong take on things. During that climate of passion and optimism, we in the women's movement thought if we pointed it out we would prevail.

The first thing to do was to clear out the cobwebs of mystification, to organise my own print version of a speakout. Speakouts were often employed within the

feminist movement as a political tool for giving voice to women's real experience of rape, battering, and so on. What really happened? To whom, and when, and why? With what commonalities and with what effects?

I placed ads in various publications saying I was a woman author doing a first-person documentary book on incest and was looking for others to share in my forum. The summer and fall of 1976, my life centred on the mail. My mail centred on incest. Over the months, the number of letters from women reached the hundreds. Women called, they corresponded, all bearing in trust the story of what had been done to them as children. Included in virtually every story was the fact that they had never told anyone before. A well-concealed truth became revealed: children were regularly molested within the home as a matter of everyday living. And the offenders had done it, not in spite of the fact they knew it was wrong, but because they believed it was their right, or at least justifiable. They wanted to, and no one in world told them they should not, could not, or must not.

We discovered, as well, the intense rage the fathers expressed towards the mother: 'that old cow', in one Dad's words. The fathers dwelt on the way mom would suffer were she to find out, as though that thought was almost delicious enough to invite them to tease discovery. What we were doing not only felt radical, it was radical: unearthing a fundamental truth of women's experience, with a hope for basic change. In those days of heady optimism, the radical felt possible.

The professionalising of incest

When did I first hear the knob click, advancing us from 'dread taboo' to 'decriminalisation' (of that which had never been treated as a crime, the very existence of which had, five minutes earlier, been denied), to medicalisation, in fact to industrialisation? At my first convention, probably. I am not much at home in large groups anyway, but it is a disorienting thing, indeed, to walk into a hotel lobby where many suited-up serious looking people have pinned to their lapels a three-by-four inch white plastic wrapped badge that announces INCEST. One's initial impression is of spoof. A *Monty Python* sketch on the convention business? An episode of *Fawlty Towers*?

The conference, held at the Bismarck Hotel in Chicago in October 1978, was titled 'Incest. In Search of Understanding'. Tellingly, it was billed as a conference on intrafamilial childhood sexual abuse. In sessions, though the surface was genial, the underlying sense was of vigorous competition. You could hear the gears of specialisation grinding, the carving up of victim-populations, the negotiations for turf, the vying for funding, for prestige, for place. Not having heard it before, I did not then identify the hum and the buzz as the sound of persons professionalising. It was here that I got a first glimmer of a previously unconsidered reality, one that would work to isolate this issue from that of adult rape, marital rape, and wife-battering, where the gendered political nature of the issues had spawned ongoing political activism.

Because of the 1974 Child Abuse Prevention and Treatment Act, child sexual abuse already had a home in existing social policy. That policy dictated a

civil/social work intervention by protection services and placed the matter of child abuse and neglect under courts that were claimed to be 'non adversarial': that is, family courts and juvenile courts whose only power over those it found to be offenders (neglectful or abusive parents) was to remove the children to state protective custody. These were courts that claimed disinterest in matters of guilt or innocence, whose stated focus was the 'best interests' of children; whose decisions were based on 'possible harm to the child'.

At the conference, a protective service official explained why protective services should manage the problem, with its non-punitive approach. This, as he went on to describe it, focuses mainly on the mother. By pointing out to her the usual pattern of a passive, dependent wife who may often be absent because she works or is sick, who in any case is not sexually attractive or co-operative, who invites the child to take over her household responsibilities, and a dominant, controlling husband, who favours the child in any case, which makes him jealous of the child's outside friends, social workers can get the mother to own up to the fact that she has failed in her father-taming role, and lead her to challenge the father's denial and to 'get an admission from him'. A certainty pervaded the proceedings: that the discovery of widespread incestuous assault would, first, cause shock, horror, social upheaval and,second, demand specialists in intervention. Alternative views were expressed. One presenter said that children actively participated, and received erotic gratification. A law professor illuminated the codification of that hoary rubric, detailing the long-standing and ongoing legal view that the child was, indeed an accomplice-witness, and therefore incest was a crime with no offender.

This critical information, that there continued a long-standing tolerance of paternal child sexual abuse built into the underlying attitudes and formal structures of society, was everywhere from the start, erased from discourse. In 1979 we began to see journalists' reports heralding 'dread taboo' and 'last taboo'. By the early 1980s, there was a deluge of books with pictures of broken dolls or limp, discarded Raggedy Anns on their covers. The key word in all presentations was the alarmist epidemic. These were the early warning signs that contemporary America's way of dealing with this issue was going to be the creation of a social delusion: the recasting of incest as a disease, precisely in order to avoid confronting the grotesquely distorted power-dynamic long permitted within the sanctified family. In other words, from the outset the medical model of incest was antithetical to the political analysis. In order for mental health ideology to win, feminist analysis had to lose.

Following the initial breaking of the silence came an outpouring of victim testimony, much of it from women born into middle class families long protected from state child welfare interventions (Armstrong 1996). The powers that be then had to dance fast. And before any time-lapse for thought or for public consideration, the public were presented with a full-scale social policy effort to decriminalise a behaviour that had never been openly acknowledged, never been spoken of, never been widely prosecuted, never been specifically prohibited.

Numerous pilot projects were funded by the National Center on Child Abuse and Neglect, mainly those that served to keep families intact. Henry Giaretto, director of the most widely publicised treatment center for what were now being

called 'incest families', advocated use of the criminal justice system as a strong-arm to get the guy to confess and the family to go into treatment, known as 'diversion to counselling'. He said that 'the problem becomes even more serious when [the families] are exposed to the criminal justice system. The youngsters see the police cars descending on the home, the father manacled and taken away' (Crawford 1977). What police cars? Where? Not a single one of the women I had spoken to at that time, and only one of the hundreds I would hear from thereafter, reported any police or criminal justice intervention. How could it be that the professionals were the only ones who had heard the sirens?

Newspapers and magazine articles reiterated that it was family disruption, not the sexual experience, that really imperilled the child's well-being (Dullea 1977). Though couched as rational, enlightened, and humane, the medical response permitted an assumption of shock, a presumption of outrage, a posture of child-protective horror, without ever allowing the cat out of the bag: without ever inviting public consciousness of the fact that a significant body of opinion continued to hold that men who chose to diddle their kids should be able to do so without consequence. This, despite the fact that 1980 brought us the pro-incest lobby and a band of outspoken professionals boldly put forward their opinion that sex between adults and children could be beneficial, was the child's birthright, and was, in any case 'so prevalent as to make prohibition absurd' (DeMott 1980).

With the escalating rhetoric of crime-dread-horror, such professional researchers pursuing 'positive' incest could be conveniently pigeonholed with fringe-group eccentrics as kooky proponents of some brand new sexual libertinism masquerading as a children's rights movement. What made this seem particularly mad was that what these guys were saying – it's normal, it's natural in nature, it's teaching, it's initiating – was pretty much what the abusing fathers were saying. In 1979, one father said on national television: 'You have to understand, at the time I thought I was doing her a favour'.

The campaign to decriminalise incest, to invest it under the civil child welfare rather than the criminal justice purview, along with the escalating rhetoric about this 'heinous crime', created logical discord. It established the logical and legal fault line that came to underlie subsequent interventions. As law professor Michael J. Rosenthal noted, when arguing against a policy of decriminalising child abuse (presumably including child sexual abuse):

> Imagine the sense of injustice and the contempt for law awakened by the following hypothetical courtroom scene:
>
> *Judge:* (to the defendant) You are charged with killing (or seriously assaulting) your two year old son. How do you plead?
> *Defendant:* Your honour, I admit that I killed (or seriously assaulted) my son, but I have a defence.
> *Judge:* What is your defence?
> *Defendant:* Your honour, my defence is that it was child abuse.
>
> (Rosenthal 1979)

With actual historical information ignored, with rational views of the actual power dynamics denied, with the growing focus on illness and treatment as opposed to cause and proscription, the landscape lay open to suggestions, imputations, allegations, all of which took up the same space, held the same weight, as known facts. The foremost, time-tested strategy was to point an accusatory finger at women: to claim that women were, at best, complicitous, and, at worst, themselves offenders. With no basis in fact, no support in any studies, the allegation became ubiquitous that women 'do it' too. The absence of evidence was accounted for by the fact that, for mothers to 'do such a thing' was far worse, so much worse that victims could not even speak of it. All but unnoticed except by those paying close attention, a Doctrine of Equal Culpability crept into law. By 1983, despite occasional feminist conferences attempting to organise around incest as a form of violence against women, for example 'Pulling Together II: Surviving and Stopping Incest', organised by the Pennsylvania Coalition Against Domestic Violence, the original feminist points had been as effectively buried as if they had never been raised.

The birth of an incest industry

By 1984 I had begun referring to the fact that we seemed to be witnessing the birth of an incest industry involving a staggering array of clinicians and counsellors and therapists and researchers and authorities and experts, all with their careers sighted on one aspect or another of incest and its aftermath. Incest, medicalised, was neutralised, stripped of its character as a deliberate act of male aggression, a violence based on the belief in male right. Survivors continued to speak out, some of them politically, but finding little support from an increasingly embattled feminism, they went where solace was everywhere promised: to therapists. The stated goal of most survivor therapy and counselling during the early to mid-1980s was forgiveness of the offender. Welcome to the age of no fault abuse.

In keeping with the illness model, a boom time in offender treatment programmes began. By 1990 the number of specialists treating sex offenders would explode from twenty-nine to more than 1,000 (Egan 1990). The majority of the therapies focused on the male sex organ as though it, as an independent actor, were the real offender. Technology kicked in with the penile erection-detector, the plethysmograph, which calibrated changes in arousal in response to elaborately sexualised video portrayals of children. In order to orchestrate such changes, what can only be described as 'pornography for professionals' was produced and marketed.

In yet another ring of the decriminalisation circus, there was a proliferation of prevention programmes, all directed not at potential offenders but at actual or potential child victims: children. As British feminists Mary MacLeod and Esther Saraga wrote, this approach 'carries risks, particularly for the very children it seeks to help. It makes children responsible for adults, and may also make abused children feel even more guilty' (MacLeod and Saraga 1987). They suggest that real prevention would involve 'changing the way that boys learned to be men, and changing our expectations of men. But that, of course, would direct

attention to men as current and potential offenders, the very aspect that decriminalisation and medicalisation were designed to prevent.

The zeal, the urgent ebullience, the declarative certainty about 'doing good and healing and help', was almost entirely uninformed by reality. By the mid 1980s, I would begin to hear from those who had, as children, succumbed to the lure of telling, and been removed to state care. I would begin hearing from children who had been hit by the full artillery of the ebulliently commercialised mental health intervention system: from kids forced into the therapeutic dictate that they tell their story over and over and over, to kids thrust into the burgeoning number of private, for-profit inpatient psychiatric facilities, based on the ever-repeated presumption that what had befallen them was in some way a mental and emotional disease requiring incarceration, psychiatric medication, threat of restraints and isolation rooms (Armstrong 1993). In connection with these subsequent events none of these children even once used the word 'help'. 'Has anyone', Florence Rush asked in 1972, 'ever thought of the fantastic notion of getting rid of the fathers?' (Rush 1974). The policy of removing child-victims was disastrous for three reasons. First, it punished the child, and for doing what you had instructed her to do: tell. Second, it brought the situation into the purview of a system that held the mothers accountable (for failure to protect), and so ensured the child's removal from her as well. Third, it delivered the issue into the purview of a system that was historically and contemporarily entirely class-specific.

The legitimacy of the child welfare system derived from the assumption that it targeted the poor, most often poor single mothers. The absence of due process, the authoritarianism of the proceedings, had long been condoned as necessary to child-saving among the less worthy. However, these assumptions would prove anathema when, with the issue of incest for the first time in history, protective service intervention was directed toward the middle and upper-middle classes. It was here that seeds were planted from the vigorous backlash of organisations like Victims of Child Abuse Laws (VOCAL), and for cries of witchhunt and of false accusations (Armstrong 1996). Quite simply, men were astonished and outraged at being treated the way poor mothers had long been treated without any such organisational protest. But then, poor single mothers, long the main target of child welfare interventions, were not accustomed to getting much in the way of attention by speaking of fairness, justice, due process: their rights.

The year 1984 was a watershed year for incest. *Life* magazine covered over twenty pages with a special report (McCall 1984). There was a five and a half hour special on public television. And a much-heralded ABC made for television movie, *Something About Amelia* about which columnist Nicholas Von Hoffman wrote perceptively:

> Americans with a new topic medicalise it. In the ABC movie, the police are pushed to the background: the shrinks take over. Incest is demoted from being a crime and a sin to being real, real bad, but a disorder, nevertheless; a candidate for help for therapy.
>
> (Von Hoffman 1984)

While the zeal for mental health treatment never reached the same pitch in the UK, the underlying ideology of victim-illness, the presumption that the kids suffered emotional disorder, the redirection of attention from offense and offenders to victim pathology was to become an American export item, packaged in professional conferences and trainings throughout the world. Because the human results of this pathologising on young victims are not reflected in the professional literature on either child sexual abuse or child welfare, perhaps it is useful here to invite my young friend Tracy to offer her take on the underlying ideology, based on her experience of it. Tracy blew the whistle on her father when she was thirteen, was removed to foster care, court-ordered to get counselling, psychologically evaluated, and then incarcerated in a series of psychiatric facilities, subjected to drugs and restraints and isolation. She says:

> I do understand that it was important . . . years ago for you to tell people this stuff happened. When nobody knew. To break the silence and all that. But we did that. Now we're just going over and over the same shit over and over again. It's kind of like, 'Okay, guys, well guess what! We've dealt with this'. At least I have. And I think it's now time to deal with how we're dealing with it. Fine, we know that incest is there. We know that these things exist. We know that it's happened to a lot of people . . . I think we all feel that we're not alone any more. I mean, give me a break: I do not feel alone.
>
> There's groups everywhere, 'counselling' everywhere. There's so much 'treatment' out there it's not funny. But they don't discuss what kind of treatment it is. They don't talk about how this stuff is helping nobody. the difference between saying 'Yo, this happened to me, too', and going out after the offenders is that all this speaking about it just makes you a patient or an inmate. It doesn't challenge power. Because if you say, 'My daddy's a big, rich man over there and he did this. Go do something about him', then you're challenging a higher power. I feel there's a war going on with all this who's gonna get which kids in treatment.
>
> And I feel in my mind that there should be a war on the treaters. Some days, I just want to go in and let all the kids in 'treatment' go free, let them out, like the animal rights groups let minks out. Set them free. But . . . what are the kids gonna do then?
>
> (Armstrong 1996)

Concerns about 'cycle of violence' theory

Also in keeping with the medical model, were the seemingly endless ominous warnings about something called the 'cycle of violence'. Abused children, it was everywhere intoned, became abusers. There was scant evidence, if any, for all this talk of incest transmission. Most important, it defied data. Offenders continued to tally at over 90 per cent male, and the majority of victims continued female. What the 'cycle of violence' shibboleth did was to exonerate men who

committed abuse so long as they claimed they had themselves been abused as children. It also implicated women who chanced to have married those men because, in attempted justification of the 'cycle of violence', it was claimed that sexually abused females grew up to marry offenders.

Much like the reiterated psychological predictive for victims (from addictions through sexual dysfunctions and on to Post Traumatic Stress Disorder and Dissociative Disorder), the 'cycle of violence' appears to fulfil a yearning to 'scientise' a social problem; to harness it so that it appears socially manageable, while not much disturbing the status quo. Thus, the lack of hard evidence to support its existence has simply allowed for great fluidity of theoretical interpretation, as creative attempts are made to breathe credibility into it, to give it legs. Not unlike the 'cycle of poverty', however, this cycle carries the inescapable implication of individual determinism, something hard-wired into the person, rather than something amiss in the larger social realm. It leads us to discuss how the poor are poor because they are born poor and raised poor, rather than discussing (and perhaps amending) the ways in which they are denied alternative vision and opportunity. Or to discuss how victims and victimisers are determined by their own personal histories, somewhat like the New Age framing of rape as a dance between rapist and rapee, rather than examining the absence of social will to impose serious sanctions; indeed, the evident presence of social will to try almost anything else instead.

To my mind, any attempts to reconcile the 'cycle of violence' and political feminism (Itzin, chapters one and twenty-one) would have to answer the following:

1 Does it help us out in the face of early uncontaminated incest offender testimony such as 'I thought I was doing her a favour . . .' or 'I'd get mad at my wife and say "To hell with her, I can always turn to my daughter"?' (Armstrong 1996).
2 Does it pose female re-victimisation in terms of the individual's psychologically internalised expectations where they are equally well explained by simple reality. For example, a child running away from home is vulnerable to pimps because she is on the streets, hungry, without resources or shelter. This would be true of any child on the streets. The role this child's abuse plays may simply be to cause her to run in the first place.
3 Is the practical effect of holding onto the idea of a 'cycle of violence' – whatever the theoretical rationale – to further justify implicating women whose mates choose to be sexually aggressive to their children? In the USA, child welfare sanctions already fall most heavily on the mother who 'knew or should have known', who 'failed to protect'. The literature has been rife with the idea that mothers 'always know on some level'. Given the gender politics that clearly underlie the blunderbuss attacks on women's and children's credibility over the past fifteen years, what of the mothers who were not themselves molested as children? Isn't there a danger that the assumption convenient to the theory will swamp these women's testimony?

Here is what I suspect: no matter the edifice one attempts to structure, the seductiveness of the 'cycle of violence' lies in its easy reduction of the issue to psychological determinism, deflecting attempts at social change, mitigating against accountability, and tossing the issue into the morass of endless treatment and psychological intervention programs. It strikes me as perilous for children as well as women in that in practice it opens the door to preventive interventions based on the ideation of contagion. These may be called 'therapeutic' but, on the evidence of US experience, in reality they confound punitive and preventive, and stigmatise child-victims both in society's mind and in the child's own mind. Indeed, in the USA during the early 1990s a near-successful attempt was made toward a federally mandated 'Violence Initiative'. This advocated a purportedly preventive, intervention among children as young as five who might be at risk of becoming violent by dint of being related to someone who had been in prison. These children, it was proposed, should be removed to 'treatment centres' where they would, presumably be 'cured' of a tendency they had not manifested (but might maybe) (Armstrong 1993). It does not seem far-fetched that similar enthusiasms might be proposed for children deemed to be at risk of themselves becoming abusers (or marrying same).

The backlash against women

In the USA two major cases of allegations of multiple offender child sexual abuse occurred in 1984. One case in Jordan, Minnesota; and the other the McMartin pre-school case, which would eventually cost more than $6,000,000 and amass over 43,000 pages of testimony. Included in this would be testimony about black-robed figures and church rituals and bizarre forms of transport. It was in connection with the McMartin case that the term 'satanic ritual abuse' was born. It was this case that would launch the backlash, handing the opposition the blunt weapon of the apparently ludicrous. With such a weapon, children's credibility could be bludgeoned and the cry of 'witchhunt!' became louder. Inevitably there was more engagement in the ever louder mutterings about vendettas being launched nation-wide against upstanding citizens plying their simple routines. All this was theatre, diversion, distraction. The real war, in progress from the outset, continued elsewhere. This was a war against women, the mothers of children who spoke of sexual abuse by fathers; mothers who believed the children (as they were widely admonished to do); who acted to protect them (as they were, by law, commanded to do); and who were then vilified, tormented, and often entirely deprived of the custody and company of the children they tried to protect.

Adult survivors (I had taken to saying) do not threaten the *status quo*. It is the children now, and the women, their mothers who seek to protect them now, who threaten the *status quo*. This was not a popular position among survivors, who saw themselves as a movement determined to gain 'empowerment'; not a popular thing to say. In my own (and only) defence, I said it because it was what I now witnessed. Everywhere I saw the ravages of a war in which women acting protectively were now being savaged; in which children were being torn from those mothers and delivered into the care and control of those men that the children

had stated were their sexual violators, or otherwise being wrenched away into state custody. Ironically, even as adult survivors at conferences I attended were expressing ever greater rage at the mothers who had failed to protect them, these mothers were, in the present, and largely unsupported, doing what the survivors wished their mothers had done. Women simply could not win for losing.

By the early 1980s, statutes in virtually every state faulted the mother 'who knew or should have known' or who 'failed to protect': both women still married, just discovering the abuse, who raced to seek protection for the child, and women who had not cottoned to the abuse yet, were at severe risk of losing custody to the state. For example:

> A natural mother who had no actual knowledge of the sexual abuse of her child by her husband, the child's stepfather, in their home, will none the less be held to have allowed the abuse . . . if the objective evidence available to her should have prompted adequate protective measures from a responsible parent similarly situated: good faith, good intentions and even best efforts are not, *per se*, defences to a child protective petition since to hold otherwise would frustrate legislative efforts to prevent avoidable injury to children.
>
> (Richmond County Family Court 1984a)

> In Matter of Alayne E. this court contended that it sympathised with the respondent mother in her efforts to shield her daughter from an abusive father. And yet, the court's sympathy did not prevail because of the simple reality that the mother's efforts were insufficient and inadequate to protect the child.
>
> (Richmond County Family Court 1984b)

> In Matter of Shane T. this court, while acknowledging the efforts of the respondent mother to protect her son, none the less made a finding of abuse against her.
>
> (Richmond County Family Court 1984c)

A finding against *her* of abuse! In case after case, in court after court, in state after state, women attempting to protect the child were labelled hysterical, vindictive, delusional. What we were therefore looking at was the non-negotiable demand that women act to protect their children from abuse by the children's fathers, and their utter denigration, vilification, discrediting, and surgical excision from the children's lives when they tried to meet that demand.

What women discovered, one by one by one, was that, wittingly or not, they had been set up as marks and stooges by a fundamentally fraudulent and duplicitous social response. To make things even more sinister, it soon became clear that this was to be a denied battle in a denied war, despite the visible casualties. Each of these protracted and agonizing torments for a mother was labelled by the media as no more than a 'custody dispute'. Additionally, a generalised belief spread that these custody disputes were increasing, were an epidemic and that fathers were being ruthlessly victimised: facts notwithstanding. A study of

contested custody cases in Orange County California, showed that over the five year period between 1983 and 1987, 84 per cent of the fathers were granted sole or mandated joint custody. In all cases where sole custody was awarded, it was awarded to fathers in 79 per cent of the cases; in 26 per cent of the cases the fathers were alleged or proven to have physically and sexually abused the children (Committee for Justice for Women and the Orange County North Carolina Women's Coalition 1991, cited in Pennington 1993).

While facts supporting women's and children's need for protection were batted off like puff balls, the message of those claiming an epidemic of false allegations took unquestioned hold in the media and the courts. Unsurprisingly, the message was framed in the medicalised terms of 'psych-science' and 'syndromes' established by the professionals who had usurped the debate from political feminists. In 1987 Dr Richard Gardner, clinical professor of child psychiatry at Columbia University, media commentator and child abuse theoretician, proposed the 'Sexual Abuse Legitimacy Scale', 'an instrument for differentiating between *bona fide* and fabricated sex-abuse allegations of children'. In conjunction with a disorder he called 'Parental Alienation Syndrome', called by one expert 'probably the most unscientific piece of garbage I've seen in the field in all my time' (Moss 1988), the scale was eventually retired. However, the myth that there existed this 'Parental Alienation Syndrome thing' held on.

The backlash-professionals' tactics were no more than blanket assertions put forth in a squawk of outrage at grotesque injustice, yet they carried the robust authority of middle-class male presumption to entitlement. While mocking 'victim feminism' they postured victim fatherhood and raised alarms about radicals out to destroy the fundamental unit of society itself, the family Most astoundingly (because it seemed to make no sense whatsoever), some of the loudest alarmists were simultaneously endorsing the rights of the adult male to have sex with children.

In 1993 Dr. Ralph Underwager, a former pastor of the Lutheran Church, with luminous credentials in the field of psychology, and a major figurehead in the assault on professionals he sees as dupes of vengeful mothers bent on falsely accusing husbands, was moved to grant an interview in *Paidika, The Journal of Paedophilia*, published in Amsterdam, in which he offered 'paedophiles' this advice:

> Take the risk, the consequences of the risk, and make the claim: this is something good. Paedophiles need to become more positive and make the claim that paedophilia is an acceptable expression of God's will for love and unity among human beings.
>
> (Geraci 1993)

In the same year, Richard Gardner of Columbia University, published a paper in Underwager's journal *Issues in Child Abuse Accusations* (Gardner 1993) entitled 'A Theory About the Variety of Human Sexual Behaviour'. Gardner's theory proposes that 'many different types of human sexual behaviour, including the paraphilias, can be seen as having species survival value'. He proposes that most men

are naturally promiscuous and that children are 'not only naturally sexual but that they may be the initiators of sexual activities'. Pertinent to his theory, he writes:

> is that paedophilia also serves procreative purposes. Obviously, it does not serve such purposes on the immediate level in that children cannot become pregnant nor can they make others pregnant. However, the child who is drawn into sexual encounters at an early age is likely to become highly sexualised and crave sexual experiences during the prepubertal years. Such a 'charged up child' is more likely to become sexually active after puberty, and more likely, therefore, to transmit his or her genes to his or her progeny at an early age.
>
> (Gardner 1993: 302)

In short, this is a theory that would seem to support sex with children as a benefit to the very survival of the species. Yet, for all the talk of 'Parental Alienation Syndrome' in the courts of the land, this theory went largely unremarked.

Where, I kept asking in the face of this onslaught, was everybody? And the answer came back: they are in therapy. By the late 1980s, you could not tell that which the survivors were calling the 'survivor movement' from what everyone else was calling the 'recovery movement'. All women with symptoms of any discomfort were equally admonished to have courage, take power, end denial and heal. You could not really tell the books apart either. They virtually all had adopted the tone of twelve-step fundamentalism, issuing calls to personal salvation. Survivors' I-Story-Books' continued to appear, all hailed for their bravery and honesty. All hailed as breaking the silence. 'We-Story-Books' had begun to appear as well, true stories of women with multiple personalities caused by abuse, often 'as-told-to', in which each component was personified, and all fought it out as, in therapy, the struggle was on to integrate and become one. Always, the entire focus was on the journey to recovery. I am not, here, asserting any scepticism about the existence in some discrete and limited number of people of a phenomenon that can be labelled Multiple Personality Disorder, or that such a phenomenon can result from horrendous childhood abuse, although both definition and identified populations have become absurdly delimited as fashion and financial reward have kicked in. What I am commenting on is that, deprived of all social context, informed only by the process of healing, the stories were bereft of any larger point. The offenders, the grotesque offences, were background to a medical curiosity.

Somewhere along the way, rather than feminism politicising the issue of incest, incest-as-illness had overwhelmed and swallowed feminism. The result was the mass infantilisation of women. As Sage Freechild of the rape crisis movement, says:

> Once it became evident that there were literally millions of survivors, the mental health industry took notice. They identified a vast land of economic opportunity. We got tons of services for survivors, self-help books flourished, and conferences on survivor issues were sponsored by professionals, who were experts on the needs of women who'd been abused. Rather than lending support to grassroots, survivor-led existing services and fuelling the

> already growing movement against abuse, therapists with the power of the mental health industry behind them took over. They seem to embrace the movement against violence against women and children. But their clinical focus works against any political agenda.
>
> (cited in Armstrong 1996: 209)

In other words, the mental health industry hijacked the issue; and they purloined the language. Borrowing from feminists, therapists rapidly came to speak of the goal of their speciality as empowering women. They spoke of the courage to heal. They transformed the meaning of 'the personal is political' into 'the personal is all'. Incest 'survivor' had become not the adding of your voice to others in activism toward change, but an acceptable defining identity. Unremembered or ill-remembered childhood rape had been positioned to account for all manner of later female experience, and the reverse was presumed: that the existence of any of an innumerable array of symptoms declared the event. Here we moved into the dangerous territory of incest as metaphor.

Then, in the late 1980s, the stakes were raised as well. Adult survivors who had not earlier presented any threat to the *status quo*, decided not only to challenge their ageing parents with sometimes no more than snatches of dim recall, but to actively confront them and take them to court. This certainly contributed to bringing down upon our heads an organised backlash which, invoking a mantle of medical authority, decided to charge forth under the banner of a newly invented disease: 'False Memory Syndrome'. So, at bottom, one main trigger for the backlash that brought us into the current morass was that well-known emotional catalyst: money.

What was most astonishing to me as I followed the uproar through the escalating caloric heat was that nowhere did anyone seem to make a connection between this newest 'syndrome' and the one by which the media had earlier been carried away: 'False Accusation Syndrome' with its cohort 'Parental Alienation Syndrome'. Nor was any connection attempted between these and the escalating activism of fathers' rights groups, or the increasingly embattled child welfare system. Data didn't help. Evidence didn't help. Publicity didn't help.

The silencing of incest

Having been failed by law, numerous mothers took their case to the public, through TV programmes such as those hosted by Phil or Oprah or Sally or Geraldo. But so did the fathers, who seemed to have the edge in the believability sweepstakes, if only because their outraged testimony reassured the largely female audience that it was not necessarily true that there was this degree of rage and injustice awaiting a woman who simply did what everyone believed should be done. In the end, the testimony and counter-testimony, within an entertainment forum, seemed to have a decidedly anti-political effect. By the nature of the format, context was absent, and the absence of context alters the content. By the late 1980s it seemed overwhelmingly clear: without the politics, the issue of incest had degenerated to a vast

and gaudy spectacle, for which children and their mothers were footing the bill. With the triumph of the clinical, with the emphasis on symptoms as speech, symptoms as declarative of past events, the possibility for error became egregious.

Added into this mix were increasing numbers of tales of satanic abuse, ritual abuse and cult abuse, all said to have produced in victims an ever escalating number of different inhabiting personalities, and scepticism came to seem the rationalist view. Events recounted by women grew ever more florid, set in the framework of huge conspiracies reaching to the highest levels of local, state, and federal government; of related cabals that signalled one another via demonic hieroglyphics and triggers by which they could recall anyone anywhere to the rule of the cult; cabals that, on innumerable days of the year, gathered in groups to chant and eat faeces and have children perform ritual sacrifices of infants, born of pubescent girls, whose blood they then drank and whose flesh they ate. Thus the command to believe came to resemble a fundamentalist call to faith. The organised backlash, or course, had only to sit there, smiling, and pick up this strangely improbable fruit to lob back at us as it fell off the tree.

For many of us who knew that a goodly number of fathers had used their children in pornography and involved them in drug rings without much ceremonial decoration, these disclosures were intensely awkward and more than a little intimidating. We were certainly aware that there were cases of grotesque abuse that had been uncovered and prosecuted, though most often not as ritual abuse. As Linda Regan of the Child and Woman Abuse Studies Unit at the University of North London said to me:

> Of course there are some cases. You have only to read Amnesty International reports about some of the bizarre things that are inflicted on children to know that. The problem comes when we are asked to believe there are hundreds of thousands.

A report to the British Department of Health by anthropologist Jean La Fontaine generated sensational headlines in London in April of 1994 quite disproportionate to the rather low key findings: 'Government Inquiry Decides Satanic Abuse Does Not Exist' (Waterhouse 1994); 'Whitewash Claim Over Satanic Abuse' (Low and Lewis 1994). First, contrary to the impression of a rampant epidemic, out of eighty-four cases of reported organised abuse, ritual/satanic abuse was alleged to constitute about 8 per cent. Three cases of ritual (not satanic) abuse were identified. These were cases in which self-proclaimed mystical/magical powers were used to entrap children and impress them (and also adults), providing a reason for the sexual abuse, keeping the victims compliant and ensuring their silence. The match to the tinderbox lay in the finding that alleged disclosures of satanic abuse by younger children had been heavily influenced by adults; interviews with the children had often been poorly conducted, with leading questions asked and substantial interviewer-interpretation of the children's answers. And, perhaps most inflammatory: 'equally important in spreading the idea of satanic abuse in Britain are the professional specialists, American and British. Their

claims and qualifications are rarely checked. Much of their information, particularly about cases in the United States, is unreliable' (La Fontaine 1994).

Satanic or ritual, or cult abuse was an instant sensation. There was an exuberance, a charge to the media attention and a quasi-messianic vigour to the treatment literature. It was hard not to get the feeling that everyone was exhilarated. And why not? Satanic/ritual abuse overrode all of the problems that had dead-ended simple incest. In these abuses, of course, offenders are spectral. Not only are women alleged to be focal actors in these pictures, but the men's behaviour is rather majestic. Gory as the proceedings are said to be, they have a certain *Grand Guignol* style, much removed from the rather sordid and somewhat pathetic machinations of everyday child molesting dads. This whole increasingly shaky edifice claimed as its fulcrum, as its moral authority, the issue of incest. It was put to us that this phenomenon was a continuation of that phenomenon: that the freedom to speak for satanic/ritual abuse survivors derived from the open conversation about incest. And that to disbelieve here was the same as, earlier, to disbelieve there.

Historically, though, women were not disbelieved (Rush 1980; Armstrong 1996). They were *silenced*. For long periods of time children's sexual abuse (as we now call it) was not seen as abuse. It didn't matter. It didn't count. It wasn't valid. Great amounts of time were spent negotiating at what age it might matter. Over long periods of time, girls were implicated in any abuse they reported, and themselves penalised as participants. And, waxing and waning in prominence, there have always been with us quite respectable men who openly advocated the child's right to be involved in sexual activity with adults.

The real problem with our airing of the issue of incest was not disbelief. It was (as it continues to be) the possibility that some damn fools might actually try to make change. The continuity of incest has both depended on and supported the dominance of men within their private realms and the devaluation of women and children. To actually do something to stop it, to prohibit it, to hold offenders accountable for it, would require breaching a tacit agreement the state has always held with respectable men: 'Their homes, their castles; their families, their turf. Paternal prerogatives, paternal privilege' (Armstrong 1983).

The incest-satanic/ritual abuse analogy, while powerful emotionally, is actually fragile. It appears to sustain because the dominance of the therapeutic ideology has driven out political understanding that would point up distinctions. Fundamentalists, the Christian right-wing, ordinary citizens, everyone would be more than happy to band together as one and drive from the land satanists, cultists, ritualists. So far, they just seem unable to find them.

There is a more general re-silencing as well. Over the past few years, more and more sentient people, having seen all too often what happens to children who tell and are then subject to state intervention, are quietly cautioning kids not to volunteer that which will bring them to the attention of the legal and social welfare systems. Those who field the imprecations of desperate mothers seeking to protect their children are similarly urging caution. At the very least, they are warning the mothers to get as much professionally documented evidence as they can before saying anything at all.

However, there is a still more worrisome result of the triumph of the therapeutic ideology, and the concomitant failure to identify this issue as political. A far stranger and more dangerous silence can now be seen in play. Not only do journalists and the media continue to be largely silent about feminist political views on incest, and the evidence underpinning those views, but they remain silent about the position underling the views of some backlash professionals as well, including the published statements of some sympathetic to paedophilia. Backlash views on children's and women's credibility are widely quoted without reference to their philosophical underpinnings. Views of those mental health professionals now labelled 'the believers' are not only mocked but erroneously derided as 'feminist' (or 'radical feminist'), thus further burying any chance that truly feminist political speech will be given a hearing. In a sense, political feminists are sequestered in a tower while impersonators perform as us, in our place.

However, even this, alas, cannot be laid at the doorstep of demonic conspiracies. It can rather be attributed simply to the early and continuing suppression of the actual political component by much of the professional community, as well as by the later backlash, and to the blinding triumph of a mental health ideology, which serves so many diverse interests, run rampant. By means of this ideology, the personal, made public, has been remade as personal and robbed of coherence, stifling social change. That this has happened, despite the fact that all the evidence continues to support the feminist understanding of incest as deeply and profoundly political, is remarkable. That a profound silence has come to envelop this fact, in the face of all the activity, all the thunder and roar, is more remarkable yet. Policy-makers concerned to effect real change, a real reduction in the incidence of incest and other child sexual abuse, would do well to re-think the re-framing of a political issue as a personal/psychological one. The former rests on the optimism of gradual problem-reduction. The latter promises nothing more than perpetual problem-management.

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3 Paedophile characteristics and patterns of behaviour

Developing and using a typology

Ray Wyre

Introduction

In this chapter I describe the characteristics of 'fixated paedophiles' which I have identified from my clinical work with sex offenders in treatment programmes. I use, and argue for the usefulness of, the concept of 'paedophilia' and typologies which classify child sexual abusers as 'paedophiles' according to their typical and predictable patterns of offending behaviour for purposes of treatment and policing. In policing, for example, forensic evidence can be used to construct a 'profile' of the possible suspect based on what is known about the different characteristics of 'paedophile' abuse to inform the investigation of sex crimes. Knowledge of 'paedophile' beliefs and behaviours – such as denial or minimalisation – can also be useful in interviewing men suspected of child sexual abuse by enabling police to recognise and challenge distorted thinking and deception.

In treatment, I have found that knowledge of what offenders are capable of doing, how they go about it, and what goes on inside their head can assist professionals working with them to anticipate and deal with the very convincing lies and manipulation which are typical of child sexual abusers. This can facilitate and enhance the possibility of successful intervention by demonstrating to the abuser that there is someone who understands them and their offending behaviour sufficiently to be able to offer meaningful help. I also demonstrate how knowledge of paedophile characteristics can help in treating victims of abuse. As my work has largely involved men who have, or have had, some connection with the criminal justice system, I refer to them in this chapter as offenders.

Types of offenders

Over the years the term 'paedophile' has taken on various meanings. The word literally means 'child love'. It has been used to describe men (and some women) who exhibit sexual arousal and attraction towards pre-pubertal children. When there is sexual arousal towards post-pubertal children who are below the age of consent, the term that has been used is 'hebephilia'. Sometimes, where men abuse boys, the term 'homosexual paedophile' is used. This is unhelpful, as it equates 'paedophilia' with homosexuality. In fact, child

sexual abusers generally are more likely to be heterosexual than homosexual. However, there are some abusers whose preference is what they call 'man-boy love' who identify themselves as 'paedophiles'.

The fact that a person has 'paedophile' tendencies does not necessarily mean that he has sexually abused a child or is going to abuse a child. Conversely, not everybody who sexually abuses a child can be described as being a 'paedophile'. A person who has 'paedophile' desires might be able to control his behaviour if he recognises that the abuse of a child is wrong. A person may have high levels of desire and fantasy about a child sexually, but if he is going to abuse, he will necessarily exhibit high levels of distorted thinking, and have to overcome his internal inhibitors. Disinhibitors can give permission to the offender to carry out the abuse. These include: certain emotional states like loneliness, depression and anger; drugs and alcohol; adult and child pornography; fantasy and masturbation to thoughts of children (here the orgasm acts as a reinforcer); and peer pressure.

Constructing typologies of sex offenders who abuse children is controversial. However, being aware that child sexual abusers sometimes exhibit different characteristics can assist both in understanding their patterns of behaviour and in recognising that certain behaviours can indicate particular motivations for abusing. Identifying the needs that are met through particular patterns of sex offender behaviour can help the police prioritise suspects in an investigation of child sexual abuse, because, in my extensive experience of working with them, there is no such thing as an 'out-of-character offender'. At the same time, it must be remembered that although it is possible to identify sex offenders by type, individuals who sexually abuse children come from all walks of life and all social class and ethnic backgrounds. The one characteristic they have in common is that they are predominantly male.

In treatment, the main purpose in trying to identify different types of offenders has been to enable the people working with an offender to look at his offence and his previous history, and talk to the man in a way that lets him know that they are aware of his actions and motives. This gives the offender the feeling of being understood and enables him to give information that he has previously hidden away. For many, it is a relief to be able to share this information, and is often seen by them as the beginning of progress. It will also offer hope in that the offender will sense he is talking to someone who not only knows about the subject, but because of this knowledge, is able to offer the help needed. Identifying types of offenders is also useful in assessing the risk they present. There is little doubt that certain types of sex offender are more dangerous than others. Whereas some remain static in their target selection and in the level of assault, others progress to more serious levels of offending.

No individual has all the characteristics of a type. However, there are a number of characteristics that can be identified with each particular type. The stereotypical image of the man in the dirty raincoat with funny eyes, or alternatively the 6ft 6in man who looks like a werewolf are all part of a problem that needs to be broken down. The community will always be vulnerable if they do not understand

that it is not monsters who sexually abuse children, but 'nice' men. By listing the different types of offenders it is hoped that rather than simply putting offenders into boxes, the typology will function to expand the knowledge and understanding of the range and behaviour of the men who sexually abuse children.

The characteristics of 'fixated paedophiles'

Child sexual abusers called 'fixated paedophiles' tend to have the following characteristics.

Their main arousal and orientation is towards children

Many men are sexually aroused by children but control their behaviour or get adult women to play the roles of children. They do not have to be sexually aroused towards children to abuse them. They may be aroused by a specific sexual practice and can manipulate the child to satisfy this desire. Flagellation, oral abuse, and abuse involving urinating are examples of this.

They may engage in highly addictive behaviour

'Paedophiles' can be very highly addicted to their behaviour. This is similar to a gambling or a drug addiction. An understanding of the devices of deceit as used by these other types of addict can help to explain why there are some 'paedophile' offenders who really do want to stop but find it impossible.

Despite appearance, they may feel inadequate

'Fixated paedophiles' in positions of power or in prominent positions within our society may not initially appear to have inadequate personalities. However, if you scratch the surface, these men will usually feel inadequate compared to their peers.

They may molest large numbers of children

Of all sex offenders, 'fixated paedophiles' are most likely to abuse again, and they can abuse hundreds of children during their criminal career. Some will stay with one child for many years and then move on to another child. Others move quickly from one child to another, and some abuse more than one child at the same time. However, we must always be careful in accepting the numbers of children a 'paedophile' claims he has abused. I have little doubt that some 'paedophiles' in treatment begin to exaggerate the scale of their abuse. There are a number of reasons for this. The most common is their desire to please the therapist; the second is that, if you wish to be seen as getting better, it can be an advantage to make it seem as though you were very bad to start with. We may never know the full extent of abuse because children who are victims of 'paedophiles' seldom reveal it.

They may adopt pseudo-parental roles or may deliberately set out to gain the trust of ('seduce') the parents or other care-givers

In the relationships they create prior to the abuse, 'fixated paedophiles' often relate to the children as a father might do to his child. For this reason, I would argue that men should retain a role in childcare, even though there have been recent debates about whether men should work with children because certain men have used their positions within care situations to abuse children. Children who have no fathers or other adult male figures in their lives are susceptible to men who give them attention, whether for good or bad motives.

'Paedophiles' need children's caregivers to trust them. They can be excellent at persuading parents to accept that their relationship with the child is in the child's interest. Some such men actually become part of a family. They are invited round at weekends and are allowed to babysit. This is very common within certain types of religious groups. The single man attending a service on his own will often find himself invited back for dinner by a family. The relationship may deepen, and the time he spends with the family will probably increase, especially if he demonstrates a willingness to help out with the family, either practically or financially.

They may be seductive in their approach

The normal approach to a child by a 'paedophile' is one of seduction. The process is very similar to the seduction process within adult relationships, but this should not be compared to the 'chat-up' line within an adult/adult relationship. This seduction can go to the very being of the child, and their identity, beliefs and fantasies will be affected by it.

Because of the secrecy and control involved in abuse, children often have only the offenders to give them information. The hands-on abuse by the 'paedophile' is often felt to be congruent by the child, because the offender has prepared the child in a psychological way to accept the abuse and has created the emotional dependency to keep the child trapped

The seduction process can often be as arousing for the 'paedophile' as the abuse itself. It often outwardly resembles the actions of someone who cares for and loves children appropriately. Investigating 'paedophilia' is extremely difficult because of this. What is it that makes one expression of affection towards a child acceptable, and when is it abusive? If the behaviour moved into genital touching, for example, the earlier affection should also be considered part of the abuse.

They take time to form relationships with children

'Paedophiles' can devote many days, weeks, months and sometimes years to targeting and seducing children. One 'paedophile' said to me that the reason it was so easy to abuse children was because most fathers know more about their cars than they do about their children. During this period, the offender may be targeting and testing certain children and will be careful before he moves into hands-on abusing.

If a child discloses the abuse during this testing period, it is unlikely that anything will happen to remedy the situation, because the 'paedophile' may claim that the activity was play-fighting, accidental touching or that the child has misconstrued something that was said. However, if the child does not disclose during the testing period, the offender will see this as a green light to proceed with hands-on abuse.

Parents should ask: 'Why does this person want to spend all this time with my child?' Parents might be happy for their child to be taken off their hands for a while. The more parents are aware, the more questions they may ask. This does not mean that the children should not be with other adults or that adults should not take children away from their families for short periods. I am concerned, however, about how easy it has been for men to gain access to children with parents' permission.

'Paedophiles' will be able to relate to children and will often be seen as 'nice men'. Monsters do not get close to children, but 'nice men' do. They can stop being a stranger two seconds after meeting a child. Children's definitions of 'a stranger' are often very different to what adults call 'a stranger'. Strangers, to children, are often 'dirty, horrible men', or 'men who make you feel uncomfortable'. Outsiders will often say of an offender that 'he really liked children', that 'he really enjoyed their company, and children enjoyed his.

They may use child erotic material and child or adult pornography to lower the inhibitions of children

The use of pornography has a number of purposes. It may arouse children, depending on their age. It can lead to sexual discussion. It helps target certain children, depending on their response. It can be used to create a collusive secret behind adults' backs, but with the offender offering reassurance about the secret. It sexualises the environment for children and they may become sexual with each other. Pornography can be used in the corruption of children. It contains within it myths and fantasies concerning women and children, and portrays people as sexual objects.

They may seek to portray their behaviour as normal

'Paedophiles' usually wish their behaviour to be seen as normal and encourage debate as to how normal sex with children is. Some 'paedophiles' emphasise how common it is in order to try to make the public believe that it is normal. They will encourage, in some countries, a political debate as to how it is normal to have sex with children. Cases in the media where young girls are described as being 'seductive', being 'promiscuous; and 'wanting to be involved with men' may be used to legitimise the behaviour, as well as some high-profile cases, like Mandy Smith's relationship, at thirteen, with Rolling Stone Bill Wyman.

Various organisations, like NAMBLA (North American Man Boy Love Association), Paidika, the former England-based Paedophile Information Exchange and Magpie, could all be described as promoting 'inter-generational sex'. They suggest that the taboo against child sex abuse is part of ageism.

They may have strong cognitive distortions and beliefs

Their beliefs can easily be seen in the magazines distributed by the organisations mentioned earlier. At times, it is hard to credit the arguments that they will use to justify their behaviour. Some 'paedophiles' use their own childhood experiences to support their present behaviour. Some men will say that they enjoyed being touched as boys, and they were not victims, that they enjoyed it and wanted it. Because of the way their abusers abused them, they might even think that they were the cause of their own abuse. If 'paedophiles' believe that children want this activity, they are unlikely to believe that what they are doing is wrong and causes damage.

Their friends and associates are probably 'paedophiles' and share common information and language

Owing to their need to have their views validated, 'paedophiles' will relate best to others who share their beliefs. We should be concerned about who their friends are. Contact with other 'paedophiles' can commence or be enhanced in prison. Offenders who have met inside have ended up running sex rings together. There are also subtle ways of letting others know that you have an interest in children. 'He's past the sell-by date', spoken about a teenager, will be enough to give the message.

They are usually over twenty-five years of age yet many have no dating pattern with men or women

Work at the Faithfull Foundation has shown that many 'paedophiles' start to abuse when they are still teenagers. However, 'paedophiles' are not normally identified until they are over twenty-five. It might also be that the behaviour of the 'paedophile' takes some time to develop. If a younger person is accused of sexual abuse, it is unusual to identify him at that stage as a 'fixated paedophile'. Most young people whose behaviour is criminal, but not sexual, grow out of their offending by their early twenties. However, this does not appear to be the case for 'fixated paedophiles'. It has been said that they 'grow into it'. The older the offenders are before being caught, the harder it is to intervene effectively to prevent further offending

By intuition and design, they may select vulnerable children, who may be physically and/or emotionally neglected

The 'paedophile's' ability to target the 'right' child is well known. Out of a group of children, he will sense which child to go for, which one to test out. He does not want the child to tell, he wants the child to become dependent upon him, thereby reducing the likelihood of anyone finding out. If he can meet other needs the vulnerable child has, then this will reduce the likelihood of the child disclosing because the child will accommodate the abuse.

They do not usually marry, but may be in a marriage of convenience

The increasing numbers of single-parent families have been an advantage to 'paedophiles'. Often adult women might see 'covert paedophiles' as non-threatening and would see their desire to care for children as something positive. They may even fall in love with them and marry them. The fact that the 'fixated paedophile' may have a sexual relationship with a woman is not out of character and does not affect their sexual arousal to children. Indeed it is one characteristic of 'fixated paedophiles' that they develop a sexual relationship with an adult woman to gain sexual access to her children. Some 'paedophiles' are sexually aroused by adult women, and others have explained how, when they are having sex with their partners, they think of children to achieve orgasm.

They may belong to children's organisations

It is important that organisations where individuals are working with children look at how they recruit staff and volunteers. There must be supervision structures set up in all organisations so that worrying behaviour or attitudes can quickly be addressed. Staff must know the difference between an aware and an unaware culture, and seek to make sure that they operate an aware culture. If such structures are not in place, then staff will feel that they cannot express their concerns about an individual's behaviour, and it will also be easier for the 'paedophile' to control the environment he is working in.

They may have a preference for children of a particular age range and the older the child, the more likely they are to select one gender

The stereotypical victim age group for 'paedophiles' is eight to twelve years. As body hair appears, the 'fixated paedophile' may give the child up. However, whilst individuals are still known to have an interest in this age range, we know that some offenders will abuse children from birth. Once children have moved from the abuser's preferred age range, they may be passed on to other abusers who have a liking for that particular age range.

In one case, a 'paedophile' was accused of being sexually aroused by boys and girls. When he was interviewed, it emerged that his main target group was girls of eight to ten years old. Within the privacy of his masturbation life, he was adamant that he did not think of a boy sexually. However, he had been charged with offences against boys. As the discussion continued, I discovered that his primary fantasy was girls, but that he enjoyed girls and boys touching each other while he watched. This not only fed his fantasy life but also reinforced his beliefs that children 'liked it' and that 'they would not do it to each other if they did not like it'. He failed to see the corruption involved and that the behaviour he was encouraging could lead to the children believing that they were sex offenders.

If the 'fixated paedophile' is abusing very young children, then it is unlikely that it will matter to him what gender the child is. If the motive for abuse is other than primarily sexual, then either gender might be abused Further, if the abuse takes the form of oral sex, then the gender of the victim may matter even less to the 'paedophile'.

Their use of language may give a clue

'Paedophiles' use of language is revealing: for example describing children as 'clean, pure, innocent rosebuds the sorts of questions they ask, the tones of their voices, the way they see children can sometimes be recognised. A man may say in all innocence to a boy in a sweet shop 'it's really nice to meet a boy who is as polite as you'. However the context of that statement and the tone of voice used could alter its significance.

They may prefer limited sexual involvement

Some 'paedophiles' are content with touching. Some may not even touch the child's genitals but may wish to cuddle and be close. Such behaviour may not be seen as offending. The masturbatory fantasies associated with this cuddling are, however, abusive in nature.

They may enjoy photographing children

'Paedophiles' may have many photos of children and enjoy taking photos. They may be seen on the beach taking photos or using a video camera to film children they do not know. Photos of clothed children may concentrate on 'crotch shots'.

The role of pornography

'Paedophiles' often collect 'child erotica' and child pornography. Collection is the operative word and the collection may become very special to them. It has been said that wherever you find child pornography you will find 'paedophilia', but not everywhere you find 'paedophilia' will you find child pornography.

Child erotica

'Child erotica' is an encompassing term. It includes any material that serves a sexual purpose. Possession of such material would not be seen as breaking the law. It includes children's catalogues, holiday brochures and photographs of children. The kind of man who uses such material may take pictures of children on the beach although he does not know them. He will also take pictures at swimming meetings, child beauty shows, in parks and at open air events. In a recent case a man had a number of films of children changing on beaches.

He will collect information on sexual abuse, incest and sex education. He will cut out pictures of children from newspapers and paste them into scrap books. In a recent collection made by a 'paedophile', the man had pictures of naked children interspersed with articles on child sex abuse and child abuse investigations, articles on the treatment of sex offenders which included myself and the Gracewell Clinic. There were also campaigning charity articles like the Lamplugh Trust and their call to treat sex offenders. He will video children's programmes and make a composite of a number of them, for example sex education and school programmes, children's gymnastic programmes or Grange Hill and films like *Kes* or *Flight of the Navigator* and *Lord of the Flies*.

He collects books, magazine articles, newspapers, photography, slides, movies, drawings, audiotapes, videotapes, personal letters, diaries, clothing, souvenirs, toys, games and paintings. When the man goes to prison he will still use as much material as he can get hold of. In prison this may be *Mothercare* magazines, holiday brochures and *Health and Efficiency* magazine for pictures of children.

In identifying possible 'paedophilia', child erotica has to be evaluated in the context in which it is found. Possession of an album filled with pictures of the suspect's own children is probably of no significance. Possession of many albums may signify a man's sexual interest in children. Photographs of children he is not related to, which may be found in a man's wallet, should also be treated with suspicion.

In the process of gathering photographs, 'paedophiles' are likely to use trickery, bribery or seduction to take pictures of children. They sometimes photograph children under false pretences, such as leading them or their parents to believe that modelling or acting jobs might result. An advert in a magazine recently asked: 'Could your child be a model? Send three pictures: one of your child in outdoor wear, one in best clothes and one in nightwear'.

Child pornography

Child pornography is the permanent record of the sexual abuse of a child. It can include sexually explicit photographs, slides, magazines, films, videos, audiotapes and hand-written notes. The only way child pornography can be produced is through the sexual exploitation of children. It can be divided into commercial and home-made material.

Home-made child pornography is continually produced, swapped and traded in all cities in this country. Sometimes it is sold to, or winds up in, commercial child pornography magazines, movies and videos. Most children who take part are not abducted sex slaves, but are seduced and bribed into having photos taken which increase in sexual explicitness and sexual abuse. In some cases parents take pictures of their own or make their children available for others to take pictures. The use of the Camcorder is now very common, it is easily available, and is not expensive to hire.

Commercial pornographers are more likely to target runaway children. The majority of runaway children in this country will be exploited sexually.

Children used to produce pornography are sensitised and conditioned to respond as sexual objects. However due to the ease with which it is possible to produce material by desk top publishing or video copying, there has probably been an exaggeration about the money involved and the extent of commercially made child pornography. Despite the fact that a child has to be abused to produce it, and the majority of men who use it will be abusing children, in some quarters collecting child pornography is still seen as rather innocent. In one court case the Appeal Judge placed the collecting of child pornography in the same category as collecting cigarette cards!

Adult pornography

When we consider possible motivations for the collection of such material it is important to be aware that this is a compulsive part of such men's fantasy life. It also includes the collection of adult pornography as well as child pornography and child erotica. It may be used for blackmail, exchange, profit and it may be shown to children to lower their inhibitions. The role of adult pornography in sexualising the environment for children is, I believe, a major and under-estimated issue; it is so easy to abuse children if adult pornography is used.

The use of adult pornography has a number of purposes. It arouses the child, depending on their age; it can lead to sexual discussion; it helps target certain children depending on their response; it can be used to create a collusive naughty secret behind an adult's back but with the offender offering reassurance about the secret; it sexualises the environment for children and then words like 'age-appropriate behaviour' might be used because of children being sexual with each other. It can be used in the entrapment of children; it has within it myths and fantasies concerning women liking and wanting to be raped and children liking and wanting to have sex with adults. It objectifies people into sexual components. It also makes it difficult for children to be witnesses, as their evidence may be presented as being contaminated by exposure to pornography, in which they have appeared to collude, rather than reflecting actual abuse. Certainly this is what defence lawyers say. The debate concerning pornography will continue, but it must be remembered that technology will have a part to play in increasing its availability.

Computer pornography

Many 'paedophiles' seem to be compulsive record keepers and now many use computers. This makes it much easier to store and retrieve names and addresses of victims and of other 'paedophiles'. Innumerable characteristics of victims and sexual acts can be easily recorded, analysed and shared. An extensive pornography collection can be catalogued by subject matter, no longer do they need to write and send packages. Electronic bulletin boards for which a security code is needed to gain access are used. The confidential e-mail also enable contacts to be made and pornography to be shared.

Over the last few years the development of pornography being produced and distributed on computers has increased its availability and made it accessible to individuals who would not necessarily have sought it out. It is possible to get all forms of pornography onto computer. The ability to scan pictures, films and photos onto screen means the images can be as good if not better than ordinary photos or films. The differences are that the graphic image can be manipulated and changed and composite pictures made that are currently within the law. The reason is that a picture of a naked adult woman can be scanned onto the screen; her breasts can be reduced in size and her pubic hair removed; her head can be removed and replaced with a child's head. The final picture is the same as a photograph and it is difficult to tell the difference. However because it is not a real child the picture does not, at the moment, constitute an offence.

These pictures can be traded and bought; it is possible to join closed user groups where confidentiality is guaranteed and the likelihood of being discovered is remote. The market is world-wide and it is clearly difficult to investigate. Legislation is not up to date with this new form of pornography and urgent changes are necessary to control this business.

Patterns of 'paedophile' behaviour

All 'fixated paedophile' behaviour has a common core that is illustrated in Figure 3.1. When doing an assessment of a sex offender I explore all of these areas. It is impossible for the offender to abuse without going through the stages in this process. Pornography can – and does – play a part in every stage of this cycle.

In addition to the characteristics of their 'typical' behaviour, it is also helpful to see 'paedophiles' in the way they sometimes use to describe themselves as 'predatory' and 'non-predatory paedophiles' in relation to how they go about abusing. In doing this I wish to make it clear that both behaviours are abusive

1 Predisposition
2 Fantasy arousal
3 Distorted thinking
4 Overcoming internal inhibitors
5 Overcoming external inhibitors
6 Targeting
7 Initiating
8 Overcoming victim's resistance
9 Reinterpreting victim's behaviour
10 New set of distorted thinking/new set of distorted fantasy
11 Normalising stage
12 Maintaining stage
13 Trapped stage
14 Ending stage

Figure 3.1 Cycle of sex offender behaviour

and although the type that call themselves 'non-predatory paedophiles' would like to minimise what they are doing, I believe their abuse of children can be even more insidious.

'Predatory paedophiles'

'Predatory paedophiles' typically sexually abuse within a context of abduction, or may express immediate anger in a sexual way; for example the rapist within the home, or the stranger rapist of children. The offender might be motivated by anger to a level where the object of this anger is irrelevant. I have worked with men who have raped their daughters in order to 'get back at' their partners.

When Robert Black, the murderer of Susan Maxwell, Caroline Hogg and Sarah Harper, abducted a six-year-old girl, he said that his actions were not violent. He said this having abducted the child, tied her hands behind her back, taken off her shoes and socks, put sticky tape over her mouth, put her head into a cushion cover and pulled the draw-string, put her into a sleeping bag, zipped it up, and thrown her into the back of his van. This was not, according to Black a violent act. Violence was hitting. Had he not been apprehended, the child would have died. He would no doubt have said it was an accident and that he had not intended it to happen.

In these contexts, the abuser is not seeking to obtain consent (even if a child could be said to be able to give it). The offender is expressing other needs in a sexual way. They are willing to grab a child, to abuse and manipulate, to threaten and to ignore the hurt and the pain the child is expressing. Despite this, they will still seek to justify their behaviour.

'Non-predatory paedophiles'

'Non-predatory paedophiles' are individuals who believe a child can give consent to sexual acts. They believe that a child is sexual; that a child would enjoy sex with an adult; and that a child can give consent. Being sexual and being aware of sex is something different, however, to wanting sex with an adult. At the extreme end of this is the 'paedophile' who believes that even a baby can give consent. The rationale is based on his belief that for example: 'If you throw a baby up into the air and it shouts blue murder you know that it does not like it. If however, they gurgle and laugh you know they do.' This led on to the 'paedophile' saying that you can know if a baby likes it 'because they will thrust their genitals towards you or they will pull away'.

Such reasoning clearly reflects the distorted thinking and beliefs with which the 'paedophile' needs to surround himself. The particular danger of 'fixated, non-predatory paedophiles' is that their actions are in fact predatory, but they do not want to accept this. They fail to see how their use of influence, power and control, and the way that they form the relationship, gives the child no choice. How does a child deal with a person who can offer what most children want: money, toys, gifts, attention, apparent love.

Anything that will attract children to a 'paedophile's' home will be used. One offender had twenty amusement machines in his garage. Children from the local school and housing estate were always there. They needed money to play on the machines. This created dependency on the offender, which led eventually to gifts being given for favours. This corruption of children is an important part of the 'paedophile's' behaviour, involving not just the sexual abuse, but the behaviour the offender engages in to entrap the children.

How do children cope when the offender turns the attention into sexual attention, especially when we have a society that often says to children 'grow up', and where sex is about being grown up? For victims of child sexual abuse, their first introduction to sexual touch is at the hands of an abuser. Much of the child protection training that goes on in schools does not give children a sense of what it is offenders want to do. One of the Faithfull Foundation staff asked his eight-year-old son following a session on child protection and child sexual abuse prevention, why was it that he should not take a sweet from a stranger. The child said it was because the sweet would probably be poisonous.

In some cases, the offender becomes involved with a child who has already been sexualised by an earlier abuser. In these cases, the offender may not see that he is re-victimising a child who is already a victim. Instead, his beliefs about children being sexual partners may be reinforced by his perception of the behaviour of the child. Any accommodating behaviour (the child not disclosing, the child appearing orgasmic) will be interpreted in a way that makes the offender feel better.

As one looks at the 'non-predatory fixated paedophile' and his pattern of behaviour one can see why it is sometimes called a 'victimless' or a 'phantom' offence. This is because victims do not disclose. If victims do not tell then the authorities will not prioritise and investigate. Why children do not tell is easily understood in the context of the 'paedophile's' actions and behaviour. Never should an adult ask 'why didn't you tell?' Such a question to a victim shows ignorance of how the offenders operate and how they control. It is actually heroic whenever they do succeed in telling.

However, it is helpful to look in detail at how the child responds to this type of abuser and what it is like to be the victim of a 'paedophile'. He is in no hurry and his selection and targeting of a child is not random. Even in the selection there is an awareness of whether a certain child is likely to inform, whether or not a child is available or is vulnerable enough. Because of the relationship he is forming, the child may have no sense at all as to what the ulterior motive is and will therefore be seeing a man who is giving him attention, maybe giving him practical things, making him or her feel special. He will often stress how he loves children. However, the boy or girl will be left and rejected as he/she grows out of the 'paedophile's' target age.

Before moving into sexual abuse the man will normally have a testing out period. This is where his discussions may become sexual, where there is innuendo, where he is asking the child about their boy and girl friends. With boys he might bring the conversation around to homosexuality. 'Play-fighting'

might begin, plus other non-sexual games. Involved in this behaviour is 'accidental touching' on purpose. He will be interested in how the child responds to this behaviour. If the child were to disclose anything during this stage, nothing has happened in legal terms. Any investigation would be unlikely to throw up any criminal behaviour. In fact anyone making enquiries would say what a lot of fuss was being made of nothing. However, the child might not even make any comments to others, but will in his/her dealings with the man make it clear that they are unhappy with the behaviour. This is achieved by the child saying 'No', although this is unusual. It is more likely done by the child avoiding the 'paedophile' because although they might not be clear as to the real intent of the man, they feel uncomfortable. They pull away from him, or if they remain in some relationship with him, he has a sense that there is no way forward. What will normally happen is that the 'paedophile' will eventually become fed up with that child and will start to move away on the basis that there are easier children to seduce.

It is not unproblematic to talk in this way, because it raises issues about victimology which often involve putting responsibility onto the victim for being abused. I am not doing this, but I am making the point that offenders do target vulnerability and availability, and that some children are easier than others to form a relationship with, with a view to being able to abuse them. With young children their protection is very much bound to their carers, and any child is susceptible to the predatory abuser.

If the offender finds that the child does not pull away and does not tell, he will probably move onto the next phase. This may involve direct touching, and it can be achieved in a variety of ways. Just talking and discussion is enough for some men, but at some point he will need to isolate the child alone, and may suggest that the child stay over one night. Usually if the child has parents, or a parent, the 'paedophile' is also relating at some level to them. He may even get the permission of the parent for the child to stay. On a children's camping trip, for example, he is the type to suggest that the other adults go off and have a drink. He offers to get the children to bed. He seems self-sacrificing.

The corruption and entrapment of the child

Because of the nature of this process of manipulation, I see the 'paedophile' as not only violating but also corrupting the child. This may prevent children being able to reveal how they may have acted out the abuse on the abuser or on other children. Offences of gross indecency, for example, when the offender gets the child to touch him, can be interpreted by children as though they are the abusers of the adult. There are no limits to the ideas and suggestions that an offender may use to sexualize the child. The 'paedophile' is the ultimate loner. He is attempting to replicate himself. He wants the victim to think, believe and feel the way he does.

At each stage of abuse, the offender may even be working out with the child what they should be saying to the parents. Children have secrets all the time.

The clever abuser is someone who makes abuse another secret, but in collusion with the 'paedophile'. This will make it even more difficult for the child to say anything in the future. Threats may also be made, and they can be varied. If an abuser uses fear and blackmail many children will not report him. The power of seduction is often misunderstood as are the manipulative threats. For example, one man said to a child: 'if you tell, no one will ever be able to cuddle you again'. However, threats imply that the behaviour is wrong. Suggesting to a child that 'I won't tell your parents if you don't' makes out to the child that it is an equal relationship and a joint secret.

It is easy for young children to be confused, which makes it difficult for the child to be believed. It is important that workers with children have a thorough knowledge of sex offenders. They will then be able to empower children more effectively, as they may hear the 'offender within the child'. They may think they are talking to an eight-year-old, but they might be talking to a thirty-year-old inside the eight-year-old child's head.

Offenders use many controls to overcome the victim's resistance. Power and control is clearly part of the motivation involved. This may also be expressed in ways other than abusing the child. The abuser will often have authority over the child and enjoy exercising it. He may offer advice and express concern about many aspects of the child's life. Some will even describe how they 'kept the child on the straight and narrow'. Offenders who have used the 'rent boy' scene have often boasted that the boy is still alive because they took him off the streets and let him share their home.

The clever abuser will get the children they abuse to recruit other children in ways described here in the words of one such child:

> They knew they could trust me, I had been having sex with a group of men since I was six and they had no come-back. If I wanted a boy, I would even write on the toilet wall at the school that X [giving his full name] was gay. This, in a homophobic society, would lead to this boy being ridiculed, he might not want to go to school and would be likely to be bullied. I would then befriend him; remember I am only a couple of years older. I would then take him to my friends, the 'paedophiles', who would give him attention, and turn this into abuse.

It is in this process that we see the corruption of children. This has a number of objectives, in that the children will be unable to tell because the abusers have made them offenders. They also become suspicious of authority, so that again they will not tell. Even if they did, their testimony would be suspect because they were involved in illegal behaviour. Too many cases are thrown out of court due to the fact that the children giving evidence have been in trouble with the law. It is as though such children are disqualified from giving evidence of being abused. More worrying is the failure of the legal system to understand how abusers get children to sexually abuse other children and make them into sex offenders. This makes it incredibly difficult to disclose. Courts always want pure

witnesses. Corruption of children, which is one consequence of sexual abuse, does not tend to produce the witnesses that courts are looking for.

'Paedophiles' who begin to sexually abuse children in collusion with others increase the possibility of their being caught. Despite this, there are many men who have been involved in this group activity. They can either abuse and share the children, or having abused a child, pass the child on to another abuser. It must be remembered that not all offenders in a sex ring will know all the children being abused, nor all the abusers. An interesting aspect of sex rings in comparison to other large-scale offending is that, if many children are involved with lots of adults, and especially if the offending is carried out in a bizarre context, it is unlikely that a successful prosecution will follow. Or if initial convictions are successful an appeal will normally reverse the verdict.

Cycles of abuse

Having knowledge of these different types and patterns of 'paedophile' behaviour can, I think, help to explain, and to understand, why some victims of abuse grow up to abuse others, and why some do not. If you look at a group of children to see why some offend and others do not, the key lies in the type of abuser who abused them, and in the nature of the relationship their abuser formed with them as part of the abuse. The controls exercised by the abuser on the relationship appear to have more bearing on the likelihood of them going on to abuse as adolescents and adults than the type of abuse.

In the treatment of victims of child sexual abuse and abusers, both adolescent and adult, I believe it is helpful to identify the following:

- What type of abuser did the child encounter?
- What relationship does the offender have with the child?
- Is he a primary carer, or is he substituting for someone else who should be in that role?
- What was the age of the child, not just at the onset of the 'hands-on' abuse but when they came under the influence of the offender?
- What were the distorted thought processes and beliefs of the offender, and how much of this has been transferred to the child?
- How long did the offender spend with the child? How many days, weeks, months, years?
- Did sex, anger, power, control or fear motivate the offender?
- Was he seduction- or anger-motivated in his abuse?
- What were the fantasies of the offender?
- What were the psychological, emotional, physical and/or social controls used to overcome the victim's resistance?
- What was the pattern of the behaviour carried out by the abuser?
- What emotional needs of the child were attached to the abuse? Did the offender meet other needs in the child? And were any of these needs anchored to the abuse?

- Did his mood change within the offending?
- What did the victim do to survive?
- Was the child at the age of developing sexual fantasies? How did the abuse affect their fantasy life?
- What behaviours did the child adopt to regain some power over their life? Did the child negotiate with the offender: 'Look, I will come to you on Friday night', instead of lying awake every night wondering if he is going to visit?
- Did the offender involve other children, and did he get the child to abuse other children, etc.?
- Did the child, having been sexualised, act this behaviour out on sisters, brothers, other children, etc.?
- What was the type of abuse, what was its range, and what was its frequency?
- Were there bizarre elements in the sexual abuse?
- Were there bizarre elements used to control the child?
- What non-abusing carers did the child have contact with?
- Were other emotional needs met appropriately?
- How did the need to keep secrets affect the relationship with the non-abusing carer?

The type of relationship with the abuser will often determine the nature of the experience for the child and influence whether or not the child is likely to be predisposed to abusing children in adolescence and adulthood. The diversity of the child's experience of abuse reflected in this list of questions demonstrates why treating all survivors the same or saying that their experience is the same is unhelpful. The offender must, of necessity, cause confusion in the victim, and different degrees of damage, and some children are inevitably more likely to go on to abuse than others. A child being approached in the street by a 'predatory paedophile' will develop a different set of beliefs about their abuse than someone who is abused by a 'paedophile' who takes time in forming the relationship. To be successful in the treatment of these children and adult survivors, we must identify the type of abuse the child experienced.

Conclusion

From a policing perspective an awareness of the characteristics of 'fixated paedophiles' and their typical patterns of behaviour as listed in appendices one and two can help to focus investigations and inform the interviewing of suspects. Indeed, it can be helpful to be aware of variance amongst 'fixated paedophiles', and the specific characteristics and patterns of behaviour of what I call 'professional paedophiles' described in appendix three. Understanding the specific patterns and characteristics of 'paedophile' behaviour can also be crucial in understanding and therefore in being able to provide effective treatment for child victims and adult survivors of sexual abuse, as well as for working with sex offenders with a view to stopping their sexual abuse of children.

Appendix 1

Characteristics of the 'fixated paedophile'

His main arousal and orientation is towards children. We do not know how many men, sexually aroused to children, control their behaviour. Some men get adult women to play the roles of children.

- Engages in highly predictable behaviour;
- Has poor relationships with peers;
- Molests large numbers of children;
- Adopts pseudo-parental role;
- Is seductive in his approach;
- Follows clear patterns of behaviour to make contact with children;
- Takes time to form relationships with children ;
- Uses child erotic material;
- Uses child pornography;
- Uses adult pornography to lower inhibitions of children;
- Seeks to portray his behaviour as normal;
- If he has friends they are probably 'paedophiles';
- Shares information with other 'paedophiles';
- Has strong cognitive distortions;
- Will claim any offence is out of character, a one-off occurrence;
- Used to live alone or with parents or mother;
- Is over twenty-five years of age, yet has no dating pattern with men or women;
- Enjoys the company of children;
- May have pictures and decor in home that appeal to children;
- Knows how to give attention to children and make them feel special;
- Knows how to talk to children, and more especially knows how to listen;
- Presents himself as a 'nice man';
- May deliberately set out to gain the trust of the parents;
- May be precise, well ordered;
- Considers status important, and uses authority to seduce;
- By intuition, selects vulnerable children, physically and emotionally neglected;
- Does not usually marry, but may be in marriage of convenience;
- May attach himself to a family to get access to children;
- May belong to children's organisations;
- Will have preference for children of a particular age range;
- The older the child he targets, the more likely he is to stick to that sex gender;
- Gives clues in his use of language about children, for example, 'clean, pure, innocent rosebuds';
- Often wants to exclude other adults when with children;
- May prefer limited sexual involvement (no buggery);
- Enjoys photographing children;

- May create or participate in networks of 'paedophiles' and child sex rings;
- Interest begins in adolescence;
- No precipitating stress needed.

Appendix 2

Typical pattern of behaviour of a 'fixated paedophile'

Stage 1

He:
- Fantasises and masturbates to previous sexual contacts;
- Fantasises over anticipated contacts;
- Gets to know a boy informally (either at a club or in the street);
- Gets to know the parents first to develop trust;
- Continues to get to know the boy socially;
- Takes the boy to the cinema, theatre;
- Accompanies the boy home;
- Develops further trust with parents;
- Gains boy's trust.

Stage 2

He:
- Finds out what is troubling the boy at home;
- Finds out what is troubling the boy at school;
- Becomes the 'counsellor';
- Develops a 'friendship';
- Sometimes targets neglected boys;
- 'Counselling' takes place in the car.

Stage 3

He:
- Invites boy to come to the house;
- Encourages the boy to tell his parents;
- When the boy leaves or arrives, some form of physical contact takes place, for example wrestling;
- Teaches the boy to play games, for example chess;
- Watches television with the boy;
- Begins to put arm around boy; if any resistance, he withdraws;
- Tries physical contact again a couple of meetings later;
- If physical contact is accepted, there is a dramatic increase in fantasy and expectation, reinforced by masturbation as he looks forward to the boy becoming a sexual partner;

- Touches the boy sexually outside his clothing;
- If boy resists, he stops and tries again later; if he is reported, there is nothing that could easily lead to a conviction;
- Having touched the boy sexually outside his clothing, he waits and then moves on to greater intimacy;
- Mutual masturbation; carries on for quite a while (ejaculation);
- Not much talking takes place;
- Finds out if boy or his friends have done it before;
- Warns boy that he had better not tell anyone;
- Moves on to mutual oral sex;
- Buggery on the boy first;
- Buggery on offender.

Appendix 3

Covert pattern of a 'professional fixated paedophile'

This typology is based on a man who was an active member of the Paedophile Information Exchange. He boasted that he was employed to make 'straight' kids 'bent'. He was paid for photographs he took of children.

Stage 1

He:

- Has intuitive feelings about a boy in the street as a likely victim;
- Follows him;
- Identifies the boy's school;
- Finds out where he lives;
- Identifies his leisure activities, for example where he plays football;
- Finds out where the boy usually goes to play;
- Finds out how late the boy can stay out;
- Tries to find out the boy's hobbies;
- Finds out which sweet shop the boy frequents;
- Finds out whether the boy hangs around outside;
- Establishes whether or not the boy is a loner.

Stage 2

He:

- Decides intuitively when to make an approach. It could be at the sweet shop: ' Do you need a little more money? Let me pay';
- Has a casual chat. If the boy accepts payment, he leaves the shop on his own: 'I'm seen as a nice man' (that is, he is not seen as a stranger). He doesn't appear to be a risk. The whole scene and pursuit gives a feeling of

power and encouragement to the offender; the final outcome is abuse; monetary gain is secondary;
- Meets the boy again and starts a conversation – very informal;
- Finds out how much pocket money the boy gets, and undermines his parents;
- Asks what the boy's interests are. If he already knows, he talks as though he does not know;
- Finds out what the boy's mother or father do not let him do, who controls the home;
- May be introduced to mum and dad; he is very happy for this to happen;
- Has sometimes used a false name;
- May begin to take the boy out. He takes them to a fairground and offers him free rides: ' Children will do anything to get free rides at a fairground';
- Introduces the boy at some stage to the fact that he is a photographer;
- Asks the boy if he can take innocuous photos;
- Starts to invite the boy home. He leaves magazines like *Health and Efficiency* lying around;
- Asks the boy: 'How would you like me to take one of you in your underpants?'
- Pays for the picture, and they go to a place where the money can be spent;
- Offers more money later for a 'natural pose';
- Leaves pornographic child pictures lying around;
- Offers more money; the boy is trapped;
- Introduces another boy; mutual masturbation takes place;
- Is willing to stop at an earlier stage as the photos are distributed through various sources to Holland, Belgium, then to America, then back to this country and Europe;
- Once the boy accepts mutual masturbation, the breaking in process has begun;
- Introduces buggery next;
- May introduce a girl;
- Passes the boy's name and address around on computer lists;
- May get the boy involved in prostitution;
- Some 'paedophiles' have 'safe houses' they use for 'sex with children'.

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4 Sexual exploitation

A new discovery or one part of the continuum of sexual abuse in childhood?

Liz Kelly, Linda Regan and Sheila Burton

Introduction

This chapter draws on our work at the Child and Woman Abuse Studies Unit at the University of North London over the last eight years. During that time we have conducted fourteen larger and smaller scale studies on various aspects of child and woman abuse.[1] This chapter draws on three in particular: a prevalence study of sexual abuse (Kelly, Regan and Burton 1991); a study of the impact and meaning of sexual abuse in childhood (Kelly, Burton and Regan 1996); and a review of what we know about sexual exploitation of children (Kelly, Wingfield, Burton and Regan 1995).

Many commentaries tell a story about child abuse which suggests that since the 1960s there has been a progressive and incremental awareness; the story begins with physical abuse in the 1960s, followed by neglect and sexual abuse in the 1970s and 1980s and sexual exploitation in the 1990s. This is the story of late twentieth century policy and media recognition, it is not the history of child abuse or of feminist theory and practice. Both child welfare organisations and feminists were aware of sexual abuse and sexual exploitation in the nineteenth century (Jeffreys 1984); of physical abuse of children and women in families (Gordon 1988); and first wave feminists made connections between woman and child abuse (Hendessi 1991). We have witnessed a process of rediscovery in the last four decades, in which feminists have again made connections. What is different is the extent of research and media attention given to the issues: both have contributed to a context in which distinctions rather than connection, novelty rather than historical accuracy, have been stressed.

In this chapter we seek to remake connections between child and woman abuse, sexual exploitation and sexual abuse, locating the issues within the continuum of violence against women and children (Kelly 1988). Our perspective is one which views both differences and connections as equally important if we are to understand the issues involved, and therefore respond to them appropriately. We have chosen five areas to concentrate on: definitions; prevalence; exploring the continuum; explanatory frameworks; and policy and practice implications.

Definitions

The definitions of both sexual abuse in childhood and sexual exploitation of children are contested, within the research literature, in policy and practice contexts and in popular discourse. What counts varies both between, and often also within, legal, research, policy, media and individual definitions. It is, for example, extremely unlikely that survivors and offenders would define sexual abuse in similar ways. Finding or creating a uniformly agreed definition is likely to prove a fruitless task; but it is possible to illustrate what more and less inclusive definitions would encompass.

Sexual exploitation of children is not easily separable from other forms of sexual abuse in childhood, since it can be an aspect of ongoing abuse by a family member/known adult as well as independent of this; it can occur in single and multiple offender contexts. For these reasons we regard it as dangerous to create classifications of sexual abuse which are constructed as mutually exclusive categories. While conceptualisation enables an increasing recognition of the various forms of sexual abuse, the contexts they occur in and the consequences they have, we need to bear in mind that these are analytical categories, and the boundaries created are often artificial

One of the most frequent issues raised in relation to sexual abuse is whether non-contact forms (such as flashing, sexualised talk) should be included.[2] Other unresolved issues are whether, when and what forms of intervention are appropriate, and on what grounds particular cases or forms of abuse are deemed 'credible' and/or proven. While social acceptance of the fact that sexual abuse is far more common than previously envisaged, adults as individuals and as representatives of powerful institutions have not just retained, but reinforced their power to decide in which contexts they will and will not believe, will and will not act.

Another significant problem is the definition of child/childhood itself. Legislation is not consistent within or between societies, frequently the age of heterosexual consent is younger than age of legal majority. This is complicated further by the United Nations (UN) and the Council of Europe (COE) taking eighteen as the age of adulthood. There is, therefore, currently no consensus about the group which is affected by child abuse and child sexual exploitation, making it extremely difficult to collect, let alone compare, incidence and prevalence figures.[3]

Similar debates have occurred with reference to sexual exploitation, there is considerable resistance internationally to broadening its definition. The first international conference in Stockholm (September 1996) made clear in its title that the focus was on 'commercial' sexual exploitation. Nigel Cantwell's (1995) paper at a European seminar argued that this approach facilitated links with the child labour provisions of the UN Convention on the Rights of the Child; his definition was a 'severe form of exploitative child labour'. Underlying this suggestion was a desire to shift attention from sex to exploitation. This may make the issue easier to deal with for many, but it does so through a loss, rather than gain, of perspective. While there are undoubtedly fruitful discussions and

alliances which can occur internationally in relation to child labour and sexual exploitation, reducing the latter to a particular form of the former limits the definition before we understand the parameters of the issue.

Defining pornography, prostitution and trafficking beyond the above caveats is also fraught with problems. Pornography includes magazines. films, videos, computer material, still photography and written text. The argument has frequently been made that during the 1970s and 1980s the commercial child pornography sector has declined, due to both legislative and enforcement responses, but that home-produced material is more widespread. This is often referred to as a 'cottage industry'. This distinction turns on a particular definition of 'commercial' as intentionally produced for sale/profit. But once material is reproduced and distributed or exchanged it ceases to be private. Entry into the public sphere means the potential for it to become commercialised exists, either in terms of personal gain, or being passed on to someone else who chooses to use it for monetary profit. The term 'cottage industry' is also inappropriate, since it suggests using outdated methods. It is now easier than it has ever been for individuals to obtain sophisticated technology with which to produce and distribute pornography. Perhaps the better analogy is with illegal drugs, where an informal and unregulated market exists, making accurate assessments of the extent of production, exchange and sale extremely difficult.

Also at issue here, as with adult pornography, is whether sexualised images of children, or innocent pictures with sexually suggestive captions/words, used in mainstream media should be included. Additionally the ways in which more mainstream media and 'soft core' adult pornography deliberately 'childify' adult women needs to be addressed. Part of the appeal of the topless models on Page Three of the British tabloid *The Sun* is that the pictures are of young women, and a number of the mainstream newspapers which publish such pictures tantalise their male readers with promises of 'future attractions': young women they cannot currently show topless as they are not yet sixteen.[4] *Playboy* developed a particularly devious way of publishing pictures of children including photos of the centrefold 'Playmate' as a child, with captions like 'Age one – *Playboy* material already', 'Age two – boy chasing already', 'Age three – anytime Dad' (Reisman 1986). Another study analysed all cartoons in *Playboy* in 1985, and found that child like naivete of women was a key theme (Matacin and Burger 1987).[5]

Osanka and Johann (1989: 451) have devised a wide definition of child pornography which is the most useful we have found to date: 'pictorial, written and audiovisual materials depicting children in explicit sexual acts or poses . . . to be considered pornography the material would have to be produced to perpetuate victimisation, sexually stimulate the user, seduce victims, or achieve commercial gain'. They further argue that 'substitute child pornography' ought to be actionable under child pornography laws; within this they include sexualised images of children and adult women behaving as/dressed like children, and would no doubt add the more recent pseudo-images produced by computer technology.[6]

Prostitution also tends to be defined as a commercial enterprise, where sex is exchanged for money. It is also usually understood as involving third parties, indi-

viduals who in various ways act as the intermediaries between those purchasing and those supplying the 'services'. We know from children and young people themselves that they may initially, or consistently, act independently, exchanging sex with adults for goods in kind, such as shelter, food and companionship. We also know about situations where third parties do indeed provide sexual access to children, but money is not exchanged. Green (1992) defines prostitution as sexual services in exchange for some form of payment, and notes that this can take the form of money, drink, drugs or a roof over one's head.

While this is a more accurate definition, it still implies that there is a direct one-to-one negotiation between the child/young person and punter. There are, however, other mediums of exchange between adults, which sexual abuse of children can be used to facilitate. The profits which can accrue to the procurer/facilitator, can include: access to other children themselves; access to child pornography (Tyler and Stone 1985), economic, political or social alliances and advantages. There can be a combination of money and other forms of 'profit'/advantage involved. While the full details of what was involved in the Kincora case in Ireland will probably never be known, what that case and others before and after have highlighted is that sexual access to children and young people is used as a power resource between men; to promote economic, political and social interests which either they already share in common, or which may be a direct outcome of the provision of children/young people to abuse.[7] Some forms of sexual exploitation of children, therefore, involve the sexual use of children as a medium of exchange between adults. The children and young people involved may or may not be aware in these contexts of the multiple uses to which they are being put. If prostitution is defined purely in terms of economic gain then many of these contexts in which sexual access to children and young people is used as a medium of exchange between adults will be excluded.

Further debate and exploration of definitions is urgently needed, since they are the conceptual framework within which legislation, policy, data collection and research are located. It is our view that attention needs to be given to this matter before other steps are taken. What is needed are analytic definitions linked to both the UN declaration and what we currently know about sexual exploitation, and less inclusive working definitions which recognise that legal frameworks, and hence available national data, do not conform to the broader definition. Without this, the disjunctions between international and national law and the experiences of children and young people will remain a barrier to practical progress.

The prevalence of sexual abuse and sexual exploitation

The many ways in which children are abused and exploited raise uncomfortable issues about adult power and responsibility, the structure of the western nuclear family, fatherhood motherhood, masculinity and male sexuality. They, furthermore, challenge the western assertion that childhood is 'a time of play, an asexual and peaceful existence' (Kitzinger 1988: 78). Many would rather not look too closely at the reality of childhood. If we did, we

would discover, amongst many other things, that large numbers of children in our own countries and internationally are sexually abused, and a proportion are caught up in the sex industry, used in the production of pornography, used in prostitution and trafficked for these purposes. As both child pornography and child prostitution are illegal in most countries, both tend to be seen as relatively small and unimportant sectors of the sex industry. Evidence of the sexual victimisation of children and adult women, though, confirms that an act being illegal does not mean it is not prevalent.

How sexual abuse and sexual exploitation are defined affects how common they are found to be; narrow definitions produce lower prevalence figures. While there is now an extensive (although more limited in the case of the UK) international knowledge base on sexual abuse in childhood (Finkelhor 1994), detailed knowledge about sexual exploitation of children is still rare. A number of factors combine to create these knowledge gaps. Most prevalence research does not ask the kind of questions which would reveal sexual exploitation, either as a factor in ongoing sexual abuse or as separate from it. Official statistics also fail to record sexual exploitation as a category. Child abuse data collated by local social services departments does not have sexual exploitation as a recordable form of abuse, and most investigations currently do not routinely ask about it. Police data also does not include it as a category, and prostitution cases involving children and young people are often hidden within overall figures.

Collating evidence for *Splintered Lives* revealed that some evidence from a range of sources existed, including: individual cases which have been investigated and/or prosecuted; re-analysis of official data: studies involving young people and adults involved in the sex industry; information collected by support agencies; research and clinical data from sex offenders; testimony from survivors of sexual exploitation (for more detailed review see Kelly, Wingfield *et al.* 1995). We briefly present data from our two studies on sexual abuse, which did include questions which enable detection of sexual exploitation. The first was an exploratory prevalence study involving 1,244 young people (aged sixteen to twenty-one), attending further education colleges in England, Scotland and Wales, who self-completed questionnaires (Kelly, Regan and Burton 1991). Using the widest definition of sexual abuse (including flashing, defining childhood as up to 18) more than one in two young women and one in four young men reported at least one experience. Restricting the definition to contact forms of abuse which occurred before sixteen produces prevalence rates of one in four young women and one in ten young men. Questionnaires are rather blunt instruments for understanding the complexity of experience. But we do know that for three young people their abuse consisted only of being shown pornography. Over a third of young women and a tenth of young men reported multiple experiences of abuse, some of which undoubtedly involved organised networks.

The second study explored the impacts and meanings of sexual abuse in childhood for adult survivors, and used a multi-methodological approach, combining questionnaires and in-depth interviews. In this study we asked more explicit questions about the role of pornography and prostitution in

abuse, and gathered more evidence on this, despite a smaller sample. Of the whole sample (353 men and women), 2 per cent reported being sexually exploited in pornography and/or prostitution. In the smaller interview sample additional experiences of sexual exploitation were revealed, often linked to abuse in family contexts.

Other UK research has aided our understanding. A national incidence study of reported organised abuse (Gallagher, Hughes and Parker 1996) revealed limited evidence of sexual exploitation, but it was made clear formally and informally that such cases often never reached the police and social services child protection teams, since they were understood as the preserve of serious crime, or vice, sections of the police. The Manchester based research team conducted their study in the early 1990s. It involved two linked elements, a survey of all police departments, social services and NSPCC teams in England and Wales covering cases from 1988 to 1991, and detailed record searches in eight areas.

The national questionnaires produced 211 cases; a mean incidence per year of fifty-three, and 1,500 children were known to be involved in these cases; 918 boys and 483 girls. There was one case involving a lone woman offender, although women were involved in almost a quarter of cases overall. The agency record searches in only eight local areas produced seventy-four cases; extrapolating from this to the whole country produced an estimate of over a thousand cases for the three year period; an incidence of 333 per year; five times the estimate based on the questionnaires. The researchers concluded that relying on practitioners' memories, which the questionnaire did, did not produce reliable estimates of incidence. In relatively few of these cases was evidence of pornography production found, but the researchers note that the police are not currently equipped to detect it, unless they are looking for it from the outset. There were, however, some cases which undoubtedly involved forms of commercialised sexual exploitation of children, and a number where child pornography formed an important evidential element in the prosecution of the cases.

A survey in 1991 by SAFE (South Birmingham Community Health NHS Trust HIV prevention outreach programme), involved interviews with twenty-two young women care leavers involved in prostitution. Over 50 per cent had been involved before they left care, that is before they were sixteen, and four had had experience of prostitution before being taken into care (Linehan 1994).

N. J. Wild has published two studies of sex rings investigated by the police in Leeds (Wild 1986, 1989). Thirty-one rings were identified in two years involving forty-seven male offenders and 334 children (296 girls and 38 boys). Pornography was shown to a third of the children. Most rings involved a single offender (in twenty-five cases) or two (in three cases) offenders, but three involved four or more. These larger rings were expanding and developing semi-commercial prostitution, one involving girls who were met outside the children's home where they were living. Children were recruited as, or alternatively promoted to, ringleaders in the majority of the rings. Two rings were known to be involved in the production of pornography, and two

additional extensive male prostitution rings were studied, but for some unstated reason not included in the thirty-one. Boys in these rings were sometimes transported to other cities, especially London, for temporary involvement in the local prostitution network. One preyed primarily on runaways and disadvantaged boys, who were sometimes coerced into prostitution through threats regarding pornographic tapes made of them having sex with their abusers. Wild found 'commercial' rings, those dedicated to the production of pornography and/or the prostituting of children for financial profit were the least common. The sexual abuse ring cases were 4.6 per cent of all sexual abuse cases and 6.6 per cent of prosecutions in the local area.

Three common themes can be drawn from the current evidence:

- that sexual exploitation cannot be easily separated form other forms of sexual abuse, and a focus on only 'commercial' forms will seriously underestimate incidence;
- currently much sexual exploitation is not being addressed as child abuse;
- that males are the vast majority of sexual abusers of children, including sexual exploitation (although women are more involved in 'organised abuse').

Exploring the continuum

The concept of the continuum (Kelly 1988) was developed to express the connections, and complex boundary issues, between forms of violence against women. It does not preclude examining particular forms in detail, but seeks to ensure that connections at both the theoretical level and the level of lived experience are recognised and explored. This can be extended to sexual abuse of children, and the links between this and woman abuse. For example, Maureen O'Hara (1995) stresses the importance of not separating the use of children in the sex industry from that of women, since where exploitation of women is tolerated that of children can thrive.

In terms of boundary issues, two examples will illustrate the ways connections can be noted or ignored. In terms of pornography and prostitution there is now a recognition that where children are involved this constitutes abuse, in terms of adult women, however, there is considerable debate about whether these constitute forms of violence against women. If we think about an individual young woman, on one day actions would be understood, and possibly even responded to as a form of abuse, but on the next day, because this individual has had a birthday, the same acts become for many an issue of choice and personal freedom. At what point can the young woman be said to have made a choice, at what point was she free to do so? Several research projects have documented the increased prevalence of rape and physical assault for those working in the sex industry (for example, Silbert and Pines 1984, O'Neill 1995b). Exploring the connections in both these examples has implications for theory and practice.

Many of the ways in which sexual exploitation is distinguished from other

forms of sexual abuse do not stand up to detailed scrutiny. Some sexual exploitation takes place within familial abuse, and here there may also be multiple abusers as well as single ones. The forms of entrapment used to gain and ensure continued access to children are common across many contexts, and forms of reward, including money are not a distinguishing factor. The survival strategies children and young people use also have common elements, the one difference here being that some use commercial sexual exploitation as an escape from abuse at home.

Conceptual and explanatory frameworks

It has been suggested in the debates on adult pornography and prostitution that focusing on children's involvement is 'too easy', and that the issues are not the same. It is not so much that focusing on child pornography and child prostitution is too easy, but rather that it is too revealing. When we see or hear about children being used in this way we tend to ask 'who is this child?', 'how did they get there?' – questions which are seldom asked about adult women in the sex industry. Child sexual exploitation forces us to face the issues of the production of pornography, how children come to be involved, undercutting the safer terrain on which most discussions take place about women's consent and participation. Since children have no legal status as citizens, and limited access to knowledge and experience, they cannot meaningfully be held to have consented, or to have entered into any form of legal contract. The very existence of child pornography undermines the distinction we are frequently asked to make between acts of sexual violence and representations of them. Libby Kroon was abused by her father and his friends, and forced to act out violent pornography with her siblings. She makes this point with revealing clarity: 'Because of my experiences I believe that the real crux of the pornography issue is not whether the national crime rate rises or falls, but what is actually done to the person or persons involved' (Kroon 1980: 1).

The most obvious point about both the production of child pornography and the practice of child prostitution is that neither can occur without an act (or more likely acts) which are defined in law as illegal taking place. Each event requires (and in the case of child pornography records) the sexual abuse of the child. Moreover, the practices of prostitution and pornography involving children can be closely connected.

Documentation of organised abuse networks has included references to sexual exploitation. But there are problematic issues of definition here too. The majority of references to networks tend to preface this with the word 'paedophile', and indeed many in the child protection field have begun using 'paedophile' as either a collective term for all abusers or to refer to what is presumed to be a particular type of abuser. As we write this the term has become virtually ubiquitous. We strongly believe that to adopt this terminology will foreclose much needed discussion and debate, and abandon much of the hard won knowledge of the last decade. We list below our misgivings about the adoption of 'paedophile' as a concept (for more detailed discussion see Kelly 1996).

- Rather than enabling recognition of abusers as 'ordinary men' – fathers, brothers, uncles, colleagues – we are in danger of returning to the more comfortable view of them as 'other', fundamentally different, not 'normal' men.
- Attention shifts from issues of power and control to notions of sexual deviance, obsession and addiction; thus paedophilia medicalises and individualises what is clearly a social issue concerning the construction of masculinity and male sexuality (Liddle 1993).
- The view (primarily proposed in self-serving ways) that paedophilia is a particular 'sexual orientation' prevents us recognising the commonness of 'sexual arousal' to children (Briere and Runtz 1989).
- Separating 'paedophiles' from other men who sexually abuse means we both presume the differences between them, and fail to notice similarities in the kinds of acts involved, in the ways they entrap and control children.
- Defining paedophiles as those interested in the production and consumption of child pornography decreases the likelihood of investigation into its potential presence in all sexual abuse case.
- A significant proportion of the clients of children/young people involved in prostitution are unlikely to fit most definitions of 'paedophile'. In the words of Sara Swann, a social worker for a Barnardos' project working with this group of children and young people: 'what is a paedophile anyway? As far as we can see on this project, he's over thirty, drives a nice car and has a wife and kids' (*Guardian*, 21 August 1996).
- In presuming difference we also fail to notice or look for other connections, such as that some families are the pivot for organised networks, or that any sexual abuse, including that in the family, may also include pornography and forms of prostitution.
- Whether intentionally or not, calling a section of abusers 'paedophiles' is accompanied by an emphasis on boys as victims, and the abuse of girls and young women outside the family becomes increasingly invisible.
- Unlike 'child abuser', or 'child molester' the word 'paedophile' disguises rather than names the issue, focuses our attention on a kind of person rather than kinds of behaviour.

In much of the literature there are inconsistencies in how 'paedophilia' is defined, although the most common element seems to be not just a preference for, but the restriction of arousal to, children. This 'fact' is however presumed, and the possibility that there may be other kinds of sexual contact with adults is never explored. Julia O'Connell Davidsons' work (1995) is documenting the fact that the dividing line between the men who exploit children and women in sex tourism is neither clear nor absolute. The focus on sexual arousal moves us into further difficulties, since the recent emphasis on individual men choosing to act or not act, and having to take responsibility for those choices is much more difficult to sustain where 'arousal' is represented as a biological/essential element within individuals.

These confusions have, if not created, at least contributed to a context in which men who seek to justify their wish to abuse have been able to organise

politically, and even seek the status of an oppressed sexual minority. They also form the basis for a differential approach in terms of intervention, with responses being discussed in relation to 'paedophiles' – such as life licences, and denial of any contact with children – which would seldom be proposed in the case of fathers.[8] The issue here is not whether the responses themselves are appropriate, but the ways in which distinctions are being made between typesets of abusers which may prove to be spurious.

At a European seminar on sexual exploitation the concept of paedophilia was linked with the equally problematic concept of 'cycle of abuse'.[9] One senior policy maker summarised a perspective held by many delegates: 'It is deplorable that one out of three children could be "paedophile" in the future'. This widespread and unquestioned acceptance of a flawed explanatory model needs to be questioned, both in terms of the evidence to support it and its consequences child and adult survivors of abuse.

In its simplest, and most common form, 'cycle of abuse' proposes that if you are abused as a child you will in turn abuse others. But if we begin with what we know about the gendered distribution of sexual victimisation and offending the proposition begins to fall apart. We know that girls are between three and six times more likely to experience sexual abuse, yet the vast majority of sexual abuse (including sexual exploitation) is perpetrated by males. If there is any kind of cycle it is a gendered one, and that in turn requires explanation.

Even if we limit our focus to perpetrators the data here is also equivocal. No study has yet demonstrated that there is an obvious 'cycle' even within samples of convicted offenders; the range of those reporting experiences of abuse in childhood varies between 30 and 80 per cent.[10] In all studies to date either a majority or significant minority cannot be fitted into the theory. Alongside these glaring problems in evidential support, there is seldom any exploration of the precise mechanisms involved whereby those who have been victimised become victimisers, since this is not simple repetition, but a reversal of roles.

Disputing this model does not mean there are no examples where experiences of abuse are present in generations of families, or that some individuals have decided to deal with past hurts by inflicting pain on others. We are, however, raising questions with regard to the limitations of 'cycle of abuse' as an explanatory framework, and the unhelpful consequences of its current popularity.

