

Diagnosing Child Sex Abuse: A research challenge

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Abstract

Child sex abuse increasingly is recognised as a societal problem that can no longer be ignored. In this paper definitions, prevalence, trends, assessment, and available diagnostic procedures are described and critically evaluated. It is argued that the lack of reliable diagnostic procedures remains one of the main difficulties in dealing effectively with the detrimental effects of CSA on the child or adult. The research challenge to find effective alternative procedures is outlined. *Key words:* child sex abuse (CSA), diagnosis, disclosure, assessment.

Introduction

Child Sex Abuse (CSA) is a social problem that demands vigorous scrutiny and formal investigation. Although some form of incest taboo has existed across most cultures, the sexual abuse of children has been denied, condoned, and sanctioned throughout history. Over the last decade research in the area of CSA has increased exponentially and has attracted increasing attention not only from health professionals (Miller & Veltkamp, 1995) but also from public, legal, and media interest. Issues surrounding CSA include the veracity of the reports, the extent of the short-term and long-term negative effects on the child, and the controversy over therapeutic interventions to help overcome the long-term negative effects of CSA.

Sexual abuse of children includes many types of sexual trauma, from single attacks by strangers to long-term incestuous relationships with a parent or close relative. In this paper, the term *sexual abuse* will be used to denote all types of sexual victimization, whereas *incest* will be used only with respect to sexual experiences between individuals related by blood or by marriage, with whom such activity is prohibited by virtue of societal taboos.

Problems with definitions

Despite efforts to promote a uniform criterion for defining CSA, there are still variations in the definitions adopted by professionals and researchers working in the field. The definition of CSA varies on several dimensions, for example, the level of physical contact, the age of the victim, the age of the perpetrator, the age difference between the victim and the perpetrator, and issues to do with consent. Legally CSA may be defined as "... any activity, before the age of legal consent, for sexual gratification of an adult or significantly older child" (Rappley & Woolford, 1998, p. 49), while most commonly CSA is defined as:

... the involvement of dependent and immature children or adolescents in sexual activities they do not fully understand and to which they are unable to give informed consent, and which violate social taboos of family roles. (Helfer & Kempe, 1976, p.60).

By-and-large researchers agree that the definition of CSA should not be confined to actual physical violation of a child by rape, as this will adversely affect reported cases. Importantly definitional differences can markedly affect prevalence rates (Haugaard & Emery, 1989; Russell, 1984; Wyatt, 1985; Wyatt & Peters 1986). In the Irish context, Ward (1997) extended the definition of sexual abuse to include exposure to pornography, sexual exhibitionism,

perverse activities, and viewing of sexual acts. Also included is a range of sexual contact between adults and children from fondling, oral-genital contact, digital penetration, (all of which do not leave any physically detectable traces), to intercourse.

Furthermore, it is widely agreed that any definition of CSA should include the use of power over the child, for example, threats and/or exploitation of relationships that include an authority differential or some kind of dependence, no matter what the age of the abuser or abused. Once all these factors are included in the definition a different picture of prevalence rates emerges.

Prevalence

Over the last two decades the United Kingdom and Ireland, like most other countries worldwide, have witnessed a substantial increase in the number of reported incidents of CSA (Benedeck & Schetky, 1987; Dammeyer, 1998; Haugaard & Emery, 1989; Lamb, 1994; Wood, Orsak, Murphy, Cross, 1996). It is unclear whether this increase in the number of reported cases reflect a real increase in the incidence of CSA, increasing awareness of the problem, increased willingness to report CSA to authorities, or a combination of these factors. Whatever the reason, the number of reported cases is quite startling.

In the United Kingdom recent statistics show increases from 3,700 new substantiated cases (.034%) in 1991 to 4,200 new substantiated cases (.037%) in 1992 (Lamb 1994). In the last two decades an enormous increase in the awareness and reporting of CSA took place in Ireland, specifically in 1982, when the Department of Health compiled national statistical frequencies on child abuse referrals (Department of Health, 1995). For example, the number of notifications for alleged sexual abuse in Ireland rose from 88 in 1984 to 1,242 in 1989 (Department of Health, 1996a). The earliest epidemiological investigation of CSA in Ireland conducted in 1987 by the Market Research Bureau of Ireland (MRBI) reported that in a sample of five hundred adults in the Dublin area, 5% of males and 7% of females reported that they had been sexually abused as a child (MRBI, 1987). This was followed by a succession of high profile CSA cases, which became public throughout the mid-1990s; for example, the X case (Holden, 1994), the Kilkenny Incest Case (Lalor, 2001), the Brendan Smyth Affair (Moore, 1995), the Madonna House Affair (Department of Health, 1996b), and the Sophia McCologan case (McKay, 1998). Following this succession of high profile cases, 970 cases of CSA were reported in 1996 in the Eastern Health Board region of Ireland alone (Eastern Health Board, 1996).

In 1993 the Irish Society for the Prevention of Cruelty to Children (ISPCC) conducted a survey of 1,001 members of the general population. The results obtained from this study elaborate on the picture of CSA that was described in the earlier MRBI (1987) survey. A total of 160 (16% per cent) respondents reported having experienced CSA. In a survey of 247 students of the Dublin Institute of Technology, Lalor (1999) reported the highest rate of CSA recorded so far; 31.8% of females in the sample reporting an unwanted sexual experience before the age of sixteen. In Northern Ireland, MacKenzie, Blaney, Chivers and Vincent (1993) examined reported cases of CSA in the year 1987 and estimated that the epidemiology lay between 0.9 and 1.87 cases per 1,000 children. Jenny (1997) thought that the prevalence of incest might even be as high as one in eight children.