The consequences for child and adult survivors of abuse are both extensive and seldom referred to. It is now commonplace for supportive and therapeutic work with children to be justified through 'cycle of abuse', to prevent them becoming abusers. This denies children's need for, not to mention right to, support simply because they have been hurt or are in distress. It is also becoming commonplace for adults who have been abused in childhood, both women and men, to believe that they cannot be trusted around children, that there is an inevitability that they will abuse them. In most of the instances we have encountered (all involving women) when this is explored in more depth the individuals concerned have never felt a desire or wish to abuse. Their

conviction that this will be the case comes solely from ideas in the public sphere. Additional worrying implications of the adoption of this explanation can be seen in Area Child Protection Committee guidelines which define being an adult survivor of child sexual abuse as a risk factor in relation to one's own children (this is especially unfair to mothers, given what we know about the gendered distribution of offending). In some places this suspicion has extended to workers who are open about the fact that they are survivors. Some adult survivors are angry and eloquent about the pernicious consequences of this model, as these examples from a recently completed research project (Kelly, Burton and Regan 1996) illustrate:

> My mother was abused by men outside her family; she hasn't abused myself or my brother. I know many people – male and female – who were abused, some continuously and severely. They have not become abusers. I am very sceptical about this theory. The majority of abused are female, the majority of abusers are male. Where are all the female abusers?
>
> I don't agree – I haven't found myself fondling three-year-olds and don't feel any desire to. It's an excuse to avoid the real issues of abuse. A person has the choice NOT to abuse. Many men go on to abuse and use it as an excuse.
>
> It confirms everything victims of abuse already believe about themselves. It offers no hope of healing . . . it denies the possibility of survival. It allows experts to look at these distant, mad, bad, sad unfortunates, sexual deviants, rather than themselves. It tends to rigidly fix men as abusers, women as victims. It removes any responsibility from perpetrators.
>
> (Kelly, Burton and Regan 1996)

Why when the evidence is shaky, and the implications for child and adult survivors so negative, has 'cycle of abuse' has become widely accepted as an explanation? On one level it is a neat and accessible concept. In offering this 'common sense' explanation though, it represents abuse as learned behaviour as if it were the same as learning a nursery rhyme. Apart from the basic fact that abusing others is a very different action to being victimised, a thinking and decision making process is involved before we act similarly or differently to events we have been witness to or experienced. Simplistic cycle of abuse models also fit uneasily with the knowledge developed on offenders over the last ten years which shows that they are careful, deliberate and strategic in entrapping children.

So powerful is this idea, though, that even academics who recognise that most people do not repeat the 'cycle' refer to this as 'breaking' it. We need to ask ourselves why this notion has taken such a hold within public and professional thinking. Most crucially it excludes more challenging explanations, those which question power relations between men and women, adults and children. 'Breaking cycles' is a much easier and safer goal to discuss than changing the structure of social relations.

Finding an appropriate explanatory framework for sexual exploitation requires returning to the premise that child pornography, child prostitution and trafficking are themselves forms of child abuse. When we locate the issue of sexual exploitation in a global context, the clear lack of options for children and young people in developing countries, the evidence of organised trafficking, and conditions which can only be described as 'sexual slavery' (Basak 1991) shifts our attention from 'sexual rights' – be they for children or adults – to the basic human rights of life, liberty and security of the person. While there is a strong argument that human rights are not divisible, it is none the less incontestable that basic survival is a requirement in order that other rights can be exercised. Changing the basic conditions of children's lives is, therefore, a necessity if we are to decrease the prevalence of sexual exploitation, and other forms of child abuse. A global perspective also demands that attention is directed towards the activities of those who trade in human beings, and organised networks of skilled abusers.

The sex industry relies upon and trades in all forms of inequality; children's particular powerlessness (in that they have more limited legal and practical options than adults), and in various contexts their individual survival needs, makes them a unique target, both for consumers and producers. The prime movers in the commercial trade in abuse have sophisticated understandings of global politics and economics, national and international enforcement patterns, and of changing commercial and technological opportunities.[11] An adequate explanatory framework needs to reflect this complexity, and be able to account for all that we currently know about sexual exploitation. Neither of the two we have examined earlier come close to passing this test.

Policy and practice implications

While several books and articles in the 1980s (for example Burgess *et al.* 1981; Wild and Wynne 1986) documented sexual exploitation as a form of sexual abuse in childhood, these were the exception not the rule. It is also instructive to remember that changes in paediatric practice, elements of which were to become problematised during the Cleveland crisis, developed through the investigation of several large sexual abuse rings in Leeds in the early 1980s (Campbell 1988: 103–11). Practitioners have been working with, and researchers have been investigating, sexual abuse outside the nuclear family, cases involving more than one abuser and many children, pornography and prostitution, but this has seldom been reflected in theoretical frameworks, training and practice guidelines.

While much has been written on theoretical approaches to child sexual abuse, the predominant focus has been on incest. More recently there has been increasing recognition that this is an inadequate base for both explanatory and practice frameworks. Although most children are abused by adults and peers they know, these are not always – or even in the majority of cases – family or household members (Kelly, Regan and Burton 1991). Theoretical perspectives which take familial sexual abuse as their centre, cannot encompass sexual exploitation, and moreover have been a hindrance to understanding and exploring the occasions

when familial sexual abuse and sexual exploitation occur concurrently. We conclude with some of the implications of locating sexual exploitation within the continuum of sexual abuse and of violence against women and children.

Explanatory, policy and practice frameworks need to be revised to encompass sexual exploitation within and outside the family

This will involve substantial revision of professional training, both at initial qualifying levels and in-service training and of internal and inter-agency guidelines. 'Adding in' sexual exploitation and/or organised abuse is an inadequate response since it will fail to note the links and connections we have highlighted. The individual case work approach is ill-suited where many children are involved, where abusers are organised and may be linked into criminal networks. While some police officers have skills and knowledge which enable a different form of response few social work departments and child welfare organisations do.

The possibility of pornography and prostitution should be a factor in all investigations of sexual abuse

This will not only ensure that the child's experiences are fully explored, but will also highlight potential problems for some children in relation to video recording interviews, and may uncover important evidence in the form of child pornography, mere possession of which is now a criminal offence.

Specialist training, and possibly regional units, need to be developed to investigate complex sexual abuse cases

This issue has been raised in discussions of 'organised abuse' (Bibby 1996). Such training and units should not be confined to sexual exploitation or to 'paedophile' rings (as the Scotland Yard unit is now named), but to all cases where multiple forms of sexual abuse, and/or multiple offenders or victims are involved. The West case alone, which combined incest, sexual abuse and torture of lodgers and kidnapped girls and young women, adult and child prostitution (and possibly the production of pornography) and sexual murder alerts us to the dangers of narrow and exclusionary definitions.

Under-sixteens involved in prostitution should be responded to through child protection and the 'children in need' provisions of the Children Act

Until 1999 many under-sixteens were responded to through criminal legislation on soliciting (Children's Society 1994) and while most were not convicted, many were cautioned. Following experiments with a child protection response in several police forces and extensive lobbying from children's charities, new

government guidelines now emphasise using the 'children in need' provisions of the Children Act; in other words, seeing this group as children who have had offences committed against them. While extremely welcome, implementation needs to be monitored and local strategies evaluated for their effectiveness in enabling children and young people to exit prostitution.

Detailed national and local investigations need to be undertaken into the connections between being in care and young peoples' involvement in the sex industry

This connection has been known about for some time within the child protection and social work fields, but little serious exploration or response has been evident. We need to know what the connections are: do local pimps target children's homes (and if so how do they detect them and why do they do this); is this the one outcome of the extensive sexual abuse of children within children's homes (and if so is the link the abusive care workers being connected to networks outside the institution or is it an attempt to cope/survive used by young people)? Unravelling the many potential factors involved will require sensitive and in depth study.

There have to be possibilities for children and young people to survive outside the nuclear family

Included here are high quality, safe, children's homes, staffed by workers who can deal with the complexity of lives marked by sexual abuse and/or sexual exploitation. The restoration of social security benefits to young people aged sixteen and seventeen would close one route into the sex industry that has been amplified, if not created, by recent social policy.

Specialist projects which are directed at children and young people involved in sex industry need to be extended

A few such projects exist in Britain, primarily funded by children's charities. The issues should be addressed in local authority Children's Plans. Such provision needs to combine support, advocacy, resettlement, education and training. For many young people their involvement in sexual exploitation is complex, and simplistic approaches which stress either 'rescue' or 'choice' will fail to address their experiences and needs.

Children and young people need access to accurate information about pornography and prostitution

Within both sex education and other areas of the curriculum (for example media literacy) these issues should be addressed. The potential dangers and harms

involved in the sex industry should be explicitly dealt with. All teaching on 'safe sex' should begin from the standpoint that 'safe sex' is non-coerced.

Policy initiatives need to address the issue of demand

Without the demand – from men – for both pornography and prostitution there would be no market for the sexual exploitation of children. To address the problem at its root requires serious thought being given to how to stem, and eventually eliminate, demand.

Our recommendations combine awareness of the connections and differences between sexual exploitation and other forms of sexual abuse of children. Some of them also point to the need for connections to be made with violence against women. We will only be able to make a difference in children's lives if we are willing to look at complexity, make the appropriate links.

Notes

1 There is continuing debate as to whether the word 'abuse' is an appropriate term, since it implies that there is some form of legitimate 'use' of women and children. Australian feminists have resolved this by adopting the term 'child sexual assault', and others have suggested that the more appropriate term might be 'sexual violence against children'. While mindful of these conceptual problems, we use the word abuse, since it continues to be the term most commonly used and understood in Britain.
2 This formed a major part of the media debate in June 1995 on findings from a survey commissioned by National Society for the Prevention of Cruelty to Children (Creighton and Russell 1995)
3 These issues, in terms of Europe, also need to be placed in the context of: the increasing permeability of frontiers; the growing mobility of people and goods; and information technology providing new production, distribution and marketing possibilities.
4 In the late 1980s, Page Three of *The Sun*, a British daily tabloid newspaper, became a focus for feminist campaigning, when Clare Short MP put forward a private member's bill to ban 'photographs of naked or semi-naked women in national newspapers' and received a great deal of popular support as a result. A feminist anti-pornography campaign was launched from the momentum gained during this period, although the bill itself was eventually talked out.
5 *Hustler* has run a particularly offensive cartoon strip 'Chester the Molester' for many years; the central character is a child abuser.
6 These images are created from combining elements of different images, thus creating a new image that does not depict a real person. Thus children's faces or bodies can be combined with those of adults.
7 The Kincora case involved accusations of regular and ongoing abuse of boys in a children's home, and allegations were made implicating politicians and the intelligence services, amongst others (Livingstone 1990). The eventual enquiry left open as many questions as it answered.
8 This 'double think' is evident in the consultation paper *Sex Offenders: A Ban on Working with Children* (1997) issued by the Home Office and Scottish Office. The proposals relate to a range of sexual offences (including – inappropriately in our view – indecency between men, which is often used to entrap gay men in 'cottaging'

offences), but in the text the issue becomes that of 'paedophiles'. There is no recognition of the fact that a man convicted of incest would under these proposals be banned from working with children, yet under the provisions of the Childrens Act not prohibited from contact with the child or children he sexually abused.

9 Child Pornography and Sexual Exploitation, European Forum for Child Welfare, Brussels, June 1995.

10 A further problem is that many of these studies define abuse in childhood differently. Some limit their data to whether the individual was abused in the same way as he has subsequently abused children, whereas others include any form of child abuse in the individual's childhood while focusing on sexual offending in adulthood. Clearly the latter will produce higher findings, but the psychological mechanisms involved in moving from experiences of physical abuse and neglect to sexual abuse cannot be the same as those where the same form of abuse is involved. There is rarely any discussion of these crucial differences.

11 At the International Conference on Violence, Abuse and Women's Citizenship (Brighton, November 1996) Laura Lederer and Kathleen Mahoney presented data demonstrating that the changing patterns of production and distribution of child pornography correlated strongly with the relative strength and weakness of national legislation and enforcement.

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5 Incest, 'paedophilia', pornography and prostitution

Conceptualising the connections

Catherine Itzin

Introduction

In this chapter I return to previously published work on pornography and child sexual abuse (Itzin 1996, 1997a, 1997b). I summarise the findings from the relevant literature and use this to highlight some of the limitations of current definitions and categories of child sexual abuse based on paedophile typologies and sex offender classifications. I am reproducing the two conceptual models developed in the earlier work (modified slightly) which illustrate graphically the organisation of child sexual abuse and the overlapping categories of intrafamilial and extrafamilial child sexual abuse and exploitation. In this paper I use those models as the basis for developing a typology which constructs the connections between incest, 'paedophilia', pornography and prostitution in a 'Continuum Typology of Child Sexual Abuse and Characteristics of Child Sexual Abusers' that captures the cross-over of victims and perpetrators, the overlapping contexts and the common characteristics of abuse and abusers as identified by survivor accounts and sex offender data. This in turn becomes the basis for constructing a 'Nosology of Child Sexual Abuse Classification' which genders the abusers and takes account both of the overlaps and of the dominant discourse currently of policing and policy in which 'paedophilia' and 'child sex offending' have become synonymous, and incest abusers have become invisible.

Identifying the connections

In 1996 I undertook a review of the clinical and research literature on pornography and child sexual abuse for a chapter in a book on organised abuse (Bibby 1996), and a paper for the 4th International Family Violence Conference, subsequently published with other papers from that conference (Kantor and Jasinski 1997) and in *Child Abuse Review* (1997b). In the absence of research on pornography and child sexual abuse, it was necessary then to draw on a range of knowledge and research from different sources and contexts to build up a picture of those relationships.

There was evidence from child pornography of child sexual abuse and serious sexual assault on children recorded on film and videotape (Tate 1992;

Kelly 1992); from the Internet of the traffic in children in the form of child pornography and prostitution (Hughes 1996, 1999); from policing in the USA and the UK of the use of adult and child pornography by 'paedophiles' to groom and to entrap children (Hames 1993); from research and clinical work with sex offenders of their use of pornography in preparing for and perpetrating child sexual abuse (Marshall 1988; Wyre 1992, and chapter three, this volume); from research on prostitution of the use of pornography by pimps and punters, and of the sexual abuse involving pornography reported by prostitutes as having occurred in their childhoods (Silbert and Pines 1984; Barry 1988; MacKinnon and Dworkin 1998); from data collected by the United Nations on the 'vast national and transnational problem' of the traffic and trade in women and children for purposes of pornography and prostitution (Muntarbhorn, 1995: 60–1) and of the market in sex tourism (Barry 1992; Ireland 1993); from research on organised abuse of the use of pornography in the entrapment of children and the making of child pornography (Burgess, 1984; Burgess and Hartman 1987; Creighton, 1993; Wild 1989).

Discovering the 'overlap' – 'crossover'

There was very little then in the literature on pornography and incest and that remains the case. Kelly, Wingfield, Regan and Burton had found in a review of the notes of seventy-eight children who over a six-month period contacted the UK charity Childline's telephone helpline for children who are experiencing abuse that for thirty-two of them their sexual abuse was 'linked to either being shown pornography magazines or videos or becoming involved in the making of abusive videos' (Kelly *et al.* 1995: 2). They cited data from Germany, where police had estimated that '130,000 children are forced by parents or other close acquaintances to participate in the production of pornography' (Groner 1992: 40). Primarily, however, data on pornography and incest came from published accounts by survivors of their sexual abuse as children (Kroon 1980; Danica 1988; MacKinnon and Dworkin 1998) and case study data from other sources (Davies 1994), and I used this material, together with a case study of a woman whose experiences I collected through a series of interviews and analysed for purposes of that work ('Edwards', chapter seven). From that material emerged a picture of the links between intrafamilial and extrafamilial child sexual abuse and child sexual exploitation, and the role of adult and child pornography in every form of child sexual abuse.

Consistent with the findings of community studies and clinical data, the sexual abuse in the survivor case studies was perpetrated primarily by men: most often by fathers on daughters, or by uncles, grandfathers and brothers, by male members of the immediate or extended family. Consistent also with the findings of research on organised abuse, women in my case study and other survivor accounts were found to be 'implicated jointly with a partner, as knowing of the abuse, not protecting the child or assisting a male abuser' (La Fontaine 1994: 12). Importantly, in the case study data it was possible to see the interfaces with

and overlap between intrafamilial and extrafamilial child sexual abuse, adult and child prostitution, and adult and child pornography. These overlaps were confirmed by findings from research and clinical work with sex offenders.

Eldridge (1997, and chapter sixteen, this volume) cites research with ninety-nine sex offenders by Weinrott and Saylor (1991) showing that, by their own account, one third of the convicted rapists admitted child sexual abuse, that one third of extrafamilial abusers were also incest offenders and half of the incest offenders had also abused children who were not their own. Becker and Coleman (1988, cited in Salter 1995) found that 44 per cent of the men in their sample who had molested female children in the home had also molested female children outside the home. In addition, 11 per cent had also molested male children outside the home and 18 per cent had committed rape. Abel *et al.* (1988) found that 49 per cent of the incest offenders who molested girls within the family, also molested girls outside the family and 19 per cent were also rapists. In their research on 'child abuse which involves kin and family friends', Cleaver and Freeman found 'considerable overlap' between the 'men who establish connections between families, and the commerce of child pornography and prostitution'. They also cite the case of a member of a 'paedophile ring' whose sexual interest and sexual abuse of his own children had been 'kept a secret from his family'. All of this, they believe, raises issues about 'current police and social services practices which deal with these . . . as if they were discrete phenomena' (Cleaver and Freeman 1996: 233, 243).

Seng (1986), in considering 'some issues of definition' with respect to 'sexual behaviour between adults and children', found the distinctions between sexual exploitation (including child pornography), incest and child molestation can become blurred by the fact that the offenders may very well be the same: 'that is, an incestuous father may involve his daughter as a participant in child pornography and child molesters are indeed very apt to involve their victims in pornography' (Seng 1986: 56). Even the diagnostic definition of 'paedophilia' as 'the act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement' is not supported by research. Langevin and Lang found that 66 per cent of 'heterosexual paedophiles' were married at some time, 91 per cent had vaginal intercourse with an adult female and even 50 per cent of 'homosexual paedophiles' had done so. They found that 'empirical controlled studies' did not support the view that 'paedophiles' were 'shy, unassertive, sexually ignorant' and have 'an aversion to adult females' (Langevin and Lang 1985: 405). Wyre's view, notwithstanding his use of 'paedophile' classifications for treatment and policing purposes, is that incest and 'paedophilia' should not be regarded as separate and different phenomena, that they are 'inextricably linked' (Wyre, in Howitt, 1995: 137, and chapter three, this volume).

I have not, however, found these overlaps reflected in the terminology used to describe abusers, which is largely constructed on the presumption that intrafamilial and extrafamilial child sexual abuse are mutually exclusive categories populated by mutually exclusive perpetrators, as if intrafamilial and

extrafamilial abusers were not in a substantial minority of cases one and the same person. I share Kelly's (1996) concerns about the use of the term and the category of 'paedophilia'. Kelly, Regan and Burton describe it as 'dangerous to create classifications of sexual abuse which are constructed as mutually exclusive categories' (chapter four) because this pathologises some men and shifts attention from the 'recognition of abusers as "'ordinary men" – fathers, brothers, uncles, colleagues', and from the 'centrality of power and control to notions of sexual deviance'; because it constructs 'paedophilia' as a 'specific, and minority "sexual orientation"', distracting attention from 'the widespread sexualisation of children', and focusing 'attention on a kind of person rather than kinds of behaviour'; because it distracts attention from the similarities between 'paedophiles' and other men who sexually abuse children with respect to 'how they entrap and control children' and their 'production and consumption of child pornography'; and because, as 'paedophiles' themselves want it to do, it puts an 'emphasis on boys rather than girls as victims' (chapter four). It leads to the presumption that all or most 'sex tourists' are 'paedophiles' which is not the case (Kelly 1996). Kelly, Wingfield, Regan and Burton found that the sexual exploitation of children for commercial purposes is 'not easily separable from other forms of sexual abuse in childhood' (Kelly *et al.* 1995, and chapter four, this volume).

Constructing models and typologies to include the 'overlap' and 'crossover'

In the earlier versions of this paper I used Kelly's concept of 'sexual violence as a continuum' developed to reflect the extent and the range of sexual violence reported in a study of sixty women, and to capture the 'basic common character underlying the many different forms of violence reported', of the 'abuse, intimidation, coercion, intrusion, threat and force men use to control women' (Kelly 1988: 76). With this in mind I constructed two models based on survivor case study and sex offender data showing how intrafamilial child sexual abuse is related to extrafamilial child sexual abuse and to child sexual exploitation; and how all of this child sexual abuse, whatever its nature and whoever the perpetrator(s), is organised in the sense of decided upon, planned, arranged and executed. This includes incest. Moreover, every form of child sexual abuse can – and does – involve both adult and child pornography. I illustrate this diagrammatically in Figure 5.1.

The organisation of intrafamilial and extrafamilial child sexual abuse and exploitation

This constructs child sexual abuse as continuous along a line from incest/intrafamilial/familial abuse (which may include one form of what is called 'organised abuse'); through nonfamilial/extrafamilial abuse by individual adults known to the child or by strangers (which may or may not

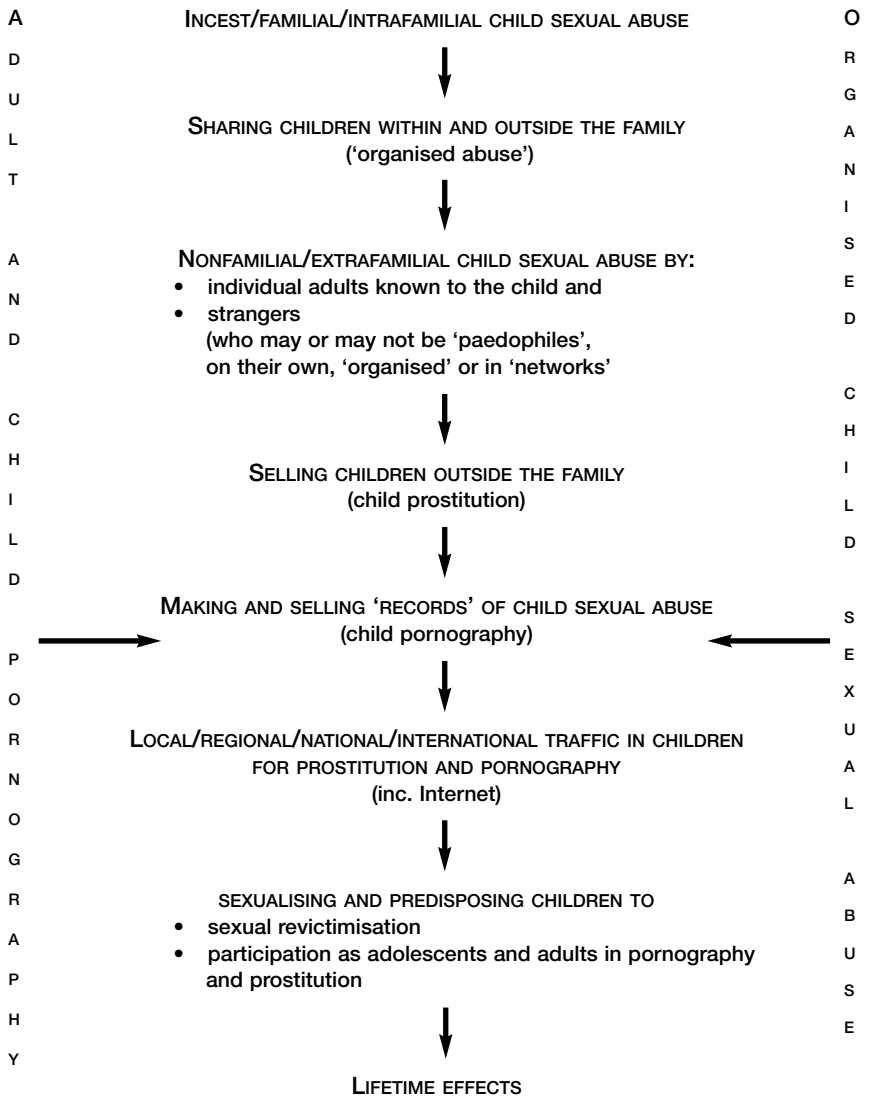

Figure 5.1 The organisation of intrafamilial and extrafamilial child sexual abuse and exploitation

include men called 'paedophiles' operating singly or 'organised' or in 'networks'); to child sexual exploitation in prostitution and pornography, sex tourism and trafficking in children locally, regionally, nationally and internationally; and the globalisation of child sexual exploitation facilitated now by the Internet. Figure 5.1 also showed how making pornography is one of the forms of child sexual abuse that is organised, and also part of the organisation of all the other forms of abuse. I argued that for any one individual victim the

line becomes a lifetime long in terms of the effects of child sexual abuse in the form of revictimisation, participation as adolescents and adults in pornography and prostitution, substance misuse, self-harm, severe depression and systems abuse (see 'Edwards', chapter seven).

The overlapping categories of child sexual abuse and exploitation

In the earlier papers, I also conceptualised these inter-relationships in the form of concentric circles, the outer circle being the boundary of child sexual exploitation and including all those who sexually abuse children for their own personal gratification or for profit. Within this boundary there are the various ways in which child sexual abuse may be organised: in the form of incest; sharing children within and between families; individual abuse by adults outside the family, who may be known to the child or strangers; abuse within groups of related and/or unrelated adults; child prostitution; the making of child pornography; trafficking and sex tourism. These are overlapping rather than discreet categories which may involve the same perpetrators, the same victims, the same or similar activities and the same locations. Figure 5.2 also shows how, in addition to the child sexual abuse which is organised for the purpose of making child pornography, all the other forms of abuse can, and do, involve the use of adult and child pornography.

The child sexual abusers known as 'paedophiles' can be found in any of the categories, and are likely to be found in the categories of incest and child sexual abuse organised between their own and other families as well as amongst known and unknown, unrelated individual adults and amongst the sex tourists. Likewise every category includes normal, ordinary, heterosexual men: fathers, grandfathers, uncles, brothers and their male friends.

A continuum typology of child sexual abuse and the characteristics of child sexual abusers

Following the publication of those models, I went on to consider, in a paper for the fifth International Family Violence Research Conference at the University of New Hampshire in 1998, other ways of addressing conceptually the overlap of perpetrators and victims, and the sites and activities of child sexual abuse. One of these involved abandoning the use of categories altogether and constructing a composite or 'continuum typology' in the form of a descriptive model which takes into account the range of characteristics of child sexual abuse identified in case study and other data. I have constructed this in Figure 5.3 (pages 94–5) in the form of 'a continuum typology of child sexual abuse and the characteristics of child sexual abusers'.

As with the earlier models, it borrows from and builds on Kelly's concept of a continuum of sexual violence to convey the nature and extent to which child sexual abuse in its different contexts, guises and personae is 'a continuous series of elements or events' – and individual men – 'that pass into one another' (Kelly 1988: 76). The construction in Figure 5.3 of 'a continuum of child sexual abuse

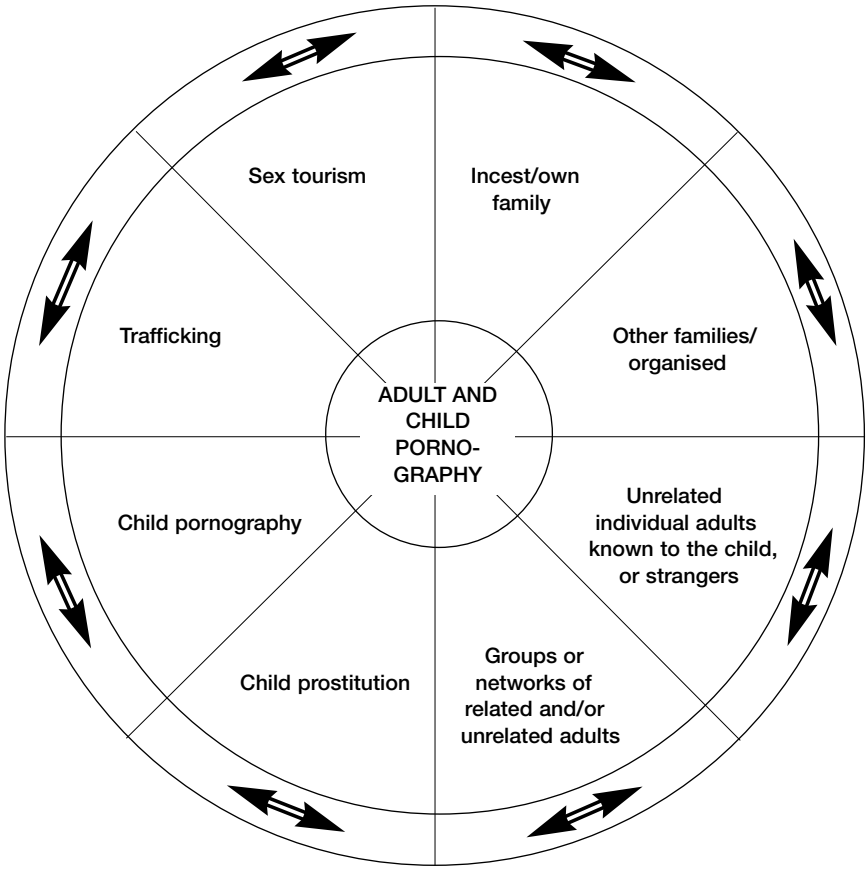

Figure 5.2 The overlapping categories of child sexual abuse and exploitation

and the characteristics of child sexual abusers' is the complete opposite of a taxonomy or typology or system of classification based on mutually exclusive categories, and does not use the words 'incest' or 'paedophilia' or 'intrafamilial' or 'extrafamilial' to describe the abusers. Being inclusive this 'continuum typology' provides a clearer and more accurate picture of the organisation of child sexual abuse and the connections between incest, 'paedophilia', pornography and prostitution as it is perpetrated and experienced.

A nosology of gendered child sexual abuse classification

Another way of addressing the problem of mutually exclusive and misleading categorisations of child sexual abuse as either 'paedophilia' or 'incest' would be to use a classification system such as that in Figure 5.4 (page 96) in which all child sexual abusers are conceptualised simply as either 'incestuous or non-incestuous paedophiles'. This construct presumes there is an overlap and

crossover between intrafamilial and extrafamilial abuse; and it conceptualises incest abusers as 'paedophiles'.

The relationship between adolescent and adult male child sexual abusers of their own and other people's female and male children is represented diagrammatically in Figure 5.4 in 'A nosology of gendered child sexual abuse classification'. This identifies:

1 perpetrator 'age' as 'adolescent' and 'adult'. Home Office statistics identify up to one-third of child sexual abuse as perpetrated by adolescent males; see Print and Morrison, chapter fifteen)
2 perpetrator gender as primarily male, diagrammatically reflecting the fact

All child sexual abuse is carried out largely by men who choose to sexually abuse children because they think it is acceptable to do so, or they believe they have a right to do so, or because they choose to allow their desire to override any inhibitions they may have, and they may rationalise this in various ways.
Sometimes it is carried out by fathers (biological or step-) or conjugal males in a parental role, or by grandfathers or uncles or brothers who are heterosexual in their adult relationships and have sex with female partners, but who may also sexually abuse either male or female children.
Sometimes it is carried out by unrelated or non-custodial males who may be strangers, but are more likely to be known to the child as 'trusted' adults, who may be either heterosexual or homosexual and who may or may not also have adult sexual relationships.
Sometimes it is carried out by men who are primarily interested in engaging in sexual activity with children and not with other adults (the so-called 'paedophiles'), who may be heterosexual or homosexual in terms of sexual preference, but who may have sex with women in order to get access to children, and who may sexually abuse either male or female children, but who may be fixated on certain age and/or gender and/or physical characteristics.
Sometimes, when carried out by any of the above, it may involve more than one adult and/or more than one child (i.e. the multiple victim and/or multiple abuser abuse usually called 'organised' abuse).
Whatever the relationship of the perpetrator to the victim, and whatever the sexual preference of the abuser, the majority of abuse occurs in the home of the child by known adults, and only a small proportion (ranging from 10 to 25 per cent in different studies) is perpetrated by strangers.
Coercion and/or violence may occur in various forms ranging from the manipulative to the brutal in all of these circumstances and contexts.

Figure 5.3 A continuum typology of child sexual abuse and the characteristics of child sexual abusers

that women are found in prevalence studies to be perpetrators of child sexual abuse in only 5 to 10 per cent of cases (Finkelhor 1994a)

3 the perpetrator–victim relationship as paternal and other familial males, and extrafamilial males (Itzin, chapter twenty-one)

4 perpetrator victims as male as well as female children, reflecting the evidence of a higher than previously recognised level of intrafamilial sexual abuse of boys (Watkins and Bentovim 1992; Itzin, chapter twenty-one).

Figure 5.4 (page 96) draws from and builds on the classification conceptualised by Abel *et al.* (1988) as 'incestuous' and 'non-incestuous paedophilia' to make a connection between incest and 'paedophilia' by presuming that paedophilia

All of this abuse is organised, in the sense of being planned or engineered, taking the form of a desire or a fantasy which is acted upon (including that which is explained as 'impulse'), or an intention that is put into action in circumstances that have been either created or presented.
However the abuse is organised, it really just represents different ways of initiating and carrying out the sexual abuse of children. This is also true when the abuse is organised around or to include elements of ritual, including satanic ritual. There may be differences that are useful for purposes of investigation, or 'treatment' of the victim or perpetrator, but they are not significant phenomenologically: they are just different ways of being a child sexual abuser, and of organising access to, and obtaining the compliance of, children.
Sometimes money is exchanged in the sale of a child by a parent or pimp or pornographer (or parent as pimp or pornographer), or a child is paid in money or kind (e.g. goods or accommodation) directly by the purchaser, i.e. the child sexual abuser as customer in child prostitution and child pornography.
Commercial child sexual exploitation in prostitution and pornography may be an aspect of any form of child sexual abuse, however it is organised.
Pornography, in the form of adult and/or child pornography used to season/groom/initiate/coerce children into agreeing to be abused, or the production of child pornography (the 'records' of children being sexually abused), may be implicated in every form of child sexual abuse, however it is organised.
All child sexual abuse is an abuse of adult male power, which has to be understood in the wider context of gendered power relations, of male dominance and female subordination, of sex discrimination and sexual inequality and men's violence against women, in the form of 'domestic violence' and sexual violence such as sexual harassment, sexual assault and rape.

Figure 5.3 (continued)

Perpetrator age	*Perpetrator gender*	*Perpetrator/victim relationship*	*Victim gender*	*Nature of the abuse*
child				
		Adolescent male		
	Adolescent	**Incestuous (intrafamilial) . . . . . .**	**Female/male**	
	male	**Non-incestuous (extrafamilial). . . . . .**	**Female/male**	
Adolescent				
	Adolescent	***Adolescent female***		
	female	***Incestuous (intrafamilial). . . . . .***	***Female/male***	
		Non-incestuous (extrafamilial).	***Female/male***	**Paedophilia**
		Adult male		
	Adult	**Incestuous (intrafamilial). . . . . .**	**Female/male**	
	male	**Non-incestuous (extrafamilial). . . . . .**	**Female/male**	
Adult				
	Adult	***Adult female***		
	female	***Incestuous (intrafamilial). . . . . .***	***Female/male***	
		Non-incestuous (extrafamilial).	***Female/male***	

Figure 5.4 A nosology of gendered child sexual abuse classification

Note: smaller typeface reflects the relatively small proportion of abusers who come into these categories; prevalence studies and clinical data identify women as perpetrators of child sexual abuse in 5–10% of cases only

includes incest: adding 'male' or 'female' indicating the gender of the victims. So 'incestuous male paedophilia' means the sexual abuse of a boy by his father or another familial male and so forth. In a similar vein, Abel and Rouleau (1990) cited in Laws (1994: 4) use the terminology of 'intrafamilial and extrafamilial male and female paedophilia' with 'intrafamilial female paedophilia' meaning incestuous abuse of a girl by a paternal or other familial male.

Conclusion

Both the 'continuum typology' (Figure 5.3) and the 'nosology' (Figure 5.4) have the merit of capturing the cross-over between incest and 'paedophilia', of being therefore conceptually inclusive of the men who sexually abuse both their own and other people's children, and target both girls and boys. Both the 'continuum typology' and the 'nosology' gender the abusers and reveal some of the power relations by showing abusers to be adolescent and adult males and the victims to be female and male children. Bringing incest and 'paedophilia' together conceptually in this way puts the emphasis on the commonality of their characteristics, and takes into account the fact that the dominant discourse of policing and public policy does largely (like it or not) construct child sexual abuse as 'paedophilia', and 'paedophilia' as synonymous with 'sex offenders'. This is likely to continue to be the case.

Both the 'continuum typology' and the 'nosology' also address the concerns expressed by Kelly, Regan and Burton (chapter four) about the dangers of mutually exclusive categories, by capturing the crossover and connections between incest and 'paedophilia', and, at the same time, by making incest more visible than it is in the standard 'paedophile' typologies. In this way the ordinary heterosexual men who sexually abuse their own and other people's children become located correctly and visibly in the same frame as the men the media represent as the 'perverts' and 'monster paedophiles' (Marr 1998), appropriately as these apparently distinct categories of abusers are often in fact made up of precisely the same people. Moreover, what the familial male sexual abusers do to their own children is as 'monstrous' and 'perverted' as the abuse perpetrated by 'paedophiles', and can be even more devastating in its effects (see 'Pearce', chapter six; 'Edwards', chapter seven).

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Part 1.2

The victim experience of child sexual abuse and its effects

6 Paternal incest

An autobiographical account

'Rachel Pearce' interviewed by Catherine Itzin

Introduction

'Rachel Pearce' is a pseudonym. This chapter is the story of her physical and sexual abuse as a child and its effects on her life subsequently. It is based on an interview I conducted with her and edited into the narrative of this chapter. She was aged twenty-six at the time of the interview. Rachel's experience illustrates the connections between physical and sexual abuse of children and domestic violence; the ways in which children accommodate their abuse in order to be able to continue to live with it and to grow up (see Bacon and Richardson, chapter thirteen); the similarities between the grooming 'paedophiles' are described by Wyre (in chapter three) as doing of their victims and their victims' families, and the grooming by 'incest fathers' of their wives and children.

In this account of her abuse and its effects on her life Rachel describes her experience of victimisation, revictimisation and systems abuse by official agencies: the police and social services, in particular, but also by the church, the hospital and the child and adolescent mental health services. She also describes how her childhood abuse history and her 'psychiatric' history have been, and continue to be, used against her, notwithstanding the fact that eventually, many years later, her father was prosecuted and convicted for the childhood sexual assault of her, his daughter, and also, at the same time, for the more recent abuse then of a girl whom he had raped. He is currently serving a fourteen-year prison sentence. Identification here would put Rachel at additional and further risk of 'systems abuse'. Rachel's story illustrates how victims of child sexual abuse are silenced, and in her experience, the particular silencing effects of the Cleveland affair.

Background data about Rachel necessary to contextualise this story is that she has two sisters and a brother. Her first sister is two years younger, her next sister is eight years younger, and her brother is ten years younger. 'So we're kind of two sets of two', she said, 'it was like having two sets of siblings in one house'. She described herself and her older sister as 'more like stand-in parents for the younger two rather than siblings.' The rest of the story now follows in Rachel's words.

Catherine Itzin

Physical abuse and domestic violence

There was always quite a lot of physical violence. My father at the time would have said chastising, but quite severe chastisement, so if I was cheeky I would get punched in the face with his fist, or he would slap me in the face with the back of his hand, quite openly in front of other people, and he would grab me by whichever part of my anatomy was closest to him and swing me around, he would drag me by my hair sometimes. If I was sitting down and if I'd been cheeky or told off for something, he would grab the top of my head by my hair and make me stand up. I was cheeky often, so in a sense it was deserved, well not that level of violence, but as a child I could understand his justification for it and I dutifully felt guilty at the right moment.

He would be violent to my siblings too but not at the same level. I don't remember him making any of the others bleed, but he gave my first sister quite severe bruising. Her entire abdomen swelled up one time. But she's littler than me, more petite, and the way it felt in the family, was that she was his favourite. But he would favour her in a way that made her angry as well as making me angry, because she didn't want his favouritism either. But that made it quite a memorable time when he did hurt her: he gave her the belt, which means he hit her with his leather belt, which he always wore. He took it off and hit it on her, and misjudged that she was that bit smaller than me and the end of the belt was that bit longer on my sister, and it flipped round onto her stomach and her entire abdomen blew up and was blue and yellow and green and purple for days, and she was very upset.

I would always rather be hurt myself than allow somebody that I cared about to get hurt. In a situation where I felt one of my siblings would get hit, I'd do something outrageous so that he would hit me instead. I'd walk up and kick him or I'd break something, or I'd swear or I'd start arguing with him, or I'd physically stand between him and them and tell them to go. They would leave the room, which would work because he wouldn't pursue them.

Partly I was protecting them, and partly I was just maintaining a situation that my parents could cope with, a level of violence that could go on without anybody finding out. I was the bad one, so they could always justify it. Whereas I think with hindsight, if I'd perhaps not been as strong a personality as I am, and I'd gone and cried in the corner, then perhaps it would have affected all four of us more visibly and something might have been done at an earlier stage. But at the time I thought I was doing all I could to protect my siblings.

The physical abuse was very visible in the family, but it was interpreted in a particular way so that it could be accommodated. The explanation within our family was always that I was a bad child, that I was naughty and rude and ill-mannered, so I deserved it: it was deserved, it was always justified. Also being the eldest of four children, responsibility and a lot of blame fell on me for the violence that was going on.

For many years my father was careful not to mark me where it would be very visible. He would try not to mark my face or my neck or my hands too much, so that people wouldn't ask questions. The only time he would really mark my face

or hands would be if we were on holiday, because nobody that knew us would see us, and then it could be explained that I fell off a wall or whatever. It was very calculated in a sense, and managed. My father is an intelligent man. I believe that he was aware that what he was doing could bring consequences back on him, and I think he was quite careful to avoid that happening.

My mother was certainly well aware of all the physical abuse, although she would try to say otherwise. She saw me being punched, and him kicking me in the stomach, kicking me up my backside, kicking me between my legs, kicking me literally everywhere from my ankles to the top of my head. He deliberately injured me with my mother present, but she claims at that time she didn't realise that what he was doing was criminal. So you have to ask what did she think it was exactly. I view my mother's decision to be inactive with quite a lot of cynicism. I think my mother had priorities other than us. I think maintaining the nice middle class happy family image was far more important to her than what was actually going on.

I can remember my father being very intimidating and threatening to my mother, not actually being physically abusive and violent, but threatening to divorce her or walk out, or close the bank account. He would slam doors to stop her leaving the room, and would throw things, not at her, but in temper would throw something in a way that was violent. And my mother could be quite violent and aggressive. My parents were always fighting: they could have won Oscars for their arguments. So if my father was getting aggressive with my mother, if they were having a really bad argument I'd do something outrageous, so I'd be the bad one. They'd stop fighting to tell me off, and mum would leave the room and he would hit me. That, at the time, felt ok because at least then she was alright. But in a sense mine and my mother's role got so mixed up they almost got inverted, and I ended up protecting my mother as if she was mine to look after instead of the other way round.

Incest – the early years

My first memories of sexual abuse are when I was a toddler, although I can't remember any time when there was no sexual abuse at all. I was being played with by my father and being tickled, I was lying on my back and laughing till my tummy hurt and he took my nappy off me, and he put his fingers up inside my vagina. As a young child there was a lot of digital penetration, putting his hands inside my pants if I came and stood by a chair that he was sat in, he would put his arm round and put his hand down the back of my pants and would be groping me between my legs. He would very quickly take his hand out if somebody came into the room, or if somebody was concerned at all. My father would put his fingers inside of me, and would mess about rubbing his hands between my legs, when I was in bed or when I was in the bath, or under the guise of playing tickling games. My clearest memories from before the age of six are the physical violence and the digital penetration normally with tickling as a game. I also have some memories of him coming into the bathroom and memories of him taking my nappy off.

I had a fear of being in bed at that time. I can't honestly say that I can remember him coming into my bedroom at that stage, because I can't visualise my bedroom at all. I can visualise the other rooms in the house, but not my bedroom. I can visualise the view out from my bedroom window, but not my bedroom. As a young child, I had a fear of being in my bedroom. I wouldn't go in without my comfort blanket, let alone go to bed. I'd be scared that I would wake up having nightmares. My mother says, at a very early age, I was waking up after having a recurrent nightmare about a nasty big bad scary man who was horrible and just like a monster and he had a big stick in his hand, and he would chase me with it and stab me with it and it was red on the end. I can't work out how my mother could say she knew nothing.

Some years later when I was about ten, I saw him abuse my little sister once when she was about two. He had her between his knees, she was standing up and he put his fingers down the back of her nappy and was rubbing her between her legs and I knew what that was. I saw him doing that to my little sister. From the stairs you could see right into the living room, and that's where I'd seen him from. So I ran down the stairs into the living room and I grabbed the baby. I'd screamed to my other sister and she came down the stairs and I said 'get her out of here'. I grabbed hold of my father's coffee mug, I screamed at him not to ever touch my baby sister or I would kill him and I meant it.

I don't remember a time when sexual or physical abuse wasn't happening, but there was a clear changing of my attitude to it when I was around nine or ten when I realised, or I started to realise that it was actually wrong rather than something I didn't like. I didn't like what he was doing and I was very frightened of him when he was doing those things, but the rest of the time he was my dad and I basically loved him and I did like who he was most of the time.

Physical and sexual abuse in middle childhood

We moved when I was six-and-a-half to a house with a garage at the very top of the garden a good distance away from the house: it was enclosed, it was lockable and it was away from other people. Consequently my father was able to use that as a place that we could go where he could hurt me, where I could scream if I had to scream and nobody would hear us. And he did. From moving, the digital penetration carried on, but I've got more memories of him being in my bedroom then. Maybe because I was older and remembered it more.

My father used to get up early for work. He worked very hard, and that gave him a lot of credibility in the local area, because he was 'such a nice man' and 'such a hard worker'. In the mornings I would wake up early because he was waking up early, and, obviously, as soon as he moves I've got to be awake to know if he was coming in my room. So I would wake up and sometimes he would come into my room and do something sexual or very commonly he would come in and demand that I make him sandwiches for work. So I would get up and make him sandwiches, and then he would take me up to the garage and sexually or physically hurt me. That got worse the older I got.

I made a huge effort as a child to try and form a good relationship with my father. Because everybody else blamed me for the relationship being wrong, I worked really hard at making it right. So I would go into the garage and admire how wonderfully he did his woodwork, and I would join in and would tidy the garage and would do the gardening, to try and make it possible to have a better relationship.

Shortly after I was seven my second sister was born, and I don't know why, but my mother was quite ill after having her. It meant that we all had to help, which was fine, because I liked playing with the baby, but it also meant a lot of responsibility. It was when I was seven years old, my father took me aside and told me that I was big now and I had to help with the baby, that I was responsible for my younger siblings and I had to help my mother and do bits of cooking and bits of ironing. I wasn't really like Cinderella, it was little bits of cooking and ironing or washing up, it wasn't big piles of stuff. He also explained to me that if I had hugs from people, or sat in people's laps, that was not allowed, that it was very bad and very rude and I would be a slag or a whore. It's at that point I can remember sexual things being worse.

My father had increasingly been making me ask for him to abuse me. He would generally abuse me first, and then he would say 'now I am going to so and so's bedroom' or 'I wonder if your sister would like me to do that to her too'. Then he would say, 'well I suppose if you ask me to, I could do it to you instead'. So I would ask him to abuse me instead, because that way at least it wasn't my sisters.

It wouldn't be fair to say he raped me: because technically he's never been charged with actually raping me, because I can't say hand on heart that I remember him raping me. I remember him being on top of me. I remember having bruising along the inside of my thigh where the weight of him had been too much and had caused a line of bruising. I can remember being bruised on the front of my hip bone. I can remember having finger marks at the back of my hips where he'd gripped me too hard. I can remember he'd wear a heavy gold chain, and that being on me and tickling me because it was moving. I remember him huffing and puffing in my ear and on my face, and hating it. I can remember having his feet on my legs, sometimes scraping down my leg. I can remember the smell of his hands, because to keep me quiet he'd put his hands over my mouth as he was doing things to me. I can remember having an irrational fear and revulsion, instant nausea if not actual vomiting, at the thought of pregnancy. I can remember having severe vaginal pain. So I know he raped me, but I can't actually remember the penile-vaginal contact. This meant the police couldn't charge him with rape. They said it wouldn't stand up in court, so he wasn't charged with rape, but with sexual assault.

While being abused, I remember having this defiance to survive and to not let him get me: it was like, 'you can have my body, but you can't get me'. Because that's what child sexual abuse is: it's not about having sex with a small body, but in fact controlling the being of the child in the small body. I wasn't going to let him do that, and I don't feel that he did.

This was going on by the time I was seven. I can't distinctly remember a time when it wasn't going on. I can't really say it definitely wasn't happening when I

was five, because I don't know, it could have been. My feeling is that it probably was, but I just didn't realise it properly. I couldn't actually say whether my father was raping me before we moved when I was six and a half, but I think he must have been. I had such strong feelings against him and about being with him on my own. I think he must have been, but I can't remember. I haven't always been able to remember everything. Sometimes I suddenly remember something else, things can trigger it, like the smell of something. I believe he did rape me then, but my memories of it aren't enough for legal purposes.

The disclosures no one ever picked up on

During this period, he got more arrogant. I suppose with having the job promotion he thought he was invincible, because he did things in front of other people quite openly sometimes. In the street we lived in, on numerous occasions, he'd drag me out in front semi-dressed, or take my clothing off and wallop me around the backside with his hand or with a belt for being bad: and people would walk their dogs and wash their cars and water their gardens and wash their windows and things.

You might think he was taking risks, but in a nice white middle class area it's not high risk is it, because nobody wants to rock the boat. It was quite a calculated risk, because he knew that people knew what a bad child I was. He'd already laid the ground work by informing the neighbours what a naughty child I was and what a terrible time they had bringing me up. Just generally undermining who I was with just anybody. People would rather accept the label rather than use their own observational skills.

My father very rarely used my name and he would use a lot of bad language at me around the house. Again this was in front of my mother. Sometimes he'd be sloppy and say it in front of neighbours or visitors to the house. He would address me as whore or slut or slag or shit. My mother was putting my food on the floor at one point because she wasn't having a whore at her table. My father always used to tell me that I was fat, that I was repulsive and he'd rather 'fuck the wall than fuck me'. He would actually say in front of other people, 'I'd rather fuck the wall than fuck her'. In front of neighbours, relatives, people from church.

I think it's fair to say that throughout my life the abuse has escalated. There's only one example of when it vaguely went the other way. That was when we visited my mother's mother, my grandmother, down in London. I wouldn't hug her because my father had passed the house rule on me that I wasn't allowed hugs by anybody other than him, because only whores have hugs. We'd gone down to my mother's mother and this ruling had been passed, unknown to her about cuddles. With my grandma I loved her very much, so I would hug her a lot. When she came into the bedroom that night to give us a kiss (my sister and I were sharing a bedroom), she said you've not given me a hug. When she tried to give me a hug, I'd recoiled because I didn't want to get her in trouble. I explained to her that I'm not allowed, and she questioned me as to who said I wasn't allowed. Once I said it was my dad, she went through the ceiling: 'this is

my house and I will not be ruled in my house, he will obey my rules in my house'. She really laid down the law. She went stomping off down the stairs and I laid in bed terrified about what was going to happen. She came up a little while later and said, 'you can have as many hugs from me as you want, that's how its going to be and if he tries to give you any hassle for this when you get home, just let me know when I phone.' And he didn't. So when I went to my grandma's, I was like a little limpet. I'd fix myself around her apron, and virtually didn't let go until we left a week later every time we saw her.

Again nobody picked up on all this. I mean I'd be concerned if a child was that affectionate towards me. But nobody picked up on it, and my grandma never asked any more questions. I don't hold her responsible at all, but if she had asked, I would have told her. Just a missed opportunity rather than any culpability. Other than that, the abuse escalated, and the only place there was some kind of reprieve was at grandma's. And if she came to us, it still applied that I could hug her even though it wasn't her house because it was her rule that was still allowed. I didn't have that from anybody else, not even my mother, so it meant a lot to me.

My mother's a cold fish. She argued with me a couple of years ago and said she felt rejected by me when I was a child. But she was aware of the house rules, and she played by his rules just as well as I did. To me, as the adult, she had control of how she related to me. She says she felt that I was rejecting her, but she was the grown up and I felt that she was rejecting me. As a teenager after my parents divorced, if I went to give her a hug, she would freeze, and she still would even now.

I actually made accidental disclosures an awful lot of the time. When I look back I'm quite appalled that nobody worked out just how horrendous things were. I remember being with a bunch of girls in the school toilet in my primary school, some time, between age seven and ten. We were in the toilet doing the moaning about parents that girls do. A friend of mine who also had really long hair said, 'don't you hate it when your parents brush your hair because it always hurts to get the knots out'. Not realising the implications of what I was saying, and not realising that everybody else's dad was not doing the same thing, I said 'oh yes and don't you hate it when your dad puts his fingers up you, especially when he then opens them, because it really smarts doesn't it, it really hurts'. Everybody in the toilet just stopped dead and stared at me, and I felt like I'd got three heads all of a sudden. I looked back at my friends, and I wasn't feeling guilty or dirty as if I'd been abused: I just stood there thinking 'what's wrong with their dads?'. It was as if someone had said that their mum never brushed their hair. It was just that parents do things that hurt, but are all right. Like brushing hair hurts, and so does fingers up you, so does having a penis up you, so does being hit in the mouth. I just thought parents do these things and they hurt, but it's okay.

So I'd accommodated everything that was happening to such a level that even at that stage, when I was junior school age, it still didn't register that it was my father that was the problem not theirs. I was very naive and I was immature to a very advanced age. Most other children had a better understanding of sex

and periods and what's right and wrong a lot earlier than I did. I suppose that's because you grow up being told what's right and wrong by your parents, and my parents were lying, but I believed them because of who they were.

I had phoned social services when I was about nine and I phoned the operator and told him what my dad was doing to me and asked him who I should phone to get help. The operator was really nice to me and gave me the number for social services. So I phoned them up and described what my dad was doing to me and could they send somebody out to make him stop, very simplistic, very naive. They took down my address and never followed it up.

Around the time I was about age thirteen, my father was visiting my bedroom on a regular basis to talk to me. He would abuse me on other visits, but he was having specific visits to talk. He would sit on the bed, or by the bed, and it started off with him saying 'are mummy and daddy happy?' And I would have to say 'no', and he would say, 'say it properly', and I would have to say 'mummy and daddy are not happy'. and I would have to repeat it for a number of minutes. Then he would go 'why aren't mummy and daddy happy?' And I would have to say 'Mummy and Daddy aren't happy because of me.' And he would say, did I want mummy and daddy to be happy? 'Well of course I want mummy and daddy to be happy,' I'd say. 'Do mummy and daddy make my sisters and brother happy?' he'd ask. And I'd say 'No, because of the fighting and arguing.' It was my fault you see that my parents argued. 'Do you want them to be happy?' he'd ask, meaning my brother and sisters. 'Of course I want them to be happy.'

He had a calender and he made me choose one of the squares with a number in it as the day when I was going to make mummy and daddy happy. He made it sound like a really good thing, really positive. I was looking forward to it, and I did a face on the number. It was a good thing, and he was helping me be good. He was spending a lot of time with me, and it was so nice of him, and I was very grateful, and I was going to be so good and everybody was going to be happy, and I would be the good girl. So I did the face on the calender.

It turned out that the way you make mummy and daddy happy was by eating daddy's tablets on the day that my picture came on the calender. I was very naive as a child. I knew you didn't take other people's medicine, but I never actually logically put this together in my head until I was in court against him two years ago at the age of twenty-four. It wasn't until the barrister in court said to me, words to the effect of: 'are you trying to tell me that your father tried to kill you?' And I said 'no'. And he said, 'are you trying to say that he got you to take a medicine overdose?' And I said 'yes'. 'That could have killed you?' And I said, 'potentially I suppose it could have.' I stood there in the witness box my head spinning and thinking 'no, it can't be that, it's the wrong words?' Yet I could see that if somebody did that to somebody else, I would agree that they were trying to kill that person. But surely my father wouldn't try to kill me. That was just too horrible to say to somebody about their father. Stupidly, I looked at my dad. I stood there in the witness box, in my twenties looking to him for the answer as to whether it was true that he'd been trying to kill me, and of course he didn't answer. I guess the answer was, 'yes, he was trying to do that'. I didn't think it at

the time: I just thought I was going to be a good girl and make everyone happy. It is on my medical file they'd asked me if I wanted to be dead, and I said 'no,' because I wanted to be good not dead. I was too naive to recognise the link, but nobody ever asked me how come I'd taken the tablets.

As long as I can remember I suffered from vaginal soreness, dryness, itchiness, water infection after water infection after kidney infection after kidney infection. Around the time I was in senior school, I needed to see a doctor quite often for this. My mother would take me if I made enough of a fuss for enough of the time. But I always felt guilty about taking up her time, because she'd got the other children as well, and she was always hassled with babies and housework. Also she was not highly motivated to take me to the doctor, so I went to the family doctor on three occasions with a friend of mine from school. I wouldn't go and see him by myself, obviously because he was a man. He was also a family friend, who went to the same church as my mother, and his children went to the same toddler group as my younger siblings, so they were friendly. I didn't dislike him but I didn't positively trust him, so I took friends with me.

One occasion that I distinctly remember, he was asking me when it was most sore between my legs, meaning my vagina because I was itching and sore there. Naively and completely misunderstanding the question he was trying to ask, I looked blankly at him. He said 'does it hurt mostly when you wee?' and I blurted out 'it hurts most when something big gets taken out like my dad's fingers or his penis, when he's just taken it out that's when it's most sore.' I can't remember what he said, but I remember he wasn't pleased. I remember feeling like I was in trouble. I went home and my mother was stood on the doorstep holding a wooden spatula, because the doctor had phoned her in the five minutes it took me to get home. He'd told her what a dreadful liar I was and I was in big trouble.

Anyway, the culmination of what I said to our family doctor about my father's penis being inside me, in combination with me having overdosed when my father persuaded me to 'be a good girl and take his tablets' resulted in my being referred to a Child and Adolescent Psychiatric Unit on the grounds that I was mentally ill. I was referred by our family doctor, friend of the family, and he knew that my father was sexually abusing me because I told him. The letter of referral from him to the psychiatrist said: 'I would like you to see this thirteen-and-a-half-year old girl with a curious story suggestive of anxiety and somewhat bizarre circumstances. I've known this family for X number of years, and so on. It's difficult to ascertain the truth of the situation because the mother does not substantiate all of what the child is saying. There are rumours around school that her father is abusing her. I'm not sure whether these rumours have been started by Rachel herself'.

That was in June of 1985, two years before the Cleveland crisis. I went to the Psychiatric Unit as an outpatient for three or four visits. Each time I went with my parents and they stayed with me for the entire duration of the discussion. The psychiatrist asked me things like 'I understand you're not sleeping well at night' and I agreed and said 'no I'm not'. 'Why aren't you going to sleep at night?' I said, 'because I'm frightened?' Now I think the logical next question is 'what are you frightened of' or 'why are you frightened', but she didn't ask. She

never worked out that the reason I suffered from insomnia, for which she put me on sleeping medication, was that I needed to stay awake until my father had been and gone because it was easier that way. Whereas when he came into my bedroom and sexually abused me when I was asleep, it was horrible waking up, and somebody already being there and already doing something, because you feel that you've not even attempted any resistance, so it's more your fault. So that was worse. But she never asked. Instead I was put on anti-depressants, because the diagnosis was that I had a mixture of, adolescent identity problems and depression. It's on my medical file now that I had 'problems with my parents', that I had 'adolescent identity problems' and made 'bizarre allegations appertaining to abuse by the father'.

My mother had to keep the tablets because I had an overdose record by then, and she would give me one dose at a time. After a while, it became obvious to me that medication was making the abusive sexual things my father was doing more painful. The medication causes body fluids to dry up, so in other words, I would have been drier vaginally and anally than before I was on the medication. I would also have felt water-logged and lethargic and unable to fight and unable to resist. So the medication made the abuse much worse. It also meant that at school I was lethargic. So I tricked my mother and I stopped taking the medication that my psychiatrist was prescribing.

I hated the psychiatrist. I didn't want to co-operate. She seemed to be so devoid of any understanding of what she was doing. My parents were with me all the time and she seemed to like my parents. I came to one meeting with her and my parents where she was harping on about how wonderfully the medication seemed to be working, 'you seem so much more settled'. Actually I was more settled because I'd stopped fighting her, and trying to explain. I was just being a 'good girl' and saying 'yes' when I was meant to be saying 'yes'. In our family we weren't allowed to swear, it was one of the worst crimes you could ever do. I turned around and said words to the effect that 'I'm not fucking depressed' and that I had faithfully been throwing my medication down the sink each day. When my parents realised that I wasn't taking the medication I got very told off. We pulled over in a lay-by and I got absolutely walloped. I got shouted at and screamed at for wasting people's time and they said they weren't taking me back again. Nobody ever followed that up.

When I was fifteen I had told my mother that my father had been sexually abusing me and she told me that she believed me. But she told me that there wasn't anything we could do. She was right. That was the year of the Cleveland crisis when all those children got taken away and I didn't want that. So we both agreed that the thing to do was to do nothing and we both agreed on that. But at fifteen or sixteen I was still a child, and with hindsight, I feel that she was culpable, that as the adult she should have risen above her fears and made something happen. She should have made it safe. Children are only taken away from home when the home isn't safe, if the abuser is there, and she could have done that. She had the power to protect me from him and her response was to do nothing.

The impact of the Cleveland crisis

By this point, the abuse was getting worse. I started my period and I was petrified of the thought of becoming pregnant by my father. I thought it through very rationally, and I had a plan of action. My fear of pregnancy was getting worse and I started dieting so seriously that I managed to make my period go away. I thought that meant I couldn't get pregnant so that was fine. I had to do something, I couldn't stay living there. But I was permanently petrified. My mother was getting worse with depression, so she was spending a large portion of each day lying down. The abuse had got to a point that I could still handle, but I knew I couldn't handle it if it got worse. I really wasn't coping.

At the same time, I didn't realise that what was happening to me was abuse. I don't know what I thought it was. Rape was something very bad that happened to other people, but not to me. So had somebody asked me 'has your father ever raped you', I would have said 'no'. It was 1987 and the Cleveland crisis was about to break. There was a lot of media attention on child abuse. I thought this was something very bad that happened to other people. Child abuse was something that was so wrong that the police were involved, doctors were involved, and the children were taken away. People knew what was happening to me because I told them. As my doctor put in my medical notes, it was quite accurate that there was a rumour that was well travelled around the school that my father was doing things to me. But because everybody knew what was happening to me and nothing was being done, it was proof that what was happening to me wasn't sexual abuse. So I decided what was happening to me was not what was happening to those poor children in the Cleveland crisis: it was similar, but very much further down the scale.

I had a lot of empathy with the Cleveland children, however, and I hoped they were going to be alright: that they would be safe wherever it was they'd gone. Because nobody ever explained where they went, they just went, they got taken away, and quite where that was to nobody ever said. You never ever actually saw the children they were talking about, so you thought it must be very bad, because otherwise they would show them. When children are kidnapped or murdered they always show their school photograph, but when children are abused it's so horrible, you can't even see a picture of them. This was what I was imagining at the time, very confusing. At this point I was fifteen or sixteen, but very naive and very confused about what was right and wrong, and what was normal and what isn't normal.

I remember distinctly seeing the video footage of Marietta Higgs looking very tired and very fed up as she walked across the television screen into the door of the building. At one point she tried to shield her face from the camera, and I sat there thinking 'I know how she feels, she feels like I feel'. Although I didn't think the sexual abuse that she was talking about was the same that was happening to me, I was being told I had to keep it quiet. Even people who knew it was happening didn't want it to get out, didn't want it to be talked about, didn't want it in there front room, no thank you very much. Like me, she was being told to be quiet and she was

being told to keep secrets. She was being told not to rock the boat, and that there would be repercussions on her if she didn't stop telling. She was being disbelieved and she was being made to feel worthless and wrong and guilty. I knew, though, that she wasn't wrong. I hoped she would be alright too. In a funny kind of way I felt protective towards her because I was on her side.

But equally I knew that she was on my side and that encouraged me and helped me to keep going that bit longer. At that point I was just so much on the edge of what I could take, and what I could cope with. I wasn't really handling things well at all, and knowing that there were grown ups out there who believed children when they told about being abused helped me. I knew that if I could get to Marietta Higgs she would believe me, she would make it stop and make it alright. I knew that very strongly. I felt that if I could get to her, I could collapse in her office and cry on her lap and feel protected, that she would really look after me and it would all be okay. This encouraged me to keep going and it made me believe that there are grown ups out there who would believe me and make it stop. It might just be her and Geoffrey Wyatt, they might be the only two in the world, but that was two more than I thought there were the day before. It kept me going, so I survived until the end of doing my A Levels.

Seeking help to stop her father abusing

When I was seventeen, my parents started divorce proceedings. I'd left home when I was seventeen to become a community service volunteer, and that meant there was nobody to look after my siblings. My mother contacted me to ask me to come home because she wasn't coping with the kids and she was worried that social services were going to take the children away. My father was threatening her that he was going to say she was mentally unstable and that the kids were better off in care than with her. She was really scared, so I went home.

While I'd been away from home, I had been given the news that my parents were divorcing and I was anxious to prevent my father having unsupervised access to my younger brother and sister. I went to see a solicitor to see if I could stop my father having the children. It seemed straightforward to me, but this solicitor was saying that it wasn't his job. I couldn't understand why it wasn't, I explained to him a little bit about what my father had done. I was very careful because I was too fragile to be able to cope with rejection, so I would rather tell somebody a little bit and them not believe me than to tell them everything and them not believe me. He was a good and kind elderly man who retired shortly after I was there. I think he saw through me though, because he was very careful with his words and he said to me:

> If what you have told me is the whole of it, then you might have a civil case against your father having the children on his own. And if you took that civil case, it would affect the likelihood of his getting access or custody. But

> if, as I suspect, what you have told me is not the whole story, then I would not be able to help you because it would be a matter for a criminal lawyer or the police.

That scared the hell out of me. He was very kind. He treated me like I was a proper person, like I wasn't mad, like I was telling the truth. And he didn't want money from me. He said I could come back if I wanted to and I wouldn't have to pay. That was really good, that empowered me. It was the start of me realising that I could actually do something. I still didn't know how much more of my story he would need for it to be criminal, but it gave me an idea.

At first when my parents were divorcing they were living in the same house. But it was a nightmare and eventually my mother left my father. He tried to get unsupervised access to my little sister and brother who were seven and nine. I told my mother, I pleaded with my mother, I argued with my mother, I screamed at my mother not to let him, but she told me there was 'nothing she could do'. So I said, 'fine, I will do it', and I wrote a letter to the divorce courts, again, very naively, telling the divorce courts that he mustn't have access.

I was eighteen at the point my mother left my father and I wrote the letter to the court. I walked in one day from sixth form to find a man in the kitchen who said: 'My name's John. I'm from the court. You sent me a letter'. He said he needed to talk to me. He asked my mother to stay in the room, but she refused. He asked me what I'd meant by various things I'd written in the letter, and I answered all of his questions. He said he had a couple of things to say to me that I wouldn't like, and he needed to ask me something, and then he'd got some good news and some bad news.

What he needed to ask me was, could he show this letter to some other people who could do something to make sure the children didn't have to go to my father and I said 'yes'. Then he said:

> The thing you're not going to like is that this is very serious and it means that you're going to have to tell this to some other people. Your mother already knows you've said this, but your father is now going to know this and this is going to be very difficult. The bad news is that you're going to have even more shit than you've already been through.

I sat there thinking this man's swearing in my mother's kitchen, because we weren't allowed to. Then he said to me the good news was that he believed me and he thought that I could cope with it. And he told me to remember, through whatever happened from then on, that I was telling the truth and that he believed me, and if he believed me other people would believe me, and this was the right thing to do, this was good. He was a social worker, a probation officer, working as court welfare officer for acrimonious divorce proceedings. He was one of the few good grown ups in my past. He was straight with me. He didn't pull any punches. He didn't pretend it was going to be easy, or good, or nice.

The failed prosecution

So began a police investigation and the police lived up to their reputation for being insensitive. They behaved very badly. I've not forgiven them yet: I still feel very angry with the police. They didn't have any interview rooms free so I was taken to a cell. Nobody was allowed to come with me and the WPC who interviewed me was was scathing and sarcastic, surly, rude, unfriendly and iceberg cold. She was just totally the wrong person to be doing her job. The Police Child Protection Unit had just been set up and she'd been drafted in from CID. She was not trained for work with children and was basically treating me the way rape victims were treated then: they're guilty until proved innocent. This was September 1989. She stuck to that rigidly even though I was the age I was.

She questioned and questioned me. She obviously didn't believe me. She was being sarcastic to me and using words I didn't understand. I was still very naive at this point. She asked me for example, 'did digital penetration occur'. I was sitting there thinking, digital what? digital clock? penetration? what does this mean?' I'm sorry but that does not mean anything to a child that's been abused. No abuser says what I'm doing to you now is digital penetration. I said 'I don't know'. She shouted at me, 'well you would know if he had or hadn't, you need to make up your mind what your story is' etc. She was writing a statement all this time that she wouldn't let me see. It is very unnerving when somebody does that. She was asking me things repeatedly, which made me feel not only did she not like me, but she was irritated at having to do this, and she didn't believe me and I was wasting her time.

One thing I did know was wasting police time is a criminal offence. I was becoming increasingly upset at the thought that she wasn't going to believe me and I was going to end up in jail for wasting her time. So I told her as she didn't believe me, I was going to leave. I was quite rude to her and told her that I didn't want to be arrested for wasting police time. I just wanted to get out. At that point she became a little bit more human and explained that it was my job to persuade her to believe me, to prove it to her first. But that wasn't true. It's for a jury to believe, not her. She should take a statement whether she believes it or not. But her attitude was that I had to make her believe it, and then she may or may not arrest my father. So I stayed to persuade her.

When I read my statement and she asked me to sign it, all I wanted to do was get out. But I read it carefully enough to see that she deliberately put things in that were wrong, to try and trick me. For example, she put he touched me in the shower, when we didn't have a shower, so he couldn't have. Things like that, playing manipulative emotional games with me that upset me quite a lot.

The police investigation closed after a few months. The way I found out was I was at home when the phone rang. It was the police woman and she asked if she could speak to my mother. When I explained that my mother was out, she said could I give her a message? I said yes, and she said, 'could you let her know that the Crown Prosecution Service, have thrown the case out'. He'd been arrested for

questioning, but that was going to be it and that's how I found out that I wasn't going to be believed. My father got full unsupervised access to my little sister and my little brother and there was nothing any of us could do.

Within days the news had gone around the community. Soon after on a Sunday when I went to church, the rumours had gone around what a liar I was even the police didn't believe me, wasn't I a vindictive person and I was trying to destroy my family. The vicar had stood up in church and preached a sermon to make sure that people didn't give a statement to the police. When I walked into church I was booed out. People stamped and I was made to walk backwards out of the door by people who used to be my friends, by people who used to be my friends' parents, people in the community that I thought were okay, and they were quite horrible to me.

So I decided that was enough. I went up to the local corner shop and bought six little boxes of paracetamol, twenty-five in a box, 24p each. The woman in the shop was a school friend's mum and she laughed at me and said, 'what are you doing, killing yourself?' And I said 'yes', and she put them in a bag and gave them to me. This was just more corroboration for me of being worthless and that nobody wanted me anyway. I went back to my mother's house and I went up to the bedroom and took the pills. My friend heard what had happened at church and came round and got me to hospital. The hospital said if I'd been fifteen minutes later, I'd have been past the time for having my stomach pumped. I left hospital about a week later and decided that I was never going to let anybody make me feel that way any more. I subsequently left my mother's home knowing that people didn't believe me and thinking that they never would.

The successful prosecution

About five years later, the police contacted me and asked me for a statement because they knew of another child that had been abused by my father. I thought wrongly that my statement was simply to corroborate the other child's. I didn't think they were going to make my case come back, I didn't think they could. I'm not sure I'd have given my statement again then if I'd realised that this time they were actually going to prosecute my father.

The police woman who came to see me recognised me from years before. We always had a 'domestic' going on in the house, and over the last few years of living with my parents I'd started phoning the police because having lived away from home, I wasn't having it any more. One time my father had picked me up by my breasts and flung me against a wall. I'd gone to phone the police, and it was her that had come out, the same police woman. She remembered my father being drunk in the doorway, swearing blind that he wasn't drunk and he'd not laid a hand on me.

She was all right, not like the other one who'd interrogated me in the police cell. She wasn't the brightest of women, and over the course of time, it became apparent that the training she'd received was inadequate for her job. She wasn't very articulate and couldn't construct what she was writing particularly clearly. This

meant that taking a statement was difficult for her, and things I would have wanted her to be very specific about she wrote in an ambiguous way which proved to be problematic in court. The first thing we had to do was go through my old statement and amend it. The amendments that had to be done on it were ridiculous. And my sister who's two years younger than me has still never been asked for a police statement. That's how effective the police investigation was and still is.

We've got a conviction now and that's very good, but his conviction was in 1996, and I first went to the police in 1989. So he had seven additional years to abuse as many children as he wanted to, including my two younger siblings had he wanted to, although he'd have been a fool to have done so knowing an allegation had already been made.

The day he was first picked up and interviewed by the police to do with the child who'd made allegations of abuse, he had, I think they said, fourteen children in his house. On another occasion, when he was re-arrested for questioning the police found nine children in his house, and on a third occasion there were eleven. These children came from the estate, they called him Uncle Jim because he was such a nice man. His story was he was divorced and his ex-wife won't let him see his children.

Because a child had made an allegation, they had a child witness who was under sixteen, and they had me, who was over sixteen and therefore regarded as a more reliable witness in that respect, although my credibility as a witness was undermined by my 'psychiatric history'. The child's case went before the jury on video. I don't know the details of the child's allegation, but I do know that he was charged with rape. He ended up being charged and found guilty of four offences. One of raping her and one of indecent assault: for one he was given four years and for the other he was given three years to run one after another. On me he was found guilty of two counts of indecent assault to run one after the other, one of four years and one of three: so seven years on her and seven years on me. The judge said that those two seven years should run one after the other as well. So in the end he's serving fourteen years.

My mother was called as a witness for the defence very reluctantly, I think, but I don't know what she said because I wasn't in court for it. She threatened to get an injunction to stop me going into court while she gave her statement. I don't know exactly what she said, but references made to it afterwards suggested that she said she didn't know what was going on. So he's serving fourteen years.

Revictimisation and systems abuse

While the police were investigating my father, I asked if I could have police protection because he was free and I was very worried for my child. I was worried that if my father turned up he would rather hurt my child than hurt me. I was told yes, I could have all the protection I needed. Shortly before the case against my father went to court, while I was supposedly a police protected witness, I had a visit from the police because of a telephone call they had received claiming that my son had been bitten. I was actually visited at home by police, some in

uniform, some not, who grabbed me and pushed me around my front room shouting at me and calling me a whore. The biggest one bent down into my face and said to me 'I know the kind of person you are, I know who you've had up you,' and I said, 'I don't know what you're talking about'. And he said, 'I've been in touch with the Leeds Police and they've told me all about you and your father'. I was quite scared during all this.

My child, who was small, at the time, woke up and came into the front room. I turned round and said, 'go back to bed' because I wanted to protect my child from seeing the incident. My child was frightened and stood rooted to the spot looking at his mummy being pushed by these big people. I was powerless to do anything. The biggest policeman bent down in front of the child and told him to 'piss off back to bed,' and asked if he was always such a naughty child. I raised my fists to the policeman and told him if he spoke to my child like that again I would hit him. He grinned at me and said 'please make my day, and I'll cuff you for assaulting a police officer'. I told him I wanted to use the telephone to phone a lawyer, but they stood around me so that I couldn't do that.

They claimed that the reason they were there was that allegations had been made that my son had adult bite marks all over him. I asked them to provide a social work child protection form, preferably with the doctor's name on it so that my child could be examined. They laughed in my face and told me that they couldn't do that. I asked them to escort me to casualty so that my son could be examined, they wouldn't do that. In the end they left having warned me that they were watching me and they knew all about me. A short while after they left my front door was smashed from top to bottom, split as if by an axe. I didn't actually see them, so I can't honestly say they did it, but the man next door saw policemen leaving from the stairwell.

I don't understand why they treated me like they did. Because of the experiences I have had with them, I have very little time for the police, and as sad as it is, if I were raped tomorrow I would not go to the police because I don't trust them. At the same time I feel that the legal system is all that we've got to work with, and if somebody told me their child had been abused I would have to encourage them to go to the police on principle. But I can't stand the police because of what they did to my child. They used me having been abused as an excuse to abuse my child.

On the Monday I went to my solicitor and I made enquiries of Social Services as to what the allegation was. I was registered with Social Services as a childminder, and assumed that if allegations had been made about non-accidental injuries to my child, they would know. But they knew nothing about it. I'd spent the whole weekend trying to phone the police to find out who the officers were and why they were there, but the police claimed they had no record. They were genuine police though because Social Services had a fax claiming that they had come out due to an allegation, that they subsequently hadn't got anything to investigate and had left. It was all terribly amicable, according to their report, although it was put that I'd been very rude. Thankfully I had a friend who was sitting there in my front room at the time. My friend was

an eye witness to everything that took place inside my flat, and the man next door was a witness to everything that took place outside of my flat. I've been unable to pursue a police complaint, because they're pretending that they've got no records. The allegations were malicious and I don't know who made them.

When I registered as a childminder, I had problems because the fact that I was known to a police child protection unit in another area was wrongly interpreted by the Social Services Department to mean I was a risk to children. Instead of putting the paper work through the normal channels, they'd tried to save time by phoning the police department which had brought the charges against my father. When they phoned to ask if I was known they asked the wrong questions and they were put through to the police officer who'd looked after me during the investigation of my father and she said 'oh yes, of course we know her.' This was interpreted to mean that I was an abuser, when in fact I was the victim.

As a result of this my childminding was suspended for a period of time, until they could deal with my case legally. This involved meeting with my solicitor and theirs, when I was interrogated on the detail of the abuse in a way which I felt made me look like I was mentally ill and dangerous. I appealed against the decision to deregister me as a childminder and won at the appeal. I was allowed to childmind, and I was given an apology from an Assistant Director of Social Services here, who said he was glad that I understood the necessity for doing what they'd done and hopefully it shouldn't cause any more problems. I asked if it would create any problems for me applying to act as a foster parent which is what I wanted to do. He assured me that it wouldn't cause any problems. I applied for fostering two years ago and I'm still not registered.

They have a problem with the fact that I was abused. They regard you as a risk with children because of having been a victim. I have been questioned a lot about this. I feel that I am made repeatedly to have to justify my right not to be treated as a perpetrator because I was abused. To my way of thinking, the fact that I was known as a victim of sexual abuse was information that shouldn't have been disclosed anyway. I resent the fact that Social Services require victims of abuse to disclose on demand. It is expected that you tell them the details, it is required that you do and their questions are very personal. Not to disclose or to withhold information from Social Services, would put you in jeopardy of losing your registration for not having been honest with them. But answering honestly puts you at an immediate disadvantage of being registered as they assume those who have been abused, will abuse.

I also have problems because technically I have a 'psychiatric history', having been seen by an adolescent psychiatrist three or four times in my teens and because of what appears to be a double overdose attempt on my record. There was the attempt my father made on me and the attempt I made on myself. They are separate attempts, and I would agree, yes, they are suicide attempts, and yes, I did want to be dead. So at that period of time yes I was mentally ill. If to be suicidal is to be mentally ill, then that assumption might be made. But to assume that someone is therefore still mentally ill would be entirely wrong. And I think there were particular extenuating circumstances in both cases. In one it was

actually an attempt by my father to kill me, and this is in the court records now. In the other I was driven to suicide in a sense by how I had been treated by my father, and then the police and then the Crown Prosecution Service when they decided not to prosecute on the first occasion, and then by the blame and rejection I received everywhere.

They are very reluctant to register you if you have been abused or have had a mental health problem. They have registered people who have been abused, but on the Social Services training course I was on for fostering, one woman disclosed that she'd been raped as a child and she was made to drop out. Another woman revealed that she had been to counselling when she was about fifteen due to bereavement, and she was also made to feel that she had such a serious psychiatric history that she couldn't continue on the course. She was old enough to be my mother. It seems that any hint of abuse in the family or any diagnosis, whether supported by evidence, that anybody has been mentally ill at any stage goes against them.

My son was being victimised by a teacher who was having a breakdown at the time and subsequently became a mental hospital in-patient. But when I complained, because Social Services had disclosed to the school that I was known to them, the school were claiming that my child had behavioural problems. To me it was quite apparent where the problem lay, but they weren't going to believe me. That of course is now on record and having received the paper work through for the fostering, I noticed that it actually includes a reference to this incident by saying that my child had initial settling in problems at school, but now seems all right. This is going to go to the panel who is going to decide whether I can foster. The wording makes it look like my child has a problem, but he didn't have a problem and I didn't have a problem, the teacher had a problem. She has now left teaching due to health problems having spent months in the mental hospital. My child has had no problems since transferring from her as a teacher, so clearly did not have behavioural problems.

It's just a repetition all the time of the blame coming back on to me or on to my child. The fact that the police visited, is evidence apparently that I'm not as safe as I should be, even though it was done in response to a malicious and unfounded allegation. There are certain staff members at my son's school who still treat me suspiciously because they obviously believe that something was going on. No smoke without fire type attitude. They have clearly been made aware that I have had a chequered past. I don't know how much detail they know, but enough to offer me family therapy, when the teacher was the problem.

Also my medical file is inaccurate. The Director of Social Services who sat on my tribunal has written a supportive letter to social services here, saying that having investigated it himself, he is aware that my medical file is inaccurate and is misleading to somebody not knowing all the facts. But rather than take out the section of the report that will go to the fostering panel, the report talks about my medical records, the first page onwards, talks all about it and something like seventeen pages into a long document there is a reference to the fact that the medical record is inaccurate and should be ignored, but by that point they can't

very well ignore it. They will have been influenced by it. So yet again, because of the fact that the family doctor was a friend of my father's, this nonsense is on my medical file, and it goes against me. But social services still insist on putting on my medical form that I have a history of mental illness, and I've been warned by them that my fostering application will be turned down by the medical officer on the grounds that I'm too mentally unstable to be in the care of children. I will fight it, but I shouldn't have to.

Basically, if I'd not told anybody that I'd been abused, had I left home at seventeen, never told anybody, got on with my life, I wouldn't have had to go through the trauma of a police investigation that failed, I would never have attempted suicide, I would not have had to go through three weeks of being on trial because of my father, because that's what it felt like, like it was me that was on trial. I wouldn't have to live with the stigma of having been abused, and being made to disclose it, and having to justify it, having to educate all and sundry that I come into contact with that this doesn't mean that I am a risk. The way in which this country deals with child abuse, social services and the police and the whole system operates in a way that is biased and weighted against the victim, not just prior to them being believed and a guilty verdict being found, but also afterwards.

7 The experience and the effects of child sexual abuse involving pornography

'Alice Edwards' interviewed by Catherine Itzin

Introduction

The woman whose experiences of child sexual abuse and its effects is the subject of this chapter was selected from a sample of 132 women who, in response to a television documentary on pornography in 1992 in the UK, contacted a helpline for people who felt they had been harmed by pornography, a number of whom agreed to participate in a pilot study researching their experience of pornography-related harm. 'Alice Edwards' (a pseudonym) was aged fifty-three at the time of the first interview in December 1994. Subsequent interviews were conducted in July 1995, August 1996 and April 1997. Each additional interview has produced new disclosures and also new developments in the story of her experience, in the form of events which have taken place during the period of lapsed time between interviews as well as elaborations at a level of detail on the accounts obtained on earlier occasions.

Material from the first interview has been previously published in the form of a case study that I have used to develop conceptual models reflecting the role of pornography in the organisation of child sexual abuse (see Itzin 1996, 1997a, 1997b, and chapter five, this volume). For this chapter I have extrapolated from those previous publications the narrative in which 'Alice' describes her experiences as a child of incest, of abuse organised within her family, of abuse organised outside her family, of being prostituted and of being used in and abused with pornography.

To this I have added subsequent, previously unpublished interview data edited into the form of a narrative in which 'Alice' describes the effects on her life in childhood, adolescence and adulthood of the abuse she experienced as a child. Her story tells of living with the 'traumatic sexualisation, betrayal, powerlessness and stigmatisation' described by Finkelhor and Browne (1985): in the words of Alice herself the 'torture and its legacy of revictimisation, self-abuse, attempted suicide, and life-long depression'. Her belief that being abused in and through pornograhy aggravated the trauma of the sexual abuse she experienced as a child is supported by the clinical observations of Hunt and Baird that 'being photographed while being sexually abused exacerbates the shame, humiliation and powerlessness that sexual

abuse victims typically experience' and that 'denial of the abuse becomes even more important . . . and is achieved at greater personal cost' (Hunt and Baird 1990: 202). They found the effects on children of being photographed in the act of being abused to be 'devastating'. The record of their sexual abuse is 'then used to reinforce the children's sense of responsibility for the abuse and to ensure their silence,' and the children 'become the instrument of their own torture' (ibid.: 201).

Catherine Itzin

The experience of child sexual abuse

My first conscious memories are from when my sister was born when I was two-and-a-half, I was sent to my grandparents and stayed with them. My abuse started there. I have a memory then of my grandfather holding me, putting his fingers into me, touching me and watching me naked, especially wanting to see me naked. I also remember sleeping in a bed with an aunt, who also wanted me in the bed naked. They all lived in the same house. I've always had these memories. I've never forgotten them. I remember it, and the time, because it was the first time that I was sent away from my mother. It was at the birth of my sister.

A child born of incest

I was born illegitimate and premature. My mother was sent away by her family to another town, as it was a disgrace. She knew of a man she'd met at a cinema who offered to marry her, and she accepted that in order to not go back to her own family. My mother used to go out to the local pub to play cards and to drink, and her brothers and her sisters used to come and babysit whilst my stepfather was working.

My mother would never profess to be an alcoholic, but she drank daily, quite a lot daily. I remember her often drunk. She smoked continually. She was very unemotional, very cold, very distant. And she was obsessively linked to her mother. But she didn't return home after she had me. I think she thought I'd be at risk from my grandfather.

One of my aunts, who is now dead, told me that my grandfather was my father. My mother would never tell me who my father was, she told me it would 'never do me any good to know'. Those were her words. But I believe that I was probably the child of incest between my mother and her father.

I think my mother's leaving home was quite an act of love. It took me a long time in my adult life to realise that she had actually tried to protect me from them, because then she went on to abuse me, so it became very contradictory. My mum's abuse of me was physical and emotional and it has had long-lasting effects. I've since been reliably told that my mother also sexually abused me. I think this is likely to be true, but I don't remember it.

My grandfather had his own business with a workshop near to where we lived. My sister and brother and I would be told to go down and see grandad,

take him something down or give him a message. Separately, not together. We were actually sent, by my grandmother, or my mother. Once I took a school friend down, and he abused both of us. He made us take our knickers off and touched us and orally abused us.

My stepfather did not abuse me. He was never there. He used to be up first in the morning, and he'd come in last at night. If we were still awake, once the babysitters had gone, he'd read us a story. He was fabulous, he still is. He didn't know that all of this was happening.

Abuse organised within the family

My mother didn't acknowledge that she knew what was going on, but I know that she knew, because she saw it and turned and walked away. On one occasion when I was eight and my grandfather was abusing me, I heard footsteps coming up the stairs. I was in a position to see my mother standing in the doorway. She stood for a while, and then turned and went away. That memory was very destructive for a long time. It was probably worse than the abuse itself, watching while my mother turned away.

I told my stepfather once, because one time when he came home from work, I was crying because I'd been hurt. My uncle had abused me and hurt me. My stepfather wanted to know why I was crying, and I told him what had happened. He told my mother. She came and got me out of bed. I told her, and she took me to my grandparents. I was about eleven years old, I think. She took me in to confront my grandparents and my uncle because he lived with them, with his parents. I was told I was fabricating, it was a lie. I stood and said to my grandfather 'you know it's true, you know this is happening.' He told me I'd got an overactive imagination. My mother hit me, and put me in the back room for telling lies, and making her look stupid. But she knew it was true, because she had seen my grandfather's abuse of me. So the whole thing was totally confusing. I got punished for talking, so I never did it again.

I was abused by my mother's younger brothers, my uncles, when they were babysitting, and also by the older aunt. They told me that they'd been taught by their father, my grandfather. I also know that my mother and her brothers were abused by their father.

The sexual abuse I experienced from my uncles when they were babysitting would be intercourse, oral sex, anal sex, and at times both. The physical abuse included needles put under my toenails and fingernails, being tied up, being frightened. The psychological abuse was always threats, the unknown, never knowing whether they would actually do what they threatened they would do. The emotional abuse was one moment to do things that indicated they cared about me, and then the next moment to hurt me. They'd tell me I was really nice and they cared about me, and they'd offer to give me a sweet and then take it away. They'd say they wouldn't hurt me, and then they would. They threatened to make up stories to my mother to get me into trouble. They said they'd tell my teachers things about me that weren't true.

They terrorised me until I did what they wanted me to do. It wasn't just what they did to me that terrified me, but the things I was told they would do at different times if I didn't obey them. Like they said they would catch me coming home from school and would take me away and hang me unless I did what they told me to do, which could be the sexual abuse, or it could be the photography.

Pornography and intrafamilial abuse

My uncle would make me look at pornographic literature and then take photographs of me doing it naked when he was babysitting. This is age four to eleven that I remember. He'd show me photographs of adults, men and women with whips and leather and children and animals. It would be photographs of oral sex, penetrative sex, both vaginally and anally. Somebody must have given him these, because he was only a teenager. Then he would make me act out some of them. If we were alone, this would be putting things inside myself, or he would put them in and then take the photographs. Sitting in provocative positions, masturbating; in sexually provocative poses and smiling. That was always the big criterion of photographs: smiling.

I don't know where his camera came from, so it's quite possible that someone had given him the money and a camera to take the pictures with. He knew ways of making money, and later he used to sell me to his friends anyway. He used to charge them to have sex with me, so it is quite possible that someone had paid him to take photographs.

One of the friends' father was a contact of my grandfather. He was a photographer, and his shop was only yards away from the school. If we were at his friend's house – the photographer's house – then often, his father would be involved and he would take photographs of the boys, the teenagers, with me and with their dog. This was just filming at home by individuals, it would just be photographs at home. Pornography was the filming later in the groups. At home it was just still photographs.

Pornography and extrafamilial abuse

This was from the age of four to eleven or twelve, when we moved. We left that house when I was twelve, and went to live next door to my grandmother and grandfather, and aunts and uncles. Then the sexual abuse accelerated with other uncles, with uncles' friends and my grandfather's friends. Prior to that, it had just been family and family connections, then it just seemed like it was everybody.

And the pornography proper started. Me on my own, and in groups and with other children I didn't know. At thirteen, my younger uncles were older than me, ranging from five years upwards. They were in the senior level of the same school. By this time, they were making money by selling me to their friends. So when I was supposed to be at school playing netball, I was being sold for sex to my uncles' friends and to their friends' fathers, including the photographer.

I didn't know who this man was when I first met him. But when my uncle wanted me to go back with him and his friend to the friend's house, I realised I'd been there before, that I'd met this photographer before when I was younger. This man had a studio at the back of his house where he took children's portraits. That was his job, taking photographs of children and later, I knew my grandfather was involved in the pornography, because I saw him paying him for the pictures.

There were groups there of children and adults, and group sex. I would then be made to be a perpetrator, and I would have to be involved in sexual abuse with younger children. Oral sex or penetrating their vagina or rectum. And that included abusing my brother. I would also be abused by other older children and by male and female adults. There were babies involved too. They would be naked. They would have their penises sucked, or they'd be involved in creating the picture. A baby could be breastfeeding while her mother was being penetrated by an adult and orally stimulating an older child. So she'd be having intercourse with an adult whilst feeding the baby. Any scenario you could think of happened, virtually. Fingers would be in vaginas, rectums, and certainly toddlers would be penetrated. Afterwards, we'd be given sweets.

For me, my greatest fear was I'd suffocate. As a small child I was terrified I would die by suffocation, and ever since being a small child, whenever I vomit I swallow it, and I still do it. After coming round from theatre when I've been for surgery, I wake up vomiting and swallowing. Because we had to swallow semen. The penis in our mouths would make us gag and retch, and we had to swallow before anything came up. If we didn't swallow it and made a mess, we had to lick it up.

In the pornography, there was also violence, tying up, restraint. There was pushing things inside us: instruments, bottles, rods, in our vaginas and rectums. Fruit, bananas, cucumbers, things like that, ice cubes. Being hung upside down, being tethered with a dog collar round our necks and on all fours. Animals mounting us in that position. There was also recording: recording pain, recording sexual excitement. Not just photographs, there were recorders going, and then they were reel-to-reel tapes, not the little things like today.

Child prostitution

In my early childhood, in addition to what was going on at home (the incest as I later learned it was) I'd be taken to places for group sex, group pornography and group prostitution. It was after one of these sessions – where we'd be in group sex, but without the cameras – that I saw my grandfather buy the pictures, and I knew that he must have been involved in the pornography too. In the making of pornography, prostitution is taking place. They go together, and I was prostituted to make the pornography. But also I was just prostituted, sold for sex. Sometimes, there was a combination of prostitution and filming. Whereas the pornography was set up for pornography, prostitution was set up so you could be sold for sex, but sometimes filmed. This film wasn't necessarily sold, it was for the individuals that were there, as distinct from the pornography which was to make pornography for sale.

The prostitution could be with just one person, or two or three, or a group, but on those occasions, there wasn't just an emphasis, like there is in pornography, on the image; the emphasis was on sexual satisfaction, and on sexual gratification, and everybody there got it. In the prostitution, I had to sexually meet everyone's needs. That wasn't always so with the pornography, where the main point was to take photographs or make film.

Perpetrator networks

There was a network of people whose paths crossed for these purposes. It could be to do with their work or socially, their paths crossed: not just related to the abuse, their paths crossed in other ways. One of our local policemen was part of the group that was into the pornography, also one of the local doctors was a part of it, and two of the local teachers were part of this abuse network. My grandfather was a freemason, and a lot of the abusing people were in high places. We knew that by the cars they used to come in, and in those days there were very few cars, it's not like now, and by the kind of clothes they wore.

No one ever told me not to say anything, not ever, but I knew I shouldn't. That came from my mother saying to me once, when I was telling her what somebody else did in their house, that it was none of my business to know what other people did in their house, and it was none of their business to know what we did in ours.

Coercion: the obedient smile

My fear has always been that the photographs of me will turn up. An ongoing concern all my life is that the pornography that was taken is going to turn up somewhere. When I was in my twenties, I saw some of it: my uncle showed me some that he still had. It was me at age nine. It was photographs taken in the shed at the back of the pornographer's house, with younger children and men and women. He had about six of these photographs. My response when I saw the photographs was total horror. And the thing that struck me more than anything else, was how small I was. I'd always felt I'd been a big girl, but I just looked so small. And the other thing that struck me was that my eyes were dead, but I was smiling. I couldn't believe that I was hurting so much and smiling. But they asked me, they told me to smile. I'd learnt from a very early age obedience was the name of the game. This was about total obedience, it wasn't about questioning anything. From babyhood, I'd been taught to be obedient, not just in the smiling but in everything. Don't vomit, be quiet, do this, do that, and I did it. I was like a human robot, that when someone clicked, I jumped. And when they let me go and finished with me, I used to say thank you. The reward was being a good girl.

Consent: the sexualised child

The biggest thing for me was being told that I was a good girl, patted on the head. That was the only affection I ever got, and I'd do anything for that. I'd go out to

the park and not actually look for people to abuse me, but I'd be very friendly with someone, and if they abused me, I'd do anything if they'd tell me I was a good girl. They'd smile at me, they'd put their arm around me, they'd stroke my head, they'd just tell me 'good girl' and it didn't matter how much they hurt me in between any of those things. That happened in the local bakery and in the park numerous times. So I was a willing accomplice to sexual abuse, having learned I could be told 'good girl'. It was the only positive feedback I had growing up.

At the bakery, for example, we were playing hide and seek one day. My brother and sister were hiding, and I was supposed to be finding them, and the man on the bread-cutting machine said they may go down in the basement, have a look down there. So I went into the basement, and he followed. He started to sexually touch me, and then he had intercourse with me. He told me I was a good girl, gave me a cake and told me to come back the next day without my knickers. I went back the next day without my knickers, and he did it again.

That went on for all of five years. At first it was a game they were playing with me that I didn't even realise they were playing. Soon I began to realise what was happening, but the man on the cake machine said if I was good for him, I wouldn't have to steal cakes, he would give them to me, and the man on the bread cutting machine was always very nice and always complimented me. Since those things weren't in my life in any other form I was quite happy to go back and let them sexually abuse me for that. They were never ever brutal.

In the park, I was talking to this man who was really nice to me. My sister and I were on the see-saw, and I went down. After he'd finished with his hand in my knickers and his fingers in my vagina, I went back to play with her. She told me she'd seen me, and I told her she hadn't, she was lying. He was a complete stranger, I hadn't a clue who he was. What he did felt nice, and he was nice, and he told me I was a good girl, and he gave me a sweet.

I used to go swimming to get clean, because we hadn't got a bath in our house. On the way home from the swimming baths, almost daily for a long, long time, seven years or so, there was a man in the local rec, where I had to go through to get home, and he was one of the men that was nice and made me feel nice who I ended up having intercourse with. I'd be ten or eleven then. At about this time, sexual activities had become the norm. I didn't even know it was wrong.

It just felt like this is what you do to please people, and if you don't get hurt, you're lucky, and if you feel nice, it's great, and sometimes you get a sweet, sometimes you don't, sometimes you get a pat on the head. Both were good: in fact, a pat on the head was better than the sweet. And I knew how to be nice, I knew how to smile, and by this time I was an expert in knowing what to do to sexually arouse. I'd been taught a whole lot by the time I was eleven. My grandad used to say: 'Alice, when you've been taught all that I need to teach you, the world will be your oyster.'

I knew what I had to do, I never questioned it. I'd learned what was expected of me. The feedback was that I was doing well, that I was pleasing, and as long as I did what I was told, I'd continue to be pleasing. I didn't think it was wrong. It was a place that I fitted into, I used to say it's the place I belong to best, it's

the thing I'm best at. It's what I knew best, and I always felt confident in being able to do well by the time I got to eleven. The rewards were affection and praise. I was desperately seeking approval, and this gave it.

Normalising child sexual abuse

I didn't know I was doing anything wrong until I went nursing at seventeen. I went to a lecture on sexually transmitted diseases, and it was there that I first heard all about incest, not only that it was wrong, but that it was illegal. It was like being absolutely hit over the head, and I was more terrified of being put in prison for doing something illegal all of my childhood than what had actually happened to me. Although I could easily have died from what was done to me as a child, the thought of being incarcerated in prison for what I'd done frightened me so much that I took an overdose.

From the moment that I heard about incest being illegal, then I had to look at what the rest of it meant, the sex with strangers, what did that mean, and the pornography. The whole lot of it just felt devastating. Everything that I'd done and felt I'd had to do I discovered at the age of seventeen that I didn't have to do, that most people don't have to do it, but I had. I was then to discover the enormity of the damage that had been done to me.

The effects of child sexual abuse

Some of the effects from childhood go on to adulthood, and the effects of how I had to cope then are still persisting now. The first effects in childhood were when I started self harming, but that was also a coping mechanism. When I'd been abused, the hardest time was always when I was on my own afterwards. Then I would feel the isolation, and intense emotional pain. That would lead me to not being able to cope so I got into biting myself, my arms, hurting myself in order to make the pain go away. I had to be on my own to be safe enough to do it, when no-one was going to stop me or punish me for doing it. At home there was always a lot of punishment, and I was always being told that I was attention-seeking.

Coping mechanisms as self harm in childhood

On one occasion, I would have been eleven, when I'd been taken by my uncles to the photographer's house and was being sexually abused by four teenagers and this adult man, during part of it I felt like I was standing outside of my body. Sometimes I would step outside of my body, and watch, completely detached. Also I could 'lose time', sometimes know that I was there, but not be aware of what was going on around me, and other times lose time altogether, become totally unaware of being there, but then discovering that I was still there, and I'd lost a given period of time. I would have a memory of arriving and leaving, but with gaps in between of what had gone on. I knew things had happened but I

didn't know what. For instance my nipples were very sore and bleeding, but I had no memory of what had happened to my nipples: I knew something had, but I couldn't remember what.

When I got to bed, when I was on my own, then I would start to feel the intense pain that I managed to block out at the time of this happening. I mean physical pain. Emotional pain was hardly ever there from a very early age. I could not feel physical pain for given lengths of time, but then when I was alone I would start to feel. The physical pains were sharp knife pains in my rectum, very intense pains in my breasts, and a very sore throat, like I'd got tonsillitis. I was also very afraid, but I didn't know what I was afraid of, because now I was safe. I wasn't with them anymore and I hadn't felt afraid that I could remember when I was with them, but on my own I could feel fear. And that consumed me. It was then that I didn't want to feel anything at all. So I would numb out completely, and wouldn't feel anything. This would be at the end of the day in bed.

I had this ability to stop feeling everything. I would stop feeling fear, stop feeling pain, stop feeling anything. Sometimes I could do that without actually doing anything. Other times I couldn't make what was going on go away. So, as before, on these occasions, I'd bite my arms until the pain was so intense that it drove everything away again. Biting my arms so hard would take away the memory of the physical pain of the abuse. It would also remove the emotional pain, and it would remove the fear. That's how it was.

On the other hand, on some occasions I would become almost robotic, and couldn't feel anything: neither joy, nor sadness, nor pain. Then I would get very scared, and I would injure myself so that I could feel something. Then feeling physical pain was better than feeling nothing. I would do it by biting my arms.

It can be unbearable not to feel anything, and it can be unbearable to feel too much. You need a control mechanism, so you can control the level of pain that you can take. If it's too much you can numb it out by dissociation, just by learning the skills, from being very small, to stop feeling. Or you can self injure to feel to a level that you can cope with. You learn to do it from a very early age. I would never do it in front of anyone, I always hid to do it.

I used to black out during the abuse. When I started blacking out at other times I was told that this was because I wasn't eating properly, or I wasn't sleeping properly. I started blacking out more and more and it became very frightening. One occasion I remember vividly was my mother sending me to the bakery, and I blacked out in the queue, when someone next to me mentioned how sexually attractive I was for my age. This was only yards away from where we lived, and my mother came, and when I came round and she was really angry. Because my blacking out might be a signal to other people that things might not be alright, because she did know what was happening.

She would take me to the doctors to find out why I was blacking out. He said I was growing too quickly for my age. That was when I was about nine or ten and I first started to menstruate. He kept putting everything down to me growing up too quickly. The interesting thing about going to the doctor was that if my brother or sister were ill, then my mother would take them on their

own, but if ever I was ill, we all went together, so I wouldn't talk. If I'd gone on my own I'd have probably said a whole lot more than I would with my brother and sister with me.

There were other forms of self-injury. For example, I went into refusing to eat food, and forcing myself to stay awake. At the time I hadn't a clue doing this was self harming: they were just a way of coping. At night, always when I went to sleep, I had awful nightmares so I wouldn't go to sleep, I'd make myself stay awake, and then go to school the next day and function just as everyone else was. To the point that then I had to have help to learn to sleep when I got older. It is still a huge problem for me, because I trained my body to stay awake to avoid the nightmares.

The same with food deprivation. My mother denied me food. Either I hadn't been good enough, or I wasn't worthy enough, or if she wanted to let me know that I was less wanted in the family than anyone else, then she would use that form of deprivation as a punishment. So I used it as a form of self punishment, and also as a weapon to get back at them. To refuse food and drink was a way of me stating that I wasn't happy with other people around me. It was something that I could do that would make people angry, that I could have control over. I could assert my authority by saying I'm not going eat, I'm not going to drink, even when I wanted to. There was little else that I could do, but no-one ever tried to force me to eat.

As an adolescent I started overdosing on laxatives. I never ever abused with alcohol, because alcohol was very over-used in our family. I knew from a very early age that alcohol could lose control for me, and I didn't want to be in a place where I would be out of control. So I never ever touched alcohol. For me the control was a survival mechanism.

The other bit of control for me was finding places to be on my own in isolation as often as I could: it wasn't very often, but when I could I would hide. I was always hiding where people couldn't find me. In the bakery opposite, I would build tunnels underneath the stacks of metal shelving. One day when I'd not eaten for three days my tunnel ended up at a rack of trays with all the cakes on, and I sat eating cakes. No one could see that I was eating them, and no one would know. That was an occasion when I got the best of both worlds.

Another way I had to cope was being busy, getting into total exhaustion, just wearing myself out to a frazzle in the hope that I would be able to fall asleep and maybe be so sound asleep that I wouldn't have nightmares. But it didn't work that way. I got nightmares every night, and I still do, I never have a night without nightmares. I wake up totally terrified. I am so scared, I just wake up shaking. I re-live it over and over.

I'd work hard so that I wouldn't have any mental space to think about anything, other than what I was doing. So I became a high achiever. As a teenager I was always organising something, or doing something, like I would do needlework and knitting, or I'd be writing, or I'd be at a youth group, or a church group, if not I was swimming. My life was full of doing things all over the place. I would just wear myself out physically, so as not to have any space to think or feel emotionally.

As a little girl, every waking moment I was doing something: looking after my brother and sister, always wanting to run errands to please people, always busy finding something to do. When I went nursing, I would just work and work and work, until someone noticed that I'd worked hours over my shift time and threw me off the wards. I used to go and hide in the laundry room and just keep working and washing things until someone threw me out. Because at night time I didn't want to be sitting around with nothing to do.

Sexualisation to abuse and sexual self harm

It took me until my early thirties to lose the need to sexually please, because that still felt like all I had. It felt the only thing I was any good at. I was still trying to find out what was normal and what wasn't because I didn't know. All the sex outside of the abuse felt very tame. Just ordinary intercourse, felt like . . . why don't you do any more, is this all that you're going to do. Because everything I'd known had been much more than just intercourse. So I used to check out in relationships; don't you want anymore, and they used to say, well what do you mean, and then I'd get too shy and too scared to explain what more there was. I used to think, well if they don't know, maybe I shouldn't say, maybe it's illegal. At that point I didn't know what was illegal and what wasn't. I was still confused and didn't dare ask in case people wanted to know why I was asking. I don't know what a normal relationship is, and I still don't have an ongoing sexual relationship.

When I went nursing, although I'd left the family, they hadn't left me and I was constantly being pursued especially by my younger uncle. So there was huge tension between continuing to be involved in the sexual abuse within the family, and trying to create a life for myself outside of the family. I couldn't do both, I couldn't be sexual in the family and sexual outside of the family. So I decided that I wasn't going to be sexual again. Having discovered that what was happening in the family was all wrong, that also terrified me. And I didn't then want to be sexual for that reason either.

But I discovered that the longer I was away from the family, and in the breaks between working myself into total exhaustion, I was beginning to feel sexual arousal on my own. The only way I could handle this was by masturbation. And I got into excessive masturbation, into self harming sexually, pushing things inside me to fulfil this sexual arousal that wasn't being met either in or out of the family. This made me feel enormous guilt, and I was afraid people might catch me and find out. So I lived in total terror the entire time. But I was absolutely compelled to do it and it was the greatest addiction at that time for me to recover from.

The masturbation started because of the sexual arousal and then the arousal led to self harming. It was more to finish the arousal than to feel satisfaction. Until the arousal had come to its fulfilment, there was no way out of it. It was like a trap, and I wanted it over and done with as quickly as I could in order to get rid of it. Sometimes the self harming took away the arousal and that was when I got hooked into it. I didn't like the arousal, it frightened me and I had to get rid of it.

Once I was aroused, I could only achieve orgasm or finish the arousal by repeating some of the abuse. The only thing that mattered was bringing the sexual arousal to an end, either by orgasm or by self injury. Unfortunately later when I went on to sexual relationships, I always wanted to end it in the same way: by self harming. So however good, or however mundane, any particular sexual experience had been, even if it was a chosen relationship I would then self harm when I was on my own again, afterwards. By masturbating, for example until I bled. I would make my clitoris bleed, I would tear my rectum, my vagina.

I allowed myself to be abused sexually in my relationships, by constantly having different relationships that would only last for a very short space of time, two or three weeks or months or one night stands. I lost count of the number of men. It could be any one, any place, any time. What I am describing is a compulsive sexual addiction, but it's not recognised as such: in women's magazines it's portrayed as being liberated.

Then afterwards, this is so important, whether it was a one night stand, or the most intimate loving tender relationship, afterwards I felt absolute self loathing, a drive to self harm and the desire to self injure. This was as compulsive as the desire to be sexual: the two went together. To be sexual and to self injure, they just happened. Then I would feel alright and I would say 'I'm okay now, I can cope', and I'd go back and do my job brilliantly and tell no one what had happened. So all of the secrecy about the sexual activities in my childhood continued into secrets about sexual activities in adulthood.

Cutting as a coping mechanism in adulthood

I started self harming by cutting my arms in my early thirties, and that spiralled into chaos for nearly ten years. Every time I felt afraid of either not feeling anything, or feeling too much I'd cut myself to control the pain levels. If I'd get any emotional feelings I would drive them out by cutting. That could be after a sexual experience, at home in the bathroom, at hospital, it could be in the park. On some occasions, one cut would be enough, on others I would need to cut three times, and then I needed to cut more. I cut my throat, and cut my face, then my arms, and then I cut both breasts, five inch deep incisions in both breasts, then I cut my nipples off.

I counted over ninety incisions on my body over a period of ten years. All of them needing hospital treatment. That resulted in people at the hospital getting furious and me being stitched up with no anaesthetic, being made to wait until the casualty department was empty. You got clear messages people were furious. Not once did anyone ask why, not once. No one ever said, 'why are you doing this?'

I was in and out of the psychiatric hospital for ten years and never once did anyone say, 'why are you doing this?' No one wanted to know. Everyone used to say, 'aren't you silly, you've got everything, you don't need to do this yourself to get attention.' Everyone saw it as attention-seeking. No one saw it as a survival strategy. There were always accusations, there was never compassion, there was never understanding, and never a hint that anyone cared.

When I cut off my nipples, I was actually in the psychiatric hospital. I'd been on leave from the hospital to home for the weekend with a view to being discharged on the Monday. At home I'd been triggered with all kinds of memories of my abuse. My uncle had been to visit during that weekend and I was completely thrown, I went back to the hospital and on the surface I looked fine, but I intended to self harm. I'd hidden razor blades in rolls of knitting wool and I'd taken two bottles of tranquillisers and sleeping tablets hidden in balls of wool, stuffed with cotton wool so no one would hear them rattle. I had a room on the second floor as a trusted patient ready for discharge, where I went to bed.

When I was sure the night nurse had done the rounds at midnight, and no one was going to come back upstairs until seven o'clock in the morning, and the person I was sharing the room with was fast asleep, I went to the bathroom, and I cut my arms and my throat, cut my breasts, and then I attacked the part of me that was the most focused on in the pornography, I had huge nipples which was always the major part of the pornography so I cut my nipples off, and took both those bottles of tablets. I came round five days later in intensive care. Apparently the person sharing my room had woken and gone to the bathroom and just couldn't believe what she found. They said the bathroom was like a slaughter house.

> Editorial note: At this point in the interview, when I asked why, after everything at that time did she cut her nipples off, Alice said 'You're the first person to ask why your nipples?' The interview continued:

Part of my being sexually attractive in my childhood was that even though I hadn't got breasts, I had large nipples, and they were a major focus of my abuse from being very young through my adolescence, especially in the pornography. Then at puberty, I developed large breasts. I was a 34C cup bra size at the age of twelve. Then I became a very sexual being. From my grandfather's viewpoint, this was a plus because some people wanted this Lolita image of this sexual little girl, and for a few years I was that image. Part of it was a minus, because some people wanted me small and a child.

As an adolescent my nipples would enlarge without any sexual activity. People could see, it was very obvious that my nipples were so large, you couldn't camouflage it, and I felt like I was a walking advertisement as a sexual being. It was hugely traumatic. The same would happen in hospital. People would remark on the size of my nipples. I became excessively traumatised by it.

On this particular occasion earlier in the week, a nurse remarked on my nipples, and how thrilling they would be for any male partner I might have. What she said just threw me to pieces. It stayed with me the entire time I was on home leave, and when my uncle came over I just decided: I'm not going to cope with this any more, I'm going to take them off.

I decided that I wasn't going to do it at home because I didn't want my children involved. I decided that I would do it at the hospital, and I'd do it at night and that with a bit of luck I wouldn't be around in the morning. My intention was to mutilate myself and die. I'd got seven hours clear and I thought

that if I mutilated enough, took enough tablets, I wouldn't be there in the morning. The hospital would have to clear it up and deal with it. I didn't want to risk strangers finding me. I felt like I would be abusing people who didn't know me to do it anywhere else. But I thought the hospital could handle it. And that's what I did. I didn't die, and you may say it is fortunate I didn't die. It feels that way now, but it didn't feel that way for a long time.

When I came round at the hospital I was furious I was alive, and for a long time couldn't speak to anyone. Not even to my psychiatrist, who I really liked. It became knowledge throughout the whole of the general hospital what I'd done. When I went home three weeks later, my neighbours knew what I'd done, via a nurse who worked at the hospital. Everyone at the psychiatric hospital knew about it, patients and staff: everyone, was coming up to me and talking to me about it. My children's friends at school knew about it from a nurse at the hospital who had told her friend. It was dreadful.

It was very hard for my children. They had to cope with lots of things, but that was particularly traumatising for them. The very thing I didn't want them to know about, they actually heard about from other people. The cutting is the major thing that affected other people. I was under the illusion that self harming just harmed me, but in fact it harmed every single person that was a part of my life that I cared about. Mainly my husband and children, but also my mother. She couldn't cope with this at all. She was nowhere to be seen, she didn't want to see me, she didn't want to talk to me, she just didn't want to know. She was terribly distraught that I was self-mutilating: that was the one thing that really upset her. It made my abuse visible if only anyone had bothered to look or to ask. But they didn't.

As a result of what I'd done, I was put on a section in a secure ward, locked up, and told that I was unsafe to myself. That was true. I was put on this ward indefinitely and had to prove my ability to function outside of it. But that is a long story for another time.

Loving the familial abusers

In spite of what they've done to me, I don't hate them. I love them: my family. This is something most people have a hard time understanding. It's a myth that you hate your abusers. There are some that do, but there are a huge number of people who don't. It's what I grew up to know. I grew up in this abusing environment that was my family: good and bad that was my family. When a colleague told me recently she would have adopted me and rescued me if she had found me as a child, I told her I wouldn't have wanted rescuing, I wanted my own family. I lived in a situation of terror, but an even bigger terror was that somebody would take me out of it and put me with strangers. At the time I would have done anything to stay where I was with my family even though they were abusing me. All I wanted was not to be hurt. I didn't care what they did to me as long as they didn't hurt me. But if they did hurt me I'd still rather be there being hurt by them than with strangers I didn't know not being hurt. I felt a huge loss when I cut myself off from them, not a relief. I'd still love it all to be normal, to be a family,

and we never will be, but that doesn't take away my feeling of love. My abusers taught me to knit, and to sew: they taught me the value of education.

If you ask most survivors of this kind of abuse what it is they want most, it's the love of a parent, and very often the mother. I wanted my mother to love me, but she never did. I have been denying for years that what my mother did was abuse. That my mother was OK really was the thing I always used to say.

The denial of love from my mother created in me the inability to be able to love someone. You can show them that you love them by buying them things, doing things for them, but actually you don't feel it: there is an inability to feel love. You can show it, but not feel it. The heartache was my mother never told me I was a good girl. So up to the moment she died, I was still seeking approval from her. When she died I was devastated and felt cheated because I hadn't got her approval, and there was no more time to get it, she'd gone.

What I wanted, as a small child, and still as an adult, is for people to understand. I've always believed my family wouldn't have done this without a reason. At the time I thought it was normal, and then when I discovered it wasn't, I always believed there had to be a reason.

I wanted someone to come in and to stop what was happening and to help us to get to live with each other without hurting one another. Or at the very least for someone to talk to. An adult I could trust to make it safe for me to talk to without the fear of them rushing in and taking my parents away from me. Somebody who would believe me.

The thing that I didn't want was for my family to be sent away or for me to be taken away. The chances of me telling anyone as a child would have been remote because I would only have told someone if I was absolutely sure they were going to be sympathetic to all of us and not just me. With hindsight, I know that you have to remove children who are being abused and put them with strangers. That's the reason why I stayed silent. Because I didn't want that. I would rather have had the abuse than not have my family. If the family is punished, the child's going to suffer by losing their family. So there has to be a way found where the situation can be sorted out without the child being punished for talking.

Breaking the silence

Throughout my childhood and my adulthood, I created a 'together' image as the best way of people never knowing what had been happening. No one would ever guess. I'd learned as a child that the exterior image was all important to keeping everything unknown, to keep it secret, and being in control: and it is the same as an adult.

Now as part of my recovery I am doing the opposite and talking. This is what I'm doing now to you. When I've done it, though, I'm terrified. That's true for people who begin talking about abuse that has been secret all of their lives; they want to do it, and then frighten themselves when they've done it. It brings everything out into the open including the fears: what is going to happen to me, what have I done, and what is going to happen to my family if anyone finds out,

it isn't only going to rebound on me its going to rebound on everyone. There are also the feelings that I am betraying my family.

It's enormously costly to speak about it even as an adult. I'm still being victimised by my family for speaking. My entire family disowned me for speaking. So in the end I have still lost the family I hoped as a child that I wouldn't lose. And my children are angry because they've lost their cousins and their aunts and their uncles. The trouble is when you start, you don't know how costly its going to be. Very often you're led into believing its the best thing to do because social workers and professional people tell you so, but then you end up discovering you've got no one and you're completely alone. Although I have spoken about the abuse as an adult, I'm not sure it has been the right thing to do.

Systems abuse and revictimisation in adulthood

I saw a psychiatrist for about eight months before I went into hospital. What was happening then, was that I was not sleeping at night time and I was driving out in the car for hours and hours most nights and getting totally exhausted, because I couldn't go to bed and switch things off in my head. I was getting less and less able to cope and my psychiatrist suggested that I went into a psychiatric hospital for a rest. At first I refused. And then he suggested that it wasn't a choice any more, that I should go into hospital. He ordered me and I went. I stayed there for eight months and then was in and out of the psychiatric hospital for about ten years.

The hospital put me on a cocktail of drugs. If one lot of drugs didn't work I put them all together and took the whole lot of them in the hope of being able to cope. All sorts of drugs were given to me at different times, because no one knew quite what label to put on me. I completely gave up.

The thing that didn't happen which I thought would have happened was that I'd sleep. I didn't sleep, so the drugs became greater and greater. I also kept going out at night. I had this drive to go out at night time, and I would just go out and walk and walk. On a couple of occasions, I found myself in London walking around Hampstead Heath. I'd got from Birmingham to London, and I'd have no idea why I'd come. I'd finish up around Kings Cross Station talking to other very distressed people.

'Losing time' in any way was always therapeutic in terms of being a coping strategy, in that it got me through a time when I might have been suicidal, or devastatingly self harming. Many times I would self harm taking drugs trying to put myself to sleep without killing myself, but very often nearly killing myself. Then it would be seen as a suicide attempt, and in fact it wasn't that at all, I just wanted to be unconscious. I played Russian roulette with drugs in that way, I would take anything and hope for the best, but above all that I wouldn't be conscious. I would often be rushed to hospital, as having another suicide attempt, but no one asked questions about that either.

As a psychiatric patient I was physically abused by two male patients and one male member of staff. The male member of staff, the charge nurse, who was in

charge of the ward, had intercourse with me and oral sex with me. I was sexually harassed by female members of staff referring to my body. When you're in a psychiatric hospital, unless you've got reliable witnesses no one believes you, so you just take it as par for the course. The hospital was anything but protective.

Physical conditions and ill health

Vigilance is one of the legacies of the abuse. I don't miss anything. As a child I learned how people walk, how they close the door, their movement in a chair, by a cough by a gesture, I knew what kind of mood they were in, or what was going to happen, and that has stayed with me all my life. That's with me every moment of every day, it never goes. It's torture: I can hear things most people can't hear, I see things people don't see, but most of all I can sense things that people don't sense, I can read intention anywhere, and I'm never wrong.

The other legacy of abuse has been chronic physical ill health. Early on I began to have gynaecological problems. I had a D&C at fourteen, and another at sixteen, and then a hysterectomy at thirty-two. As a child and adolescent, I was constantly getting urine infections which went on to bladder infections which went on to kidney infections, because I didn't get the help I needed when it was just a urine infection. From thirteen onwards I was in and out of hospital constantly with severe kidney infections. As an adult, I've had bladder surgery, bowel surgery, my uterus removed, kidney surgery because of continuing infections and now I am receiving disability allowances because my mobility has reduced considerably as a result of all this. These are some of the lifelong effects of the sexual abuse.

I still suffer from the stigma of cutting myself. The scars are visible all over my body. When they see my arms, doctors and nurses don't take me seriously. Twice I've almost lost my life as a result of it. I've gone to hospital with severe pains and when they've taken my blood pressure, they've seen my arms and seen me as being psychosomatic and not had the proper investigations done to help me. On one occasion when I had this very severe kidney pain, they sent me away from the hospital and I actually was returned unconscious with a gangrenous kidney. I've often been dismissed as attention-seeking or psychosomatic: not that they were real physical pains, but that they were imaginary. I thought this had long gone, until recently when I was in the emergency room at the local hospital with pains in my chest, but I had to wait seven hours in casualty because no one could make up their minds if this was real or not because of the scars on my arms. The registrar said that if I had mentioned that these scars had been done twenty years ago, then I would have been taken more seriously. He said, when you come into hospital again, explain to them that these injuries are not recent, they're from the past and if you explain that to them then you will be seen much more quickly, and taken much more seriously.

Throughout my entire life, because of this disbelief and this lack of understanding, I have never gone to doctors until I've been desperately ill, I never go soon enough, so in a way it's been self harming to not get to the doctor before

its become an emergency. I don't have confidence in going to hospital unless there are visible symptoms of something. So I just wait. So when I get a chest infection I wait until I've got pneumonia before I go to the doctor. If I have any illness it has to be so extreme that I can barely walk before I go any where.

You can never get away from the abuse. I'm always having to explain the effects of it. In hospital last time for bladder surgery, I was flooded with memories of the abuse of my childhood. It stopped me sleeping, it created nightmares and fear, and I withdrew into a total state of isolation. It's a matter of having to constantly inform people, because they're not going to notice or ask what's wrong. I have to tell them, and it takes a lot of energy and courage to do that, because I don't know what their responses are going to be. So that in itself it quite traumatic, and fifty years on I'm still surviving as I did as a four-year-old.

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8 Once I was a child and there was much pain

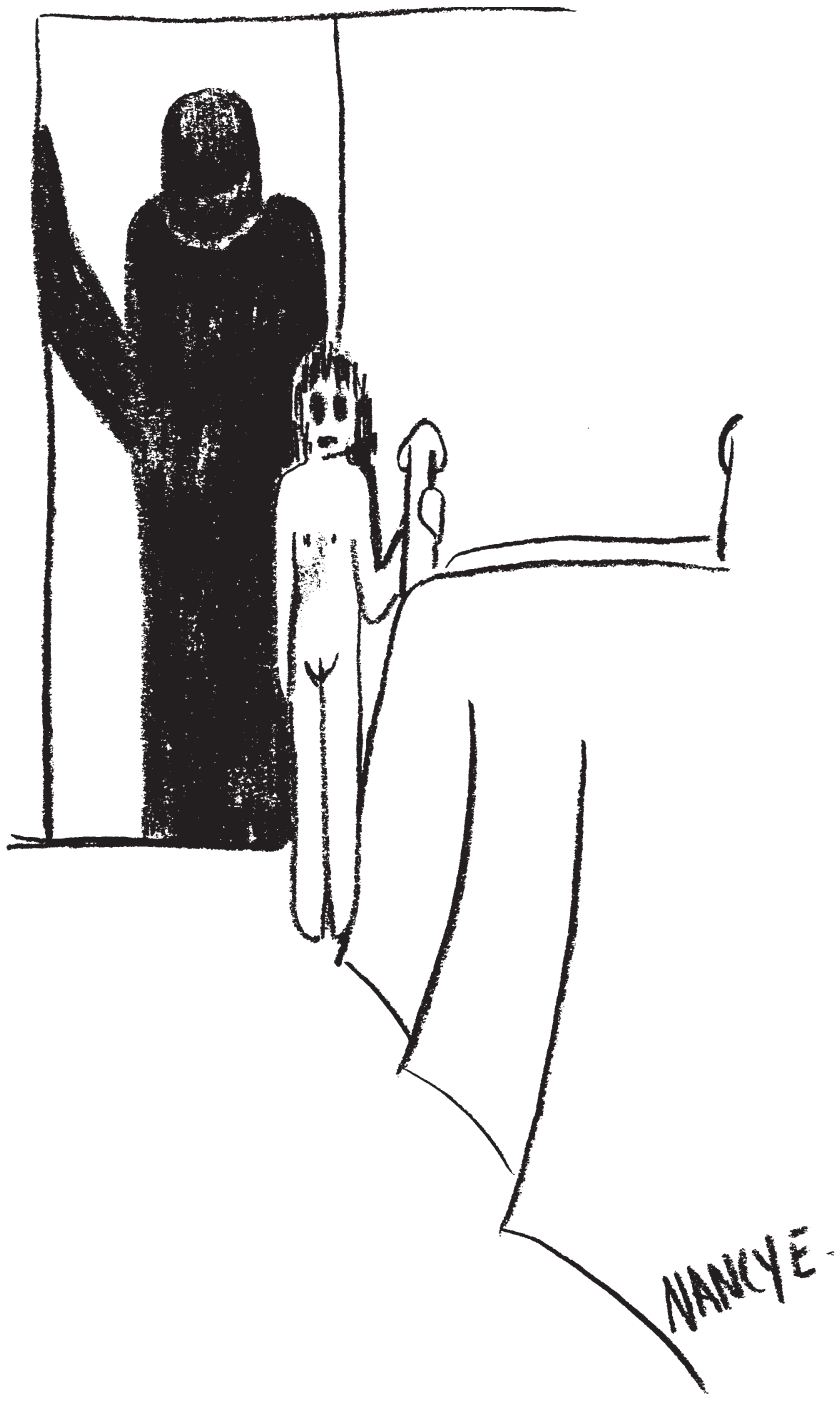
A glimpse into the soul of an incest survivor

'Nancy E'

This chapter consists of a collection of drawings with captions by a woman who was aged twenty-eight at the time of their original publication in 1988. It is the story of her experience of incest as a child. This contributor like 'Rachel Pearce' (chapter six) and 'Alice Edwards' (in chapter seven) uses a pseudonym to conceal her identity as a victim of sexual abuse as a child. These are the words that accompany the drawings:

> I was a child once and there was much pain.
> I am a woman now and I speak of that pain through my art
> Here as a chapter in this book I share it with you.

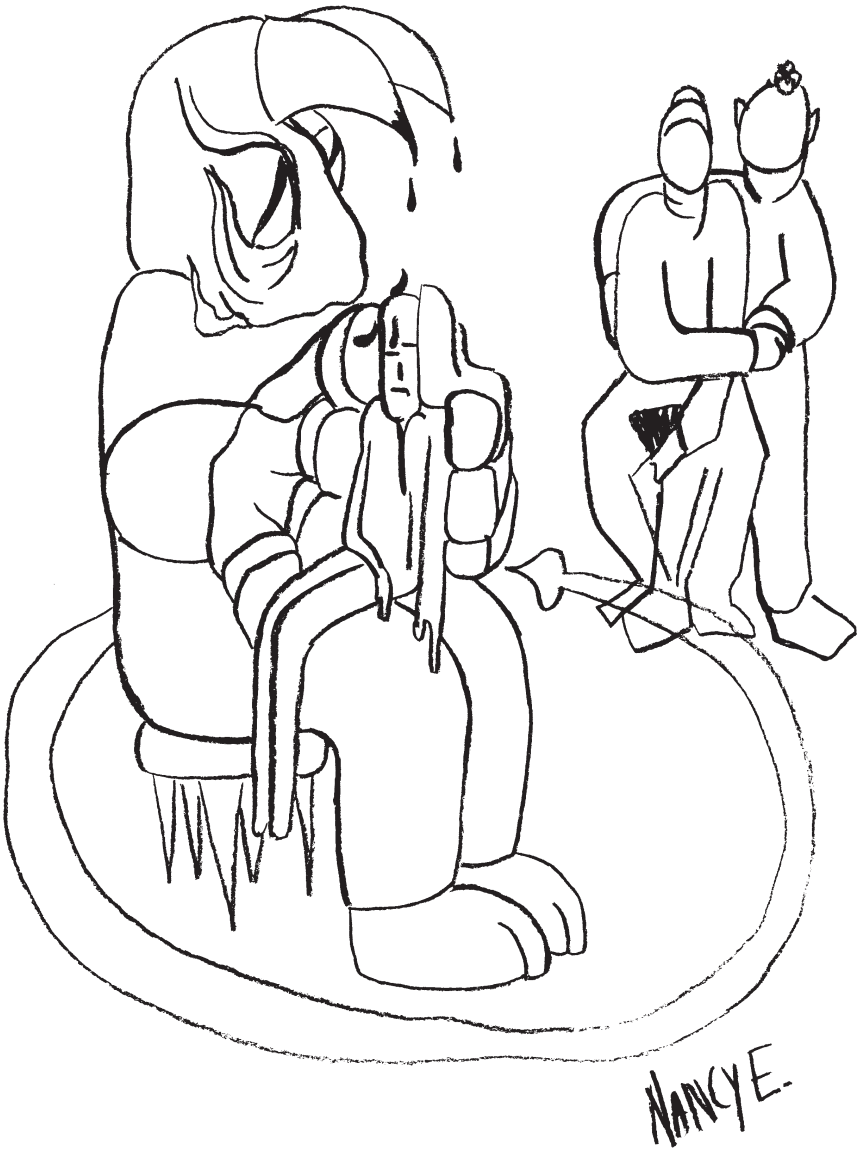
Oh Daddy! . . . NO
The scream within is deep and silent.
I am bad.
Oh isn't she pretty! Would you like to use her?
I am not seen. I am not heard.
All is torment.
Where are the faces?
The dream. I am alone. The room is boarded, window and door. There is no escape.
Not a dream. Imprisoned.
I am hurt. I am torn.
We musn't see this. Why do we see this!
Another dream. My coat is strong and warm. I know not of the key.
The idea of death was good.
I am breaking into pieces.
Evil in all its forms threatens to engulf me.
I am the family toy.
Watched. Used. Left.
Born female. Used child. Tormented creature.
I draw all that I am.
Insecure hide away.
I know they are there.



Oh Daddy! . . . NO.

The scream within is deep and silent.

I am bad.

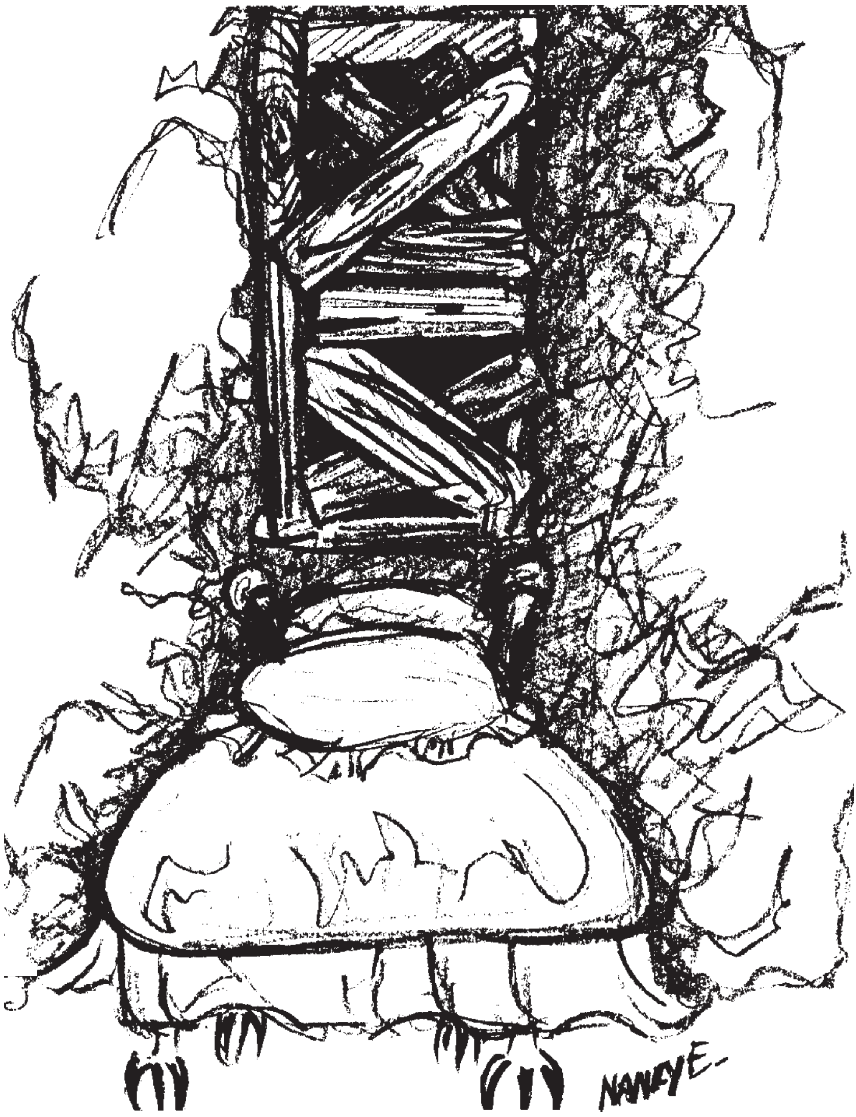


Oh isn't she pretty! Would you like to use her?

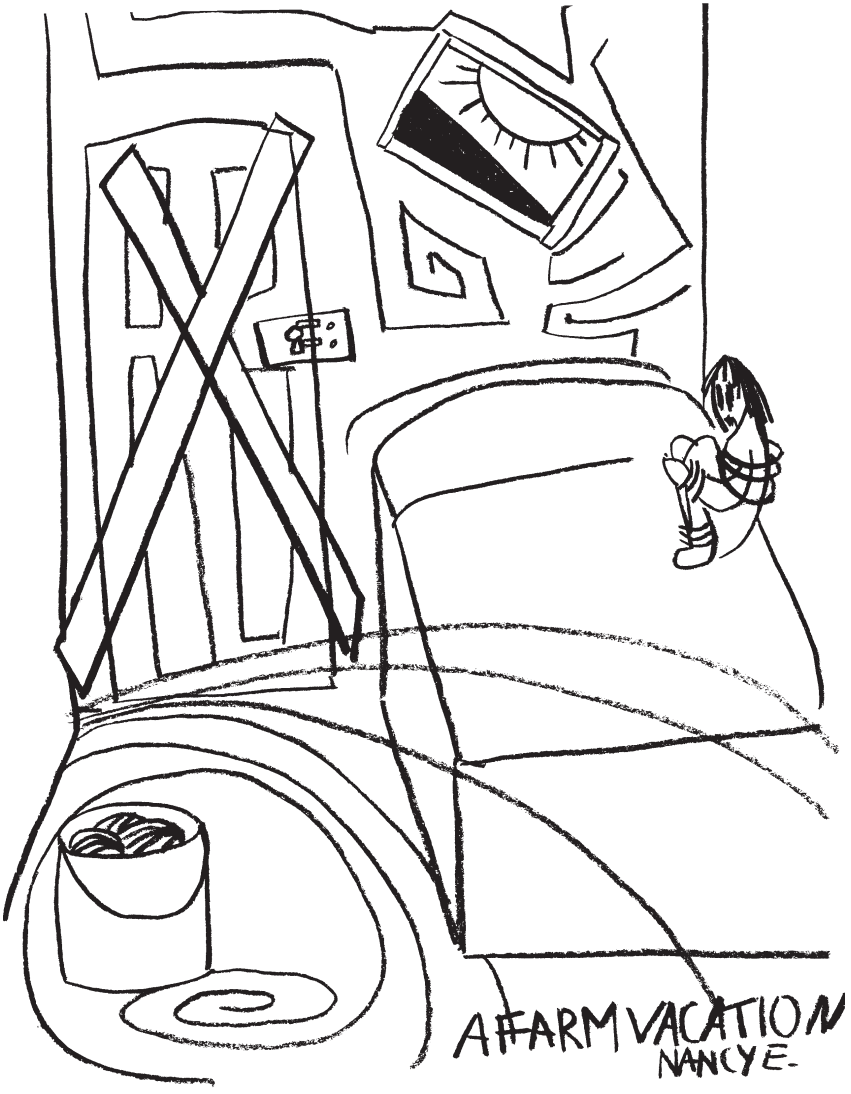
I am not seen. I am not heard.

All is torment.

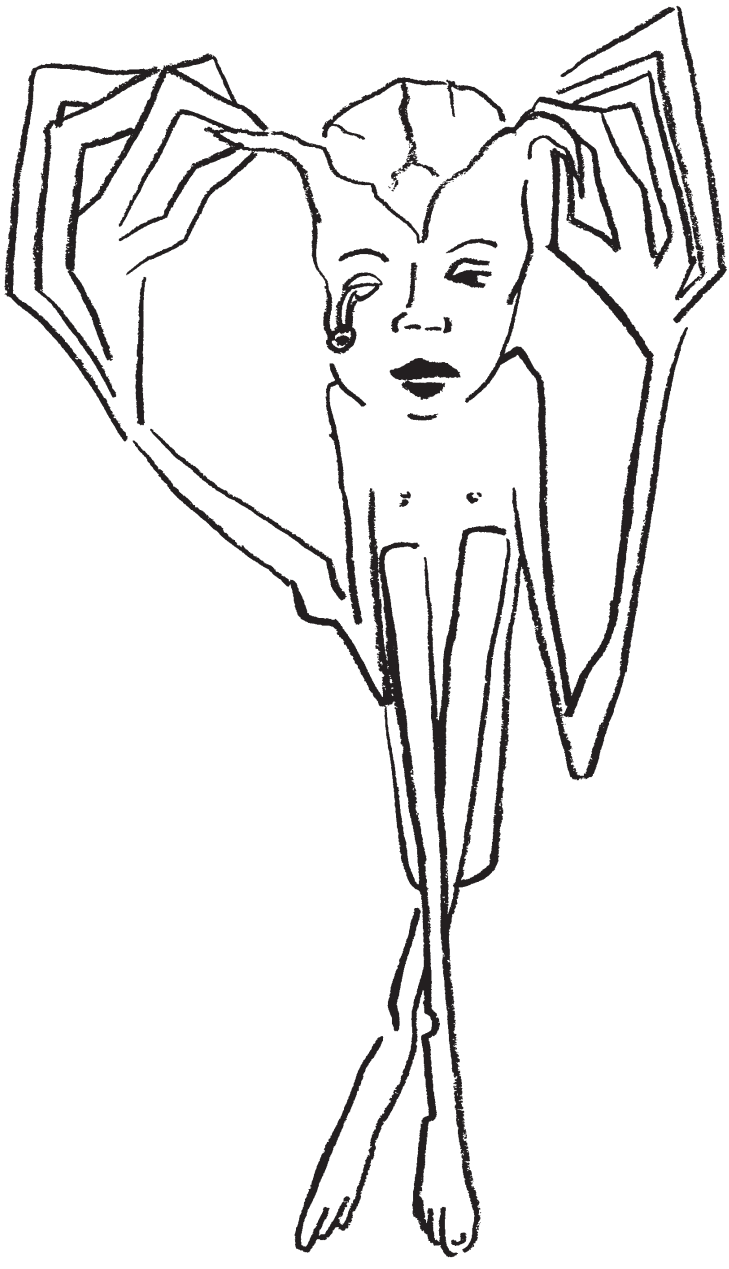
Where are the faces?



The dream. I am alone. The room is boarded, window and door. There is no escape.

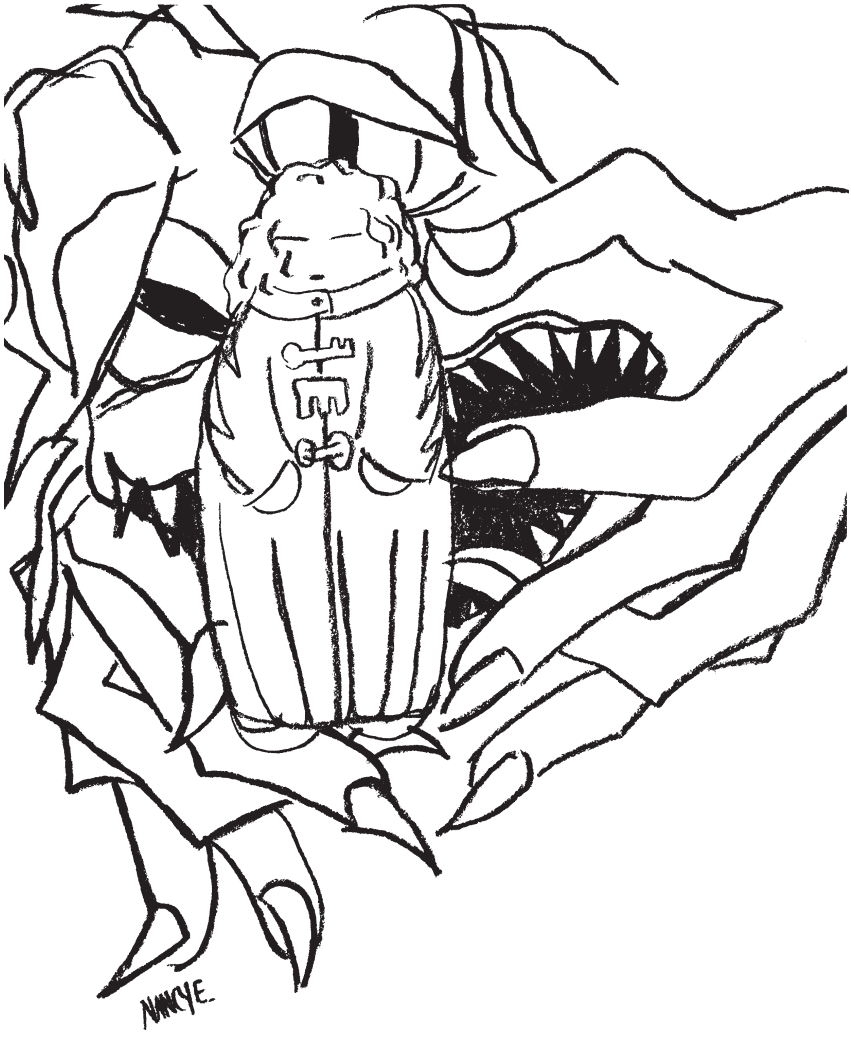


Not a dream. Imprisoned.



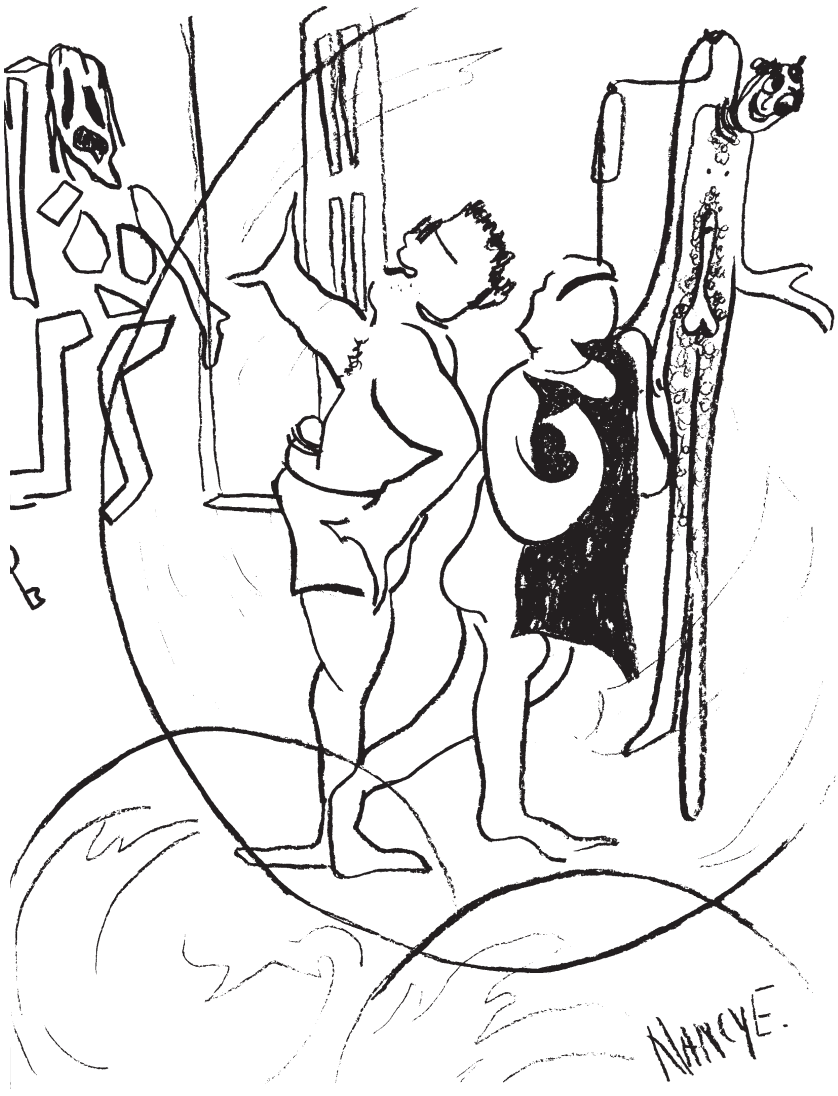
I am hurt. I am torn.

We musn't see this. Why do we see this!



Another dream. My coat is strong and warm. I know not of the key.

The idea of death was good.

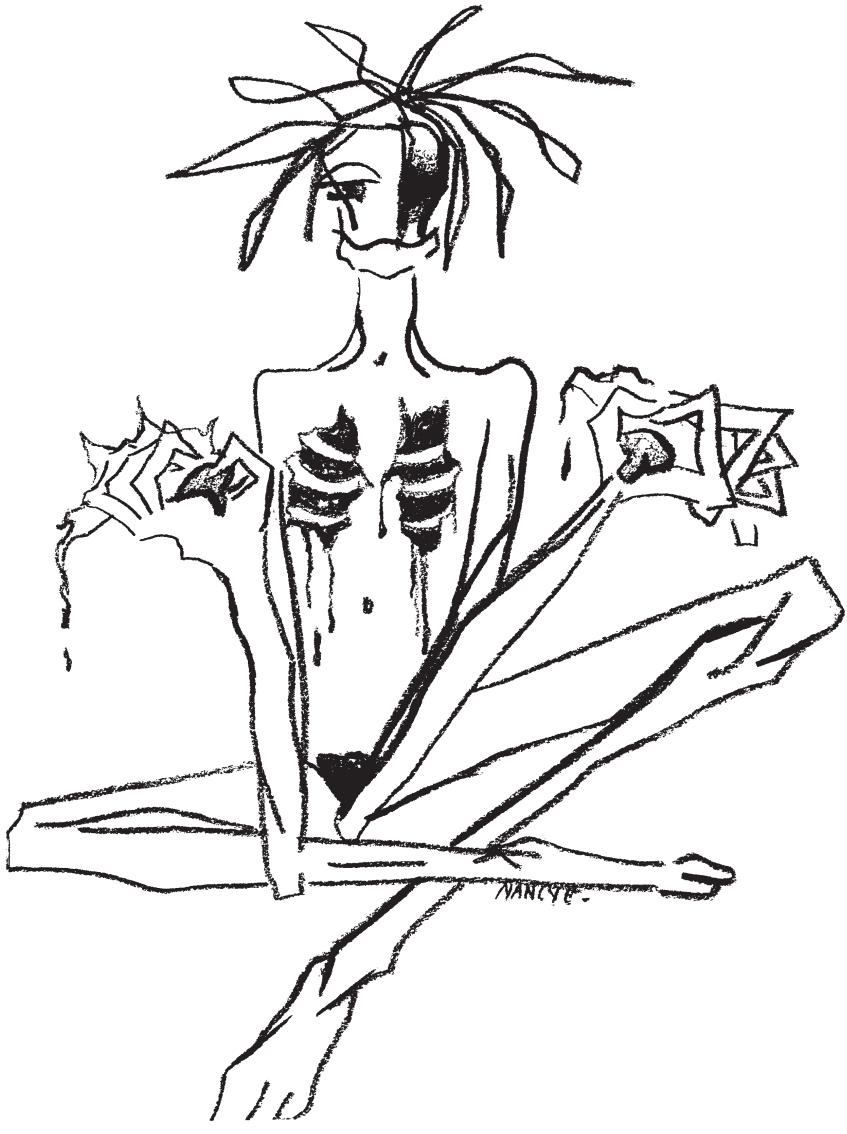


I am breaking into pieces.

Evil in all its forms threatens to engulf me.

I am the family toy.

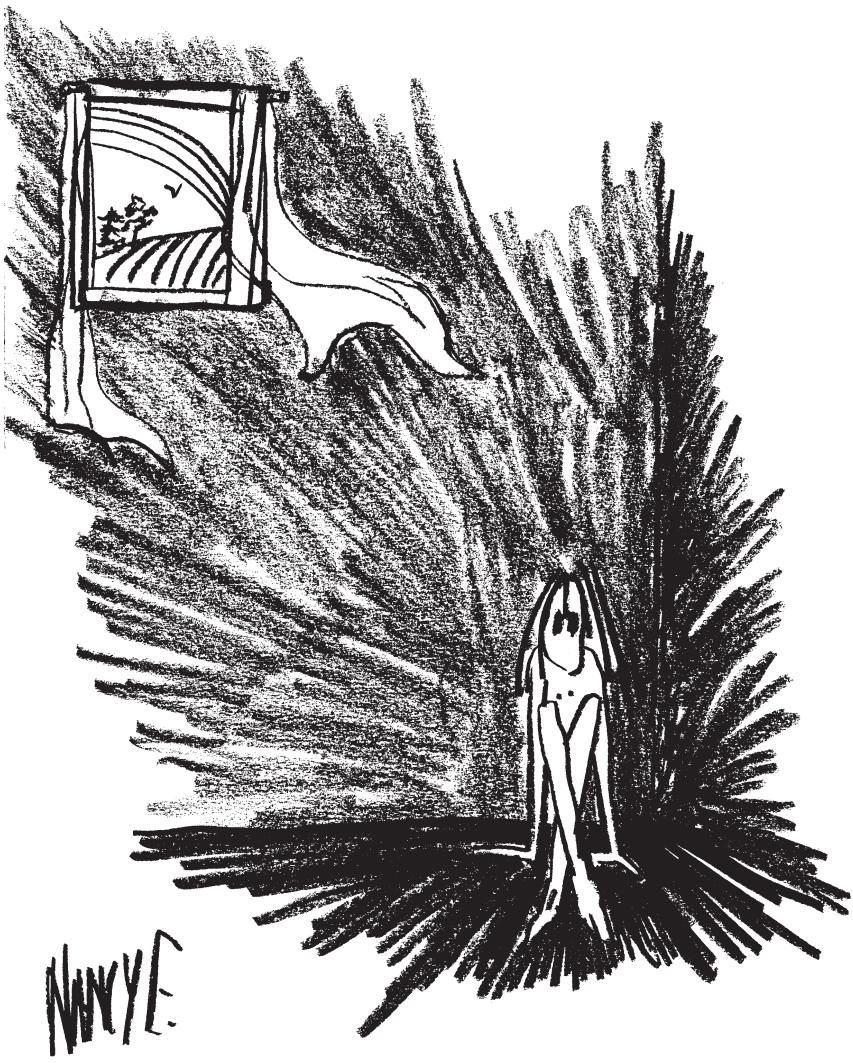
Watched. Used. Left.



Born female. Used child. Tormented creature.

I draw all that I am.

Insecure hide away.



I know they are there.

9 The newly recognised shattering effects of child abuse

Alice Miller

Introduction

Alice Miller's books about child abuse as it is perpetrated by adults and experienced by children, and its effects on individuals and society have attracted a large world-wide readership, and made her a major figure in present day psychoanalysis notwithstanding her renunciation of classic psychoanalysis (see Itzin, chapter twenty-one).

What – broadly – has been original and radical about Miller's work is to conceptualise many of the normal and routine practices of child-rearing as abusive and damaging, although they are not seen as such. This is reflected in the titles of her books: *Thou Shalt Not Be Aware: Society's Betrayal of the Child* (1981); *For Your Own Good: The Roots of Violence in Childhood* (1987); and *Breaking the Wall of Silence* (1992). Another of Miller's contributions has been her belief in the need, if therapy is to be effective, for the therapist to recognise and to bear witness to the pain of the child which inhabits the adult, and for the adult in therapy to experience the pain in order to become free of the effects of the child's experience and suffering associated with it.

When I approached Alice Miller through Joan Woodward, asking her to contribute a chapter distilling the core messages of her work, she responded immediately by fax, literally with the essence of her work condensed into a two page text headed 'The Newly Recognised Shattering Effects of Child Abuse'. That text is published here as her contribution to this book.

It should be read in the context of Woodward's chapter, and Bacon and Richardson's, both of which draw from Miller's work. Together these chapters represent what, in my view, is important to child sexual abuse prevention: that is, in explaining the contributing factors and causal relationships between violence and abuse experienced in childhood, and violence and abuse perpetrated in adulthood, as emotional and psychic processes; how childhood experience becomes replicated at both individual and societal levels; and the processes required at the level of the individual to break the 'cycle of violence and abuse'.

Catherine Itzin

A twelve point analytical framework

After twenty years of work as a psychoanalyst, I decided to give up my practice in order to write and to share with others the startling insights I had unexpectedly gained about how child abuse disguised as education, and therefore unrecognised, produces the violent and mentally sick society we now have. New forms of therapy and direct observations of newborn babies confirm my findings: people whose integrity has not been damaged in childhood, who were protected, respected, and treated with honesty by their parents, will feel no need to harm another person or themselves.

For some years now there has been proof that the devastating effects of the traumatisation of children take their inevitable toll on society. This knowledge concerns every single one of us, and – if disseminated widely enough – should lead to fundamental changes in society, above all to a halt in the blind escalation of violence. The following points are intended to amplify my meaning.

- All children are born to grow, to develop, to live, to love, and to articulate their needs and feelings for their self-protection.
- For their development children need the respect and protection of adults who take them seriously, love them, and honestly help them to become oriented in the world.
- When these vital needs are frustrated and children are instead abused for the sake of adults' needs by being exploited, beaten, punished, taken advantage of, manipulated, neglected, or deceived without the intervention of any witness, then their integrity will be lastingly impaired.
- The normal reactions to such injury should be anger and pain; since children in this hurtful kind of environment, however, are forbidden to express their anger and since it would be unbearable to experience their pain all alone, they are compelled to suppress their feelings, repress all memory of the trauma, and idealise those guilty of the abuse. Later they will have no memory of what was done to them.
- Dissociated from the original cause, their feelings of anger, helplessness, despair, longing, anxiety, and pain will find expression in destructive acts against others (criminal behaviour, mass murder) or against themselves (drug addiction, alcoholism, prostitution, psychic disorders, suicide).
- If these people become parents, they will then often direct acts of revenge for their mistreatment in childhood against their own children, whom they use as scapegoats. Child abuse is still sanctioned – indeed, held in high regard – in our society as long as it is defined as child-rearing. It is a tragic fact that parents beat their children in order to escape the emotions stemming from how they were treated by their own parents.
- If mistreated children are not to become criminals or mentally ill, it is essential that at least once in their life they come in contact with a person who knows without any doubt that the environment, not the helpless, battered child, is at fault. In this regard, knowledge or ignorance on the part

of society can be instrumental in either saving or destroying a life. Here lies the great opportunity for relatives, social workers, therapists, teachers, doctors, psychiatrists, officials, and nurses to support the child and to believe her or him.

- Until now, society has protected the adult and blamed the victim. It has been abetted in its blindness by theories, still in keeping with the pedagogical principles of our great-grandparents, according to which children are viewed as crafty creatures, dominated by wicked drives, who invent stories and attack their innocent parents or desire them sexually. In reality, children tend to blame themselves for their parents' cruelty and to absolve the parents, whom they invariably love, of all responsibility.
- For some years now, it has been possible to prove, thanks to the use of new therapeutic methods, that repressed traumatic experiences in childhood are stored up in the body and, although remaining unconscious, exert their influence even in adulthood. In addition, electronic testing of the foetus has revealed a fact previously unknown to most adults: a child responds to and learns both tenderness and cruelty from the very beginning.
- In the light of this new knowledge, even the most absurd behaviour reveals its formerly hidden logic once the traumatic experiences of childhood no longer must remain shrouded in darkness.
- Our sensitisation to the cruelty with which children are treated, until now commonly denied, and to the consequences of such treatment will as a matter of course bring to an end the perpetuation of violence from generation to generation.
- People whose integrity has not been damaged in childhood, who were protected, respected, and treated with honesty by their parents, will be – both in their youth and adulthood – intelligent, responsive, empathic, and highly sensitive. They will take pleasure in life and will not feel any need to kill or even hurt others or themselves. They will use their power to defend themselves but not to attack others. They will not be able to do otherwise than to respect and protect those weaker than themselves, including their children, because this is what they have learned from their own experience and because it is this knowledge (and not the experience of cruelty) that has been stored up inside them from the beginning. Such people will be incapable of understanding why earlier generations had to build up a gigantic war industry in order to feel at ease and safe in this world. Since it will not have to be their unconscious life-task to ward off intimidation experienced at a very early age, they will be able to deal with attempts at intimidation in their adult life more rationally and more creatively.

Part 1.3

The nature and extent of child sexual abuse

10 Child sexual abuse prevalence

A review and re-analysis of relevant studies

Rebecca M. Bolen, Diana E. H. Russell and Maria Scannapieco

Introduction

The study of the magnitude of childhood sexual abuse in our society has engaged many scholars through the years (Finkelhor 1979; Kercher and McShane 1984; Kinsey *et al.* 1953). Yet, there is no agreement on how prevalent child sexual abuse is in North America, despite the fact that establishing a reliable prevalence estimate has far-reaching implications for etiology, practice, and social policy in, but certainly not limited to, child welfare, mental health, law enforcement, and the medical profession. With estimates of the prevalence of child sexual abuse ranging from 2 per cent (George and Winfield-Laird 1986) to 62 per cent (Wyatt 1985), a great deal of misunderstanding and controversy exists.

Because of this wide range of prevalence estimates, professionals as well as lay persons can selectively choose the information that suits their interests. Until a sounder estimate of the prevalence is established, statements like the following will continue. 'Research that defines almost half of women under twenty-five as victims of sexual molestation is only part of the radical feminist effort to impose new norms governing intimacy between the sexes' (Gilbert 1991: 61). One of the 'radical feminist' research studies cited by Gilbert as promulgating advocacy numbers (Russell 1983) is still considered one of the most rigorously sound prevalence studies in the field. Others declare that the 'child abuse witch-hunt threatens family unity' and compare children who disclose molestation by family members, teachers, or foster parents as similar to Stalin's collectivization genocide in the early 1930s (Beichman 1994: 22). Placing blame on Marxists, radical feminists, or radical egalitarians (Beichman 1994; Gilbert 1991) stifles the discussion and exploration of the horrific phenomenon of childhood sexual abuse.

The general lack of empirically sound estimates of the prevalence of childhood sexual abuse also brings into question other related phenomena such as recovered memory and dissociative identity disorder (DID). In a recent popular press article, Acocella questions the validity of MPD (DID) and the recent explosion of diagnosed cases among women, especially those with a history of childhood sexual abuse. She asserts that 'the MPD craze was probably

a side effect of the women's movement', and that the women who claimed to be MPD did so to escape their lives of dependency and 'with the establishment of the abuse history, they were no longer downtrodden . . . they were courageous – survivors' (Acocella 1998: 69). These examples are all reflective of society's inability to confront the reality of sexual abuse and the continued denial of the extent of childhood maltreatment.

Financial and personnel resources are ideally allocated based on the perception of a problem in society. Establishing a more reliable estimate of sexual abuse prevalence can be expected to shape and inform policy decisions concerning this serious social problem.

The purpose of this chapter is to briefly discuss qualitative and quantitative reviews of the prevalence studies done to date, followed by a more in-depth presentation of two more recent reviews. These reviews (one qualitative and the other quantitative) indicate that the prevalence is much higher than suggested by all earlier reviews.

Previous reviews of child sexual abuse prevalence studies

To our knowledge, there are eight known reviews of studies of child sexual abuse prevalence: Feldman *et al.* 1991; Finkelhor 1994; Gorey and Leslie 1997; Leventhal 1990; Painter 1986; Peters, Wyatt, and Finkelhor 1986; Salter 1992; and Wynkoop, Capps, and Priest 1995 (see Bolen and Scannapieco 1999, for a comprehensive review of these studies). These reviews are most notable for the different conclusions they draw. For example, the research reviews vary in the number of studies examined, ranging from three (Feldman *et al.* 1991) to a maximum of thirty studies (Salter 1992). Further, only two reviewers (Feldman *et al.* 1991; Painter 1986) restricted the surveys they included to population based randomised studies. College samples, community samples, and general population samples were reviewed in the majority of cases. Three of the eight reviews included historical studies (Feldman *et al.* 1991; Leventhal 1990; Peters *et al.* 1986), and the other five included studies from 1979 to the present. All but one of the reviewers (Gorey and Leslie 1997) used qualitative methods to compare the sexual abuse prevalence studies. Further, only one reviewer (Feldman *et al.* 1991) limited the definition of child sexual abuse of the studies compared to contact only, although two other reviewers (Gorey and Leslie 1997; Leventhal 1990) later adjusted their operational definitions to contact only for the purpose of providing summary estimates. Finally, one reviewer (Feldman *et al.* 1991) limited inclusion of prevalence studies based on age of the victim, choosing to report only prevalence rates for victims under the age of fourteen. All research reviews included studies that examined both intrafamilial and extrafamilial child sexual abuse.

Prevalence of child sexual abuse for females was estimated by half of the reviewers to be around 20 per cent. Gorey and Leslie (1997), who did the only quantitative analysis of prevalence studies, had an unadjusted estimate of 22 per cent for women. However, when they adjusted for response rates, they arrived

at a more conservative prevalence estimate of between 12 per cent and 17 per cent. Similarly, Feldman *et al.* (1991: 30) concluded their review by noting that the prevalence of child sexual abuse for females has remained steady at about 12 per cent and that 'no increase in the prevalence of child sexual abuse of females younger than fourteen years of age has occurred over the past four decades'. Four of the eight reviewers of studies on prevalence of child sexual abuse reported on estimates for males (Finkelhor 1994; Gorey and Leslie 1997; Leventhal 1990; Salter 1986). All prevalence estimates for males were in the 5 per cent to 10 per cent range. Three of the eight reviewers did not attempt to estimate prevalence for either males or females (Painter 1986; Peters *et al.* 1986; Wynkoop *et al.* 1995).

Other conclusions reached by some of these reviewers are that the number of screen questions seemed to be the major source of variability among the studies' prevalence estimates and that face-to-face interviews resulted in higher reporting (Finkelhor *et al.* 1994; Peters *et al.* 1986). Wynkoop *et al.* (1995) also suggested that regional differences and problems with memory and retrospective surveys were related to variability in prevalence.

Recent reviews

Given the numerous limitations of these reviews, two attempts have been made recently to improve on the methodology of these reviews so that more sound estimates of child sexual abuse can be determined. The first analysis, done by Russell and Bolen (in press), was qualitative in nature and focused only on female child sexual abuse. It improved upon the previous reviews by limiting some of the methodological disparities among studies. Russell and Bolen's criteria for selection required that studies be published and that they have random samples of community, state, or national populations within the United States. Further, the age range for the respondents had to be at least eighteen years. By this criterion, Wyatt's (1985) study of women ages eighteen to thirty-six just qualified. Applying these criteria, nine studies qualified for inclusion.

The second analysis by Bolen and Scannapieco (1999) was quantitative. Studies chosen for this analysis had to use random sampling and the population had to represent a community, state, or national North American adult population. An exhaustive search of the literature uncovered twenty-two studies. The studies in this sample varied from those in the Russell and Bolen analysis (in press) by including Canadian samples, unpublished studies, samples with a more narrow age range of respondents, and those reporting on male child sexual abuse. The studies in this sample were similar to those in the Russell and Bolen analysis in that they excluded college and other nonrandom samples and surveys of adolescents. The studies included by these two review teams overlap considerably. Therefore, Table 10.1 reports on studies reviewed by both sets of researchers, with studies marked accordingly. The next two sections examine these two reviews in greater depth.

Table 10.1 Random prevalence studies of child sexual abuse done in North America using a community population

Study	*Year of study*	*Region*	*Sample size*	*Response rate*
Abma *et al.* 1997 (National Survey of Family Growth)	1995	National	10,847 females oversample of African American and Hispanic	79%
Badgley *et al.* 1984	1983	Canada – national	1,006 females 1,002 males	94%
Bagley and Ramsay 1986		Canada – community	377 females	94% of original survey
Bagley 1991		Canada – community	750 females ages 18–27	66%
Elliott and Briere 1992		National	2,963 professional women	55%
Essock-Vitale and McGuire 1985		White, non-Hispanic middle class women in Los Angeles raised by at least one natural parent	300 women ages 35–45	66%
Finkelhor 1984	1981	Boston: parents of children aged 6–14 living at home	334 women 187 men	74%
Gallop Poll 1995*	1995	National: parents of children <18 living at home	1,000 parents	Response rate 57.3% Refusal rate 19%
George and Winfield-Laird 1986[1]		Piedmont of N. Carolina	1,157 women ages 18–64; oversampled elderly	77% of original sample

Mode of administration	*Screen question*	*Definition*	*Age restriction*	*Female prevalence*	*Male prevalence*
FTF & Computer-assisted SAQ	2	Forced or nonvoluntary intercourse	<18	12%	
SAQ	4	Contact and noncontact clearly differentiated	<18	18% contact 30% non-contact	8% contact 15% non-contact
FTF	1	Genital fondling and force/contact	<16 If no force or threat, perpetrator had to be 3 years older	22%	
FTF	1	Unwanted touch or interference with sex parts	<17	32%	
Mailed SAQ	9[6]	Contact	<16 and perpetrator had to be 5 years older	27%	
FTF	1	Raped or molested	<18	17%	
FTF & SAQ	2	Sexual things done or attempted they defined as sexual abuse	<17 and perpetrator had to be 5 years older	15%	6%
TEL	2	Forcible or unwanted contact by adult or older child	<18	30%	9%
FTF	1	Forced contact	<16	2%[6]	

(continued p 174)

Table 10.1 (continued)

Study	*Year of study*	*Region*	*Sample size*	*Response rate*
Keckley Market Research 1983		Nashville area[6]	603 adults[6]	61%[6]
Kercher and McShane 1984*		Valid Texas driver's licence	593 females 461 males	53%
Kessler *et al.* 1995 (National Comorbidity Study)**	1990–1992	National	3,065	57%
Kilpatrick *et al.* 1985**	1983	Charleston Co. S. Carolina	2,004	84%; 78%
MacMillan *et al.* 1997	1990–1991	Ontario	5,434 females 4,519 males	77%
Moore, Nord, and Peterson, 1989 (National Survey of Children and National Longitudinal Surveys Of Labor Forces Behaviour of Youth)	1987 NSC	National	565 females 556 males Ages 17–23	82% of second wave which was 82% of first wave
Murphy 1987		Central Minnesota	777 males and females	65%
Nance 1992[8]*	1991	Kentucky	354 females 283 males[6]	73%[6]
Russell 19834*	1978	San Francisco	930 women	81% if include only refusals 65% if exclude those refusing to list members in house 50% if exclude those not home

Mode of administration	*Screen question*	*Definition*	*Age restriction*	*Female prevalence*	*Male prevalence*
TEL[6]	1[6]	Anything sexual that was unwanted or that felt uncomfortable[6]	<18 Excludes playing with peers or dates[6]	11%[6]	7%[6]
SEQ mailed to house	1	Sexual abuse	As a child	11%	3%
TEL	4	Touched genitals	<18	12.3%	
TEL	1	At least a serious sexual advance with no sexual activity		6%	
SAQ	4	Non-contact and contact	While growing up	13%	4%
TEL	1	Forced sex against will or raped	<18	8%[7]	2%[7]
TEL	1/6[9]	Exposure, nude photographs or sexual contact	<18 By an adult	18%	11%
TEL	1[6]	Respondent's perception of sexual abuse	<16	28%	9%
FTF	14	Divided by sexual contact and non-contact – I/A – exploitative E/A – unwanted	For victims 14+ and perpetrator within 5 years of age, had to be rape or its attempt	38% contact 54% non-contact	

(Continued page 176)

Table 10.1 (continued)

Study	*Year of study*	*Region*	*Sample size*	*Response rate*
Saunders *et al.* 1992[5]		National	4,008 women oversampled ages 18–34	85%
Siegel *et al.* 1987*	1983–1984	Los Angeles	1,480 males 1,645 females	68%
Springs and Friedrich 1992		Patients using rural outpatient family clinic	511 females ages 18–50	39%
Timnick, 1985[2,6]*	1985	National	1,145 men 1,481 women	76%
Wilsnack *et al.* 1994		National	1099 females >21[6]; oversampled heavy drinkers	85% for follow-up of 1981 survey; 91% for new survey*
Wyatt, 1985*	1981–1984	Los Angeles	248 Caucasian and African American females ages 18–36	73% with refusals only; 67% if include those who could not be contacted before eligibility; 55% with all who could not be contacted

Notes

For certain of these studies, several papers were published, in which case the original report of the study was reported in the table (George and Winfield, 1986; Murphy, 1987; Russell, 1983; Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen, 1992; Timnick, 1985)

1 Also see Winfield, George, Swartz, and Blazer (1990)
2 Also see Finkelhor, Lewis, Hotaling, and Smith (1990)
3 Also see Murphy (1991)
4 Russell has written numerous papers and books that refer to this study. The most comprehensive are *Sexual Exploitation* (1984) and *The Secret Trauma* (1986).
5 Also see Resnick, Kilpatrick, Dansky, Saunders, and Best (1993)

Mode of administration	*Screen question*	*Definition*	*Age restriction*	*Female prevalence*	*Male prevalence*
TEL	4	Penetration by force or threat by male	<18	9%[6]	
FTF	1	Pressured or forced sexual contact	Before 16	6.8%	3.8%
SAQ	1	Sexual experiences	<18 and 5 perpetrator had to be 5 years older	22.1%	
TEL	4	Respondents' perception of sexual abuse: contact and non-contact	<18	27%	16%
FTF	8	Used both Russell's and Wyatt's definitions	Same as Russell and Wyatt	19% Russell's definition 23% Wyatt's definition	
FTF	8	Divided by contact and non-contact; unwanted or wanted in <13; unwanted only >12	Perpetrator had to be 5 years older unless coercion occurred	45% contact 62% non-contact	

6 As reported by the original researcher
7 Computed based upon figures provided in report
8 Also see Wolf (1992)
9 In the 1987 paper Murphy appeared to use only a single screen question. However, in the 1991 paper discussed by Russell and Bolen (2000), he reported using six screen questions

* Also included in study by Russell and Bolen (2000)
** Only included in study by Russell and Bolen (2000)

Qualitative review by Russell and Bolen

Comparison of methodological characteristics across studies

As mentioned previously, Russell and Bolen (in press) found nine prevalence surveys that met their criteria for inclusion. (These studies have an asterisk by the researchers' names in Table 10.1.) Russell and Bolen closely scrutinised these studies across a variety of methodological factors, including the definition of child sexual abuse, the type and quality of interview format, the number and type of screen questions, the participation rate, and the sample size, among others. (See Russell and Bolen (2000) for a comprehensive review of these studies.)

Definition of child sexual abuse

An optimal definition (for research purposes) of child sexual abuse must be neither too inclusive nor too exclusive. Researchers appear to be moving toward agreement that contact sexual abuse fits these criteria. Within this definition, any type of sexual contact of a child (most often, but not necessarily, unwanted, as in the case of an older adult fondling a young child) meets the criteria for child sexual abuse. Non-contact abuse such as sexual propositions, genital exposure, and posing for pornographic pictures is excluded. While these experiences may induce trauma, they are considered less serious types of child sexual abuse. A more exclusive definition of child sexual abuse is one that is limited to only rape. Other definitional issues include the age cutoff for the victimisation of adolescents, the type of victim/offender relationship, and the age differential between the victim and the perpetrator. Less consensus has been reached on these factors.

Of the nine studies included in the Russell and Bolen analysis (in press), six either restricted their definition of child sexual abuse to contact abuse only or reported both a broad and narrow definition. Most studies required only that the victim be seventeen years of age or less, and two studies had at least some situations in which the perpetrator had to be at least five years older than the victim (Russell 1983; Wyatt 1985).

Type and quality of interview format

Until the early- to mid-1980s, self-administered questionnaires were assumed to be the mode of choice when asking questions about sensitive material. Yet in 1986, Peters, Wyatt, and Finkelhor found that studies employing self-administered questionnaires had lower prevalence rates of child sexual abuse than studies employing face-to-face interviews. These researchers, among others, believed that rapport was easier to establish, especially considering the sensitive nature of the topic, during a face-to-face interview. More recent multivariate analyses on the effect of methodology on prevalence rates for child sexual abuse found that, after controlling for other factors, no significant relationship between the mode of administration and prevalence was found (Bolen and

Scannapieco 1999; Gorey and Leslie 1997). Russell (1986) contends, however, that it is necessary to make a distinction between the quality of the interviewing when evaluating the strengths and weaknesses of different modes of data collection. More specifically, she hypothesises that skilled, unbiased face-to-face interviewing on sensitive subjects like child sexual abuse is more effective at obtaining disclosures than self-administered questionnaires, whereas unskilled biased interviewing on this topic is inferior to self-administered questionnaires. To add to the confusion, an Australian study (Martin *et al.* 1993) that employed both a postal survey and a face-to-face interview format found that the relationship between type of format and rate of disclosure was more complicated. These conflicting findings and opinions suggest that future research must address this issue more directly.

Given the sensitive nature of the topic (child sexual abuse), other issues concerning the interview format such as matching of interviewers and respondents by gender and race/ethnicity, specific interviewer training on child sexual abuse, and duration of the interview might also be significant factors. Further, the overall context of the interview (that is, whether it is focused around issues of child sexual abuse or sexual victimisation as compared to other issues such as mental health, alcoholism, and so on) might be more or less conducive to disclosure. The duration of the interview might also be relevant to the success of rapport-building, which in turn almost certainly affects the respondent's willingness to disclosure experiences of child sexual abuse. A final issue is whether the interview is private. Clearly, respondents may be less willing to disclose incidents of childhood sexual abuse if others are present during parts or all of the interview or if it can be overheard.

Of the nine studies reviewed by Russell and Bolen (2000), four studies used a face-to-face format, four used a telephone format, and one used a self-administered questionnaire. Only three studies matched for gender (Kilpatrick *et al.* 1985; Russell 1983; Wyatt 1985), which is considered critical for enhancing an atmosphere conducive to disclosing about child sexual abuse. One study matched on ethnicity (Wyatt 1985), although one other probably did (Siegel *et al.* 1987) and still another did so in most cases (Russell 1983). Only two were known to conduct child sexual abuse-sensitive training for their interviewers (Russell 1983; Wyatt 1985). Of the five studies in which interview time was known, interviews ranged from ten minutes to eight hours. Excluding Wyatt's (1985) study in which the interviews lasted three to eight hours, Russell's (1983) study was the next longest, lasting an average of one hour and ten minutes.

Number and type of screen questions

While consensus is often lacking on other methodological factors, there is considerable agreement among prevalence researchers concerning the importance of the number and type of screen questions. A recent study highlights the importance of the number and type of screen questions. Williams, Siegel, and

Pomeroy (2000) asked a series of nineteen screen questions to a group of 136 women who, before the age of thirteen, had a documented case of child sexual abuse. This study reviewed the capability of the screen questions to elicit the respondents' histories of child sexual abuse. Although 80 per cent of disclosing women were identified after four questions, it was only after eight questions that 90 per cent of the disclosing women reported their first incident of sexual abuse. Fourteen questions were required to elicit all of the disclosures (including multiple incidents of abuse by the same respondent) that were forthcoming in the interview. Even after fourteen questions, however, over a third of the index incidents were never disclosed and 12 per cent of the women never disclosed any abuse incidents. These findings suggest that a larger number of questions is necessary to elicit disclosures of most child sexual abuse cases. This study also demonstrates the serious problem of underdisclosure.

Other problems with screen questions may lead to less willingness by respondents to disclose their experiences of childhood sexual abuse. Among these are the use of words such as rape, molestation, or incest in the screen questions or vague definitions that require the interpretation of the respondent. The lack of behaviourally specific terminology is also generally considered a methodological limitation in some studies since the use of such language is thought to help respondents to place their experiences within the context of the study definition for child sexual abuse.

Of the nine studies reviewed by Russell and Bolen (in press), four studies employed only a single screen question, two studies employed four questions (Finkelhor *et al.* 1990; Saunders *et al.* 1992), one study employed six questions (Murphy *et al.* 1991), one employed eight questions (Wyatt 1985), and one employed fourteen screen questions (Russell 1983). Thus, most of these studies suffered from having too few screen questions. Finally, five of the surveys were specifically about child sexual abuse or sexual victimisation. The others focused on crime (Kilpatrick *et al.* 1985), mental health (Siegel *et al.* 1987), mental disorders (Kessler *et al.* 1995), and the disciplining of children (Gallup 1995).

Participation rate

Participation rate is also a very important methodological factor. Gorey and Leslie's (1997) quantitative analysis found that a lower participation rate was related to a higher prevalence rate. They concluded from this finding that the higher prevalence rates were not valid because child sexual abuse victims were more likely to self-select into surveys on child sexual abuse. It must be noted, however, that Gorey and Leslie offered no evidence to support their assumption. Further, a more recent quantitative study (Bolen and Scannapieco 1999) found that, after controlling for more methodological factors than was done by Gorey and Leslie, participation rate was not related to prevalence.

In the nine studies reviewed by Russell and Bolen (in press), participation rates ranged from 50 per cent to 99 per cent depending on the way they were

measured. However, because researchers used different methods of calculating response rates, they are difficult to compare.

Other factors that may increase reported prevalence

Other methodological factors may contribute to higher disclosures of child sexual abuse. For example, the age of the respondent probably elevated Wyatt's (1985) and the Gallup Poll's (1995) prevalence rates. Several studies have now found that older respondents disclose less abuse (Russell 1984; Saunders *et al.* 1992), although there is no conclusive evidence to determine whether older respondents simply disclose less abuse or actually experienced less abuse. Hence, because Wyatt's sample was limited to women ages eighteen to thirty-six and the Gallup Poll's sample was limited to families with children under the age of eighteen residing in the home, this factor likely raised their prevalence rates. The geographical region in which the study was done might also be related to variability in prevalence. Indeed, Finkelhor *et al.* (1990), in their analysis of the *Los Angeles Times* Poll, found that respondents in the Pacific region reported higher rates of sexual abuse than respondents in other parts of the United States. However, the Bolen and Scannapieco (1999) analysis of twenty-two prevalence studies found no regional differences among studies, after holding other variables constant.

Conclusions of Russell and Bolen

Prevalence of child sexual abuse

The nine representative studies analysed by Russell and Bolen (in press) obtained immense differences in their prevalence rates for the sexual abuse of girls, ranging from a low of 7 per cent for Siegel *et al.*'s (1987) survey (which excluded non-contact abuse) to a high of 45 per cent for Wyatt's (1985) survey when non-contact sexual abuse was excluded, and 62 per cent when noncontact abuse was included. (Table 10.1 shows prevalence rates for these studies.) However, as already noted, Wyatt's prevalence rates are probably elevated by their being based on relatively young respondents. The other high prevalence rates were obtained by Russell (1983) (38 per cent, excluding noncontact abuse) in San Francisco, by the Gallup Poll (1995) for mothers and mother substitutes (30 per cent, excluding noncontact abuse) throughout the nation, and by the *Los Angeles Times* Poll (Finkelhor *et al.* 1990) (28 per cent, including noncontact abuse), also throughout the nation.

Further, four studies reported separate prevalence rates for incestuous child sexual abuse, ranging from a low of 1 per cent in Kilpatrick *et al.*'s (1985) study (excluding noncontact abuse) to a high of 21 per cent in Wyatt's survey (excluding noncontact abuse, and 23 per cent including noncontact abuse). Only three of the studies reported separate prevalence rates for extrafamilial child sexual abuse, ranging from a low of 5 per cent in Kilpatrick *et al.*'s study to a high of 32 per cent in Wyatt's survey (excluding noncontact abuse).

Comparison of incestuous and extrafamilial child sexual abuse

Many individuals believe that incestuous abuse, and especially father–daughter incest, are the most frequent types of child sexual abuse. This belief appears to be confirmed by the latest National Incidence Study, NIS-3 (Sedlak and Broadhurst 1996), in which the vast majority of reported and investigated child sexual abuse cases are incestuous. However, this conviction is not supported by the nine studies reviewed by Russell and Bolen (in press) when they compared the prevalence of intrafamilial and extrafamilial abuse. More specifically, Russell found that 7 per cent of female respondents had been sexually abused as a child by a stranger, 16 per cent by a relative (4.5 per cent by biological, step- and adoptive fathers), and 28 per cent by someone known to the victim. Overall, 31 per cent of respondents in her sample were abused by someone unrelated to the victim.

When the focus is on victimisation experiences (as opposed to victims), the percentage of all child sexual abuse cases that are incestuous versus extrafamilial was quite similar across Russell's (1983), Wyatt's (1985), and the *Los Angeles Times* Poll's (Finkelhor *et al.* 1990) studies, the only studies reporting these percentages. Russell found that 71 per cent of all sexual abuse of females was extrafamilial as compared to 76 per cent for Wyatt and 68 per cent (females only) for the *Los Angeles Times* Poll. Based on the mean percentages of these three surveys, 28 per cent of all cases of female child sexual abuse was incestuous whereas 72 per cent was extrafamilial. These studies therefore contradict the myth that most child sexual abuse of females is incestuous.

Child sexual abuse by type of perpetrator

Only a few studies compared how many sexual abuse incidents of female children were attributed to each type of perpetrator. Of all incidents, 11 per cent of Russell's (1983), 22 per cent of Siegel *et al.*'s (1987), and 23 per cent of the *Los Angeles Times* Poll's (Finkelhor *et al.* 1990) incidents were perpetrated by strangers. Comparable percentages for abuse by known others (excluding relatives) were 60 per cent (Russell), 56 per cent (Siegel *et al.*), and 45 per cent (*Los Angeles Times* Poll).

Conclusion: the soundest estimate of prevalence

After comparing nineteen retrospective surveys in the United States and Canada that obtained data on the prevalence of child sexual abuse, Finkelhor maintains that, 'These prevalence studies have led most reviewers to conclude that at least one in five adult women in North America experienced sexual abuse (either contact or noncontact) during childhood' (Finkelhor 1994: 37 citing Peters *et al.* 1986; and Leventhal 1990). Russell and Bolen (in press), however, disagree with Finkelhor (1994) that the best estimate of child sexual abuse is only 20 per cent, a figure that is identical to the prevalence estimate that Alfred Kinsey and his colleagues (1953) reported over forty years earlier. Although Finkelhor states that

he based this figure on the 'more methodologically sophisticated studies' (ibid.: 37), he does not identify these studies, nor does he mention what definition of child sexual abuse he has in mind. He merely states that 'enough credible figures cluster around or exceed 20 per cent to suggest that the number [percentage] of female victims has been at least this high' (ibid.: 37). Moreover, Finkelhor maintains that this 20 per cent prevalence rate applies to contact and noncontact sexual abuse, despite the fact that the inclusion or exclusion of noncontact abuse presumably has a great impact on the prevalence rate obtained. Thus, the basis for this 'best estimate' is not sound. Instead, it is more preferable to select the studies with the soundest methodologies for measuring the prevalence of child sexual abuse.

Regrettably, most studies reviewed by Russell and Bolen (in press) suffered from serious methodological problems that rendered their estimates of prevalence less meaningful and sometimes almost uninterpretable. Following are the most important weaknesses of these studies.

Kercher and McShane (1984) Use of only one screen question that was too technical, academic, and ambiguous; exclusion of individuals without driver's licences.

Kilpatrick et al. (1985) Use of only one screen question; use of a definition of child sexual abuse that was too exclusive; lack of behaviourally specific terminology in the screen question.

Siegel et al. (1987) Use of only one screen question that was poorly stated; lack of privacy for some interviews; no matching of gender for interviewers and respondents.

Los Angeles Times Poll (Finkelhor et al. 1990) Use of only four screen questions that were overly broad; an age range of victims that was overly broad; brevity of interview (thirty minutes).

Murphy (1991) Brevity of interview (ten to fifteen minutes); overly broad definition of child sexual abuse.[1]

National Comorbidity Study (Kessler et al. 1995) Use of only one question that was poorly operationalised.

Gallup Poll (1995) Use of only two screen questions that were not behaviourally specific; narrow age range for respondents.

In contrast, both Wyatt (1985) and Russell (1983) had multiple screen questions (eight for Wyatt and fourteen for Russell) that were behaviourally specific. Interviews were face-to-face, private, and sufficiently lengthy to establish good rapport before asking the more sensitive questions. Child

sexual abuse-sensitive methodology was employed throughout the study design, including extended training of interviewers, and matching of interviewers and respondents for gender and ethnicity.[2] While both studies employed rigorous methodology, Wyatt's study had two problems that Russell's did not. Wyatt had a more youthful sample (restricting respondents to the ages of eighteen to thirty-six) and her sample size was small for the type of generalisations she was attempting to make. Further, both studies had somewhat low response rates.

Russell and Bolen (in press) concluded, based on their analyses of the strengths and weaknesses of the nine representative United States samples, that Russell's methodology is the most sound. Her estimates of incestuous abuse, extrafamilial abuse, and total child sexual abuse prevalence are as follows.

- Prevalence of incestuous abuse of female children involving sexual contact/attempted contact: 16 per cent. Thus, one out of every six women was incestuously abused before the age of eighteen.
- Prevalence of extrafamilial child sexual abuse involving sexual contact/attempted contact: 31 per cent. Thus, close to one third of women were victimised by extrafamilial sexual abuse in childhood.
- Prevalence of incestuous and extrafamilial child sexual abuse (combined) involving sexual contact/attempted contact: 38 per cent. Thus, well over one third of women were victimised by incestuous and/or extrafamilial sexual abuse before the age of eighteen.

Yet these are probably underestimates, for three reasons. First, Russell's (1983) sample excluded women in institutions and those who were not living in households, that is, the groups considered to be at high risk for child sexual abuse. Second, some women in this sample reported that they were unwilling to disclose their experiences of child sexual abuse to the interviewers. Third, some women do not remember their experiences of child sexual abuse. Hence, while backlashers continue to claim that researchers are seriously exaggerating the prevalence of child sexual abuse (for example, Gilbert 1991), exactly the opposite is the greater problem. Thus, Russell and Bolen (in press) conclude that female child sexual abuse is of epidemic proportions in the United States.

Quantitative review by Bolen and Scannapieco

The second study to be presented in this chapter was by Bolen and Scannapieco (1999). Studies chosen for this analysis had to use random sampling and the population had to represent a community, state, or national North American adult population. PsychINFO and NISC Discover were searched between 1980 and 1998 using the keywords of 'prevalence' and 'child sexual abuse' to locate studies or reviews of child sexual abuse prevalence and available reviews. From those that were located, studies of college or adolescent samples or those using nonrandom samples were eliminated. Other studies were eliminated because

they did not define their populations broadly or because they analysed only intrafamilial abuse. The twenty-two studies meeting the criteria for the Bolen and Scannapieco metanalysis are listed in Table 10.1.

After attempting to get copies of all studies, either by locating the paper, writing the researchers, or contacting the reviewer of the study, two studies remained unavailable. For other cases, the available information about the study did not report all variables of interest. When a study, or a specific variable, was not available, the information reported in Table 10.1 was based on the report of the original reviewer. These studies and variables are marked accordingly in the table. To enhance reliability, this table was reviewed independently by both authors. Afterwards, discrepancies were discussed until a consensus could be reached.

Variables for the current study were operationalised based on information available in Table 10.1. The dependent variable was the prevalence of child sexual abuse reported in each study. The independent variables were the methodological characteristics of the studies. Variables that were included for analysis were as follows: number of female and male respondents; response rate; year in which the survey was reported; mode of administration; number of screen questions; type of survey; region of survey; upper age limit for child sexual abuse; level of contact; age differential between perpetrator and victim; and age of respondent.

The analysis proceeded in two primary steps. The first portion of the multivariate analysis determined which of the methodological factors were significantly related to the prevalence of both male and female child sexual abuse. The information gained from these analyses was then used to develop an empirically based estimate of the prevalence of child sexual abuse for both males and females. Because the analysis of the effect of methodology on prevalence informs the estimates of prevalence, this portion of the analysis is briefly reviewed first.

Predictors of the prevalence for female child sexual abuse

All predictors were placed into a stepwise linear regression analysis, with the prevalence of female child sexual abuse as the dependent variable. Given the small number of variables, the probability of F was set to .10 for entry into the equation and .15 for removal from it. Three variables entered the equation, although the last variable to enter the model was only marginally significant (Table 10.2). The log of the number of screen questions was the first variable to enter, followed by the log of the number of female respondents, and finally the log of the year in which the study was first reported. These three variables accounted for 58 per cent of the variance in prevalence of female child sexual abuse, with the number of screen questions and number of respondents accounting for the greatest proportion of the variance. These findings indicate that more screen questions, a smaller sample size, and a more recently conducted study are related to a higher reported prevalence for child sexual abuse.

Table 10.2 Stepwise regression of predictors on prevalence of female child sexual abuse

Step	*Order of entry*	*B*	*β*	*T*	*p*	*Tolerance*	R^2	*p for* R^2
1	Constant	15.173		5.608	.000		23.9	210
	Screen questions (log)	5.847	.489	2.505	.021			
2	Constant	52.745		4.398	.000		50.4	.001
	Screen questions (log)	8.203	.686	3.965	.001	.873		
	No. of female resp. (log)	–5.804	–.551	–3.189	.005	.873		
3	Constant	58.164		4.952	.000		57.9	.001
	Screen questions (log)	9.049	.756	4.493	.000	.825		
	No. of female resp. (log)	–7.650	–.727	–3.813	.001	.643		
	Year of study (log)	4.078	.320	1.794	.081	.736		

Number of screen questions

The variable that accounted for the greatest variance in the prevalence of female child sexual abuse was the log of the number of screen questions. The prevalence of female child sexual abuse increased as the number of screen questions increased. The logarithmic relationship suggests that the rate of increase lessened as the number of screen questions increased. This finding supports that of Williams *et al.* (2000), reported earlier, who found that fourteen questions were required to elicit all disclosures that were forthcoming in the interview. These findings also emphasise that underdisclosure remains a significant problem even with the use of multiple screen questions.

Number of female respondents

The next variable that entered the stepwise regression was the log of the number of female respondents, with a greater number of respondents being related to smaller prevalence estimates. The logarithmic relationship suggests that the rate of decrease lessened as the number of female respondents increased. This finding is less intuitive because one would expect that sampling more individuals would give a better estimate of the prevalence of child sexual abuse. Possible explanations are that smaller samples either over-report abuse or that larger samples under-report abuse. Alternately, it could be that either smaller or larger samples are more accurate at ascertaining abuse prevalence.

Because greater attention can be paid to respondents in smaller samples, Bolen and Scannapieco (1999) suggest that smaller samples may provide more sound estimates of child sexual abuse prevalence. On the other hand, very small samples are overly susceptible to sampling biases. A sample size of 1,000 to 2,000 may be optimum, although there is currently no empirical data to support this assertion. Samples below that size may not be able to support inferences made from smaller groupings of respondents, such as when they are

categorised by race. Samples larger than that, however, may not be able to devote sufficient time to individual respondents during the interview so that adequate rapport develops before asking questions concerning an abuse history.

Year the study was reported

The final variable that entered the model was the log of the year in which the study was reported, with studies in more recent years having higher prevalence estimates. The relationship between prevalence and the year of the study has at least four possible explanations. First, it could be due to chance. Given the marginal statistical significance, this explanation certainly cannot be ruled out. Second, it could be a spurious finding and could be confounded by a third predictor that covaries with the year in which the study was reported. It is possible, for example, that with notable exceptions, the ability of surveys to adequately tap respondents' memories of abuse has improved in recent years. Third, because the acceptance and knowledge of child sexual abuse has increased substantially since the mid-1980s, it could be that women are more willing to disclose actual abuse incidents in more recent years. Given the remarkable success of both Wyatt (1985) and Russell (1983) in the early 1980s in eliciting disclosures of sexual abuse, these latter two explanations are less likely. The final possibility is that the prevalence of child sexual abuse is increasing. Because of the implications for such an interpretation, this latter possibility certainly cannot be discounted. One important implication of this possible explanation is that the already overburdened child protective services system could become overwhelmed. The most recent National Incidence Study (Sedlak and Broadhurst 1996) found that, in 1993, only 44 per cent of all child sexual abuse in which harm occurred was investigated, decreasing from 75 per cent in 1986. Increases in child sexual abuse cases could result in even fewer cases being investigated. The most important implication of a possible increase in child sexual abuse, however, is that children are at increasing risk to experience the often devastating consequences of child sexual abuse – at terrible cost of human well-being and potential.

Predictors for prevalence of male child sexual abuse

The same method of analysis was used for male prevalence (see Table 10.3). When variables were allowed to enter at any step, no variables entered the equation. Raising the probability of F to .15 for entry and .20 for removal did allow the first variable to enter. Because the previous model had indicated a suppressor relationship among independent variables, this was deemed an appropriate choice.[3] With this configuration, the first variable to enter was telephone interview (as compared to self-administered and face-to-face), followed by the log of screen questions.

Table 10.3 Stepwise regression of predictors on prevalence of male child sexual abuse

Step	*Order of entry*	*B*	*β*	*T*	*p*	*Tolerance*	R^2	*p for* R^2
1	Constant	4.980		3.022	.014		.265	.105
	telephone	4.020	.515	1.802	.105			
2	Constant	2.460		1.395	.200		.551	.040
	Telephone	5.280	.676	2.734	.026	.917		
	Screen questions (log)	3.636	.559	2.260	.054	.917		

Telephone interview

It is unclear why telephone interviews had higher prevalence estimates of child sexual abuse than self-administered questionnaires and face-to-face interviews. It is perhaps easier to explain why this relationship is only apparent for males. Two of the more methodologically rigorous studies of prevalence (Russell 1983; Wyatt 1985) surveyed only female respondents and used face-to-face interviews. While these studies would have affected the variables that entered the model for females, they would not affect the results for males.

Screen questions

Like the prevalence for females, the prevalence for males increased as the number of screen questions increased. This finding offers confirmation for the importance of the number of screen questions in eliciting more accurate disclosures of child sexual abuse.

Factors that did not predict prevalence

Several variables entered into the stepwise models were not statistically significant. These null findings are also important. Some of these variables were expected to have a significant relationship with prevalence, including the operationalised definition of child sexual abuse (that is, non-contact, contact only, or penetration only), age limit for child sexual abuse, age differential between perpetrator and child, and age of the respondent. That these variables were not significant most likely reflects the methodology of many prevalence studies rather than the variables in question. When a larger pool of methodologically rigorous prevalence studies exists, we may find that these variables are important.

The other non-significant variables – mode of administration, response rate, type of survey, and region – were entered to address current debates concerning the role of these methodological factors in prevalence studies of child sexual abuse. These findings suggest that, after controlling for other important methodological characteristics, prevalence estimates do not vary by region or by type of survey. They also suggest that, properly administered,

telephone interviews or questionnaire formats may be as capable as face-to-face interviews at eliciting disclosures of child sexual abuse.[4] However, they will probably be less effective at gathering some of the characteristics of the abuse events, especially when victims experience multiple abuse incidents. For instance, Russell (1983) found that respondents were reluctant to provide details of all incidents of abuse when they realised that doing so would prolong the interview substantially. Face-to-face interviews will probably be more successful in these cases. Another concern is that telephone interviews may not be compatible with the large number of screen questions needed to accurately assess for a history of child sexual abuse.

One issue that could not be assessed in this study but that is critical to the accuracy of prevalence estimates is the ability of the respondent to accurately recall incidents of abuse. There are multiple reasons that respondents may not be able to do so. First, they may not remember the abuse incident. For example, Linda Williams (1994) found that 38 per cent of 129 victims whose documented abuse had occurred seventeen years earlier did not recall that abuse. Of those who were molested by family members, 47 per cent either did not report or recall the abuse, nor did more than half of the victims whose abuse occurred prior to the age of seven.[5] Another reason respondents may not accurately report abuse incidents is that they may be uncomfortable doing so. In a secondary analysis of Russell's (1983) community prevalence survey on females (Bolen 1998), disclosure rates varied not only by how comfortable respondents were with the interview, but also by race/ethnicity. White women differed little in the number of disclosures regardless of how comfortable they were with the interview, whereas Asian American women who were less comfortable with the interview disclosed significantly less abuse. Older respondents may also be less likely to disclose remembered abuse events. Alternately, older women may have less abuse incidents to report, as this study suggests. Studies have not yet successfully examined these alternate explanations. Yet, the relationships of age and race to stated prevalence suggest that cultural norms may be involved.

Another issue is the fallibility of memory. A controversy rages concerning how many adults falsely remember abuse events. One concern is that falsely remembered abuse events may inflate prevalence estimates. However, researchers of child sexual abuse and rape uniformly believe that under-disclosure is a far more serious issue than false disclosure (Koss 1992; Russell and Bolen, in press). Williams' (1994) findings that indicate that 38 per cent of all documented abuse was not disclosed confirm these researchers' opinions.

In sum, a well-designed survey must have a sufficient number of well-constructed behaviourally specific screen questions to garner accurate disclosures of child sexual abuse history. Given the impact of the number of screen questions on prevalence estimates and the findings by Williams *et al.* (2000), between eight and fourteen screen questions appears to be optimum. Obviously, the greater number of screen questions provides greater accuracy. Because underreporting is always a significant problem in prevalence surveys,

the larger number of questions should simply lead to a more accurate estimate of child sexual abuse prevalence, as opposed to over-reporting (that is, false reports) of abuse. An optimal sample size is more difficult to suggest, although a range of 1,000 to 2,000 was previously suggested. It may be that the most important issue is that the respondents feel that they have the time to disclose and that the interviewers are interested, knowledgeable, respectful, and patient. When we analyse studies that had the most success at eliciting disclosures (for example, Russell 1983; Wyatt 1985), we find that they are also the studies in which the interviewers have been trained to handle sensitive topics and to establish good rapport. Although there is currently no empirical evidence that this factor is related to accurate disclosures of child sexual abuse, it is certainly a very likely possibility. Larger samples that sacrifice respondent contact, interest, and rapport may also sacrifice accuracy.

Predicting the prevalence of child sexual abuse

Finally, we need to consider a reasonable estimate of the prevalence for male and female child sexual abuse. This information can be predicted from the Bolen and Scannapieco (1999) analysis using the unstandardised beta weights and the constant.

Several permutations of the equation to predict prevalence were done so that the effect of varying the significant predictors could be evaluated. Predictions were forecasted using four, eight, and fourteen screen questions, as well as 1,000 and 2,000 respondents. However, all predictions were based upon a survey done in 1997.

For females, the predicted prevalence estimate for child sexual abuse ranged from 24 per cent (using four screen questions and a sample size of 2,000) to 40 per cent (using fourteen screen questions and a sample size of 1,000). Estimates for eight screen questions were 30 per cent (2,000 respondents) and 35 per cent (1,000 respondents). Because of the critical relationship between the number of screen questions and disclosure rate, it is likely that the estimates based on eight and fourteen screen questions are more accurate. Thus, Bolen and Scannapieco (1999) believe that at least 30 per cent of all female children are sexually abused and that as many as 40 per cent may be abused.

For males, the predicted prevalence of child sexual abuse is not as precise, primarily because surveys of males employed a maximum of four screen questions. If males also require a high number of screen questions to elicit accurate disclosures of child sexual abuse, then the estimates provided by these surveys of males are low. Based upon a survey done in 1997 using one to four screen questions and controlling for the type of interview done, Bolen and Scannapieco (1999) estimate that between 3 per cent and 13 per cent of all male children are sexually abused. However, the highest range (13 per cent) may represent the lower bound for an estimate of child sexual abuse of males. Because the highest number of screen questions used was four, the model cannot accurately support an estimate beyond four screen questions. It is

probably safe to say, however, that the prevalence would increase if more screen questions were used.

Conclusions and implications

It is intriguing that a qualitative review of nine random prevalence studies on female child sexual abuse in the USA and a quantitative review of twenty-two random studies of male and female child sexual abuse in North America come to the same conclusion – child sexual abuse is an epidemic. Both studies provide prevalence estimates that fall in a range of 30 per cent to 40 per cent for female child sexual abuse. Further, Bolen and Scannapieco's analysis (1999) found that 13 per cent or more of males are probably sexually abused.

These reviews move the question of the prevalence of child sexual abuse for females in North America to a more substantial level. By establishing sound estimates of the prevalence of child sexual abuse, the debate should now move from minimising this social problem to addressing its causes and treatment. To the extent that policy makers and the public continue to deny the magnitude of childhood sexual abuse, the problem continues to be handled irresponsibly.[6]

Additionally, with the awareness that childhood sexual abuse affects so many families and children, policy and practice can evolve to meet the needs of those affected by childhood sexual abuse. Removing the doubt that numerous children are being victimised will reduce the overall trauma for the child and the family by providing the respect and professional response that is required.

To respond professionally to the magnitude of the problem, however, will require an overhaul of the existing child welfare system. According to the latest National Incidence Study (Sedlak and Broadhurst 1996), 300,200 children were sexually abused during 1993, for an incidence rate of 4.5 per 1,000. The incidence rate for females was 6.8 per 1,000, and for males it was 2.3 per 1,000. Even at the current levels of investigated and substantiated abuse, however, Sedlak and Broadhurst state that 'CPS investigation has not kept up with the dramatic rise' in child maltreatment cases (Sedlak and Broadhurst 1996: 61). Indeed, only 44 per cent of all child sexual abuse cases in which harm occurred were investigated in 1993, down from 75 per cent in 1986. Thus, the system cannot keep up even with the cases of which it is aware.

Contrast this 6.8 per 1,000 incidence rate for females with projected incidence rates based upon prevalence estimates of 25 per cent, 33 per cent, and 40 per cent. For example, for a 25 per cent prevalence estimate, the concomitant incidence rate would be 25 per 1,000.[7] Using the higher prevalence estimate of 40 per cent, the concomitant incidence rate is 40 per 1,000.

Even with a prevalence of 25 per cent, only 27 per cent of incidents of female child sexual abuse are being investigated and substantiated by authorities.[8] When the prevalence estimate increases to 33 per cent, only 21 per cent of cases are substantiated, decreasing to only 17 per cent with a prevalence

estimate of 40 per cent. (Estimates for male child sexual abuse could not be estimated because the average number of incidents of abuse for each victimised male is still unavailable.)

Thus, even with the most optimistic prevalence estimate, 73 per cent of female children abused each year are not being identified, assessed, and treated. More realistically, up to 87 per cent of female children are not being identified, assessed, and treated. While similar projections for male children are not available, it is probably safe to say that the majority are also not being properly identified. While some of this problem is the children's reluctance to disclose, it is also due in large part to the inability of the child welfare system to handle even the cases that come into the system. To adequately intervene, the child protective services system must expand substantially. Yet, the system as it currently exists cannot do so. The call must be for a complete overhaul of the system that allows for the potential for each abused child to be identified, assessed, and treated.

Another important implication for future research is that only the most rigorous prevalence studies will add to our current knowledge base. The review of studies has shown that methodological characteristics affect the prevalence rates of child sexual abuse reported in studies. With an issue of such importance, poorly designed studies only contribute to confusion. Studies of prevalence should be methodologically rigorous or they should not be done.

The possibility that child sexual abuse continues to increase must also be considered. Russell (1984) first suggested such a possibility when she examined cohort trends in her prevalence study. Given the findings and scope of the present study, research designed to better understand trends in child sexual abuse patterns and to consider societal patterns that may influence such patterns is necessary.

Perhaps the most important call for future research, however, is to move to the level of causality. Recently, the General Accounting Office (GAO) concluded that 'focuses on such topics as the causes and effects of child sexual abuse' and other topics are mostly irrelevant to 'most local agencies' attempts to reform their services' (Child Protection Report 1997: 132). Based upon the findings of this review, we consider research on the causes and effects of child sexual abuse to be fundamental, not only to local agencies, but also to state and federal agencies that provide funding and that legislate these agencies.

In a society in which child sexual abuse is epidemic, understanding causality is paramount for implementing appropriate prevention strategies. Given the prevalence of child sexual abuse, it is not enough to believe that child sexual abuse is, for example, simply a problem of family dysfunction. Instead, the role of the culture in which the child lives and especially the societal influences that promote child sexual abuse must be more carefully scrutinised. Only when we understand the different pathways to child sexual abuse can we hope to reduce its prevalence. Until then, we suggest that, for intervention efforts to be sufficient, federal and state governments must commit vastly increased resources to the problem of child sexual abuse.

Notes

1 Little information is available concerning this study and so it is difficult to evaluate its methodology.
2 In Russell's study, ethnicity matching was done in most cases.
3 In a suppressor relationship, the addition of an independent variable into the multivariate model causes an increase in the beta coefficient for another independent variable.
4 Earlier, Russell suggested, however, that the skill of the interviewer must be considered.
5 It is possible that these women recalled but did not report the abuse. This is unlikely, however, given that most of these same respondents were willing to report other incidents of abuse.
6 The implication section derives from the 1999 paper by Bolen and Scannapieco.
7 Based upon a population estimate of 33,100,000 females and a prevalence estimate of 25 per cent, 8,275,000 female children will have been sexually abused prior to the age of eighteen. Given a 1.8 incidence rate per abused child (Russell, 1983), the concomitant number of incidents is 14,895,000. Dividing by 18, 827,500 incidents of abuse to female children occur each year. Dividing this number by the total female population equates to an incidence rate of 25.0 per 1,000. Similar calculations were made using prevalence estimates of 33 per cent and 40 per cent.
8 225,000 divided by 827,500.

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Part 1.4

Contributing and causal factors

11 Sadistic, sexual and violent acts in the young

Contributing and causal factors

Susan Bailey

Introduction

This chapter is based on the author's work as Consultant Adolescent Forensic Psychiatrist with children and adolescents who have committed 'the grave offence' of murder. She has become a specialist and an expert of international standing for her work with these children. This chapter includes new material commissioned for the purposes of this book. It also incorporates material which has been previously published as follows: 'Sadistic and Violent Acts in the Young' (*Child Psychology and Psychiatry Review* September 1997 (2.3) Cambridge University Press); 'Adolescents Who Murder' (*Journal of Adolescence* 1996 19: 19–39); 'Fast Forward to Violence' (*Criminal Justice Matters* 1993 2: 6–7); 'Violent Children and the Media' (*Psychiatric Bulletin* 1997 21: 371–2).

Characteristics of family violence

In a brief clinical note entitled 'Violence Breeds Violence – Perhaps?', Curtis (1963) expressed concern that abused and neglected children would 'become tomorrow's murderers and perpetrators of other crimes of violence, if they survive'. The idea is appealing, making intuitive sense and allowing society to attribute blame and absolve itself of guilt, accountability or responsibility (Garbarino and Gilliam 1980). However, the theoretical work of the 1960s and 1970s provided a framework for understanding the multi-determined nature of abuse and neglect. Ecological models in which social, cultural interactional, individual and situational factors were positioned to interact and converge to bring about family violence, led in turn to the emergence of a more focused interest in clinical assessment and treatment. The 1980s saw the arrival of more sophisticated and ambitious epidemiological research, which documented the widespread prevalence of child abuse and neglect, spouse battering, elder mistreatment and psychological abuse, fuelling the development and evaluation of intervention for both victims and perpetrators.

Evidence continues to accrue establishing a causal link between maltreatment and short and long term psychopathology in victims. In children, physically abused and neglected infants typically have insecure attachments

with care givers (Youngblade and Belshy 1990). This, in turn, places these children at high risk for further disruptions and lags in social, emotional and cognitive development. Disturbances during this critical period in the formation of trusting relationships are viewed as important to adult interpersonal functioning and the intergenerational transmission of abuse (Zeanah and Zeanah 1989). Child victims of sexual abuse suffer a variety of consequences such as depression, anxiety and post traumatic stress disorder, and survivors of incest and other child sexual abuse carry these problems into adulthood.

The aetiology of family violence is complex and multi-determined, incorporating influences from individual, family systems and societal sources (Wolfe 1991). Their onset is insidious, family violence almost never occurring in isolation, inextricably linked with events, situations and states (unemployment, crowding, alcoholism, poverty), that in their own right lead to deleterious consequences. There can be no simplistic understanding and intervention as there is no unique and specific constellation of symptoms for victims or perpetrators of any form of family violence.

Assessment and diagnoses of the psychological functioning of children and adolescents is now, and has historically been, a dynamic and disputed field of study. Understanding the nature and extent of how parental commissions and omissions traumatically affect the psychological functioning of children can be viewed as a continuing urgent need, but at the same time a seemingly impossible task. Longitudinal evidence converges on the findings that hostile or rejecting parenting and lack of supervision have direct effects on antisocial behaviour and delinquency, and that the effects of family structure variables, (broken homes, separation from parents, and number of parents in the family) are indirect and mediated by parenting variables (Bales *et al.* 1991). Loeber and Stauthamer-Loeber (1986) carried out a meta-analysis of longitudinal studies on the relation of family factors to anti-social behaviour and delinquency finding that lack of parental supervision, rejection of children, and lack of involvement with children had the strongest predictive power, parenting variables being a more powerful predictor of delinquency than other risk factors such as child behaviour and family instability. Depressed mothers were found to have a higher risk of having children with persistent aggressive problems than did non-depressed mothers (Downey and Coyne 1990).

Homicidal children

Surveys of the general population show that over 90 per cent of boys admit to acts that could have led to appearance in court, however most are minor in their nature. Delinquent acts by young children are less frequent, more likely to be associated with psychological abnormalities that are persistent, and reflect both social dysfunction and individual psychopathology. However, the rate of 'grave offences' committed by children and young adolescents, in particular juvenile homicide, has not risen to any significant extent (McNally 1995). None the less sadistic violent acts carried out by children and adolescents bring with them a

surfeit of public and media interest and reaction, a response that at times risks becoming a voyeuristic end in itself.

It can be argued that individual case reports by journalists can and do inform, as in Patrick Wilson's review of *Children Who Kill* (1973), but most individual case reporting only serves to escalate society's ever pervasive fear of crime at the hands of the young. Such fear, without apparent hope of safe resolution, then serves to increase the groundswell of negative feelings towards the non-offending majority of children and adolescents some of whom through the very developmental process of adolescence are already perceived as delinquent. The literature reveals that children and adolescents who murder share a constellation of psychological, cognitive, neuropsychiatric, educational and family system disturbance that may be amenable to treatment interventions, which have included, psychotherapy, psychiatric hospitalisation, institutional placement and psychopharmacological treatments.

Contributing and causal factors

Recent reviews of the mass of available research (Smith 1995) have found that for the generality of juvenile offending and delinquency there are three major risk areas: child-centred, family-centred and contextual. They have an interactive effect on juvenile offending, providing support for a cumulative protection model of delinquency prevention. Antisocial behaviour is heterogeneous and for many is still a normal phenomenon, a deliberate principled act of protest, of transient adolescent onset and cause. Those with early onset, however, are at risk in the adult life course for development of antisocial personality disorder and of affective disturbance. The broad child-centred factors are genetic vulnerability; perinatal risk; male gender; cognitive impairment; school under achievement; autonomic hyperactivity/inattention; and temperament. Family factors include criminality in parents and siblings; family discord; lack of supervision; lack of positive feeling; abuse; scapegoating; rejection; and neglect. Influential contextual factors include drug and alcohol abuse, unemployment, crime opportunity, pornography and peer group interaction.

Genetic and neurophysiological factors

There is an accumulating body of evidence on the contribution of genetic factors to individual differences in antisocial behaviour in general (Carey 1994; Di Lalla and Gottesman 1989; Goldsmith and Gottesman 1985; Rutter 1996). The importance of recent genetics research lies not just with the genetic component, but in understanding how the risk is mediated and how genetic factors combine with environmental factors, both at the behavioural and neurochemical level. Neurochemical mediation is being explored in relation to dopamine and serotonin systems. The evidence suggests serotonin plays a role in predisposition to violent behaviour and risk taking behaviour that includes suicidal as well as antisocial acts (Virkkunnen *et al.* 1995).

What is inherited may be a set of dispositions collectively called temperament. This includes such basic features of behavioural and emotional responsiveness as activity level, attentiveness, adaptiveness to new situations, quality and intensity of mood expression, distress proneness or distractability. Zuckerman (1994) argues that the temperamental variable 'impulsive unsocialised sensation seeking' underpins the development of antisocial personality traits in adulthood. Major achievements in early socialisation are control of anger and tolerance of frustrating situations. The emotional response to aggression and frustration and the subsequent contribution to violent acts, in particular rage reactions, is complex. Individual differences in temperament emerge very early in life, pre-school children with 'difficult temperament' (Thomas *et al.* 1968) being associated with high rates of mother–child conflict (Lee and Bates 1985). Temperament is possibly an inborn dimension, but influenced by very early social experiences (Emiole *et al.* 1992). Mothers respond in their control and discipline of their child to the temperament of the child *per se*, some children finding it particularly difficult to socialise successfully (Kochanska 1993). 'Difficult temperament' reported by parents is then associated with increased likelihood of aggression (Kingston and Prior 1993; Sanson *et al.* 1993). However, the link between difficult temperament and later violent acts is less clearly understood.

Over the last thirty years, authors (Bender 1959; Lewis *et al.* 1988) have delineated a range of neurological abnormalities in children and adolescents who have made serious fatal, non-fatal and sexual assaults on others evidenced by findings of organic brain damage, history of head injury, abnormal EEG's, past and present seizure disorder deficits on neuropsychological testing, and soft neurological features. These findings have also been identified in a series of juvenile homicides in the UK (Bailey 1996a).

There is evolving evidence in the field of PTSD (Pynoos and Nader 1993) that children suffering the after effects of traumatic stress can manifest this in later violence, the violent behaviour sometimes mirroring the traumatic experience the young person has endured as a previous victim (Dodge *et al.* 1990). Perry (1994), studying the neurological sequelae of childhood trauma and their links to PTSD in children, suggests traumatic events may have a lasting effect on the neurological functioning of the individual, thereby having a permanent effect on brain function. Perry therefore concludes that severe trauma during childhood can have a devastating effect on all functions of the developing brain: emotional, cognitive, behavioural and physiological. Le Daux (1994) suggests that 'changes in behaviour can be brought about by controlling the fearful response rather than by eliminating the emotional memory itself.'

Psychological factors

Psychological theories and explanations of murderous and sadistic acts in the young are substantially more common than those based on physiological factors. The three main frameworks – psychodynamic, behavioural, and

humanistic existential – although widely divergent in their theoretical origins share common threads and strands. Each points to a final common pathway of violent and abusive behaviour that arises from the child or young person's maladaptive attempt, whether consciously or unconsciously, to deal with their own ultimate sense of personal failure, embedded within their early experiences within the family.

Bowlby (1953) clearly recognised prolonged separation from the mother during the first years of life as a primary cause of delinquent character formation. Insecure attachment relationships in infancy predict later behavioural problems, in boys this shows itself in aggressive non-compliance. During pre-school years, insecure girls may be either aggressive or especially compliant (Greenberg *et al.* 1992). Insecure attachment is sometimes associated with maternal depression, which promotes externalising problems (De Mulder and Radke-Yarrow 1991) and an aggressive stance. Insecure attachment is more deserving of attention in the specific areas of child and adolescent sadistic violence.

The interactive effect of early maternal insecure attachment and chronically inconsistent or rejecting parental behaviour was prominent in a series of forty child and adolescent murderers (Bailey *et al.* 1997). Chronically inconsistent or rejecting parental behaviour leaves the child in a constant state of uncertainty about both the physical and emotional availability of the parent, leading to the experience of frequent and intense anger. Over time, the relationship model has, at its core, anger and insecurity, leaving the child at heightened risk of aggression. Entering adolescence they view themselves as less competent and critically less in control, seeking control through domination and via deviant fantasy. Where the attachment relationship between mother and child remained most insecure, violence was more likely to be committed against a more vulnerable family member. Older children and young adolescents who killed outside the family had increasing difficulty in seeking and achieving safe autonomy in contrast to competent adolescents by whom they were rejected. Repeatedly victimised juveniles are more likely to become aggressors (Hotaling *et al.* 1989).

Family based violence, abuse and neglect

Factors within families that contribute to longer term aggressiveness and risk of violence are in child-rearing and parenting styles (Farrington 1995). Against the background of multiple deprivation (Kolvin *et al.* 1988) the following clusters emerge. First, the presence of criminal parents and of siblings with behaviour problems. Second, the day to day behaviour of primary care givers. In addition to parental conflict, inconsistent supervision, physical and emotional neglect associated with risk for delinquency, some parents provide little direct reinforcement of prosocial behaviours, reinforcing instead coercive behaviours. Thus the child learns that their own aversive behaviour serves to stop unwanted intrusions by parents (Patterson and Yoerger 1997). Assaultative adolescents have been shown to have lower rates of positive communication with their families

and aggressive relations with peers. The third cluster of family factors, linked with later violence in the child, includes cruel authoritarian discipline, physical control and in particular shaming and emotional degradation of the child.

Severe physical abuse (Lewis *et al.* 1985), sexual abuse (Ressler *et al.* 1988), exposure to repetitive or extreme violence (Pfeffer 1980) and parental mental illness. (Hellsten and Katila 1965) have been identified as predominant factors. In common with other reviews and studies of children and adolescents who murder, our own review (Bailey 1998) of forty child and adolescent murderers has revealed family backgrounds characterised by mental illness and violence within the family. Of particular note were violent fathers and violence, inconsistent in its nature, shown towards the adolescent from early years, together with a history of sexual abuse in a third of cases. As in previous studies alcohol abuse in the adolescent group was common. This particular group, however, showed higher levels of disruption in school than in other studies and a higher number of victims were known to the offender and the offender's family.

Sociocultural factors

Increasing concern has centred, particularly in the USA, on gang participation (Busch *et al.* 1990) and the availability of weapons, especially guns (AACAP 1991). Both in the USA (Heath 1986) and in the UK (Bailey 1993; Newson 1994) concern has also focused on the quantity and level of media violence and children's response to it. Substance abuse, in particular alcohol abuse, and latterly drug abuse is common and becoming an increasingly significant trigger in serious acts of violence by adolescents (Labelle *et al.* 1991; Lang 1993; Chaiken and Chaiken 1990).

The nature and origins of sadistic violence

Kraft-Ebbing (1886) suggested that mastering and possessing an absolutely defenceless human object is the key element of sadism. Since Brittain's classic paper (1970) on the sadistic murderer there has been a growing professional awareness of the extent of sadistic and aggressive behaviour in normal populations and a growing understanding of adult sadists, especially those already detained in maximum secure health settings. MacCulloch *et al.* (1983) argued that it is precisely the wish to control that is the primary motivating force in sadism, defining it as the 'repeated practice of behaviour and fantasy which is characterised by a wish to control another person by domination, denigration or inflicting pain for the purpose of producing mental pleasure and sexual arousal'. The range of controlling behaviour form a continuum from subtle verbal control through gradations of psychological control to physical interventions ultimately rendering the victim unconscious or dead.

MacCulloch and colleagues identified the following core features from both their own Special Hospital series of sadistic murderers and Brittain's original series. Developmentally these men had had ambivalent relationships with their

mother, authoritarian punitive fathers, but additionally were themselves socially alienated from others. Their personality development was one of introspection, solitariness and obsessionality, rarely displaying actual violence but dwelling on hidden themes of aggression. They grew to feel sexually inferior to other men and had developed a substitute and deviant fantasy life. Few were described as psychotic, but noticeably they displayed increased anxiety and depression as a resistance to increasingly violent, sadistic and murderous drives. Critically the grave offence often followed an episode that had led to lowered self esteem, the planning of the criminal act making them able to feel superior, and the actual crime bringing with it a sense of feeling better with normal behaviour after the act.

In a survey of forensic psychiatrists (Spitzer *et al*. 1991) 90 per cent (eighty-seven) of the cases reaching diagnostic criteria for Sadistic Personality Disorder had childhoods characterised by a history of emotional abuse, one or both parental figures being repeatedly hostile, demeaning or neglecting; 76 per cent (seventy-four) had been physically abused in multiple incidents resulting in bruises or permanent injury; and 52 per cent (forty-eight) had experienced multiple losses, death or abandonment by parental figures, the latter consistent with the psychoanalytic view of the importance of object loss in the development of the disorder. Forty-one per cent (thirty) had been sexually abused. The key criteria for diagnosis were the use of physical violence/cruelty to achieve dominance over another; humiliation of people in the presence of others; harsh treatment of those under their care; pleasure in the act of psychological or physical harm to animals or humans; lying to cause pain; control of others through fear; restriction of autonomy of those in a close relationship; and a fascination with violence, weapons, injury and torture.

Ressler *et al*. (1988) in their description of thirty-six adult sadistic murderers identified the following most consistently reported internal factors reported over the three developmental periods of childhood, adolescence and early adulthood: day dreaming, compulsive masturbation, social isolation and poor body image. Most consistent external behaviours over the same developmental periods were lying, rebelliousness, stealing, cruelty to children and assaults on others. In a study of a series of child and adolescent murderers Bailey (1996a) found that a third had been sexually abused. Males described uncertainty about emerging sexuality and identity; negative experiences of sexual experimentation with age similar peers, and inappropriate sexual experience with older females and males. In a third of cases there was both a sexual and sadistic motivation to the offence, but more importantly, undetected and previous offence behaviour of a violent, sadistic and sexual nature.

The adult literature points to antecedent history in late childhood and early adolescence of rehearsals for a final violent sadistic act. Often, because not overtly sadistic or violent, the significance of apparently trivial components of stealing had been overlooked, for example conduct disordered youngsters engaged in burglaries retaining keys and photographs, using these as a focus for developing sadistic fantasies. There was a failure to make such connections in

the thinking patterns and early fantasies of these youngsters: this had not been explored, with later grave consequences. Liebert (1985) has pointed out the resistance amongst clinicians to uncovering the sexual basis for 'grave acts' committed by young people, particularly when conventional evidence for a sexual motivation may be lacking at the scene of the crime.

Adolescent sex offenders

Juvenile sexual offending represents an important mental health issue, first because abusers often come from disadvantaged backgrounds with a history of victimisation and many suffer from psychiatric disorders and, second, the victims of abuse suffer high rates of psychiatric disorder. Child mental health services are being asked to assess and provide treatment not only for victims, but also increasingly, alongside their adult forensic colleagues, to provide services for the young offenders themselves. The one-year period incidence rate of offending taken from a postal questionnaire (overall response rate 65 per cent) of 1.5 per 1,000 twelve- to seventeen-year-old males reflected only official cases. While recognising the limitations of their survey, James *et al.* (1996) found results were remarkably similar to the findings of the US National Task Force on Juvenile Sexual Offending (UDCS, NAPN, Kempe Centre, UCHSCE, Denver ongoing). The majority of abusers were male, with a history of neglect, physical and/or sexual abuse, with below average ability, and high rates of behavioural and psychological problems.

In a series of 121 male juvenile sex offenders referred to a specialist child and adolescent forensic service, a third of the group had used physical violence or threats (Dolan *et al.* 1996). Their sexual offences were not isolated incidents in normally developing adolescents. Many had a previous record of similar or less serious offences, but multi-agency and, indeed, previous psychiatric assessment had not explored the presence or evolution of rape fantasies. The authors urge that psychiatric interview of young sex offenders in both contact and also non contact offences should always include an enquiry into the presence of rape fantasies and the use of pornography, and other concurrent violent behaviours, in addition to the paraphilias.

A semi-structured interview designed by Vizard *et al.* (1996) was used to assist clinicians in the task of assessing risk, dangerousness and the treatability of juveniles who abuse other children. The model was developed from psychiatric assessment of eighty young abusers, but with emphasis on a multi-disciplinary team that can create a full inter-agency systemic context around each referred case of a child as a young abuser, following a child protection procedure. A case is made for early intervention to stop, in particular, sexually aroused boy victims from moving into abusing behaviour by means of early preventative input. The majority of adult sexual abusers of children started their abusing in their own adolescence, and yet there is as yet no diagnostic category for paedophilia for those under sixteen years of age either within DSM-IV (American Psychiatric Association 1994) or ICD 10 (World Health Organisation 1992). The authors suggest the creation of a new

disorder, Sexual Arousal Disorder of Childhood, to help identify this vulnerable group who in turn can place vulnerable others at risk.

Of eighty-four incarcerated child molesters and ninety-five non-incarcerated comparison subjects (Briggs and Hawkins 1996) all the non-incarcerated offenders and 93 per cent of the incarcerated child abusers had been sexually abused in childhood. As children, the prisoner group had several characteristics that have implications for child psychiatrists working with adult paedophiles. Prisoners were both more socially disadvantaged and experienced more verbal and physical abuse. They were more accepting of their abuse, either not understanding it or thinking it was an inevitable part of normal childhood, liking some aspect of the initial abuse. They were, by comparison, abused by a larger number of people, did not put forward their own abuse as an excuse for their adult offences, and were more likely to be abused by females. It is possible to see what constitutes sexual abuse to an outsider being construed positively by some victims, bringing for them sexual acts in a context of attention and some affection, setting the scene for replication of abuse across generations. In treatment of adult offenders, failure of perpetrators to accept responsibility for sex abuse is often rated as a problem in treatment. This paper adds a new dimension to this problem, adults who discount the damage of their own abuse are more likely to discount the damage they cause to their victims.

The authors stress that child protection programmes that depend on children's assertiveness, or their recognition of unwanted touching are unlikely to be effective in stopping abuse which may not, in its early stages, be viewed as unpleasant. Parents and teachers should be made more aware of the risk to boys, so that they can become more protective. This is echoed in the paper by Vizard *et al*. (1996) which suggests that scarce resources may need to be shifted from work with older girl victims to work with boy victim/abusers.

Juvenile sexual offending constitutes a substantial health and social problem. There are high rates of behavioural and emotional problems among abusers, combined with substantial history in many cases of neglect, emotional and sexual abuse. The stage is set for epidemiological surveys using standardised instruments and interviews, and it is essential that within the UK there should be prospective studies using good baseline data. Information from such studies should inform the planning of treatment programmes that should be tailored to adolescents and not just rely on adult programmes.

The role of fantasy in sexual and violent acts

Psychodynamic explanations of child and adolescent aggression (Glover 1960; Bender and Curran 1940; Satten *et al*. 1960; Easson and Steinhilber 1961; Bailey and Aulich 1996) have related the violent act to a powerful sense of unconscious guilt. McCarthy (1978) postulated that such young people are not merely lacking impulse control, acting out Oedipal guilt or expressing poorly controlled rage. They are characterised by a vengeful narcissistic rage, expressed through violent acts as attacks on a poorly integrated self object, deprivation and

rejection by early objects providing the framework for the narcissistic disturbance. In tracing the growth of healthy narcissism and regulation of self esteem Kohut (1972) stressed the importance of the parent's availability for the self enhancing mirroring process.

In violent murderous youngsters, later parenting styles serve only to perpetuate their narcissistic vulnerability and feelings of shame and inadequacy. The violent act enables and comes to represent not only an expression of immediate rage, but a defensive response to lowered self esteem and an attempt at repair of the self. Miller and Looney (1974) stress not just loss of control, but the young person's tendency to dehumanise their victims, allowing a pathological projection of an unacceptable part of the self onto the victim. Narcissistic rage invokes not only a need for revenge, but a compulsion to pursue it, developed through the sadistic fantasy. The violent act, loss of control and sadistic fantasies serve to restore omnipotence to the young person in an attempt at reparation of the self. The important implication for successful interventions with such children and adolescents is the need for a dual focus not only on the evocation of the individual's rage, but, if a safe resolution is to be achieved, on the presence of the underlying narcissistic disturbance.

Fantasy is characterised as an elaborate thought with great preoccupation and anchored in emotion. It is a normal way for a child to obtain and maintain control of an imagined situation. Rates of fantasy development and frequency differ considerably and may either substitute or, critically for some, prepare for action. How many young people activate sadistic fantasy and in what context remains uncertain (Crepault and Couture 1980). Once a fantasy builds to a point where inner stress is unbearable, action may follow. Early expression of fantasy development is clearly seen in children's play, and in adolescence thinking patterns emerge from and are influenced by earlier life experiences.

Violent and sadistic children particularly in the latency period, start to demonstrate repetitive acting out of the core aggressive fantasy, persistent themes emerging in their own play or in play with others. Secondary attempts at mastery and control over others appear in set situations when the repetition can often become a direct expression of an original assault either against or witnessed by the younger child. A high degree of egocentricity evolves in both fantasy and play and gradually other children, family, and significant adults merge to become extensions of the child's inner world.

Adult sadists often report an absence of positive fantasies in their early life, whether never present or lost in very early negative experiences is unclear, but what emerges is the overwhelming importance of the secret reality of the fantasies to the individual in adolescence. The early aggressive behaviours serve to displace anger onto the victim but clinically, as fantasies elaborate, the displayed aggression (whether still in play or against an individual), occurs with diminishing fear or anxiety about adult disapproval. Each subsequent act serves to allow increasingly intense emotions to be incorporated into their imaginations, in turn allowing the intensity of violent thoughts to escalate.

During adolescence the nature of the first sexual experience may be crucial in

determining sexual deviation and the sexual component to subsequent sadistic acts. Early general difficulties in social relationships are epitomised after puberty by an inability to make any sort of appropriate approach to their preferred sex. In contrast, through the pattern of fantasy in which the young person controls their inner world, he/she becomes the success they would like to be but are unable to control in the real world. Fantasy of successful control and domination of the world becomes the key which unlocks the increasing probability of its own recurrence, given the relief which it provides from a previous sense of failure. The stage is thus set for the violent sadistic act.

The role of pornography and media in sexual and violent acts

Within the cycles of abuse and violence literature are studies that address the impact of witnessing violence on children's later behaviour. These studies fall into three basic types: large scale surveys that correlate self reports of exposure to violence with adult approval of violence or marital violence; studies of the children of battered women; and studies of television violence and aggressive behaviour. It is important to note that television and violence literature is characterised by a variety of designs, viewing stimuli, circumstances and measures of aggression.

Whether the aggression and violent behaviour measured in the television violence studies can be generalised beyond the laboratory to real life behaviour or delinquency or criminality has been seriously questioned. However, in prospective longitudinal studies the amount of violent television watched at age nine was a good predictor of juvenile delinquency offences related to aggression at age nineteen. Increased levels of aggression after viewing television violence, emotional insensitivity and a distorted perception of reality bear a marked resemblance to findings from research on delinquency, and in particular violent offenders. The extent of a young person's reported television viewing may not in and of itself be the best predictor of violent criminal acts; rather it is the interlacing interaction of large amounts of television and exposure to earlier and/ or ongoing parental abuse that is related to violent crime.

Humans are in constant interaction with their environment, reacting to information they take in and adjusting to demands placed upon them. Within a vulnerable group of young people (that may include up to 10 per cent of the population of young people), unaddressed, traumatic and early damaging experiences set in motion a certain thinking pattern. A structure of thinking begins to emerge that motivates and sustains deviant behaviour through developmental and interpersonal failure and through the alliance of distorted perceptions. Of particular importance is the activation of aggression and its link to sexual expression. Ressler *et al.* (1988) reviewed the child sexual experiences of thirty-six adolescents and adults who later committed sexual homicide. This study revealed the strong reliance offenders placed on visual sexual stimuli; pornography ranked highest (81 per cent) and re-emerged in their subsequent act of organised or disorganised killing.

In a recent study of forty child and adolescent murderers, twenty aged five to eighteen years and twenty aged between eighteen and twenty-one years, Bailey (1998) found similarities to classic studies in the USA. Past history of violence was coupled with neuropsychiatric vulnerabilities, parental brutality, mental illness within the parent group, and a history of the young person being out of control within home, community and school in the months prior to the offence. Motivating factors were multiple and overlapping. Causal factors were out of control behaviour, alcohol, drugs, mental illness, and, in 25 per cent of cases, repeated viewing of violent and pornographic videos, especially in the weeks of increasing social isolation prior to the offence. In this group there were young people who had adopted reverse sleep patterns, viewing videos in the early hours, returning to particular parts of a film and reliving these over and over again. The technology of visual imaging, in particular the piping of such images directly into family homes, continues to advance too quickly for us to take stock and react safely.

A recent study of 121 child and adolescent sex offenders by Bailey (1999) has revealed high psychiatric morbidity in families of the offenders and psychiatric morbidity in the young people themselves. They started to offend at an early age, and have been responsible for many offences resulting in many victims. In individual cases, particularly those where most aggression has been shown in the sexual act against very vulnerable victims, the adolescent, in a state of anger and rage, has incorporated into his/her fantasy, elements of sex and aggression taken from violent visual imaging. Young sex offenders offending in a family, babysitting context give a history of easy access to violent and pornographic videos, watched sometimes not only with peers but in the presence of their young victims. This provides a potent source of immediate arousal for the subsequent act.

In vulnerable children and adolescents in vulnerable families, it is likely that censorship will not take place. Beyond the immediate content of violent and pornographic videos is the all too often spoken and unspoken message that violence and sexual assault are acceptable and related to individual success and satisfaction. Viewing of such videos for adolescents who currently have no prospect of success in their own lives, no sense of future vocation or constructive avocation, linked with the potential for them to view such material for hours on end, will contribute to the nature and content of subsequent offences.

Interventions

Family violence represents traumatic events that disrupt a dynamic growth process. As a clinician it is important in my assessment and treatment of children and adolescents who commit grave crimes that I provide both justification of data I collate and that this data must directly inform practical interventions to encourage both myself and others to focus on 'building health' rather than always 'fighting sickness' (Cowen 1991). Whatever the treatment model, safe interventions have to be based on an assessment that has established

a holistic picture of the young person, the situations in which the behaviour occurs; specific triggers, and quantifying frequency intensity and severity of the behaviour. Cognitive and emotional assessment has to examine perceptions, thoughts and feelings associated with the behaviour, applying interventions with continuous monitoring and evaluation of treatment outcome on all aspects of the young person's life.

Individual psychotherapy

Realistically therapy with young people who have committed sadistic murderous acts has to be tailored to the demands of the external environment and has to be approached cautiously. Motivational dynamics are complex and the monitoring of ongoing level of risk critical, especially if the young person remains within the community and with their family. The emergence of a sense of guilt involves the appreciation for negative outcomes resulting from an act of commission or omission (often a key agenda where two or more youngsters have been involved in a sadistic act). A sense of shame is associated with negative feelings on the basis of a perception of self and others: the emergence of a true sense of guilt and shame can be and often is a slow, difficult, painful and angry process.

Detention itself can provide an allowance of time for further neurodevelopmental, cognitive and emotional growth, allowing the adolescent to gain better control of his or her emotional and aggressive impulses. Irrespective of the available treatment model if any, provided by the care or custody institution, the parallel process of education, vocation, avocation, consistent role models and continued family contact are of critical importance. This parallel process is best facilitated in a *milieu* characterised by warmth and harmony, with clear organisation, practicality and high expectations, allowing for the establishment of positive staff–adolescent, staff–staff and adolescent–adolescent relations (Harris *et al*. 1987). Significant turning points include the establishment and maintenance of a harmonious stable relationships, and the continuing potential for growth and developmental change in the individual.

The majority initially dissociate themselves from the reality of their act, but gradually experience a similar progression of reactions and feelings akin to a grief reaction (Hambridge 1990). Their grief is initially about their own loss of freedom and enforced separation from their family, and lastly to grieve about their victim. The effects of the grave offence on the young person's family can be as devastating as on the victim's family (Macleod 1982). Against the inevitable waxing and waning of outside pressure, the child has to move safely through the process of disbelief, denial, loss, grief anger/blame and now, the increasingly recognised post traumatic stress disorder arising from participation in the sadistic act either directly or observing the action of co-defendants has to be treated, as does trauma arising from their own past personal, emotional, physical and/or sexual abuse.

Our own service has found in working with the sadistic children and adolescents referred to us over twelve years, that a combination of cognitive

behavioural psychotherapy and non-verbal therapies have most to offer those who have committed sadistic acts (Bailey and Aulich 1996). Qualities such as previous, frequent and severe aggression, low intelligence and a poor capacity for insight weigh against a positive safe outcome. The clinician has to remain alert to the possibility of emerging formal mental illness, in particular depression (Stewart *et al.*1990).

In understanding the role of violence in the youngsters life, it is necessary to understand the depth of their sensitivity and reaction to a perceived threat, seeing threat and ridicule in many day to day events. A related theme is saving face. As the youngster starts to discuss their sadistic act, they have to face past loss, trauma and abuse, disclosing fears of being vulnerable in the knowledge that therapy may bring about change they do not like and above all cannot control.

Non-verbal therapy

Burgess *et al.* (1990) described the use of drawing, painting and sculpture with juveniles in accessing memory of sadistic acts and allowing further insights into the motivational dynamics. Art therapy (Aulich 1994) makes easier the task of enabling the young people to face the most sadistic elements of their own acts and past abuse, particular in those cases where the spoken word has become such a painful and destructive reminder of how systems have dealt with them. The drawing series has given a potentially non-evasive way of providing information and, critically, has allowed the youngster to make contact with gaps in their own emotional state. Both can then help direct intervention that will diminish rather than escalate future risk.

A range of motivational dynamics have become apparent in the drawings of these children and adolescents: victim provocation, the victim of a physical threat and role reversal of victim and offender with often gross size distortion. Victim and offender will often merge and the drawings show a remarkable variation in use of detail and colour, some critically showing clear attribution of blame and emotional expression. The exposing of the distortions via non-verbal images can represent the first therapeutic effort to separate out causal constraints in believing another person is the cause to being responsible for one's own rage. This can help the young person come to terms with their own behaviour and their sense of needing to seek revenge on vulnerable people.

Addressing victim empathy, saying 'sorry' and reattributing blame does lead to expression of anger and distress within sessions, often sexualised in both form and content. When the emotion this engenders spills outside sessions, it leads to disruptive behaviour within the institution. This is both difficult for the child and carers, and can in turn lead to both becoming collusively rejecting and dismissive of the therapists. However, disclosure and understanding is essential if safe resolution is to achieved. In this process, the youngster can assume far more responsibility for the content of sessions, honesty is enhanced, acting out diminishes and, critically, the youngster starts to consciously link their sadistic

behaviour to conflict, loss and trauma in the past whilst coping with their feelings in the present.

Very little is known about the long term outcome of juveniles who commit homicide, but with few exceptions the limited follow up information available is surprisingly positive (Bailey 1998). Authors suggest that juvenile murderers tend to adjust well in prison, relate well to their families and attain an adequate social adjustment after release from custody (Cormier and Markus 1980; Duncan and Duncan 1971; Tancy 1976). However these include cases where the child's crime was an isolated act of violence, where there was no history of chronic delinquent behaviour. More often their homicides were motivated by interpersonal conflict with the victim, especially in the context of abuse or mistreatment by the victim.

Psycho-social interventions

Social skills training enhances abilities in positive social interaction. Behaviourally based tools include instructions, modelling, role playing, coaching and feedback for children and young people who have previously dealt with new social encounters through aggression (Goldstein 1986). Self instructional training is designed to modify the things children say to themselves and the autonomic cognitive events which play a regulatory role in everyday behaviour. Interventions containing cognitive elements have better outcomes than ones which do not (Izzo and Ross 1990).

In social problem solving training, an attempt is made to foster interpersonal problem solving skills, in order to lead to conflict avoidance and hence reduce risk of aggression (Kazdin 1997). Anger control training is a widely used form of cognitive behavioural work, combining self instructional methods with relaxation training in a model of stress inoculation. The best results reported have been with aggressive adolescent inpatients with severe behaviour disorders (Feindler and Ecton 1986). Increasingly combined multi-model treatment programmes have been employed. The most complex approach to reduction of violent behaviour in young offenders is the Aggression Replacement Training (ART) formulated to meet the growing problem of juvenile gang violence in the USA. ART brings together social skills training, self instructional/anger control training and moral reasoning enhancement, and is carried out in community and institutional based settings.

Early prevention: policy implications

Successful early preventative interventions for juvenile offending depend on efficacy of parent training, problem solving, school interventions, and preschool programmes which enable young children to understand more readily the consequences of their behaviour for self and peers, critically helping them to make safe choices. In part, therefore, factors which are associated with manifestations of aggressiveness are similar to those associated with offending behaviour

in general. As such, those intervention studies of early identification and prevention focused on 'chronic' general delinquency rather than aggression, provide a valuable context for treatment interventions with aggressive young people and a possible framework for those who present specifically with violent sadistic acts (Yoshikawa 1994).

A number of successful preventative programmes have now been mounted. In the review by Yoshikawa (1994) which focused on early identification and prevention of chronic delinquency, the most effective programmes were those which addressed multiple risk factors with components responding to the economic plight of families through provision of family support and education. The best strategy appears to be the dual one of delivering services both in schools and at home, focusing on parenting and on cognitive variables. Gaps remain in understanding, however, hence best interventions take account of dynamic risk factors over medium term periods between childhood and adolescence.

Rutter's (1979) work with families found that a good relationship with one parent, marked by warmth and the absence of severe criticism had a substantial protective effect against the development of conduct disorder. The importance of nurturant parenting as a protective factor against later antisocial behaviour have emerged from subsequent studies (McCarol 1986). Quality of parenting has been found to interact with such variables as psychological well being, life stress and social support of the parent in predicting antisocial behaviour. Zahn-Waxler *et al.* (1990) found that parental sensitivity and non rejecting control were protective against persistent severe aggressive behaviour amongst children (age two to five) of depressed mothers.

Kazdin (1995) in a review of conduct disorder points to multiple opportunities to reduce influences that can contribute to violence: in particular, social practices that permit, may facilitate or tacitly condone violence and aggression. No single influence accounts for or causes violence, but certain key factors contribute significantly to it as this paper has attempted to illustrate. If a risk factor model is adapted with respect to policy, practice and research, it will help to understand and then act upon influences that may have a small impact, but can still have great importance in terms of ultimate individual and social outcome. Examples of this are addressing and endeavouring to minimise the effects of pornography and media violence (Newson 1994). There is a pressing need for a specific study to look at the evolution of violent and sexual fantasy in normal populations of young people, and the evolution of sadistic fantasy in a vulnerable group that are at the margins of society, a margin that is currently widening.

Multiple influences may combine to increase the likelihood of violent outcome, or may as importantly, interact to influence outcome positively (Bailey 1994). The purpose of reducing risk factors in a group of potentially violent and sadistic children and adolescents is not to remove the problem in its entirety, but to ensure a positive palpable impact. The expressed fear is that such action, on the one hand, requires infinite unavailable staffing and funding resources, and that, on the other, interventions required may clash with the rights of the indi-

vidual, or more likely the perception and interpretation of such rights. The real risk is that in the cut and thrust of the debate, our capacity to effect change and reduce risk in our work with violent sadistic, or even troubled and troublesome, youth is diminished.

The importance of situational effects on violent behaviour is readily accepted, but our understanding of how these effects work is limited. Improved ways of conceptualising measuring and classifying situations are much needed. No single influence accounts for, or causes, aggression resulting in violent behaviour. The full range of influences is best conceptualised in terms of a risk factor model in which there are multiple influences that contribute to some outcome: in this case the overall level and type of violence in society.

Breaking the cycle of violence: strategies for the future

It is important that child mental health professionals share their wealth of research knowledge and clinical experience to inform policy makers and to influence public opinion. Any proposed national action plan would need to include:

- prioritising parenting, helping parents to deal with the difficulty of raising children, in particular those with special needs
- the incorporation of child development and parenting skills courses into secondary school education
- parental education about child abuse and neglect both directly through courses for mothers and fathers, and indirectly through educating children who might be in abusive or potentially abusive situations
- provision of information via the education system to children about the effects of parental alcohol and drug dependency, to help children and adolescents learn to differentiate functional from dysfunctional families, and to know that abuse and neglect are often a consequence of the latter
- helping children and adolescents to access support groups and professional help within the field of mental health
- using education settings to improve the communication skills of pupils, to increase self esteem and to help learn peaceful methods of conflict resolution, and anger and stress management; developing curriculum and support networks in school linking with other agencies, including child mental health, that can help address the social and psychological needs of children, enabling them to relate within their domains of social interaction without resort to bullying and violent behaviour
- enabling local communities to play a pivotal role in helping young people make pro-social choices: for example, it takes a village to raise a child (Heide 1995).

This might be achieved through the involvement of male and female mentors; part-time employment; training programmes with neighbourhood businesses (to

enable young people to earn money legitimately to acquire goods and services); and adequate sports and relaxation facilities, to provide constructive activities as an alternative to boredom and the temptation of drugs and alcohol.

At a national level there is a need:

- to support quality day care for children and promotion of an attitude that supports both parents to combine and balance paid employment with the care of their children
- to accept that programmes aimed at prevention and early intervention may take a minimum of ten years to demonstrate direct results
- to recognise that failing to provide the mental health and social services resources to children in need today in order to save money, will ensure that in future the prison population will grow
- to harness the enormous potential and resources of the media to halt the cycle of destructiveness (rather than fuelling it as is now often the case) through more socially responsible programming, and through its capacity to raise public consciousness about constructive solutions.

Last, but not least, it could be critical to outcomes at the level of the individual child or adolescent to recognise the power of any one individual adult to influence, decisively and instrumentally the life of any child. This has been evidenced by adults who as children and adolescents demonstrated many of the risk factors for acts of violence, and acknowledge the important single adult who, however briefly, communicated to the child that they as an adult believed in the child and cared about him or her. It is in the power of every individual adult to make this difference to any individual child at any time.

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12 Risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys

Cross sectional study

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Key messages

- The risk of sexually abused boys in early adolescence abusing other children may be associated with experiences in early life that are independent of sexual victimisation.
- Exposure to persistent violence within the family may be a particularly important risk factor.
- Management of sexually abused boys should take into account the impact of early life experiences that may be associated with increased risk with a view to the secondary prevention of sexually abusive behaviour.

Abstract

Objective To identify factors that may increase the risk of a sexually victimised adolescent boy developing sexually abusive behaviour.

Design Sexually victimised boys who had sexually abused other children were compared with sexually victimised boys who had not done so.

Setting Social services departments in south east England were invited to refer sexually abused and sexually abusing boys to a London postgraduate teaching hospital.

Subjects Twenty-five adolescent boys aged from eleven years to fifteen years and eleven months.

Main outcome measures Adjusted odds ratios estimated from unconditional logistic regression.

Results Unadjusted odds ratios for witnessing (8.1) as well as experiencing (18.0) intrafamilial violence and discontinuity of care (7.2) discriminated boys who had sexually abused from others who were solely victims of sexual abuse. Only the adjusted odds ratios for witnessing intrafamilial violence (39.7) discriminated the two groups.

Conclusions The risk of adolescent boys who have been victims of sexual abuse engaging in sexually abusive behaviour towards other children is increased by life circumstances which may be unrelated directly to the original abusive experience, in particular exposure to a climate of intrafamilial violence. Our findings have implications for the management of boys found to have been sexually abused and raise important questions about the possibility of secondary prevention of subsequent abusive behaviour in those at greatest risk.

Introduction

A substantial proportion of both boys and girls are sexually abused during childhood. Prevalence figures vary (boys 3 per cent to 37 per cent; girls 6 per cent to 62 per cent) (Dhaliwal *et al.* 1996: 613–39; Peters *et al.* 1986: 15–59), but even the most conservative estimates indicate this to be an important public health issue. Such experiences have been linked to mental health disorders in later life, including depression and sexual dysfunction (Beitchman *et al.* 1992: 101–18). Society is increasingly concerned about these worrying figures and there have been calls to develop strategies aimed at the prevention of paedophilic behaviour (Ryan 1997: 433–54).

Some have argued that the very experience of sexual victimisation puts an individual at risk of becoming a sexual abuser (Freeman-Longo 1986: 411–14). Studies report high rates of former sexual victimisation among adult sex offenders, but most victims do not go on to abuse (Watkins and Bentovim 1992: 197–248). We hypothesised that an individual who has been sexually victimised during childhood would go on to abuse only if other risk factors were also present. We focused exclusively on adolescent boys as most perpetrators are male (Smith and Bentovim 1994: 230–51) and a pattern of sexual offending is often established in adolescence (Groth *et al.* 1982: 450–8).

We compared two groups of boys matched for age who had been victims of sexual abuse. One of the groups had subsequently sexually abused other children, the other had not. A wide range of interpersonal and intrapersonal variables that could potentially discriminate between these groups was measured. The choice of measures was based on specific hypotheses about predisposing factors, derived from clinical experience and a review of the relevant literature. We undertook an intensive (with respect to the individual concerned) and extensive (with respect to the range of sources of information about potential risk factors) investigation of the risk of sexually abusive behaviour in sexually victimised adolescent boys.

Subjects and methods

A London postgraduate teaching hospital invited social services departments in south east England to refer boys aged from eleven years to fifteen years and eleven months who had been victims of sexual abuse, including those who had in addition sexually abused other children. In total seventy-eight boys were referred to the study, of whom thirty-two had abused others. Twenty five boys were selected to enter the full assessment procedure. This sample consisted of eleven boys who had sexually abused other children and fourteen who had not. Reasons for exclusion included practical constraints on the completion of the assessment procedure (usually connected with travel arrangements), overtly aggressive behaviour, and denial of documented sexually abusive behaviour. Only participants who took part in the full assessment are reported here. Ethical approval for the study was given by the Research Ethics Committee of Great Ormond Street Hospital for Sick Children NHS Trust and the Institute of Child Health.

In the first stage of the assessment information was collected on intelligence (Wechsler intelligence scale for children, Wechsler 1992), pubertal status, socioeconomic circumstances, and friendships (network relationship inventory, Furman and Buhrmester 1985: 1016–24) (BW). Socioeconomic circumstances were measured with the Osborne social index (Osborne 1987: 429–48); those obtaining a score of above fifty were considered to live in adversity compared with the general population. Pubertal status (based on Tanner staging, Tanner 1989) was assessed by self-report (from photographs) of testicular development and pubic hair growth. Each characteristic was scored from one (prepubertal) to five (postpubertal). Peers' perceptions of the boys were obtained by sociometry (Asher and Dodge 1986: 444–9; Parkhurst and Asher 1992: 231–41). The technique requires classmates to complete checklists about the popularity and personal characteristics of all other pupils in the class. It entailed measurements in twenty-five schools, with a total of about 500 pupils. These methods have not previously been used in studies of sexually abusive children.

The second stage consisted of three months of individual weekly psychotherapy sessions (Hodges *et al.* 1994: 283–308; Lanyado *et al.* 1995: 231–42), conducted by psychoanalytically trained child psychotherapists (ML, CA). Six sessions were semistructured with standardised instruments, including measures of attachment (adult attachment interview, George *et al.* 1985) and hostility (Buss-Durkee hostility-guilt inventory, Buss and Durkee 1957: 343–49). A grounded theory approach was applied to verbatim transcripts of the adult attachment interview to derive childhood themes relating to history of care and maltreatment (Glaser and Strauss 1967). Six less structured sessions covered the boy's life history, his own sexually abusive behaviour, and his sexual fantasies. Boys' reports of their early experiences were verified from independent sources including interviews with others (mother, social workers) and from social services records. No boys revealed having engaged in sexually abusive acts that were previously unknown.

Birth mothers were interviewed about their life history (MN), including their

experience of maltreatment, with an interview designed for the study. Current carers were seen if a boy was no longer living with his family of origin. Mothers also completed the Beck depression inventory (Beck and Steer 1987).

Statistical methods

The two groups were compared with t tests, Mann-Whitney U tests, contingency tables, and odds ratios. On the basis of the psychotherapeutic assessment and a review of the relevant literature we identified thirteen potential risk factors and calculated unadjusted odds ratios and 95 per cent confidence intervals for each of these. Definitions of the potential risk factors are given in Table 12.1 (page 226). The unadjusted odds ratios indicated that three of the thirteen variables were significant, the lower 95 per cent confidence limit being greater than one. A second stage of analysis used unconditional logistic regression to determine adjusted odds ratios.

Results

There were no significant differences between the two groups on most of the measures of personal and familial characteristics (Table 12.2, page 227), although those victims who had sexually abused reported more advanced puberty in terms of testicular development (Mann-Whitney U test $z = -2.42$; $P = 0.02$). No differences were found between the groups in terms of their experience of sexual victimisation (based on personal accounts and contemporaneous records). Severity of sexual abuse was ascertained from evidence of penetration ($x^2 = 0.00$; 1 df; $P = 0.97$), duration (Mann-Whitney U test $z = 0.71$; $P = 0.48$), whether the abuse was within or outside the family ($x^2 = 0.00$; 1 df; $P = 0.97$), and the number of perpetrators involved (Mann-Whitney U test $z = 0.40$; $P = 0.69$).

We then analysed specific risk factors, hypothesised to distinguish the groups. Unadjusted odds ratios and 95 per cent confidence intervals were calculated for each of thirteen variables (Table 12.3, page 227). Three of the thirteen factors were associated with an increased risk of being in the sexually abusive group: experiencing intrafamilial violence, witnessing intrafamilial violence, and discontinuity of care. All related to events that preceded the sexually abusive behaviour that led to referral. All of the eleven boys in the abusers group had either experienced intrafamilial violence (two) or witnessed violence (one) or both (eight). Among the fourteen boys in the victim only group, two had experienced violence, two had witnessed it, and two were in both categories. Discontinuity of care had been experienced by six abusers and two victims.

The three significant risk factors were then assessed further in a series of unconditional logistic regressions. The measure of testicular development was also entered in the regression as the distribution of scores differed significantly between the two groups. The logistic regression was run twice. On the first occasion, testicular development and all three significant risk factors were

Table 12.1 Definitions of potential risk factors for abused adolescent boys becoming abusers themselves

Potential risk factor	*Description*
Experiencing intra-familial violence[a]	Report by boy during adolescent adaption of adult attachment interview[b] of recurrent acts of physical abuse
Witnessing intra-familial violence[a]	Report in adult attachment interview[b] of exposure to recurrent acts of marital violence or physical abuse of siblings, or both
Rejection by family[a]	Report by boy in adult attachment interview[b] of rejection, emotional abuse, or neglect
Discontinuity of care[a]	Report in adult attachment interview[b] of marital breakdown, being in care of local authority, in children's home or foster home
Rejected by peers	Calculated by using sociometry[c, d] and designated as present if boy's rating of peer inclusion was >1SD below mean for whole class
Generalised sense of grievance	Present if boy scored >1SD above population mean on resentment scale of Buss-Durkee hostility-guilt inventory[e] or rating of generalised grievance was made by boy's psychotherapist, or both
Poor identification with father figure/s	Rating made by psychotherapist of extent to which boy identified with his father figure/s
Absence of a non-abusive male attachment figure	Scored as present if all father figures in boy's life were emotionally/physically or sexually abusive, or both
Mother was sexually abused in childhood[a]	Report by mother during maternal interview of having been sexually abused in childhood
Maternal depression	Present if mother scored >15 on Beck depression inventory[f]
Poor sibling relationship	Present if boy scored >1SD above mean on negative sibling support subscale of network relationship inventory[g] or >1SD below mean of positive sibling support subscale
Mother was physically abused in childhood[a]	Report by mother during maternal interview of having been physically abused in childhood
Low levels of guilt	Present if boy scored >1SD in direction of low guilt on guilt subscale of Buss-Durkee hostility-guilt inventory[e] or guilt rated as not present in adult attachment interview[b]

Notes
a These risk factors preceded sexually abusive behavious in subgroup of abusers
b Kaplan and Main 1985
c Asher and Dodge 1986
d Parkhurst and Asher 1992
e Buss and Durkee 1957
f Beck Depression Inventory 1987
g Furman and Buhrmestor 1985

Table 12.2 Personal and familial characteristics of a sample of sexually abused adolescent boys

Demographic factor	*Victim only (n = 14)*	*Victim and perpetrator (n = 11)*	*P value*
Testicular development (Tanner staging[a])	2.6 (1.2)	3.9 (1.0)	0.02[d]
Pubic hair growth (Tanner staging[a])	3.0 (1.0)	3.6 (0.8)	0.11[d]
Age (years)	13.1 (1.7)	14.1 (1.3)	0.12[e]
Socioeconomic adversity index score (Osborne social index[b])	49.4 (7.5)	46.1 (5.0)	0.24[e]
Intelligence quotient (Wechsler scale[c])	91.6 (15.9)	85.4 (11.4)	0.28[e]

Notes
Values are means (SD)
a Tanner 1989
b Osborne 1989
c Wechsler 1992
d Analysed with Mann-Whitney U-tests
e Analysed with *t* tests

Table 12.3 Unadjusted odds ratio for potential risk factors for sexually abused adolescent boys becoming abusers themselves

Potential risk factor	*No. exposed to risk factor*		*Unadjusted odds ratio (95% CI)*
	Victim only (n = 14)	*Victim and perpetrator (n = 11)*	
Experiencing intrafamilial violence	5	10	18.0 (1.8 to 184.7)
Witnessing intrafamilial violence	5	9	8.1 (1.2 to 53.2)
Rejection by family	8	10	7.5 (0.7 to 75.7)
Discontinuity of care	2	6	7.2 (1.1 to 48.6)
Rejected by peers	3	5	3.1 (0.5 to 17.5)
Generalised sense of grievance	4	6	3.0 (0.6 to 15.8)
Poor identification with father figure/s	4	6	3.0 (0.6 to 15.8)
Absence of a non-abusive male attachment figure	9	9	2.5 (0.4 to 16.4)
Mother was sexually abused in childhood	6	7	2.3 (0.5 to 11.8)
Maternal depression	6	6	1.6 (0.3 to 7.8)
Poor sibling relationship	5	5	1.5 (0.3 to 7.5)
Mother was physically abused in childhood	7	6	1.2 (0.2 to 5.8)
Low levels of guilt	13	10	0.8 (0 to 13.9)

entered simultaneously. On the second occasion 'experiencing intrafamilial violence' was excluded as it made no independent contribution to the variance in outcome. In the second regression, witnessing intrafamilial violence emerged as significant (adjusted odds ratio 39.7; 1.1 to 1472.6), and discontinuity of care approached significance (15.0; 0.9 to 245.2).

Discussion

This study has found adolescent male victims of sexual abuse who have abused other children can be discriminated from those who have not done so in terms of life events that are unrelated directly to the experience of sexual victimisation. The risk of becoming an abuser was not found to be related to the severity of the victimisation experience, but the risk that is independently associated with having been a victim of sexual abuse cannot be determined from this study design. Accordingly the findings are applicable only to boys who have been sexually abused. In addition, as the study focused on adolescent perpetrators the findings may apply only to boys who began abusing before or during adolescence. It is perhaps surprising that witnessing rather than experiencing intrafamilial violence seemed to be the most potent risk factor, although many boys were exposed to both risks. At this stage it may be more useful to conceptualise this influence in terms of a climate of intrafamilial violence, which may or may not have directly involved the boy as a victim. An experience of discontinuity of care may also be important in predisposing sexually abused boys to abuse others, although with this small sample the adjusted odds ratio fell just short of significance. Just why these experiences are discriminating needs further investigation; at this stage we are unable to identify causal mechanisms. The findings are, however, in line with those from other recent research. For example, Ryan *et al.* (1996: 17–25) reported that 63 per cent of adolescent offenders had witnessed intrafamilial violence and 56 per cent had experienced the loss of a parental figure.

Limitations

The research reported here was largely exploratory and the results require independent replication. Limitations include the small sample size; this reflects the considerable labour involved in the assessment procedure, which was both more extensive and intensive than any previous comparable investigation. Replication of the findings with a substantially larger sample is necessary. A small sample size reduces power and hence increases the likelihood of failing to find a significant difference that really exists (a type II error). The fact we were able to identify significant differences between our groups is therefore all the more compelling, unless a systematic bias, which was correlated with the risk factors, independently accounted for group differences. Such a potential bias includes the possibility that abusing boys were more likely to reveal, or claim, that they had been exposed to the risk factors. Systematic examination of infor-

mation from independent sources (contemporaneous social service records, social workers, mothers) enabled us to refute that explanation for our findings.

The correct assignment of boys to perpetrating and non-perpetrating groups is difficult given the reluctance of sexual abusers to reveal their behaviour. The design of the study incorporated an intensive psychotherapeutic investigation to maximise the possibility of correct assignment. We recognise there remains the possibility of misclassification. Boys who were not sexually abusive at assessment may develop such behaviour in the future. Our findings can only indicate an increased risk of abusive behaviour occurring before the age of sixteen years, and there may be an increased risk independently associated with sexual maturation. Finally the sample was by necessity highly selected, consisting of boys whose abuse (and abusive behaviour) had been revealed and who were in contact with social services. So far as we have been able to ascertain, referrals were nevertheless a representative sample of all boys in the appropriate age range seen by cooperating social services departments during the period of recruitment. Bias due to selection after referral is unlikely to account for our findings.

Conclusion

This study provides evidence that boys who are victims of sexual abuse are more likely to become abusers of other children themselves in early adolescence if they have witnessed intrafamilial violence, an objectively verifiable risk factor which is unrelated to the experience of sexual victimisation. The impact of marital violence on the emotional and behavioural development of children is a subject that requires greater attention than it has been given so far. At this stage, however, it may be more appropriate to view a climate of violence as conferring an increased risk, whether or not the boy is a direct victim of the physical abuse. These findings have implications for the management of vulnerable youths by statutory agencies who are dealing with sexually abused children. While it would be inappropriate to label a child a potential abuser just because he has been exposed to intrafamilial violence, our data do imply that relatively greater support may need to be given to boys at high risk with a view to averting future abusive behaviour.

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Contributors

David Skuse, Arnon Bentovim, Jill Hodges and Jim Stevenson were responsible for the design of the study. The psychotherapeutic investigation was conducted by Chriso Andreou and Monica Lanyado in collaboration with Jill Hodges. Michelle New interviewed the

mothers, and Bryn Williams conducted the assessments in the first stage of the study, including the sociometry. David Skuse, Arnon Bentovim, Jill Hodges, Jim Stevenson, Chriso Andreou, Monica Lanyado, Michelle New, and Bryn Williams generated the hypotheses about the predisposing risk factors. David Skuse, Jim Stevenson, and Dean McMillan were primarily responsible for the data analysis and the drafting of the paper.

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Part 2
Interventions

Part 2.1

The ‘treatment’ of victims and abusers

13 Child sexual abuse and the continuum of victim disclosure

Professionals working with children in Cleveland in 1987

Heather Bacon and Sue Richardson

Introduction

Cleveland: a shift in assumptions

Prior to developments in the medical diagnosis of child sexual abuse, most strategies for intervention and treatment were based on the assumption that the child had moved or could be enabled to move to what Sgroi (1984: 19) has termed 'purposeful disclosure'. This presupposed that the child was old enough to communicate and encountered the right conditions such as finding a sympathetic, believing adult. In other words, the responsibility was mainly with the child to take the initiative to begin the disclosure process. This rendered young, pre-verbal children particularly vulnerable.

In Cleveland in 1987, medical findings suggestive of child sexual abuse were the starting point of investigation for several children. In some cases there was a vigorous denial by both the young child and possible perpetrator. An assertion that the medical findings were erroneous prompted the explanation that the investigation had produced a 'false positive'. In other cases, children (again young) who were spontaneously able to give a recognisable account of sexual molestation could be seen as confirming the precisely similar medical findings. Children with medical findings suggesting the most serious forms of penetrative abuse were often unable to speak, or gave accounts which contradicted or did not confirm the medical findings.

At that time in Cleveland, such children were increasingly presenting for evaluation. Thirty-two of the 121 index cases reviewed by the Cleveland Inquiry were under the age of three. The youngest sexually abused child mentioned in the Report (Butler-Sloss 1988: 146) was a baby of six weeks. The youngest caught up in the crisis was aged seven months. Gale (1988) in reviewing American studies, found that one-third or more of children in case samples were under the age of six years. A study by Hobbs and Wynne (1986) of thirty-five children in the UK found that twenty-four were aged five or under, with an age range starting at fourteen months. The Chair of the Cleveland Inquiry, Lord Justice Butler-Sloss described recognition of the sexual abuse of young children as a 'new phenomenon' for professionals, highlighting the fact

that, for these children, their plight has only just come to light' (Butler-Sloss 1988: 5) and they are likely to present via 'non -traditional routes' (ibid.: 93). This chapter is based on our experience of working as a child abuse consultant (Sue Richardson) and a clinical psychologist (Heather Bacon) with these, and other older, children who were diagnosed with medical signs and symptoms suggestive of child sexual abuse in Cleveland in the period 1987–8.

The continuum of disclosure of child sexual abuse

We have found it helpful in our clinical work with sexually victimised children to view them as presenting on a continuum of readiness to disclose their experiences of having been sexually abused (Figure 13.1). The point which the child has reached when abuse is detected or suspected is significant because it is likely to determine the outcome of the intervention which should be planned with this in mind. Where the child has not spontaneously disclosed, it is difficult to determine the child's psychological state in advance. Other indicators or alerting signs may be present but, equally there may be none to guide the practitioner. Events in Cleveland taught us that the key lies in a match between the child's pre-existing state, the intervention, and factors in the environment such as the presence or absence of a supportive adult in the child's family. Figure 13.1 illustrates some of the relevant factors and the concept of an interactive process of movement on a continuum.

Intervention can potentially move children in either direction. The aim should be to understand and maximise the factors most likely to move any individual child in the direction of disclosure and minimise those pulling in the direction of silence. Support from a non-abusing carer and the availability of an advocate for the child are clearly important in relation to other pressures the child may be under from the perpetrator in addition to her or his own inner psychological processes.

There are some forms of intervention, such as removal from home, whose impact can operate in either direction, depending on other prevailing factors. Accidental disclosure via medical examination has had the effect of facilitating some children to move immediately to the point of disclosure, even for children who had accommodated to the abuse. As Sgroi (1984) points out, accidental disclosure can have the effect of precipitating an acute crisis for the child, the family and the wider system. For some children, who were not psychologically ready or who were subject to strong external or internal pressures to deny, this same event appeared to have the effect of intensifying their 'stuckness' or precipitating processes leading to denial.

Any intervention needs to enable children who are old enough to speak to move up the continuum. It is important to bear in mind that movement along the continuum is likely as part of an interactive process. All that is known about children's psychological development indicates that children actively process incoming information about external events, matching this against their existing internal perceptions of how the world works. If children find themselves

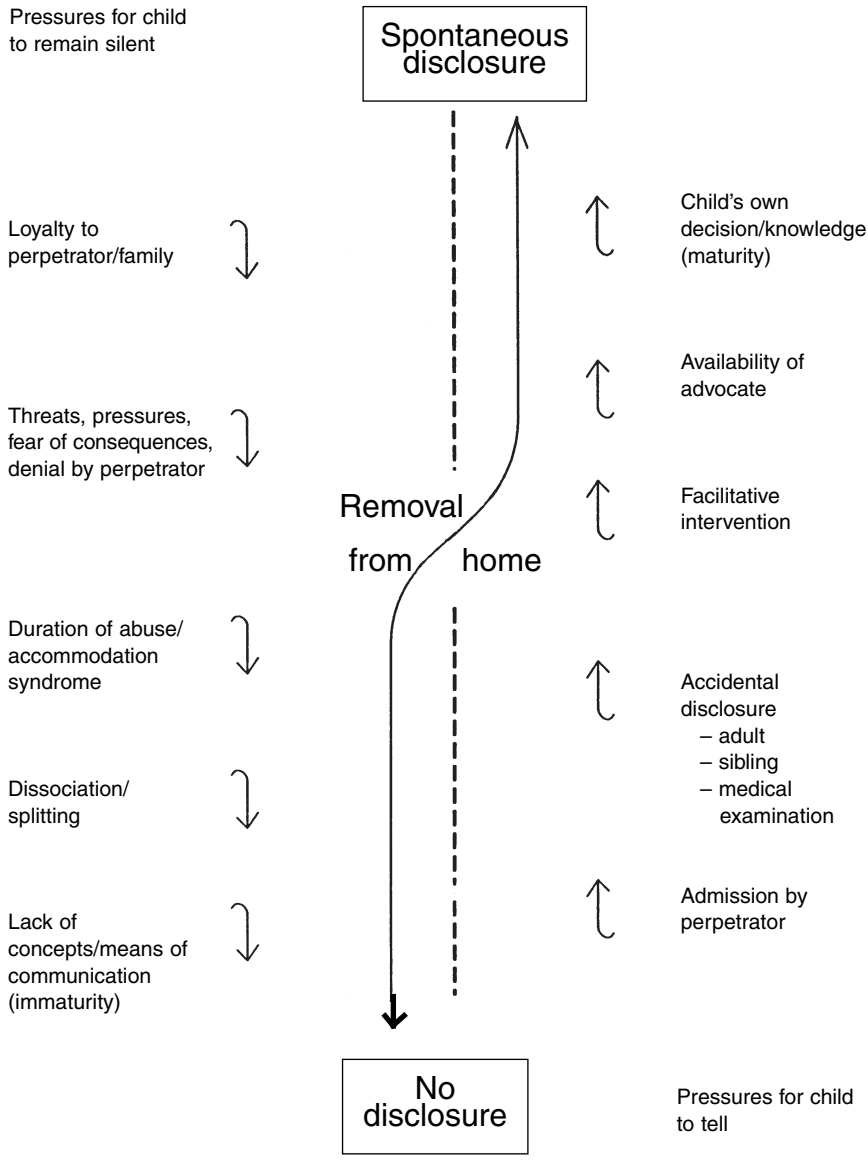

Figure 13.1 The continuum of child disclosure of sexual abuse

with too great a mismatch when contemplating a new event, they have the choice of changing their 'world view' to incorporate the new information or simply ignoring it and persisting in their original schema. Healthy children are therefore often more flexible than adults, who, as initial resistance to awareness of child sexual abuse demonstrates, often seem to ignore new information rather than change their world view. A similar process operates when a child has to

deal with a trauma or stressor. A developmental model posits that children actively seek to adapt to a new situation and to develop various coping mechanisms so that the thrust of development can continue. Sexual abuse is clearly a stressor and children take an active role in creating coping mechanisms for themselves. Friedrich (1988) sees the range of children's responses as reflecting individual ways of coping in which the child will either externalise or internalise the traumatic event with various psychological and social consequences.

The Official Solicitor, who interviewed children subject to the Cleveland Inquiry, records that their reactions to the same forms of intervention 'reflected variously: misunderstanding, mistrust, discomfort, anger, fear, praise, gratitude and sheer relief' (Butler-Sloss 1988: 25). We would incline to the systemic view put forward by Bentovim *et al.* (1988: 27) that 'the pattern seen clinically depends in part on the internal "digestion" of the experience by the individual and the way that the family and the social context processes it'. In turn, the 'internal digestion' will be based on the processes available at the child's developmental level.

Practitioners are becoming more aware of how this digestion is influenced at all levels by dissociation. Dissociation defends against trauma by storing the experience in an unprocessed, fragmented state which ensures that it is excluded from consciousness. Putman (1993) describes how children can resolve what Driver (1998) terms the 'moral double bind' of repeated abuse via the use of dissociative coping mechanisms. Listening to children shows us that disclosure is a process rather than an event.

The concept of disclosure as an interactive process is underlined by Sorenson and Snow's analysis (1991) of a large number of confirmed cases. Purposeful disclosure took place in only 25 per cent of cases. For the majority, disclosure progressed in phases, initial denial (79 per cent) being followed by 'tentative disclosure' as a common middle step (78 per cent). Active disclosure (96 per cent), recantation (22 per cent) and reaffirmation (93 per cent of those retractions) were part of the process. A similar pattern was noted by Gonzalez *et al.* (1993). Their findings support the notion that silenced children, particularly those involved in sadistic or ritualistic forms of abuse, cannot respond readily to investigative interviewing, but need active support, possibly involving multiple interviews, in order to move up the continuum. Our experience is of dealing with children who had already taken up an emotional position on the continuum and whose responses varied considerably.

The child's journey

This section is devoted to children's own words and experiences, in an attempt to understand what can happen to them and to relate this to their position on the continuum at the time of intervention and investigation. It is important to listen to children's accounts, as children may have quite a different framework for thinking about and experiencing what we as adults call child sexual abuse. In

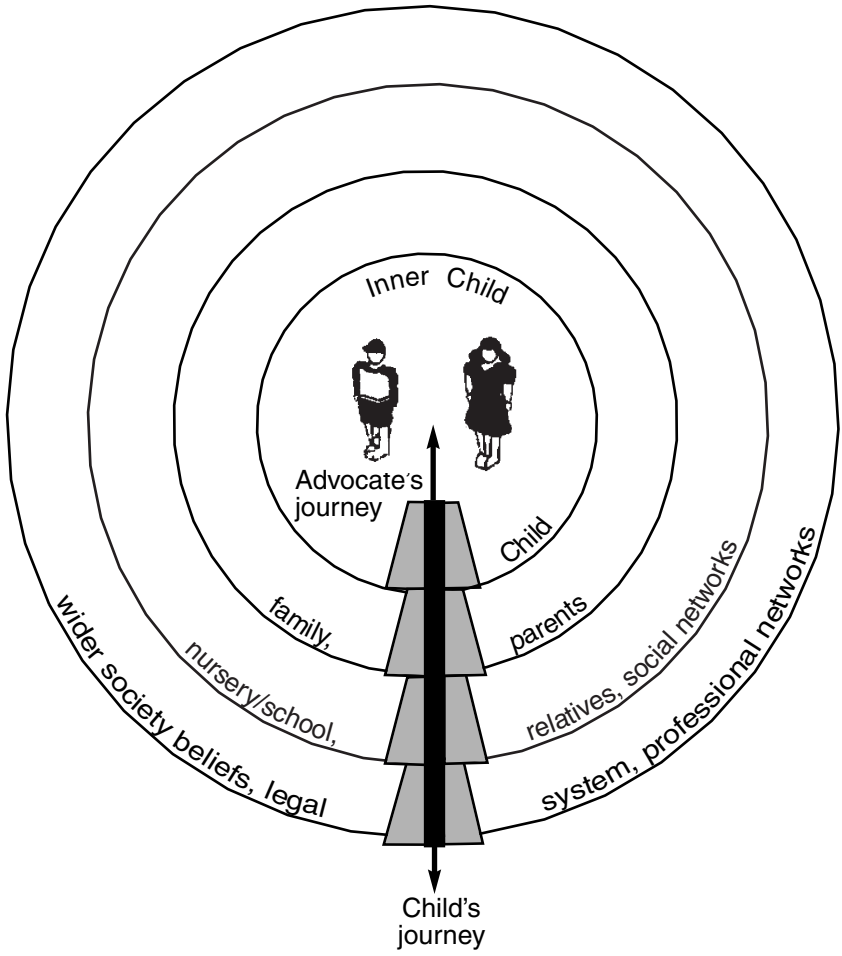

Figure 13.2 The child's journey from silence to disclosure

our model the child is envisaged in the centre of a series of concentric circles, the innermost being the family, the next the social context, and the outermost the systems for intervening in the family, namely the child protection agencies (Figure 13.2).

Several boundaries have to be negotiated for children to register their plight. If this produces an unmanageable crisis, the family or other layers of the system will often be able to block the disclosure process. However, an advocate may be able to reach the child, listen to what the child is trying to say, and provide a safe way for the child to negotiate the boundaries. Children may get stuck at any stage, but the advocate can guide them through the layers.

In practice, we have found that children tend to fall into three groups on the

continuum. The first group are those who spontaneously move to the top of the continuum and disclose: the second, those whose disclosure needs to be facilitated over a period of time, often under specific conditions such as safety: the third, those for whom the abusive experience is and remains inaccessible, either because of age, or the effects of dissociation, or through the accommodation syndrome. Summit's description (1983: 181–8) of the latter reminds us that disclosure is not the norm because the child's survival depends on a process of secrecy, helplessness, entrapment, delayed or conflicted disclosure and retraction. A large number of children who present for evaluation therefore probably fall into the second and third groups on the continuum.

Group One children: spontaneous disclosures

Girl, fifteen years who told her mother that her father was 'interfering with her'. At the police interview she said: 'He took his penis out and got me to rub it. It felt like jelly at first and then became big and hard. He had hold of my hand to rub; then sperm came out of it'.

Girl, seven years to her mother: 'He comes in my bed and kisses my tuppence.'

Girl, three years to mother and police officer: 'Daddy wee-wees inside my fou-fou.' (What colour is the wee-wee?) 'White.'

Characteristics of children in Group One

A developmental model such as that proposed by Baker and Duncan (1989) suggests an age-related progression of emotional reactions to abuse which leads to symptom formation. The earlier emotions remain but are overlaid at each stage. The progression is from anxiety (pre-school) to guilt (six years onwards) then justifiable anger (eight years onwards) to grief and desolation (twelve years). In this model, each emotion may generate denial, which emerges as the most important internal coping mechanism for the child, or outward expression of the feelings in characteristic symptoms. Baker and Duncan suggest that the stage most likely to result in disclosure is that of anger and injustice. The child may exhibit antisocial behaviours, such as violence, promiscuity, minor crime, running away, wetting and soiling, or may direct the emotion against themselves, in such forms as parasuicide, secret self-destructiveness, drug dependency, or depression. We suggest that an emotional shift, similar to that seen with age, will accompany a move in the child's position on the continuum. Helping the child to move from an internalised coping mechanism, namely denial, to an externalised one where disclosure is possible, will involve gaining access to a wider range of feelings.

For children in the first group, already near the top of the continuum where the possibility of disclosure is greater, we contend that the tasks of intervention and treatment are theoretically easier. The children have a shorter distance to

travel or may be more likely to move. They have their own momentum which helps to carry them to a point where they can engage with helping adults. For this group, there is a greater possibility of matching the intervention to the child's needs. The child has won, or is ready to win its internal battle and will permit the adult to intervene.

Nevertheless, problems remain. Most difficult and painful for the child of any age, but more so for the older child, is denial by the perpetrator. In Cleveland, few perpetrators admitted the abuse even when a clear and believable disclosure was made, for instance by an articulate adolescent. Children trying to break free from the secrecy of an abusive relationship which has possessed them depend initially on the presence of a non-abusing adult in the family who will believe them and intervene. Without such an advocate the family may negate the disclosure by rejecting the child, thus putting her in the role of double victim. Only an emotionally healthy child can choose self-preservation if it means leaving the family.

The implications for older children facing these pitfalls are that although they may remain safe from further abuse, they are a vulnerable group who require and deserve practical and emotional support in order to achieve independent living and to resolve their anger and grief. Otherwise they may become victims of the system, drift into other abusive relationships, take refuge in denial by developing a false and impenetrable persona, seek vengeance, perhaps by becoming abusers themselves, or simply become sad. Baker and Duncan (1989) pointed out: 'Denials are hurdles holding people back from facing the final desolating insight – if he could do that to me then I must have been worth less than nothing to him.'

There are also problems regarding the management of intervention for this group. To reiterate Summit's (1983) findings, this group is not the norm and it is necessary to change our expectations of how victims should react. Those who do disclose may have kept the secret for a long time or made previous attempts to tell and been disbelieved. Bentovim (1988) found that over half of children who were able to disclose had been abused for twelve months or more and the period prior to disclosure could be as long as five years. A sample of cases in Cleveland (Bacon and Oo 1989) found that few children disclosed during the initial investigation. The crisis itself prompted many adults to disclose for the first time, figures for the Cleveland Rape Crisis Centre (1988) showing a peak of calls in the summer of 1987. It is now well established that children do not readily make evidentially valuable disclosures during investigation, especially under the current constraints of the Memorandum of Good Practice (Department of Health 1992) for interviews. This is because children will rarely repeat initial disclosures during formal investigative interviews (Keary and FitzPatrick 1994), and are likely to take years before making an initial disclosure, during which time corroborative evidence will have been lost.

Even when the child is able to tell her or his story the disclosure is likely to be incomplete. When sexual abuse occurs repeatedly, it is very difficult for the child to describe a specific event. In trying to synthesise one description from a

series of events, the child may appear inconsistent, muddled or confused, and this may lead investigators to conclude that the evidence is unreliable (Prior *et al.* 1997). Friedrich (1988) supports the experience of many therapists that children tend to under-report the duration, frequency and severity of abuse. Of a sample of sixteen children, six were found to have under-reported. A further four began to minimise what had happened and retreated into denial, illustrating the difficulty for children of carrying the pain of the memory of abuse.

However, for children in this group, their degree of dissociation or accommodation is not so great as to prevent them from breaking silence. A key factor on which the child is dependent is the response of the non-abusing carer, usually the mother, or the degree of validation received from another adult. Intervention strategies which enable the child to remain in his or her own home are then more feasible. For example, a five-year-old boy in Cleveland who disclosed to his mother that an uncle who had been babysitting had abused him, was taken to hospital and discharged straight away because of his mother's protection and belief. Even where the child can readily disclose, other factors can undermine the outcome. An example is given in Butler-Sloss (1988: 33) of how a twelve-year-old boy was under pressure to accommodate after disclosing abuse by his stepfather. The boy himself decided that the abuse would not be repeated and that he 'was going to make it work and behave himself' (Itzin, chapter twenty-one).

Factors undermining successful intervention include insufficient evidence for a prosecution, even where children can maintain their position, and the age of the child: by definition the decision to disclose can only come with maturity. Although young children can make clear spontaneous disclosures, problems of evidence for the courts can undermine the outcome. Abused boys, as indicated by a review of research (Vander May 1988), and continuing lower levels of abuse reported by boys (Kennedy and Manwell 1992), may find it difficult to progress from the lower end of the continuum. For boys in particular, worries about sexual orientation can prevent disclosure as the child gets older.

Older children subjected to prolonged abuse

This model is helpful in understanding the complex inner world of children, usually approaching puberty or already adolescent, who manage to reach the top of the continuum after a long period of abuse. Of the few children in Cleveland who made a disclosure before the formal investigation, the majority were in the older age group. Older children may survive by accommodating (Summit 1983) and suppressing the experiences of earlier childhood, some parts of which may remain inaccessible to the child despite a decision to tell. This could be why some children focus on one recent episode, insisting this is all. A fifteen-year-old girl first told a teacher about a single event, being raped by her father one night whilst her mother was out. She did not describe a more gradual approach, beginning with suggestive

teasing, progressing to touching her breasts and so on, until she felt sure that her social worker believed her and had assured her that she was not to blame. Her initial story of rape could have been dismissed as it does not fit in with the currently accepted model that most intrafamilial perpetrators carefully 'groom' the victim, creating complicity in order to ensure secrecy (Christiansen and Blake 1990).

Problems of credibility in turn lead to management dilemmas. In particular, less pressure can be brought to bear on the perpetrator if the disclosure is incomplete. Older children, with compound reactions, are often very confused about blame, responsibility, and the part played by their own sexuality. These factors can prevent a full disclosure. The child may be heavily burdened with her compliance and active participation, or her failure to disclose and prevent the abuse in the past. He or she may then censor the disclosure, limiting both the nature and extent of what has taken place, especially if the interviewer emphasises that what happened was wrong. A sensitive approach can help the child by 'assuming' a much wider involvement and thereby giving permission to the child to tell, whilst avoiding statements about blame. Reassurances that the child was not to blame only apply to what is told: what was not told will remain as the part the child feels responsible for. A further reason for incomplete disclosure is that the child may have tried to tell earlier and been met with disbelief. If the child tries again, it is likely to be by presenting a small piece of information, carefully observing how this is received (MacFarlane and Waterman 1986).

Children often seem to discredit themselves in their attempts to conceal the perpetrator's identity. One six-year-old told of being looked after on a particular night by a relative who had an alibi. The girl gave small details such as the television programme they had watched. The details of the abuse tallied with her later disclosure about her father, but the investigation foundered because her story had been transposed into a different context. Older children may draw attention to intrafamilial abuse by signalling distress about some other sexual experience. A twelve-year-old disclosed intercourse with her seventeen-year-old boyfriend. Following the police interview she expressed her fear that the police 'might think it was her stepfather who had abused her'. On further questioning it turned out that the girl had regularly been shown pornographic material during access visits to her natural father. Investigation of a story of rape by an unknown perpetrator should always include questions designed to probe whether the child could be covering up for another abuser. Unfortunately it is all too easy to convey disbelief and prevent the child revealing the true picture.

Many abused children love and want to protect the perpetrator, and desperately fear losing the good parts of the relationship. They may eventually move beyond this by becoming angry on their own behalf, perhaps with the dawning realisation that their experience is not a normal part of childhood, or that the emotional closeness with the abuser was gained at too great a price. This healthy anger may at last prompt a disclosure, but the child will be devastated when the perpetrator denies the abuse and angrier still if the helpers to whom she has

entrusted herself fail to intervene effectively. A child who has come this far on her journey towards potential healing may then move back down the continuum, turning her anger inwards because it is denied outward expression. This can result in self-destructive behaviour such as overdosing, arm cutting, solvent abuse and promiscuity.

Younger children in Group One

We move now to the group of younger children who spontaneously make an alerting disclosure. We suggest that they can do so because they are less enmeshed in the abuse, which may be extrafamilial, of shorter duration, or less intrusive to the child, who may have a foundation of nurturance by, and trust in, adults to set against the abusive episode. The developmental model (Baker and Duncan 1989) suggests that the predominant emotional response of the very young child to abuse will be anxiety, which in time becomes overlaid with guilt.

Children can disclose passive experiences more easily than ones they feel they shared in or initiated. We may learn more about the abusive relationship and acts from younger children who are not caught up in this dynamic. A two-year-old girl, in hospital for investigation of physical injury, asked a nurse to touch her genitalia. Another eight-year-old girl alerted her foster parents about abuse by her natural father when she sat close to her foster father on the sofa and began to unzip his trousers. Sensing his horror, she asked 'don't you like it then?' He left her in no doubt that her behaviour was unacceptable. The next day the girl climbed into bed with her foster mother and began to caress her breasts, checking out whether this was equally unacceptable.

Children who have been sexualised by the abuse are often ashamed and distressed; it is hard for them to talk freely. One consequence of premature arousal of sexuality may be compulsive masturbation. A ten-year-old girl who asked for help with this, said that she had to 'go on until she got dizzy and then sometimes she got a pain in her back like electricity'. She was distressed that this happened in school and that she felt 'she had to love whoever was there when she opened her eyes again'. Other children feel that the abuse has damaged them, so that they will not be able to marry or have babies, or that they will be disoriented sexually. One little boy of six years said that his father and his father's (male) cohabitee 'were poofters, and I will be a poofter too and so will my sister'. Although not strictly relevant in a single joint interview for evidential purposes, efforts to understand the child's fears can help in treatment planning.

Some children may have a condensed memory of years of abuse which have blurred into one seemingly stereotyped event. Ongoing abuse tends to follow a set pattern, with entry and exit routines, and the child may be giving an accurate account. Demands for corroborative details such as dates and place, are essentially irrelevant to the child, but may cause such confusion that her story is disbelieved. A seven-year-old boy who said his father had: 'stuck his two big fingers up me gap (bottom) in the dining room' could give no details of time, the

whereabouts of other family members, or surrounding events, and could only say: 'about twelve times' when asked about frequency.

Because young children do not possess an adult frame of reference they may make puzzling remarks, often describing what they felt, or giving an analogy. A four-year-old girl said that her daddy 'put a toy inside her bottom'. When her social worker asked what kind of toy, she replied 'it's an extra leg on Daddy'. Another described a knife in his bottom. The adult may need to question gently before the child can give detail which can be seen to refer to an abusive experience. For example, a two-year-old boy who initially said of a babysitter 'He bitten my bum-bum', when questioned by his mother elaborated: 'Tail into bum-bum'. A police interview with a seven-year-old boy went as follows: 'He smacked my bum. He was poking me.' 'What with?' 'His finger'. 'Did he poke his finger inside your bum?' 'Yes he cut me with his nail, his finger nail. He said keep it a secret or I smack you more.' Another three-year-old said 'Daddy punches me in my tummy' but after the medical examination she explained 'Daddy wees on my tummy.' It is easier to protect children who can give more detail, especially if this is supported by medical findings. Their statements give us the best 'window' into how the abuse has affected the child. The initial investigative interview is a precious and often unique opportunity, which can point to treatment needs. However information about how the child understood the abuse, any threats used, and the extent of the abuse, may be lost at this stage, because many adults, on hearing a graphic disclosure, will not probe for more information for fear of distressing the child.

We must allow ourselves to hear and respond to what children actually say, as with a seven-year-old girl who said:

> 'I put my fingers up my bottom and up my front and I get feelings . . . I don't like a part of Daddy.'
> 'Which?'
> 'His tail.'
> 'Why?'
> 'It might hurt my tuppence.'
> 'Might it give you feelings?'
> 'Yes.'

Another eight-year-old had been found by her foster parents administering cream to her younger sister's genitalia, and simulating intercourse with her. On questioning she said:

> 'It's only what me Dad used to do. He used to pull his willy with his hand, he used to put it next to my tuppence.'
> 'Did it hurt?'
> 'No.'
> 'Were you frightened?'

> 'Yes I said it was hurting me and he said it shouldn't 'cos its doing you no harm.'

Descriptions by younger, prepubertal children show the unmistakably sexual nature of sexual abuse. Although most authors stress that child sexual abuse is primarily an abuse of adult power, we attach equal importance to the abuse of sexuality and the consequences this has for the child's sexual development (Bolton *et. al.* 1989.)

Some children take time to acknowledge that the abuse has hurt. Although we are aware (from perpetrators) that a gradual escalation of the intrusion can prevent major physical trauma, this is another reason why children who describe painless penetrative abuse may be disbelieved. However, the feelings may be unlocked once the child is confident that the recipient of the disclosure can cope. P. (a ten-year-old girl), gives this account:

> He put his finger up my hole – then he tried to put his thingy up, the thing where he wees out – but he couldn't. He tried to open me up a bit more, I was screaming all the time because he keeped hurting me.

P. suffered recurrent nightmares and separation anxiety.

In summary, younger children who are able to tell spontaneously may nevertheless need specialist interviewing techniques to help them share their experience in an understandable way. The resulting interview may not always be acceptable to an adult-oriented legal system. The children's strong feelings may be accessible in therapy when they may be extremely angry, aggressive, overtly sexualised or sad. The child has not accommodated to years of abuse before moving up the continuum, does not have to make a decision weighing the consequences of disclosure, and, if intervention to protect the child has to mean separation from the family, there is a better chance of successful substitute parenting. There is a range of responses and outcomes for children who reach the top of the continuum, but making a purposeful disclosure is generally a healthy action for the child. However, this will only benefit the child when the self doubts and guilt are understood and an alliance is made with the child which does not break down under the pressures of the investigation. This will almost certainly mean ensuring a period of protection, sometimes by removal from home, although the family may then scapegoat the child. We have seen that older children can weigh up the damage either way and many do not wish to be returned home.

We conclude that a positive outcome is often possible for children in Group One but there is a risk that the child may elect, by retracting the disclosure, to move down the continuum again in response to the crisis they see themselves as producing. On the one hand, if the child is the recipient of positive and protective responses to the disclosure, he or she may start to move beyond the abuse and be receptive to treatment for its effects. On the other hand, the child may be rejected by both family and external agencies in addition to carrying the unresolved consequences of years of abuse.

Group Two children: gaining access to the experience within

Boy, nine years Medically examined following disclosure by his sister of abuse by the father, who had been arrested and charged. No presenting symptoms or signs other than discipline problems. Fifteen days after the medical examination he told the psychologist: 'Something going up my bum, it felt yucky and hairy, I couldn't see because I was facing down on the bed'.

Girl, three years History of dysuria and complaint of buttock pain. Medical findings: hymenal opening 0.8 cm. with irregular patch on margin. Whilst in hospital she told a social worker: 'Daddy hurt me with his finger'. She demonstrated with a doll.

Girl, twelve years Medically examined after her older sister had spontaneously disclosed non-penetrative abuse by the father. Findings on examination: hymenal orifice more than 1 cm; irregular hymenal edge; reddening and oedema. After nine days in a family group home she said: 'He opened my legs with his hand and put his dick into me. He made funny breathing sounds and it hurt.'

Characteristics of children in Group Two

The second group is where there is a high index of suspicion and the child can be helped to disclose under certain conditions. The availability of an advocate for children in this group is crucial. The experience remains psychologically accessible to the child but cannot emerge without the advocate's assistance. In Cleveland, a sympathetic medical examination enabled several children in this group to move immediately to the point of disclosure, even after longstanding abuse. These children do not always need facilitative interviewing. In our experience, protection is often enough to enable them to speak. This involves, however, a degree of planned intervention which may include removal from home. The examination of siblings is also important to this group. In two families, involving a total of seven children, the abuse of siblings was discovered only following medical examination, even though in each case a perpetrator had been convicted in respect of one child in the family.

A key factor in the Cleveland crisis was that children in this previously rarely seen group were referred to the child protection agencies in relatively large numbers. Action was seen to depend on obtaining a supporting statement from the child during the formal investigation. If this was to happen the child had to move up the continuum fairly rapidly. This movement may be possible for children who are old enough to overcome the communication barrier of immaturity but are not yet trapped in the secrecy of the accommodation syndrome and have not dissociated from their experiences.

The predominant emotional underpinning for this group is a compound of anxiety, guilt and anger. Consequently a wide range of reactions will occur when the child's feelings come to the surface. The energy released by this process can

be part of healing, particularly when anger is positively connoted and at the same time safely contained by a trusted therapist. The reactions of the family may make it impossible for the child to go through this turbulent process without a safe space created by intervention.

Some children may be helped to disclose in a facilitative interview which focuses on overcoming the child's reluctance. However, since this reluctance has it's roots in the child's acute fear of crisis, loss of control, and panic, a facilitative interview may make matters worse. The merits and drawbacks of this kind of interviewing are considered in more detail for Group Three children, by definition those who cannot be facilitated to tell within the time-scale of the intervention, or indeed, at all. However, we often found facilitation unnecessary for children in Group Two. Ensuring immediate physical protection seemed enough to help children move to the point of making a disclosure during routine interviewing; simply recognising that the child might have something to say can 'give permission' to take this step. A sympathetic medical examination can include an opportunity for the child to comment on the doctor's statement, 'It looks as if something might have been happening to you down here.' A significant number of children (nine out of thirty-two in a group evaluated by the psychologist) disclosed immediately after the medical examination. For many others the main factor in feeling safe enough to break silence was separation from the possible perpetrator, especially but not invariably if the child had access to a supportive family member. Twenty out of twenty-three who made explicit disclosures were living apart from the named perpetrator at the time of disclosure; only one child was able to disclose whilst living at home with an adult abuser.

We suggest that children in this group are potentially flexible and undamaged enough to accept help provided a policy of active intervention is pursued. Although this is inevitably intrusive, we have found that children can cope with the upsetting consequences and eventually reach a healthy resolution both of this and of their whole experience of abuse. This may be because, as with the younger children in the first group, the abuse has been detected at a relatively early stage, is still emotionally and psychologically accessible to the child, and there has been a relatively short time to learn patterns of behaviour which might protect child and perpetrator in the short term but will be damaging to the child in later life. Unlike very young children who are more likely to remain in Group Three, these children are old enough to communicate their experience in an understandable way. A worrying feature of this group is the demonstration that very many young children are already enmeshed in the secrecy of routine penetrative abuse and are unable to make a spontaneous disclosure.

Taking notice of what children say and do

Many children in Group Two came to attention in Cleveland in 1987–8 via another child in their family rather than being a cause for concern in themselves. Various symptoms might then be recognised, such as wetting, soiling,

fearfulness, insecurity, sleep disorder and regression, acting out and sometimes preoccupation with violence and sex. One such boy, aged nine years, was seen in a family session where his mother explained why their older sister had been removed into care. The girl had disclosed long-term abuse by her father, who had been arrested after making a limited admission. The boy, who was said to get on badly with his sister, described his intense anger at the father, saying that he would sleep sitting by the front door every night ready to knife the father if he tried to return home. A younger boy sat hiding his face on hearing his brother speak. Their drawings showed large monsters eating or overwhelming small figures. After this session both children were medically examined, when signs consistent with anal penetration were found. The boys confirmed to the police that they had been abused over several months, and the older boy told of being asked to stand guard at the front door in case anyone came when his father was upstairs with his sister. The younger boy told of digital and penile penetration:

> He was sitting on my back he got on top of me with Dad's hands on my head. He did different things – his willy was big and hairy and it stuck up P's bum, sometimes a hand, sometimes a willy.

Neither child had previously told anyone.

Sometimes the child's disclosure seems bizarre and unrelated to sexual acts. Rather than risk a move down the continuum the intervention should give the child time to make the meaning clearer; this may require a structured and authoritative intervention. One eight-year-old girl noted in the Cleveland Inquiry Report as disclosing that her father and his girl friend 'squirted tea in a syringe up her front' (Butler-Sloss 1988: 16) went on later to say that this had been a 'needle which pricked and hurted' and (several months later in therapy) that it had 'really been what Mummies and Daddies do to make a baby' but that this had been 'too rude to tell'. She said the abuse began with a game of doctors and nurses, which became Mummies and Daddies. This little girl, who presented initially via her GP with a vaginal discharge, made a spontaneous statement in hospital, shortly after the paediatric examination. Medical corroboration of her report enabled the investigating team to take her story seriously. Previous attempts to tell her mother had been ignored. Once the investigation was over and she was placed in foster care, she once again became reluctant to talk, wondering whether the therapist's promise of confidentiality could be trusted. She did not want her new Mum to know the details. The time in hospital gave what might have been the only 'window' into her situation.

A four-year-old girl who was terrified of brushes said: 'He sweeps me up with him in the bedroom, the brush hurts because he bites me with it, and he sweeps Mummy's head off with the brush.' Later on: 'He bites my bottom with the brush.' She pointed out a daddy doll's moustache. With safety and support children in this group can tell enough of their experience to ensure a successful outcome in terms of child protection, but it may be many months before fuller

details come to light. As with Group One, once children feel safe they may be able to acknowledge and reveal more serious prolonged abuse. One little girl of four years who stamped on, threw away and locked the daddy anatomical doll in a cupboard during initial interviewing, said that her mother had been 'at the chip shop' when Daddy had hurt her bottom. Later on, during a period in care whilst her mother was in hospital, she began to say that 'Mummy hurts me when she pushes the special soap into my private parts, tell Mummy not to do it any more.' The girl only began to tell of abuse by both parents after the psychologist had spent several sessions crouched in a large cardboard carton, obeying the child's injunction not to look whilst she re-enacted and gained control of the experiences.

It is very important to remember that children in the same family can be at different points on the continuum. Thus an older child who reaches the top of the continuum can be scapegoated as 'seducing' her father, and whilst attention is focused on helping the mother move to a less punitive position, younger children can remain locked in secrecy about ongoing abuse. We experienced this pattern in Cleveland. In one family where the father had been previously convicted and older children disclosed non-penetrative abuse, the younger children showed no sign of disturbance and were deemed 'too young to know' what had happened to their sisters. However, when medically examined there were signs of penetrative abuse which the children disclosed on being taken into care. The power of this family to close ranks and maintain secrecy was such that the mother, although participating in family work where she heard her pre-pubertal daughter describe being raped and her six-year-old son describe being digitally penetrated and threatened with murder, later went on to assert that there had been no abuse. These two children then retracted their disclosures and eventually the family was reunited. Helping the children to move up the continuum had only a limited value in the longer term when the social services had no mandate to intervene further. Professional disputes about this demonstrated 'conflict by proxy' (Furniss 1983) which added to the difficulty of matching intervention to the children's positions on the continuum.

In summary, for Group Two children, years of further abuse may be prevented and the child given help, provided the intervention is authoritative in ensuring protection from ongoing abuse and from the reactions of others to the crisis of disclosure, and supportive of the child's need to express difficult emotions. Without intervention the child would have to make her own way up the continuum with the concomitant risks of being overcome by the processes of accommodation denial, and dissociation. Children in this middle group need to be identified and offered appropriate help while they can respond. Since they may be the group able to change their position most significantly, it is vital to tailor the intervention to their individual needs. Otherwise, there is a risk of their moving down into the third group of children who remain unable to disclose, even when they present with a high index of suspicion.

Group Three children: trapped in silence

Pre-pubertal girl, nine years Recurrent urine infections from three years, daytime wetting, history of intermittent bleeding which mother thought was menstrual. On examination intact hymenal ring admitting index finger (1.5 cm), rectum fissured and dilated. The girl vehemently denied that anything could have happened although her mother had told the social worker of her own worries.

Girl, eleven years Hymenal opening ragged at seven o'clock position, introitus two cm. This girl who had presented with hysterical fits and night terrors was extremely distressed on gentle questioning (during a clinical session rather than an investigation) and repeated 'nothing has happened, I would tell you if it had'.

Note

In Cleveland in 1987 these girls were identified by the paediatricians as having physical signs and symptoms suggestive of child sexual abuse. The second opinion of a police surgeon, however, was that the findings on both girls were within normal limits. Policy at that time dictated that intervention could not proceed on medical grounds without prior agreement on the significance of the medical findings. No case conference could be held, and as neither child disclosed they both remained at home with no further action.

Characteristics of children in Group Three

Children in the third group present with very similar signs and symptoms to children in Group Two. Despite indicators of abuse, including medical findings, which must be taken seriously, on investigation the child is unable to disclose any evidentially acceptable details of abusive experiences, or may completely deny them.

The existence of a dissociative condition (Putman 1993) should be considered in respect of these children. In contrast to Groups One and Two, they are on a different point on the continuum in relation to their inner world, external factors or developmental maturity. Very young children, without the means of verbal communication, will automatically be placed at this end of the continuum unless they have a committed advocate willing to act on their behalf. MacFarlane (1986: 45) notes the dilemma for the child and the professionals who both may have to wait for the child 'to grow up and become more verbal before anything can be done'. To circumvent this dilemma for very young children, we consider that the role of the medical examination can be crucial. Our developing understanding of organised abuse including ritual forms, which induce dissociative states through fear or a deliberate use of conditioning techniques, suggests another group of children who will tend to be placed in Group Three on the continuum.

Another difficulty is in identifying and characterising those children who will

tend to remain stuck in response to intervention. It is clear from the accounts of adult survivors, that children have previously been left to make their way along the continuum on their own. Many have found it impossible. We believe that there are dangers for this group of children in aiming for the 'middle ground' recommended by Butler-Sloss (1988: 183). The task of setting up systems or seeking to balance interests, while helping some children, will not, of itself, provide solutions. As MacFarlane (1986: 80) says: 'Giving abused children permission to tell secrets that they have been warned not to divulge puts them in an emotional double bind virtually unknown to children who do not carry these kind of secrets'. The defence mechanisms used to survive the abuse can be difficult to overcome. In addition, the behaviour of the perpetrator has to be considered a vital part of the equation.

Research by Budin and Johnson (1989) and Conte *et al.* (1989) found that a sample of convicted male offenders had employed a range of knowledge and strategies to select the most vulnerable victims and obtain their compliance whilst minimising their ability to protest. The offenders indicated that some of the concepts behind prevention techniques such as 'saying no', were not likely to be effective in response to their selection and coercion of children into sexual activity. Our experience in Cleveland confirms this picture of perpetrators changing their behaviour according to the status of the child, even within the same family. Children who have been thus trapped or coerced into silence by the perpetrator, or by their own internal defences against the traumatic event, are not necessarily able to respond even to the most ideally planned intervention. Moreover, the needs of this group risk being overlooked or denied if we are reluctant to use assertive legal intervention.

Some reasons why Group Three children cannot disclose

These children come to professional attention indirectly, perhaps via a disclosure from another child, often a sibling, who has witnessed or been involved in abuse, or because of medical findings which suggest chronic penetrative abuse, venereal disease, or rarely, an admission by a perpetrator. Despite protective intervention they remain unable to speak. Doyle (1990: 1) gives convincing reasons for the apparent paradox of children in this group, who apparently resist rescue. Many seriously abused children will defend their parents, guard the family secret, and try to avoid removal from home. Like victims of kidnap and captivity they depend on their abusers and may come to feel responsible for them. Continuing abuse can lead to despair and to helpless behaviour even when chances of escape are offered.

These children may have fragmented memories of their experiences (MacFarlane and Krebs 1986: 83).The presence of such memories is indicated by avoidant reactions and negative associations to material presented by the investigator. Repression acts later as the 'psychological time-bomb' frequently reported in the literature. It also functions as an important survival mechanism for children who do not see disclosure as an option at the time of the abuse

(MacFarlane 1986). Some children in this group will be pre-verbal: one little girl was seen because her six-year-old brother gave the following description of the father's behaviour on access visits: 'He (Daddy) sticks his tail up D's fou-fou, his tail is bumpy'. On examination the three-year-old girl had physical signs of a scarred lower vaginal wall but an intact hymen. She had not disclosed, but suffered from sleep disturbance, stomach ache and bedwetting, and her mother had noticed rectal bleeding.

Older children in this group rarely present for evaluation until the medical 'window' provides a way in. They evince the greatest puzzlement, confusion and controversy, because the key to reaching and helping these most damaged children lies in understanding why they deny abuse. Attempts to help the child break silence may be met with misunderstanding and sometimes hostility. These children are very likely to deny that anything has happened, and to become extremely disturbed when asked to consider the concerns of the adults who wish to intervene on their behalf. Children who have been involved in organised or ritual abuse, particularly where they have been inducted into sexual behaviour with other children by an adult, or forced to commit destructive and hurtful behaviour, are very likely to fall into Group Three. Sophisticated and psychologically destructive techniques are used to silence them, and silence may be maintained by cues triggered in even the most child-led interview.

As a way forward for the abused child who remains trapped in silence, we suggest paramount consideration be given to entering and understanding the child's inner world. These children are likely to be the most emotionally damaged. Some may have lived in an abusive environment for a long time and their degree of accommodation may be such that they are unable to respond to being removed from it. Other children may have lost the memory of the abuse so that the experience has become inaccessible. These children can be severely puzzling to the intervening adult, because their lives are effectively split by the dissociative process. Provided the child has been accurately identified as belonging to this group, a low key creative response which allows the child to unfreeze may be better than a formal interview with the time pressures of an investigation, but it must be recognised that some children are beyond reach.

We need to acknowledge that the impact of intervention such as removal from home may cause these children to increase their defences against the pain of what has happened to them. The problems of evidence in such a case are acute. The believing adult may come under pressure to retract, with the result that such cases are lost to the system. The child is left frozen in fear, from which even the most enlightened intervention may not free them. As one survivor (Sharratt 1998) puts it, by the time help came, 'it was already too late for me – the terror had already set in'. MacFarlane (1986: 83) reminds us that repressed memories are 'rarely retrievable during short-term intervention' and support and involvement may be required over a long period.

Understanding the child's inner world

Child advocates finding themselves faced with these circumstances need to hypothesise about what may be happening in the child's inner world. When faced with some very dissociated or accommodated children, an initial hypothesis based on alerting signs and symptoms may be all an advocate has.

Adults who choose to work this way may themselves be rendered powerless to help because they may be rejected by the adult world. It may be helpful however, to consider some hypotheses, beginning with the key nature of early experience up to the age of three. At this stage of development, the child does not have the mechanisms to deal with trauma to the emergent sense of self. Miller (1987) quotes Winnicott's comparison of the infant's emotional world with that of the psychotic. Psychological survival can only be assured by splitting off the memory of abuse by an adult upon whom they are dependent. The experience then becomes inaccessible to consciousness. Finkelhor (1986) notes the deepening of trauma over time. The effect of early signals being ignored is also described from the victim's perspective by Butler (1985). Many victims in her study felt overwhelmingly betrayed by both the abuser and non-abusing carer for failing to recognise and stop the abuse. She describes how, by this time, irrevocable damage has been done to the developmental process and the child is unable to cope with the rage, frustration and conflict generated by the abuse.

The consequences may be as follows. The child may have to idealise the abusing figure if it is someone on whom they are dependent for basic nurturance and care. That is essential for the child's survival, to protect her or him from the threat of annihilation inherent in the violation by a trusted adult. Cases of extreme loyalty were noted in Cleveland. The Inquiry Report contains the evidence of a nineteen-year-old who had hated the abuse by her father and had wanted it to stop but 'for my brother's sake I didn't want my family split up. . . . I loved my father so much. I respected him as a father' (Butler-Sloss, 1988: 9).

The child's position may only be understood if the professional accepts the over-riding necessity to the young child of preserving the attachment bond on which the child's survival depends. For children who have had to seek ways of coping with intolerable conflicts, any attempt to dismantle their defences exposes them to the threat of unbearable emotional pain and confusion. The need to have regard to this may not coincide with the length and timing of an investigation. Ten years on, it is known that the time taken by some Cleveland children who have disclosed their abuse, has varied from one to five years. MacFarlane (1986: 45) notes that the younger the child, the more time will be needed for evaluation, and months or years of work with the same person may be needed to reach the point of disclosure. How to protect children over such a long period and provide the conditions of safety which they need is a difficult issue. The decision on intervention needs to take into account what Miller stresses: 'Children cannot achieve integration by themselves. They have no choice but to repress their experience, because the pain caused by their fear,

isolation, betrayed expectation of receiving love, helplessness and feelings of shame and guilt is unbearable.' (Miller 1985: 313).

In the absence of validation by an adult, the inability to make sense of perceptions, feelings, and cognitions which are so contradictory leaves the child no option but to separate from either the feeling or the thinking so that some consistent picture of the real world is achieved. This splitting or lack of integration may lead the child to rely solely on affective cues (reacting without thought), or solely on thinking (acting without feeling). This enables the child to cope with the 'intolerable confusion' referred to by Miller (1985).

Survivors who have regained their memories after many years provide a vivid illustration of one end of the spectrum of such processes. Sylvia Fraser's (1988: 15) autobiographical novel describes the recovery of her memory after a similar length of time. In order to deal with the unbearable conflict caused by the sexual abuse by her father she split herself in half: 'Thus, somewhere around the age of seven, I acquired another self with memories and experiences separate from mine, whose existence was unknown to me.' Her loss of memory was 'retroactive'. She could not remember anything sexual ever having taken place and forgot each incident as it happened.

Children becoming sexually aggressive

Some children try to integrate or master their experiences of traumatic victimisation by compulsively 'playing them out'. The child goes from a passive to an active role (helpless victim to dominant perpetrator), and this gives the child temporary or permanent relief. (Gil and Johnson 1993). Butler-Sloss (1988: 11) gives an example of a boy who was referred for investigation due to his sexualised conduct at school and had to be watched all the time to prevent him from molesting children. Johnson's research (1988, 1989) shows that children who molest other children are highly likely to have been abused themselves. Although this may be their way of communicating what has happened to them, in our experience this possibility may not always be taken seriously during investigation.

Children who become sexually aggressive towards other children will at the same time be very likely to feel guilt, shame and further helplessness. In Cleveland we did not fully understand or anticipate the process that some of the children had already been through to become both eroticised, and sexually aggressive to younger siblings, or the difficulty this created for such children when asked to disclose their own victimisation. Such children were virtually trapped in silence by the secret of their own 'abusive' behaviour. Their younger siblings rarely disclosed that this was part of the overall puzzle. The sexually aggressive child could not bear to name an adult perpetrator with whom they were so much identified. In addition, many children are confused by abuse which is masked as caregiving, or rationalised as loving behaviour.

Butler (1985) found that nearly all children she spoke to sensed that what the adult was doing was not right, although for some this realisation might take years to dawn. This can be accompanied by a considerable degree of mystification and

confusion, especially where the adult exploits the child's attachment. A survivor quoted in Butler (1985: 31) recalls that: 'When I was small, I never thought to get angry with Daddy. He was very gentle and kind while he was touching me. He never hurt me and it usually felt nice. I was just utterly mystified about him touching me that way'. Older children at the lower end of the continuum who feel this way are very dependent on the reactions of adults and the availability of an advocate in order to understand and trust their own perceptions. Otherwise:

> if children are talked out of what they perceive, then the experience they undergo will later be seen in a diffuse, hazy light: its reality will remain uncertain and indistinct, laden with feelings of guilt and shame, and as adults these children will know nothing of what happened or will question their memory of it. This will be even more the case if the abuse occurred in early childhood.
>
> (Miller 1985: 313)

The effects of interventions and their implications

Children in Group Three present us with the most difficult dilemmas in child protection. If, for example, strong suspicion is raised by a medical examination, but the child denies or cannot speak of abuse, one has to conclude that either the medical findings have been wrongly interpreted and no abuse has occurred, (a false positive) or that the child has been abused but something is preventing him from saying so. Experience in Cleveland seems to indicate that the process of investigation and entry into the legal system makes it more likely that the first view will prevail.

However, in the case of some children who did not immediately return to their families, those who cared for and talked with them slowly became convinced they had most probably been abused and effectively silenced. This applies particularly to a group of girls in the middle years of childhood, with signs of chronic genital and anal penetration. In the group evaluated by the psychologist none of these children disclosed. They may correspond to children identified by Wynne and Hobbs (Butler-Sloss 1988: 318), who are at the crossover point where, with increasing age, anal abuse becomes less common and genital abuse more likely.

Non-abusing mothers

The mother's position is crucial for Group Three children, who may feel that she is the only person who can 'give permission' for them to disclose. The mother may find herself in an impossible dilemma. Butler Sloss (1988: 8) comments that: 'in the conflict between her man and her child, the relationship with the man, and the economic and other support which she receives from him may disincline her to accept the truth of the allegation'. The problem is worse when,

as in this group, the child cannot say anything directly or clearly to the mother about sexual abuse. It will seem to be a choice between the word of the professional and the possible perpetrator. Mothers in Cleveland became subject to public pressure, the media portraying them as 'innocent parents' rather than separate individuals: anything else would imply that their partner was guilty.

How can a non-abusing mother in this situation support a child against her partner? When the public crisis reached a height, news cover was intensive and virtually one-sided. This was later mentioned in the Butler-Sloss Report (1988: 171): 'the impact of the reporting . . . can have a disproportionate influence on those caught up . . . .and may create uncertainty, confusion and injustice'. Social workers felt that the media coverage: 'created even more difficulty for some parents attempting to accept and believe what their children were saying . . . leaving the children confused, vulnerable and in some cases totally unprotected' (Nelson and Long 1988).

Many of the children may have watched on television their parents' public denial of abuse. They realised that a drama was being enacted. This enhanced the pressures for family loyalty and denial. Despite this some mothers still managed to support their children. One six-year-old girl, for example, who had gross physical signs of anal and vaginal abuse, initially named her grandfather but then became reluctant to say anything. She was admitted to hospital for investigation, her mother choosing to stay with her. Confusion arose when the signs reappeared even though the grandfather was living in a bail hostel following the initial allegation (Butler-Sloss 1988: 14). The mother agreed to suspend visiting by all male members of the family while a further investigation took place. In hospital S. was frozen, fearful, and regressed: she insisted on staying wrapped in a blanket. The mother came to realise that logically the perpetrator must be her husband and felt able to hint to her daughter, so as to give her permission to tell, that 'she had an idea who it might be'. That night S. gave her mother an unmistakably sexual tongue kiss and when asked who had taught her, she spelled out the letters 'daddy'. S. subsequently wrote this down during an interview with the psychologist. She was never able to write or say more than that: 'daddy had hurt her bottom with his fingers on the inside', but her drawing of 'daddy when he hurt her' gave many clues as to what had taken place: she pointed to the penis in her picture saying: 'and then he gets his razor out' (Figure 13.3).

She declared that as she had been asleep she hadn't been able to see what happened. This was a common assertion, and may be a distancing mechanism, perhaps protecting the child from the feeling of active participation. In any case sleep probably precedes and follows the event for many children abused at night. No further police investigation took place but S. remained safe from further abuse, initially whilst she stayed in foster care and later at home under wardship conditions. Interestingly the wardship judge decided not to hear the case, saying he felt he would be unable to reach a satisfactory verdict on the available evidence. This little girl had the benefit of a supportive mother but remained unable to talk freely about her experiences. She said later, on watching the television: 'I was a child sex abuse wasn't I Mummy, but I'm not now'.

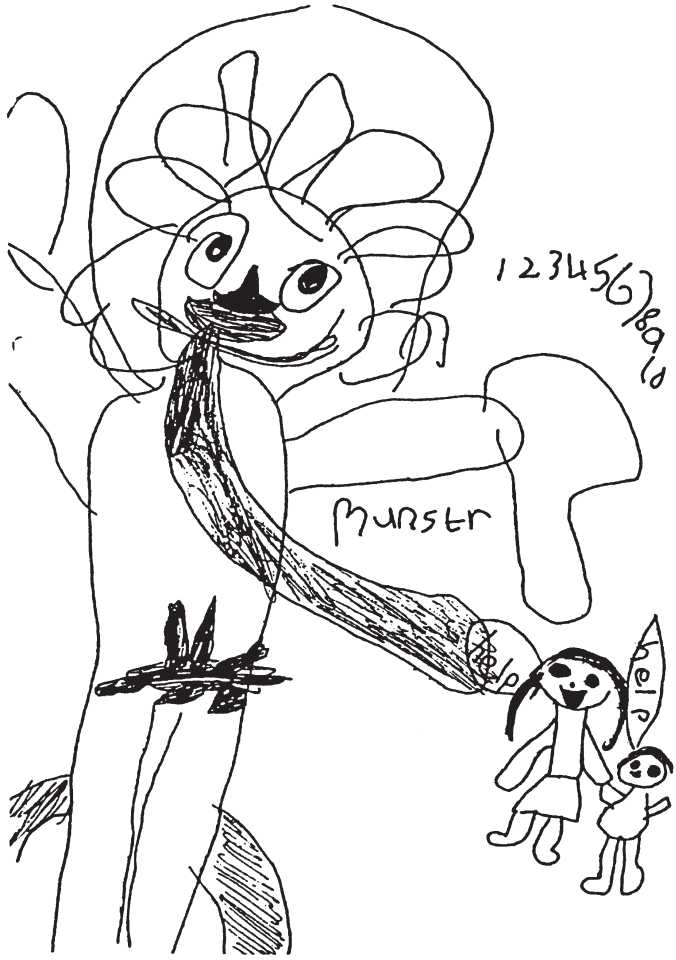

Figure 13.3 A girl aged six: disclosure by drawing

The tasks involved for a mother to become an advocate for her child are complex. Conerly (1986) emphasises the process of 'teaming' with the mother, who will be in crisis after the disclosure. Hooper (1992) identifies similarities between the processes involved for the mother and those involved for child protection workers. Her study demonstrates that 'such similarities do not lead to easy alliances'. Finding a way through this may provide the best protection for the child in the future, but may create immediate problems for the mother in separating from the perpetrator, nurturing the children over this period, and making practical decisions. Unless greater emphasis is placed on giving support without separating mother and child, mothers may have to turn to other sources of support, such as the perpetrator. The advantages of leaving responsibility with the mother throughout the period of disclosure must be weighed

against the danger that she may be unable to resist the pressures for denial from the perpetrator or other family members.

Processes of denial by the wider system

If the mother's position is ambivalent or unsupportive the child depends on the external system for help. Lawson and Chaffin (1992) reported that only 17 per cent of children whose caretakers were unreceptive to the possibility of abuse, were able to disclose. In Cleveland, such children fared less well. Although the process of accommodation to long term abuse has been well-described in the literature (Summit 1983; Sgroi 1984; Bentovim 1988), the concept is likely to be lost during legal proceedings, and the current format for investigation and presentation of children's evidence is unhelpful to most children.

Lack of regard for children as people may underpin the prevailing climate of public opinion: this was shown by press coverage of the Cleveland crisis which seemed to assume that the main issue was a dispute between parents and professionals (Newell 1988). In the words of Butler-Sloss (1988: 95): 'The voices of the children were not heard.' Children who remain unable to speak for themselves and lack the support of a believing parent, require advocates who can cope with their confusion and contradictions. As yet, the views of the child's advocate may not be given equal weight with those acting for the parents. This can create profound difficulties: 'If public agencies abandon the family when it becomes clear that a legally proveable case cannot be made, their actions become part of the problem' (Taubman 1984). Children are then caught up in a process of denial by the wider system, which in turn compounds their problems. Outside experts may be asked to comment, and may sometimes give opinions based on indirect evidence, not truly child-centred, which do not take into account what is known about the processes of accommodation, dissociation, and retraction (Vizard *et al.* 1987).

Group Three is characterised by polarisations and contradictions in medical diagnosis, psychiatric opinion, and interpretations of what children actually say. For example, a pre-pubertal girl who had been examined following a medical diagnosis of sexual abuse to her brother, had medical findings of 'gaping vagina, fixed open, hymen absent 1.5 x 1cm, anus lax, reflex dilatation to 0.5cm, with scarring six and twelve o'clock'. The second medical opinion was that this was 'consistent with digital or partial penile penetration; a third by a police surgeon was that the 'findings were within normal limits'. The child said virtually nothing on initial examination, but had confirmed on gentle questioning by the doctor that 'something had been poked up her bum and up her fanny.' She said that this was 'several times . . . over a long time' and that 'a grown-up living in her house' had been responsible. She later confirmed her brother's statement: 'I don't know what's happened – if it's happened – Dad might have put his penis up our backsides . . . this is how it really was' (demonstrating with anatomical dolls). A judge who saw videotapes of the interviews concluded that 'the children had not and did not disclose'. An independent psychiatrist acting for

the parents said: 'So far as the children are concerned I think it inconceivable that they could have withheld details or hints of what had happened if they have actually been abused.' The children said that what happened must have been at night. The psychiatrist added: 'In my opinion anal penetration and even less intrusive sexual abuse is very unlikely to occur during sleep'.

The pressures of the investigation are impossible for children like this, who remain at the bottom of the continuum. The best chance for them to talk is probably right at the beginning, as they soon become even more trapped by the family reactions. Sensitive and specialised interview techniques may be the only way to reach them, or alternatively, a chance to talk in the clinical setting before a formal investigation is started. There is inevitably a worry that the child will be silenced even at this stage. Problems in the initial investigation can consign a child to Group Three from the start. A pre-pubertal boy who was medically examined following a diagnosis of abuse to a brother, showed signs on examination thought to be consistent with sexual abuse: 'anus lax, reflex dilatation to 0.5cm., scarring to give smooth shiny skin, peri-anal redness, deep fissures twelve, two, five, seven, and nine o'clock.' Until that time, no concerns had been raised about the child and the only history of note was a previous referral for behaviour problems. The second opinion was that the medical signs were consistent with 'chronic anal abuse with penetration'. Like the majority of children caught up in the crisis, during the formal investigation that followed he was unable to tell of anything that had happened. The key to why may lie in what he later said to the psychologist about the police interview: 'The police seemed to blame it on me. At first I didn't really believe it when they said it was me, and now I feel slightly angry that it was like that. . . . You see, Dad sat with me when the police interviewed us.' It never became clear whether this boy had, as he put it, 'done something slightly by mistake' to another child in the family. However the police concentrated on this aspect, accepted this as the likely explanation of medical findings for the other child, and in the absence of any admission by an adult, closed their investigation. They sought no explanation for the medical findings on the boy.

A dilemma arises in such cases when no perpetrator is identified. In Cleveland, social services felt bound to act on what they saw as valid evidence of sexual abuse. In order to protect children, and to carry out further assessment of both children and parents, child protection procedures, including place of safety orders, were invoked. Where the perpetrator could not be identified or a protective adult found in the child's family, the children might be placed in foster homes. Some children in this situation were then seen regularly, by the clinical psychologist/social work team, over a period of weeks after the formal investigation had been ended but prior to any decisions by a court as to whether they had in fact been abused. The children have been described as 'double victims – of abuse and of well-meaning but misdirected and harmful responses to it' (Newell 1988). However, despite the trauma of separation from their families many children, although remaining unable to speak directly, expressed relief that they were protected. One girl, who agreed that 'she had had some bad touches

in her private parts', concurred with her mother 'that one good thing was that it had stopped' and told us that her recurrent nightmare of 'wolves with long noses coming into her room' had gone and that she felt 'sad and glad' to be in care. However, children who have been threatened with leaving home if they tell of the abuse, may react quite differently and vigorously deny that abuse has occurred.

Helping children to break the silence of fear

Group Three children often spoke in an oblique way. One highly intelligent and articulate boy at first seemed unaware of any past event that he could understand as abuse, but said that he 'believed what the doctors had told him, that: 'He had marks in his private place and someone had put something in to cause the marks'. He 'did not know what had happened', however, 'it must have begun before the family had moved house'; several years previously. He spoke hypothetically, prefacing his remarks with 'if it has happened'. The team adopted the same style, encouraging him to explore what might have happened.

This approach has been described by the team at Great Ormond Street (Vizard *et al.* 1987). It does not depend on the child making a spontaneous, unled statement, but aims to talk about abuse in a way that enables the child to speak. This has been much criticised, as inappropriate, misleading or leading, and there are doubts as to whether evidence obtained in this way can be legally helpful or valid (Waite 1986). Nevertheless it may prove to be the best way of helping some children, as in this instance when the child began to say 'what might have happened', volunteering that it was 'probably at night, when 'Mum could be out' and 'if it was M. (brother) it could be any time because Mum might take me shopping and then Daddy would look after M.' Whilst prefacing his remarks with 'if it happened', he demonstrated a remarkably sophisticated reaction which convinced us that this was a protective mechanism: he was unable to betray his abuser directly. MacFarlane and Krebs (1986) also advocate the use of hypothetical questioning: what does the child think an experience would have been like if it had happened? This can help children who deny abuse, especially where answers are needed urgently and the child cannot be left to come to a direct disclosure in his own timescale.

Conversations with children in this group help us to understand the cognitive and emotional tasks imposed on them when the abuse comes to light. The abuser may have taught the child that the experiences he has undergone are normal and unimportant, whereas the interviewer will regard them as significant and unusual. The child will therefore have to adjust his whole viewpoint. Prior to the publication of the Cleveland report, Vizard *et al.* (1987: 116) gave help and guidance for therapists working with such conflicted anxious children. They pointed out that 'no matter how long the therapist allows for the child to name the alleged perpetrator, this simply will not happen', and that facilitation of some kind is necessary. Even when it has been established that abuse has taken place there is a risk that the perpetrator is wrongly identified. In our experience

this is a real risk, as children do try to protect the perpetrator. Sometimes the interviewer can help children by reassuring them that this difficulty is understood. This remains a perilous path for the interviewer, who will be perceived as prejudging the issue, but it is a child-centred way to help the frozen and anxious child over the block created by the denial process.

The difficulty of breaking the secret is forcibly brought home to us by children who talk about their fears for the family. One child who named his father: 'Although I'm not saying that he has done it', broke down in tears, after a while managing to say: ' I'm frightened – I'm frightened about Mummy – I feel so sorry for her'. He went on to talk of his fears for the emotional and economic position of the family if his revelation led to divorce. At this stage it is vital to understand and give reassurance that these are adult responsibilities.

Some children want the task of disclosure to be taken by a protective and more powerful adult, in the hope that the perpetrator will then be enabled to confirm the child's allegation: 'I think, if you tell him, I think he did it to us, Dad might say who it is as well.' This is the point at which an advocate for the child must be willing and able to take over, thus helping the child with his burden. The problem in doing so is that the disclosure may be partial and hypothetical, with few or no details of what actually happened. Nevertheless the child has reached a vital point and his effort must be 'marked' in some way. However, telling the child that a partial disclosure is believed has legal as well as ethical implications. Butler-Sloss (1988: 205) comments: 'In Cleveland there was confusion as to whether some interviews were conducted to ascertain the facts or for therapeutic purposes or a mixture of both. It must also be clear whether it is intended to facilitate the child to speak and if so in what way'. However, a child-centred professional approaches any interview with a therapeutic aim whether or not facts are ascertained, or a legal decision has been made as to whether there has been abuse. In some cases where abuse had not been proven this sort of interview was heavily criticised for placing an intolerable burden of emotional abuse on the child. Such comments may reflect the distress experienced by adults on witnessing the child's pain. The real significance is that despite the pain and the absence of detail, the child has shared the experience. This means he can transfer to others the responsibility he carried, for keeping the secret for himself and for his family. In acknowledging that his experience is perceived by us as sexual abuse, the child entrusts us with the task of acting on his behalf. The ethical considerations here are almost overwhelming. How is any child to handle such an accidental disclosure which intrudes into the child's life and may require him to dismantle his defences, coping mechanisms, and eventually his perceptions and cognitive framework?

It is difficult to convey the certainty experienced in this situation that the child's emotion expresses a profound relief. This may be disqualified as simply a projection on the professional's part of the relief at finding an explanation. However we feel sure that at such moments we are the recipients of a momentous communication, with the power to alter things positively for the child. This feeling characterises all the purposeful disclosures we have received

from children in the middle years of childhood and from previously silent adults. It cannot easily be shared with a court or conveyed adequately in legally acceptable terminology. The admission of videotaped evidence as recommended by the Pigot Committee (1989) would have greatly assisted in child advocacy and in the central task of conveying the child's position to the court.

Another way to help the child who feels powerless is by confronting the denial which invariably operates in the family when children have been abused in secrecy over a long period. MacFarlane and Krebs describe a way of doing this:

> Some non-abusing caretakers and parents, particularly those in incestuous situations, are so disinclined to believe an interviewer's impressions or conclusions, and so unwilling to accept even the possibility of abuse, that it may be useful to show them the videotape . . . [of the interview] out of the presence of the child.
>
> (MacFarlane and Krebs 1986: 171)

We were criticised by parents in Cleveland for employing this strategy which they saw as deliberate cruelty. One mother said that a video clip of her child 'had said nothing to her'. How should we mitigate the pain of such a confrontation, without lessening the urgency we feel about obtaining help for the child from an adult who loves him? We must also acknowledge our own confusion and reactions when a parent is unable to take the step of believing. The professional must remain aware of the possibility of her own anger in response to the fact that a mother in such a situation may not behave in a way that might be expected or desired.

How medical findings can help silenced children to disclose

Some children who can acknowledge the medical findings of abuse, may then begin unlocking the experience. The following conversations took place after medical findings of abuse in a brother and sister both under eleven years:

Interviewer:	Would it just be a normal thing that happened in your family do you think?
Child:	Yes. . . . I think we would have thought that it was just happening to us on the spur of the moment – probably it was only happening to me.
Interviewer:	You wouldn't have been able to say to anyone else?
Child:	The first few times it happened, then I would have thought about it, and then I would have just forgot about it, it would be routine, and then I might not be able to tell you straight away that it is. He might have said, forget this has happened today, it will be our secret.
Interviewer:	I wonder what Daddy would have thought, what would happen if it wasn't a secret?
Child:	That he'd get into trouble.

The boy said he thought the same might have happened to their father as a child: 'daddy might have thought it was a normal part of growing up, that could be why he might have done it.'

Girl: But now he, since he's been married he would know it was wrong.
Boy: He would know; he couldn't change.

Such sophisticated conversations show how well children understand the dynamics of secrecy, and the consequences of disclosure. It is important to establish whether the child still feels at risk. One child in foster care had described his uncertainty about past abuse:

Child: I don't think I knew what was happening to me. . . . I might have sort of imagined, instead of seeing what was really happening, may be sort of being awake but like a strong dream or something, sort of being in a trance. . . . A trance is when something's happened and you – it's like being hypnotised, you believe not that it's happened.
Interviewer: How do you think you might have got into the trance?
Child: He might have said, go back to sleep or something like that. . . . Go back to sleep, I'm just coming to fetch something from your bedroom.
Interviewer: Do you think that if you went back home again-?
Child: I think I would start to know really because just say if we went back, now we know it's happened we might not fall asleep so easily, and be anxious . . .

One ten-year-old girl was quite certain of why abuse would continue:

Interviewer: Do you think if you went back home it would happen again?
Child: Yes. But the abuser might wait a while, so we sort of half forget it.
Interviewer: What makes you think it wouldn't stop altogether?
Child: Well, say I was pinching biscuits, I can't stop pinching biscuits. Might be an addiction. If the abuser's done that, he can't stop.
Interviewer: Do you think anything could help him stop?
Child: Yes. If the abuser said it was him. Or if he got some help – if he gained help. And then, he might feel sorry for the children, and all the worry we've had, and he might, part of him could recognise, it's a bad thing, and he shouldn't really do it. . . . Well I wondered, about us all talking and things.

It seems that relatively young children can have a clear idea that although the sexual behaviour is the adult's responsibility and is damaging to the child, the adult is himself unable to control it. Children in this group do not see disclosure as a real possibility. Two pre-pubertal children who were examined and taken

into care following diagnosis of sexual abuse to another sibling, were asked: 'What do you think would have happened if X [younger child] hadn't gone to see the doctor?'

Girl: It would just of carried on.
Boy: I think after a couple of years, when we were older, we might have found out what had happened and we might, have had the courage to tell somebody.
Interviewer: How old do you think you might have been before you were able to work that out?
Girl: I think just about married.
Boy: I think maybe we'd have to be in the senior school.
Girl: Just about leaving.
Boy: No not just about leaving, about maybe two or three years on from now. Because if you'd been older, then you wouldn't spend so much time in the family and then you wouldn't be so prone to this happening and you wouldn't be so docile to it.
Girl: What does docile mean?
Boy: Fragile, that's really the word, it's because, like if you're a slow runner and there's a fast runner, you can be easily caught can't you in a game of tig, but the older you get you're more mature . . . you've got more freedom then.

Children trapped in silence may be convinced that nothing significant has happened to them, because their perceptions have become distorted through the accommodation syndrome. The following conversation suggests this:

Interviewer: Say if you decided that you wanted to tell someone. How would you start to tell do you think?
Girl: I'd probably say, um, can I talk to you in private, and then I'd say, – I'd try to get to know you first, and then I'd say, someone's been abusing me, in a certain way, and then, I don't know what to do about it, what do you think I should do, and then, can you help me please.
Interviewer: And what would you say to convince us, we need to know a bit more than that.
Child: I might have gone to a doctor to convince me, to make sure whether I was right or whether I was making it up, to make more certain; like Dr X's photos and that.
Interviewer: We might not be sure what you were talking about.
Child: I might say how I'd been abused. I don't know really.
Interviewer: What do you think we'd need to know before we could do anything to help?
Child: Um – who it was. I'd say, and then, probably, write it down on paper maybe, or say it very quickly . . . if I said who it was . . .

Interviewer: Go on then . . .
Child: Daddy.
Interviewer: How do you know it's Daddy I wonder?
Child: I just know.

It is possible to see how adults (in this case, the mother) could disbelieve the child on the grounds that 'the doctors have put words in her mouth'. In fact the child may be seeking to validate the unbelievable by reference to an authority figure who can have equal weight with the parents. In this case the child later shifted stance in line with that of the father, who told her that he did not believe the abuse. The child replied, 'I only accept that I've been abused because I've been told by the doctors.' A confused and frightened child cannot resist such re-framing, which will lead to retraction of the disclosure in many cases. Such children seem to inhabit a topsy-turvy world where they are uncertain of the validity of their own experiences. A vehicle of expression which does not depend on words may be helpful. Older children in this group were aided by the use of anatomically correct dolls, a technique usually reserved for much younger children.

A similar confusion for the child about whether forbidden things really happen or not was shown by a six-year-old girl who presented with sexualised behaviour. When telling of an assault by an older child in the neighbourhood she reported that her much older brother had said 'It's alright for your big brother to do this but not for someone outside the family.' When questioned as to whether her big brother had done anything, the child said, 'I don't think he has done really because Mummy would be cross if he did.'

The child's need for secrecy to protect the abuser can involve a delicate balance when there are other vulnerable siblings or adults. Sometimes children may be helped by an analogy of the family on a see-saw, with them at one end and the abuser at the other. The children are asked to place themselves to show whom they are protecting. In one family a girl who had made a partial disclosure placed herself at the opposite end, i.e. not protecting the abuser. Her brother placed himself in the middle, balanced between protecting the abuser, by not telling, and the younger children, by telling. After making a partial disclosure himself he moved his position to the end with his sister and crossed out the word ' abuser', replacing it with 'Dad'. The mother was then able to respond to this by saying that she had been at the middle point but could go on to place herself at the end with the children.

Some children become so dissociated from what has happened that they cannot recall the abuse. Two children, a girl aged ten and her brother aged eight, whilst initially able to tell of penetrative abuse by their father, later 'forgot' about it during the investigation. The girl later changed her christian name, and the boy could only describe events in the third person, talking of abuse to an imaginary boy he named 'Peter'. An older brother had however witnessed the actual abuse. The younger boy and his sister were already distancing themselves from the abuse by choosing different names. This is reminiscent of those adults who

develop multiple personalities in response to the need to keep part of the inner person intact, or to split off the angry feelings. Although it is difficult to understand how such experiences can be forgotten, many adult survivors report loss of childhood memories. In Group Three children the experience may already be inaccessible. MacFarlane and Krebs comment further:

> Children who we have reason to believe have repressed abuse, i.e. where there are clear medical findings of abuse, where the child re-enacts molestation in play, or where there is evidence to suggest that all other children in their circumstances, especially in their family, were abused, usually need time and the emotional support that only long-term treatment can give.
>
> (MacFarlane and Krebs 1986: 84)

This can be misinterpreted by expert witnesses, who may conclude that a mistake has been made: a false positive.

Commentators have concluded, in respect of such children in Cleveland, 'Some children who were clearly not sexually abused were retained in the system far too long' (Bagley and King 1990). This statement highlights a central confusion which recurs whenever the events in Cleveland are debated. Since Butler-Sloss (1988: 183) found herself unable to consider the question of whether individual children had been abused, the public has been left in doubt. This has made it impossible for anyone to decide whether the cases were appropriately managed or not.

Principles of child-centred practice

Supporting the protective mother

We emphasise that the context of the abusive relationship is all-important in understanding the effects on the child both of the abuse and of disclosure. We stress the needs of the child for an advocate within the family. We have learned from Cleveland that the mother's response is one of the key elements in how the child will cope with the pressures to move up and down the continuum of disclosure. The importance of the mother's role is underlined by the way in which protective mothers have been targeted by the backlash. Some mothers, particularly those estranged from the alleged abuser or who have believed their child's account of organised abuse, have found themselves in a 'nightmare scenario' (Nelson 1994) in which they have been disbelieved and pathologised by the child protection and legal systems.

Mothers in Cleveland did not behave in a uniform or stereotyped way. It seems likely that, like children whose recovery from the effects of abuse depends on their developmental stage and emotional health, mothers will respond in different ways to the process of abuse coming to light. This view is supported by Salt *et al.* (1990) whose study reported considerable variety in mothers' response,

influenced by the quality of the mother's own relationships. Salt showed that more than 90 per cent of mothers showed at least a 'moderate degree' of concern for their child, and more than 80 per cent took some action to protect them. Seventy-seven per cent expressed no anger towards the child. The most difficult situation for mothers to deal with was an abuser who would not leave the child's home. When asked to do so, only 22 per cent of mothers could make this demand of the abuser. Another key finding is that almost half the mothers were as preoccupied with the effects on themselves as with those on the child.

In focusing on protective mothers we do not imply that mothers cannot or do not sometimes perpetrate sexual abuse, but this was rarely the case in the group of children we saw. We do not know with any certainty what influenced the mothers in Cleveland, but we observed consistently that if the mother could hear a clear account of an abusive experience directly from the child, this was very likely to elicit a protective and supportive response. The combination of advocates for both child and mother seemed to help children over the hurdle of telling their mothers. Mothers who were offered their own worker at a special resource centre in Cleveland could act more supportively towards the child and with less hostility to the professionals acting on behalf of the child. The mother's emotional dependence on the child may have been one important element for some children who wanted to protect their mothers from the consequences of their becoming able to tell. Sadly, some children accurately perceived that even with support their mother would remain unable to free them from keeping a protective silence.

This has important implications for children where the concern is not raised by a disclosure from the child. If we are to utilise the medical window into sexual abuse for these children we have to be prepared for the mother's problems in accepting not what the child, but a professional is saying. In such a circumstance the mother has a great distance to move along her own 'continuum of belief'. She may not be able to do so in time with the child. This is why a temporary period of separation between mother and child is so problematic for some mothers, who need the child's actual presence to reinforce their will to put the child first. Even if the mother does not see the child, the child will have an active image of the mother, and of what she is likely in the child's mind to say or do. Separation can lead the child further away from the reality of a mother who might react differently given support. Mothers may also be influenced by the child's age. Some mothers could not contemplate that their very young children had been abused, but tended to believe and sometimes blame older children. The outcome could be very positive for younger children where the mother did believe. This dimension may be underpinned by the length of time the mother perceived as elapsing before the child reported the abuse.

Once mothers accept that their child has been abused they go through a complex grief reaction which may include guilt, self recrimination, anger and depression. As with young children, we suggest that mothers who have more inner resources to draw on, and can accept and be offered appropriate support, will be better able to gain access to and express the full range of emotions

necessary for resolution of the crisis. We ignore the needs and strengths of mothers at our peril: they are the child's best resource and without them, children can only have a second best chance to overcome the effects of sexual abuse.

Advocacy for the child

The need to contain the problem of child abuse within manageable limits and avoid challenging the social structure of the family has produced a new orthodoxy, in which the emphasis has been on adult consensus at the expense of children's interests. Where adult and child interests conflict irreconcilably, the dilemmas of case management have remained unaddressed. We argue that if children are to be protected there is no neutral position to be taken: our response should be based on unequivocal advocacy for the child. This involves breaking an unwritten rule that the professional should remain detached from the family system, keeping an overview rather than taking sides. One important and overlooked factor in children's response to an investigation may be the way the child perceives the power discrepancy between themselves, the abuser and their advocates. The child's relationship with the potential advocate will depend on their position on the continuum of disclosure. The advocate will need to empathise with the child without becoming disempowered by legal and procedural requirements.

We believe that conflicts of interest should be resolved by allowing the interests of the child to take precedence over the welfare of the family or of other individuals. The child should not have to put up with continuing abuse in order to keep a family together. Many children remain in their families, subject to ongoing abuse, despite the best efforts of child protection agencies.

At the heart of the Cleveland controversy lay painful dilemmas of case management which arose from the medical diagnosis of sexual abuse in children who had not previously disclosed. The dilemmas for this group of children, still present in daily practice, remain undebated and unresolved. We believe that a medical diagnosis is sometimes the only way to begin to help such children. If the medical diagnosis of child sexual abuse is to be reinstated, its implications for the child, the family and the abuser must be carefully considered in the context of a debate that encompasses not only clinical practice but also the wider societal expectations of professionals.

We recognise the validity of the stance that any therapeutic effort directed towards the perpetrator is child protection work. Perpetrators are often trapped in patterns of thinking which rationalise and deny the meaning of their acts for the victim. Lindblad (1990) questions the assumption that few perpetrators make a confession, finding that eight out of nineteen accused of intrafamilial abuse were able to confirm what the child had said. More effective interviewing techniques for suspected abusers may help some to confirm the allegations. By helping children to talk and making their statements available, we may provide better ways to confront perpetrators with what happened. A note of caution here is that if the investigation still fails, the child whose confidentiality has been broken may be in danger. The best chance to protect children while at the same

time ensuring a therapeutic attitude to families may be to combine statutory authority to control the perpetrator, with support for the non-abusing caretaker, and treatment for the child.

Sexual abuse of children with disabilities and among ethnic minorities are neglected areas of study. Our experience in Cleveland did not extend to these groups. However, there is evidence, for example from surveys by Kennedy (1989, 1990) in relation to deaf children and Brown and Craft (1989) in respect of learning difficulties, which suggests that children with a disability may be more vulnerable to abuse and less able to climb the continuum without the help of an adult. As Stubbs (1989) points out, a perspective on race is also needed to inform child protection work. Kelly and McCurry Scott (1986) suggest a range of clinical issues where socio-cultural factors need to be considered, affecting utilisation of services, the helping relationship, perceptions and expectations. Russell *et al.*'s (1988) research confirms the importance of ethnicity as a factor to be considered in relation to abuse, the effects of which, she found, were more severe in Afro-American women. We suggest that in the wider context of our racist culture, the provision of advocacy which can ensure upward progression on the continuum will be even more difficult for children from ethnic minority groups.

Professionals as child advocates

Miller (1986: 18–19) comments that it was not until she wrote her books about childhood suffering that she found out how hostile society is to children and how this fact is ignored. Her writings capture the difficulty of acting for children where this conflicts with prevailing societal beliefs, where the memory of the advocate's own childhood hurts may be stirred and where the advocate risks rejection. Most adults, needing not to question the emotional sacrifices they made in their own childhood, are threatened by the stand of unequivocal advocacy. Miller's views are born out by Summit (1988: 45) who concludes that: 'unlike ordinary frontiers of discovery, sexual abuse provokes an authoritarian insistence for obscurity over enlightenment.' As a result, the task of protecting children will often have to be undertaken in a hostile or adversarial context. Surviving in order to carry out this task is as much a necessity as an act of courage, since: 'At stake is the survival of one's authentic self, and in this regard there is no alternative but to try to survive' (Miller 1986: 14).

We would define professional survival as the ability to remain child-centred and committed to working with the issue of child abuse, irrespective of the outcome for us as professionals when we may be criticised or restricted in our work. The authors have experienced maintaining this commitment in professional adversity. This has led us to understand the need for freedom as professionals to move on a continuum of our own, as shown in Figure 13.4.

Like the concept embodied in the continuum of disclosure, we view professional survival as a process rather than an event. A dynamic interaction of forces can produce the potential for movement in either an adult or a child centred direction. The child's distress can motivate movement either way, depending on

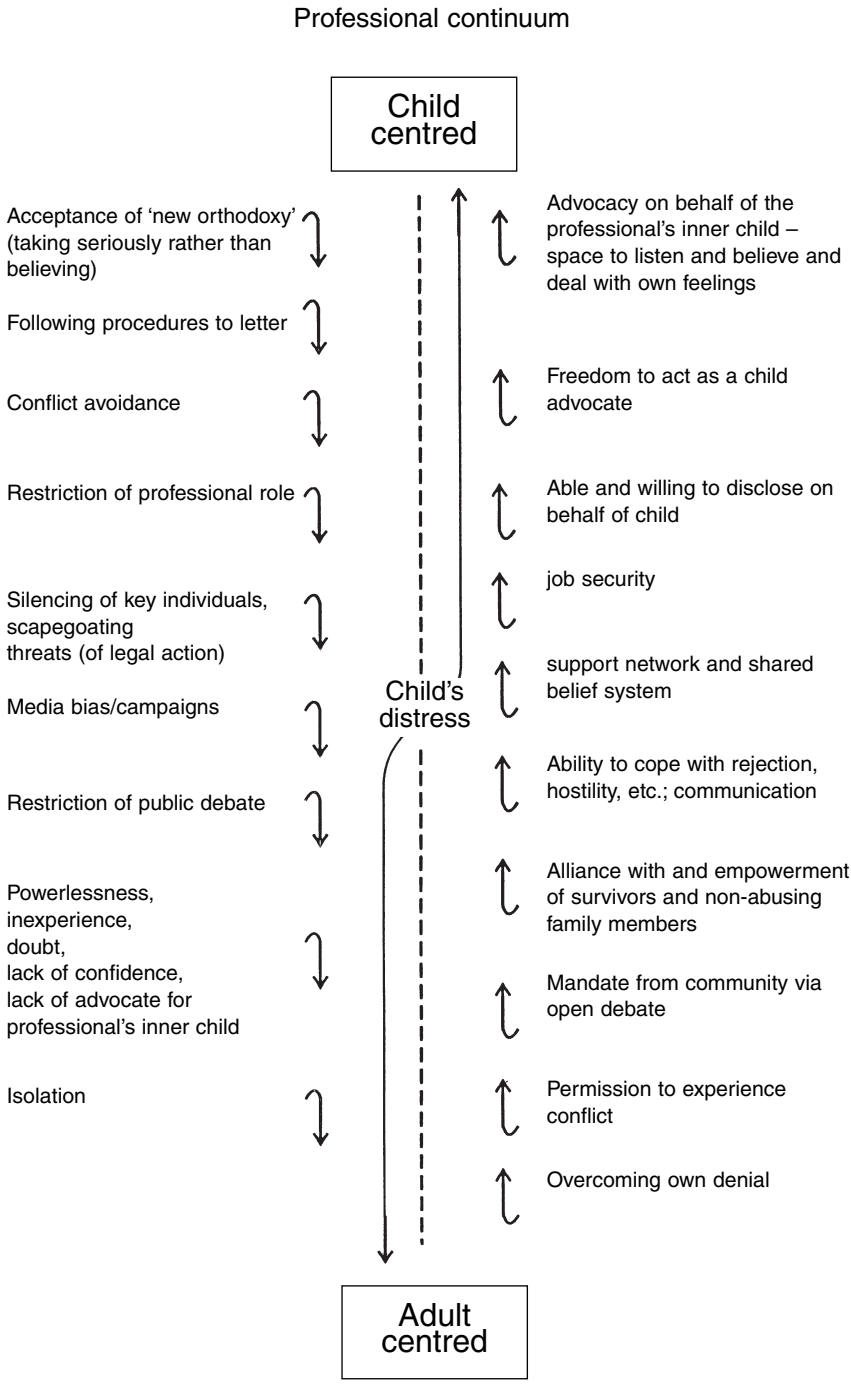

Figure 13.4 Pressures on child advocates: the professional continuum

how the adult perceives and copes with this. The interaction of conflicting pressures means that the advocate's place on the continuum can never be static. Decisions have to be made as to whether to shift position when this might lead to rapid and dramatic changes. This 'may in some small way mirror the process the child undergoes when sexual abuse is disclosed, and an appreciation of the enormity of the task strengthens our willingness to become involved ourselves' (Bacon 1988). In a different context social workers at the frontiers of ritual abuse who were praised by the high court for their work in protecting children were subsequently vilified and attacked, had their work questioned, and came into dispute with their employers (Dawson and Johnston 1989). There is a particularly powerful fear surrounding work in the area of ritual abuse. Hopkins (1989) has pointed out the need for staff care in the child protection field, and the pressures which can be exerted on individuals not to continue exposing levels of abuse which are potentially difficult for the organisation to handle. He makes comparisons with the Vietnam experience, involving estrangement from others, symptoms of post-traumatic stress and rejection from a world which does not want to hear. The particularly stark nature of this estrangement for those who work with child and adult survivors of ritual and satanist abuse is underlined by Sinason (1994). The profound personal and professional costs for workers who recognise the reality of such abuse are highlighted by Youngson (1994).

In our experience, it takes time to acknowledge the reality of finding oneself in this situation. The initial perception is of being in a 'short race' (Hopkins 1989). At this stage, which lasted for us up until the publication of the Butler-Sloss Report, the assumption is that a shift in opinion is imminent as the facts become known and resources are made available. Survival is taken to be a matter of maintaining one's position in the short term while alliances are made on the basis of rational argument. As events begin to stretch without resolution over a longer period, the realisation gradually dawns that the race has turned 'into a marathon' in which 'it requires stamina and commitment just to keep going' (Hopkins 1989: 17). By this stage, individual room for manoeuvre is likely to have been limited. Silencing and the imposition of restrictions on the work professionals are allowed to do are key factors which can threaten any movement on the continuum. These measures can be used by employers to defend their own interests in response to wider pressures from the media, parents' pressure groups and public figures. Unlike some countries such as Scandinavia and the USA, freedom of speech is not guaranteed in British law. Most employees, particularly in local government, are subject to conditions of employment which restrict this right. This increases professional vulnerability to attack since their inability to share their situation isolates them from other members of the community.

In Cleveland, the adoption of strategies whose prime purpose was the management of controversy rather than the interests of truth and justice entailed the closure of public and professional debate. For example, in the wake of the Butler-Sloss Inquiry Report, Cleveland County Council banned all discussion of events by its elected members and its employees for a period of

twelve months. It decided to draw a line under the past by removing key figures. This led to the departure of the Director of Social Services, Mike Bishop and of the Child Abuse Consultant, Sue Richardson. Marietta Higgs was transferred to a different health authority. Both she and Geoffrey Wyatt were restricted from dealing with child abuse cases. A financial settlement, without admission of liability, was made to aggrieved parents who had not accepted the medical diagnosis.

Efforts to prevent the making of a television documentary in 1997 on the ten year anniversary of Cleveland ('MP Stamps on Child Abuse Film', *Observer* 13 April 1997), illustrate the legacy of this strategy in terms of unhealed wounds. We had hoped that the Butler-Sloss Inquiry would act as a truth commission by establishing an agreed record of the past as a basis for everyone to move forward. Instead, eternal argument threatens to hold sway about whether or not the children were abused. The resulting climate of uncertainty, apprehension and fear of becoming the next target of controversy has inhibited workers from uniting in defence of their own and children's interests. The private anguish is not voiced. Professionals are expected to remain detached from events and even from their own pain. A distancing mechanism takes place, even from other beleaguered colleagues who fear adding to their own problems by identifying with their peers.

Advocacy for the advocates

What can be done to prevent this isolation and silence? Miller (1983, 1985) talks of the importance for the victim of having an advocate who will stand by them unequivocally. Advocates themselves need help in the task of identifying with the suffering child, to cope with the impact of the child's pain on their own inner world. Additionally, the advocate who chooses not to act as a 'servile representative of society' (Miller 1985: 155) will encounter external pressures. Without advocacy for the advocate, which often means relying on peers, it can be difficult to sustain the risks inherent in adopting a child-centred position on the continuum.

In learning how to support child advocates, principled leadership is needed which accepts controversy in this field as the norm and supports employees in their witness to injuries to children. The creation of a whistle-blowing culture is the best response organisations providing services to children can make to the challenges of the abuse of children entrusted to their care in the past, and of ensuring that services are safe in the present. This entails providing a supportive environment and repair work for staff suffering secondary trauma (Richardson 1999). To seize these challenges means affirming and developing a vision with the courage to be mistreated too, by standing alongside the child advocates or their staff rather than attempt to silence them by threats concerning their employment.

We emphasise that the development of practice should be informed by a guiding ethos of child advocacy. Post-Cleveland practice has appeared cordoned off by the process of giving adult rights more consideration than is given to children. In our opinion this new orthodoxy means that in practice, only children in Group One will be identified. By and large, children in Groups Two and Three will be left to

make their own way up the continuum. In this context one question which still requires an answer should be asked: what would society want professionals to do if it accepted the full reality and widespread nature of child sexual abuse?

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14 Helping girls involved in 'prostitution'

A Barnardos experiment

Sara Swann

Introduction

Barnardos is the largest childcare charity in the United Kingdom, operating over 200 childcare services nationwide. Established in the nineteenth century, Barnardos focused on child rescue, working with street children in East London, and it is an interesting reflection that while it has grown and developed to meet the demands of the 1990s, it has recognised the need for services for 'child prostitution' a hundred years later. Barnardos is committed to the development and maintenance of innovative work with children and young people. It is committed to working in partnership with other agencies, and most importantly with children and young people themselves, seeking to promote within its work the needs and rights of children, as embodied in the UN Convention of the Rights of the Child. I was the social worker employed by Barnardos to run the Streets and Lanes Project (SALs) in Bradford which is the subject of this chapter. Subsequently, I have been responsible for establishing similar projects in other areas of the UK.

In March 1995, Barnardos' Streets and Lanes Project (SALs) became operational. The project, supported and jointly funded by Bradford statutory agencies, provides services for girls and young women up to the age of seventeen who are at risk of, or involved in, what is commonly referred to as 'prostitution'. In order to inform our practice, we needed to know how a young woman became involved, why she stayed and what if anything, would support her in finding a safer future. In its first two years, we had contact with nearly a hundred children, girls between the ages of twelve and seventeen years of age, and we spent considerable time listening to their life stories and coming to understand their situation. The evidence from this work at SALs has given us a model for understanding the issues and this paper explains the process.

How girls become involved in prostitution

Talking to these girls, we have come to recognise a pattern of control, which not only facilitates their entry into the system, but creates a complete dependency which sustains their abuse through 'prostitution'. This is quite a defined process,

which has many similarities to the actions of other abusers, particularly abusers in domestic violence relationships, but also 'paedophiles'. The final analysis has been reproduced in the 1997 Utting report.

Seldom does a young girl make her own decision to 'sell sex'. Rather she is shown a way into this world by an older person, most frequently a man. An older 'young man', within the age range of eighteen to twenty-five years, begins a relationship with a vulnerable girl. This age range is not exclusive, as we have had examples of men in their thirties and forties, but it is certainly the most common. Interestingly, presently in law, a man below the age of twenty-five can use as a defence to the charge of unlawful sexual intercourse, that he believed the girl to be sixteen. The girls are usually in the age range twelve to fourteen years.

Stage one: ensnaring

When she meets her 'boyfriend', he impresses her through his maturity, good looks, money, car and lifestyle. He makes her feel special and important, lavishing attention on her, buying her clothes and jewellery, and often a ring as she then believes that he is serious and making a special commitment to her. They begin a sexual relationship and she falls 'head over heels' in love. This part is not difficult and can happen with the girl living at home. Contact will be three or four times a week and we have had many examples of girls being collected from the school gates by their older 'boyfriends' in cars.

There is an enormous amount of pressure on twelve- and thirteen-year-old girls in our society to 'have a boyfriend', and if you've got one who is older, good looking and materially successful then you have made it. He very quickly becomes the most important person in her life. Like 'paedophiles', these men are very plausible and can ingratiate themselves with the families of the young women. Their parents have commented that: 'He seemed such a polite young man, although we were concerned that he was a lot older than her,' and 'She really seemed to settle down after she met him.'

Stage two: effecting dependency

He needs to make her completely dependent on him. He becomes very possessive and she is constantly required to prove her love. If she loves him she does not need anyone or anything else, and she interprets this possessive attention as a sign of his passionate love. She thinks he is jealous. She feels flattered, comforted and even protected by his intense interest.

She willingly destroys particular objects of importance or sentimental value that have any significance to her life outside the relationship, such as photos, jewellery and address books, or he destroys them with her consent:

> 'You don't need that ring, if you want a ring I'll buy you one.'
> 'If you've got that photo of your baby, you love that photo more than you love me.'

In some cases they will even call the girl by a different name and psychologically this begins to break down her sense of autonomy. At the beginning she persuades herself that she's only making small sacrifices, that are not important, but gradually he destroys her ties to others. She can also become physically isolated, by agreeing to be kept in a room or flat, so that 'I could prove he could trust me,' and 'he could see I didn't need anyone else but him.'

Stage three: taking control

He now begins to control all aspects of her life, including where she goes, who she sees, what she wears, when and what she eats and even in extreme cases when she goes to the toilet. We have had two cases of fourteen-year-old girls who have been locked in rooms without toilet facilities and in one case she had to use a box with newspaper in a corner on the floor. This is completely humiliating and degrading. We have had many other cases of children being kept in flats and houses and on occasions being moved to separate towns. They are not visible on the streets.

This is the stage when he begins to be violent. Whilst most of the project users have experienced physical violence, it is often the threat more than the actual act that maintains them in a constant state of fear. His violent outbursts tend to be inconsistent, reinforcing petty rules, and is similar in ways to men's abuse of women in domestic violence situations:

> 'He hit me because I deserved it.'
> 'He said I did wrong and I've got to learn to do right.'
> 'You don't understand. He beats me because I need to learn: I need to learn and so he beats me. Do you get it now?'

Because he does not constantly hit her, when he stops it means that he is a 'good guy' really.

During this stage the girl often becomes frightened but she makes excuses for his behaviour not only because she cannot face up to what's happening, but because she still loves him. She justifies his behaviour by taking the blame upon herself:

> 'I know I really wind him up.'
> 'I shouldn't have, I was asking for it.'

She believes that one more sacrifice, one more proof of her love, will end the violence, save the relationship and her boyfriend will return to be the loving, caring person he was at the beginning. Similar to other victims of abuse, she feels it is her fault, she feels guilty. It must be her fault, because he used to be so nice, so she must have done something wrong to change him. How can she tell anyone, especially as she has boasted about the relationship to all her friends? She is alone and isolated and cannot believe that anyone

would understand. The granting of small indulgences at this point, such as soft drugs and alcohol, reinforces him as 'the good guy' and, again, is part of the process of undermining her resistance. It is more effective than constant physical harm and abuse.

Stage four: total dominance

This is the result of the three previous stages whereby he has now become the all important person in her life. He has created what can be referred to as a 'willing victim'. Simple compliance rarely satisfies him. He needs to justify his behaviour and he demands respect, gratitude and love. He also needs to know she needs his control. The final step is when she agrees to have sex, often with someone he describes as a friend, and she will never see any money change hands. We have known particular cases when young women have been put straight on to the streets and been watched and told how to earn the money. Sometimes the 'boyfriend' will demand that she violates her own moral principles, doing sexual favours for other men, by convincing her that he desperately needs her help:

> He owed money to a loan shark and they were going to beat him up, so I had to do it.

In another case, a fifteen-year-old girl was told to meet him in a night club at 8.00 pm. At 9.30 pm, a man approached her, asking for her by name, and offered to give her a lift. She was sexually assaulted in his car. The girl will endure extreme sexual humiliation, and will even entrap other girls for her 'boyfriend' and his friends, as a result of this completely dominating relationship. The triangle in Figure 14.1 depicts these relationships as the girl perceives them.

The term 'boyfriend' is crucial, as it is the young woman's perception of the relationship that sustains the control and abuse. The girl will never think of her abuser in any other terms than her 'boyfriend'.

Any relationship with an abuser is so intense that it takes on a quality of specialness, so that any future 'normal' relationship can be difficult, if not impossible, to sustain. This experience at any time in a woman's life is very damaging, and it can take an average of seven years for a woman to leave a violent partner. But for this to happen during early adolescence is even more damaging. It compromises the three essential adaptive tasks of the adolescent development stage:

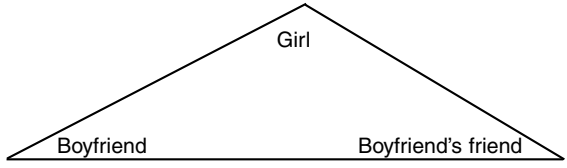

Figure 14.1 Child prostitution from the girl's perspective

- the formation of identity
- the gradual separation from the family, and
- the exploration of a wider social world.

After a few months, the girl can be 'sold on' to another 'boyfriend', although she is often not aware of that happening and her 'boyfriend' will move on to ensnare another vulnerable girl. Similarly, we were told that the 'boyfriend' of the last young woman who was supported to safety through SALs, had another thirteen-year-old within five days.

Re-conceptualising child prostitution as child sexual abuse

The pimp

In 1984 the Canadian Government commissioned a committee of enquiry into child sexual abuse in which they included 'juvenile prostitution'. In looking at the role of the pimp it is worth quoting:

> In the Committee's judgement, the relationship between young prostitutes and pimps encompasses one of the most severe forms of abuse of children and youths, sexual or otherwise, that currently occurs in Canadian society. The relationship is based on ruthless exploitation. The pimp exploits and cultivates the prostitute's vulnerability – her low self esteem, her feeling of helplessness and her need for love and protection. The cost to the prostitute of working for a pimp goes far beyond the earnings she gives him; it amounts to the girl's forfeiture of her future. Opportunities to obtain a better education, to become free of drugs and alcohol addiction, to sort out emotional problems, to return to a normal lifestyle and to enter a healthy, caring relationship are seriously jeopardised or permanently destroyed. The relationships between juvenile prostitutes and pimps are parasitic and life-destroying. In the Committee's judgement it must be viewed as a problem of the utmost gravity. It must be stopped.
>
> (Badgley *et al.* 1984)

In the UK, the maximum sentence for causing or encouraging prostitution of girls under sixteen is two years (Sex Offences Act 1956 Section 22). This is not an arrestable offence, and the girl's evidence alone is often not enough, as the Crown Prosecution Service usually require collaborating witness statements.

'B' is a fourteen-year-old girl with whom we at SALs had a fragile contact, and we learned that she had not been seen for two weeks. Staff were concerned as they had been given information by another project user, that her new boyfriend (twenty-three years old) had previously kept another girl (sixteen years old) virtually locked in for ten months. He was also known to have been extremely violent. SALs contacted the police (Vice Squad) with the address. An officer broke down the door and got her out, took her to the police station

and contacted SALs. The 'boyfriend' was never questioned or arrested as the girl said she 'wanted to be locked in'. They are completely loyal and will defend their abusers against any external threat.

During an interview with a researcher, a Minnesota police officer made the following analysis of the relationship between pimp and prostitute:

> The pimp–whore relationship is a very precise one, with rigorously defined and mutually accepted conventions. The primary one – a fundamental part of the game – is that she denies even to herself that he cheats her; and at the same time, she never cheats him. If she does, he punishes her, and in this morbid and pathological relationship she expects and even provokes the punishment . . . this dishonesty . . . is not just part of, it is the relationship. It is the emotional corruption which the young girls find almost impossible to erase or reverse, even if they manage to break away from the life.
>
> (Ennew 1986)

One fourteen-year-old girl came to the SALs project in an extremely distressed condition: both of her breasts had been burned with cigarettes and she had been raped by her boyfriend and by two other men, because she hid £10 in her shoe. She said she should not have hid the money, not that he should not have hurt her. At the same time, a young woman will believe absolutely that he is not cheating her, even if she knows that he is 'working' other women. 'But I'm special, I'm the one he loves, they are tarts, I'm not like that', she tells herself.

In an attempt to explain this, we can liken it to someone who is having a relationship with a married person. The relationship is often sustained by the belief that they will leave their partner. If the realisation comes that this is not indeed the case, then they are either half way to getting out or half way to staying in a possibly unsatisfactory situation. Similarly, in our work with these young women, if they begin to see the relationship for what it really is, then often they can begin to move onto a safer future. However, we have found that it can be almost impossible to promise the girls and young women protection, even when they are prepared to give statements outlining extreme incidents of abuse, as their abusers have many networks with people who frighten and intimidate them into withdrawing their statements.

An example of this was a fourteen-year-old girl who made a statement to the police against two men, who were subsequently charged with serious offences of abduction and kidnap, as well 'as living off immoral earnings'. They were bailed at court, with conditions that they should not approach the witness. Having then threatened the girl, they were remanded in custody. The following week the girl was overheard on the telephone, by residential care staff, saying, 'I know you can slash my face', and later told the police she wished to withdraw her statement. The police refused, but had no alternative when they received a letter from a solicitor informing them that the girl had made a mistake with identification in the ID parade. The men were released and the charges were dropped. How did this young woman know to approach a solicitor? These men are often extremely clever.

The punter

The Home Office Police Research Group, Crime Prevention Paper No. 43, observed that 'much less is known about clients than prostitutes'. Between 1989 and 1990 research looked at the nature and composition of the 'clients'. The findings indicated that a considerable number were married with children, and the report cited responses such as:

> 'Not that. I am a married man. I have got a small kid.'
> 'Look, I'm a married man with two children sir. I don't want this trouble sir. Can I speak to you about this?'
> 'Does my work have to find out?'
> 'Oh, come on officer. You are a young bloke, you'll understand.'
> 'Does this have to go anywhere? This is the first time I have done this.'

The other surprising factor was the age of the customers/punters, the vast majority being between twenty and thirty-five years of age.

When looking at the punter this scenario may help in offering some clarification to the issue:

> The police car approaches the suspicious vehicle reported in a quiet street close to the 'red light' area. Not knowing if they will find young lovers or a rape in progress, the officers shine their torches into the car. They find neither. What the officers do find is a man being masturbated orally by a thirteen-year-old girl. A radio check reveals that the man has no criminal history, not even a parking ticket on his record. The girl is another story. The check reveals she is a runaway. In fact, the girl is a chronic runaway, eight incidents in the last twelve months. Her criminal record includes arrests for drugs, burglary and assault on a police officer.

The police officers could handle this situation in a variety of ways:

1 arrest the man and charge him with indecent assault or an indecent act with a child under fourteen; causing or encouraging prostitution of a girl under sixteen; or public indecency; and take the girl into protective custody; or
2 release the man (warning or no warning) and charge the girl; or
3 take no action at all.

The triangle in Figure 14.2 shows our perception of this situation, that is, society's perception as reflected in current legislation. Each character in the triangle cannot function alone, and the supply side (the pimp) and the demand side (the punter) together ensure that the child is abused and exploited.

The police appear often unable to intervene to protect girls from adult male customers, as they are influenced by public attitudes and perceptions of that particular situation: 'she's that sort of girl, she was asking for it, she's getting

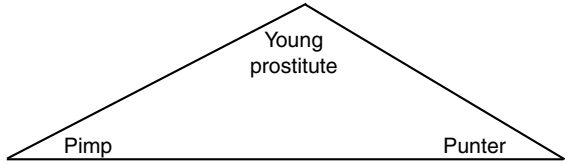

Figure 14.2 Child prostitution as reflected in current legislation

paid for it anyway'. Would the action taken be clearer if the man concerned was her teacher, social worker or her stepfather and why? Would the action taken be different if the thirteen-year-old girl was a thirteen-year-old boy? Is the law more protectionist towards boys?

We recognise that actually catching someone in the act seldom happens, and we know that much of this abuse is not visible on the streets, but happens behind closed doors. However, one fifteen-year-old was caught 'doing business' as she called it, and two men were charged with unlawful sexual intercourse. She said they had asked her how old she was before she got in their car. The men pleaded not guilty and went to trial at Bradford Crown Court. The young woman was obliged to go to court and give evidence, and of course had to confirm that she was 'selling sex'.

Judge Adams said in his summing up that this girl had been a prostitute since she was thirteen years old, that if the men had waited three months, until she was sixteen, there would have been no case to answer. He considered that the trial had been a complete waste of time. Both men were acquitted. It should be remembered that offences against children are usually 'strict liability', that is to say that a child's consent cannot make an illegal act lawful. Children *cannot consent to their own abuse*. However, consent often results in a lesser charge being brought and in mitigation in sentencing. This case illustrates clearly that it also can result in complete acquittal.

In 1996 it was reported by the media in West Yorkshire that there were eleven- and twelve-year-old 'crack heads' on the streets of Bradford selling sex. This was later retracted, as eleven- and twelve-year-olds are not visible on the streets. That week three girls were approached by men in cars who wound down the window and asked: 'Where are the eleven- and twelve-year-olds?' One girl said she didn't know, that she was fourteen and the man said: 'You'll do'. This, and other evidence from work at the project, confirms that there are men who are going out specifically to look for children for their sexual gratification. One sixteen-year-old girl, who is extremely anorexic, dresses in vests and knickers from chain stores to make herself look twelve years old. She told us that is what the customers want. These men should be terrified of winding down the car windows and admitting they are seeking to buy sex from eleven- and twelve-year-old children. Barnardos believes that adult male customers who procure young women under the age of sixteen years for sexual gratification should be considered child sexual abusers. They should be arrested, charged and brought before the criminal court. Without

the customers there would not be the market for vulnerable girls and young women for the pimps to exploit.

The young prostitute

It is unlawful for young women in the UK under sixteen (seventeen in Northern Ireland) to have sexual intercourse, although they are not committing a criminal offence. Consequently young women below sixteen cannot give consent to sexual intercourse, and it is illegal for adults to have sex with a child under sixteen. Whilst prostitution is not illegal, charges of loitering and soliciting may be brought. The law permits young women under sixteen to be officially cautioned on two occasions for loitering and then labelled as a 'common prostitute'. Subsequently charges may be brought for loitering and soliciting, resulting in a criminal record for sexual offenses. This criminalisation was detailed in the Childrens Society report, *The Game's Up* (1995). It does seem a legal absurdity that a young woman under sixteen can be convicted of soliciting and labelled as a 'common prostitute' when she is not old enough to give consent to sexual intercourse. At Barnardos we believe that no child should be labelled as a 'common prostitute' and there should be no such thing as a 'young prostitute' or a 'child prostitute' or a 'juvenile prostitute': there is only a child who is being abused.

This is extreme abuse that is not only sexual, but is often physical and emotional as well. The SALs project has many examples of physical abuse that has resulted in children suffering bruises, burns and broken bones; of sexual abuse, rape and assault which have led to sexually transmitted diseases and infertility; of cases of terminations of unwanted pregnancies, or a baby who was still-born. A child who was raped with a tampon inside her, which was not removed for three days, could have died from toxic shock. Emotional abuse usually manifests itself in self mutilation, overdosing, eating disorders and drug addiction. Particular cases of serious harm include the sixteen-year-old who was dumped at a hospital by three men. It was estimated that she had been unconscious for three days and she suffered brain damage. The men were never found, she will never recover. There was the fifteen-year-old who was strangled and whose body was left undiscovered in woods for three weeks. It is not risk of harm, it is actual harm that is occurring daily to these children.

How language obscures abuse and abusers

It follows that there is no such thing as a pimp when we are referring to children, but there is an abusing adult. This is an adult who controls and coerces, who assaults and rapes, and who in extreme cases tortures. He humiliates and degrades vulnerable children and also makes a considerable amount of money by exploiting them sexually. This is seen in law as living off immoral earnings. Should there be an offence of living off the immoral earnings of a child and can this be the same offence as living off the immoral earnings of a thirty-year-old woman? This is adult abuse of a child, as represented in Figure 14.3.

It also follows that there can be no such thing as a 'punter', or a 'customer'

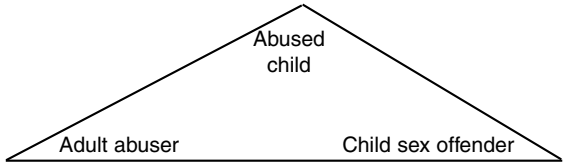

Figure 14.3 Child prostitution as child sexual abuse

or a 'kerb crawler'. These exist in the world of prostitution, in the sex industry. It is a kerb crawler who winds down his window and asks for sexual services from a child. Is this the same as a kerb crawler who winds down his window and enters into an agreement with an adult to purchase services? Traditionally prostitution has been seen as a nuisance or public order offence and as a victimless crime. In this situation there is a child victim. When a man seeks to satisfy his sexual desires on a child, he is not a kerb crawler, which is classified as a non-arrestable offence, he is quite clearly a child sex offender. Should it make any difference that the child is a 'willing' victim? Would it be acceptable for a father, stepfather, older brother, or teacher to pay a girl for sexual services if she was agreeable. Would this be prostitution or would this be abuse?

Language is so important as this informs assumptions, attitudes and perceptions that relate to prostitution. Referring to a child as a prostitute implies that children are making informed choices and decisions. The girls and young women known to the Streets and Lanes Project seldom have any choice at all. One sixteen-year-old had her head forced back, with a kettle of boiling water held above her throat, as she had refused 'to go to work'.

It is acceptable in our society for men to purchase sex from women and Barnardos' work shows that it is also acceptable for men to purchase sex from children. It is so easy for the abusing adults and child sex offenders to continue their actions, without fear of identification or any repercussions for their actions. There must be a basic shift in understanding that this is an issue about child abuse, not about prostitution. There are no accurate local or national figures for the number of children and young women involved in this activity. The Council of Europe noted in 1991 the paucity of information and statistics available. We do not have any way of understanding the scale of the problem or identifying the numbers of young women and children abused through prostitution. The experience of SALs would suggest that this is to a great extent 'a hidden problem', with girls being kept in rooms and flats and not necessarily being visible on the streets. A third of the users profiled at SALs were not involved with any statutory agency.

Changing public policy

In summary, young women and girls are not prostitutes, they are children who are being abused and sexually exploited. Young women and girls should be regarded as victims of abuse and sexual assault and should not be criminalised

or labelled as prostitutes. A shift is required from the notion of informed choice and consent, to sexual assault on under-age girls and young women. Boyfriend/pimps are abusing adults inflicting physical and sexual harm and control over under-age girls. Men who seek out young girls for sexual gratification are child sex offenders and should be recognised as such.

The issue is complex and requires changes at a number of levels including changes in society's attitudes and new legislation. There is no single or easy solution, however, and the issue and the solution are influenced by society's attitude towards the notion of that 'type of girl'; the exploitation and abuse of power by adults towards children; and undervaluing of children's rights.

The priority should be to change the current emphasis; to protect young women rather than punish them; and to prosecute the offending adults, the pimps and punters who sell and buy sex with children. Sexual exploitation of young people should be considered a child welfare issue. Changes are needed in the response of statutory agencies to recognise young women and girls being sexually exploited as children in need and at risk of significant harm, leading to action under the Children Act involving, where appropriate, child protection procedures. The case is particularly strong for young people under the age of sixteen, who are not in law consenting adults. Sex with minors should be seen for what it is: the sexual abuse of children, and should be dealt with as such. More effort should be put into gaining convictions of men who sexually exploit young women as child prostitutes and who have sex with under-age children.

There is a legal context and framework with the potential to underpin change. In the UK, the Children Act 1989 provides a range of responsibilities to local authorities for the care and protection of young people under the age of eighteen, most particularly:

1 Section 31: the local authority has a duty to protect children from 'significant' harm, defined as: ill-treatment, impairment of health and development.
2 Section 47: the local authority has a duty to investigate allegations of child abuse.

Article 34 of the United Nations Convention on Human Rights states that member countries should act 'to protect the child from all forms of sexual exploitation and sexual abuse'. Section (b) continues: 'to take measures to prevent the exploitative use of children in prostitution or other unlawful practices'. The Council of Europe recommends that

> emphasis should be placed on children and young people as victims of sexual exploitation, not as perpetrators or as accomplices to criminal offences. Greater emphasis should be placed on the identification of clients and those involved in the prostitution of children.
>
> (Council of Europe R(91))

Changes are required in child protection in the following areas:[1]

1 A review of the policy and practices of social services and the police, to ensure that young people being sexually exploited are deemed at risk, within the meaning of the Children Act. The Association of Directors of Social Services (ADSS) position statement and Association of Chief Police Officers (ACPO) pilots are positive moves in this direction.
2 Guidance from the Department of Health to ensure that the policies of local Area Child Protection Committees (ACPS) address the needs of children involved in sexual exploitation and prostitution; acknowledging the issue and providing multi-agency responses, including the contribution of the voluntary sector.
3 The provision of services which are preventive and offer alternative and constructive options. These must take into account practical support and resources as well as situations where the triggering of full inter-agency child protection procedures can be counter-productive by 'losing' the young person from contact with agencies, before action can be taken.

Prosecution of pimps as abusing adults

The present penalties and processes for causing or encouraging the prostitution of girls under sixteen are inadequate in relation to the level of exploitation and abuse occurring. The maximum penalty should be increased and it should become an arrestable offence. Barnardos supports the recommendation of the Parliamentary Group on Prostitution 1996 that 'sanctions should be increased against those who encourage young people to enter prostitution and against those who avail themselves of the services of juveniles'. More appropriate charges (such as abduction, kidnap, sexual assault on a minor) should be considered, as opposed to the 1950s sex offences legislation.

Prosecution of 'punters' as child sex offenders

Greater emphasis should be placed on the nature of sexual relationships with under-age children as abuse and illegal behaviour. The present maximum sentence for sexual intercourse and sexual assault against children aged thirteen to sixteen years is inadequate and should be increased. In addition to recommending increased sentences against those who have sexual intercourse with children, the Parliamentary Inquiry 1996 recommends 'stronger action against kerb crawlers including the power of arrest'.

There is not a single or simple solution to the needs of young women being sexually exploited. In the present circumstances, taking into account the limitations of effective legal processes and the level of violence and abuse exercised by the men controlling the young women, services can only have limited impact. Fundamental change is required in attitudes and systems to achieve significant improvements. This does not, however, diminish the need for

services to intervene in the present situation. Services are required that provide opportunities for young women to receive care and support, and to explore choices to move into safer and healthier environments.

Note

1 Influenced by the work of Barnardos and the Children's Society, the Home Office and the Department of Health produced draft guidance in 1998 on working with children involved in prostitution advising agencies to treat these children as 'suffering' or 'at risk of suffering significant harm' as defined in the Children Act 1989. This represented an important shift in policy, but did not propose to decriminalise children (or women) involved in prostitution nor to criminalise men who purchase sex from children (or women) (see Itzin, chapters one and twenty-one):

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15 Treating adolescents who sexually abuse others

Bobbie Print and Tony Morrison

Introduction

The problem of child sexual abuse in this country is now recognised as a major concern. This recognition has resulted from growing awareness, over the past ten to fifteen years, of the significant numbers of children that are sexually abused and the damaging effects that can occur as a result. A British study (Kelly *et al.* 1991) revealed that one in two girls and one in four boys are likely to experience some form of sexual abuse before reaching the age of eighteen. A number of studies have identified that the effects of sexual abuse can be severe, numerous and long lasting (Browne and Finkelhor 1986; Peters 1988). As we have come to more fully appreciate the prevalence of sexual abuse and its impact on victims, we have begun to recognise that prevention of sexual abuse must depend not only on the development of child safety programmes, but also on the extent to which we can stop abusers from committing these crimes.

Much of the focus of any such preventative work with sex offenders has been with adult males and until very recently views about adolescent males who abused were predominantly that they constituted a nuisance. The overriding attitude was of 'boys will-be-boys' and the sexually abusive behaviour was thus seen as experimentation and therefore as unimportant. (Finkelhor 1979; Gagnon l965; Maclay 1960; Reiss 1960; Roberts *et al.* 1973). The failure to recognise the significance of sexual abuse committed by adolescents has been confounded by a lack of knowledge surrounding sexual development in adolescents, as well as the fact that victims are likely to be family members (Becker 1988; Knopp 1982) and parents frequently do not report such abuse. It was also assumed that much of the abuse committed by adolescents was a 'one off' incident and that their victims often suffered little harm (Chatz 1972; Roberts *et al.* 1973).

Now, however, research (Kelly *et al.* 1991; Glasgow *et al.* 1994, Home Office 1990) has identified that adolescents and younger children are responsible for approximately one-third of sexual assaults committed on children. However, despite such research and increase in knowledge about child sexual abuse by adolescents within the professional community, fundamental inadequacies in responding to this group remain. Abusive behaviour has continued to be denied,

minimised or redefined by professionals, perhaps because an appropriate response to the problem has not been possible. Thus the NCH Committee of Enquiry into Children and Young People who Sexually Abuse Other Children (1992: 12) found that 'support for the development of work with young abusers (in this country) appears to be patchy. Managerial and professional peer group denial of the "problem" as an area for legitimate professional involvement was certainly raised as a significant hindrance in the development of services; indeed it appears reasonably easy for the existence of the problem to be denied altogether'.

This chapter will examine some of the current knowledge base, theories, models and methods that underpin intervention with adolescent abusers and will also suggest a systematic professional response that would aim to reduce the overall number of sexual assaults committed by adolescents. Whilst some attention is given within the chapter to young females who sexually abuse others, current research suggests that a vast majority (95 per cent) of adolescent sexual abusers are male (Fehrenbach *et al.* 1986). Most of the information included therefore is regarding young males who sexually abuse, and the male pronoun has been used throughout the text in reference to adolescent sexual abusers.

Definitions

The term adolescent is used throughout the chapter to include all those young people aged approximately between thirteen and eighteen years of age. This definition has been selected so as to help to differentiate between adolescents and:

1 those younger children who sexually act out but whom research and clinical experience identifies as having different characteristics and needs
2 adult offenders who are developmentally mature and subject to a different system response.

It must, however, be noted that such a definition cannot be used rigidly. It must incorporate both chronological and developmental aspects of adolescence. Therefore, some young people whose age would suggest that they should be incorporated within this group may be developmentally inappropriate. The opposite may apply to some who are outside of the stated age range.

Within this chapter the term adolescent sexual abuser has generally been used to include all those young people who sexually abuse others and not merely those who are convicted of such offences. The definition provided by Ryan and Lane (1991) of juvenile sex offenders is also relevant to adolescent sexual abusers and is used as the basis for all further references to sexual abusers regardless of whether the adolescent was investigated, prosecuted or convicted:

> The juvenile sex offender is defined as a minor who commits a sexual act with a person of any age:

a) against the victim's will
b) without consent
c) in an aggressive, exploitative or threatening manner.

> Juvenile sex offences may be characterised by an array of behaviours. Molestation of young children or peers may involve touching, rubbing, disrobing, sucking and/or penetrating behaviours. It may include rape. Penetration may be oral, anal or vaginal and digital, penile or objectile. Non-contact offences may include exhibitionism, peeping or voyeurism, frottage (rubbing up against others), fetishism (such as stealing underwear or masturbating into another's clothes), and obscene communication (such as obscene phone calls, and verbal and written sexual harassment or denigration).
>
> (Ryan and Lane 1991)

In order to clarify which sexual behaviours should cause concern as being abusive or exploitative as opposed to those sexual behaviours that can be regarded as a normal or experimental part of adolescent developmental behaviour, Ryan (1989) and Ryan and Lane (1991) suggest that the notions of consent, equality and authority are very important. They make the point that the distinction must include not simply the behaviour, but the context of the behaviour in terms of the relationship between those involved. Ryan goes on to define the basic elements for consideration thus. Consent is seen as having four elements:

- Understanding the proposal.
- Knowing the standard of behaviour.
- Awareness of possible consequences.
- Respect for agreement or disagreement.

Equality can be thought of at a number of levels in relation to perceived differentials of power which can be affected by: age; size; race; gender; power of peer popularity; strength, often previously demonstrated in non-sexual behaviour; self image difference; arbitrary labels such as leader/boss; fantasy labels in the context of play such as king or slave.

Authority is to do with control and coercion. Ryan identifies a continuum of control in sexual acts ranging from:

- Normal: no coercion, activity done in fun.
- Manipulation/peer pressure at a subtle non-physical level.
- Coercion by threats and bribes.
- Physical force, weapons and other direct physical threats.

Ryan further distinguishes between consent, co-operation and compliance. Co-operation is participation regardless of one's own beliefs or desires. Compliance is to allow something to happen despite your behaviours or desires. Co-operation and compliance are thus different from consent. The definition

developed by Adamas and Fay is particularly useful in clarifying the basic concept of consent:

> Consent is based on choice. Consent is active not passive. Consent is possible only when there is equal power. Forcing someone to give in is not consent. Going along with something because of wanting to fit in with the group is not consent. . . . If you can't say 'no' comfortably then 'yes' has no meaning. If you are unwilling to accept a 'no' then 'yes' has no meaning.'
>
> (Adamas and Fay 1984)

Incidence and prevalence of adolescent abuse

Our knowledge of adolescents who sexually abuse has increased considerably over the past decade for a number of reasons. In the first place, there has been recognition of the numbers of adolescents who commit sexual abuse. Ageton's (1983) national probability study in the USA estimated that up to 4 per cent of all adolescent males in the USA had reported committing sexually assaultive behaviour. Deisher *et al.* (1982) found that 42 per cent of children treated at sexual assault centres reported their abuser as being an adolescent. Finkelhor (1979) found that 34 per cent of women and 39 per cent of men who recalled having a sexual encounter during their childhood with someone five or more years older, reported that the older person was between ten and nineteen years. Additionally, approximately half of adult sex offenders report the onset of sexual offending during adolescence (Abel *et al.* 1985). Surveys of child protection register statistics in the UK have revealed that approximately a third of sexually abused children were assaulted by an adolescent or pre-adolescent (Northern Ireland Research Team 1991; Horne *et al.* 1991). Criminal Statistics in the UK (Home Office 1990) covering offences reported during 1989 show that out of the 10,729 individuals found guilty or cautioned for sexual offences, one-third were aged twenty years or younger.

Additionally, knowledge has developed regarding the habitual nature of sex offending. Abel *et al.* (1984) suggested that the average adolescent sex offender, who does not receive treatment, will go on to commit 380 sexual crimes in his lifetime. Finally, research has also identified the risk of untreated adolescent sexual abusers developing more intrusive and violent abusive behaviours. For example in a study by Longo and Groth (1983) 35 per cent of the incarcerated adult sex offenders interviewed reported progression from compulsive masturbatory activity, repetitive exhibitionism and/or persistent voyeurism as adolescents, to the more serious sexual assaults, rapes and other offences for which they were convicted as adults. Research on adolescents who sexually abuse has significantly improved our knowledge of this behaviour. We now know that adolescent sexual abusers are found across all socio-economic, religious and ethnic groups in our society. They commit every type of known sexual crime and the effects of their assaults on their victims are just as traumatic as abuse committed by adults.

Range of offences

In a large scale survey, undertaken by Fehrenbach *et al.* (1986), looking at 279 adolescent sexual abusers the breakdown of offence types was as follows: 59 per cent indecent liberties (fondling); 23 per cent rape; 11 per cent exhibitionism; 7 per cent non-contact offences. Wasserman and Kappel (1985) examining the actual sexual behaviour as opposed to the legal charge for 149 male adolescent sexual abusers found a much higher proportion of penetrative assaults as follows: 59 per cent penetrative offences (including 31 per cent intercourse); 12 per cent oral/genital contact; 16 per cent genital fondling; 12 per cent non-contact acts.

McDermott and Hindelang (1981) found that one-third of offences perpetrated by adolescents resulted in a physical injury to the victim. Groth (1977) found in 43 per cent of cases, where the victim was a peer or older, a weapon such as knife or blunt instrument was used. In general terms, the level of coercion has been found to be proportional to the relative ages of victim and abuser, with peer aged and older victims generally being subjected to greater levels of force (Davis and Leitenberg 1987).

The victims of adolescent sexual abusers are predominantly young children. Fehrenbach *et al.* (1986) found that 62 per cent of those abused by adolescents were under twelve years and 44 per cent were six years or younger. The Northern Ireland (1991) study found that of those victimised by sixteen-year-olds, half were aged under nine years and two-thirds under twelve. In a review of the large scale study conducted by the National Adolescent Perpetrator Network, Ryan (Ryan and Lane 1991) found that in only 15 per cent of cases was the victim of sexual assault a peer or older. Such findings clearly indicate that these sexual behaviours are exploitative rather than experimental.

The majority of victims of male adolescent sexual abusers are female (Awad *et al.* 1984; Van Ness 1984; Wasserman and Kappel 1985). Van Ness (1984) found that 91 per cent of adolescent and adult rape victims were female but that as the age of the victim decreases the child is more likely to be male (63 per cent). Most victims are known to the adolescent abuser. Wasserman and Kappel (1985) found that 20 per cent were in the immediate family, 20 per cent were extended family members, 51 per cent were friends or acquaintances and only 9 per cent were strangers.

Very few credible studies on female adolescent sexual abusers have been conducted but the findings of the few that do exist suggest that between 2 and 7 per cent of adolescent sexual abusers are female (Mathews 1987; Fehrenbach *et al.* 1986; The Utah Report on Juvenile Sex Offenders 1989). Ryan and Lane (1991), found that the range of offence behaviours in adolescent female sexual abusers is similar to that of male adolescents but that the compulsive or addictive behaviours associated with male abusive behaviour are less prevalent. They suggest that many female abusers want to be detected and may encourage or facilitate the victim's disclosure. Research on, and experience of, working with female abusers is limited, and it is not possible therefore to ascertain how similar their motives and treatment needs are to those of adolescent male abusers.

Characteristics of adolescent abusers

There have been very few controlled studies comparing adolescents who sexually abuse others with other delinquent or matched groups. The majority of observations are based on clinical descriptions of adolescent abusers and therefore of limited value in identifying which factors are specific to adolescent abusers. Notwithstanding these reservations, many clinicians have reported a variety of factors in relation to the family environment in which adolescent sexual abusers are brought up, as well as their psychological and intellectual functioning.

History of child abuse

Van Ness (1984) found that 41 per cent had been physically abused or neglected, as compared with 15 per cent in a group of non-sexual delinquents. Smith and Monastersky (1986) found that 36 per cent had a history of sexual or physical abuse, and 30 per cent had a sexual offender living within their extended family. They also noted that 26 per cent had witnessed family violence. It is also interesting that adolescent abusers frequently report access to pornographic material within their own homes. Studies of incarcerated male adolescent sexual abusers (Lewis *et al.* 1981), however, report much higher rates of childhood histories of physical abuse (75 per cent) and having witnessed family violence (79 per cent). A significantly higher proportion of adolescent female sexual abusers (93–100 per cent) are reported as having a history of sexual victimisation (Ryan and Lane 1991). It thus appears that adolescents who sexually abuse others have a greater than normal likelihood of having been physically and sexually abused. Significantly, however, Ryan (Ryan and Lane 1991) found that only 30 per cent of the adolescent sexual abusers who had been sexually abused had had their abuse investigated. She concludes that this may well contribute to a lack of empathy in the adolescent abuser: 'no protection for me, no empathy for you'.

Sexual histories

The sexual histories of adolescent sexual abusers have revealed that a large number had prior sexual experience with a consenting partner (Groth 1977; Becker *et al.* 1986), thereby further challenging the notion that adolescent offending is simply a form of misguided experimentation. Sexual adjustment problems such as premature ejaculation or impotence have also been noted especially among older adolescents (Longo 1982).

Family background

Many writers have commented on the disrupted care histories of adolescents who sexually abuse. In Fehrenbach *et al.*'s (1986) group 27 per cent lived with a

step parent, 23 per cent with a single parent, and less than a third with both natural parents. Adolescent sexual abusers often report other types of loss in the period prior to the onset of offending, such as the loss of grandparents, pets or moving home. High rates of family instability, disorganisation and violence are also commonly reported (Awad and Saunders 1989; Robertson 1990; Smith 1988). In summary, adolescents who sexually abuse others often have major care deficits and frequently grow up in families in which they experience and/or witness violence, lack of empathy and a lack of sexual boundaries.

Social and psychological adjustment

Many case reports have noted a range of social and psychological problems in adolescent sexual abusers, including poor school attainment (Gomes-Schwartz 1984), low self esteem, social isolation, loneliness, fear of intimacy and poor social skills (Becker and Abel 1985, and Fehrenbach *et al.* 1986). Others (Van Ness 1984) have reported more serious problems in anger management for incarcerated sex offenders than for their non-sexual offending counterparts. Katz (1990) in a matched study of adolescent sex offenders, non-sexual offenders and non-offenders concluded that adolescent sex offenders were more socially incompetent, had more problems with loneliness, social anxiety, assertiveness, negative self evaluation, self consciousness, depression and low self esteem. They perceived social situations as threatening, and doubted their ability to perform well in them, and were more easily threatened by heterosexual relationships.

Causation

Sexual behaviour appears to be learned and shaped by many interacting factors including environment, social learning, family, inter-personal relationships and experiences, psychological and biological influences. The configuration of these factors are unique in each case. There are no single factor explanations, and adolescent sexual abusers are not a homogeneous group. Common to most is that they are male, and to many is that they have experienced child abuse and neglect, including physical and sexual abuse and been witnesses to domestic violence. The following summary of O'Brien and Bera's (1986) six-strand PHASE typology provides a very helpful outline of possible categories of young abusers:

Naive experimenter

A young person in this category is generally younger (eleven to thirteen years) with little previous history of problem behaviour. He has adequate social skills and friendships with peers. His family is fairly stable and there is unlikely to be a history of physical or sexual abuse. This young person tends to be sexually naive and has engaged in only a single or small number of events of opportunistic exploration, usually with a young child (aged two to six years), using no force or threats.

Pseudo-socialised child exploiter

This young abuser is generally older (sixteen to eighteen years) with apparently good social skills. Typically, he has numerous peer acquaintances but no close friends and he is often intellectually gifted. He has little history of problem behaviour and appears self-confident in most social settings. He is likely to have been physically, sexually, emotionally abused or neglected in childhood. Such a young person demonstrates a chronic pattern of sexual behaviour with children which he strongly rationalises and thus feels little guilt or remorse for his behaviour. He will often view his abusive behaviour as mutual, non-coercive and caring.

Sexual aggressive

This young person's family is often highly dysfunctional and abusive. He may be a very personable or charming young man with good peer aged social skills. He is, however, likely to have poor impulse control and a history of anti-social behaviour, including substance abuse. He may often fight with members of his family and friends. He often uses force, threats or violence during sexual assaults against adults, peers or children.

Sexual compulsive

This young person often cannot express negative emotions in an appropriate manner. His parents are often also emotionally and behaviourally repressed. His family is frequently enmeshed with closed external boundaries. He is likely to engage in repetitive non-contact sexually arousing behaviours of compulsive nature such as stealing women's underwear, making obscene telephone calls, window-peeping.

Disturbed impulsive

Young abusers of this type may have histories of psychological problems, substance abuse or significant learning problems. Their abusive behaviour is often impulsive and they may have high reality distortions. They may have committed a single, unpredictable act or a number of bizarre ritualistic acts. The offences committed by these young people reflect a thought-disordered or drug-induced lack of normal inhibition.

Peer/group influenced offender

This type of abuser is a person who is dependent on his peers or peer group. He is unlikely to have a history of criminal behaviour and his family and background are essentially 'normal'. His abusive behaviour occurs with a peer or peer group present and his victim is likely to be pre-selected and known to him. The young abuser is likely to place responsibility for the abuse with the victim or his peers.

Causal factors contributing to child sexual abuse by adolescent males

Despite the work of those such as O'Brien and Bera (1980) there is, as yet, no standard psychological profile of an adolescent sexual abuser. However, bringing together knowledge from research and clinical experience it is possible to hypothesise that a variety of the following factors are commonly associated with young people who sexually abuse others. Becker (1991) and O'Brien (1992) have integrated these factors into models which hypothesise that young sexual abusers are young people with significant unmet needs which act as predisposing factors. Early sexual experiences lead them to believe that sex with children is a way by which adults or adolescents make themselves feel better in times of difficulty or stress. This message is strongly reinforced where the young person believes that the adult or adolescent involved encountered no negative consequences as a result of their behaviour.

Additionally, the young person may use some of the messages regarding male sexuality, use of aggression, objectification of females and so on available in his environment, (for example, his family, the media, pornography, his peer group) to develop general patterns of distorted thinking which allow him to further enhance the idea that sex with children is acceptable. The development of such distorted attitudes, beliefs and thoughts in this way can then lead onto the acquisition of an inappropriate sexual interest in children. This is often further reinforced by the use of inappropriate fantasy and masturbation. Once an opportunity arises or is created, the young person may act out some of these thoughts and fantasies and thus commit a sexual assault. The use of 'offence specific thinking errors' then allow the adolescent abuser to suspend his moral/legal awareness as well as his awareness of the possible consequences of his actions for both self and victim. If there are no negative consequences as a result of the behaviour, the young person's distorted thoughts that his behaviour is not serious or damaging are very likely to be strengthened. The psychological and sexual gratification the young person gains from the abusive behaviour are inclined to intensify the attraction of the behaviour and may well lead to the occurrence of further sexual assaults. The more the behaviour is used to inappropriately solve both sexual and non-sexual problems, the greater its salience and the weaker the young person's control becomes. Figure 15.1 models the causal relationships of factors leading to child sexual abuse by an adolescent.

Sexual assault cycle

Another model used to explain the compulsive nature of sexually abusive behaviour is one first developed by Lane and Zamora (Ryan and Lane 1991). Rather than explain causal factors the cyclic model demonstrates the self-reinforcement and repetitive nature of the behaviour. Sexual assault is depicted not as an impulsive act but as the product of non-sexual and sexual events, thoughts, feelings and behaviours. It suggests that the adolescent's previous experiences,

Predisposing factors: leading to unmet need

- Cold parenting/ lack of empathy/disrupted attachment
- Inconsistent care
- Physical abuse
- Emotional abuse
- Domestic violence
- Attention deficit/conduct disorder/severe learning difficulties
- Parental or other loss
- Lack of close friendships/poor socialisation
- Delinquent peer group
- Poor social/coping skills and anger management
- Affective disorders including conduct disorders
- Low self esteem - inability to trust
- Limited capacity for anger management
- Over-controlled/enmeshed family
- Chaotic/disengaged family

Early sexual experiences

- Pornography
- Sexual abuse
- Lack of protection or validation
- No resolution of abuse experience
- No negative consequences for their abuser
- Lack of sexual boundaries in family
- Sexual issues not discussed or lack of appropriate information
- Sex seen as dirty

General cognitive distortions: attitudes, values and beliefs

- Sexism and patriarchism
- Adult men can do what they like to children and/or women and get away with it
- Media and pornography messages about masculinity/sexuality
- Sexual activity fused with aggression and divorced from relationships
- Sexual ignorance and myths
- Females as sex objects
- Attributions: I am not responsible; I am the victim; I can't win

Inappropriate sexual interest

- Inappropriate sexual behaviour is learned and self-reinforcing. Early intervention is therefore crucial
- Inappropriate sexual behaviour is reinforced by use of pornography, sexual fantasy, masturbation and sexual activity
- The strength and nature of 'inappropriate' sexual fantasy varies greatly among adolescent abusers, but is likely to increase in response to the number of abusive acts committed
- Sexual activity used as compensation for non-sexual problems/anxieties such as powerlessness, relationship failure or loss
- Sexual preoccupation/rumination especially when alone, bored, hurt

Figure 15.1 Causal factors contributing to child sexual abuse by adolescent males (continued overleaf)

Opportunity

- Victim availability,such as babysitting, probably more significant than specific victim characteristics
- Peer group influences
- Family context and arrangements
- Absence of adult supervision, minimum threat of detection

Sexual assault

Offence-specific cognitive distortions or 'thinking errors'

- It didn't hurt me when it happened to me
- It's normal
- She wants it to happen because she hasn't said no or resisted me
- No-one will know
- She won't tell
- It won't hurt her
- I have no-one else to do it with
- It's not as bad as that rapist
- I didn't force her
- I won't do it again

Further sexual assault

Figure 15.1 continued

perhaps of abuse, rejection or unmet needs, have led him to have a poor self image. He thinks he is not likeable and therefore avoids getting close to others as he expects rejection. He does not have the self-confidence or skills to respond assertively towards others, so withdraws and dwells on his discomfort. He blames others for his situation and is angry with them. He fantasises about ways in which he can be powerful and thus make himself feel better. He views sex with someone who cannot reject him, such as a younger child, as a way to make himself feel better. He masturbates to these fantasies and so reinforces them and he may increase his interest in pornography. He plans ways in which all/part of his fantasies can be acted out by considering potential target victims and ways of gaining access to them. He then grooms intended victims by making himself known to them and seeking increasingly close contact with them. Obviously, in the case of sibling victims, the targeting and grooming process is much easier. When an opportunity occurs or is created he commits the sexual assault. There then follows a period of transitory guilt which is based on fear of getting caught rather than any empathetic remorse for the victim. During this period the young person will promise himself that it will never happen again. If he is not caught these fears are gradually suppressed and cognitive distortions, such as 'what I did wasn't really that bad' are used in their place.

Clearly each individual's cycle will be different and progress through the cycle will also differ. Figure 15.2 illustrates this 'cycle of sexual assault'. In general terms the more entrenched the cycle and the faster the cycle is repeated the more gratifying and habitual the behaviour. The strength of this model is in

bringing together factors to do with previous history, cognitions, affect, sexual arousal, and the environment (grooming/targeting). The cyclic nature of the model also underlines the self-reinforcing nature of the behaviour. The arc in the middle shows that for many adolescent abusers, who have already begun to abuse, further abusive behaviour is not dependent on a return to feeling low, as the gratification from their sexually deviant behaviour will generate further/escalating fantasies, be reinforced by masturbation and pornography and lead to a heightened desire to commit more serious offences. Ryan (1989) states that the cycle is equally relevant for male and female adolescent abusers.

Professional intervention

Whilst there remain significant gaps in knowledge about adolescents who sexually abuse others it is clear that if we are to effectively reduce the numbers of children who are sexually abused then we must develop an effective, systematic response to young abusers. We know from studies with adult sex offenders that a predominantly punitive response does not stop sexually abusive behaviour (Soothill and Gibbens 1978; Marshall and Barbaree 1990). The problem is much more complex. Most adolescent sexual abusers come from dysfunctional family settings and are often themselves victims of sexual, physical or emotional abuse (Fehrenbach *et al.* 1986; Monastersky 1986; Van Ness 1984). Whilst we do not know precisely why such behaviours develop, the consensus of opinion is that aggressive sexual behaviours are learned primarily through observation and by direct experience. Cultural influences, the male socialisation process, viewing pornography, dysfunctional families, imbalances of power and status, early childhood experiences, particularly those involving sexual trauma are all contributory factors in this learning process. It is therefore these factors

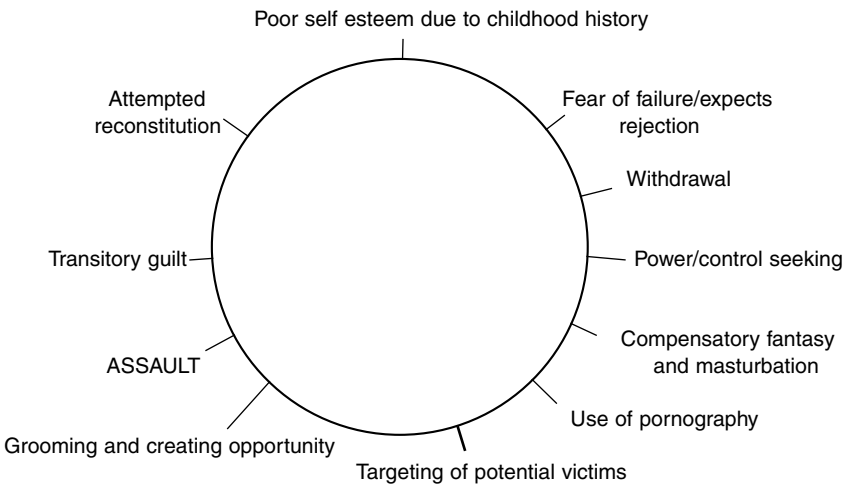

Figure 15.2 Cycle of sexual assault

that should be the targets of any intervention designed to prevent sexually abusive behaviour developing into a chronic cycle of sexual abuse.

Research with adult sex offenders indicates that involving them in intensive, offence specific, treatment programmes has had some significant success in reducing the incidence of sexual abuse by helping some men change their distorted thinking and control their abusive behaviours (Marshall and Barbaree 1990). While there have not been any long term studies on the effects of treatment on adolescent abusers, many programmes have reported encouraging results (Knopp 1988). It will also be apparent that specialised community based treatment in lower-risk cases, provided at the point of problem recognition or at the time of first legal involvement is likely to be much less expensive than later institutional treatment for more serious offences. There are therefore a number of compelling reasons to advocate early intervention with adolescents who sexually abuse others:

- Adolescents are responsible for a third of all sexual abuse of children so, aside from the possible escalation of abuse behaviour, there is an overriding need to intervene with this group.
- Inappropriate behaviours are less deeply ingrained than in adults and are therefore more amenable to change.
- Adolescents are at a developmental stage with regard to their sexual relationships and behaviours and are likely to have a mixture of appropriate and inappropriate sexual attitudes and fantasies. They are therefore more open to consider alternatives to abusive behaviour patterns.
- Distorted thoughts, beliefs and attitudes are less deeply entrenched than in adult abusers and more susceptible to change.
- Adolescents are more accustomed to education and more open to being taught new and acceptable skills.
- Adolescents are liable to be dependent on parental or carers help and support and the potential for them to be positively influenced by parental figures is greater than with adults.
- Fiscal economy is enhanced by intervening at an early stage before more assaults are committed.

Philosophy of intervention

If intervention is to be successful then not only must we consider different targets and methods for affecting change, but we must establish a common understanding of the problem and develop a shared philosophy and rationale for intervention. A suggested outline for such a philosophy, based on our current level of knowledge, is provided below, although such principles necessarily require review as understanding and cultural values change:

- Adolescent sexual abuse accounts for a significant proportion of all sexual offending.

- It is harmful to victims.
- It involves the misuse of power and breaching of the victim's informed consent by the abuser for his/her psychological and sexual gratification.
- The causes of adolescent sexual abuse are multi-factorial involving socio-cultural, environmental, familial, inter-personal, and developmental elements. These are unique in each case. Many adolescents, however, were physically, emotionally and sexually abused or neglected as children and subject to domestic violence.
- Common to all adolescent sexual abuse is that it is largely committed by males and the victims are females.
- Adolescent sexual abusers generally have low self esteem and poor social skills.
- Adolescent sexual abuse is reinforced and triggered by use of pornographic material, distorted thinking, sexual fantasy and masturbation.
- Without intervention, such behaviour is more likely to escalate than diminish, and there will always be a risk of recurrence.
- Intervention needs to be based on an accountability approach, recognising that sexual abuse is illegal.
- Adolescent sexual abusers are adolescents who sexually abuse, and not sexual abusers who happen to be adolescents.
- The overarching goals of intervention are:
  - The protection of victims
  - The prevention of further offences
  - The development of abusers' self control in order to reduce the risk of re-offending. Sexually abusive behaviour is very rarely the result of 'illness' and is therefore not 'curable'. It is possible, however, for abusers to be helped to manage their behaviour so as to avoid committing further abusive acts.
- No single agency can manage adolescent sexual abusers. Child protection and criminal justice agencies need to collaborate.
- Intervention must recognise the young person in his/her total context, in particular the role of some families as instrumental in creating and supporting the sexually abusive behaviour, and other families as a potential source of support for the young person in ceasing to sexually abuse.
- Adolescents who sexually abuse may be of either gender, any race, culture, class, sexual orientation and learning ability. The position of an abuser as a member of an oppressed group does not diminish his/her individual responsibility.
- Oppression is always a block to effective intervention. However, work with adolescent sexual abusers which leaves victims vulnerable and risk factors unchallenged can never be anti-oppressive. The opposite of oppression is not collusion i.e. anti-oppressive practice should not be collusive.
- Adolescent sexual abusers are unlikely to engage in treatment unless there are significant negative consequences for them not doing so.
- Intervention should be at the least invasive level commensurate with the protection of actual or potential victims.

Levels of intervention

Intervention can be considered at three different levels. Primary intervention, which would involve societal based strategies aimed at changing familial and cultural understanding, attitudes and behaviours. Secondary intervention would involve specialised preventative intervention with groups of young people who were considered to be at increased risk of developing abusive behaviours. Tertiary intervention, aimed at preventing continued offending by identified abusers.

Primary intervention

It is not enough to simply work with the young people who are known to have sexually assaulted others. This would mean not only waiting for abuse to happen before intervening, but working only with the tip of the iceberg as most cases of sexual abuse do not come to the attention of professionals. In order to be effective a comprehensive range of educative and information sharing strategies are required. For example, professionals and the public should have a much clearer understanding of: what is acceptable and developmentally 'normal' sexual behaviour and what should be regarded as abusive; how individuals should respond if they have concerns; the professional services that are available and the resources they offer. Dissemination of this information will necessitate a more open discussion on issues surrounding childhood and adolescent sexuality than we have seen as yet in this country. Government, educators and the media have a responsibility for placing these issues on the public and social policy agendas.

There is also a need for research to develop further insight into the role of pornography, patriarchy, and oppressive attitudes towards sexuality in promoting and maintaining sexually aggressive and abusive behaviour. Additionally, at an educative and awareness raising level, it is important for children and young people to be given the opportunity to explore issues of sexuality and sexually appropriate and inappropriate behaviour. While many are involved in sex education programmes at school, few programmes enable young people involved to examine issues of consent, sexism, gender stereotypes, responsibilities in relationships and the nature and effects of abusive relationships.

Secondary intervention

Whilst we are not able to predict accurately who will become a sexual abuser, there is sufficient knowledge to direct preventative work towards some higher risk groups. For example, whilst the majority of victims of sexual abuse do not go on to sexually abuse others it is known that a significant number of sexual abusers have been physically, emotionally or sexually abused themselves, (Becker, Kaplan *et al.* 1986; Monastersky 1986; Ryan and Lane 1991). It would therefore seem highly appropriate, as a secondary prevention measure, to include

preventative work as part of a therapeutic programme with all children and young people who suffer child abuse of any kind. Models for such programmes already exist (see Ryan 1989; Ryan and Lane 1991).

Additionally, the work of Hartman and Burgess (1988), in looking at trauma outcome, indicates that males tend to externalise the effects of abuse whilst females tend to internalise effects. Such models suggest that it is particularly important that preventative intervention be provided for young males who have been sexually abused. Unfortunately, however, there remains a high incidence of under-reporting by male victims of abuse and consequently there are relatively few intervention programmes designed to focus on their needs. Until the professional system tackles this problem and provides specific prevention programmes as part of a therapeutic response to all children and young people who have been abused, the scope for secondary intervention will remain limited.

Tertiary intervention

Effective intervention with young people who are known to have abused others requires a co-ordinated multi-agency response at all stages including identification, investigation, assessment and treatment. Such an approach require the involvement and commitment from all relevant agencies at an organisational and strategic level (DoH 1991). In particular Area Child Protection Committees (ACPCs) have a vital role in co-ordinating a professional response. NOTA (1993) stated that: 'Effective practice (in responding to sexual abuse) can only be achieved and sustained in an organisational environment in which agencies, managers and practitioners establish an infrastructure both within and between agencies' (NOTA 1993: 26).

Morrison (1994) suggests the framework model shown in Figure 15.3 for a comprehensive response to the management of adolescents who sexually abuse. The framework can be applied to both individual agencies and to inter-agency arrangements.

Whilst the need for a well co-ordinated multi-agency approach is especially necessary at the tertiary level, effective primary and secondary level intervention

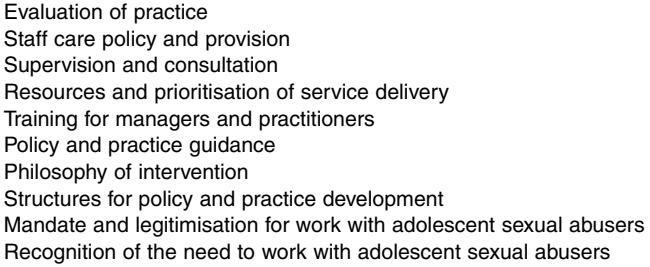

Figure 15.3 A framework for multi-agency response

relies just as much on inter-disciplinary and cross-departmental/governmental co-operation.

Figure 15.4 (G-MAP in association with NSPCC (1988)) indicates the various stages of professional intervention and those agencies that are likely to be involved at the tertiary level. Whilst assessment of the adolescent will continue throughout the period of professional involvement, the chart identifies the context in which a substantive assessment of an adolescent sexual abuser is likely to take place.

As this framework indicates, the substantive assessment and treatment phases are particularly specialised and intensive areas of work. They require a high level

Initial action

- Need to establish details of abuse and gather/share information across relevant agencies (child protection workers/police)

Initial evaluation of risk

- Preliminary assessment
- Immediate protection measures
- Decision re: legal action/NFA/Caution/Prosecution
- Further evaluation required?
- (Child protection and youth justice workers/Police/Caution Panel/Case Conference)

Substantive assessment

- Full risk assessment
- Placement decisions
- Medium term protection measures
- Establish primary treatment goals
- Range of provision e.g. group, individual, family
- Identify treatment providers
- Devise individual specific treatment mandate
- Recommendations to court, case conference etc.
- (Specialist workers e.g. from health services, youth justice, child protection, probation)

Treatment phase

- Identify community supervisor
- Treatment contract
- Establish review system
- Clarify objectives and methods of change and evaluation
- (Specialist workers e.g. from health services, youth justice, child protection, probation)

Treatment conclusion

- Establish relapse prevention measures
- Identify remaining child protection/community supervision/after-care issues
- (Specialist workers, SSD, relapse network members)

Post treatment

- Long term follow-up to maintain relapse prevention, monitor recidivism, evaluate treatment effectiveness
- (Specialist workers, researchers, multi-agency monitoring)

Figure 15.4 Adolescent sexual abuser assessment and treatment model

of expertise based on a detailed knowledge base, specific training and access to high quality supervision. They also require robust agency commitment to the work. The purpose of a substantive assessment is to evaluate risk and dangerousness; to predict recidivism; to identify needs; to decide who is suitable for treatment; to recommend appropriate placements; to recommend necessary restrictions (for example regarding contact, babysitting and so on); to evaluate treatment efficacy. Assessments in this context are not to decide on guilt or otherwise. There are no sufficiently accurate assessment instruments to know who is/is not guilty. It is the job of the court to decide who is guilty.

Treatment or therapeutic intervention is also a complex area in which the goal is self-control, the intention being that the young person will be able to identify and appropriately respond to situations or circumstances which could lead to further involvement in abusive behaviours, thereby reducing the risk of re-offending. Those who sexually abuse others are generally not mentally ill. Thus intervention is not based on medical models. Adolescent sexual abusers require a continuum of care, ranging from educational-oriented community based facilities to secure residential provision. They also require work at individual, group and family levels. The principle must be to employ the least invasive method commensurate with the protection of known or potential victims and to seek to ensure that there is a sufficient mandate to motivate the client into, as well as sustain him through, treatment. The key therapeutic goals for the adolescent sexual abuser are listed in Figure 15.5.

Family involvement in treatment of young abusers is a further crucial area of work in order to: to supervise the adolescent abuser; to get a developmental history; to support the adolescent through treatment; and to involve families in treatment. This is often very difficult, particularly when there is a history of abuse within the family. In some circumstances it may not be appropriate for the young person to remain at home because other family members are unable to support them or are unwilling to engage with therapeutic services. It is very problematic indeed trying to intervene in abusive behaviour whilst the

- Education re: sexual aggression, sexual abusers, victimisation and human sexuality
- Taking responsibility for the thinking, feeling and behaviour that enables abusive behaviour
- Understanding their own sexual assault cycle and how this can be inhibited, for example by improved anger management, social skills, giving up use of pornography, and so on
- Understanding and restructuring cognitive distortions
- Development of victim awareness and empathy
- Victim apology and restitution work
- Understanding and modification of deviant arousal patterns
- Assertiveness and anger management
- Interpersonal communication and social skills
- Developing positive self esteem
- Relapse prevention skills
- Dealing with own victimisation

Figure 15.5 Therapeutic goals

- Denial, minimisation and projection of blame
- Lack of empathy for the victim
- Abuse of power, powerlessness and empowerment
- Intergenerational abuse
- Family secrets
- Blurred role boundaries
- Human sexuality
- Treatment needs of siblings
- Divided loyalty
- Loss, separation, grief and abandonment
- Behaviour contracts re: overall goals; family philosophy; expectationa and responsibilities; consequences; signatures

Figure 15.6 Issues in family work

adolescent remains at home under these circumstances. In all but extreme cases, however, there is a need for outreach work and educational work to try and assist the engagement of families in treatment. The exact nature, duration and intensity of work with a family will be determined by a thorough assessment of the family and their circumstances, but Thomas (1991) suggests a useful five stage approach to guide such work which incorporates the following stages: first, the crisis of disclosure; second, assessment; third, therapeutic intervention; fourth, reconstruction; fifth termination and after-care. She also identifies the issues in Figure 15.6 as likely components of any therapeutic plan of work with a family.

Conclusions

Recognition that young people are responsible for a significant proportion of sexual assaults in this country has led to a consensus view that professional intervention aimed at preventing such behaviour is essential. Whilst there has been some move to develop a systematic response to young people who sexually abuse others through the publication of government guidance, local authority policies and professional procedures, we have yet to establish a consistent and comprehensive approach to intervention. The problems that have impeded progress include: a scarcity of resources to implement specific programmes of work; inconsistencies in whether a therapeutic or punitive response is required and a lack of research to identify the effectiveness of various interventions. These difficulties could result in the impediment of progress being further prolonged. What is required; is agreement on how we can develop our knowledge and skills whilst improving and extending the interventions that currently exist. The issues identified in this chapter suggest that if we are to provide an effective response to sexual abuse by young people we must:

1 Develop a better understanding, through research and public discussion, of the sexual development of young people and the impact upon them of sexism, pornography, patriarchal attitudes and so on.

2 Raise public and professional awareness of the impact of sexual abuse by adolescents and improve public education on how parents might protect their children. Parents should be provided with information regarding what behaviours should cause them concern and who they can approach for advice. Additionally educational programmes on preventing child abuse should be included as an element in 'preparation for parenthood' classes within the education and/or health services.
3 Increase recognition of the importance of early intervention.
4 Develop prevention awareness amongst the community, families and professionals. Teachers and nursery staff, for example, should be trained on recognising and responding to early indications of concern.
5 Develop prevention programmes in schools and as part of response services to abused children.
6 Recognise and take seriously the inappropriate sexual behaviour of young people and ensure accountability from young people who sexually abuse others.
7 Establish a systematic response to young abusers by clarifying agency responsibilities and ensuring inter-agency collaboration.
8 Produce policies and procedures to guide the work of all involved professionals.
9 Provide specialised assessment, evaluation and treatment services for young sexual abusers in order to intervene in such behaviour as early as possible.
10 Establish a continuum of care for young abusers ranging from community-based non-residential to secure residential facilities.
11 Undertake further research in this field to develop our understanding of both causation and of effective treatment.

Current knowledge regarding adolescents who sexually abuse others provides us with impelling reasons to develop a co-ordinated and systematic response aimed at preventing and intervening in the development of sexually abusive behaviours of young people. It is clear that to do nothing at all, to ignore such behaviour and not to attempt to prevent it or demand accountability and responsibility from young abusers for their actions simply reinforce the likelihood of further abuse.

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16 Patterns of sex offending and strategies for effective assessment and intervention

Hilary Eldridge

Introduction

Myths about the people who abuse children, and how they do it, are legion. Most common are beliefs that offenders can be stereotyped as an isolated group of sick individual men; or that sex abuse is restricted to single incidents of aberrant behaviour by otherwise ordinary men; or that it is caused by family problems. The aim of this chapter is to draw together evidence to show that the reality is quite different, and to demonstrate that accurate knowledge about offenders helps society both protect children and provide effective intervention programmes for their abusers.

The research reviewed here challenges some deeply held beliefs about the types of men who abuse children. In reality there is no type. Abusive behaviour occurs in many different situations and in different and various social groups. Those concerned with child protection need to know that diversity is the main factor characterising men who abuse children, that most sex offending takes place within the context of a relationship which the offender makes with the child in order to gain compliance and prevent disclosure, and to move away from the idea that the family itself is at fault when a child is sexually abused by a family member. Effective therapy, not only for offenders but also for those affected by abuse, recognises that offenders create or exacerbate family dysfunction in order to ensure that they can abuse undetected.

The recognition of different offending patterns is very important in establishing appropriate intervention with offenders. The thinking processes of abusers usually includes 'distorted thinking' which legitimises offending. This thinking, together with the cyclical patterns which many offenders develop, are key targets for change in effective offender intervention programmes. In summary, the aim of this chapter is to stress the importance of using knowledge of offenders to inform assessment, intervention and prevention of sex offending.

Characteristics of offenders

Who are they?

Despite there being an increasing number of female sex offenders coming to public attention in clinical settings, available conviction data, clinical data and community-based prevalence data continues to show that most sex offending is carried out by males and hence this chapter is primarily about males (Itzin, chapter twenty-one). Men who sexually abuse children are not a homogeneous group. They have different motivation, different personality types, and different modi operandi. Some have a clear sexual preference for children, but many do not and hence cannot be described as paedophiles. There is increasing recognition that a person does not necessarily have to be sexually aroused to children in order to harm them in a sexually abusive way (Wyre, chapter three). Sex offenders are a diverse group who commit different types of offences and present different kinds and levels of risk. They can come from all walks of life. Myers *et al.* (1989) describe sex offenders as

> a heterogeneous group with few shared characteristics apart from a predilection for deviant sexual behaviour. Furthermore there is no psychological test or device that reliably detects persons who have or will sexually abuse children . . . there is no profile of a 'typical' child molester.
>
> (Myers *et al.* 1989: 142)

Salter's overview 'What do we know about sex offenders' (1995: 5–35), cites a number of key studies which confirm the heterogeneity of offenders. For example, she notes that:

> Maletzky (1991) concluded in his sample of more than 5,000 sex offenders that 'There has been no documentation of a typical 'offender personality'. . . . Rather these men are characterised by their diversity. An offender could as well have been a professor as a pauper, a minister as an atheist, a teetotaler as an alcoholic, a teenager as a septuagenarian. . . . Moreover, an offender...might as well have had an extensive history of arrests or none at all, and might as well have had associated diagnoses as none. . . . In retrospect, these patients did not seem to share any definable demographic or personality traits to render them distinctive
>
> (Salter 1995: 16–17)

Salter also cites Herman's view that 'the most striking characteristic of sex offenders, from a diagnostic standpoint, is their apparent normality' (Salter 1990: 180).

Studies show that pathological profiles are not a consistent feature of men who abuse children. For example, Abel *et al.* (1985) found that 60 per cent of 232 child molesters had no other psychopathology than sexual deviancy, and

antisocial personality disorder was found in only 12 per cent of that group. Pithers *et al.* (1988) found that only 35 per cent of 136 paedophiles had personality disorders.

Research available on female sex offending is far less extensive than that related to male offending. This is linked to the fact that very few women are actually convicted of sexual assaults. The low conviction rate may be partly because women commit fewer offences, but information from survivors indicates that although female abusers are in the minority, it is a larger minority than statistics suggest. For example, 9 per cent of 8,663 children who contacted Childline during 1990 and 1991 said they had been abused by a woman (Harrison 1993). Saradjian (1996) notes that Finkelhor and Russell (1984), surveying the data then available, concluded that of all children who had been sexually abused the percentage of sexual contact by older females to be about 20 per cent (range 14 to 27 per cent) for male children and about 5 per cent (range 0 to 10 per cent) for female children (Finkelhor and Russell 1984: 177 cited in Saradjian 1996).

Like others (Matthews, Matthews and Speltz 1991; Finkelhor *et al.* 1988) Saradjian (1996) identified, in a clinical sample of fifty British women, that like their male counterparts, women offenders are a heterogeneous group who come from all walks of life. The three typologies most frequently discussed in the literature are the inter-generationally predisposed group who abuse their own young children often regarded as replicating their own childhood abuse; the 'teacher/lover' who sees herself as such and abuses adolescents with whom she believes she is having an 'affair'; and the male coerced woman who is initially coerced into abusive behaviour, may cease offending after the departure of the coercive male or may develop her own independent pattern. Societal denial commonly accompanies female sex offending leading to inadequate assessment and intervention with the women and a paucity of therapy for survivors of their abuse, even if they are heard and believed. However, professionals are beginning to recognise this problem and more research is becoming available.

Choice of victim: crossover issues

In recognising the heterogeneity of sex offenders it is also important to recognise that although some always target a particular type of person within specific circumstances, others will abuse more widely. Studies based on confidential self report show that multiple paraphilias among certain groups are not uncommon. Weinrott and Saylor (1991) asked a group of child molesters about the range of their activities. These men had been classified as sexual psychopaths, that is presumed to specialise in sexual misconduct and having deviant behaviour beyond self control. Of these men, 85 per cent had been previously classified, based on criminal records, as having only one type of victim, either adult female or child outside the family or child within the family. Based on confidential self report, only 48 per cent stayed in that category. 32 per cent of the rapists admitted abusing children, 12 per cent of the child abusers admitted to at least one attempt of forced sex with an adult

female, 34 per cent of the extrafamilial offenders had committed incest, 50 per cent of the known incest offenders admitted child abuse outside the home.

Incest offenders are the group most commonly placed by professionals into a mythical box in which it is believed that offending is linked to family dysfunction and the offender is unlikely to re-abuse outside the home. Studies show this to be false. Faller (1990: 67) examining a sample of sixty-five biological fathers in intact families found that 'about four fifths of these men sexually molested more than one child, and in a third of the cases there were victims outside of the home.' Salter (1995) cites a series of reports on an expanding sample of male outpatient sex offenders (Abel *et al.* 1987; Abel *et al.* 1988, Abel and Rouleau 1990) in which varying but always high numbers of incest offenders perpetrated outside the home. Using confidential self report gathered from 561 nonincarcerated paraphiliacs who abused adults and/or children, Abel *et al.* found that:

> of the 153 subjects involved with boys outside the home, 51 per cent had histories of also having been involved with girls outside the home, 12 per cent with girls within the home and 20 per cent with boys within the home. Of the 159 subjects who reported involvement with female incestuous pedophilia, 49 per cent had histories of also having been involved in female nonincestuous pedophilia, 12 per cent in male nonincestuous pedophilia and 12 per cent in male incestuous pedophilia. Of the forty-four subjects who reported involvement with male incestuous pedophilia, 61 per cent had histories of also having been involved with female nonincestuous pedophilia, 68 per cent with male nonincestuous pedphilia, and 43 per cent with female incestuous pedophilia.
>
> (Abel *et al.1988:* 162)

Abel and Rouleau (1990) found that only 12 per cent (sixty-eight men) in their sample engaged in incestuous behaviour alone, whereas 23 per cent (131 men) had abused both within and outside the home. Becker and Coleman (1988) found that 44 per cent of their sample who had abused girls in the home had also abused girls outside the home. From the same sample, 11 per cent had abused boys outside the home, 18 per cent had raped, 18 per cent were exhibitionists, 9 per cent were voyeurs, 4 per cent were sadists, and 21 per cent had other paraphilias.

It is not clear, however, that the samples described in these studies are representative of sex offenders generally. Grubin comments that 'the likelihood is that there are a small number of offenders who offend against large numbers of victims, but they are not typical, and generalisations based on them are best made cautiously, if at all' (Grubin 1998: 11).

Comments from offenders in my own clinical practice suggest that a man who can persuade himself it is acceptable to abuse one type of child, can make it acceptable to abuse another, especially if his distorted thinking helps him define it as love and friendship rather than abuse, or if he has an 'I want, I take' attitude in which his own desires are always paramount. The deciding factor is whether he wants to do it and how far he can minimise the risk of being caught. An

extensive offender with a clear preference for boys, who targeted two boys and moved in with them, their mother and sister, commented 'I'd never seen a little girl running around near me with not much on before. I thought I'd see what it was like'. He abused her to see, before reverting to the boys. An incest offender who had abused his daughter said he had not abused her schoolfriends, not because he had not wanted to, but because he could not get sufficient control over them to prevent them telling their parents. A stepfather abuser who initially presented himself as offending because he was 'in love' with his step-daughter, later admitted that although she was his favourite so far, he had abused (in his terms, been 'in love with'), children in two other families.

In assessing offenders we need to entertain the possibility of crossover whilst not assuming that a man who has abused one child has or will necessarily abuse others. However, if he has not, it may not be because he is averse to the idea, but rather that the inherent risks are too great. If the risk of being caught is reduced by some means, the risk of crossover offending may rise. If we are assessing risk to children who may not be direct targets of abuse, we must consider the possibility of significant harm to their developing sexuality from the distorted attitudes and beliefs of the offender. For example, a man who abuses his daughter may harm her brother by virtue of his abusive attitude to women and girls and to sexuality.

Patterns of sex offending

Denial

When initially assessed, offenders usually engage in denial. They deny, minimise, excuse or justify their offending and blame others in much the same way as most human beings who are guilty of engaging in reprehensible behaviour. They pretend 'it just happened', 'it was an accident', 'it was circumstances, stress, relationships, drink, drugs' and so on. In order to break through the excuses into the reality, the assessor needs to know that what usually happens is that the offender thinks before he acts: imagines what he might do, and chooses or targets a child. Many offenders plan how to get the child to comply and prevent them disclosing, having first disempowered or manipulated people who might protect the child. The extent of conscious planning is, however, highly variable between individuals. Sexual abuse of children is rarely incident based, it usually takes place within the context of relationships and involves the corruption of those relationships.

Motivation

Most sex offenders do sexual things to children because they want to. For some, motivation is linked more strongly to the desire to control and overpower, whereas others have a more strongly sexual motivation. Some have an emotional congruence with children linked to a sense of inadequacy with adults and seek to meet their needs for human contact by creating abusive relationships with children.

Others are anger motivated, in some cases directed at children and in others at adults. Sexual arousal to the pain and suffering of another is clearly present in sadistic offenders. In a minority of cases, offenders are initially coerced or drawn into inappropriate behaviours, for example, when they are adolescent, or in the context of a residential school or home run by abusers who corrupt others.

In instances of abuse within families, family dynamics were traditionally seen as causal, and the adequacy of the sexual relationship between the parents was often questioned. Faller found that in-depth interviews with her sample of sixty-five biological fathers and their partners revealed that:

> in only six cases were there significant sexual difficulties and in only eleven reports was the relationship a hostile one. When there were sexual difficulties, they were as likely to be the consequence of the husband's sexual preference for children as to be the wife's lack of desire or lack of desirability. (Faller 1990: 67)

Examining family relationships within her sample, Faller concluded that rather than abuse being caused by family dynamics, the father's determination to abuse appeared to be the primary causal factor.

Fantasy and pornography

Thoughts and sexual fantasies about abuse usually precede action. In fantasy anything goes: the would-be offender can imagine a rape in which the victim resists at first but ends up enjoying it, or in which children smile and say 'please do it to me'. Pornography which depicts children appearing to enjoy sexual acts is attractive to many offenders and helps them confirm their distorted beliefs. Pornography often shows children smiling, but the smile is usually a frozen one. The offender who wants to believe the child is enjoying it simply sees a smile: he looks no further because he does not want to spoil his fantasy.

In some cases fantasy is focused on a particular individual who is then targeted, in others it is focused on an act or on a type of person. When a target person has been selected, fantasy may remain non-specific or may become focused on that person. Fantasy acts as a disinhibitor and as a reinforcer, and allows the offender to picture the child of his choice doing what he wishes. Barry, an abuser of both girls and boys, talked about 'putting the mask of my fantasy on to the real-life child' (Eldridge 1998: 34).

Planning, targeting and grooming

The essence of choosing safely and grooming effectively is to persuade the child that it is 'something about you (the child) that made me do it'. The essence of manipulating those who might protect is to persuade them that 'I am not the sort of person who would do these things', or failing that 'It's your fault if I did them, and hence you can't tell'. Offenders do not just choose children, they often

choose a child from a family in which they can exert control. Some like a challenge, but most prefer to take less risk. They frequently choose children from their own families, as this usually allows the greatest scope for control because of issues relating to trust and dependency. Most choose children who they get to know through family, social or professional contacts: they can be the kind, trusted relative or helper who comes to the rescue when things go wrong. Some approach strangers, often children who are truanting from school or engaging in addictive pursuits, for example, at amusement arcades, or in banned under-age activities. Offenders who plan, often home in on normal, ordinary human problems and use these to gain access and control. It's not 'something about the victim', it's more likely to be something about the way the offender looks for and uses circumstances and times of family stress.

Whatever the motivation or belief system of the offender, most have in common the use of highly manipulative tactics to control the victim and other people who might recognise and reveal their offending. Tactics used to control vary between offenders. The sadistic offender who wishes to hurt and cause pain to children; the man with a sexual preference for children who either pretends he loves children or actually believes he does; and the father who abuses his daughter out of a desire to control or a distorted belief that this is love, use tactics to control their victims, but the tactics and their effects are very different.

Offenders manipulate not only children but also those who could protect them. The tactics used include overt physical violence, threats of violence, bribes and treats, emotional dependency, and often a combination of all. The 'Mister Nice Guy, Mister Nasty Guy' approach: 'I can be loving and kind, but if you don't do what I say you'll see my teeth!' is very common.

Post-disclosure of intra-familial abuse, problematic dynamics are commonly observed. However, offenders in therapy tell us how they cause these by manipulative tactics designed to disempower potential protectors and keep children quiet. Although some offenders show direct violence to the non-offending parents, others are more subtle. They may use verbal violence, or be violent to inanimate objects. One stepfather offender said 'I was decorating. My ex-wife looked up at me and said something that upset me, so I slashed all the wall I'd done with a knife. I knew I'd got some more wallpaper to replace it with, but she didn't!'

Offenders often divert the victim's anger on to the non-offending parent and encourage the victim to believe s/he knows or is in some way to blame. Some offenders achieve this by being aggressive to the non-offending parent but seemingly loving to the child they are abusing, or by being someone who behaves like a child with the children and sets his partner up to be the disciplinarian. This may be done in a secretive way which is not obvious to the non-abusing parent. Drawing on their clinical work Eldridge and Still (1998) comment that:

> Post-disclosure we often see a child victim who is closest to the offender and furthest away from everyone else in the family, especially the mother. This is no accident. Knowledge of offenders tells us that they arrange it that way. As one man said 'I drive a wedge between the child and anyone they might

> go to.' Dysfunctional family dynamics don't cause sex abuse; rather, sex offenders willfully exacerbate or create such dynamics.
>
> (Eldridge and Still 1998: 48)

Cyclical patterns

A pattern which may become cyclical often develops. The *modus operandi* varies within each stage of the cycle depending on the type of offender and his motivation. For example, an anger motivated offender who abuses children and adults may have different thinking patterns and use very different tactics to a man with a sexual preference for children. The way in which the cycle starts depends on the beliefs and arousal patterns of the offender.

In earlier work I have described two types of cycle: continuous and inhibited (Eldridge 1992, 1995, 1998). Whatever the type of perpetrator, cycles seem to be either continuous (that is, uninhibited) or inhibited, depending on the basic attitudes and beliefs the perpetrator holds, and the strength of his desire to offend. It is important when assessing a perpetrator, to identify his individual pattern or patterns, rather than force-fitting him into a general category. However, as a starting point, it is useful to understand some of the differences between continuous and inhibited cycles.

Continuous cycles

Offenders with continuous cycles have no internal inhibitors other than fear of being caught or a change in who they perceive as desirable, to prevent them offending. Many have strong beliefs that their behaviour is acceptable and that the law should be changed in line with it. Men with such patterns who have a sexual preference for children may build a life around seeking them out. Breaks in the cycles of such perpetrators occur if they discover that the child they have chosen

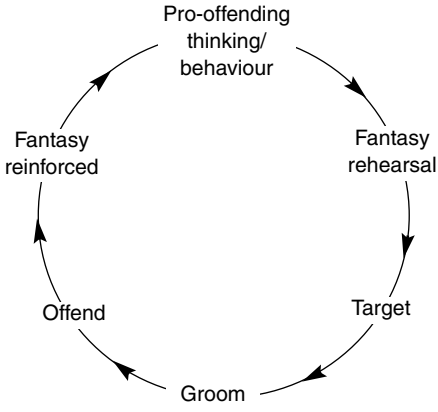

Figure 16.1 Continuous cycle

may tell, and is therefore too risky to pursue. In this case they may look for another child or children. Continuous cycles can be found in men who do not have a sexual preference for children, but believe, for example, that young teenage girls 'lead men on'. Such offenders may not be obsessed with trying to find young girls, but will make and take opportunities without wrestling with their consciences.

Inhibited cycles

Some offenders have inhibitions about offending, feel guilty and need to provide themselves with an excuse to offend. They may engage in very distorted thinking not only about the behaviour itself but also about how they get from the thought to the offence. Internal inhibitors operate to break the cycle. The length of the breaks depends on the strength of the internal inhibitors, of the distorted or pro-offending thinking which legitimises offending, and of the arousal or desire to offend. They may make plans to avoid offending, but these may be inadequate of counter productive. During breaks between offences, such abusers often indulge in thoughts which legitimise offending, and they may still fantasise about it, thereby strengthening the desire to reoffend. They are good at finding excuses to offend. They may make a whole series of seemingly irrelevant decisions leading to the opportunity to carry out the secretly desired behaviour. This process enables them to avoid facing the pain and responsibility of recognising that reoffending did not 'just happen'.

Other offenders may break through their internal inhibitors by indulging in self fulfilling prophecies which lead them to feel sorry for themselves and entitled to comfort. For example, someone whose self image is poor either due to past experiences, or to his identification of himself as a 'pervert', may expect other people to realise he is 'no good' and reject him. He sees rejection even if it is not

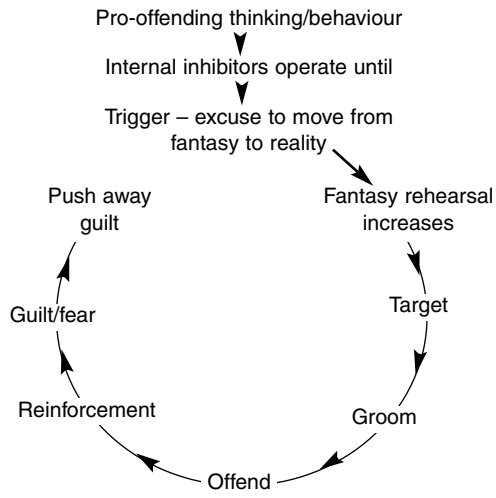

Figure 16.2 Inhibited cycle

there by seeing and hearing selectively. He may then behave in ways which create rejection. Hence, he eventually sees that the world is against him and this provides an excuse to seek comfort in his own distorted beliefs. He may fantasise increasingly about children, using as justification the belief that only children love and understand him while the adult world does not. Someone who perceives rejection may indulge in revenge type fantasies about attacking and hurting others because he feels attacked and hurt. Sometimes fantasies may include both distorted love and revenge components. Offenders who tell themselves they love children may, for example, also be anger motivated. A main theme is the interpretation of external events and the behaviour of others in a distorted way, thus providing a distorted rationale for the offender to do what he wants: namely reoffend.

Having begun offending after a period of abstinence, some offenders feel guilty and may not reoffend for periods of time ranging from a few days to several years. However, as their core beliefs have not changed and at some level they still wish to offend, they may reoffend by repeating the pattern.

'Short circuit' cycle

Some perpetrators are inclined to 'short circuit' the phases of an inhibited cycle once they have started reoffending. Some go into 'binge mode'. They feel they have failed and so give up, or drown their sorrows in further fantasy and offending which temporarily makes them feel better. In some cases alcohol abuse may become part of the cycle, to provide 'dutch courage' before offending and to drown guilt feelings afterwards.

'Short circuiting' of the various phases of the cycle may also occur within families where one victim has been targeted and groomed. For example, a father or stepfather abuser will have groomed the victim to comply without telling, and will have manipulated family relationships in such a way that the abuse is unlikely to be discovered. Hence, he no longer needs to target the victim, and the odd tweak on the strings of those he is seeking to control, is all that is required to keep his offending secret. He may push away guilt feelings by telling himself that his daughter would have told someone if she really minded. He conveniently forgets that he said discovery would kill her mother! Eventually, content in the belief that he has a consenting, if secret, relationship, he no longer needs to fantasise much either. He arranges when he will be able to abuse, and he simply goes from the thought to the offence.

Assessment, intervention and relapse prevention programmes for adult male offenders

Good knowledge of patterns is important if assessment is to be accurate and intervention and relapse prevention tailored to the needs of the individual, which it must be if it is to be effective.

'In order to engage the offender it is crucial that the therapist presents him with concepts to which he can relate. The concepts must include recognition

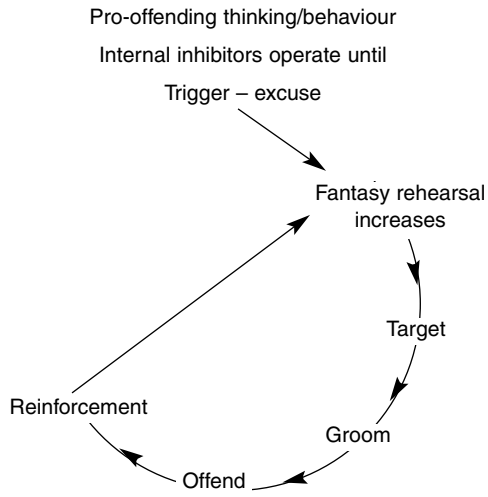

Figure 16.3 Short-circuit cycle

that there are individual differences among types of offender and patterns of offending' (Eldridge 1998: 8).

It is important, therefore, for programmes to be developed tailored to the treatment needs and risk levels of different types of offenders. However, as has been shown there are some common areas which should be addressed in most programmes and there are approaches which are known to be effective. Programme length needs to reflect the extent of the problem presented which usually relates to the level of risk. Contextual differences take account of risk levels, and it is valuable to have a range of programmes of different levels of security and intensity through which offenders can progress. In an ideal system, offenders assessed as extremely high risk who cannot be managed safely within the community, would not be released to live freely in the community. Those assessed as high risk, but having made progress, may be released gradually but with extreme caution and maximum supervision. Those who present high but more manageable risk may be released more quickly, but still with supervision, or may in fact start their sentences in a supervised but non-secure environment. Medium and lower risk offenders may be appropriately treated entirely within non-residential community-based programmes.

There needs to be co-ordination between prison and community-based programmes, and a smooth transition from one to the other. This requires sharing of data about offenders' patterns and progress, or the lack of it, and about programme content. In England and Wales, the existence of a prison programme running on twenty-five sites, The Lucy Faithfull Foundation's Wolvercote residential clinic, and large numbers of probation community programmes has made this possible. However, more resources are needed to provide consistent service delivery across the country. The establishment of the joint panel to accredit prison and probation service programmes in line with research about what works in treatment will aid this process.

Outside the criminal justice system the picture is much less promising with poor treatment facilities for unconvicted abusers. This is a major problem given that the vast majority of allegations of child sexual abuse do not reach the criminal courts, resulting in risk assessments for civil court proceedings and little chance of follow up treatment once risk has been established.

Effective child protection based programmes for offenders include the following components:

A clear policy of non-confidentiality in the interests of child and community protection

This policy was adopted at Gracewell Institute and at The Lucy Faithfull Foundation, Gracewell's successor. Offender therapists must be clear that they are first and foremost agents of child and community protection. A clear, stated policy of non-confidentiality follows naturally from that. Linked to this there must be:

Close communication and detailed information sharing with workers supporting child victims and non abusing parents

Throughout their change process offenders give information which can be used by therapists working with children and families to enhance their work. Hence, the need for good liaison between therapists.

At the Lucy Faithfull Foundation the team works with whole families. On the basis of knowledge of offenders and issues for those on the receiving end of the offender's cycle, the programme is based on an integrated approach which acknowledges individual needs and uses information from work with the offender to free children and other family members from the sense of guilt and responsibility the offender has placed upon them. This can lead to greater freedom of choice for the non-offending parent. The goal is to protect children, not necessarily to re-unite families. However, in some cases there is hope for safe family reconstruction providing appropriate work is done with all the parties. In these cases:

> Grooming needs to be fully revealed in order for the family to be reconstructed in a new way in which children can be heard and believed and the offender cannot operate undetected. This includes work with any siblings who have been groomed and whose resistance might be overcome by the offender in the future.
>
> (Eldridge and Still 1998: 50)

Multi-disciplinary staffing

Multi-component programmes are likely to be most effective when staffed by a multi-disciplinary group bringing different skills and an understanding of the perspectives of all the agencies concerned in child sexual abuse. Team members

can work together in combinations which best suit the treatment needs of the offenders and their families. It is important to ensure that staff spend sufficient time together to understand each other's perspectives and to develop a common language in order to work in a collaborative way. Where this is lacking conflicts can arise which enable the offender to divide and rule.

Detailed assessment to inform identification of risks and of treatment needs

When considering appropriate intervention, it is crucial that a thorough assessment is done to ascertain the individual treatment needs of each offender. Individual interviews can be combined with psychological testing and group assessment work. The psychological tests used can inform intervention while acting as a benchmark against which to measure progress. Alongside such testing, individual and group assessment may include exercises which provide information about thought, feeling and behaviour patterns, personal history, relationships, self image, generalised thinking patterns, victim awareness and empathy, perspective-taking ability, attributional style, sexual attitudes and arousal pattern, and self control. Ability to engage in self challenge and prognosis for change can also be assessed in such settings. Whether assessment is done individually or in group, sufficient time should be given to assess whether the offender is able to develop motivation to change. Very few offenders are truly motivated at the point of referral: motivation can come through engagement in the assessment process.

The essential task in all assessments is to identify the scale and pattern of the man's offending. In making an accurate risk assessment, it is important that the assessor is well informed about sex offending behaviour patterns and is prepared to entertain all the possibilities without allowing fear of hearing painful information or anxiety about resource implications, to lead to a focus on the presenting behaviour only. This is not to say that all offenders indulge in every possible 'paraphilia', rather it is to recognise that the assessor will not be told if he or she does not ask! Maletzky (1991) found that many offenders were not even asked about arousal patterns and masturbatory practices during assessment.

Creating an environment for effective therapy

Effective therapy takes place in a psychological environment which is conducive to change. This is a major issue regardless of whether work is done individually, in group or in residential settings. Assessment and therapy needs to take place in an environment which deplores sexual abuse and is unequivocally challenging of attitudes which legitimise it. However, there has to be an ethos of respect and care for the individual. This allows perpetrators to become vulnerable enough to break through their own defences and face the fact that they have done real harm to the children they have abused.

In the case of men who were themselves abused as children, this involves facing the pain of their own childhood as well as the pain of the children they have abused. The environment needs to be sufficiently therapeutic for the

offender to allow himself to experience painful thoughts and feelings. Whilst recognising that sex offenders cannot be cured of sex offending, there needs to be a belief that control and change are possible. In describing the operating principles of the Wolvercote Clinic, Eldridge and Wyre (1998) comment that:

> The offender is not on a course where at the end he receives a certificate that says he has 'made it'. The work must be more than just about delaying another offence, and hence each man needs to recognise that his learning and control must go on for the rest of his life. Cure implies sickness. Most sexual offenders are not diagnosed as mentally ill and therefore the work will usually be done within a criminal framework. The words 'intervention' and 'control' are more appropriate than 'treatment'. We believe offenders can change their behaviour: they can exercise control and they can be different.
>
> (Eldridge and Wyre 1998: 83)

A variety of models for assessment and intervention is essential. Current research shows that multi component therapies are more effective than single component therapies. Thoughts, feelings and behaviours come together to produce offending and all three need to be addressed to prevent reoffending.

A structured group therapy programme

When it comes to knowledge of offenders, it is the offenders themselves who are the experts. Although individual work can be very effective, it is often in group that the most powerful challenge comes. The notion of offenders challenging each other's distortions works particularly well in situations where there are 'anti-offending culture carriers'. There is no-one like the converted for challenging denial or distancing and minimising comments.

Groupwork is cost effective and a valuable way of facilitating change. It is often when listening to another man voicing his thinking errors, that other group members begin to recognise their own. The ludicrousness of their own arguments becomes clear, and self challenge begins. Groupwork is supportive too and can promote offender belief in change. However, care must be taken to ensure that work plans are individually tailored with each man. Groupwork programmes can include cycle and relapse prevention plan identification, victim empathy development, assertiveness and anger management, sex, sexuality and relationship issues, and in appropriate cases personal 'survivor' issues.

The Lucy Faithfull Foundation's Wolvercote Residential Clinic emphasises the value of groupwork in its programme for offenders presenting with multiple offence related and interpersonal problems. The programme begins with a four week in-depth assessment which includes daily groupwork, followed by a pre-intervention period to overcome personal blocks to effective intervention, and a twelve month intervention/relapse prevention programme. The intervention programme includes a core group work programme that operates on a modular basis and has as a constant theme the

offender's need to relate all that he learns to developing relapse prevention strategies suited to his own pattern of inhibitors and activators. The modular program consists of four core elements: victim awareness/empathy development; sexuality and relationships education, the role of fantasy in the offending cycle, and assertiveness and self efficacy. Each core element is divided into modules which are different from but not necessarily more advanced than each other. Each module includes ten sessions, each of three hours duration. The core programme is supplemented by groupwork focusing on special issues, for example, thinking skills, and personal survivor issues for men who have themselves been sexually victimised as children. The living environment plays a key role in the change process offering opportunity for the learning of new skills and the practice of pro-social behaviours. A fuller description of the Wolvercote Clinic residential programme is described elsewhere (Eldridge and Wyre, 1998).

Individual work

Some work is done more effectively and appropriately in individual sessions: for example, behavioural work for sexual fantasy control, individually structured work on changing negative thinking patterns, family related work, and some aspects of personal survivor work. The Wolvercote Clinic runs such sessions alongside and linked to its groupwork programme.

A focus throughout on relapse prevention

Relapse prevention should never be an add-on to a programme. It should be an integral part, and should provide a theme running throughout, increasing in emphasis as the offender progresses. The offender should be introduced to notions of control rather than cure at an early stage. Later, when there are signs of developing victim empathy and a recognition of the need to prevent reoffending, the offender can begin detailed learning about relapse prevention concepts. When there is the will for an offence-free life, the offender is at a point where he needs to plan how to handle high risk scenarios, emotional and physical steps towards reoffending and lifestyle issues, and to begin to change not only long held beliefs and thinking patterns, but behaviour as well. If he is to live his plan long term, he must own it and it must be tailor made to his particular offending pattern and lifestyle issues. He becomes an active participant in the creation of his relapse prevention plan, with the therapist acting as facilitator and monitor. Relapse prevention workbooks can be used throughout programmes to enhance the sense of personal responsibility for developing the relapse prevention plan. Ways of engaging offenders in this process are described in Eldridge (1998).

Sufficient time to produce feeling and belief as well as word and thought change

The change process is not linear, but it is usual to find word and thought change before new thinking becomes internalised and belief and feeling change

develops. Programmes need to be long enough and intensive enough to facilitate the degree of change required by different individuals. 'Behaviour is the great test. Word, thought, feeling and belief changes are a waste of time without it. However, sustained, as opposed to transitory, behaviour change may not happen until the other changes are in place' (Eldridge 1998: 14).

Monitoring of change

Offenders often learn to say the 'right' things before they actually believe them and carry them out. This is to be expected, but if a man is making real progress, then his beliefs and actions will become congruent with what he says. Wherever possible, his actual behaviour needs to be monitored on a regular basis. Change can be monitored using observation, case review, psychological testing, psychophysiological testing, clinical interviews, video recorded exercises related to the cycle, relapse prevention plan presentation, and external programme monitoring.

Ongoing monitoring of change maintenance post intervention

Whatever model is adopted, it is important to remember that offenders who are attempting to change the habits of a lifetime are likely to need long term support and monitoring in maintaining an offence-free lifestyle. The length and intensity of monitoring required should relate to the extent of the problem presented and the assessed risk level. Risk classification protocols such as the Structured Anchored Clinical Judgement (SACJ), developed by Thornton, which assesses risk of reconviction, aid this decision making process. The SACJ is valuable in that it uses dynamic as well as archival data thereby allowing for both positive and negative change. However, it should be noted that Thornton considers that whatever the outcome of an SACJ assessment, a raised risk is presented if a man is returning to a situation in which he has previously offended. Hence, although some intrafamilial offenders present a low risk to the community at large, they may present a greater risk within their own families and monitoring should take account of this. Monitoring networks can be composed of members of the community, including doctors, teachers, employers, community leaders, appropriate family members, linking to a professional with the statutory power to act if necessary, for example, a probation officer, or social worker. Change is possible, but both internal and external monitoring is required.

Part 3: evaluation

Therapeutic techniques and their effectiveness

Increasingly evaluation studies are beginning to identify that multi-component therapies are most effective in sex offender treatment. The emphasis is on using approaches in combination. Behavioural techniques can

be effective in controlling deviant sexual fantasies, but abusers have no reason to use them if they still believe their offending did no harm. Hence, these techniques need to be combined with cognitive restructuring and affective techniques to address issues such as attitudes to women and children, power versus intimacy in relationships, and perception of self. 'Talking therapies' should be supplemented by opportunity to practice new interpersonal skills which are critical to the development of an offence free life.

The need for techniques which deal with the emotional needs being met by offending and the offending habit itself is of even greater importance in working with offenders who have themselves been victims of sexual abuse. Gail Ryan (1987) comments:

> To resolve the issues which made . . . [an offender] feel powerless without developing internal controls for his anger and desire to overpower others, would enable him to complete more of the assaults he had envisioned. On the other hand, to teach him behavioural controls without addressing the origins of his anger and powerlessness is equivalent to sealing a volcano of issues which may erupt at any time.
>
> (Ryan *et al.* 1987: 389)

The programmes which show the most consistently positive results are those which combine cognitive and behavioural techniques with relapse prevention. Therapies which focus only on the offender gaining insight into the causes of his behaviour do not look so promising. Salter comments that 'the development of insight has not been demonstrated, by itself, to decrease sexual acting out, even as it has not been shown to control other addictive behaviours' (Salter 1988: 129). Salter cites Field and Williams (1970) who termed the results of psychoanalytic treatment with sex offenders as 'disappointing', and found that their offenders questioned whether even if a psychoanalytic explanation 'were understood and accepted, this knowledge alone would give to him sufficient control over his impulses to avoid the next offence' (ibid.: 29).

Treatment needs and outcome

Marshall *et al.* have carried out a major review of treatment outcomes with sex offenders. They concluded that 'comprehensive cognitive/behavioural programs (at least for child molesters, incest offenders, and exhibitionists) are most likely to be effective, although there is a clear value for the adjunctive use of antiandrogens with those offenders who engage in excessively high rates of sexual activities' (Marshall *et al.* 1991: 465). They emphasise the need to view treatment with antiandrogens as temporary controls until psychological treatments can begin to build effective self control.

Marshall *et al.* identified that some of the previous reviews 'have taken either a severe methodological stance and concluded that treatments have not been demonstrated to be effective with sex offenders, or they have ignored

methodological considerations and expounded about the value of particular treatment approaches' (Marshall *et al.* 1991: 465). Their own work attempts to adopt a position somewhere between these two and they have concluded that some treatment programmes have been effective with child molesters and exhibitionists but not, apparently, with rapists. They comment that in a previous review of sex offender treatment outcome, Furby *et al.* (1989) did not distinguish between different types of treatment and hence it is not surprising that outcome rates varied dramatically. Marshall *et al.* see no reason to expect all treatment programmes to be equally effective.

The importance of ensuring that offenders receive treatment appropriate to their individual needs was highlighted by a British team (Beckett *et al.* 1994). They produced a report which evaluated the effectiveness of six non-residential probation service run programmes and the Gracewell residential programme. They used personality and offence related measures to test men pre- and post-treatment. A successful treatment effect was related to the extent to which the men progressed to reach the profile of a non-offending sample. Pre- and post-treatment measures were used to test a sample of Gracewell residents. 75 per cent of the sample were categorised as higher deviancy on offence and personality related scales. The higher deviancy offenders made much greater progress at Gracewell than those similarly categorised in non-residential community based programmes. Of the men in the Gracewell sample who were categorised as higher deviancy, 60 per cent reached the profile of the team's 'normal' sample when tested post-treatment, showing a very positive treatment effect.

Although Beckett *et al.*'s study showed probation programmes to be less effective than Gracewell with high deviancy men, they did well with lower deviancy men of whom a good proportion showed a positive treatment effect. At the two year follow up point this pattern appears to have been maintained with a nil reconviction rate for the men in the Gracewell and probation programmes who were assessed as significantly treated (Heddermann and Sugg 1996). Longer term follow-up is planned.

Similar pre- and post-treatment measures are being used in Gracewell's successor programme at The Lucy Faithfull Foundation's Wolvercote Clinic which treats men who present a high risk of reconviction and for whom change is difficult. Independent research by David Thornton, Head of the Prison Service's Programme Development Unit (1998), showed the percentage of men starting with a specific criminogenic problem who demonstrated major improvement, that is, more than one standard deviation, in that area by the time they left Wolvercote. The results are shown in Table 16.1.

David Thornton commented: 'Typically just under three-quarters of offenders with a problem will have shown a major improvement by the end of treatment. These good results are obtained equally in relation to offence-related thinking and affective/interpersonal risk factors. In addition, by the time they leave, virtually all offenders will have progressed to the point where they have a well-developed relapse prevention plan' (1997 personal communication).

Table 16.1 Criminogenic problems and improvements

Criminogenic factors	*% Improving*
Offence related thinking	
Minimising own offending	86%
Distorted images of children	67%
Distorted images of victims	75%
Affective/interpersonal factors	
Submissiveness (i.e. under-assertiveness)	73%
Self rejection (low self esteem)	77%
Emotional loneliness	70%

Cost effectiveness of treatment

Marshall *et al.* point out the benefits to society of even marginal success in treating sex offenders.

> Since most sex offenders who do reoffend after release from prison or discharge by the courts, do so against more than one victim, then just effectively treating one offender who would otherwise have reoffended, is beneficial in that it saves two or more innocent victims from suffering.
>
> (Marshall *et al.* 1991: 468)

They cite Prentky and Burgess (1988) who comment on the cost effectiveness of treatment:

> Calculating the cost to investigate a reoffense by one of these men, to prosecute and jail the offender, and finally, to offer minimal assessment and treatment to the victim, the estimates of costs provided by child protection agencies, police, the courts, correctional services and hospitals, amounted to $180,000 for a single offense by a single offender. Similar estimates derived from Canadian sources (Marshall 1986) produced similar costs. Since it costs far less than this to treat each offender, treatment is not unnecessarily expensive to society.
>
> (Marshall *et al.* 1988: 468)

One of the problems in looking at outcome relates to the high levels of underreporting in the area of sexual abuse generally. The Kingston Behaviour Clinic in Ontario searched nation-wide official police records and were given access to unofficial files held by police and child protection agencies. Information obtained from these unofficial sources revealed recidivism rates that were more than double the official rates. Marshall and Barbaree (1988: 479) were then able 'to match treated child molesters with untreated men on a number of important variables' (p. 479). Their findings were as follows:

> Recidivism rates for heterosexual pedophiles revealed far better outcome for the treated (17.9 per cent unofficial, 7.5 per cent official) than the untreated men (42.9 per cent unofficial, 17.9 per cent official). For the men who molested boys, the corresponding figures were: treated 13.3 per cent (5.5 per cent official); untreated 42.9 per cent (19.2 per cent official). For the incest offenders the rates were: treated 8.0 per cent (2.9 per cent); untreated 21.7 per cent (7.0 per cent).
>
> (Marshall and Barbaree 1988: 480)

Hence, treated men had lower recidivism rates than untreated men in all the categories.

In Marshall and Barbaree's study those specifically identified as incest offenders show lower recidivism rates than other types of sex offender, and this is consistent with the literature. However, the question must be asked as to how likely it is that a child who has been abused by a close relative and has suffered the associated trauma, will disclose again? A family code of silence would affect unofficial as well as official figures. Inadequate monitoring and media imagery in which sex offending is seen as synonymous with predatory paedophilia, increases the likelihood that seemingly respectable husbands and fathers will be excused by friends and neighbours as tempted by circumstances and out of the norm: mother and victim blaming is often part of the excusing process. Such attitudes reduce the chance of such men being detected a second time.

Long term monitoring and community education

Registration under the Sex Offenders Act 1997, the development of Multi Agency Risk Management Panels and the recent adoption by Police of the SACJ risk classification, has enhanced the process of monitoring convicted sex offenders.

However, although there is good quality information about perpetrators who have attended intervention programmes, it could be used more effectively for follow up supervision. As I have suggested elsewhere (Eldridge 1998: 120), this could be done through the development of databases for sharing of information about patterns and relapse prevention plans on an area, or ideally national basis. Databases could be shared by police, offender programme delivering agencies and the main child protection agencies, and include all offenders who have engaged in programmes: not just those who have been imprisoned. It could also include unconvicted abusers who have taken part in programmes: agreement could be made a condition of programme attendance. The database would include details of type of offender, previous convictions (and or including alleged offences), target group, grooming tactics, detailed risk factors and relapse prevention plan including details of any external monitoring network.

The community needs to be involved in offender monitoring in a way which empowers rather than panics people. Community notification without consciousness raising about the heterogeneity of offenders and the relationship-based nature of much sex offending, simply perpetuates the monster image portrayed

in the media. Most perpetrators are someone's relative, friend, neighbour, church minister or youth leader, and no one, least of all the perpetrator, recognises him in the media imagery. In the USA, a group called 'Stop It Now', Massachusetts, has been successful in using a public health education approach to combat this problem. A campaign involving advertisements, leaflets and telephone helplines has made it possible not only for non-abusing parents to seek help, but also for previously undetected adult and adolescent abusers themselves, to come forward for assessment and treatment linked to the criminal justice system. Combined with a range of effective intervention programmes, responsible public education can do much to create a safer more aware society and reduce the risk of children being sexually abused.

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17 The uses of therapy

Understanding and treating the effects of childhood abuse and neglect

Joan Woodward

Introduction

The material in this chapter is drawn from my book *Understanding Ourselves: The Uses of Therapy* (1988). It is based on my experience as a feminist and a psychotherapist working with fairly ordinary but deeply distressed individuals whose problems are readily recognisable and easy to identify with. The material selected for inclusion in this book illustrates the processes by which people come to repeat or replicate distressing experiences from their childhood. It also explains what therapy can contribute to understanding these repetitive cycles and to helping afflicted individuals to stop abusing themselves and others.

The importance of therapy

Psychotherapy is a process that enables us to work towards a better understanding of ourselves and the forces that operate both within us and outside us in society, which determine our feelings and behaviour. It is this understanding which plays such a crucial part in enabling people to work towards the sorts of changes that they want for themselves.

I believe it to be particularly important for people who work in the so-called 'caring professions', who help other people to develop and change, to have experienced this process of increasing their understanding of themselves. This is because it is a two-way process. Only through working on understanding ourselves can we begin to understand others. Likewise, when we see clearly why someone else feels or behaves as they do, we can sometimes break through some of our own blindness concerning ourselves.

We nearly always know, even if only dimly, that severe conflicts which make us feel torn and helpless and seem so hard to resolve, have been very strongly determined and deeply patterned at an early stage of our lives. Just as we can sense that our inner conflicts started very far back in our own history, so there is a similar sense about the forces at work creating conflict in society.

When we seek to bring about better solutions to conflicts both within ourselves as well as those outside, it is important that we do not under-estimate either the complications or the strength of the forces opposing such changes. We need to give

proper recognition to this, and to the length of time it may take some people to discover how to resolve their severe conflicts in new ways.

In this chapter the stories of some of the people I have worked with illustrate how early childhood experiences of violence, abuse, or neglect (of their need for love, nurture and care) have affected them. It goes on to show how the process of therapy can help the person concerned to repair some of the damage caused by these experiences, which have led to various forms of self abuse, self-neglect, and most commonly self-sabotage. In some cases it has led to the abuse of other people.

Most of the therapy described in this chapter applies to long-term work, which means for both the therapist and client, a readiness to engage in the task over a period of some years, rather than a few weeks or months. The chapter includes some of the theories of therapy that help to explain the effects of childhood abuse and neglect, which provide a basis for therapeutic intervention.

Case studies

Margaret: looking after everyone

When Margaret first started therapy, she was aware of her huge need to look after everyone: her husband and children in particular, but also other family members, her friends and neighbours and all the students in the classes she ran at evening school. This 'looking after' took many forms and Margaret felt she must never say 'no'.

On the other side of the 'good fairy' vision of herself was the person she described as the 'bad fairy', who raged and screamed and wept and felt resentful about all the demands that everyone seemed to make on her, which not only overwhelmed her, but also left her feeling she could never express any needs of her own. As she spoke of these feelings she became deeply distressed at her own sense of unworthiness.

The more Margaret talked, the more she became aware of the compulsive aspect of her need to care for others, with a lot of anxiety created for herself if she failed to do it to the full. Margaret soon began to recognise that at times she felt that if she did not give the right sort of care to someone she would actually feel responsible for the person dying.

Her conflict was clear: she was feeling and behaving as if she was the sole life support system for everyone, as if she had to give constant caring to keep people alive. If she failed they would, or could, die, as she alone had not only the power to keep them alive but a driving responsibility to do so. The burden of all this felt so massive that it often exhausted her, and at times felt quite unbearable.

As Margaret's history was slowly shared, she was able to recall the occasion in her childhood when there was a flu epidemic, and she begged her father, whom she loved dearly, to take her to the cinema which she specially enjoyed. Her mother said 'no, it was too dangerous to go to a crowded place as they would catch flu and die'. Margaret persisted and her father took her. Later he did develop flu and died from it.

Almost immediately their entire lifestyle changed. They moved to a gloomy house belonging to some elderly aunts. Their mother had to go to work and Margaret's brother made it clear that he considered the entire disaster her fault. The belief that her 'wants' had killed her father and ruined the lives of her mother and brother, left her believing that her wishes had led to his death. Her only 'solution' was to make sure that she never asked or chose anything more for herself, and that she worked hard to keep everyone alive, to avoid any repetition of such destructive powers ever occurring again.

Rosemary: the compulsive need to care

Rosemary was another person feeling compelled to care. She came for therapy requesting to work on her deeply distressed feelings about being let down by a man she had loved very dearly. He had been giving her double messages, showing her that he loved her and that she was very important to him, then he would let her know of his continuing obsession with a previous girlfriend. This would be followed by remorse and further vows of love from him. This reached a peak when he asked her to marry him, and on the morning after she had agreed, he suddenly told her that he had made love to his previous girlfriend only three nights before and was missing her very much. At that point Rosemary felt near to breaking. She left him, her home, and her work and returned to her parents. She realised that promises of love followed so rapidly by denials, terrified her and the frequent nightmares she was having, led her to fear that she was 'going mad'.

Gradually she realised that she was someone whose standard of loving and staying within a relationship actually increased the greater the hardship or rejection she endured. As she realised how unstintingly she gave loving and caring to others, she saw how very little love and care she gave herself.

When she started to examine when this pattern of behaving began, she recalled a time that stood out very strongly in her memory. Her father was frequently verbally abusive and violent, beating her mother badly on occasions. Her mother told Rosemary that 'if it wasn't for you children I would leave'. Rosemary took on the responsibility for putting it right and continually gave to others the loving care she never had, that she so badly needed for herself, but felt compelled to give away. As women like Rosemary give out more and more love and care in order to try and get the love and security that they failed to receive originally, so they feel increasingly empty inside, as their 'neurotic solution' fails to meet their needs.

Robert: sexually addictive and compulsive behaviour

Robert, a man in middle age, presented his need for therapy because of a conflict in his life that caused him deep distress. For many years he had felt driven to dress in female clothes, originally his mother's and now his wife's. So dressed, he would ask his wife to tie him up, always in the same way, using belts. This

produced enormous levels of sexual arousal and he would then masturbate to orgasm. He felt his problem was getting worse and his feelings of guilt, shame and depression concerning it were increasing.

As Robert began to describe what came to be known as 'the charade' in detail, he said how pleased he felt that he was not viewed as a weird or alarming person by the therapist, and that he could feel relaxed and accepted as attention was directed towards understanding his behaviour as a very uncomfortable 'neurotic solution' to a severe state of conflict stemming from childhood difficulties in separating from his mother.

In the 'charade' he first dressed as his mother and then tied 'her' up (which was the height of the excitement). He was then both the helpless tied up 'mother', and the man who had captured her. The moment the act of masturbation was complete, he felt that being the tied up woman as well as being the man who had violated her utterly intolerable. His anxiety was acute until he was freed, which he needed to have done as quickly as possible.

When he was the 'man who had captured her' and was anticipating having her sexually, he could feel very excited and powerful. Once it was over, he was in touch with an agonising level of powerlessness which he saw as the source of his need to 'have her again'. So the 'neurotic solution', although it appeared to give him 'power' over the mother who had seemed all-powerful in his childhood, merely recreated his feelings of powerlessness, which drove him to repeat the act. His huge sense of guilt about his 'wicked desires', as he perceived them, seemed overwhelming.

James: self denial

The more we examine 'neurotic solutions' the more complex and maze-like we find them to be. Not only do they exist so strongly in themselves, but they are supported by a series of beliefs that we actually create to maintain them. Some people devote a great deal of energy to maintaining their 'neurotic solutions'. An example of this was shown by James, a man in his early thirties. He once described his feelings about losing everything that he tried to have when he told the story of his buying some shoes.

He was an only child of rather elderly parents, and he had always felt that every achievement had to be denied. He moved from job to job, from relationship to relationship, always intolerant of anything that seemed to be succeeding because he would then have to own, or accept responsibility for achieving, which he could not bear to do. He told me how he saw a pair of shoes in a shop window. He needed some and he liked the look of them, but he felt positive they would not be his size. It took him some days to dare to go and find out. Eventually he did, and they were not only his size but they fitted him perfectly. He tried them on, and walked about in the shop. They were right in every way. He could not bring himself to buy them, however, and he continued to regularly look at them in the shop window. He considered them 'his shoes', but he was then in a great state of agitation because now he knew they were perfect and if he did not buy them someone else might do so. Finally he went and bought them.

When I asked if he felt happy when he had them, and if he enjoyed wearing them, he shook his head. 'No', he said, 'they are still in the box in my wardrobe. You see, I can't bring myself to wear them, for then they would start to get worn'. They would become less than perfect. His wanting them and his use of them would lead to their destruction.

This story shows so clearly how the beliefs formed in early childhood concerning the damage some people feel their very existence will bring about, can last right on into adulthood, and render them incapable of even ordinary acts such as buying clothes for themselves.

Anthony: loss of self

Anthony was torn with conflict about how he could be himself without threatening his father. When he started therapy he was on sick leave from his job and had been resting at home for some weeks. He not only felt unable to go to work, but at that stage felt unable to venture out of the house. He was sleeping badly, and often felt compelled to get out of bed at night and seek a place to hide in the bedroom. Such feelings were experienced as frighteningly inappropriate to him, as well as to his wife. He spent many hours in his study doing immaculate exercises as the 'pupil', marking them in red ink as the 'teacher'.

Anthony had had two previous points of breakdown earlier in his life when he had also felt unable to continue at work. Both had come at stages when promotion was around for him, as it had been on this occasion too. The trigger each time seemed to be when a relationship between a deeply loving father and son were vividly portrayed to him, once on the stage in an opera, and once on television. Anthony described his father as a very intelligent and ambitious man, but he worked far below his potential ability. He was extremely violent to his wife and sons. When Anthony secured a grammar school place, this produced a negative response in his father. Struggling to avoid this, Anthony became sick with a mysterious, very prolonged and undiagnosed illness that postponed his move to grammar school for many weeks.

For Anthony to develop or to achieve, especially in the sphere of intellectual work, was so threatening to his father that it appeared to Anthony as if it would cause his father to die. Anthony recoiled from the violent physical aspect of his father, rejecting all manual work for himself. Instead he moved to develop his intellectual work exclusively, which actually threatened his father the most.

Understanding the effects of distressing childhood experiences

These examples of conflict were experienced by the people suffering them, as painfully inappropriate. They are described as they were presented in the early stages of therapy. Let us now turn to examine the characteristics of these types of conflict to see what they hold in common, while acknowledging that each one has its own unique variations and many complications because of its individual history.

Each of these stories illustrates the person's sense of being torn between how they want to be, and wish so much they could be, and yet how driven they feel to be the opposite. How these conflicting feelings have come about gradually becomes understood as the person recognises the beliefs that they hold about themselves. These come from their early life experiences even though there may be no clear memory of them. The responses that they have created, however, are strongly felt in the present. These are generally experienced in the form of the person feeling consistently 'bad' or 'guilty' or unable to accept ordinary, good feelings about themselves. As therapy proceeds, the client and therapist share recognition of the 'neurotic solutions' that the client has felt compelled to put into effect, but which have failed to resolve the conflict for them.

'The return of the repressed'

Freud provided an explanation of why we persist in repeating patterns of behaviour in his theory of 'the return of the repressed'. This is a rather complicated theory, but in ordinary language it means that the very method we choose to solve unbearable conflict actually recreates it. The word 'repressed' means that the feelings have been pushed out of our awareness, so that we do not know about them. This does not make them go away, and they reappear in a disguised form in the 'neurotic solution'. This is not recognised by the person involved, who is striving to escape from their painful feelings.

As feelings reappear, albeit in a new form, so more preventative action is required. This means the 'neurotic solution' is put into practice even harder. Hence we see how the compulsive nature and persistence of 'neurotic solutions' are endlessly recreated. This re-creation of the original fears also explains the sense of hopelessness so characteristic of the 'neurotic solution'. We may all at times feel deeply convinced that such solutions must be carried out to protect us from some deeply threatening fears, but in reality such solutions solve nothing. Most people who put such solutions into practice feel exhausted, trapped and despairing, like a rat caught in a wheel. The more the rat runs, the faster it has to keep moving.

The compulsive and persistent nature of 'neurotic solutions'

People who are struggling to find a solution to an unbearable conflict feel driven to behave in certain ways even when they are aware that these ways are not how they really want to be. They are also aware that they have felt, said, or done, whatever it is, so many times before. Yet this behaviour has not resulted in their achieving what they want for themselves.

During therapy people have the opportunity to examine slowly and in detail both when it is, and in what sort of situations, that these behaviours occur. As they look at how frequently they recur, they often express the feeling that at that particular time no other way of behaving feels known to them. It seems as if alternatives have been shut out of their mind, however much they dislike the ones that they feel driven to do.

Another characteristic of the 'neurotic solution' is its persistence. For the person experiencing it, it is as if the need to behave in the same old way is never-ending and that the conflict is incapable of solution. For people who feel they have to withdraw; push people away who come too close; feel that they must have an alcoholic drink; must eat, or not; must work late into the night; or whatever the compulsive behaviour may be, it is as if no choice exists, because to change their behaviour would bring about unbearable anxiety or distress. The strength of these compulsive forces and their persistence never ceases to amaze me, no matter how many times I hear them described by others or experience them in myself.

The destructive element in these compulsive urges to carry out the 'neurotic solution' can be immense. It not only drives some people to suicidal feelings, but it often leads them to damage themselves and other people. It is common for women who have been incest victims to inflict quite severe injuries to themselves. This is usually done by cutting and is rarely experienced as painful at the time. Through these acts such women often get a sense of relief. Paradoxically the acts also demonstrate and maintain, the women's feelings of being 'bad' and 'dirty', although this image is always horrendous for them.

The 'abandoned child'

Another example of 'the return of the repressed' comes about in the person who rejects a deeply longed for attachment, or love relationship, because of the fear that they will lose it. This is a common response if a parent dies, or leaves home, and the child who is left has overwhelming feelings of loss. There is evidence that some twins who lose their twin respond similarly (Woodward 1987, 1998). This response to rejection of an attachment figure can also occur in a rather different way, when a much more trivial seeming event occurs, such as a young child being separated from its mother for a short period in hospital. Small children in hospital feel deserted and uncomprehending of why their mother, whom at this point is particularly needed, has gone away. When the child's mother comes to visit, particularly if there has been a gap of some days, she finds her child turning away from her. Separation of this sort is not so common now, due to an improvement of awareness in hospitals of children's emotional needs. Separation is more likely to occur now, if the mother has been in hospital, because it is less usual for young children to visit their ill parents.

The 'turning away' is not because the child has forgotten its mother (a very superficial explanation that was offered at one time). It is because the child is now rejecting its mother. This is not because the child does not love her, or need her as much as ever, but it is a chosen solution to avoid the pain of being attached and belonging to someone of utmost importance who then goes away. The pain of risking another loss seems too great to bear. The child's solution is not to trust a close relationship or not to have it. As I believe it to be the case with adults, the choice of having none is perceived as less risky than being very close and giving someone else the power to withdraw the love. The paradox that remains inside this 'neurotic solution' and why it is a perfect example of 'the

return of the repressed', is that in the very turning away, the child determines that there will be no mother love for it. Yet this is the very thing that the child has such dread of losing.

I believe that when we choose to reject the thing we most want, because of deep fears about it making us vulnerable to the risk of its loss, we choose one of the worst of all 'neurotic solutions'. The sense of gaining control through rejection is a false one. We remove our energies from the task of finding ways of getting something we want. In the process of choosing 'nothing', we actually experience the greatest sense of loss of control which lies at the heart of all conflict. In some cases the need to reject, even to the lengths of getting rid of the object or person whose love we deeply need because we fear it will not be available, can lead to the most violent and destructive behaviour.

The effect of violent and abusive behaviour

The person who has a compulsive need to bully or to be violent and abusive seeks out another who is vulnerable and perceived as weak, in order for the bully to hurt them. In the process, the bully, who always deep down feels himself to be unloved, unworthy and above all powerless, hopes to lift himself up from these feelings by the sense of power he has over his victim. The method or solution of lifting oneself up through putting someone else down is, however, always ultimately self-defeating. This is because people who bully others never do feel really good or worthy, in any fulfilling sense. All they have done is to give someone else who is easy prey the experience of being hurt which the bully himself feels deep inside. The feelings have not been got rid of, but merely replicated. Sometimes people who behave in this way can, in their more enlightened moments, actually see what they have been doing. When this occurs they sometimes condemn their own behaviour very harshly. It seems that such people who then turn to the chastising of themselves, partly do so because they genuinely despise their own behaviour, but also as a way of protecting themselves from criticism.

An example of this arose in a man who had beaten up his wife and later another woman he lived with. He always suffered great feelings of remorse and shame afterwards. The physical attacks always occurred because of his acute sense of frustration, due to the woman not seeing that his advice or way of doing something was right. If she criticised, or ceased to be grateful or appreciative, or wished to do something differently, he became very distressed and angry. His belief in himself as knowing best, in providing something wonderful, was strongly challenged. He found it impossible to look at the fact that his way of behaving actually deprived the woman he lived with, from having the very right that he demanded for himself. He saw no solution in compromise, for he perceived his way as best and found it hard to understand why others could not accept it. He wept from feelings of being unappreciated, not only at home but also at work. He sought a therapist who would confirm his rightness and support his view of how wrong everyone else was in failing to appreciate the expertise he had to offer. He could see, in theory, that gifts and advice can only be fully appre-

ciated if they are in the form that the receiver wants them to be, but for him to carry this out in practice, would have meant letting go some of the power to control other people's lives, which he felt unable to do.

People who behave in abusive ways are very fearful of those they perceive as powerful above them. This is because they expect in turn to be hurt or put down by others. This has always been the bully's earliest experience. The only gain from bullying is the short-lived excitement that may come at the time of the bullying incident. Afterwards, at a deeper level, the bully always feels worse. He knows that the victim is undeserving of the hurt and also how that pain feels. His guilt feelings, generally operating just below the bully's awareness, actually serve to maintain bad feelings about himself. These are the very ones from which he was trying to escape through the violent, abusive and bullying acts in the first place, but sadly they merely perpetuate the cycle of violence.

'Neurotic solutions' as survival strategies

Nobody yet knows why early patterning holds so much strength in determining life-long behaviour in certain people rather than others. It seems probable, however, that three factors play a part. The first is to do with the severity of the fear when the pattern originated and how far it destroyed the child's ability to experience a good attachment with at least one parent. The second concerns whether the same type of situation was experienced again in later childhood or adolescence. The third factor, is how far other people or events in the person's life helped to make up for, or counteract, the original experiences.

Many people experience other people's knowledge and achievement as if it were their own loss. This is because the knowledge or position of others has been experienced in the past as a source of power that was intimidating. For adults who frequently experience this sense of loss, there is nearly always a history of this having occurred for them in painful ways in their early life. I would support the view that such adults have had insufficient parental care and love (Miller 1983). A very dominant parent may have deprived them of good feelings about themselves. Such children can become highly competitive, as they compulsively continue their search for parental love and approval. Alice Miller points out that most frequently any clear memory concerning feelings about these experiences is actually denied. The childhood experiences are exposed again by the adult behaving in exactly the same way as he or she was treated in their own childhood.

People engage in remarkably complicated mechanisms to shore up their belief systems. The reason 'neurotic solutions' are put into practice with such tenacity is that they were originally created as necessary for purposes of survival. Bowlby (1980) suggests that the way we all process information acts as the best protection we have, for not knowing the things we do not want to know. He suggests that we are able to filter out ideas that challenge our ways of thinking. This is a very important contribution to understanding how individuals handle how they are hurt. We can actually hold, at a clear level of awareness, two totally contradictory pieces of information about ourselves. We shut one out, and

behave as if the other is the only true version, as a method of avoiding the conflict and the need to solve it, that would otherwise occur.

It seems that this 'shutting off of our minds', this virtual inability to hear what might provoke too deep a challenge to our belief systems, may well be the most effective method that we use to prevent us from changing regardless of the pain and distress that may be present, because we so deeply fear exposing ourselves to any need for change. It is no wonder that clients in therapy express acute anxiety at even thinking about change, let alone carrying it out. Nobody can remain calm and talk rationally about letting go of ways of behaving that were originally created to protect them from life-threatening situations. It is for this reason that therapists need to work slowly and above all to appreciate the courage it takes for people to face these deep fears and to talk about them. Such work can only be done in small amounts at a time.

The processes of therapy

So much has been written concerning theories of human behaviour and about therapy, but much of this concerns diagnosis and classification of symptoms. Surprisingly little seems to have been written about the experience of therapy: how it is carried out and above all how changes in feelings and behaviour actually occur. I believe it is this lack of information that makes many people think that psychotherapy is some little-known, mysterious process. In fact it is nothing of the kind. We are all continually confronting the very basic question of how, as individuals, we can use our understanding of ourselves to move away from ways of behaving that we dislike and from which we wish to free ourselves and move towards less distressing ones.

Sometimes feelings or ways of behaving are experienced as driving us so compulsively that we can feel trapped and quite unable to see any way out of them at all. This is particularly true for anybody with very strong, deep-rooted fears. I believe that all feelings and behaviour make sense, and can be understood, provided both the actual experiences and the resulting beliefs that have been formed are examined carefully. In this way the beliefs that people hold about themselves are recognised as having come out of actual experience, the loss of a parent, their place in the family or most commonly their parents' expectations or attitudes towards them.

Therapy is sometimes a difficult and complex matter, particularly for those whose abuse started early in life, or has been severe or long lasting. Some vital ingredients must be present in all therapies if changes are to occur in the person concerned, of the kind that they seek for themselves. It is absolutely necessary for the person to tell their history as they experienced it and to have it fully heard and received by the therapist, without the therapist distorting it. For many people this is in itself a frightening and daunting task. This form of listening can provide, sometimes for the first time, 'the enlightened witness' whom Alice Miller (1991) refers to who truly hears the voice of the inner child. It also starts to provide an experience of the 'secure base' that Bowlby describes. This 'telling of the story' continues throughout therapy and throws

more and more light on the original life-saving survivor strategies, or 'neurotic solutions', as I have named them (Woodward 1988).

Jean Baker Miller (1991) also endorses the need for this proper connection between client and therapist, and, like Alice Miller, she would stress the importance of lessening, as far as possible, the power structures in therapy. All three therapists emphasise the absolute need for the client to express their feelings: without this, nothing changes. This may not be done through words alone, as drawing, painting or drama are additional ways. Therapy should never be a cool, intellectual, one -way activity, but as Bowlby says a 'shared exploration'.

Alice Miller (1991: 179) describes two further requirements as: 'querying the situation' and then for the client to express her needs and to find ways of getting them met. This may sound simple, but they can be immensely difficult stages to bring about. This is because 'querying the situation', actually means recognising where the guilt and blame really belong: not in the child, but in the abusive and neglectful acts experienced by the child. As this is something the person has found it impossible to do as a child, it often remains, understandably, very frightening to do even as an adult.

Enough has already been written to explain how 'strategies' or patterns of feelings and behaviours arise from the child's absolute need to repress full knowledge concerning their abuse, whatever its form. Bowlby (1980, 1988) and Alice Miller (1987, 1991) have contributed a proper recognition of why these patterns are so hard to change. This is due to their originally being survival tactics in an endeavour to retain 'attachment', even though they are doomed to fail. They hold for the person some sense of power or control: as illustrated by the child who threw away his most loved possession because his father was going to take it away and only by throwing it away himself could the child feel he had gained some power and control in that situation. As a perfect example of 'the return of the repressed' he was then left without his toy, the very thing he felt so upset about in the first place. This is often the only sense of being in control that the person has. To strive in that way is the only way that the person 'knows themselves' so to give that up, can feel like falling into an abyss!

During therapy, it is possible for the client to recognise how much 'loss of self' and deep emotional pain is involved in maintaining these strategies, as well as recognising their futility, so that gradually they can be 'let go' and new ones found in their place. Baker Miller (1995) has written an important paper, stressing the importance of the therapist 'honouring the strategies of disconnection'. This means the therapist joining with the client in deeply understanding how and why the strategies were created in the first place, but also acknowledging the suffering so many of them bring in their wake.

The main aim of therapy centres round working with the client to recognise that all the 'strategies' were created as a form of resistance to the child's threatened emotional survival. The task of change is described by Gilligan *et al.* (1994) as changing the 'resistance for survival' into the 'resistance for liberation'. I believe many people hold onto their sufferings for three other very specific reasons. One is that they represent testimony of the original pain. If it was given up, who would

know of it? Second, the suffering carries a demand, in a sense, that the 'solution' must be provided by someone else. It is as if the person feels the love and care that was their due was not given and the seeking of it and demand for it continues to be sought 'from out there'. For the person to believe that they can begin to find this for themselves (but not in the sense of being isolated or self-sufficient) can feel like letting the original abusers off the hook. It also feels like losing the power to 'make' people be there for them. The third tenacious strand in maintaining the suffering is the feeling that it can hold of punishing or taking revenge on the original abusers. These feelings can be present even after the parents have died. It can be a most powerful factor in self-injury and suicide bids.

Letting these patterns go and moving into the last stage of therapy, when the person feels able to value themselves and feel safe in doing so, can take a long time for some people. Bowlby and Baker Miller stress the importance of using the transference in therapy. This is not a mysterious process, only occurring in therapy, but something we all engage in all the time. It simply means transferring onto someone feelings about them, that actually stem from somewhere else. For example, clients who have been deprived of 'good attachments' in their very early life, can feel extreme anxiety when their therapist is ill or goes on holiday, as it can arouse early memories of abandonment. This gives the therapist an opportunity to help the client see this, not as a babyish dependence, but due to him or her not having the care they should have had in childhood.

All psychoanalytical and psychodynamic therapists use the transference because it provides evidence of feelings from the past, which are re-lived with the therapist. It enables a sharing of the ways in which the client may be experiencing the therapist as if he or she was a parent or sibling. Often these transferences only come to be recognised through what is known as 'counter-transference,' that is the feelings the therapist experiences. For example, the therapist may feel as if he or she is experienced as constantly threatening or rejecting the client and is not to be trusted. It is important for the therapist to examine with care, whether their own behaviour actually justifies this response in the client, rather than it being a fearful re-enacting of the client's feelings from the past. When such feelings can be recognised as arising from real experiences in the past that have previously been buried, the client can begin to free him or herself from them.

To give an example: certain people behave in a very aggressive, critical, attacking manner with others, as if they were constantly expecting to be attacked themselves. Such people's earliest experiences have led them to protect themselves in this way. Originally, such a method of defence may well have been experienced as essential for their survival, but in their adult life its inappropriateness is very evident. Those around such a person in their family or at work, respond either by becoming cowed and frightened (as the person once felt themselves to be) or they retaliate with even greater aggression. This enables such a person to maintain their belief that the world is full of people who would 'do them down'. It also keeps hidden from them, any recognition that it is their behaviour which plays such a big part in creating the aggressive response in others and that this could actually be changed.

In therapy it is possible for such a person to begin to recognise that it is no longer necessary to confront every situation as if they were fighting to the death for their space! With the therapist's caring support, such a person is enabled to muster the courage to lay down the 'swords' he or she has carried since early childhood. Such a person then discovers that not only are the 'swords not needed', but that people actually respond, often with patience and kindness when no 'swords' are around. This new and sometimes unbelievable experience enables the person to begin to believe in their own goodness.

Striving to understand feelings and behaviour within the context of the person's actual experiences is, I believe, an essential part of therapy. But it is only part of the work involved. Sometimes people understand very well how they come to feel and behave as they do, but they also need to have a deep wish to move towards new ways. Only then can their understanding be used as part of the means to obtain a change. Changes come only when certain beliefs are let go, and such beliefs need in the first place to give us considerable discomfort before we will even examine them, let alone consider therapy. How easy we all feel it would be to achieve certain goals if only we did not feel afraid, or lack confidence, or whatever the barrier is perceived to be. The fact is, however, that we have to tackle the goal in spite of the fear, sadness or the inadequacy feelings that grip us.

As recognition of where these feelings started and how they built up becomes clearer, so their present inappropriateness becomes more obvious. The purpose for them that once existed does so no longer, and it is the recognition of this that forms the first step in enabling the person to experiment in letting them go. Some people imagine that deep traumatic experiences must lie at the back of such fearful patterns. This is not necessarily so. Family attitudes, or even those of teachers or neighbours may all contribute to the perceptions about oneself that can cause ways of behaviour that can last a lifetime. As people begin to talk about aspects of their life that they feel are unbearable, it is often possible to discover quite quickly what it is that they are feeling that they must do or not do, in spite of hating it or experiencing deep distress about it. As therapy continues the person slowly recognises the process that occurred leading to their compulsive need to put the 'neurotic solution' into practice. Simultaneously they begin to see why its inappropriateness increases as the years go by. Once this stage is reached, nearly all the remaining therapy time is given to supporting and encouraging the client as they try to behave differently, but it is important not to under-estimate the depth of the effort that is involved for some people in achieving change in themselves.

The uses of therapy

Psychotherapy offers people the opportunity to work for a greater understanding of themselves, which leads to change and growth in a way that they determine. It is not the therapist producing a 'cure' for a particular symptom with the client passively 'made better'. Psychotherapy is a hard struggle during

which the client uses their unique relationship with the therapist, in order to explore the sources of the client's conflicts and to help them to discover new and better ways of resolving them. Without the security of the therapeutic relationship, I believe few people can manage to do this.

Although the uses of therapy described in this chapter apply mostly to long-term therapy which enables people to make changes in their life-long patterns of feeling and behaviour, short-term therapy has many valuable uses as well. Short-term therapy is generally understood to last a few weeks or months and it usually, though not always, works at a fairly superficial level. This does not mean that it is insignificant to the client. Such therapy is generally focused on to a specific concern or problem that the person wishes to make a decision about or attempt to change. I believe short therapy is more likely to be effective for someone who generally feels good about themselves and has a perception of their 'normal way of being' that they strongly want to regain.

It is a tragic fact that some people have experienced such terrible losses, such repeated deprivation, such cruel treatment from people who should have provided them with loving care, that they may be unable to use a therapeutic relationship to rebuild a new validation of themselves. The extent to which this is true, however, has not been tested: nor have the costs of individual psychotherapy as described in this chapter been balanced against the costs to society of the harm that is done by violent and abusive 'un-treated' individuals to themselves and to others. There is some evidence that psychotherapy is cost effective (Woodward 1991). Figures (in 1988) from the Finnish National Pensions Institute (equivalent to Social Security in Britain) showed a 50 per cent increase in people in paid employment after a year of psychotherapy, with 37 per cent fewer on unemployment or social insurance benefits. It is often thought that psychotherapy is only of value for 'neurotic' patients, but the Finnish experience showed an improvement in 83 per cent of neurotic and 75 per cent of psychotic patients (Pylkkanen 1989). Psychotherapy in Finland has been widely state-funded as the Finnish government recognised its cost-effectiveness.

In Sweden, a study by R. Sjostrom (1984) evaluated the effects of psychotherapy on a group of patients six to eight years after it ended, and compared then with a similar group that were only treated with drugs. There was a statistically significant difference in the group that had psychotherapy with regard to their ability to work, a greater length of time out of hospital and their improved social contacts.

In Germany, A. Von Duhrssen (1962) examined the results of 1,004 patients offered psychotherapy by well-known experienced therapists. This was largely with chronically sick patients. It showed improvements in 81 per cent of them and that these were long-lasting. Hospital stay was reduced to 0.78 days per year, as against the average stay reckoned by insurance companies of 2.4 days. As in Finland, this research has influenced the funding for psychotherapy in Germany as it is viewed as a highly cost-effective option by insurance companies.

In spite of evidence of the effectiveness of psychotherapy in treating mental illness (including individuals diagnosed as psychotic) – such as fewer suicides, lowering of prescribed drugs, fewer days in hospital, fewer visits to GPs and an increase in the ability to work in chosen job fields, increased earning capacity, more social contacts and subjective assessments of an increased sense of well-being – there is a general lack of knowledge about this on the part of relevant policy makers (Fonagy and Higgitt 1989). There is the potential to redirect resources away from responding to the effects of violence and abuse to prevention through early therapeutic interventions. There is a failure to provide adequate resources for it.

My paper (1991) on psychotherapy as a cost-effective option brings together research findings from other European countries. In Finland, a body similar to the NHS provides psychotherapy on the grounds that it enables people to return to work. If they go into hospital this is a less likely outcome. A German study describes how psychotherapy is widely funded by private health insurance companies, on the basis that it reduces stays in hospital. Interestingly, again, this study includes those with the psychiatric label of 'psychotic' as well as 'neurotic'. In this country another study showed that group therapy offered in a supportive, residential setting was also effective. The paper includes a strong challenge to Eysenk's negative findings about the outcome of therapy. My basis for urging the widespread availability of psychotherapy is not so commercially driven. It is more a response to the ethical principle of recognising the importance of meeting the needs of people in severe emotional distress. Whatever one's personal views may be for advocating psychotherapy, these research findings now need to be both widely disseminated and acted on as a matter of health service policy.

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Part 2.2

Child protection policy

18 Gender and the child protection process

Elaine Farmer and Morag Owen

Introduction

As practitioners and managers in social services departments struggle to find a new balance between child protection and family support in the wake of the Department of Health research on child protection (Department of Health 1995) an important issue has been absent from the debates. That issue is the way in which gender affects the current operation of the child protection system. An official summary of Inquiry Reports (Department of Health 1991) concluded that inquiries into child abuse gave too little consideration to structural issues, in particular those relating to race and gender. None the less, the overview of recent Department of Health (1995) research on child protection did not highlight those messages which had emerged from the research programme in both these areas (for example Owen and Farmer 1996).

This article will draw on that programme of research to show that, at each stage of its operation, the child protection system shows a significant gender bias. The implications of this bias for child protection will be demonstrated. We will draw in particular on the study of decision-making, intervention and outcome in child protection work which we conducted as part of the Department of Health programme (Farmer and Owen 1995). Our study gathered data on forty-four children whose names had been placed on the child protection register. The sample was drawn from seventy-three newly registered cases, after attendance at 120 initial child protection case conferences in two local authorities. The parents, older children and key workers were interviewed after the initial case conference and again twenty months later. Since the research was undertaken, there have of course been practice developments in the participating authorities, such as the increased involvement of non-abusing mothers in investigations. However, the broad messages from the findings continue to require attention.

The children in the study represent a fairly typical cross-section of cases registered by social services departments. Concerns centred on physical abuse in a third of cases, on sexual abuse in another third, and neglect and emotional abuse in the remainder. Two fifths of the children were under five, a quarter were aged five to ten, and a third were aged ten or over at the time of the case conference.

Forty four mothers were interviewed and also, in fourteen of the sixteen two-parent families, the father, stepfather or male partner was interviewed.

The stage of first referral

When the evidence on the sifting of referrals from all sources is examined, a pattern emerges in which mothers are under-included in relation to offers of service and over-included in respect of agencies' efforts to control them (see also Dominelli 1989). A study of 1,825 referrals of suspected maltreatment by Gibbons and colleagues (1995) showed that among the referrals most likely to be filtered out at the referral stage were those relating to lone mothers where the concerns were about neglect or emotional abuse. Similarly, at the next stage, when cases were investigated, those concerning allegations of neglect or emotional abuse by mothers were particularly likely to be filtered out without a conference, which would have meant that an inter-disciplinary planning meeting considered their problems. At neither stage were services provided for these mothers. Thus it can be seen that the referrals which concerned mothers who had parenting difficulties were not given priority and, indeed, were systematically passed over in the allocation of services.

In spite of this, our research showed that mothers were actively involved in seeking help from child protection agencies. They were the single largest group to initiate action which led to a child protection referral. This occurred in 27 per cent of the cases in our study. Similar results were found in a study which examined child sexual abuse referrals (Sharland *et al.* 1996). Women's efforts to engage professional agencies to protect their interests and those of their children are frequently obscured by studies which trace referrals only as far back as the first professional agency to be contacted. Yet our study, like Gordon's historical research (1989), shows that women do turn to professional agencies in the hope that they will receive assistance either in dealing with their own problems or in regulating the actions of the men with whom they are living.

However, when mothers sought help from professional agencies, because of their concerns about suspected abuse either from inside or outside their family or because of child management difficulties, the action which was forthcoming was sometimes very different from that which they had hoped to elicit because they themselves often came under suspicion. For example, the mothers who had approached social services to seek assistance in managing their children felt unjustly condemned when child protection procedures were enacted. In some cases, this meant that they refused later offers of help. This situation can be illustrated by the case of a young mother who requested help from social services during her pregnancy. Her previous baby had been removed permanently because of an injury. When her self-referral led to child protection registration, she said: 'I thought it was so stupid, because things that I would tell them I'm not going to tell them now. Because up to the next six months I'm going to be absolutely petrified.'

Mothers were particularly alienated when, after they had talked openly about

their children to a professional, a referral was made to social services without their being informed. After a referral had been made behind their backs, such mothers subsequently felt so distrustful of the child protection agencies that later intervention was often vitiated.

Thus it can be seen that mothers played an important part in identifying children who might require assistance or protection and that the way in which these referrals were handled had a considerable impact on them. Yet, rather than being seen as allies in the protection of their children, they were often treated with suspicion. On the other hand, when the referrals involved neglect or emotional abuse, mothers frequently received no service at all.

Child protection investigations

When, in our study, referrals resulted in an investigation, the focus on children's safety often meant that very little attention was paid to keeping parents informed about the course of events. Those who were overlooked in this way were usually mothers, although in cases of sibling abuse both parents might be ignored. Worried parents would be out searching for children who had not returned from school, only to find out much later that their children were being interviewed at the police station. Indeed, in eleven of the fifteen cases of sexual abuse in our study, children were interviewed without the non-abusing mother being informed, let alone involved. This occurred even when it was the mother who had reported her concerns to the social services department. In such cases, mothers who were struggling to assimilate the notion that their partners had violated their children, found that the children had been encouraged to talk about the abuse to professionals while they themselves had been excluded. In this way the conduct of the investigation could marginalise non-abusing mothers and replicate their experience of discovering that their child had been abused without their knowledge. This exclusion could leave them feeling angry, vulnerable and distrustful about the agencies and it could influence the way in which the case developed, to the detriment of the mothers and their children (Farmer 1993).

Once non-abusing mothers had been brought into the investigation, however, they also became the subject of scrutiny. Judgements were made about mothers who were in a state of shock. If they did not react as the investigating team expected, they were sometimes held to be unable to protect their children. When an allegation of sexual abuse was made against a male partner, there was an expectation that the mother would immediately sever her relationship with the alleged abuser to ensure the child's safety. The difficulty of the mother's position and the complexity of her emotions were rarely acknowledged. If mothers were uncertain whether or not they believed their children's allegations of abuse (a situation more likely to occur when the mother had not been present to hear the evidence given by the child during the investigation), or were thought to have retained their attachment to the abuser, the possibility of removing the children was given active consideration.

When, as often occurred, alleged perpetrators protested their innocence, mothers could be torn between their child and their partner, caught in a position where believing one meant losing the other. As one mother put it, when allegations of sexual abuse were made against her partner:

> It was ten years of my not knowing that I find hard to believe. Especially of a man that I'd loved and deep down I still love now. . . . My husband is maintaining he's done no wrong. But the two girls are both saying, 'Yes, these things have happened'. So I feel as if I'm in the middle of a see-saw.

Such mothers badly needed help in dealing with their feelings about what had happened. However, an exclusive focus on mothers as secondary perpetrators rather than as secondary victims of the abuse of their children often led social workers to judge them as 'non-protective' mothers. There was a need for a woman's feelings of shock, self-blame and loss to be understood and for support to be offered at this time. When such support was not forthcoming, this in turn made it more difficult for mothers to provide the understanding needed by their abused children (Gomes-Schwartz *et al*. 1990). Thus, the conduct of the investigation affected the way in which mothers and other family members reacted and who they turned to for comfort and help.

Clearly, what is needed is consideration at the outset of an investigation of how best to intervene strategically in order to strengthen the support given to the child. This will often mean strengthening the alliance between the non-abusing mother and the child, particularly as research has shown that children have the best prognosis for recovery when they are believed and supported by a parent (Conte and Schuerman 1987; Wyatt and Mickey 1988; Berliner 1991). Women who do not immediately reject an abusing partner may still be able to sort out their painful and conflicting feelings, with appropriate help, and succeed in protecting their children (Macleod and Saraga 1988; Faller 1989).

Initial child protection case conferences

The next major stage of the child protection process is that of the initial child protection case conference, which is convened to determine what risks children face and whether their names should be added to the child protection register. In our study, parents or other family members were present at 59 per cent of conferences. Eight out of ten of these conferences were attended by mothers, of whom five out of ten attended alone. Whether or not the mothers were considered to have maltreated the child, they tended to take responsibility for their families and to mediate between their husbands or partners and the outside world.

Although they were keen to participate and the meetings did sometimes provide access to more resources, the experience of attending the conference was extremely stressful. Mothers felt that they were blamed and that their moral fitness as parents was being judged. The experience was intimidating and humiliating. Overall, attendance at conferences often served to make mothers feel

that their views had been discounted and to underline their position of powerlessness (Farmer 1993).

After details about the allegations of abuse or neglect had been given to the conference, the conference members were given background information about the family. This was in order to put the allegations in a context in which they might be more easily understood. However, one result was that the attention of conference members could become diverted from the original allegation on to a more general scrutiny of the quality of the mother's care, partly because of assumptions that mothers were responsible for their children's welfare and partly because the agencies usually had more information about the mother than about the father.

Even if the abuse was committed by the father figure, responsibility for the abuse might be seen as shared by the mother on the grounds that she ought not to have allowed it to happen in the first place. The responsibility for protecting the child was then laid at the feet of the mother. Indeed, whilst the question of whether the mother could protect the child was considered at 60 per cent of the case conferences in our study, the issue of whether the father figure could protect the child was considered in only 19 per cent of those cases where there was a father figure in the family. Clearly, expectations are placed on women that are very different from those placed on men. Yet, as we shall discuss later, mothers may not be in a position to protect their children from their male partners, especially when the latter are violent.

If the degree of risk to a child is assessed according to the mother's actions and attitudes, it is a small step to deciding that the child is actually at risk from the mother, not only because of her limited ability to protect but also because of what are regarded as her poor parenting skills. Assessments of risk undertaken in this way can easily turn into assessments of the mother. In some cases of this sort in the study, the subsequent actions of social services reinforced a situation in which male abusers found it easy to opt out. Worse still, the stresses on the mother might not be recognised, and the conference members could end up by placing the whole duty of protecting the child on a woman who did not have the power to carry it out.

Registration and removal

Whilst these findings show that mothers are often marginalised and undermined in the early stages of child protection procedures, it is not long before mothers start to attract negative attention. It was surprising to find that at initial child protection case conferences physical abuse by mothers was much more likely to lead to registration than was physical abuse by men (see also Milner 1993). In our study, in over three-quarters (77 per cent) of cases where mothers were held responsible for physical abuse, the child was registered, in contrast to less than half (48 per cent) where a father, stepfather or male cohabitee was held responsible. What might be the reason for this astonishing finding? All the mothers who had physically abused a child were lone mothers, whereas all the father

figures were in two-parent families. It may be therefore that lone parents of either gender will be vulnerable to registration and that mothers are disproportionately affected because they constitute the majority of lone parents. In addition, it might have been thought that the mothers in the two parent families would be able to protect the child. What is certain is that there were times when social services departments were unwilling to intervene where a man was seen as uncooperative and threatening (see also Miller and Fisher 1992).

The fact that their child's name had been placed on the child protection register had a considerable impact on mothers. Most felt blamed and stigmatised, even when the abuse had been committed by their husbands or partners and not by them. The impact of the investigation was often to intensify pre-existing arrangements in the family. Mothers who took most of the responsibility for child care assumed even more after the investigation, even to the point of giving up their part-time jobs, either to safeguard the child or to try to meet what they thought was the local authority's view of how they should be more responsible for their children's safety and welfare. Father figures, on the other hand, sometimes reacted to registration in the opposite way, by opting out of the parenting role. Those father figures who had physically abused their children often decided that, henceforth, they would offer no discipline at all. This opting out put further pressure on their wives and partners.

Not surprisingly, for quite a number of mothers, registration was experienced as an additional pressure or burden and this could actually lead to a worsening situation, where their ability to cope with their children suffered. One lone mother described the effect of registration on her state of mind, after some minor but unexplained bruising was found on her baby:

> Every time I go to the doctor's surgery I feel that they all know – you know, behind reception. They probably don't, but I feel that they're looking at me or whispering, and I feel that they all know. I mentally cut myself off, because otherwise I get so uptight.

This bias towards regulating women rather than men is also reflected in decisions to remove children. Thorpe's study of child protection practice in Western Australia (1994) showed that the children of single female parents were more likely to enter care at the time of the investigation than children from other types of family. Gordon (1989), in her research, also shows that this practice has long historical roots. At the turn of the century, recommendations for removal of children in the USA were more often made in respect of single mother households than two-parent families.

Intervention in cases of child sexual abuse

This differential treatment of mothers was also a feature of case management after registration, but there were differences in the way in which sexual and physical abuse were handled. Mothers whose male partners sexually abused their

children tended to be treated as possibly having known about or colluded with the abuse, and as if they were guilty until proved innocent (Driver 1989). The impact of their experience of secondary victimisation by their partner was given little attention. A strong atmosphere of moral censure pervaded these cases. Women were harshly judged in relation to their reaction to the discovery of the abuse, and even mothers who made arrangements to ensure their children's protection were considered suspect if they continued to feel affection for their former partners. Those women who were thought to harbour a continuing allegiance to the abuser, or whose parenting skills were seen as deficient, were viewed as partially culpable and found themselves subject to regulatory visits, even when the abuser was securely off the scene.

However, when women were able to demonstrate to the authorities that they had taken steps to protect their children from their partners, generally because they had separated from them, their cases were usually quickly closed. This left them with the full responsibility of coping with the aftermath of the abuse and its consequences for them and their children:

> I think to start with they were concerned about Hannah's welfare and safety, but it just seemed as if once they realised that she wasn't in any real danger, then they didn't want to know. They just left you to get on with it.

Only one woman in our study received any counselling about the impact which the discovery of the child's abuse had had on her. Yet the discovery that a child in their care had been abused and violated by their partner had a traumatic effect on women and necessitated a wholesale re-evaluation of the past, of their parenting capacity, and of their relationship with the child. Hooper (1992: 32–3) described the experience as similar to a bereavement in which there is 'a series of losses extending over time through the life course' and one in which 'a whole world view was threatened'. By our follow-up stage, twenty months after registration, a worryingly high number of women were still expressing deep feelings of anger and pain at their child's abuse which they had been unable to resolve. This was apparent in seven of the ten cases where a child had been sexually abused by a father figure or sibling while the mother was in residence. Without outside help, these women had been unable to move on emotionally. This in turn impaired their ability to comfort their children and aid in their recovery. In addition, four women were known to have been sexually abused themselves as children and their child's victimisation stirred up painful feelings from the past. Only one received a referral for counselling for herself.

These women were also left without assistance in dealing with the disturbed behaviour of their sexually abused children. This lack of management advice left them having to fashion their own ways of dealing with such problems as depression, suicidal thinking, self-blame, eating disorders, stealing, sexualised behaviour, and indiscriminate approaches to strangers. In addition, little assistance was provided about the ways in which they could help in their children's recovery, for example, by giving them opportunities to talk about the abuse. The

children themselves had often had no access to direct work about the abuse; only 58 per cent of these registered children had received such help. The proportion of sexually abused children who received any treatment amongst a population of referred children is even lower. Sharland *et al.* (1996) found that only 29 per cent of their referred group were provided with direct work and Farmer and Pollock (1998) show that only 44 per cent of sexually abused children in a sample of looked after children had ever had any therapeutic work relating to the abuse.

In relation to cases of sexual abuse, there was professional clarity about who the perpetrator was. A kind of blame by association meant that non-abusing mothers were censured and regulated if they did not meet the exacting expectations of professional agencies about how they should protect their children. However, when they did meet those expectations, services were abruptly withdrawn. Without assistance, the ability of the mothers and their children to recover from the abuse was impaired.

Intervention in cases of physical abuse

Whilst the interventions offered in cases of sexual abuse show a number of shortcomings, the broad parameters of intervention in this area have been influenced by feminist analysis (Macleod and Saraga 1988; Driver and Droisen 1989). As a result, there is now an assumption that the way to make a child safe after sexual abuse is to separate the child and the abuser, and this occurred in almost all the cases in our study. No such assumptions are made in relation to physical abuse. The physical injuries in our study had been inflicted in equal proportions by mothers and by father figures. After registration, 56 per cent of these children stayed in the same household as the abuser. Although professionals remained clear about the identity of the alleged abuser during initial child protection case conferences, thereafter, this clarity rapidly became obscured. As subsequent intervention progressed, the centre of professional attention quickly moved away from abusing father figures and onto the mothers. In all cases, once attention had focused on mothers, the issues around which the work revolved were not the abuse itself but more general concerns about childcare.

A typical pattern of work in cases of physical abuse by a father figure was for social workers to offer emotional support to the mother, sometimes coupled with material help and occasional services to the children, such as activity groups. In addition, for children under five, monitoring was sometimes undertaken by the health visitor. When babies had been physically abused, this could involve regular weighing of the undressed baby so that any subsequent injuries would come to light.

Hearn (1990) has identified two approaches to the social work management of physical abuse. The first is the notion of providing a transfusion of mothering or re-parenting for deprived parents. This was pioneered by the NSPCC Special Unit in London (Baher *et al.* 1976) and involved long-term work and twenty-four hour availability by social workers. This was superseded in the late 1970s by prescriptions for a 'responsibility model', advocated by the Rochdale NSPCC

Child Protection Team, in which parents were expected to take responsibility for their own actions, to change those actions if possible, and to suffer the consequences if not. In this model, mothers were seen as culpable even when the father figure had abused the child:

> it is a fundamental premise of change that the perpetrator should become able, through the assessment work, to *take responsibility* for the abuse, and that where appropriate the partner should recognise his or her responsibility for behaviour which involved *collusion* with the perpetrator and *failure to protect* the victim.
>
> (Dale *et al.* 1986: 157)

In our research, neither model appeared to be in ascendancy. Rather, practice seemed to be loosely based on a model of stress reduction, together with the provision of emotional support. Although this type of intervention could be helpful, no differentiation had been made at case conferences in relation to the different circumstances in which physical abuse could take place. The situation of lone mothers who undertake the care of their children, and who through lack of social support, impoverished circumstances and diminished personal resources are unable to cope with a child, is likely to be very different from that of father figures who are not undertaking the main care of the children and for whom physical violence is an established response to frustration or a way of establishing dominance (Straus 1979; Bowker *et al.* 1988; Hearn 1990; Parton 1990). This lack of differentiation seemed to permeate subsequent intervention, in which an approach characterised by trying to offer support and to reduce stress – a response suitable to the situation of some lone mothers – was offered whether the physical abuse had been inflicted by a man or a woman. When there was a male perpetrator, this approach was still essayed but, puzzlingly, as we have seen, the interventions were offered to the abuser's female partner and not to the male abuser.

Indeed, direct interventions addressing the abusing behaviour were entirely absent in relation to both men and women. The absence of work directed at abusing behaviour is, however, understandable when we consider that appropriate skills are not well developed nor are they generally in the repertoire of methods used by social workers (Adams 1988; Hague and Malos 1993). Some psychiatrists and probation officers offer work on anger management but this is not a service which can readily be accessed and in our study it was recommended for only two men, both of whom refused treatment. Its appropriateness in situations of domestic violence is, in any case, subject to debate (Mullender 1996).

How was it that the risks posed by these men who had already physically harmed their children were given no attention? How had this occurred? In some cases, this deflection away from work with men was assisted by the men themselves who ensured that they were out during social work visits or who refused to engage in discussions with the worker about the child. Moreover, since these father figures were often known to be violent men, they could be intimidating to professionals, many of whom were female.

An analysis of the cases of physical abuse by men in our study shows that there were three principal processes by which attention was deflected away from these men and onto their female partners. One occurred when the social worker considered the father figure to be a serious risk to the child and tried to arrange for him to move out. If no charges had been brought by the police, workers could only try to put pressure on mothers to exclude their partner. If this was unsuccessful, workers might concentrate their attention *faute de mieux* on the mothers and on general childcare issues. The mother's opposition to the worker's initial strategy was unlikely to form the basis for a trusting relationship and, in many of these cases, the mothers were withholding information about the man's continuing violence to them and their children. A second process, which was observed in two cases, was when a male social worker became strongly identified with the father's view of the family situation, taking on his viewpoint that the children were disobedient, and did not take action when the children were physically abused. The father's abuse was reconstructed as discipline, albeit occasionally excessive. Intervention was, again, general support by means of financial and material help, and a reliance on the mother to 'protect' the child. The latter strategy was unrealistic if the man was known to be physically violent to his wife. In one of these cases, the daughter's attempts to get help in relation to her father's physical abuse were unsuccessful until she reported him for sexually abusing her. Ironically, her motivation was to gain some protection for her mother who had been hospitalised after a particularly violent episode at home.

The third process occurred where, either because the man denied causing the child's injury or because, in the absence of any direct evidence, it was unclear which parent had abused the child, the worker focused on some other area of family difficulty. In one such case the father, having admitted the abuse of his baby son and his drink problem under police interrogation, subsequently denied both. In this case, the worker made the focus of the work the father's past history of separations. This approach seemed to represent a 'safe' area for them both but failed to address the risks posed by this father to his child. After the case was deregistered, the father re-abused his baby son.

This absence of a clear focus on the source of risk to children is important because, in such situations, child protection registration or any form of supervision is unlikely to be effective. This has been a theme in a number of inquiries into child deaths, such as those concerning Jasmine Beckford and Tyra Henry (London Borough of Brent 1985; London Borough of Lambeth 1987). Indeed, in a child protection system developed and then driven by child deaths, most of which were committed by men, it is a paradox that attempts at regulation are unrelentingly directed at women.

The invisibility of men's violence to women

The shift of focus away from men had a second and very important consequence. It allowed men's violence to women to disappear from sight. Where children had been sexually abused in our study, there was also domestic violence in two-fifths

of the cases. Amongst the cases of physical abuse, neglect and emotional abuse, this rose to 59 per cent. However, there was little attention to the relationship between these two manifestations of violent behaviour, domestic violence and physical abuse to children, despite the increasing research evidence which demonstrates the connection between them. A study by Bowker *et al.*(1988), for example, found that women who experienced abuse also reported their partners as physically abusing their children in 70 per cent of the cases where children were present in the home. Other studies reviewed by Hughes *et al.* (1989) found similar levels of association. The importance of the link between domestic violence and child abuse was explicitly brought out in the report on Sukina Hammond's death (Bridge Child Care Consultancy Service 1991) and has also featured in other inquiries into child deaths.

Some of the domestic violence in our study was known about by professionals at the initial case conference. However, a good deal was concealed since women feared that revealing it would worsen their position and might lead to their losing their children (Mullender 1997). Indeed, by the end of the study, we knew about twice as many cases of domestic violence as had been known about at the time of the initial conferences. Women spoke to us more openly as the events of the investigation receded and, by the time of our follow-up interviews twenty months later, some had left their violent partners and so felt able to speak out about their previous situations. In addition, only occasionally was the fact that children were witnessing violence to the mother noted as unsatisfactory by professionals, and in only two instances was concern expressed about the possible effects on the child (Jaffe *et al.* 1990; Mullender and Morley 1994; Hester *et al.* 1998).

Thus, after the initial case conference, professional attention veered away from physically abusing men and focused almost exclusively on women. When it was known that the men were violent to their female partners, this was not taken into account in case management, either as a warning sign about risks to the children or in relation to the power imbalance in the family. Yet the lack of attention to the abusing men left women in the position of trying to regulate the actions of their partners.

Relying on women to protect their children from violent and abusive partners is clearly a flawed policy. It may not even be one in which professionals believe. At no point in our study did social workers apparently discuss with mothers how far they had been successful in protecting their children, with a view to strengthening that protection if it proved inadequate. However, when women who live with violent men are clearly unable to protect themselves, the chances of their being in a position to protect their children may be remote (Kelly 1994; O'Hara 1994). When allegations of sexual abuse are made, professionals do not consider that the mother will be able to protect the children if the abuser remains in the household. Very different and yet untested assumptions are made with respect to physical abuse.

The shift of focus away from men tended to occur early on in intervention and it occurred in all the cases of physical abuse by men in which the child and

abuser had not been separated. In the highly proceduralised child protection system, it might be thought that the lack of attention to male abusers would be called to account at review meetings. However, we found that once a pattern of case management had been established it was usually endorsed at subsequent reviews, even when it was clearly deficient. For example, the child protection plan at the initial conference recognised the fact that a father figure had been physically abusive in 86 per cent of relevant cases. However, the subsequent shift away from dealing with the implications of this recognition in all these cases was not challenged at the subsequent reviews, with one exception, even when there was evidence of continuing risks to the children. Our study found that most of the children with the worst outcomes at the twenty month follow-up (23 per cent of the forty-four cases) were living in families where there was continuing violence by the man towards his female partner.

Background to the gender bias in the child protection system

What might some of the reasons be for this systematic gender bias in the operation of the child protection system and, in particular, for the shift of focus away from a full recognition of the significance of physical abuse by men? Two issues need to be highlighted. The first is that, historically, child abuse committed by men tends to remain invisible unless concerted attempts are made to bring it to public attention, in contrast to abuse or neglect by mothers. The second is that, even when the significance of male violence to children is recognised, because of the gender divisions in child rearing, in practice, parental responsibility for child mistreatment is generally taken to mean maternal responsibility (Parton 1990). These two issues will each be illustrated.

The first issue is well demonstrated by historical analyses which show that, at different periods, different kinds of harm to children become the focus of public concern. The remedies invoked also alter over time. Such analyses show that when women have a strong voice, as in the late Victorian and early Edwardian era, the effect of their campaigns is a tougher response to child abuse and particularly to male violence (Jeffreys 1985; Gordon 1989; Parker 1995). In the 1880s the campaign for the improvement of the social and legal position of women and mounting pressure from the NSPCC to protect children from cruelty led to the Prevention of Cruelty Act 1889 and then to the Incest Act 1908 which, for the first time, criminalised incest. These campaigns ensured that the focus of concern at that time was physical and sexual abuse by men. However, after equal voting rights had been won, the women's movement fragmented and, in the inter-war years, societal concerns turned to the question of neglect and in particular to neglectful mothers. In the late 1940s a group of campaigning women again attempted to bring the issue of child protection back into public prominence. However, it met resistance from the Government, which feared that inadequacies in living conditions would be exposed, and from the NSPCC, which saw its preeminent role as being threatened. There followed, to some extent, a return to complacency about child abuse. The emphasis remained on

maternal neglect, which was seen as responsible for juvenile delinquency, an issue which became a major concern in the 1960s (Parker 1995).

As the women's movement gathered momentum in the 1970s and new radiological techniques became available, there was renewed concern about physical abuse in the wake of the death of Maria Colwell (Secretary of State 1974). However, the medical profession identified 'battering parents' as the cause of the problem, not battering fathers. A decade later, after the Cleveland inquiry report (Secretary of State 1988), sexual abuse reemerged as a preoccupying issue. Although the Cleveland inquiry report barely referred to the central relevance of gender, intense activity by feminists (for example, Campbell 1988) ensured that there is now widespread recognition that, in most cases, the perpetrators of sexual abuse are men. This very brief account highlights the fact that abuse by men tends to become invisible unless women are sufficiently powerful to have an impact on the public agenda.

The second issue which needs to be examined is that even when abuse by men does lead to professional concern, there is a tendency for professional practice to revert to regulating women, unless strenuous efforts are made to retain the focus on men. Assumptions are often made about motherhood, based on conventions about the gendered division of labour in which women care for children. Since women are seen as responsible for the care and control of children, when something goes wrong the mother tends to be blamed for inadequacy and negligence. For example, in spite of the inescapable fact that most perpetrators of sexual abuse are men, blaming the mother was, until recently, an entrenched part of practice in such cases. Using a family systems approach, analyses of sexual abuse frequently came to the conclusion that the mother was ultimately responsible, for example because she deprived her husband of his 'conjugal rights', was emotionally distant from her daughters who were being abused, or was frequently ill (Kempe and Kempe 1978; Porter 1984).

However, feminists had, alongside this, been instrumental in bringing the issue of sexual abuse to public attention through their work with incest survivors. Their continuing involvement eventually ensured that feminist analyses became influential in the late 1980s (Macleod and Saraga 1988; Driver and Droisen 1989) and, as a result, practice began gradually to change, to place responsibility for the abuse onto the men who committed it.

Similarly, a few commentators have been working to show that the literature on child physical abuse has been preoccupied with the mother's direct or indirect responsibility for child abuse, since mothers are held ultimately responsible for their children's welfare (Breines and Gordon 1983; Lahey 1984; Parton 1990; Milner 1993; O'Hara 1994). At the same time, the majority of research has concentrated on mothers or has failed to distinguish the abusing parent by gender (Martin 1983). Practice based on a family systems model, for example, has viewed child abuse as involving a triangular relationship between victim, abuser and the partner who fails to protect (for example, Dale *et al.* 1986). Mother-blaming, again, has been and still is an entrenched part of intervention. Fowler and Stockford, in a review of reported cases in Norfolk, made this point in the 1970s:

> There is an underlying assumption in much of the literature on non-accidental injury that the person who is responsible for the child's injuries, even if she had not actually inflicted them, is the child's mother. This assumption is often disguised by apparently neutral references to 'the battering parent' or 'the family', but careful reading will usually reveal the underlying assumption that the person who is actually responsible, and in particular the one for whom therapeutic techniques are designed, is female.
>
> (Fowler and Stockford 1979: 855)

Mother-blaming is well illustrated in the case of Wayne Brewer, who was killed by his stepfather Nigel Briffet. In a report written for the court when Wayne was made the subject of a care order, the social worker commented on his mother:

> Her inability to restrain her husband, together with the rather negative handling of the child, characterised by her unwillingness to readily handle him, and to generally care for and stimulate him, indicate that she has not really been able to accept responsibility for him.
>
> (Somerset Area Review Committee 1977)

Feminist activists worked hard to bring the issues of domestic violence and child sexual abuse to public attention, and practice on both fronts has been greatly influenced by them. In contrast, Gordon, writing almost a decade ago, commented on the lack of sustained feminist analysis of child physical abuse: 'There has been a tendency in the recent decades of family-violence scholarship to assume that marital violence requires a gender analysis while mistreatment of children does not' (Gordon 1989: 114).

Thus, although some feminist writers from the 1980s onwards have pointed out how widespread mother-blaming is, and more recently other writers such as Parton (1990) and Milner (1993) have applied a pro-feminist analysis to child protection practice in cases of physical abuse, no major campaign has been mounted which might have had an impact on re-thinking practice in this area.

It has also been suggested that another reason for the lack of direct attention paid to men who physically abuse their children may be the extent to which practice is controlled by men, who occupy the majority of senior management positions in social services departments. Feminist critiques have highlighted the way in which men have hijacked the child protection industry and 'assumed disproportionate control and influence' over it (Hudson 1992). Feminist commentators have suggested that professionals have clung to the idea of mothers as collusive in the abuse of their children partly because it is a powerful defence against admitting the male abuse of power, which would otherwise have to be faced (Nelson 1987). More specifically, Milner (1993) suggests that child protection procedures are designed not to upset the men in charge of the system since they do not expose them to the widespread incidence of fathers' violence. However, although practice is often managed by men, it is women who form the

majority of the front-line workers. The threats posed by violent men impinge most directly on them in an area in which training and support has been lacking.

Some ways forward

The policy shift towards more family support services and a slower recourse to child protection intervention provides an opportunity for social services departments to offer services to those needy mothers who have in the past been filtered out at the stages of referral and investigation. It should also make it possible to offer more support and therapeutic help to non-abusing mothers and their children after the discovery of sexual and physical abuse. Whether such opportunities are taken will depend on the resources provided by individual local authorities for family support services and the priorities set for their deployment. However, the research findings are unequivocal that this is the way forward if the welfare of such children is to be improved in the future.

There is also an urgent need for the source of risks to children to be clearly disaggregated. Maltreatment caused by a father figure, a mother, a sibling or a combination of family members raises different issues and requires differentiated practice. Similarly, more attention is needed to the implications of power imbalances within families. The increasing recognition of the link between domestic violence and child physical abuse (Bowker *et al.* 1988; Hughes *et al.* 1989; Browne 1993; Goddard and Hiller 1993; Mullender and Morley 1994, Farmer and Owen 1995; Ball 1996; Mullender 1996; Mullender 1997) provides potential for a greater emphasis on the inequalities in power within families, and this does provide the starting-point for a review of child protection practice in cases of physical abuse.

In child protection work, much might be gained if more attention were paid to asking women about their own strategies for protecting their children (Boushel 1994) and attempts made to assist mothers to strengthen these (Boushel and Lebacq 1992; Boushel and Farmer 1996). Many women will gain by being linked to agencies such as Women's Aid which focus on women and their needs.

Child protection practice in relation to men who physically abuse requires a major re-think. Assessments of parenting should always include an assessment of the father figure in the family and the question should be raised in workers' minds that there may be male violence to the mother when physical or sexual abuse to a child is discovered. More ideas about motivating and working with men need to be developed and assessed for effectiveness. Such work may need to be separated from work with mothers. It may require the deployment of male workers or joint work by a male and female worker; locations outside the home may need to be found and groupwork initiated. Social workers need training on dealing with situations of domestic violence (Mullender 1997), including work on getting men to confront and acknowledge their violent behaviour, its sources and consequences (Pence and Paymar 1990). Training for professionals needs to address these issues, and child protection reviews should routinely check

whether the workers involved are addressing the family member who presents the major risk to the child.

It is an interesting and disturbing paradox that in child protection work there is so much focus on controlling and regulating the actions of mothers, given that the child protection system was set up in the wake of public anxiety about child deaths, most of which were inflicted by men. Perhaps it should not surprise us that, once again, men have remained almost invisible in the debates about change. However, what the child protection system does is to concentrate attention on questions of responsibility and blame for child maltreatment and, since women do the majority of child rearing in our current society, this blame is often laid at their feet and felt acutely by them. The major change in policy and practice which has emerged from this and the other studies in the Department of Health programme of research on child protection (Department of Health 1995) is the need for a greater emphasis on family support services. This ought to benefit mothers who have lacked much needed services and whose situations have sometimes worsened when they have been brought into the child protection system. However, such improvements are only likely to occur if child protection agencies are ready critically to review their current work and to set in train the changes which would reduce the gender bias that is such an enduring feature of the child protection system.

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19 The medical diagnosis of child sexual abuse in Cleveland in 1987

The paediatrician's dilemma

Geoffrey Wyatt and Marietta Higgs

> You will readily admit that it would be a good thing to have a second method of arriving at the aetiology of hysteria, one in which we should feel less dependent on the assertions of the patients themselves. A dermatologist, for instance, is able to recognise a sore as leuetic (ie. syphilitic) from the character of its margins, of the crust on it and of its shape, without being misled by the protestation of his patient, who denies any source of infection for it; and a forensic physician can arrive at the cause of an injury, even if he has to do without any information from the injured person.
>
> (Freud 1896)

Introduction

In this chapter Geoffrey Wyatt and Marietta Higgs, the two consultant paediatricians at the centre of the child sexual abuse inquiry in Cleveland in 1987, discuss the 157 children whose diagnoses were the subject of dispute and whose details were submitted by them to the judicial Inquiry at that time. They describe the children forming two groups. In Group A, there was concern about sexual abuse before the child saw the paediatrician. In Group B the paediatrician was the first to raise the possibility of sexual abuse in children referred with other health problems. What they describe as 'essential data' is provided in this chapter to show how the medical diagnosis was made for each group. They discuss the grounds for, and the role of, a medical diagnosis of child sexual abuse as a possible explanation for particular and persistent symptomology which has no other determinable or identifiable organic aetiology. The case for doctors making a medical diagnosis of child sexual abuse is considered, together with the factors which influence whether the medical diagnosis is corroborated by a disclosure from the child. They discuss the importance of medical intervention especially for children in Group B, who depend on a doctor to initiate the multi-disciplinary assessment, and the dilemmas that this creates.

The case for a medical diagnosis of child sexual abuse

Since doctors usually work in a surgery or hospital clinic, the diagnosis will be made following a process of history-taking and examining the child.

Paediatricians see children as their patients and are therefore bound to come into contact with child sexual abuse. Some of these children may have symptoms and signs, and if they have not disclosed the abuse they depend on a doctor to initiate concern about it. Both doctors and children will benefit from medical practice that accepts and recognises a level of medical concern expressed in terms of 'reasonable medical certainty' (Krugman 1989).

A medical diagnosis of child sexual abuse can be a reference point which can enable other agencies to make a more informed response during a multi-disciplinary assessment. This is particularly important in preventative health terms for the young child where the doctor is able to initiate concern (Group B) and may have a vital role in beginning further assessment by making a medical diagnosis. Doctors are more likely to take on this initial responsibility on behalf of children if they believe that an accurate diagnosis is possible and, that in the absence of information to corroborate the diagnosis, they will be supported and protected. Appleyard makes the point that 'If the necessarily strict criteria, that of beyond reasonable doubt which is required by a criminal court of law are relied upon as the only indicator that child sexual abuse has occurred, then most sexual abuse would remain unrecognised' (Appleyard 1990: 42).

To be able to discharge their role in sexual abuse effectively, doctors may need first to overcome a sense of hopelessness towards their patients whose health may be suffering because of sexual abuse. The following comments by the British Paediatric Association show how similar feelings about childhood illness have been overcome by doctors in the past:

> Cancer is the main disease preoccupation of our age, and is no longer a forbidden word. Many remember the darkness which surrounded discussion of the disease in children in the 1930s. When the diagnosis was made there was little further the physicians could do. Then in 1942 came the bizarre news from the USA that nitrogen mustard, a product developed in the First World War as a lethal gas, was effective against certain types of cancer of the lymph glands known as lymphoma and lymphosarcoma. However, problems continued.
>
> The next decade (1950s) was a distressing time for children, parents and paediatricians as the latter struggled to discover the effective dosage and necessary duration of treatment with these new drugs. The ulceration of the mouth, the loss of hair, and the wretchedness of the child, which were the unfortunate concommittants of treatment with these drugs, could only be endured. Yet parents, however distressed, never asked for the treatment to be stopped; they realised that they and the paediatrician were held together by a common bond of suffering and hope.
>
> (Forfar 1988: 16)

Co-ordinated efforts between professionals from different disciplines, and support from the general public, have resulted in a better outlook for children suffering from childhood illnesses such as cancer. In child abuse generally, and in

sexual abuse particularly, the doctor and the parents must find that common bond of suffering and hope despite all the difficulties that arise.

It may not always be helpful to look on child sexual abuse as a disease process in the organic sense. Nevertheless the health of the child is likely to be at risk in both the short and the longer term. Browne and Finkelhor (1986) and Finkelhor (1988) describe the initial and long term effects of sexual abuse. Initial effects include fear, anger, hostility, guilt, shame, depression, sleep and eating disturbance, teenage pregnancy, disturbance of sexual behaviour, difficulties at school, truancy, running away from home, early marriage and delinquency. Long-term effects include depression, self destructive behaviour, anxiety, feelings of isolation and stigma, poor self esteem, a tendency towards revictimisation, substance abuse, difficulty in trusting others and sexual maladjustment. We agree with Corwin (1988) that short of preventing the sexual victimisation of children, early identification, protection and treatment offer the greatest hope for diminishing its lasting effects.

While doctors sometimes treat their patient symptomatically, they always have to bear in mind that there might be a serious underlying cause. If a patient presents with fever and cough these symptoms can be treated independently, but if the underlying cause is an infection (for example pneumonia), specific treatment is necessary to restore health. Similarly, if a child has symptoms such as soiling, behaviour disturbance and urinary symptoms, each of these may be treated symptomatically, but if the cause is sexual abuse, further action is necessary to restore health. In any opinion that a doctor gives, there is always a spectrum of certainty or uncertainty. When a doctor is certain about his or her opinion, a medical diagnosis can be made. When there is uncertainty in the mind of the doctor a medical diagnosis should not be made. The International Collaborative Committee For Child Health (1988) recommends that, if gross signs are seen, the diagnosis may be made there and then. They cite as an example, a child seen in a routine outpatient clinic because of soiling.

The doctor's professional obligation to help the child is broadened when other professionals are also looking to the doctor for help. Kerns describes this process:

> With the explosive rise in the reporting of suspected child sexual abuse over the past decade, the socio-legal system has increasingly looked to the medical profession for diagnostic assistance. Given the mismatch of the complexities of a developing child's communication with the traditional evidential requirements of the legal system, and given the heated arena of adversary proceedings, media scrutiny, and passionate lobbies for all parties, it is not surprising that social workers, police officers, lawyers, and judges have turned to medical examiners in pursuit of 'certainty' in alleged child sexual abuse cases. In response, ever increasing numbers of clinicians have been evaluating these children, measuring their findings in the context of their experiential knowledge base of anatomy acquired in paediatrics and gynaecology.
>
> (Kerns 1989: 177)

It is important to remember that sexually abused children may have no physical signs on medial examination. Thus, on the one hand, a child with no symptoms or signs may disclose abuse to a social workers and name a perpetrator who confesses to a police officer. In that situation there would have been no medical diagnosis, but the probable conclusion of both multi-disciplinary assessment and court hearing would be that abuse had taken place. On the other hand, a doctor may make a medical diagnosis of sexual abuse on the basis of symptoms and signs. There may be no corroborative information and this may result in the case not going to court. Nevertheless, the doctor should be able to say on behalf of the child that there is a medical diagnosis of sexual abuse. In other cases, on the basis of the symptoms and signs, the doctor may reach the opinion that sexual abuse is a differential diagnosis, but that opinion will fall short of the degree of certainty required to make a medical diagnosis. In this way there would still be flexibility for doctors accurately to express their opinion. If the multidisciplinary framework is strong it should be able to accommodate the full spectrum of medical opinion. This would decrease the risk of scapegoating individual professionals when difficulties arise.

It is recognised that, as in any other subject, the knowledge base will change in the future. Nevertheless the process of multidisciplinary assessment involves attributing the appropriate weight to any level of medical concern expressed by the doctor. The responsibility for making the medical diagnosis rests solely with the doctor. If this is the only information which has come to light as a result of the assessment, the doctor is dependent on the multi-disciplinary framework to avoid becoming isolated and vulnerable to criticism and discreditation. There are two possible responses in this situation. One is for the doctor to avoid making a medical diagnosis at all; the other is to use the medical information to alert the system without giving a medical diagnosis. As doctors we regard both of these options as unacceptable. We have to accept the risk that a medical diagnosis may sometimes not be corroborated, with the result that the doctor may be discredited.

Presentation and the importance of the child's history

Before 1987, medical involvement in child sexual abuse was usually confined to Group A children. The police evidence to the *Inquiry into Child Abuse in Cleveland in 1987* describes a change in the way the police came to be involved. This historical shift in context is tellingly outlined in the Cleveland report:

> They (the police) were accustomed to receiving referrals for involvement in the investigation for sexual offenses by complaint from the victim, either directly or through a third party or agency such as a parent, social worker, health visitor, school etc. This was called by Mr White the 'traditional route'. The reports now coming to them were from non-traditional routes:
> 1 They originated from the examination of the child at hospital by a paediatrician.

2 In some cases the referral to the paediatrician appeared to be unconnected with sexual abuse.
3 In some cases the child was of such tender years that any complaint or disclosure by the child was unlikely to be obtained in the conventional manner.

(Butler-Sloss 1988: 93)

A paper by Hobbs and Wynne (1986) drew attention to the importance of taking a thorough history and to certain techniques in the medical examination. Roberts (1986) countered: 'Without a more thorough investigation it is not possible even to be sure what is being alleged'. Hobbs and Wynne (1986) responded that their patients differed from those seen by Roberts in several respects: they were younger; there were more boys; and the presentation was more varied. Hobbs and Wynne reviewed 337 referrals seen during 1985–6:

> 39% presented because they had disclosed abuse, 11% presented after allegation by relative or carer; 16% were siblings or children in contact with a suspected or proven abuser; 10% presented with physical abuse. In 22% alerting symptoms or indicators led to referral – including behaviour (7%), non-specific physical or psychosomatic (3%), and genital or anal (12%) signs and symptoms. 2% were detected during routine examination in special schools.
>
> (Hobbs and Wynne 1987: 837–41)

The paediatricians and police surgeons in Cleveland in 1987 were to experience similar differences in their acceptance of the observations of Drs Hobbs and Wynne (Butler-Sloss 1988: 14).

In Cleveland, out of the 157 children, eighty-two were referred directly to the paediatricians (index children). The paediatricians asked to see seventy-five because they were either a sibling or a close associate of an index child. It is normal practice in child abuse work to assess the siblings and associates of index children. Out of the eighty-two index children (those referred directly to the paediatrician), forty-two belonged to Group A and forty to Group B. Allegations were made that Group B children who attended hospital for routine injuries and ailments were subjected to examination for sexual abuse (Butler-Sloss 1988: 164). This was rejected by the Inquiry report:

> The Inquiry was satisfied from the evidence presented that there was no routine screening for sexual abuse. In each instance of a child attending hospital for 'routine injuries and ailments', there were grounds in the professional judgement of the examining consultant for the investigation of the child for the possibility of sexual abuse.
>
> (Butler-Sloss 1988: 165)

Because the children in Group B did not present in the traditional manner, physical signs, in particular reflex anal dilatation, became the subject of intense

debate in both the lay and professional press. Hobbs and Wynne (1987) subsequently reported an increasing rate of diagnosis in child sexual abuse and further correspondence followed in the *Lancet* (1987 31 October: 1017; 21 November: 1217; 12 December: 1396) about whether reflex anal dilatation was indicative of child sexual abuse. Just before the Cleveland report was published, reflex anal dilatation was associated with bowel disease (Evans and Walker-Smith 1988; Magnay and Insley 1988). Butler-Sloss concluded from the evidence that 'the consensus is that the signs of anal dilatation is abnormal and suspicious and requires further investigation. It is not in itself evidence of anal abuse' (Butler-Sloss 1988: 193). The report also addressed the concern that the diagnosis was based solely upon this sign, but stated that in only eighteen cases out of 121 was it the sole physical sign and in no case was it the sole ground for the diagnosis (ibid.: 165). On the basis of our usual medical practice in other clinical situations, namely by interpretation of the history and examination, we felt able to make a medical diagnosis in 121 children out of the 157 seen.

The thirty-six remaining children did not have physical signs to enable a medical diagnosis to be made. Krugman (1989) states:

> The medical diagnosis of sexual abuse usually cannot be made on the basis of physical findings alone. With the exception of acquired gonorrhoea or syphilis, or the presence of forensic evidence of sperm or semen, there are no pathognomonic findings for sexual abuse. Critical to this diagnosis is a child's history. A hymenal diameter of more than 4mm alone, reflex anal dilatation alone, or a scar at six o'clock alone is not diagnostic of sexual abuse. Observing these findings should make one want to know more, and should lead to a multi-disciplinary investigation if the history is positive. Courts can then decide whether there is enough information available to reach a level of certainty to enable to civilly protect a child, and/or enough to permit the criminal prosecution.
>
> (Krugman 1989: 165–6)

Guidance for Doctors (DHSS 1988) also emphasises the history of the child's complaint or health problem, and advises doctors that 'child sexual abuse should be remembered in the differential diagnosis of many physical conditions'. Appleyard, in support of the DHSS Guidance, goes on to say, 'No one physical symptom or sign is absolutely diagnostic of child sexual abuse. However, patterns of symptoms and signs may be diagnostic' (Appleyard 1990: 43).

We think that the child's medical history can directly suggest the possibility of child sexual abuse (Group A) or indirectly by way of symptoms of illness (Group B). If on examination, the paediatrician then finds physical signs consistent with child sexual abuse, a medical diagnosis of sexual abuse could be made. This medical diagnosis is the doctor's contribution and does not replace or anticipate the overall diagnosis which results from the multi-disciplinary assessment. Unless a medical diagnosis is made, children in Group B may not benefit from a multi-disciplinary assessment. Doctors can and should take

responsibility for identifying the possiblity of abuse in these children with health problems. Unless doctors refer these children on for further assessment their health problem may persist.

Cleveland's children: essential data

During a seven-month period of 1987 there were 2,708 attendances at the paediatric outpatients, Middlesbrough General Hospital. One hundred and fifty-seven children, who were presented to the Cleveland Inquiry, were mainly seen in May and June. Tables 19.1 and 19.2 show how these children were classified.

Group A Index children were referred to the paediatrician with an existing concern of sexual abuse. Group B Index children were referred to the paediatrician with a health problem but no pre-existing concern of sexual abuse. Group A and Group B siblings and associates were requested to attend because of concerns of sexual abuse in index children. The 157 children are those where a high level of concern existed. In 121 children the doctor expressed a medical diagnosis of sexual abuse and in thirty-six children a medical diagnosis was not made. In other words we believed no other cause could explain the symptoms and signs in 121 children. Of the remaining thirty-six children, there was a pre-existing concern of sexual abuse in thirty-five of them (seven Group A index children and twenty-eight siblings or associates), and in one index child in Group B there was a concern of physical abuse; in all thirty-six cases, however, there were insufficient physical signs to make a medical diagnosis of sexual abuse.

There was another group of children not included here and not reviewed by the Inquiry, where a medical diagnosis was considered but not made because the doctor was unsure. In these children there were symptoms leading to referral to a paediatrician, so they were potentially Group B children. In these circumstances a doctor is dependent upon the presence of physical signs to make a medical diagnosis.

Returning to the 157 children considered by the Inquiry, there were more siblings and associate children in group B (59) than in Group A (16). This is

Table 19.1 The medical diagnosis of sexual abuse in index children and in siblings or associates in Cleveland in 1987

	Index children		*Siblings or associates*		*All children*	
Total	82		75		157	
Medical diagnosis of sexual abuse	74	(90%)	47	(63%)	121	(77%)
No medical diagnosis	8	(10%)	28	(37%)	36	(23%)

Table 19.2 The medical diagnosis of sexual abuse in Group A and Group B children

	GroupA			*GroupB*		
	Index	*Sibling/ assoc.*	*All Gp A*	*Index*	*Sibling/ assoc.*	*All Gp B*
Total	42	16	58	40	59	99
Medical diagnosis of sexual abuse	35 (83%)	7 (44%)	42 (72%)	39 (98%)	40 (68%)	79 (80%)
No medical diagnosis of sexual abuse	7 (17%)	9 (56%)	16 (28%)	1 (2%)	19 (32%)	20 (20%)

because children with health problems (Group B) are usually referred and seen individually, whereas when a concern about sexual abuse is raised for example by a social worker (Group A), the siblings and associates of that child may all be referred to the paediatrician as index children.

The mode of referral and reason for referral in Group A and Group B children differ as shown in Tables 19.3 and 19.4.

Guidance for Doctors (DHSS 1988) asks doctors to remember the possibility of sexual abuse in certain physical conditions: non-accidental injury; lower genitourinary tract symptoms, injuries and abnormalities; faecal soiling, retention or rectal bleeding; rectal abnormalities and sexually transmitted disease. The guidance also mentions behavioural and emotional problems. Eighty per cent of the index children in Group B had one of these physical or behavioural conditions An additional factor influencing the doctor's opinion is the length of time that the patient has been suffering from the symptoms. Sadly, half of the children in Group B had had symptoms for longer than a year and fifteen of them for over two years.

Butler-Sloss (1988: 194) cites other clinical situations, for example failure to thrive, where a thorough examination including the ano-genital region is

Table 19.3 Mode of referral for Group A and Group B children

Mode of referral	*Group A*	*Group B*
Social services	32	2
Outpatient revisit	2	20
General Practitioner	3	8
Hospital doctors and nurses	0	7
Community doctors and nurses	3	3
Guardian at litem	1	0
Parent	1	0
Total	42	40

Table 19.4 Reason for referral for Group A and Group B children

Reason for referral	*Group A*	*Group B*
Concern re. sexual abuse	37	1
Previous child abuse	0	1
Nonaccidental injury	0	8
Concern re child care	1	2
Behaviour problem	3	5
Growth problem	0	4
Developmental problem	0	2
Urinary problem	0	4
Vaginal problem	1	4
Anal problem	0	10
Total	42	40

recommended. In addition Appendix B (ibid.: 277) includes wider criteria quoted by the Tavistock Foundation (1984); other physical indicators (both anogenital and general) and behavioural indicators (sexual and general). All the children in Group B would be encompassed in these criteria, either as having some indicator of sexual abuse, or on the basis of the history, the need for a complete physical examination.

Most Group B children had already been seen by doctors on previous occasions without child sexual abuse being considered. One half of them were estimated to have received over three hours of medical consideration as outpatients, inpatients or in follow up appointments. Despite this no explanation had been found for their continuing problems.

A medical diagnosis of sexual abuse was made for thirty-five out of the forty-two Group A children. In the seven remaining children there were no findings on physical examination and no medical diagnosis was made. This does not disprove sexual abuse since the abuse may not have left physical signs, or the signs may have been solved. In Group B the symptoms and signs were sufficient for a medical diagnosis of child sexual abuse to be made for thirty-nine out of the forty children. It cannot be emphasised too strongly that the medical diagnosis is based on both symptoms and signs.

The physical signs present for children in each Group are shown in Table 19.5. Two index children in Group A, and one index child in Group B, had only one physical sign: reflex anal dilatation. The Group B child also had one of the health problems quoted in the *Guidance for Doctors* (DHSS 1988).

The independent panel

Further information on the accuracy of the diagnoses in Cleveland is available from the conclusions of an independent panel of consultants. This was set up by the Northern Regional Health Authority at the request of Cleveland Social Services to provide second opinions on children where the diagnosis was disputed (Butler-Sloss 1988: 117). The panel elected to review only those

Table 19.5 Physical signs of sexual abuse in Group A and Group B children

Physical sign	*Group A*	*Group B*
On or below 3rd percentile wt or wt and ht	6	11
Bruising consistent with nonaccidental injury	6	14
Anal skin verge abnormality	14	25
Reflex relaxation of anal sphincter	29	35
Dilation of the anal orifice	26	35
Fissuring or fissures	18	24
Abnormal genitalia	22	19
Number of children with a medical diagnosis	35	39

children where parental consent was forthcoming, so their sample was highly selective. They saw twenty-nine children from twelve families; eight of these families were already known to social services. In 86 per cent of the children, the independent panel agreed with the diagnosis or the concern of the doctors. The diagnosis was confirmed in twelve children, and in another six the signs were considered sufficient to warrant further investigations. In seven children the panel supported the original medical opinion that there were no findings indicative of abuse. In four children the original diagnosis of abuse was not confirmed. However, it is important to remember that time had elapsed between the original opinion and the second examination (ibid.: 118).

Corroboration of the medical diagnosis: pointers from the Cleveland children

The age of the child is a factor in whether the medical diagnosis will be corroborated by a disclosure. Forty-five of the total of 121 children with a medical diagnosis of child sexual abuse made a disclosure. The mean age of these forty-five children was 7.43 years (Standard Deviation = 3.03 years). The seventy-six children who did not make a disclosure can be divided into two groups, thirty-three for whom there was supportive information of child sexual abuse, and forty-three for whom there was none. The thirty-three children who had supportive information, but did not make a disclosure were considerably younger, with a mean age of 5.86 years (Standard Deviation = 3.08 years). For these thirty-three children, supportive information included sexual behaviour/abuse observed, worrying comments made, previous non-accidental injury or suspected sexual abuse and behavioural symptoms. The forty-three children who did not disclose and had no supportive information were even younger, with a mean age of 4.57 years (Standard Deviation = 3.22 years). The youngest child in this group was under one year.

The availability of a safe, neutral environment also influenced whether the child disclosed. Of the forty-five children who made a disclosure of a sexual nature, thirty-six did not do so until admitted to hospital or foster care. Of the nine other children able to disclose without the same environment, eight disclosed abuse by a perpetrator who was not living with the child at the time.

These figures are consistent with those for an overlapping but largely separate group of children evaluated by the clinical psychologist over the same period. Of the forty children referred with suspected sexual abuse or a medical diagnosis of sexual abuse, twenty-one had medical findings and sixteen of these twenty-one children subsequently disclosed abuse by a named perpetrator. Three prepubertal girls with both anal and vaginal findings vehemently denied that anything had happened, and a boy and girl, both of two years, were unable to say anything. A total of thirty-two children out of the whole group of forty made a disclosure, eight of them prior to the assessment and medical examination Only one of these eight children disclosed while still living at home with the named abuser. The timing of the disclosure for the remaining children varied. Nine of the remaining thirty-two disclosed during or immediately after the medical examination, but thirteen of them did not speak until the psychological assessment had taken place. In some cases this was months afterwards. There may not have been sufficient time for some of the diagnosed children to reach the point of readiness to disclose (see Bacon and Richardson, chapter thirteen) before investigations finished or was terminated by legal proceedings and the children returned home.

A sensitive medical interview and examination may help a child towards disclosure. Children are unlikely to say anything spontaneously during a medical consultation, but it is part of normal medical practice to ask for clarification if something is found on examination, especially in the case of children where most if not all of the history has been given by a third party. For example the doctor may find a lump which the child has not previously mentioned to anyone and may need more information: how long it has been there, whether it comes and goes and so on. The doctor will ask the child, if he or she is old enough. With some of the children in Cleveland, a neutral comment such as 'it looks as though something's been happening to your bottom' was sometimes responded to by a disclosure of abuse.

Concern was raised in another way when a social worker noted that the father of a Group A child was on record as a Schedule 1 offender previously convicted of indecent assault on young boys. He had received no treatment. The subsequent case conference requested medical examination and the eleven-year-old girl was found to have signs consistent with anal abuse. During the medical consultation the doctor had said: 'it looks as though something might have been happening to you down here'. Afterwards in the police/social work interview, the child readily described anal abuse.

Some children may be too young, too frightened or too loyal to the abuser to respond to this approach. For example, a Group B girl of seven years had been referred to the paediatric outpatients by the school doctor who was concerned about her poor growth. There were no obvious medical reasons to account for this. During the history-taking, episodes of great unhappiness were described for which she had given no reason. After physical examination, it was put to her that it looked as though something had been happening to her bottom and her front. She dropped her head and nodded. It took her months, while living with

a foster family, to be able to tell of regular abuse by her uncle. Both Group A and B children depend on trusting adults, in many cases the doctor, to take the responsibility for speaking on their behalf.

Since 1987 many adults who were abused during childhood have found the strength to speak out. Many describe how as children they saw various doctors with a variety of non-specific problems for which no explanation was given. They would sometimes deliberately feign illness such as abdominal pain. They had thought and hoped that somehow the doctor would see what was happening and help them.

To summarise, the likelihood of obtaining a corroborative disclosure for a medical diagnosis of child sexual abuse often depends on the child's age and the safety of his or her environment during the multi-disciplinary assessment. The absence of a disclosure does not necessarily mean that the diagnosis is incorrect; it simply means that there is no corroboration. Young children will be disadvantaged if the criterion for beginning a multidisciplinary assessment is a disclosure by the child rather than a medical diagnosis of sexual abuse. In other areas of preventative medicine, for example, immunisation, developmental assessment and the identification of rare metabolic diseases, society concentrates its resources on young children. Child sexual abuse should be no exception to this. La Fontaine says, 'What abused children most want, according to survivors, sounds relatively simple to provide: they want to be believed, they want information and they want help to stop the abuse'(La Fontaine 1990: 11).

Dilemmas for the doctor

Guidance for Doctors (DHSS 1988) stops short of advising doctors when they should make a medical diagnosis of sexual abuse. This may leave doctors uncertain as to when they should initiate concern for a child with a health problem. Further difficulty arises from misunderstanding whether a medical diagnosis can ever prove anything in a legal sense. Although it is rare in medicine to find uniquely diagnostic signs for any condition, differences in medical opinion which fuel the adversarial nature of court proceedings arise from the expectation that doctors can be relied upon to prove whether abuse has occurred.

The Butler-Sloss Report is ambivalent about the term medical diagnosis. Whilst stating that child sexual abuse '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', the Report also states that 'child sexual abuse describes aberrant adult behaviour; it causes physical and emotional damage to the child'. Doctors may be left confused by the conclusion: 'While recognising that it is not an accurate description, the term "diagnosis" has been used throughout the course of the Inquiry to describe the conclusion reached from the symptoms and signs' (Butler-Sloss 1988: 183). At the same time many people may have unresolved doubts about whether the children diagnosed in Cleveland were sexually abused. Butler-Sloss explicitly states 'It is not the function of the inquiry to evaluate the

accuracy of any diagnosis nor to resolve conflicting evidence nor to assess whether an individual child was or was not sexually abused' (ibid.: 183).

One dilemma is that if the doctor waits until the child has come forward with an alerting statement, the responsibility for bringing the abuse to light then remains with the child, who may never be able to speak. Taken to the extreme, and seen in the context of other medical problems, the doctor would have to seek confirmation of the medical diagnosis only in the post mortem room. If the doctor decides not to make a medial diagnosis, he carries the responsibility for leaving the child unprotected and at continued risk of ill health which may continue into adult life. The key dilemma for the doctor, however is that if he raises a cause for concern about sexual abuse in a child where there is no prior complaint and where the medical diagnosis is not supported by the subsequent assessment, he may be accused of starting a process of secondary abuse. For example, if a child is removed from the home only to be returned months later because a court felt there was insufficient medical evidence to prove that sexual abuse had occurred, the doctor may be blamed for the trauma inflicted on the child and family.

We have described factors which affect corroboration of the medical diagnosis by a disclosure. A rational approach to resolving the doctor's dilemma depends on a balanced assessment of these factors. Doctors need to be supported by other professionals and society generally so that they can raise concern when appropriate. A multi-disciplinary approach can then help both the child and others involved in the abuse, particularly the perpetrator and the family. When the doctor is the first to raise concern, the opinion given must be as accurate and helpful as the current knowledge allows. The crucial question for doctors is what they may consider to be adequate to initiate concern, and how to work with other professionals to respond creatively on behalf of the child.

Conclusion: professional and political considerations

There have always been professional and political implications for doctors who highlight issues that society find unpalatable. Gaulter (1833) describes the scene following a medical diagnosis of cholera at a time when there was little therapy and commonly a fatal outcome: 'Here the scene which followed the announcement of the van [for removing corpses] was often most distressing. While the neighbours insist on removal, the relations would refuse to allow it and support their refusal by a denial of the nature of the disease'. Over 150 years later in Cleveland the unacceptability of sexual abuse may have led to a similar denial.

We believe that some of the public furore which accompanied the crisis was essentially a reaction to child sexual abuse becoming visible. The Inquiry focused on the professionals involved, but the uncertainty as to what the interaction between the doctor and the child can include remains unresolved. There must be an ongoing debate about the role of the paediatrician in identifying children who may have been sexually abused. It is vital that paediatricians are

able to exercise their professional judgement, and that they are free from political restraint. Society must advance beyond crisis rather than retreat from it.

The General Medical Council, the British Medical Association and the Defence Organisations all support the view that it is the duty of the doctor to initiate concern for some children (DHSS 1988). The bleak alternative for Group B children is that doctors may choose only to respond to concerns raised about child sexual abuse by other professionals and so concern themselves with Group A children only. Since the publication of the Inquiry Report and 'Guidance for Doctors' there has been a significant drop in the number of children referred from Middlesbrough General Hospital to the social services by the paediatricians. In 1987 there were seventy-six such referrals, in 1989 there were only four children referred for joint examination by paediatricians.

While the focus of the medical diagnosis is the child's health, the multi-disciplinary assessment must have regard for possible legal proceedings. Doctors need to be willing and able to justify their diagnosis so that other people, professionals and the lay community, can understand how and why they come to that view.

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20 Confronting sexual abuse
Challenges for the future

Sarah Nelson

Introduction

The material in this chapter was originally presented as a keynote paper at the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN) Third National Congress in Edinburgh in 1997, and part of it was subsequently published in *Child Abuse Review* (1998). In this chapter I identify as vital issues the fact that children's testimony carries so little credibility in spite of the evidence that it is children who are telling the truth and adults who are lying; that the survivor movement remains highly marginalised; that the male survivor movement has been so slow to develop; that non-abusing parents' groups are often disparaged or seen as a threat; and that there has been a lack of progress in reducing the incidence of child sexual abuse. I argue that reducing or preventing child sexual abuse is dependent upon both professionals and the public finding out and facing up to its full scale and nature however grim the truth may be. I also argue for reframing child sexual abuse as a major public health and criminal justice system issue which recognises the limited capacity and power of professionals to confront socially influential abusers and networks. At the same time it is necessary for professionals, their employers and professional bodies to take a position publically in support of individuals who are misrepresented, and against distortion of facts in highly publicised cases.

Facing up to the facts

There are a number of very serious challenges to be faced, nationally and transnationally, in sexual abuse work as we enter the next century. Even to list them can sound depressing, demoralising and even overwhelming: yet I am a cautious optimist and believe that we all should be. The ordinary people of Belgium, that supposedly boring country where nothing much happens, have been inspiring to this optimism when demonstrations of 350,000 people have voiced their anger at police and politicians handling of the case of child sexual abuse, torture and murder by 'paedophile' Marc Detroux, and demanded political action on behalf of abused children and young people.

I believe that for the first time in history, enough people in many societies

across the world can face up to the facts about child sexual abuse sufficiently to stoke the political will to begin reducing its incidence. This can ensure that for the first time unpalatable truths will not be suppressed as they have been over and over again through the past 150 years, as Olafson, Corwin and Summit have so well documented in their historical paper 'Cycles of Discovery and Suppression' (1996). The burial and re-burial of the truth, they point out, has not happened

> because child sexual abuse is peripheral to major social interest, but because it is so central that as a society we choose to reject our knowledge of it, rather than make the changes in our thinking, our institutions and our daily lives that sustained awareness of child sexual victimisation demands.
>
> (Olafson, Corwin and Summit 1996)

Slow progress on some vital issues

Returning to child sexual abuse research after a ten-year interval has given me perhaps a clearer perspective on what has and has not changed in the meantime, on areas where little progress seems to have been made and which still present serious challenges for the future. For instance, the credibility of children's testimony in the investigative and court process seems to have been little enhanced despite all the rhetoric about listening to children; and despite repeated and continuing evidence (for instance from large-scale investigations of past paedophile abuses in residential care) that it is children who were telling the truth and adults who were lying. That lesson never seems to be learned. This lack of progress points not just at the much-argued need to reform legal systems, but more fundamentally at children's relatively powerless status within society, and at the way they are still dismissed and distrusted.

The women's survivor movement remains highly marginalised, ill resourced, scattered, and pigeon-holed into therapy and counselling work. It remains largely excluded from policy making, from involvement in setting research priorities and from consultation in investigations. Indeed child sexual abuse work has become even more 'professionalised' over the past decade. This continued marginalisation is very disappointing, as is the slow development of the male survivor movement.

While survivor groups and feminist support organisations themselves need to explore the reasons for the lack of a united campaigning voice, the main issue about their exclusion must be faced by well resourced, high-status professional organisations. Why is the expertise, experience, special knowledge, wisdom and energy of survivor groups and indeed of non-abusing parents' groups still so often rejected, disparaged or seen as a threat? How can these vital elements be integrated into every stage of the policy making and research process? There can be few more important and urgent questions for the future than that.

Most depressing for many people is the apparent lack of progress in reducing the incidence of child sexual abuse, or in effective strategies for prevention. This

is despite the fact that it is now one of the highest-profile public issues, despite mountains of research from many disciplines, despite equally mountainous guidelines, good practice procedures and countless case investigations. The remarks of the National Commission of Inquiry into Prevention of Child Abuse about public inquiries seem equally relevant to these other issues

> Despite a series of wide-ranging, well-published and expensive inquiries . . . over the past 20 years, and despite a flow of recommendations deriving from these inquiries, the abuses that gave rise to these reports persist, largely unaffected by such efforts as have been made to prevent them.
>
> (National Commission 1996)

Indeed the more child sexual abuse is looked for, the more it is identified. Radical feminist Louise Armstrong offers more caustic comment on behalf of incest survivors: 'In speaking out, we hoped to raise hell. Instead, we have raised for the issue a certain normalcy. We hoped to raise a passion for change. Instead, what we raised was discourse and a sizeable problem-management industry' (Armstrong 1996).

Prevention must be based on knowledge of the problem

Thus the greatest challenge of all is actually to begin reducing the incidence of abuse, and to make a priority of prevention strategies. These need to inform all research programmes and public policy, both nationally and internationally. Definitions of prevention itself also need to be reviewed, because much of what is currently described as prevention work is actually about earlier official intervention in families already known to be at risk. So-called prevention schemes also underplay power relationships in sexual abuse, targeting victims rather than perpetrators. For example, five-year-old school pupils are not expected to prevent physical violence, burglary or murder, but they are asked to stop sexual abuse and to 'keep themselves safe'. Liz Kelly, in contrast, has an admirably succinct definition of prevention: that it is about stopping abusers from abusing (Kelly *et al.* 1991).

Prevention or reduction of child sexual abuse is not possible, except in a very limited way, until both professionals and the public discover and confront its full scale and nature. To tackle a social evil you must know what you are dealing with, and however disturbing the truth may be, it is necessary to know the worst before building an effective strategy. I suspect that we still have very little idea of the true extent, nature, savagery, planning and organisation of child sexual abuse in society. Many new clues have been garnered, especially over the past decade: what Roland Summit describes in his moving paper 'Hidden Victims, Hidden Pain' as 'fleeting glimpses of the reality brought by each brief clearing of the fog (Summitt 1988). These include revelations about the extent of repressed memory among adults; the scale and organisation of paedophile rings, especially in the residential childcare sector; the existence of sadistic child murder; the

scale of the multi-million pound international child pornography industry, and of international 'sex tourism'; and the existence of ritual abuse by cults, who use hitherto unimagined physical, sexual and emotional torture and mind control.

New technology, such as the video recorder and the Internet, has both encouraged and revealed alarming levels of child sexual exploitation. For instance in November 1996 Father Adrian McLeish, a Newcastle priest, was convicted after international police monitoring of the Internet identified him as one of an international ring of thirty-seven paedophiles. He had more than 8,000 photographs of children on his computer system. Many recent revelations of this kind suggest that sexual abuse of boys, in most cases by other males, is a massive and still largely unchartered problem.

Finally, the complex way in which different forms of child sexual abuse may overlap has been suggested by police investigations, by survivor accounts and by intensive neighbourhood investigations, such as Snow and Sorenson's very valuable American neighbourhood studies of ritualistic abuse networks (Snow and Sorenson 1990). Some people have suffered abuse across a number of settings: within a family, within a neighbourhood ring or paedophile ring, among teenage peers, within organised prostitution and pornography. Snow and Sorenson's study was particularly valuable in revealing the sheer complexity of involvement within a small geographic area. Through babysitting and other activities, teenagers were inveigled both into abusing others and into recruiting new victims and perpetrators.

The class dimension of child sexual abuse

Child sexual abuse knows no class boundaries; but many people have failed to perceive the extent to which it is connected with forms of class oppression. Ever more evidence is emerging that influential and high-status middle and upper class people consciously and deliberately target an underclass of highly vulnerable children, young people and adult women. I have concluded, after puzzling about this a great deal, that the reason exposure of child sexual abuse has been so uniquely subversive and threatening since before Sigmund Freud's time, through to the 1987 Cleveland crisis and up to the present, must go beyond the fact that it benefits countless ordinary men in many societies. It has to be that it also benefits many powerful and influential figures throughout the professions and among the highest social classes, more of these than we have hitherto even imagined.

Their targets are not the conventionally perceived social underclass, though many victims will be drawn from that, but are rather from a collection of groups who form the fodder of abusive networks; who are subjected over and over again throughout their lives to multiple abuses; whose very status as soiled goods, as the stigmatised, excluded, unnoticed and expendable, as the very people whose disclosures are given the least credibility by society, make them the ideal targets for family and neighbourhood abuse, cult and paedophile ring recruitment, pornography, prostitution, physical attacks and sometimes murder.

They include young runaways from all social classes; the thousands of young people who disappear every year; those entrapped in inter-generational cult abuse; children and teenagers in care; children with physical and mental disabilities; children from racial minorities; young gay men; the poorest single mothers and their children; the single homeless; young prostitutes; drug misusers; so-called delinquents; young people and adult women with mental health problems. They form a constant supply of easy prey and fresh meat to powerful respectable abusers.

The urgent challenge for the future is for the non-abusive society to make these vulnerable people special targets, as abusers do, but for very different reasons: they must be targeted for proactive, assertive protection throughout their lives. Societies must anticipate and expect their particular vulnerability, but at the same time respect their special credibility and importance, as the possessors of the most vital information about the secret perpetrators of child sexual abuse.

This is an international as well as a national effort, because a similar underclass exists in every society, but also because these oppressions connect with the sexual imperialism perpetrated by sex tourists and pornographers from wealthy western countries on children, young people and women in the Third World. What is happening in our own society helps to give a clearer, more empathetic and committed understanding of those despicable forms of international exploitation, and of the ways in which class power, sexism and racism interconnect to promote large-scale sexual exploitation.

If our societies are to build on this wide range of clues about the extent and nature of child sexual abuse, to develop a better baseline of knowledge from which to devise detection and prevention strategies, we need to build upon sources of knowledge which are ignored or under-utilised in conventional prevalence and incidence studies.

Making full use of information sources

I think there are many problems about conventional incidence and prevalence studies, and that the continual quest to make them more accurate and achieve consensus on very varied findings is largely unproductive. There is only space here to touch briefly on a very extensive subject, but a few points can be summarised. Even in the improved, broad-based community studies, many survivors will have repressed their memories or will choose not to disclose information. Abusers do not tend to reveal their deeds in community surveys. Conventional approaches and classifications militate against tapping into complex, interlocking forms of abuse; and dry statistics guarantee neither public concern nor political action. The National Commission's disturbing conclusion that more than a million British children suffer some form of abuse or neglect made newspaper headlines for a few days, then sank without trace. In contrast one shocking case, like the Belgian child abduction and murder scandal which erupted in 1996, may have the power to galvanise large numbers of people.

First, retrospective information, both from survivors and from convicted offenders, needs to be drawn upon as a major source of knowledge. Second, there is a mass of information to be extrapolated from police or customs investigations, and official inquiries, including those into organised abuse, information which is still largely ignored by academic or other professional researchers. Third, intensive 'searchlight' studies are likely to yield much more detailed information than surveys of large populations. For instance, multi-disciplinary investigations in Leeds in the mid-1980s identified a large number of sex rings in a single area of the city, simply because interested and aware professionals were looking for them there. Paediatricians Jane Wynne and Chris Hobbs wrote: 'It was hypothesised that other rings must exist elsewhere . . . but were unrecognised' (Hobbs and Wynne 1994).

Fourth, the range of stigmatised, marginalised or distrusted outcast groups identified earlier need to be consulted respectfully for valuable information they have, and imaginative ways need to be found to enable them to give it more safely (and perhaps, anonymously). Young prostitutes under sixteen form one group who will hardly be motivated to provide information, so long as they are treated by the criminal justice system as criminals, rather than as victims of sexual exploitation by their adult pimps and customers.

All these approaches are much more likely to enable us to map accurately the scale, forms and nature of sexual exploitation, and to give us a much clearer understanding of their interconnections. What will be revealed is likely to be shocking: it will also form, at long last, a sound knowledge-base for planning future strategy.

Welfare problem, crime or public health issue?

The challenges this creates will be numerous and great. For instance, evidence is likely to mount that the majority of child sexual abuse cannot be tackled as a welfare problem. Rather it must be reframed as crime, often as serious and organised crime, which requires, in the effort to combat it, many of the techniques which are used against that level of crime. It also requires an end to naive liberal optimism and trust. We do not assume those suspected of other serious crimes will automatically tell us the truth, nor that they will even be remotely concerned about issues of truth and integrity. Yet as the credulous response among many professionals and most media to 'false memory syndrome' has revealed, the smokescreens constructed by accused adults are often misperceived as scientific revelation.

The sense and the fairness of asking professions in society's middle ranks of power and status – particularly social work – to play the major part in tackling the social problem of sexual abuse will also be called into serious question. These professionals are not powerful enough to confront socially influential abusers and networks, and are at the same time frequently oppressive to families at the bottom of the social pile. That is an invidious position for any profession to face. Instead the greatest needs for action may be at the top and bottom of the ladder:

concerted measures and major redirection or resources against powerful abusers by governments and criminal justice systems; along with equally concerted moves to create protective local communities at the grassroots of society.

This will include basic preventative work: to give one simple example, opportunistic sexual abuse would be greatly reduced if safe babysitting and childcare schemes were widely funded. The current wave of angry vigilantism against known sex offenders within more deprived communities is one symptom of the class divides which have opened, and the professional exclusion of ordinary people from constructive processes of child protection.

The challenging task in future for middle-level professions like social work will be to identify what skills they can contribute, in a multi-disciplinary setting, to the pursuit of powerful abusers; and how, on the other hand, they can lend resources and support to the active protection of young people in the communities in which they live. At that level, the protection of young people has to be de-professionalised.

Child sexual abuse also needs to be re-framed as a major public health issue. There are enormous resources in health, and the impact of harnessing even a few of these to the identification and prevention of sexual abuse – especially through high-profile public education campaigns – could be great. It is, after all, extraordinary that child sexual abuse is not already viewed as a major public health issue, though less extraordinary perhaps to cynical feminists, since like domestic violence, it has been seen as mainly a women's issue and of secondary importance.

Almost exactly 100 years after Freud declared child sexual abuse to be the 'source of the Nile' of mental illness (Masson 1992), the enormous and wide-ranging effects of child sexual abuse trauma on adult mental health are finally being recognised by a growing minority within the mental health professions. The extent of physical damage, injury and lifelong ill-health is being recognised more slowly, but will I think also prove another time-bomb of knowledge. At the extremes, child sexual abuse kills: not only are murders committed, but it is a significant contributor to suicides, especially among children and teenagers.

Yet most health service practice and research in child sexual abuse is concerned with therapy and amelioration of symptoms, including endless debate and discussion over which forms of treatment are more or less appropriate. Having the best possible support services is very important to recovering from the trauma of child sexual abuse. Every survivor who needs them should be entitled to them; at present the great majority have no service at all.

The extent and acceptability of this 'convalescence/recovery model' by health professionals, however, does seem remarkable compared with their approach to other forms of violence or risks to health. They would not consider head injuries clinics or counselling an appropriate response by society to the abuses wrought by drunk drivers, violent street gangs or child batterers. Ameliorating the symptoms of chronic lung disease or poisoning is not seen as an adequate response either to damaging habits like smoking, or to environmental hazards. Lead pipes are removed and asbestos stripped from buildings.

Major public education campaigns are waged against many of these threats to public health.

Health professionals seek the causes of diseases, and inoculate people from catching them. They are not content to continue building fever hospitals, offering new forms of ameliorative treatment for the typhoid which was rife when Freud declared child sexual abuse the 'source of the Nile' of mental illness in 1896.

We have to ask why increasing evidence of the links between sexual abuse and ill health only spurs the quest for therapy and amelioration. Why is the obvious conclusion not drawn: that if child sexual abuse trauma leads to such serious and varied damage to mental and physical health, to so much lifelong suffering and anguish, then it is unacceptable and intolerable for anyone to suffer it in the first place. That conclusion, from health professionals who are society's frontline witnesses to the trauma caused, would place health services in the front line of prevention.

Breaking professional silences

The final challenge for the future that I want to discuss here is the need for professional courage in speaking out publicly on behalf of abused children and adults. This is such an important issue that it deserves considering in some detail.

The enforcement of silence has been and remains the most potent weapon of abusers, both individually and collectively. Breaking the silence has likewise been seen as the most vital first step towards bringing about change and a safer environment. Through doing this the survivor movement has made an enormous impact in forcing child sexual abuse on to the agenda and keeping it there. Abused children and adults are asked by professionals to break the silence. They must tell and keep on telling, until someone listens to them and acts to protect them. Their bitter experience has often been that this simple demand is not enough: it has held out false promise, for many have not been believed, or when they were, professionals were not able to protect them.

Indeed professionals themselves have often been silenced, vilified or marginalised. The silencing of professionals has itself been a major feature of child protection work internationally in the past decade: it is not surprising, therefore, that sexually abused children are silent. It is very important that childcare professionals address this issue of their own silencing and actively explore together ways in which they can speak out more assertively; not just about sexual abuse in general but about the facts of specific, often highly publicised cases. This is because so often it is through a few such cases that the public and the courts have their opinions shaped about child sexual abuse, about recovered memory in adults, or about the child protection authorities for a decade or more.

We live in an era where abusive adults and their powerful supporters use the media as a weapon to shape public and legal and medical opinion, where they have no qualms about identifying vulnerable children and adults, publishing their photographs in the press, libelling individual professionals, and spreading

lies and distortion on a wide scale. Breaking silence to challenge them with the facts will also involve communicating through the media, for the clock cannot be turned back on modern technology and global communication.

We have to ask why by far the most valuable, timely and effective vehicle in Britain for revealing the facts about child sexual abuse cases, challenging the powerful abusers' lobby – especially on 'false memory syndrome' – and reviewing important research findings has not come in recent years from government, nor from statutory or voluntary child protection organisations. It has come from the *Accuracy About Abuse* newsletters put together by one busy journalist, Marjorie Orr. The importance of her work in keeping up to date on what abusers and their apologists are doing and writing is immense, and the information that she collates is of great value. It may be easier for some journalists and academics to speak out than it is for people working in the childcare professions, but has it really been necessary that she has been left to plough such a lone furrow?

I am increasingly concerned by the scale, the apparent effectiveness and damaging consequences of professional silencing: by how easily many senior professionals seem to have been intimidated by accused adults and by the media. Distrust and disillusionment with the media is understandable, but succumbing to silencing and misrepresentation does not help children and adults who have been abused. New approaches must be developed, especially at a time when some among media and public are reassessing their past assumptions, and are willing to listen.

There is indeed censorship and many people have experienced it, but there is also a great deal of self censorship. Professionals now need to think hard about the reasons why they refuse to comment on or use the mass media assertively, and whether these reasons are justified.

What are the reasons for silencing?

I am sure we can all agree that some forms of silencing are quite unacceptable and unethical, as when Clwyd County Council declined to publish a damning inquiry report on pervasive paedophile abuse in its children's homes in North Wales over decades, because its insurers warned them this could make them liable to financial claims by victims.

Most fear of litigation is, however, fear of abusers or suspected abusers, especially influential middle class men. These are genuine concerns, especially given worrying examples from the USA, such as accused adults suing therapists. However there are also dangers in other countries using the USA as a warning model, for it is a uniquely litigious society. Fear of being sued can paralyse and intimidate a whole system, making it obsequious and timid, more concerned about apologising to aggrieved adults than about monitoring risks to children.

I think if abusers knew there was a real willingness to risk court cases where embarrassing evidence about them would be revealed, that many would actually think twice or melt away. If they were faced with a new attitude of polite and determined defiance, this would force them on to the defensive where they now

have the upper hand. If authorities started to contemplate behaving differently they could think about what backup might be needed: for instance, new national and regional funds to cover possible costs of litigation.

The need to protect the confidentiality of children, young people and vulnerable adults has been a central concern and point of principle. But we have to ask with brutal realism how often this has actually worked to protect abused people, when the other side has used every media weapon available to lie about their case, vilify them or spread rumours that they are mentally disturbed. This supposedly 'child-centred' policy simply has not protected those it is designed to protect and has left them feeling disempowered. Serious consideration needs to be given to this blanket policy of confidentiality, and a way found to protect the privacy of victims which at the same time maximises the potential of their disclosures to stop abusers.

For instance, there are many discreet ways of briefing sympathetic media on or off the record about the basic facts of a case, including facts about suspected adults. Letters correcting blatant untruths about families or staff should be written to newspapers as a matter of course on each occasion there is misrepresentation of the facts. Older children, teenagers and adults should actively be consulted about what they wish to have revealed, or whether they wish a forum to speak, when there is a concerted media campaign of distortion.

Another reason for silence is the fear of being misrepresented and manipulated. Sadly this has often proved true, but it can also be a self-fulfilling prophecy and counsel of despair. If professionals do not speak their views, they will not be heard. Professionals need to spend as much time thinking creatively about how to use the media as they do thinking about how they can avoid appearing in print.

I have met many professionals who know what has really happened in highly-publicised cases, and we talk about it at great length on the phone or in the pub. However it is no use us talking to each other if this information never reaches a public forum, and does not bring a public reassessment of child sexual abuse. If communicating with the public through the media was recognised as truly important, different methods could actively be considered, from collaborating on books and journal articles to using Internet sites or making broadcast programmes, especially with sympathetic independent producers so that they could exercise more editorial control.

Another reason for silence, or at least for very cautious, restrained comment, is the perfectly honourable one that professional agencies have respect for law and due process, and they have standards to maintain of courtesy and moderation in public utterances. In particular one does not 'murmur' the judges; at one time people could lose their heads for that! No-one is suggesting social work directors or prosecutors should suddenly issue a stream of invective or outrageous statements, but there is an unresolved issue about how protectors of children respond to a situation where the other side has no qualms about how it whips up support, or how often it libels individuals.

It is possible to be outspoken in a courteous way from the principled position that the primary duty is to protect children. It is also possible to speak more often

through professional associations and trade unions. How far is reticence based on over-bureaucratic caution, mere tradition, or an outdated deference towards certain professions? What would the consequences be of responding to dubious decisions in a blunter way on behalf of young people? Would the world really come to an end, and would senior officials lose their jobs? I suspect not.

This was something I found myself pondering on a great deal in the much-publicised Scottish Ayrshire case, which alleged particularly horrendous forms of sadistic organised abuse with ritual features. In this case, eight children were returned home by Sheriff Colin Miller in 1995 after a new hearing. This took place several years after the original sheriff (Neil Gow) had declared the facts proved, and after numerous subsequent hearings had upheld his verdict.

Strathclyde Social Services department did indeed issue a detailed and considered written statement afterwards (Strathclyde Social Services 1995), but this case seemed so important that it merited a wider and more outspoken professional response, because if that case fell, it could be argued, any child sexual abuse case would fall. The evidence of abuse was so overwhelming, the grounds for calling a new hearing under the nobile officium so questionable, the supposed new evidence so absent, the sheriff's conduct of the case so dubious, his treatment of the child JF so outrageous, the prospects for the children so terrifying, the ratification of Miller's decision by three of Scotland's most senior judges so concerning for the whole Scottish legal system's ability to protect children, if ever there was a time to speak out forcefully, perhaps it was then.

This is not to criticise any professional over what they found a profoundly distressing judgement on behalf of the children they care about. It is simply worth reflecting on what might have happened if Strathclyde Social Services, the Association of Directors of Social Services, the Chief Reporter to the Children's Panel and his professional association, plus statutory and voluntary child protection agencies had issued immediate public statements saying: 'We disagree fundamentally with these court decisions and believe they were wrong. We stand by all the previous legal process. We think the conduct of this hearing was not impartial, that the treatment in court of the child JF was disgraceful, and we believe children have as a result been placed in serious danger?'

Certainly it would have raised controversy, even sensation; it would have been front page news. It is not a course to be taken lightly or often. The public and media, though, would have been forced to confront and debate this serious disagreement, raised by highly respected people, and scrutinise the case again. The judiciary would have had to respond and realise that it was now accountable to other professionals as well as the public. While such frankness in this or any similar legal case would initially be unnerving, it might make a big impact on the conduct of future child protection cases.

Another reason for silence among individuals who were scapegoated or suffered professionally for their support of children is that they found the whole experience so damaging and traumatic that they cannot face talking about the issue once again. They simply want to get on with their lives. This is really understandable when we consider the extent of vilification many have faced

along with the personal burdens they carry. They knew the children who were returned home, they can never forget their faces or their suffering, and often they blame themselves heavily for what happened, whether or not that blame is in any way deserved.

I think we must allow people to make their own decisions without pressure. All they may sincerely be asked is this: 'Has living with this really made you feel better? Have the pain and guilt diminished by your silence? Will the indignities and injustices you have suffered – for instance, by being stripped of child protection work which was a strong personal commitment – be changed by your continuing silence? Is it possible that speaking out might restore self respect, channel anger where it should rightfully go, and change the way the public perceived you as a person and a professional?

Unfortunately, another major reason for silencing is that senior managers in particular professionals or workplaces want neither to have such individuals speak, nor to comment themselves. I am concerned about the pervasiveness of this situation and its effects. For instance, in the 1997 Channel 4 documentary series *Death of Childhood* about highly publicised sex abuse cases like Cleveland, Orkney, Rochdale or Nottingham, the vast majority of agencies involved in child protection declined to comment or take part. Many either forbade individuals to do so or made clear they did not wish them to. There was a deafening silence except from a very few individuals who made a noted and positive contribution. Subsequent press reviews of the first (Cleveland) programme suggested they made a significant impact on media and public perception of the whole case.

Unjustifiable practices?

This silencing raises worrying issues. First is that of human rights and civil liberties. It seems to me unjustifiable and oppressive for any agency to prevent one of their employees from defending actions they took ten years ago, usually while working for someone else, when that person's professional career has been blighted and they wish to speak up both to defend abused people and to explain their past actions. I believe there has to be a debate about when 'gagging clauses' in employment contracts or severance agreements are justified.

Second, if influential agencies and senior managers are more concerned about some vaguely anticipated public embarrassment or offence to adults than they are about justifying actions they believed in and principles they themselves preach, then that represents a very depressing vista for child protection. Third, if their agency lost credibility over a particular case, they do not improve it by keeping quiet and hoping everyone will forget, but rather by presenting the public with different facts to consider.

Childcare agencies, statutory and voluntary, are the public faces of child protection, and they speak for many child and adult survivors who cannot yet do so. If they cannot stand up to be counted and face the consequences, then who else will? If they run away from their knowledge that certain forms of abuse exist, how will these facts ever be established in the courts, and survivors protected or supported?

For instance concerning the contentious subject of satanist ritual abuse (SRA), all we seem to have heard from British statutory and voluntary agencies in recent years are disavowals and retractions in the face of ridicule or criticism, along the lines of: 'We never said it was satanic, we never said it was ritual, it was the media who attributed it to us'. Yet they know what they have been dealing with. They know what these cases were about and at one time some were prepared to say so. Awkward facts do not go away, and one is that satanist cults have been heavily implicated in organised ritual abuse. SRA survivors will reply, 'We are sorry this is embarrassing, because embarrassing is hardly the word we would use to describe our own experiences'.

Who benefits from this lack of honesty? Not the people agencies are set up to protect. What message does it give to their own clients, whom they have urged to break the silence, and why is it not possible for agencies to acknowledge now, 'Much of our practice may have been misguided in this or that case, but we still stand by our deep concern at the evidence'? That, after all, is the truth; that is what they really believe; that is what they confide to others in private.

There have been many examples of individual professionals being penalised for attempting to defend the interests of children. I do not mention examples here in order to put organisations on the spot, nor to single them out unfairly when many others have reacted in the same way; but rather because skirting tactfully around real injustices that have happened to real people is itself a form of collusion in a silence that has to be broken.

In the spring of 1997, the staff team of the internationally-renowned Frederick Stone Unit, a pioneering multi-disciplinary unit for sexually abused children in a Natinal Health Service setting, made serious complaints to Yorkhill NHS Trust in Glasgow. These concerned the conduct of their own head of service, and included claims that she had either withheld or delayed reporting positive findings of physical and sexual abuse to child protection authorities.

However while the paediatrician involved continued to work with sexually abused children, the rest of the team appeared to be penalised for 'whistleblowing'. They variously had their contracts ended, were threatened with immediate redundancy, were moved to other duties, were asked to sign 'gagging clauses', or were given the option of moving out of child protection work. The unit's work was narrowed and the Trust of this historic children's hospital decided to terminate the new children's counselling programme. In a case which was still continuing at the end of 1997, the Trust portrayed the crisis as a bitter personality dispute between doctors, aggravated by the supposed stress under which team members were working. Apart from the repercussions for staff, the interests of abused children were hard to detect in the Trust's response (Nelson 1997a).

In another example, it seemed quite unacceptable that for ten years after the Cleveland crisis, for ten years after the Second Opinion Committee considered that at least 70–75 per cent of the paediatricians' diagnoses were accurate, Dr Geoffrey Wyatt was forbidden by his English health authority to deal with cases of suspected child abuse, even in a team context or with other

safeguards. That seems a case of shooting the messenger, or rather of giving him a life sentence, one which must have caused him much personal pain. An even more important question is whether any abused children slipped through the protection net as a result.

Thus I regret that Children First, a respected organisation which had a long and largely honourable involvement in the Orkney case, declined to defend itself and set the record straight in the Channel 4 *Death of Childhood* documentary concerning Orkney, and only had to say to reporters who asked for a comment that the case was 'a long time ago' and 'the organisation no longer did investigative work'. It was in 1991, and police forces across Britain are currently investigating alleged abuses in children's homes and other settings which stretch back to the 1960s. No one is suggesting this makes them less important.

Thus I regret very much that in May 1997 a major figure in the Cleveland affair, Sue Richardson, saw no option but to resign from her own leading childcare organisation where she was doing excellent work with adult survivors in Glasgow, because she risked dismissal simply for taking part in the Cleveland documentary (Nelson 1997b). The reason was apparently, that through identification with her, the organisation might have suffered negative publicity; yet this organisation publicly proclaims the very values on which she was speaking out on TV. I cannot think of a line that she said in that programme which was not in keeping with the values and work of NCH-Action for Children.

Inspiration for the future

I am proud of what Sue Richardson said, of her courage in declaring that evidence was withheld from the Cleveland courts in 1987, and that deliberate decisions were subsequently taken that nobody would know what later happened to children who were returned home by those courts. The programme provided documentary evidence that this was indeed the case, and that official records were destroyed. I believe her example – along with those of Heather Bacon, Marjorie Dunn and Frank Cook MP – pointed the way to the future direction both agencies and individuals, mutually supporting each other, should take in publicly asserting the interest of children.

This will not be an easy task, but courage can be found from at least three sources: first, from collective will and united action so that individual agencies, managers and workers are not left isolated and exposed; second, from the gradual but definite change in public opinion towards more open minded reconsideration of the extent of child sexual abuse, and of the facts in publicised cases. Activities in Gloucester and Belgium have been important in influencing this public opinion. Third, it will come from the persisting example of child and adult survivors who have spoken out, and protective mothers who have battled for years against abusers, and against unsympathetic child protection systems and courts to protect their own children, often spending thousands of pounds in the process.

Surely professionals, with all the advantages they have, with all the sufferings

most have not experienced, can draw on some of their courage and commitment to speak the truth more fearlessly from now on. After all it is not embarrassment, it is not bad publicity, it is not even possible loss of a job that survivors and non-abusing mothers have already risked, both in their everyday lives and in their decisions to stick their heads above the parapet. It is their basic physical safety, their bodily integrity, their sanity, their freedom from being incarcerated in mental institutions or prisons; it is loss of any contact with their children, it is even sometimes risk to their very lives and the lives of their children.

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Part 3

Conclusion

21 Child protection and child sexual abuse prevention

Influencing policy and practice

Catherine Itzin

Introduction

In this chapter I draw on the material in the book to develop an analysis which considers the nature and extent of child sexual abuse; the contributing factors and causal relationships for boys between having been sexually abused and becoming a sexual abuser; and the psychoanalytic as a theory of process. I develop an analytical framework with which to explain the 'male monopoly on molestation' and the 'female monopoly on self harm and revictimisation' in terms of what I call the social and psychological construction of gendered power relations. There is a section on 'gendering the language of child sexual abuse', which shows how men who are identified in community and clinical studies as primarily the sexual abusers of children become invisible as the abusers in the normative use of the ungendered language of 'parents' and 'families' in research, and in child protection and criminal justice system policy. I consider also the 'language of "paedophilia"' and how that obscures and protects ordinary heterosexual men's sexual abuse of their own and other people's children. I then turn to how this gender-neutral language leads on to women being blamed and held responsible for men's sexual abuse of their children. In the final section on child protection and child sexual abuse prevention conceptualised as stopping abusers abusing, I set out a 'philosophy of treatment intervention'; argue the need to abandon current child sexual abuse prevention which puts the burden of protection on children; describe, as a model, an integrated multi-disciplinary and multi-agency community response to the sexual abuse of children in Grand Rapids, Michigan, USA; and argue for making child sexual abuse a public health priority.

The nature, extent and gender of child sexual abuse

Because of differences in methodology, and in particular the age ranges covered, the definitions of sexual abuse used and the ways in which questions were asked, the prevalence rates of child sexual abuse for women and men found in studies in the USA and UK over the past twenty years have varied considerably. Peters, Wyatt and Finkelhor (1986), for example, found, in a review of community

samples, a prevalence range for women from 6 per cent to 62 per cent and for men from 3 per cent to 31 per cent. In the USA, in one of the first major studies of its kind, Finkelhor (1979) found, in a higher education student sample of 796, a prevalence of 19.6 per cent for women and 8.6 per cent for men. In the same year in a community study of a representative sample of women in San Francisco, Russell (1983) found a prevalence of 38 per cent using a narrow definition and 54 per cent using a broad definition (Russell 1983: 138). In another representative sample, Wyatt (1985) found a prevalence of 45 per cent for women. In the UK, Kelly, Regan and Burton (1991) found, in a sample of 1,244 further education college students, a prevalence of 21 per cent for women and 7 per cent for men based on a narrow definition, and up to 59 per cent for women and 27 per cent for men based on a broader definition (Kelly *et al.* 1991: 11).

In a meta-analysis of most of the adult retrospective surveys in the USA and Canada using community samples completed and reported since 1980, Finkelhor (1994a) found evidence to show that at least 20 per cent of women and 5–10 per cent of men experienced some form of sexual abuse as children (Finkelhor (1994a: 31). In the UK the Royal College of Physicians (1997) have estimated that 1 per cent of children will suffer some form of sexual abuse each year, with approximately 20 per cent of children experiencing some form of abuse before reaching adulthood. Peters, Wyatt and Finkelhor (1986) concluded that 'even the lowest rates indicate that child sexual abuse is far from an uncommon experience [for either girls or boys], and that the higher reported rates would point to a problem of epidemic proportions' (Peters *et al.* 1986: 19). At the same time there is a consensus amongst researchers that 'under-reporting . . . is consistent and universal' (Watkins and Bentovim 1992: 201) and that these figures are almost certainly an under-estimation of the prevalence of child sexual abuse.

This is the conclusion drawn by Bolen and Scannapieco (1999, and chapter ten, this volume) in a 'corrective metanalysis' of twenty-two random prevalence studies which found that 'at least 30% of all female children are sexually abused and as many as 40% may be abused' and that 'between 3% and 13% of all male children are sexually abused, with 13% representing the lower bound for an estimate for males'. Russell and Bolen (2000, and chapter ten, this volume) also consider 'these rates constitute an underestimate of the prevalence of these crimes' (Russell and Bolen 2000: 154). Furthermore, Russell (1983, 1986) found 'a prevalence of 20.6% for forcible and non-forcible completed and attempted rape of children and adolescent females, including oral and anal penetration as well as penile-vaginal penetration'.

The strongest evidence for concluding that the levels of child sexual abuse reported in prevalence studies are an under-estimation is in the findings of a prospective study reported by Williams (1994) of the extent to which child sexual abuse empirically evidenced in medical records is subsequently unremembered by its victims. Williams found a very substantial level of unremembered abuse: nearly two-fifths (38 per cent) of the sample of women interviewed did not recall the abuse for which they were treated by the hospital as children. In addition, she found a very high level (68 per cent) of sexual abuse that was

remembered but never disclosed or reported prior to the time of the 'index abuse' in their medical records, or subsequently. Williams concluded that:

> this may . . . provide a conservative estimate of the proportion of women sexually abused in childhood who have no memory of the abuse. . . . [that] these findings suggest that having no memory of child sexual abuse is a common occurrence . . . among community samples of women who were reported to have been sexually abused in childhood. . . . [that] large, community-based retrospective studies of child sexual abuse may misclassify as non-abused a significant number of women who were abused in childhood. . . . [that] retrospective studies miss information about a significant proportion of the abuse that women have suffered . . . [and] therefore, that understanding of the prevalence of abuse is affected, as is understanding of the nature of that abuse.
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> (Williams 1994: 1173–4)

As with prevalence, research findings have varied about what proportions of child sexual abuse are intrafamilial and extrafamilial. Finkelhor (1979: 58) found that almost half (44 per cent) of the experiences of sexual abuse reported by girls were with family members. The figure for boys was 17 per cent. He concluded that for something that was supposed to be taboo 'sex within the family seems to be remarkably widespread' (ibid.: 87). Finkelhor found, across the nineteen North American studies he analysed, consistency of prevalence rates reported for intrafamilial abuse: that 'between one-third to one half of girls were victimized by members of their family, and from 10–20% of boys' (Finkelhor 1994a: 31). He concluded that 'although offenders are generally known to their victims, whether sexual abuse is *primarily* [his emphasis] an intrafamilial problem is an issue about which there has been much uncertainty'. His concerns have focused on the bias towards intrafamilial abuse in child protection agency data in the USA (Finkelhor 1984: 157).

Russell (1983), on the other hand, found, in the USA, nearly twice as much extrafamilial abuse (31 per cent) as intrafamilial abuse (16 per cent) of women. The accuracy of these figures was validated in the findings of a detailed analysis of the methodologies of nine representative studies (Russell and Bolen 2000, and chapter ten, this volume). In the UK, Kelly, Regan and Burton (1991) found abuse by relatives in 14 per cent of cases and have concluded (chapter four, this volume) that 'although most children are abused by adults and peers they know, these are not always – or even in the majority of cases – family or household members'. They describe as 'a myth' the view that there is a preponderance of incestuous abuse, as do Russell and Bolen, in the USA. However, Russell and Bolen thought it was 'safe to assume that at least some of Russell's 930 respondents were unwilling to disclose experiences of child sexual abuse to the interviewers, particularly incestuous abuse' (Russell and Bolen 2000: 153). It was also their view that 'victims who are raped by strangers are much more likely to report this abuse than are the victims of relatives or other known perpetrators' (ibid.: 186). In the UK, Childline, the national

children's charity helpline reported answering 'more than a million calls in 1997,' a '12% increase on the previous year,' the 'largest group of children calling because of physical and sexual abuse by fathers and father figures' (White 1998: 7).

Williams (1994), in the USA study cited earlier, found that of the 38 per cent of women who 'did not recall the index abuse, over one third (35%) told the interviewer about other sexual abuse perpetrated by family members'; that 'those molested by strangers were more likely to recall the abuse than those molested by someone they knew, such as a friend of the family, a peer, or a family member'; that 'the women who were molested by family members or had genital trauma were more likely to have no recall'; and that 'repeated abuse may be associated with no recall' (Williams 1994: 1170–3). Her study showed that girls are more likely to remember extrafamilial rather than intrafamilial abuse, and one-off rather than repeated abuse over a long period of time. She concluded that 'abuse of very young children and abuse perpetrated by individuals with a close relationship to the victim may be more likely to go undetected in retrospective studies' (ibid.: 1174). This suggests that the sexual abuse of girls which is the most under-reported is intrafamilial rather than extrafamilial abuse; that it may be very substantially unreported; and that the incidence of intrafamilial sexual abuse of girls is likely to be very significantly greater than reported in retrospective prevalence studies.

There is also evidence of under-reporting of intrafamilial sexual abuse of boys. Watkins and Bentovim found, in their review of the research, that 'sexually abused boys have not been coming to public attention to the same extent as sexually abused girls (Watkins and Bentovim 1992: 200), and that 'research on sexually abused boys has clearly lagged behind that of girls' (see also Finkelhor 1984: 157). This was, in their view 'partly because it has been seen as an uncommon, if not rare, problem and partly because it was doubted that sexual abuse had significant effects on boys, or their subsequent development' (ibid.: 197). In particular, they found an emphasis in the research they reviewed on the extrafamilial sexual abuse of boys: 'most of the reported evidence . . . suggest[s] that extrafamilial abuse is more common in boys than intrafamilial abuse, but is divided over whether boys are more prone to abuse by strangers, with some studies supporting this proposition and a similar number not doing so' (ibid.: 203).

There have been a number of mutually reinforcing assumptions that have directed the focus to the extrafamilial abuse of boys. One is the assumption that boys are primarily victimised sexually by men who are 'paedophiles', conceptualised as 'not family'. This is reinforced by the further assumption that 'paedophiles' have a sexual preference for boys. This, together with the assumption that the victims of incest are primarily girls, and what Watkins and Bentovim (1992) have termed the 'denial of father–son abuse', has functioned to keep the 'gaze diverted' away from the intrafamilial abuse of boys, 'even though fathers are cited as amongst the most frequent, if not the most frequent abusers of boys, including sons', with stepfathers 'the alternative most frequently cited perpetrators' (for example Faller 1989; Hobbs and Wynne 1987). In the 'few exceptions to the clinical findings that fathers/stepfathers are the most

frequent abusers of boys,' Watkins and Bentovim found the methodologies flawed, with 'the samples . . . strongly slanted towards stranger abuse' (Watkins and Bentovim 1992: 206).

Watkins and Bentovim also suggested that 'denial of sibling and cousin incest, and child–child, and adolescent–child sexual abuse' was another reason for the under-recognition of the intrafamilial sexual abuse of boys (ibid.: 207). Certainly Finkelhor was surprised to have found 'unexpectedly' that the sexual victimisation of younger sisters by brothers was 'alarmingly common' and that 'brothers were sexually involved with other brothers about as often as they were with sisters' (Finkelhor (1979: 90). Their scarcity amongst reported cases was, he thought, 'merely another indication that they are unlikely to be revealed, either by victims or their families' (ibid.).

Furthermore, there is also evidence to suggest that where one child in the family is being abused, the others are also. In Russell's sample of 930 women, nearly one-third (32 per cent) of the women who reported intrafamilial abuse, also reported that the intrafamilial abuser had sexually abused 'one or more other relatives' (Russell 1983: 142). La Fontaine found in nearly one-half of a social services sample and one-third of a hospital sample, that 'the brothers and sisters of a victim are likely to have been abused as well' (La Fontaine 1990: 65). Watkins and Bentovim cite 'the available evidence' which 'points to the increased possibility of boys being abused in conjunction with their sisters, rather than in isolation'. It is their view that 'sexual abuse of a sister is a clear indication to interview brothers' and that 'if this is not done their will be under-diagnosing' of the sexual abuse of boys by familial males (Watkins and Bentovim 1992: 205). Like Finkelhor (1984: 164), they think 'it is unwise to assume, when abuse of a girl has been disclosed, that any boys in the family have not been abused' (ibid.: 233). This higher than recognised incidence of child sexual abuse within families will have contributed to an under-estimation of prevalence of intrafamilial abuse of both girls and boys, and will be a confounding factor methodologically in prevalence study samples which necessarily count only one abused child in each family.

In turn, this evidence of the under-reporting in prevalence studies of intra-familial child sexual abuse involving both girls and boys needs to be considered in the wider context of findings from research which show that the vast majority of child sexual abuse is 'undisclosed'. Only 35 per cent of children in Finkelhor's study told anyone: 'only a minority of the experiences are ever reported, even to parents and friends, let alone police' (Finkelhor 1979: 72). In the study conducted in the USA by Russell, only 6 per cent of cases of extrafamilial and 2 per cent of intrafamilial abuse were reported to the police (Russell 1983: 142). In the study conducted in the UK by Kelly *et al.* (1991), only 5 per cent of the child sexual abuse was reported to anyone; only 2 per cent was reported to an official agency; and only 1 per cent was prosecuted. Finkelhor thought that 'the weight of evidence from victimisation surveys and from studies of sexual behaviour' suggests the 'withholding of disclosure of child sexual abuse' (Finkelhor 1994a: 42).

Using projected incidence rates based on prevalence figures, Bolen and Scannapieco (1999, and chapter ten, this volume) concluded that 'even with the

most optimistic prevalence estimate, 73% of female children abused each year are not being identified, assessed and treated . . . and more realistically up to 87%'. Although they could not calculate similar projections for male children because of insufficient data, they thought it was 'probably safe to say that the majority are also not being properly identified'. Peters, Wyatt and Finkelhor argue that:

> most cases of sexual abuse do not come to the attention of any child welfare agency or any professional . . . [because] the nature of the problem – its secrecy and shame, the criminal sanctions against it, and the young age and dependent status of its victims – inhibits discovery and discourages voluntary reporting.
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> (Peters *et al*. 1986: 18)

Russell and Bolen considered 'under-disclosure [as] perhaps the most challenging problem for prevalence researchers to overcome' (Russell and Bolen 2000: 155, and chapter ten, this volume).

Williams concludes that:

> disclosure of intrafamilial abuse is arguably much more difficult for a child to make and therefore much less likely to occur than a disclosure of extrafamilial abuse. . . . For the child, abuse by a stranger may be a highly salient event – easily remembered because of its one-time occurrence, its frightening aspects, its novelty, or because it is more likely to be discussed later with family members or friends. The family may also be more likely to provide support and comfort for the child molested by a stranger. Abuse by a perpetrator with a close relationship to the child is likely to combine elements of betrayal, fear and conflict, which may cause the victim to be confused about the nature of the abuse and to experience difficulty with her memory of it. Such abuse may be associated with high levels of guilt and psychological distress focused on issues of betrayal and, possibly, confusion about her role in precipitating the abuse (Finkelhor and Browne 1985). Furthermore such abuse may be more likely to be ignored or hidden by other family members. This may send a powerful message to the child to forget about it.
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> (Williams 1994: 1174).

The non-disclosure of intrafamilial abuse will be reflected in what researchers agree to be a vast number of unreported as well as unremembered cases, and will result in an under-estimation of the intrafamilial sexual abuse of both girls and boys.

With respect to the gender of the abusers, however, there has been consistency in the findings of prevalence studies and clinical samples that most child sexual abuse, whether intrafamilial or extrafamilial, is perpetrated by adolescent and adult males, regardless of whether the victims are male or female. Finkelhor observed that 'the most obvious characteristic of sexual abusers [is] they are almost all men' and that 'this finding is just as true for boys [in 84% of cases] as girls [in 94% of cases]' (Finkelhor 1979: 75). Finkelhor (1986) cites the findings of Finkelhor (1984) and Finkelhor and Hotaling (1984) that 'among reported cases of abuse 90% or more

offenders appear to be men' (Finkelhor 1986: 126). He cites the figure of 95 per cent for girls (ibid.). In the study by Russell, men were the abusers in 96 per cent of cases (Russell 1983: 139). In the study by Palusci *et al.*, 95 per cent of the abusers were male (Palusci *et al.* 1999: 390). In Williams' sample 'all of the perpetrators were male' (Williams 1994: 1169). In the UK, in the study by Kelly, Regan and Burton, 95 per cent of abusers were male (Kelly *et al.* 1991: 25). Like Finkelhor (1984: 160), Baker and Duncan found that 'the majority of boys are abused by men' (Baker and Duncan 1985: 465), and all of the abusers of the boys in the study by Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) were male.

The proportion of women found to be the sexual abusers of children in the prevalence studies cited in this chapter has been consistently in the region of 5–10 per cent, and this is corroborated by victim and perpetrator reports in the findings of clinical studies. Saradjian states that there has been 'no British or American study that has *specifically* [her emphasis] addressed what percentage of children are sexually abused by a woman' (Saradjian 1996: 15). 'This,' writes Kelly, 'is simply not true':

> All of the broad sample prevalence studies in the US and Britain (see, for example, Finkelhor 1979; Russell 1984; Kelly *et al.* 1991) have included questions which allow the gender of abusers to be analysed, and in each case the percentages for adult female abusers are between five and seven per cent. Whilst some local figures for reported cases have been cited recently as indicating a much higher incidence, the NSPCC, in a section of their 1990 Annual Report . . . stated categorically that their figures did not support the popular 'tip of the iceberg' view of women as abusers.
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> (Kelly 1996b: 43).

Finkelhor and Russell concluded from their 'review of both the evidence and the arguments' that 'there appear to be no sound reasons to believe that we have been wrong in presuming the amount of sexual abuse by adult female perpetrators to be small' Finkelhor and Russell (1984: 184). They argue that the increase in the numbers of women abusers seen in clinical settings has simply reflected 'their appearance in proportion to their actual prevalence,' and 'to take [this] to mean that sexual abuse is not primarily committed by men is . . . wrong and has no support in any of the data' (ibid.).

Contributing factors and causal relationships for boys between having been sexually abused and becoming a sexual abuser

I have set out the evidence from research of a substantially higher incidence and prevalence of the intrafamilial sexual abuse of boys by paternal and other familial males than is generally recognised. Watkins and Bentovim (1992: 231) suggest that one effect of child sexual abuse for boys is a predisposition to becoming a child sexual abuser (see also Skuse, Bentovim *et al.* 1998, and chapter twelve, this

volume). This is supported by data from adolescent and adult male sex offenders about both their sexual abuse *of* boys and their own sexual abuse *as* boys. Watkins and Bentovim cite some of 'the accumulating evidence that a majority of sex offenders begin their "careers" in adolescence' (Watkins and Bentovim 1992: 208). They also cite evidence of the sexual abuse of boys by adolescent sex offenders: this ranged from 35 per cent (Conte *et al.* 1989) to 55 per cent (Becker 1988). Adolescent and adult male sex offender data on the sexual abuse they experienced as boys by paternal and other familial males provides corroborating evidence of this. Watkins and Bentovim (1992) cite studies conducted with *adolescent* male sex offenders which identify a history of sexual victimization in their childhoods in the region of 50 per cent of cases, but frequently higher (Longo 1982; Johnson 1988; Smith and Israel 1987; Katz 1990). Itzin (1996a, 1997a, 1997b) cites similar findings in studies of *adult* male sex offenders who were sexually abused as boys (Carter *et al.* 1987; Seghorn *et al.* 1987).

Williams and Finkelhor found, in a study comparing 118 incestuous fathers with 116 non-incestuous fathers that incestuous fathers 'reported significant histories of child abuse', both physical and sexual victimisation and they were four or five times more likely than non-abused fathers to sexually abuse their daughters (Williams and Finkelhor 1995: 106). In another study, citing clinical literature as well as community studies, Finkelhor identifies the 'apparent greater likelihood that men who were sexually abused as children will express some sexual interest in children' and the 'clinical perception that abused boys, more often than girls, are at increased risk to become perpetrators' (Finkelhor 1994a: 47). Briere and Runtz (1989) found that 'having been sexually abused as children' was one of the main predictors of self-reported sexual interest in children in a sample of 193 university under-graduate males. Watkins and Bentovim observe that 'it is clear that those who work with perpetrators, particularly adolescent offenders, think the victim-abuser cycle is relevant' (Watkins and Bentovim 1992: 220), and that (citing Sebold 1987) 'sexual offending in preadolescent or adolescent boys should be considered as possible indications that the boys have been abused' (ibid.: 205). Citing Hall's (1990) 'inclusion of past sexual victimization as one of the posited predictive variables of sexual aggression in men' (ibid.: 232), they found evidence for 'a developmental continuity between child, adolescent and adult perpetration following preceding childhood sexual abuse [sufficient to] suggest that an increased risk of perpetrator outcome should be included as one of the potential long-term effects' of child sexual abuse' (ibid.: 240).

Watkins and Bentovim also identify 'as a recurrent theme in the literature on sexual offenders an association between offending and prior physical abuse' (ibid.: 231). They found that 'clinical reports universally link sexual abuse of boys . . . with concurrent physical abuse' (ibid.: 214–15). 'There is some suggestion,' they write citing relevant sources, 'of there being an association between the physical and sexual abuse of boys, particularly with father–son incest . . . which, if sustained, has practical implications regarding awareness and detection' (ibid.: 207). This association has, in fact, been sustained subsequently in a study by Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume)

which found that 'experiencing intrafamilial violence' (defined as 'recurrent acts of physical abuse') was one of the main 'factors . . . associated with an increased risk of becoming a sexual abuser' in an adolescent who was also sexually abused as a child (Skuse, Bentovim *et al.* 1998: 177).

Print and Morrison (chapter fifteen) cite findings from a number of studies which show high levels of both physical abuse and having 'witnessed family violence' among adolescent sex offenders, and in particular, studies of incarcerated male adolescent sexual abusers (Lewis *et al.* 1981) which report much higher rates of childhood histories of physical abuse (75 per cent) and having witnessed family violence (79 per cent). Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) also found 'witnessing intrafamilial violence' as another of the three main risk factors in sexually abused boys going on to become adolescent sexual abusers' (Skuse, Bentovim et al. 1998: 177). From the findings of research it appears to be sexual abuse, physical abuse and 'witnessing domestic violence' that are, in various combinations, key predisposing factors in the pathways of boys becoming adolescent and adult child sexual abusers.

Bailey (chapter eleven) describes the 'motivating factors between having been abused and becoming an abuser as multiple and overlapping'. In Bailey's schema, motivating factors in the category of 'family' include 'abuse, emotional deprivation, scapegoating, rejection, neglect, family discord and lack of supervision'. Bailey and Woodward (chapter seventeen) also include the absence of, or an insecure 'infant/maternal attachment' amongst the factors predisposing abused or neglected children to subsequent 'repetitions' of childhood experiences. Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) found 'discontinuity of care', one consequence of which is impaired attachments, as the third of the three main factors that predisposed boys who had been sexually abused to become adolescent sexual abusers (Skuse, Bentovim *et al.* 1998: 177).

Clearly 'multiple and overlapping motivating factors' involve a number of different variables, relationships and processes, and a range of effects. Becker's (1988) 'broad contextual model' cited by Watkins and Bentovim, 'includes individual, family and social variables'. A 'history of physical and/or sexual abuse' is an individual variable, and the 'family variables' include 'parent(s) engaged in coercive sexual or physical behaviour towards each other', and/or 'family belief systems supportive of coercive sexual behaviours' (Watkins and Bentovim 1992: 228). Watkins and Bentovim conceptualise these motivating and predispositional factors as 'threshold phenomena'. Why some, but not all, boys who have experienced all or some of these 'threshold phenomona' become perpetrators is explained by variations in the combination of 'triggering' and 'mediating' factors experienced at the level of the individual (ibid.: 232).

In this model, psycho-socialisation and psycho-sexualisation through child sexual abuse, physical abuse and 'witnessing' domestic violence in childhood would be 'threshold phenomena', making boys who were victimised as children in these ways vulnerable to the predisposing influences of 'trigger phenomena'. Becker (1988) includes amongst 'trigger phenomena' social factors such as

'society supportive of coercive sexual behaviour', and 'society supportive of the sexualisation of children' (Watkins and Bentovim 1992: 228). For Bailey (chapter seven) 'trigger phenomena' include 'the effects of drugs and alcohol abuse and the use of pornographic and violent media'. She conceptualises these as 'contextual and environmental risk factors'. Dobash and Dobash (2000) regard drugs and alcohol as triggers, but, importantly, not the reason for or the cause of sexual violence. Watkins and Bentovim include 'exposure to pornography' in their 'Perpetrator Risk Index Following Child Sexual Abuse' (Watkins and Bentovim 1992: 232). Bailey (1993, 1997b, and chapter eleven, this volume) sees causal relationships between having been abused as a child; the role of fantasy; the viewing of violent and pornographic media; and the committing of acts of violence and abuse.

Wyre (1992) has identified, from work with sex offenders, the role of adult and child pornography in constructing, reinforcing, maintaining and activating fantasy, and specifically in fantasy arousal to abuse; in predisposing men to commit abuse; in legitimising and normalising abuse; in creating and reinforcing false belief-systems about victims of abuse; in reducing and overcoming internal and external inhibitions to abuse; in targeting victims and overcoming victim resistance; and in reinterpreting victim behaviour to support further abuse. Marshall (1988) found, from research with non-incarcerated sex offenders, that half of those who committed child sexual abuse deliberately used pornography in preparation for commiting their offences.

Itzin (1992, 1994, 1996b) argues that men's sexual desire for children is conditioned through sexual arousal and orgasm to children's bodies in child pornography; in adult pornography where very young looking women have their pubic hair shaved and their genitals posed to look like children's; and now in computer composites constructed from women's bodies and girls' faces. Malamuth found, in a review of the literature on pornography effects, 'scientific support for the . . . harmful effects on some men of certain types of pornographic stimuli'; that pornography's impact on adolescent males was likely to be 'stronger'; and that decisive factors in the influence of pornography was the combination of sexual exploitation with degradation and violence and the fact that 'sexual arousal is generated' by the content of this material (Malamuth 1993: 573–4).

Bailey (chapter eleven) suggests that up to 10 per cent of the population of young males are vulnerable to the influence of violent and pornographic media. However, the higher than previously estimated incidence and prevalence of child sexual abuse, and of physical as well as sexual abuse, and the 'witnessing of domestic violence' as 'threshold phenomena' would suggest that the proportion of boys who are vulnerable to the effects of pornography is significantly higher than 10 per cent. Briere and Runtz (1989) found, in their sample of 193 'normal' (that is, non sex offender) young adult male college students that nearly a quarter (21 per cent) reported sexual attraction to small children; 9 per cent reported sexual fantasies involving children; 5 per cent reported masturbating to sexual fantasies involving children; and 5 per cent reported 'some likelihood of having sex with a child if they could avoid detection or punishment'. The other main

predictor of this self-reported sexual interest in children was found by Briere and Runtz to be, in addition to having been sexually abused as children, their masturbation to both adult and child pornography.

The extent to which 'threshold phenomena' predispose children to become abusers is influenced by a range of 'mediating' as well as 'motivating' factors. Wyre argues that the characteristics of the abuser and the nature of the abuse experienced will influence whether the child is predisposed to revictimisation or to victimising or to both. The relevant factors include:

> type of abuser; the nature of the relationship (that is, if it is the child's father); the age of first contact and the age of first hands-on abuse; to what extent distorted thought processes and beliefs were transferred to the child; the length of time over which abuse took place; the frequency within that time frame; how the abuser exercised psychological, emotional and physical control and power over the child, and whether this involved anger and fear; the emotional needs the child attached to the abuser; the effects of the abuse on the child's fantasy; what the child had to do to survive; whether the child was got to abuse other children; whether there were any "bizarre" elements; and the effect that keeping secrets had on the child and the child's relationship with 'non-abusing carers'.
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> (Wyre, chapter three)

'Mediating' factors that would be likely to prevent sexually abused children either becoming abusers or subject to revictimisation are, in Wyre's schema, the nature and extent of contact with 'non-abusing carers', and the extent that any of the child's emotional needs were met appropriately.

Finkelhor has expressed concerns about the dangers of a single-factor 'cycle of violence' theory which implies that victims automatically become victimisers (Finkelhor 1986: 119): 'that it is exaggerated, that it ignores sociological aspects, that it will strike terror into the hearts of victims and worse, that it might become a self-fulfilling prophecy', and that it does not take account of the fact that 'not all victims become victimisers' (ibid.: 123). On one level, these causal relationships are simple and inevitable: this is how children respond to victimisation; how they cope with, accommodate and survive being victimised. But 'cycle of violence theory' is not a single factor theory, rather a multiple factor theory which describes complex developmental pathways, involving 'mediating factors' as well as 'motivating factors'. There is a clear direction of causality from having been abused to abusing others, but the direction of causality can change, influenced, for example, by the existence of a non-abusing parent or carer (which, in most cases, is the mother). The direction of causality can also *be* changed as a result of treatment interventions: with abused children; with adolescents and adults who were abused as children; and with perpetrators as perpetrators, and perpetrators as victims of abuse in their own childhoods (see Bailey chapter eleven, Print and Morrison chapter fifteen, Eldridge chapter sixteen and Woodward chapter seventeen).

To accept the evidence of the links, for males, between having been abused and becoming a sexual abuser is a step in the direction of prevention defined as stopping abusers abusing (Kelly *et al.* 1991; Itzin, chapter one). Watkins and Bentovim argue that 'if the evidence continues to support [these links] then it cannot be ignored, particularly if it offers a potentially valid preventative strategy' (Watkins and Bentovim 1992: 219). The Department of Health funded study by Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) confirmed the links between what they termed 'exposure to a climate of intrafamilial violence' and sexually abused boys subsequently becoming sexual abusers, and this does, as they argue, suggest 'the possibility of secondary prevention of subsequent abusive behaviour in those at greatest risk' (Skuse, Bentovim *et al.* 1998: 178). Print and Morrison (chapter fifteen) outline a model of the kind of primary, secondary and tertiary interventions that have been effective in work with adolescent sex abusers.

The psychoanalytic as a process and as a theory of process

The correlational evidence of the links for boys between childhood victimization and adolescent and adult perpetration is sufficiently strong to hypothesise these as contributing factors and causal relationships. The psychoanalytic as a theory of the subconscious and its psychic processes provides an explanation of how and why early experiences of violence and abuse are 'repeated' and 'recapitulated'. Watkins and Bentovim (1992) cite Rogers and Terry (1984) and Cantwell (1988), for example, describing this 'as a tendency among boy victims to recapitulate their own victimisation, only this time with themselves in the role of perpetrator and someone else the victim'. The 'mechanism which would appear to facilitate the transition from victim to victimizer' is described as 'identification with the aggressor' (Watkins and Bentovim 1992: 219), and Watkins and Bentovim include 'identification with the aggressor' as one of the effects of the abuse in their 'Perpetrator Risk Index Following Child Sexual Abuse' (ibid.: 231). Freeman-Longo (1986) describes the tendency for abused boys to become abusers as 'a desire to replicate their own victimisation, the abusive experience becoming a template for future sexual experience'. The psychoanalytic conceptualises the construction of identity in terms of causal relationships between childhood experiences and their effects on the individual in adolescence and adulthood in which the subconscious, through a process of 'repression', accommodates what is unbearable for a child to endure and impossible, in its powerlessness and dependency, to resolve ('Edwards' chapter seven, Miller chapter nine, and Bacon and Richardson chapter thirteen).

Woodward (1988; chapter seventeen) uses Freud's concept of 'the return of the repressed' to define 'repetitions' and 'recapitulations' as arising out of 'the feelings from childhood which are pushed out of awareness' into the subconscious, but which do not go away and which re-appear in disguised forms as 'feelings over which the person does not seem to have control except to behave in certain ways over and over again'. According to Woodward, 'whatever the

compulsive behaviour may be, it is as if no choice exists, because to change their behaviour would bring about unbearable anxiety or distress'. 'The strength of these compulsive forces never ceases to amaze me', she writes. She sees the 'destructive element in these compulsive urges as being immense, in not only driving some people to suicidal feelings, but leading them to damage themselves and other people'.

In psychoanalytic terms, it is possible to see the 'cycle of violence' as an internal process which by its nature is not volitional, and which becomes externalised in acts of abuse or self-abuse and a state of being vulnerable and predisposed to both. The psychoanalytic as a theory of process has, in this way, the power to explain how desire is constructed as a response to abuse, and how abusive and self-abusive behaviour becomes compulsively driven. The psychoanalytic – in the form of psychoanalysis – is also a process whereby what has been psychically constructed can be psychically deconstructed and reconstructed. Psychoanalysis contains the potential to repair – through the process of 'transference' – some of the damage of childhood abuse. Doing so involves understanding the psychic and unconscious effects that result from abuse and lead to repression and repetition in the forms of revictimisation, self abuse and the victimisation of others.

There has been a radical feminist resistance to the psychoanalytic as theory because of its association with Freud's retreat from the *evidence* of child sexual abuse and its effects as seen in his female patients, to the *hypothesis* that the sexual abuse of girls by their fathers was a fantasy (Masson 1984, 1988; Macleod and Saraga 1988). Freud's 'retraction' is seen as having protected the perpetrators and abandoned children to another century of continued, hidden, and relatively unhindered child sexual abuse by familial males (in Armstrong's words, to the 'dreadful actuality of paternal child rape'), and to the experience of children and adult survivors being denied and discredited and their disclosures not believed.

Radical feminism has also been unhappy with the practice of psychoanalysis on the grounds that it does not listen to 'the child' in the survivor, or believe in the child's abuse. This was the basis of Alice Miller's repudiation of Freud (Miller 1983, 1984), her rejection of psychoanalysis as a form of therapy, her resignation from its international professional body, and her enthusiasm for a form of therapy (Stettbacher 1991) the fundamental tenet of which is to bear witness to the pain of the injured child and to assist the child at whatever life stage that child is speaking (the actual child in childhood, or the 'inner child' of adulthood) to free itself from that pain (Miller, chapter nine).

These deficits in, and distortions of, the theory and practice of psychoanalysis have made it difficult for radical feminism to recognise the power of the psychoanalytic to explain the processes involved in 'cycles of violence', and its potential as a process of deconstruction and reconstruction. In particular there is the potential for psychic and psychological resocialisation through the process of transference to free the victims of child sexual abuse (including perpetrators as victims) from continued destructive and self-destructive repetitions: that is, to stopping abusers abusing. If radical feminism is serious about wanting abusers to stop abusing and to reduce the incidence and prevalence of child sexual

abuse, it needs to take on board the psychoanalytic as a theory of process that explains and provides a way of understanding crucial elements of the effects of child sexual abuse (the 'incest transmission' about which Armstrong is sceptical), and as a therapeutic process that can be used to treat (or to inform the treatment of) both victims and abusers (and abusers as victims) with some reasonable expectation of being effective.

Explaining the 'male monopoly on molestation' and the female monopoly on self harm and revictimisation

The psychoanalytic as a theory of process goes some way towards explaining the 'recapitulation of boys who are abused becoming abusers as a conscious and subconscious identification with the aggressor' (Burgess 1985). However, it does not explain the mechanisms by which this reversal takes place, nor why men might do this and women do not. Kelly (1996a), Armstrong (1996, and chapter two, this volume) and Kelly, Regan and Burton (chapter four) have, from a radical feminist perspective, expressed 'misgivings' about 'cycle of violence' theory. They describe it as a 'flawed explanatory model' because it is inconsistent with 'the gendered distribution of sexual victimisation and offending', that is, the majority of victims are female and the majority of perpetrators are male. Kelly (1996a) and Kelly, Regan and Burton (chapter four) are sceptical about 'cycle of violence' theory because for men it would 'require a reversal of roles from having been abused to becoming an abuser', and that, writes Armstrong (chapter two) 'doesn't make sense'.

Finkelhor (1979), citing Brownmiller (1975), referred to 'male supremacy' as a theory which he considered 'fairly effective in explaining the sexual abuse of women by men and the preponderance of male offenders and girl victims' (Finkelhor 1979: 30). However, he did not pursue this and in 1986 challenged theorists to explain within their model the 'male monopoly on molestation': 'this male preponderance among offenders needs to be explained', he wrote, 'and the explanation could serve as a touchstone for theories of sexual abuse ' (ibid.: 126). Kelly, Regan and Burton (chapter four) argue that, 'if there is any kind of cycle, it is a gendered one, and this requires explanation'. I will argue that it is because the 'cycle of violence' is gendered that the effects of child sexual abuse are fundamentally different for males and females, and why, therefore, there is a 'male monopoly on molestation' and a 'female monopoly on victimisation, revictimisation and self harm' (Itzin, chapter one).

To understand this it is necessary to overlay the psychoanalytic paradigm of 'cycle of violence' theory with the gendered power paradigm of radical feminism in terms of what I conceptualise as the social and psychological construction of gendered power relations. This makes it possible to see the 'precise mechanisms' by which this takes place, (to address the question posed by Kelly, Regan and Burton in chapter four) as *processes* of social and psychological construction of gendered identity, in the context of *systems* and *relations* of gendered power, with which the reversal of roles for males, from subordinate

victim to dominant perpetrator is completely congruent, as it is for females to continue largely in the 'subordinate' role of self harm and victim. In the pages that follow, I have constructed an explanatory framework within which it is possible, I think, to see how and why 'cycles of violence' might be gendered in apparently contradictory ways.

The social and psychological construction of gendered power relations

The domains of gendered power include the economic, the social, the political, the domestic, and the sexual. In each domain, gendered power operates at the level of the individual and the interpersonal, and also at 'group', at organisational and institutional, and at societal levels. In each domain gendered power is constructed socially and institutionalised materially, quantifiably and measurably in terms of male dominance and female subordination. This is evidenced empirically, and generally recognised in inequalities in pay and income; in the predominance of men in senior positions in organisations and of women in the lower grade, lower paid work; of inequalities in promotion; in the levels of women's poverty by comparison with men's, particularly in later life; with inequalities in pensions as a result of lifelong inequalities in employment, experienced most acutely during child-rearing years when women are most likely to be in low-paid part-time work; in the inequalities in the division of domestic labour and women's work in the family regardless of whether women are in full or part time employment whilst rearing children (Itzin 1995a). In addition, gender-based power is manifest in the gender-based violence and abuse experienced as rape and sexual assault; as sexual harassment; and in domestic violence as defined by Mooney (1993, 2000) to include mental cruelty in the form of verbal abuse, or being deprived of money, clothes or sleep, or being prevented from going out, or as threats of violence or force, and sexual violence as well as physical violence. Gendered power relations in these forms and these domains operate iteratively and interactively with and within, and at the interfaces of other social power relations such as race, class and wealth (Williams and Macalpine 1995; Vincent 1995; Pringle 1998) so that the status of individual women may involve multiple subordination.

Male dominance and female subordination are encoded and embedded in every aspect of gender relations, in every domain and at each interface. Socially constructed gendered power is experienced at the level of the individual in one form as a process of psychological construction of identity which is gendered significantly in terms of

dominance and subordination. Through the processes of psychological construction, the 'quantifiable material' of social constructs becomes the 'experiential material' of psychological constructs, which are embodied in the form of attitudes, beliefs, emotions, fantasies, desires, images, ideas and knowledge. The process of psychological construction recreates the paradigm of gendered power which exists at the societal level, as engendered power at the level of the individual.

The psychological construction of gendered identity is accomplished in part through processes of gendered socialisation which are usually conceptualised in terms of the 'learning of sex-roles', and the 'scripts' of masculinity and femininity (Sharpe 1976, 1994). In part, therefore, processes of gendered socialisation construct identity as gendered in various versions of masculinized dominance (MacLeod and Saraga 1988; Hearn 1992; Hearn and Morgan 1990; Pringle 1995) and sexualised femininity (Jackson 1982). 'Sex roles' and 'masculinity' and 'femininity' are, in whatever form, social constructs to which there is always attached value which is gendered and reflects the systems and relations of male dominance and female subordination.

The use of violence and abuse, or its threat, by males against women and children is instrumental in constructing, exercising and maintaining the gendered power relations of dominance and subordination in individual relationships, and by men as a group, in forms that have been permitted and protected at the societal level. Reiterating Dobash *et al.* (2000): The use of violence or its threat is how 'normal men establish and maintain control in their relationships'. They conceptualise 'male violence as one end of a continuum of male domination'. Domestic violence is one example of this; child sexual abuse is, as I see it, another.

Like gendered identity constructed psychologically through the processes of socialisation, the effects of violence and abuse become embodied emotionally and psychically. The emotionally embodied effects of violence and abuse – in the form of pain; of humiliation, shame and guilt; of helplessness, powerlessness, and hoplessness; of anger, rage, fear and terror – are the 'material' of psychological construction. Violence and abuse and its effects are embodied, both consciously and subconsciously (unremembered and/or dissociated wholly or partially), and acted and re-enacted gendered in terms of male dominance and female subordination.

Desire conditioned by abuse is often, therefore, experienced as a perceived need in males to sexually victimise a child, and in females to

be sexually victimised. Being embodied subconsciously, these needs are often experienced as compulsive, and as a *re-experiencing* of the *original experience*, in a form of *enactment* which is a *re-enactment*, the same or similar to the abuse that conditioned the desire in the first place, including power based on age relations as well as gender relations. In process terms, 'the social' constructs 'the psychological' and 'the psychic' whenever an adult abuses a child: in turn this constructs 'the social' when a child goes on to become an abuser (and not all do): this is the cycle. It is gendered and engendered in its entirety and its every detail in terms of male dominance and female subordination. Violence and abuse and its effects are experienced as gendered (power); embodied as gendered (power); and enacted and re-enacted as gendered (power).

The socially gendered structures of male dominance and female subordination, and the construction psychologically of masculinised dominance and sexualised femininity, will influence how a child's psychic corruption through sexual abuse becomes engendered and encoded as dominant or subordinate, and enacted in the form of (re) victimising, or (re) victimisation and self harm. The experience of abuse also has gendered meaning and significance influenced by the relative value of gendered power, the male being valued more highly than the female in every domain. In the economic and the social spheres, this is reflected in pay and position.

In the domain of the sexual, what it means to be a boy, for example, and buggered in a homophobic culture where successful masculinity is defined in terms of heterosexuality, can explain what motivates boys consciously and subconsciously to reverse the roles and to act aggressively, as abusers, both physical and sexual. Boys undergo a reversal of roles in order to re-align themselves congruently with male dominance and heterosexual masculinity, motivated by not wanting to be used as a girl, which is, as pornography graphically depicts, literally both *as* a cunt and *like* a cunt. The male response is, therefore, to become – or to be predisposed to become – the aggressor and the abuser. In psychoanalytic terms this is what has been conceptualised as 'identification with the aggressor', this being a way to avoid both consciously and subconsciously feeling the pain of having been victimised (Woodward 1988, chapter seventeen this volume; Watkins and Bentovim 1992: 219). In addition, for boys, physical abuse and 'witnessing/experiencing' the abuse of their mothers by their fathers becomes internalised, influenced by and consistent with the constructs and systems and structures and attitudes, beliefs and behaviours of 'male power' and male dominance. Stoltenberg

(1989, 1992) describes how dominance and aggression can become sexualised in adolescence as a matter of routine in a culture in which violence is eroticised and institutionalised, for example, in pornography.

Power being gendered and valued in terms of male dominance and female subordination; institutionalised societally and internalised through the processes and experiences of gendered socialisation; constructed, enforced and maintained by male violence – or its threat – against women and children and the sexual abuse of children; the female response is, unsurprisingly, to be vulnerable to, and to become predisposed to being targeted for revictimisation in childhood, adolescence and adulthood. This can take the form of 'allowing', 'encouraging' or 'inviting' revictimisation in similar ways (compelled subconsciously); being attracted to victimising men (the subconscious reason why women may marry abusers being that this is how they experienced 'love' as children); being drawn to participation in pornography and prostitution (believing they like it or that it is harmless); and being compelled to self harm to avoid feeling the pain of the childhood victimisation or the numbness and emptiness of dissociation (see 'Alice Edwards' in chapter seven, this volume).

For girls, therefore, their sexual abuse and sometimes physical abuse, and watching the abuse of their mothers by their fathers and/or other men, when it becomes internalised, is also sexualised, and translated into forms of self-harm and sexual revictimisation (in pornography and prostitution, for example), influenced by and consistent with women's subordination. Self harm is complex ('Alice Edwards' in chapter seven, this volume), but centrally, crucially, critically it reflects how women are valued. There is a gendered logic in females 'repeating' or 'recapitulating' their abuse on themselves as a reflection of the valuelessness of being female.

Furthermore, the vulnerability of having been previously or already victimized as a child is an effect of the abuse. Embodied, it can be perceived, and is, by pimps for example, targeting teenage girls for prostitution (Swann chapter fourteen, this volume) and by 'paedophiles' targeting children and their families (Wyre 1992; chapter three, this volume). One of the effects of the construction of gendered identity through abuse is its embodiment, and once embodied, the messages this can communicate subconsciously, and the signals it can send unintentionally and unawarely to men whose own gendered identity and sexuality have been constructed – and 'corrupted' – by and through abuse.

The capacity for – and seeming inevitability of – women's experience

of abuse to be 'recapitulated' in revictimisation, in sometimes precise repetitions of their original abuse, in a cultural and societal context of power gendered in terms of male dominance and female subordination, is illustrated by the phenomenon of female genital mutilation. The procedure is usually performed by women on behalf of mothers, to ensure that their daughters are regarded as sexually attractive and marriageable by men who want women's genitals with the clitoris cut out and the labia sewn together as evidence of their wives' virginity. It consists of a traumatic and violent physical assault causing grievous bodily harm and sometimes death, the trauma of which is aggravated by it generally being carried out in non-medical settings without anaesthetic, causing unimaginable and unforgettable pain (Dorkenoo 1994: 123; Dorkenoo and Elworthy 1994). This illustrates the power of male dominance to institutionalise the physical and sexual abuse of girls into a social and cultural norm which, to satisfy the socially constructed sexual desire of these particular men, requires an assault on the genitals of the girl which destroys her physiological capacity for sexual arousal, for sexual intercourse (until she is 'opened up' by knife or penile penetration) and for sexual pleasure. FGM is not regarded as abuse by most of those – male and female – who practice it. Dorkenoo regards the practice of FGM as a 'cycle of violence', and writes of the need to 'break it' (Dorkenoo 1994: 123–61).

These constructs and processes, which I conceptualise as 'the social and psychological construction of gendered power relations and gendered identity and gendered desire', are consistent with the concepts of 'internalising' and 'externalising' described in the clinical literature by Watkins and Bentovim (1992: 202–3, 218), except that I see both males and females as 'internalising'. Men internalise the attitudes, beliefs, identities and desires of dominance, and women internalise these constructs as subordination. Men then 'externalise' the dominance of these internal constructs in the behaviours which are described as 'acting out': in perpetrating violence and abuse against women and children. Women also internalise the experience and the effects of their victimisation and then 'externalise' these internal constructs in behaviour which is congruent with subordination: in the form of self-abuse and a predisposition towards revictimisation. 'Cycles of violence' apply 'equally' to both women and men, and the processes operate consistently in congruence with external social constructs and internal psychological constructs as they are differentially gendered in terms of male dominance and female subordination.

I have attempted here to outline an explanatory framework for understanding the male 'monopoly on molestation' and the female monopoly on victimisation, revictimisation and self harm. This needs to be developed further theoretically and tested empirically. Most immediately, however, it provides an explanatory context for what has already been established empirically. Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) found the discriminating factors between sexually abused boys who went on to abuse and those who did not to be the additional factors of 'experiencing and witnessing intrafamilial violence' (Skuse, Bentovim *et al.* 1998: 177). Once the perpetrators of intrafamilial violence and abuse have been gendered as primarily men, there is, as we have now seen, a group of males who have been sexually abused by men as children, by their fathers or father figures or father substitutes and/or other familial males; and/or physically abused by their fathers; and/or witness to the physical and sometimes sexual or sexualised abuse of their mothers by their fathers; and sometimes, the physical and/or sexual abuse of their sisters and their brothers by their fathers.

It is likely that the proportion of men who come into one or more of these categories in various combinations in time and over time, will, at the very least, correlate with the number of men who sexually abuse their own and other people's children (boys as well as girls) and use physical violence against children and women as wives and ex-wives, cohabitees and girl friends (Mooney 1993, 2000). UK government statistics (1999) found that one in four women experience domestic violence at some point in their lives; that one in eight had done so in the previous year; and that domestic violence accounts for one quarter of all violent crime (*British Crime Survey*, Home Office 1998). Given this level and scale of domestic violence, it is possible to see that the number of adult males who come into the categories of having, as boys, experienced and witnessed men's violence against women and children, is actually likely very substantially to exceed the number of men who victimise women and children. This would be consistent with the fact that not all boys who are abused go on to become abusers, and evidence of the influence of 'mediating' factors in their developmental pathways. Given the level and the scale of men's violence and abuse experienced by boys in its different forms, it is surprising, really, that more boys do not go on to use physical and sexual violence and abuse against women and children.

Gendering the language of child sexual abuse

Invisible men

The ways in which child sexual abuse is constructed conceptually, and how language is used in its construction, determine what is visible and what is not visible; what is seen and what is not seen; what is known and what is not known (epistemology); how it is understood and explained (theory); its status and value in terms of social power relations; and what is and is not done about it (policy and practice). The use of ungendered or gender-neutral language contributes to

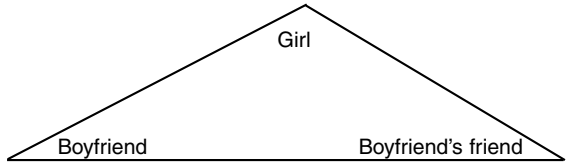

Figure 21.1 Swann's representation of the prostituted girl

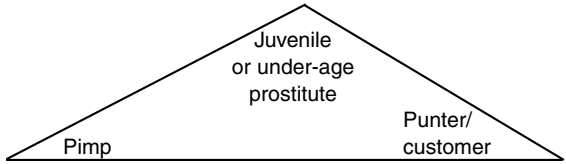

Figure 21.2 The societal construction of girls entrapped in prostitution

the invisibility of men as primarily the sexual abusers of children, and in particular to obscuring the recognition of ordinary heterosexual 'family' men as the majority of perpetrators of child sexual abuse in any of its many forms. This analysis uncovers, with respect to child sexual abuse, what Dobash and Dobash (2000) have observed about domestic violence: 'that the violent male is elusive, and male violence is invisible'.

Child prostitution and the businessman in Bradford

There is an example – from Swann (in chapter fourteen) – of how the gender of the abusers and the nature of their relationship with their victims is obscured in the ways 'under-age prostitition' is conceptualised by the different participants. Girls entrapped and controlled by pimps, for example, can perceive themselves not as child or juvenile prostitutes, but as doing their 'boyfriends' a favour because they love him and he loves them.

Swann produces this as a triangulated construct which is represented in Figure 21.1. The societal construction of this triangle of relationships, as reflected in current legislation, is represented in Figure 21.2. When Swann conceptualises the relationships in child protection terms, they become redefined as represented in Figure 21.3. In each of these constructions, how the

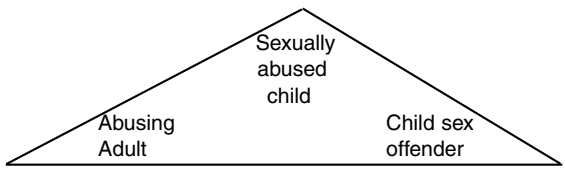

Figure 21.3 Pimps and punters from a child-protection perspective

participants are conceptualised determines what is visible, what is seen, what is known, how it is understood and explained, its status as knowledge and what is or is not done about it. The current public policy response is based on the constructs in Figure 21.2. Swann argues for a public policy response based on the constructs in Figure 21.3, in which the police would initiate child protection rather than criminal justice proceedings on behalf of the abused child, and criminal justice proceedings against the pimp and 'the punter' for child sexual exploitation and child sexual abuse respectively. Influenced by the Children's Society's campaign (see Lee and O'Brien 1995) and the Barnardos' work with girls in Bradford, government moved in the direction of 'Model 3' in Home Office/Department of Health *Draft Guidance on Children Involved in Prostitution*, disseminated as a consultation document in 1998. At the time of going to press in February 2000, the guidance was unpublished. In any event, the publication of the guidance would leave the law unchanged and it remains as it is represented in Figure 21.2 (see Itzin, chapter one). In research conducted by Barnardos of child prostitution in Bradford, the men who are 'the customers for child sexual abuse conceptualised as prostitution' are between the ages of twenty-five and thirty-five, married with children: that is, these sex offenders are ordinary heterosexual family men.

'Paedophiles' and child pornographers: married, with children, driving a nice car

Pornography, including both adult and child pornography, is a multi-billion pound international industry (Baxter 1990), trading in the sexual arousal of men to the desire that has been constructed by, and for, whatever the content of particular pornography might consist of: to women being penetrated orally, anally or genitally by animals for example, or to the sexual abuse of children. Pornography, both adult and child, is one of Becker's (1988) contextual variables (that is, 'society supportive of coercive sexual behaviour and the sexualisation of children'), and one of the environmental factors discussed by Bailey in chapter eleven, which normalises and legitimises abuse, and is used by abusers to construct and maintain 'distorted thinking', 'reinterpreting' the victim response and rationalising the harmlessness of abuse. It can also function as a trigger to fantasy and desire and sexual arousal in precipitating abuse for individuals who may be predisposed by such threshold phenomena as their own childhood experiences of abuse.

Kelly, Regan and Burton (chapter four) argue that 'child sexual exploitation cannot easily be separated from other forms of child sexual abuse', and Eldridge (chapter sixteen) cites the clinical research literature showing an overlap between 'intrafamilial' and 'extrafamilial' child sexual abuse and rape. I show in chapter five, contextually and diagrammatically, how incest, 'paedophilia' and child sexual exploitation are overlapping rather than discrete categories which may involve the same perpetrators, the same victims, the same or similar activities and the same locations. Conceptualised as separate, there is a presumption that incest abusers and

'paedophile' abusers are not the same people, but research and work with sex offenders shows that often they are. Furthermore, wherever it is done and whoever does it, it can – and does – involve both adult and child pornography.

The message is clearly that what appear to be separate and distinct categories are not. They simply represent different ways of being a child sexual abuser. All of the categories contain 'adolescent and adult male child rapists by many other names', but the categories are gender-neutral, and this obscures the gendered identity of the abusers as men, and also their relationship to the child: by creating the impression that 'paedophiles' are not fathers who commit incest, and that fathers who commit incest only victimise their own children and not – conceptualised as 'paedophiles' – other people's children. This, as Eldridge shows (chapter sixteen), is emphatically not the case. Apart from the men who call themselves the 'man/boy lovers', and who like to regard themselves as 'the only true paedophiles' (Brongersma 1990), most of the rest of the child sexual abusers are heterosexual, not homosexual men, often 'family' men who abuse both boys and girls, their own and other children. This includes the men who seek sex with 'under-age' (that is, child) prostitutes in British cities, and leads Swann to define 'a paedophile' as married, with children, 'driving a nice car, (Swann 1996, cited by Kelly, Regan and Burton in chapter four). Wyre (chapter three) points out that 'paedophiles' are often perceived as 'nice men'.

There is an example of the 'overlap' from an abuser perspective between 'intrafamilial' and 'extrafamilial' child sexual abuse and child sexual exploitation, and evidence of the extent to which ordinary heterosexual men are engaged in these activities, in a newspaper article about the release from prison in the UK of a 'child-killer paedophile' (Rayment 1997). The article described a 'recent' French police inquiry into child pornography 'detaining more than 200 people [sic gender-wise] in one day, including members of the judiciary, seven teachers, and a television journalist'. They seized 5,000 videos which included 'sexual acts with babies'. 'The net caught all social classes' and 'the suspects', according to a police chief, were 'mainly married professional men' (ibid.: 32).

This illustrates something of the nature and scale of child sexual abuse in the form of child pornography; how routine a part it apparently is in the lives of 'fine upstanding male citizens' (as Armstrong describes them in chapter two), who would not typically be regarded as 'paedophiles'; how close together along a continuum are the 'everyday' and the 'extremes' of child sexual abuse, and the extent to which they flow into or interface with each other (Kelly 1988). The 'child killer paedophile' being released from prison in the UK (the subject of the article) was described as 'wanting to rape a little girl and then kill her slowly by burying her alive.' He was described as 'living with the wife of another convicted paedophile', and she was quoted as describing this man – her pen friend for three and a half years when he was in prison and now her new 'partner' – as 'the most gentlest bloke I have ever met'. He was a man 'who had used his fingers over a long period of time to prepare an infant for buggery' (ibid.: 38). A video of his sexual abuse of that baby might well have been among the 'child pornography' in the possession of the judges and the teachers in Paris.

The Cleveland parents

All or most of the child sexual abuse in Cleveland took place within the family (see Itzin, chapter one). The Inquiry was explicit and unequivocal about this: its findings identified ordinary heterosexual family men as the alleged and the actual abusers, and the mothers, with one exception, as the 'non-abusing parents'. In the conclusions and recommendations of the Report of the Inquiry, however, this recognition is lost and the gender of the abusers becomes invisible in the use of the gender-neutral language of 'parents'. For example, in the conclusions there is a paragraph (Butler-Sloss 1988: 244, para. 12) about 'the understandable response from parents when a diagnosis of child sexual abuse was made'. Under the heading of 'parents' the Inquiry makes various recommendations. These are written as if 'the parents' are one; as if the mothers and the fathers (or father substitutes) are in the same position in relation to the sexually abused child. The complete opposite is the case when the father is the abuser and the mother is the non-abusing parent which is almost always the situation. Disaggregated by gender, taking this into account, the recommendations on 'parents' acquire an altogether different meaning:

> 3b [The abusers] should be informed and where appropriate consulted at each stage of the investigation by the professional dealing with the child, whether medical, police or social worker. [Abusers] are entitled to know what is going on.
>
> (Butler-Sloss 1988: 246)

Where the male parent is the alleged or the suspected or the possible abuser, clearly the same response for the abusing and the non-abusing parent would not be appropriate. The Inquiry acknowledges this subsequently in its recommendations for the 'medical profession' when it says that: 'on a medical examination for forensic or other evidential purposes unconnected with the immediate care and treatment of the child, the informed consent of the parents should be sought', and that 'this may present difficulties for the police surgeon or doctor from the approved panel or the specialist assessment team in cases of suspected abuse within the family'. The report concludes that 'this problem needs to be considered further' (ibid.: 248, para 6e).

I do not know what consideration 'the medical profession' has given this problem, but it is child protection orthodoxy now (see Platt and Shemmings 1996 and PAIN/NISW/NSPCC 1997) to seek 'parental' permission and 'parental' participation in the process of investigating abuse. However, there is an example from Cleveland in the practice of the police which illustrates the difficulties that arise from failing to take into account that the 'male parent' may be the abuser:

> A pre-pubertal boy who was medically examined following a diagnosis of abuse to a brother, showed signs on examination thought to be consistent with sexual abuse: 'anus lax, reflect dilation to 0.5cm, scarring to give smooth

> shiny skin, peri-anal redness, deep fissures 12,2,5,7, and 9 o'clock.' Until that time, no concerns had been raised about the child and the only history of note was a previous referral for behaviour problems. The second opinion was that the medical signs were consistent with 'chronic anal abuse with penetration'. Like the majority of children caught up in the crisis, during the formal investigation that followed he was unable to tell of anything that had happened. The key to why may lie in what he later said to the psychologist about the police interview: 'The police seemed to blame it on me. At first I didn't really believe it when they said it was me, and now I feel slightly angry that it was like that . . . You see Dad sat with me when the police interviewed us.
>
> (Richardson and Bacon 1991: 105, and chapter 13, this volume)

How necessary it is, in the interests of abused children, to disaggregate 'parents' by gender in child protection policy was also illustrated by a social worker at an NSPCC conference on 'organised abuse' who described having interviewed a child about being sexually abused. The child requested that the parents not be present during the interview. Given the child's age, the only way to accommodate the request was to have the parents in the same room but behind a screen. The child would not name her abuser. It later transpired that the abuser was in fact the child's father. 'Rachel Pearce' (in chapter six) describes a similar experience in being seen by a psychiatrist in the Child and Adolescent Mental Health Services with her parents present, and how this made it impossible for her to obtain help for her problem which was physical and sexual abuse by her father. The outcomes in all of these examples was to silence the victims and to protect the abusers.

'Incest families'

The use of the word 'family', as in 'family violence' or 'familial' or 'intrafamilial' sexual abuse, is another example of language rendering men the abusers invisible. This can be seen in the language used by Bagley and Thurston to summarise their review of the literature on child sexual abuse. They refer, for example, to 'sexual abuse occuring with greater frequency in two types of families . . . one with dysfunctional interactions (perhaps with an alcoholic parent)' (Bagley and Thurston (1996: 4). Later they consider whether the 'alleged offender should be removed from the home, in the case of within-family abuse' and to the treatment of 'incestuous families' (ibid.: 9). Once they refer to 'families in which physical violence is directed towards the mother' but they fail to mention 'by whom'. There are also examples of this in the chapter by Bailey in this book (chapter eleven), in the psychiatric literature she cites. This refers to 'family structure variables mediated by parenting variables', 'parenting styles', 'criminal parents' (the vast majority of criminals are, of course, males), 'parental brutality', 'family discord' and 'violence within the family' (the vast majority of which is known to be committed by males). Then, eventually, finally the statement that 'of particular note were violent fathers'.

Armstrong (chapter two) discusses the medicalising and professionalising of incest in the USA, and how, in the clinical disciplines of psychiatry, psychology

and counselling, incest has been constructed as a 'family problem'. Writing for this book in 1998, she describes attending an academic conference in Chicago in 1978, the year of the publication of her book on incest *Kiss Daddy Goodnight*. The conference was 'billed' as being on 'intrafamilial childhood sexual abuse', and she describes finding 'many suited up, serious-looking people . . . carving up victim populations . . . vying for funding, for prestige, for place', and hearing the sound of the 'gears of specialisation grinding', the 'hum and the buzz of persons professionalising'. She describes how this led on to the advent of the concept of 'incest families', to the 'national funding of projects that serve to keep [incest] families intact', to 'family incest treatment', and to the focus on 'family dysfunction' as 'the cause' of incest, and of 'family therapy' to treat it.

All of this, she argues, has managed to obscure 'the dreadful actuality of paternal child rape', and, as the results of her research had shown, that the 'rape of one's own child was not entirely rare', that 'children were regularly molested within the home as a matter of everyday living' by 'thousands of upstanding male citizens' – ordinary heterosexual family men – who 'believed it was their right, or at least justifiable', because 'they wanted to, and nothing in the world told them they should not, could not, must not'. From that conference in Chicago, 'family violence research' went on to become a huge academic and clinical enterprise: reflected in the two-volume compilation of summaries for which Bagley and Thurston (1996) reviewed 3,000 publications on child sexual abuse; and reflected in the presentation of hundreds of papers at the bi-annual International Family Violence Conferences organised by the Family Research Laboratory at the University of New Hampshire.

Precisely how inappropriate the concepts of 'dysfunctional families' and 'incest families' are is illustrated graphically by Eldridge in chapter sixteen. 'Those concerned with child protection', she writes, 'need to know that diversity is the main factor characterising men who abuse children, that most sex offending takes place within the context of a relationship which the offender makes with the child in order to gain compliance and prevent disclosure'. 'This,' she says, 'can be achieved with the least risk by abusing their own children'. Eldridge advises that 'those concerned with child protection need to move away from the idea that the family itself is at fault when a child is sexually abused by a family member'. 'Family dynamics or dysfunction have traditionally been seen as causal', writes Eldridge, whereas research with sex offenders shows that it is 'the father's determination to abuse that is causal in creating dysfunction in a family', and 'where there are sexual difficulties in the marital relationship these are as likely to be the consequence of the husband's sexual preference for children as to be the wife's lack of desire or lack of desirability' (Eldridge citing Faller 1990). Eldridge has found that 'offenders in therapy tell us how they cause these [dysfunctional family dynamics] by manipulative tactics designed to dis-empower potential protectors and keep children quiet'. Eldridge and Still have found that: 'Dysfunctional family dynamics don't cause sex abuse; rather, sex offenders willfully exacerbate or create such dynamics . . . to ensure that they can abuse undetected' (Eldridge and Still 1998: 48). 'Effective therapy,' she writes, 'not only for offenders, but also for those affected by abuse, recognises [this]'.

Eldridge thinks the way the media constructs 'paedophiles' as synonymous with sex offending is misleading, as is the mythology that incest offenders are unlikely to abuse outside the home and she cites studies which show this to be false. Thus, for example, in one of several relevant studies Eldridge cites in chapter sixteen, Weinrott and Saylor (1991) found that among ninety-nine convicted sex offenders, one-third of those convicted for extrafamilial abuse were also found to have been incest offenders, and half of those convicted for incest were also found to have abused children who were not their own. In common with the findings of other similar studies, one-third of the child sexual abusers were also rapists.

In this context, again, the use of the word 'family' is problematic, and the meaning of 'family support' ambiguous in cases of child sexual abuse 'within the family'. There are implications for public policy in the use of ungendered or gender-neutral language with respect to paternal incest: in the meaning, for example, of 'partnership with parents' which does not specify which parent: the perpetrator father or the protector mother, the dangerous male or the non-abusing mother who is often herself a secondary victim of the incest. Continuing to construct the family as two parents and children, in need of support *as a family,* in cases of child sexual abuse within the family, without gendering the parents, is to misconstruct the family for purposes of child protection. It is also to construct the family inappropriately for purposes of determining the appropriate response to the abusing parent (usually the father), and the 'non-abusing parent' (usually the mother), particularly as the support the 'non-abusing parent' can provide for the abused child is recognised clinically as instrumental to whether and to what extent the abused child is able to overcome the effects of the abuse (Bacon and Richardson 1991, and chapter thirteen, this volume).

Not only does the ungendered or gender-neutral language of child sexual abuse keep men invisible as primarily the abusers, it also makes women as mothers invisible as primarily the non-abusing and protective parent. This is achieved simply through the unilateral use of the term 'non-abusing parent'. Thus in the current, dominant child sexual abuse 'discourse' which is, actually, about adolescent and adult male abusers and mothers who are not the abusers and who are, or who may be, or who have the potential to become, protective, the use of the term 'non-abusing parent' or 'non-abusing partner' implies, bizzarely and perversely, on each and every occasion it is used, that the 'non-abusing parent' might be either the mother or the father. As this is absolutely and evidentially not the case, it contributes to keeping both men the abusers and mothers the non-abusers unseen.

The confounding effects of ungendered or gender-neutral language on research and policy

The use of ungendered or gender-neutral language at conceptual, theoretical and methodological levels can have serious confounding effects on research and its findings, and consequently on policy. This can be seen in the paper by Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) reporting on

Department of Health funded research in the *British Medical Journal* on 'risk factors for development of sexually abusive behaviour in sexually victimised adolescent boys' (Skuse, Bentovim *et al.* 1998: 175–9).

This study was designed to 'identify factors that may increase the risk of a sexually victimised adolescent boy developing sexually abusive behaviour' (ibid.: 175). There were thirteen 'potential risk factors for abused adolescent boys becoming abusers themselves' defined as (in the order they appear in Table 1):

> experiencing intrafamilial violence, witnessing intrafamilial violence, rejection by family, discontinuity of care, rejection by peers, generalised sense of grievance, poor identification with father figure/s, absence of a non-abusive male attachment figure, mother was sexually abused in childhood, maternal depression, poor sibling relationship, mother was physically abused in childhood, low levels of guilt.
>
> (Skuse, Bentovim *et al.* 1998: 177)

The researchers found (using unadjusted and adjusted odds ratios estimated from unconditional logistic regression) that 'three of the 13 factors were associated with an increased risk of being in the sexually abusive group': these were 'experiencing intrafamilial violence, witnessing intrafamilial violence and discontinuity of care' (ibid.: 177).

Given what is known from the findings of the relevant research literature, from both clinical and community studies (some of it dicussed earlier in this chapter), and in particular from the 'review of the current research on the sexual abuse of male children and adolescents' conducted by Watkins and Bentovim (1992), one would be bound, I think, to hypothesise that the risk factor *most* likely to impact on boys' development of sexually abusive behaviour would be having been physically and/or sexually abused by their fathers or father figures/substitutes and 'witnessing' those men's (domestic) violence against their mothers. Inexplicably, however, violence and abuse *perpetrated* by fathers or father figures/substitutes was not considered to be a risk factor: the *absence* of a non-abusive male attachment figure was, but not the *presence* of an abusive male attachment figure.

The conceptual invisibility of these violent and abusive paternal and conjugal males functions, in this study, to introduce a theoretically confounding factor into the design of the research in the form of the risk factor defined as 'poor identification with father figure(s)'. Considered, again, in the context of the literature on men's domestic violence and their physical and sexual abuse of their children, poor identification with such a father might more appropriately be regarded as a protective factor than a risk factor, particularly in relation to 'cycle of violence' theory which conceptualises 'identification with the aggressor' (that is, a violent and abusive paternal male) as central to the process by which abused boys become abusers (Watkins and Bentovim 1992). Failing to identify, or poor identification, with the aggressor, would therefore surely be likely to be a 'mediating factor' rather than a 'motivating factor', reducing the likelihood of an abused boy becoming an abuser.

In the report of the research as published in the *British Medical Journal*, it is not possible to see to what extent the fathers or father figures/substitutes in the lives of these boys were violent and abusive, and to whom, because the potentially relevant risk factors are conceptualised in the ungendered and gender-neutral terms of 'experiencing intrafamilial violence' (defined as 'recurrent acts of physical abuse') and 'witnessing intrafamilial abuse' (defined as 'exposure to recurrent acts of marital violence or physical abuse of siblings or both'). However, the co-occurence of domestic violence and child physical and sexual abuse is becoming increasingly recognised, and research on domestic violence and child sexual abuse provides a growing body of evidence that primarily this is male-perpetrated. Hester and Pearson found in a sample of all children accepted for services by the NSPCC within a specified two and a half year time frame, that three-quarters of the cases involved child sexual abuse. This in itself is evidence of a very high incidence of sexual abuse among children who are abused. In addition:

> Analysis of the case files indicated that of the sexual abuse cases, over half involved domestic violence . . . virtually always violence against the mother by her male partner. With regard to the perpetrator, in over half (53%) of the child sexual abuse cases the abusers were the children's fathers or father figures. This rose to over two thirds (69%) in instances where domestic violence was also identified. In other words, fathers or father figures were even more likely than other men to be sexually abusive to their children where these same men were also violent and abusive to the mothers.
>
> (Hester 2000, in press)

These findings corroborate those cited earlier in this chapter of a higher than recognised prevalence of intrafamilial child sexual abuse perpetrated by paternal males.

Hester cites other research findings which corrobarate co-occurence of domestic violence and child abuse of this nature, including Humphreys (1997), Brandon and Lewis (1996), Farmer and Owen (1995), Forman (1995) and Goddard and Hiller (1993). Farmer and Owen (1998, and chapter eighteen, this volume) found, in a Department of Health funded study of forty-four children on the child protection register, that there was domestic violence in two-fifths of the child sexual abuse cases, and in three-fifths of the cases of physical abuse, neglect and emotional abuse (Farmer and Owen 1998: 17).

Farmer and Owen (1998, chapter eighteen) draw attention to the fact that 'historically child abuse committed by men tends to remain invisible unless concerted attempts are made to bring it to public attention,' and they identify as an example of this the gender bias in the child protection process whereby as the violent and abusive males become invisible, the focus of responsibility for the sexual abuse having occurred shifts to the non-abusing and protective mothers. It is possible to see this happening just as they describe it in this study by Skuse, Bentovim *et al.* (1998).

In the process of excluding the violent and abusive males from their study, the focus of the risk factors shifts to the mothers: not to any violence and abuse which may have been perpetrated by the mothers against their sons, but to their mothers' experiences of physical and sexual abuse in their own childhoods, perpetrated by a group of men now twice removed from the men who victimised the boys and their mothers and siblings who were the subjects of this study: a generation away down the maternal line. Even 'maternal depression' as a risk factor masks the effects of men's violence and abuse in what is known to be a strongly correlated relationship for women between having been sexually abused as a child and suffering from depression in adolescence and adulthood (Perry 1993; Finkelhor 1995; Mullen *et al.* 1993). In the absence of studies on links between domestic violence and depression in women, it would be possible, with some confidence, to hypothesise such a correlation, as the Department of Health has done in its *Mental Health National Service Framework* (1999: 17), on the basis of the Cabinet Office/Home Office domestic violence statistics (Home Office 1999: 7).

Having been confounded conceptually and theoretically by the absence of the violent and abusive fathers, the study by Skuse, Bentovim *et al.* (1998, and chapter twelve, this volume) becomes further confounded methodologically by the fact that the mothers were interviewed 'about their life history, including their experience of maltreatment', and about their sons' early experiences of abuse, but that the fathers were not. Moreover, had the paternal and conjugal males been included in the study, one of the relevant instruments for testing physical and sexual aggression might have been used, with the findings arguably more correlational and explanatory than the findings of the Beck depression inventory that was used with the mothers. However, the absence of interviews with fathers and father figures/substitutes and with relevant conjugal males about *their* physical and sexual victimisation as children, the 'domestic violence' *they* may have 'witnessed' as children, and the violence and abuse *they* perpetrated against the boys and their mothers in this sample, is perhaps the most regrettable omission in this study, for the opportunity it would have provided to study the processes involved in 'identification with the aggressor'. This is the most widely accepted explanation of inter-generational transmission in 'cycles of violence', and arguably the most relevant possible focus for a study such as this, seeking to understand the 'development of sexually abusive behaviour in sexually victimised adolescent boys'.

Had the fathers of these boys been studied, or were they being studied, one might expect, and therefore hypothesise and test for, congruence with the findings of the study by Williams and Finkelhor (1995) comparing 118 incestuous fathers with 116 closely matched non-incestuous control fathers. Their study found that 'incestuous fathers reported significant histories of child abuse,' specifically:

i. Men who had been severely abused [physically] by their fathers were more than four times as likely to become incestuous fathers than were men who had not.

ii. Rejection by the father increased the odds of being an incestuous father more than four times, as did rejection by the mother.
iii. Sexual victimisation occurred during the childhood of 69 per cent of incestuous fathers compared to 28 per cent of nonincestuous fathers . . . [and] fathers who were sexually abused during their own childhood were more than five times as likely as nonabused fathers to incestuously abuse a daughter.

(Williams and Finkelhor 1995: 106).

It is possible, in this way, to see how the use of ungendered or gender-neutral language has confounded the design of the study by Skuse, Bentovim *et al.*, and its methodology, and how inevitably this compromises the findings and distorts the knowledge-base it provides. This will also distort the process of developing from that knowledge base an understanding of the inter-generational connections and processes involved in 'cycles of violence' and 'developmental pathways' for boys sexually abused in childhood becoming adolescent and adult abusers.

We have seen in this study, and in the contexts considered previously in this chapter, how paradoxically – and perversely – in the use of the ungendered or gender-neutral language of 'parents' and 'families' and of 'intrafamilial' and 'extrafamilial' abuse, the attention shifts from men, who are largely the sexual abusers of children, to the women, who are largely not the abusers, but who then become defined as in some way 'causal' in relation to the abuse having occurred. Precisely how perversely this operates can be seen in the next section of this chapter, in the short step we find there is between constructing the invisibility of men the abusers in this way, and women becoming regarded as a risk factor themselves as mothers because of their victimisation in childhood, or, even more bizarrely, being 'blamed' and held responsible for the physical and sexual abuse of their children by their husbands or other conjugal males.

Blaming women for men's sexual abuse of children

Earlier, I argued for the relevance and the power of a 'gendered cycle of violence' theory in providing an explanation of the preponderance of adolescent and adult males as perpetrators of child sexual abuse, involving boys as well as girls as its victims. However, at the same time as I have challenged feminist resistance to 'cycle of violence' theory, I share the concerns of feminists about it. Armstrong, (chapter two) calls it a 'shibboleth'; Kelly, Regan and Burton (chapter four) describe it as a 'pernicious idea,' and regard it as 'reworking old orthodoxies and placing mothers back into the collusive frame'. The fears of feminists are well-founded, and the dangers the theory poses for women are supported empirically. There are a number of examples of situations in which, and processes whereby, women, the non-abusing protective mothers of sexually abused children have come to be held responsible for and 'blamed' for the sexual abuse of their children by men.

In the USA

Armstrong (1996, and chapter two, this volume) describes various ways in the USA in which women have been blamed and held responsible for incest committed by men. In one form, she finds these constructed in the 'dysfunctional family' terms described by Eldridge earlier: as the 'multiple and pervasive failures, inadequacies and sexual shortcomings of mothers which were seen as driving their husbands into the beds of their five year olds' (Armstrong 1996: 9). She cites 'psychiatric' literature from the 1960s and 1970s which refers to 'the incest family', to 'sexually repressed households' in which the 'mother rejects the sexual role with her husband and the maternal role with her daughter', or 'the mother is a very powerful and controlling person' (ibid.: 10–11) or even 'maternal mutilative and castrative destructiveness' as a 'causative factor' in incest (Armstrong 1983: 35):

> We may not say that maternal destructiveness is the prime factor in all pathological states, but the total evidence at hand seems to permit one to say that it enters causatively into a greater range of disorders than any other factor. . . . Even the nurturant mother 'is not without destructive effect'.
>
> (Rheingold 1967: 105–6, cited in Armstrong 1983, and at greater length in chapter two, this volume)

Finkelhor (1979, 1986) and the commentators he cites also tend to explain men's abuse in terms of a mother's failing or fault. Although the findings of his studies, and the others he analyses, are unequivocal about the 'fundamental and long-recognised fact' (Finkelhor 1986: 126) that the sexual abusers of children are predominantly adolescent and adult males, male violence is not developed as an explanation of child sexual abuse. Rather Finkelhor (1979) offers as a 'theory of sexual victimization' the 'hope' that he has 'firmly established the idea that the family plays a crucial part in creating vulnerability to sexual victimization' (ibid.: 147). By 'the family' he means mothers: 'Our data show that girls without natural mothers are particularly vulnerable to sexual victimization, as are the daughters of poorly educated, ill and alcoholic mothers' (Finkelhor 1979: 148).

He recognises and makes the 'highly plausible inference from this finding' that 'the oppression of women as wives and workers' is connected to what happens in the family. Nevertheless there is some considerable irony that 'alcoholic mothers' are identified as a predisposing factor in child sexual abuse, given what is known about the connections between men's abuse of alcohol, and their physical and sexual violence and abuse of women and children under the influence of alcohol (Kantor and Straus 1989). Moreover he puts the burden of protecting children from child sexual abuse on to mothers, rather than on to the men his research has identified as the perpetrators: 'If girls are going to learn self-protective coping behavior, especially in sexual situations, they will have to do so from their mothers' (Finkelhor 1979: 148).

If mothers fail to protect their children, they, not the perpetrators are regarded as responsible for the abuse happening: 'Our data . . . give strong confirmation to the idea that mothers are important in preventing sexual abuse . . . Not just maternal absence, but also inability to protect can contribute to sexual victimization' (ibid.: 125). Finkelhor found this institutionalised in the practice of child protection agencies in reporting mothers as 'co-perpetrators' in 41 per cent of cases of sexually abused boys and 31 per cent of girls, 'not because they molested the child themselves' but because they 'failed to take steps to stop it' (Finkelhor 1984: 160). Finkelhor and Baron also cite studies which found 'the mother's employment outside the home' being 'related to sexual abuse' (Finkelhor and Baron 1986: 73).

Armstrong finds this view of women as responsible for men's sexual abuse of their children reflected, from the early 1980s, in the way in which child protection was constructed by the legal system in the USA, in the 'statutes in many states that faulted the mother who "knew or should have known" of the father's assault on the child and the mother who "failed to protect"'. She describes:

> mothers whose children spoke of sexual abuse by fathers; mothers who believed the children (as they were widely admonished to do); who acted to protect them (as they were, by law, commanded to do); and who were then vilified, tormented, and often entirely deprived of the custody and company of the children they tried to protect.
>
> (Armstrong 1996, and chapter two, this volume)

She cites legal findings which show how, when women become engaged in custody disputes with husbands who are known to have sexually abused their children, non-abusing mothers are held responsible and the children are given in custody to the sexually abusing father because:

> A natural mother, who had no actual knowledge of the sexual abuse of her child by her husband, the child's stepfather, in their home, will nonetheless be held to have allowed the abuse . . . good faith, good intentions and even best efforts are not, per se, defenses.
>
> (Armstrong 1996: 24, and chapter two, this volume)

She cites, in particular, a study in Orange County, California which found that:

> over the five year period between 1983 and 1987, in all contested custody cases, 84 percent of the fathers were granted sole or mandated joint custody. In all cases where sole custody was awarded, it was awarded to fathers in 70 percent of the cases; in 26 percent of these cases the fathers were alleged or proven to have physically and sexually abused the children.
>
> (Pennington 1993, cited in Armstrong 1996, and chapter two, this volume)

Armstrong in chapter two, like Macleod and Saraga (1998), charts the conceptual drift away from the 'dreadful actuality of paternal child rape' and men the abusers; through to children's responsibility for provoking it, either because they want it, or they ask for it, or they deserve it, and certainly they are not harmed by it; on to the blaming of mothers for allowing it to happen or not stopping it.

In the UK

In the UK there is evidence of 'systems abuse' of women who were sexually abused as children, by some social services departments, for example, which consider them at risk of sexually abusing their own children, although the evidence from clinical work and research is overwhelmingly that women do not sexually abuse children except in a small minority of cases (Finkelhor and Russell 1984; Itzin chapter one). Kelly, Regan and Burton (chapter four) have found cases where 'experiences of abuse are presumed to make women less able to protect their children': 'It is becoming commonplace for adults who have been abused in childhood, women and men, to believe that they cannot be trusted around children, that there is an inevitability that they will abuse them'.

They find 'additional worrying implications of cycle of violence theory for women in Area Child Protection Committee guidelines, which define being an adult survivor of child sexual abuse as a risk factor in relation to one's own children'. They have found the 'influence of this idea so strong that some social services departments consider knowledge of a woman's abuse in childhood sufficient to place her children on the "at risk" register'. 'The tragic irony' which, in their findings, some women encounter, is that 'if they reveal their own abuse their report may be accorded less validity' .

There is evidence of this in the 'systems abuse' experienced by 'Rachel Pearce' (chapter six). Knowledge of her abuse as a child has been used by official agencies on many occasions to discredit her and to question her veracity. Her medical records, for example, continue to refer to her 'bizarre allegations' of sexual abuse by her father as if they were unsubstantiated, when in fact her father has been convicted and is serving a fourteen-year prison sentence for incest and child rape. Her applications for adoption and fostering have been turned down by social services because 'she is known to the police' (as a sexual abuse victim). She was bullied and intimidated by police investigating her allegations of incest, and more recently harassed by police in response to a malicious complaint they had received about her.

Kelly, Regan and Burton (chapter four) describe this 'systems victimisation' as 'extending in some places to workers who are open about the fact that they are survivors'. Browne has also found that 'many professionals who have themselves been abused are afraid to disclose this fact at work due to suspicion, stigma, and the cycles of abuse theory' (Browne 1996: 47). One such person is quoted as saying: 'It's easier to say you've got AIDS than it is to say you were sexually abused' (ibid.: 51).

Furthermore, what Armstrong describes as happening in the USA is also

happening now in the UK. Farmer and Owen (1998, and chapter eighteen, this volume), in a study commissioned by the Department of Health, of forty-four children whose names had been placed on the child protection register in two local authorities, found systematic bias against women at each stage of the child protection process, and systematic ways in which, within the child protection system, violent and abusive males become invisible and the protective mothers come to be treated as if they were responsible for the sexual abuse of their children. They found that when non-abusing mothers sought help because their children were being physically or sexually abused by their fathers or father substitutes, the 'non-abusing mothers rather than the abusing fathers became the subject of suspicion, scrutiny and surveillance' (Farmer and Owen 1998: 4, and chapter eighteen, this volume). At the initial case conference stage of the child protection procedures, risk assessments in cases where men were responsible for the abuse would become assessments of the quality of the mother's care. It was, they observed, 'a small step to deciding that the child was actually at risk *from* the mother, not only because of her limited ability to protect, but also because of her poor parenting skills' (ibid.).

They found that 'mothers whose male partners sexually abused their children tended to be treated as possibly having known about or "colluded" with the abuse' (ibid.: 8). Even if the abuse was committed by the father figure, 'responsibility for the abuse might be seen as shared by the mother on the grounds that she ought not to have allowed it to happen . . . and responsibility for protecting the child was then laid at the feet of the mother' (ibid.). They found that mothers who needed help as 'secondary victims' in dealing with the shock of their children's disclosures, were often treated as 'secondary perpetrators' and judged by social workers as 'non-protective mothers' (ibid.). So, ironically, although she had actually taken action to protect her child/ren by reporting the abuse to an official agency, she was then blamed for the abuse taking place.

Farmer and Owen point to the need to 'review the work of child protection agencies for its gender bias'; to 'disaggregate' sources of risk to children in the family'; to 'gender the abusers' and recognise 'inequalities in power within families'; to recognise the links between domestic violence and child sexual abuse and child physical abuse; to provide 'more support and therapeutic help to non-abusing mothers and their children after the discovery of sexual and physical abuse'; and to 'develop and assess for effectiveness ways of working with men' (ibid.: 17). They conclude that 'once again', men have remained almost invisible as they have always done unless strenuous efforts are made to retain the focus on men' (ibid.: 15). They cite 'feminist commentators' (such as Nelson 1987) who 'have suggested that professionals have clung to the idea of mothers as collusive in the abuse of their children partly because it is a powerful defence against admitting male abuse of power, which would otherwise have to be faced'.

Children 'engaged in prostitution', as for example in Bradford (see Swann, chapter fourteen) are criminalised because women engaged in prostitution are criminalised. Women selling sex – that is, women whose bodies are used and traded by men for sexual purposes – are criminalised, not the men who buy their

bodies for sex, or exchange their bodies with each other for money for sex. This, I would argue, is another example of women carrying the burden of blame for sexual ab/use and exploitation perpetrated – or perhaps more appropriately with regard to women rather than children, practiced – by men. To reconceptualise child prostitution as child sexual abuse and sexual exploitation risks revealing prostitution as the sexual abuse and exploitation of women, and men as the exploiters and abusers. Seen as such, the flaws in the logic of criminalising women but not men for prostitution are exposed: as blaming women for what men want and do. The public policy proposal often advocated by liberals and libertarians is not, however, to criminalise men for this abuse, but rather to legalise it and regulate it. As Kelly, Regan and Burton point out (chapter four), prostitution, child or woman, would not exist if there were not a market for it. This market is men, and the laws relating to prostitution which prosecute women and hold them responsible for this crime, operate in practice to protect men's sexual access to women and children.

Child protection and child sexual abuse prevention: stopping abusers abusing

A philosophy of treatment intervention

Kelly, Regan and Burton (chapter four) argue that 'crucially, "cycle of violence" theory excludes more challenging explanations' and specifically 'those which question power relations between men and women, adults and children';'and 'that "breaking cycles" is a much easier and safer goal to discuss than changing the structure of social relations'. However, from the perspective of 'cycle of violence' theory gendered as I have framed it earlier in this chapter, it is possible to see that 'breaking cycles' can challenge power relations between men and women (gender) and men and children (gender and age), because it contains the potential, through a process of change and the exercise of choice at the level of the individual, to stop abusers abusing. But 'crucially' this involves recognising and treating perpetrators as victims as well as perpetrators. Treating abusers as victims does not, as Kelly, Regan and Burton argue, 'transform them into victims'; findings from research tell of their childhood victimisation.

The recognition that abusers are victims is important to making an accurate assessment of the risk any particular individual might pose; to forming a judgement about their suitability for, and the extent to which they actually respond to, 'treatment'. Inevitably some abusers will be so damaged as a result of their victimisation that they will not be treatable. Those who pose too great a risk, or are either unwilling or unsuited to engage in 'treatment', or cannot be effectively 'treated', would, if there was a genuine intention to protect children, have to be subject to indefinite detention because of the inevitability that they will offend again. It is not a question of whether a child will be abused, but which child it will be, unless the abuser decides not to and doesn't.

There is a paradox in the inevitability of continued abusing (without effective 'treatment') and, at the same time, the power – and the necessity – of the

individual to choose not to. Knowing that both are true is crucial to the protection of children. Indeed, if the objective is to prevent the sexual abuse of children and 'child protection' means protecting children from being sexually abused, then both child protection and child sexual abuse prevention must be conceptualised – and defined – in terms no other, and no less, than stopping abusers abusing.

There is a virtual certainty that the sexual desire for children will never go away, although it may abate, because it has been so deeply conditioned into and corrupted the very being of the man when he was abused as a boy (Wyre chapter three), and reinforced by sexual arousal and orgasm to the sexual abuse of children in fantasy or pornography or both (see Itzin 1992, 1992b, 1994), or to the actual child sexual abuse he has previously perpetrated. All of the evidence suggests that it is inevitable that the sexual abuse of children will continue unless the individual can resist the desire to abuse and choose not to. To do this requires the exercise of choice and a decision not to abuse, supported by interventions which assist the individual to reiterate this decision as often as necessary to stop himself abusing; which place the responsibility for 'prevention' and 'relapse prevention' with the abuser; and which provide the abuser with the help he needs to make his prevention possible.

Treating abusers as victims in this way does not exonerate them as Armstrong (chapter two), and Kelly, Regan and Burton (chapter four) suggest. On the contrary, understanding the reasons for their abusing can help them to take charge of preventing the abuse happening. What Dobash *et al.* (2000) observe about domestic violence also applies to child sexual abuse: that is, 'a fundamental principle [of 'pro-feminist' domestic violence treatment programmes] is to hold men responsible for their violence [and to] seek to increase men's insight into their own behaviour'. 'Treatment' is theoretically consistent with the 'gendered cycle of violence' in that it is premised on changing the direction of causality, on deconstructing and reconstructing the desires conditioned in response to childhood experiences of abuse, and through a process of re-education and resocialisation changing the distorted thinking that supports acting on those desires.

'Treatment', however, is not a word Eldridge (chapter sixteen) uses about the work she does with abusers in sex offender 'treatment' programmes. In her experience, offenders 'do sexual things to children because they want to', the point which Armstrong stresses in her chapter (two), and they need, therefore, to be 'introduced to notions of control rather than cure at an early stage'. Central to its effectiveness, this approach to 'treatment' requires, in Eldridge's view, operating from a position that 'deplores sexual abuse and challenges the attitudes which legitimise it', but with 'an ethos of respect and care for the individual'. Success depends on operating from both positions simultaneously, and providing abusers with a 'treatment' response to their own childhood sexual victimisation, as part of their 'rehabilitation'. This 'involves them in facing the pain of their own childhood as well as the pain of the children they've abused'. At the same time, the effectiveness of this approach requires abusers to take responsibility for preventing any further abuse.

Print and Morrison (chapter fifteen) have developed a 'philosophy of intervention' based on the predisposing and causal factors which they see as contributing to the sexual abuse of children by adolescent males: the behaviour they have learned through their own childhood abuse and neglect; through pornography and 'domestic violence'; and media messages about masculinity and female sexual objectification. They argue that current knowledge about 'adolescents who sexually abuse others' provides compelling reasons to develop a coordinated and systematic multi-agency response aimed at preventing and intervening in the development of sexually abusive behaviour in young people. This approach would target preventative work towards those at higher risk, and target for therapeutic intervention children who are already known to have been physically, sexually and emotionally abused or neglected or the child victim of 'domestic violence'. Skuse, Bentovim *et al*. (1998, and chapter twelve, this volume) also recommend this approach.

If, as the evidence suggests, there are conscious and subconscious causal relationships and processes involved in having been abused and becoming an abuser, then ignoring this abandons children to the developmental pathways that may take them towards abusing. Acknowledging the vulnerability, the predisposition and the risk to themselves, and offering help with the effects of the abuse they have experienced in the form of 'treatment', is to introduce an ameliorating factor with the potential to be instrumental in changing the direction of causality. There exists the professional knowledge and skills to provide the help that is needed, represented in this book in the work of Wyre (chapter three), Bacon and Richardson (chapter thirteen), Swann (chapter fourteen), Print and Morrison (chapter fifteen), Eldridge (chapter sixteen) and Woodward (chapter seventeen).

In all cases 'treatment' programmes would be required to deal with the use of sexually salient and pornographic materials, in the ways described by Wyre (chapter three) and Print and Morrison (chapter fifteen). In the UK the National Association for the Development of Work with Sex Offenders (NOTA) have developed a policy for work of this nature in the 'treatment' of sex offenders (1994). Addressing the role and use of pornography in the sexual abuse of children is an integral part of the 'treatment' programme at Peterhead Prison in Scotland, where three-quarters of the prisoners are convicted sex offenders, and there is the potential to use this approach as a model in both prison and community 'treatment' settings (Spencer 1998).

Removing the burden of prevention from children

Currently, child sexual abuse prevention is largely conceptualised in terms of 'teaching' children how to say 'no' to stop abusers abusing (Corcoran 1987). Bagley and Thurston describe the 'most widespread type of primary prevention programme' as being 'directed at children in school settings, using brief presentations aiming to give children some knowledge about the nature of sexual abuse and how to avoid or escape situations where sexual abuse might occur' (Bagley and Thurston 1996: 5). In the UK this kind of prevention has taken the form of the Kidscape programme for parents, teachers and children in schools with the 'aim of helping

children to recognise and cope with . . . the possibility of sexual abuse' by 'teaching children to trust their own feelings in sensing dangerous situations; to differentiate between safe and unsafe forms of touching'; to break rules when necessary in order to protect themselves; and always to seek adult help' (Elliott 1985). However, from their review of the relevant research, Bagley and Thurston found 'no direct evidence from evaluation studies that such programmes actually reduced the prevalence of [child sexual abuse]' (Bagley and Thurston 1996: 5), and they cite critical analyses which argue that 'pseudo-empowerment of children is . . . likely to fail and may actually impose responsibility (and guilt) on children for failing to prevent their own abuse' (ibid.: 7).

A policy of prevention which expects children to keep themselves safe and to prevent themselves from being abused is absurd and dangerous, given what is known about abusers, and it is asking the impossible of children. It is setting them up to fail as they do not have the power to stop abusers abusing. Nelson (chapter twenty) describes these 'so-called prevention schemes' as 'underplaying power relationships in sexual abuse, targeting victims rather than perpetrators': 'for example, five year old school pupils are not expected to prevent physical violence, burglary or murder. But they are asked to stop sexual abuse and "to keep themselves safe"'. In so far as this so-called prevention makes children more rather than less vulnerable (falsely confident, for example, or sensitive to stranger abuse but not to familial abuse, and unaware that abusers are largely male), it can be regarded as contributing to rather than preventing abuse. In the interests of child protection, 'the responsibility for offending has to be shifted [from children] to where it belongs – the perpetrators' (Laws 2000: 34).

An integrated multi-disciplinary, multi-agency approach: the Grand Rapids Michigan model

The Children's Assessment Center at the De Vos Children's Hospital in Grand Rapids, Michigan, USA opened in January 1993. It is a free-standing, non-profit agency, housing a medical unit, legal and protective services, and counseller and support personnel. This model combines medical evaluation and law enforcement, child protection and perpetrator prosecution in a genuinely multi-disciplinary approach to integrated working towards the two primary objectives of successful prosecutions and addressing the health and mental health needs of the abused child. Evaluations are provided by multiple paediatricians and nurses. Outcomes are measured.

Medical examination consists of a physician's overall evaluation which includes:

1 assessment of the child's statements made during the medical evaluation
2 parental report or other report of behavioural changes or concerns
3 interpretation of physical examination findings using an accredited methodology
4 collection of forensic and/or laboratory evidence for sexually-transmitted disease.

The medical evaluation includes an assessment of the child's overall health, with a comprehensive physical examination, an interview with the child by the physician and/or the nurse and/or the social worker, and documentation from the parent of medical history and behavioural concerns. Anal dilatation plays a role in making a medical diagnosis of child sexual abuse, to the extent that it exceeds standardised norms. For example, spontaneous anal dilatation greater than 20mm without evidence of a stool being present is defined as a positive finding.

In the evaluation of the programme, it has become clear that medical evidence has a significant impact in the legal system, particularly in regard to family and probate court. In the family court the child's statements, as part of the medical evaluation, carry significant weight. In criminal matters, however, the child's statement becomes less important than the medical examination, because a child usually only testifies in court starting at the age of seven. Positive medical findings, therefore, are very important in determination of guilt and have been found to be independently predictive of that determination (Palusci, Cox *et al.* 1999).

The overall medical evaluation helps the prosecutor in a variety of settings, and is useful as a method of documenting the child's health, reassuring the child that they are well, letting the child understand the importance of talking about these issues and bodily safety, and as a basis for further counselling and meeting the mental-health needs of the child. The medical evaluation is just that, with special attention to medical–legal, forensic and other uses' (Palusci 1998). 'Post-Cleveland' this approach to responding to child sexual abuse is likely to be atypical in the UK (see Itzin, chapter one). Its merits lie in the value attached to medical evaluation and medical evidence of abuse, and the fact that multi-disciplinary and multi-agency working is not just a process governed by protocols, but innovatively brought together in the form of an *integrated* multi-disciplinary and multi-agency service, including law enforcement.

Treating the effects of child sexual abuse as a public policy priority

In this book many effects of child sexual abuse in childhood and throughout the lives of the victims have been identified. Wyatt and Higgs (1991, and chapter nineteen, this volume) refer to the physical signs and symptoms that may be differentially diagnostic. These were described in DHSS *Guidance for Doctors* (1988) as 'non-accidental injury; lower genitourinary tract symptoms, injuries and abnormalities; faecal soiling, retention or rectal bleeding; rectal abnormalities; and sexually transmitted disease'. The Royal College of Physicians (1997) guidance for doctors also lists 'constipation and anogenital pain, irritation, or discharge'. Failure to thrive, and various behavioural and emotional problems, can also be a result of the effects of child sexual abuse.

Wyatt and Higgs cite the findings of Finkelhor and Browne (1986) describing initial effects as being fear, anger, hostility, guilt, shame, depression, sleep and eating disturbance, teenage pregnancy, disturbance of sexual

behaviour, difficulties at school, truancy, running away from home, early marriage and delinquency. They identified long-term effects as being depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self esteem, a tendency towards revictimisation, substance abuse, difficulty in trusting others and sexual maladjustment. They described the impact of child sexual abuse as 'traumatic' and the effects as 'traumagenic,' conceptualised in terms of 'traumatic sexualisation, betrayal, stigmatisation and powerlessness' (Finkelhor and Browne 1985).

Alice Miller (chapter nine) describes the effects of child abuse as 'shattering.' Children who are 'exploited, beaten, punished, taken advantage of, manipulated, neglected or deceived' will have 'their integrity . . . lastingly impaired,' she writes. Being dependent on the abuser/s for its very life and passage through the developmental stages of childhood into adolescence and adulthood, the abused child has no choice but to 'suppress their feelings of anger and pain, repress all memory of the trauma and idealise those guilty of the abuse':

> Dissociated from the original cause, their feelings of anger, helplessness, despair, longing, anxiety, and pain will find expression in destructive acts against others (criminal behaviour, mass murder) or against themselves (drug addiction, alcoholism, prostitution, psychic disorders, suicide).
>
> (Miller chapter nine)

Bacon and Richardson (chapter thirteen), citing Finkelhor (1986), describe 'the trauma of child sexual abuse deepening over time', and the 'irrevocable damage done to the developmental process' of the abused child.

Importantly, what this actually means in the personal, individual, experiential terms of the sexually abused child is described by 'Alice Edwards' (chapter seven). As a child, during and after the abuse, she experienced various injuries and the pain associated with them: 'her nipples sore and bleeding, sharp knife pains in her rectum and vagina', and in later childhood and adolescence 'very severe pains in her breasts'. She experienced, at one extreme, intense fear and emotional pain, and at the other 'robotic numbness' and an inability to feel anything. In either case she would cope as a child by biting her arms and harming herself in this way. This would drive away the memory of the abuse, or it would make her feel 'something' other than what she describes as the terrifying absence of any feeling at all. 'Nancy E' depicts the pain of the child who is sexually abused graphically in her drawings reproduced as chapter eight with captions such as: 'all is torment'; 'the scream within is deep and silent'; 'I am hurt, I am torn'; 'I am breaking into pieces'; 'born female, used child, tormented creature'; 'the idea of death was good.'

As a child 'Alice' experienced 'sleeping disorders', created initially as a coping ('survival') mechanism to avoid the nightly nightmares: she trained herself to stay awake. Consequently, as an adult she has only been able to sleep with difficulty. As another form of 'dissociation' (as she came to understand it through therapy and reading about child sexual abuse) she

suffered 'black outs' and 'losing time' in ways which distanced her from the pain of the abuse, but which also put her at additional risk of harm. She experienced 'eating disorders': created initially as a response to 'food deprivation' being used as a form of punishment in childhood, it was followed later by denying herself food, or bingeing, and as an adolescent she started overdosing on laxatives.

As a result of her premature sexualisation, she entered puberty early and began menstruating at the age of nine or ten. In addition, sexualisation in and through abuse conditioned her sexual arousal and orgasm to her experiences of abuse, and from an early age she experienced spontaneous sexual arousal over which she had no control. This led to compulsively and excessively masturbating as relief from the arousal, but orgasm achieved only through repeating the abuse and self-harming sexually, pushing things inside herself, masturbating until her clitoris started to bleed, or her rectum or vagina would tear. She describes allowing herself to be sexually exploited, simply by being compulsively sexual with 'any man, any time, any place,' sometimes in a dissociated state, returning from 'lost time' to find herself in bed with a man she did not know.

From biting her arms as a child, she went on to cutting and self-mutilation as an adult. By the time she had overcome what she describes as 'this overwhelming compulsive desire and addictive behaviour', she had made more than ninety incisions on her arms, legs, neck and breasts, most of them needing hospital treatment. In one catastrophic act of attempted self destruction, she cut off her nipples, which she describes as having been the focus of her sexual abuse in childhood and adolescence, particularly in pornography.

Over time she overdosed on the prescription drugs prescribed to treat her depression, and she attempted suicide on several occasions: when she could not endure the emotional pain, she tried to achieve unconciousness through ever larger amounts of drugs. She experienced nearly ten years of psychiatric hospitalisation, some of it voluntary but also, on occasions, being sectioned and compulsorily detained. In hospital she was physically and sexually assaulted and harassed by patients and staff.

As a result of her sexual abuse as a child she acquired serious physical conditions, and she has suffered lifelong physical as well as mental ill health, and been subject to a multitude of medical interventions. These have included gynaecological problems (two D&Cs by the age of sixteen, a hysterectomy at the age of thirty-two). From the age of thirteen she was in and out of hospital constantly with urine infections, bladder infections and severe kidney infections. Subsequently she has had bladder surgery, bowel surgery and kidney surgery.

There are also other effects of sexual abuse in childhood: the 'cycle of violence' effects, for example, associated with revictimisation (for girls in the ways described by 'Alice Edwards'), and a predisposition for boys who are victims to become perpetrators (see Skuse, Bentovim *et al.* 1998, and chapter ten, this volume). This is a problem of sufficient significance to be included by Watkins

and Bentovim in their 'Perpetrator Risk Index Following Child Sexual Abuse' (Watkins and Bentovim 1992: 231). Bailey (chapter eleven) regards the behaviours associated with sexualisation through abuse for boys who become sexual abusers to be a problem of sufficient significance to warrant creating a new diagnostic psychiatric disorder category.

Effects of child sexual abuse are, as evidenced, multiple in the case of each individual child and there are both immediate and long-term effects (Edwards chapter seven). The social costs of dealing with the effects of child sexual abuse by health and mental health and social services and the criminal justice system are huge even when considered at the lower end of prevalence findings (see Bolen, Russell and Scannapieco, chapter ten; Eldridge chapter sixteen). Nelson (chapter twenty) argues for treating child sexual abuse as a major public health issue (see also Laws 2000). The public health costs of the effects of child sexual abuse on adolescents and adults have not been calculated, and Woodward (chapter seventeen) argues for a cost–benefit analysis which sets these costs against the costs of treatment for child sexual abusers, and for sexually abused children, with the expectation that the cost of therapy for sexually victimised children would result in significant health service and criminal justice system savings aggregated in life course terms. In particular, there is evidence now to suggest that psychodynamic therapy, systemic therapy, cognitive behavioural therapy and other focused psychological 'talking therapies' are cost-effective, even in quite 'difficult' cases (Woodward 1991, and chapter seventeen, this volume; Department of Health 1999).

For the most seriously damaged children, the girls who may come to self-harm and suffer from severe depression, and the boys estimated by Bailey as the 10 per cent most likely to become adolescent and adult perpetrators, a cost–benefit analysis would balance the cost of incarceration against the cost of 'treatment' in the form of long-term psychotherapy for each individual child (what I would conceptualise as the 'cost-value of transference', that being a process with the potential to repair the damage of the most serious abuse in childhood). These costs need to be set against the knowledge that without the right kind of 'help', some offenders will have abused many, sometimes estimated in hundreds of children in a lifetime 'career' as an abuser. The Faithfull Foundation residential programme for sex offenders costs £625 per week (at 2000 prices) inclusive of 'treatment', as compared to a week in prison without the cost of 'treatment' at £520, making 'treatment' only £5460 more per year per offender than prison (Eldridge 2000). Marshall (1992) calculates cost benefits of sex offender treatment in terms of reducing the numbers of future victims. Cohen and Miller (1998) calculated the cost of treatment for victims of recent child sexual abuse as exceeding $600 million, and for victims of historical childhood sexual abuse as totalling over $4 billion (at 1991 prices). Marshall *et al.* conclude, from what is known about the benefits of prison programmes in reducing recidivism, that 'governments are, in fact, in the odd positon of being unable to afford to not treat sexual offenders' (Marshall *et al.* 1999: 163).

Conclusion

We can see the protection of men's sexual access to their own and other people's children being maintained at great personal cost at the level of the individual for every abused child in childhood and throughout their life, and at great public cost in dealing with the effects of child sexual abuse. Ending the sexual abuse of children defined as 'stopping abusers abusing' should therefore be a public policy priority. To start, however, never mind succeed in this endeavour, will require facing the empirically evidenced fact that the sexual abusers of children are ordinary heterosexual men, often with wives and children, on what prevalence data tell us is a very substantial scale. It is necessary to recognise that there is no solution to the problem without addressing the 'men thing' of it, the matter of men wanting it and doing it and largely getting away with it, and nothing effective being done to stop them. It is necessary to understand that child sexual abuse won't end until the men who want it and do it decide to stop it; and the men who don't want it or do it decide to stop the men who do.

Bibliography

The bibliography for this chapter is included in the bibliography for chapter one, pages 17–24.

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