There is overwhelming evidence that more girls suffer CSA than boys. For example, Finkelhor and Berliner (1995) examined research from 19 different countries and concluded that girls were abused 1.5 - 3 times more often than were boys in the general population. Similarly,

Dobash, Carnie, and Waterhouse (1993) reported that girls made up 74% of the CSA population in the UK.

However, it is becoming more and more evident that the sexual abuse of boys is vastly under-reported (Briggs & Hawkins, 1995; Cermak & Molidor, 1996; Violato & Genuis, 1993; Watkins & Bentovim, 1992). Lamb and Edgar-Smith (1994), DeVoe and Faller (1999), and Gries, Goh, and Cavanaugh (1996) reported that proportionately more girls disclosed their abuse to an interviewer than did boys. The statistics outlined above are based upon official reports to child protective services and are undoubtedly a substantial underestimation of the true incidence and prevalence of CSA both in Ireland and Britain and, in fact, probably represent only the tip of the iceberg (Mordock, 2001).

There are several reasons for the underestimation in prevalence rates including the variation in the definition of CSA employed (Glaser & Frosh, 1993; Haugaard & Emery, 1989; Kelly, Regan, & Burton, 1995; Kempe & Kempe, 1984), the sample not being representative of the general public (The Research Team, 1990), methodological differences in data collection (interviews versus questionnaires), survey response rates (Haugaard & Emery, 1989), or the fact that sexual abuse is a social taboo and as such is underreported (MacFarlane, Waterman, Conerly, Damon, Durfee, & Long, 1988).

Disclosure

It is generally accepted that the crime constituting CSA is intertwined with the issue of “victim by secrecy” (Finkelhor, 1986; Glaser & Frosh, 1993; The Research Team, 1990), with only the victim and the perpetrator witnessing the crime, thus making it more difficult for the child to “disclose” the actual events. Fears of retribution and abandonment from the family, feelings of complicity, embarrassment, guilt, and shame all conspire to silence children and inhibit their voluntary disclosure of CSA. The fear of negative consequences of disclosure usually is particular salient in cases of incest, because children fear the abusing parent, relative, or sibling will be punished. Children also may fear that, by disclosing the abuse, they will create a disruption in the family (Lawson & Chaffin, 1992).

An additional factor is that it is difficult for the child to understand that the abuse is wrong when the perpetrator is a trusted member of the family. Consequently, children who are abused by a family member are more ambivalence about disclosing the abuse oftentimes because they have mixed feelings toward the perpetrator, including feelings of loyalty, injustice, guilt, trust, dependence, mixed up with the love and incomprehension. Empirical research suggests that 53% of children who are victims of interfamilial CSA never disclose the abuse (Arata, 1998; DiPietro, Runyan & Fredrickson 1997; Mian, Wehrspann, Klajner-Diamond, LeBaron, & Winder, 1986; Sas, 1993; Saunzier, 1989; Smith, Letourneau, Saunders, Kilpatrick, Resnick & Best 2000; Wyatt & Newcomb, 1990).

Because there is often little if any physical evidence of sexual abuse, intervention depends heavily on children’s voluntary disclosure (Saunzier, 1989). By not disclosing, children may be subjected to longer or repeated abuse and may not receive treatment for psychologically damaging sequel. Non-disclosure also precludes protection from further abuse, prevents the child from obtaining therapy, and may even put other children in danger of being sexually abused. Thus, sexually abused children face a serious dilemma in deciding whether or not to disclose. In the remainder of this paper we outline why much more research is needed on ways to help victims

of CSA to disclose and on identifying factors that may alleviate the tremendous pressures placed on children to maintain the silence so often associated with CSA.

Reasons for non-disclosure

There are various reasons children do not disclose abuse immediately, but one of the main reasons is that the abuse usually occurs at an early age and many victims of sexual abuse are too young to verbalise such information. Developmental factors, particularly cognitive limitations, may inhibit disclosure in young children (DeYoung, 1987; DiPietro, Runyan, & Fredrickson, 1997; Gries, Goh, & Cavanaugh, 1996; Keary & Fitzpatrick, 1994). For example, as concluded by Goodman-Brown, Edelsrein, Goodman, Jones, and Gordon (2003), young children's lack of sexual knowledge may hinder their voluntary disclosure of sexual abuse. Similarly, very young children and children with developmental delays have limited knowledge about societal sexual taboos, which may in turn inhibit their verbal reports.

Research suggests that interfamilial abuse is associated with increased perceptions by the child of at least partial responsibility for the abuse (Kendall-Tackett, Williams, & Finkelhor, 1993; Quas, Goodman, & Jones, 2003). Consistent with the notion of perceived responsibility, Hazzard, Celano, Gould, Lawry, and Webb (1995) reported that among female CSA victims, younger children were more likely to blame themselves for the occurrence of CSA.

Reasons why male victims of CSA are more reluctant to disclose abuse may include the stigma attached to being sexually abused by another male, for example, being labeled as "queer" or "homosexual" (Goldman, 2000), being stigmatised as a victim (Mordock, 2001), or in the case of a female abuser, that the unwanted sexual experience with an older female is something to be proud of. Additionally, medical findings are very often not as apparent in boys as in girls. If tears to the anal tissue do occur, they heal so rapidly (10-14 days) that there may be no trace of CSA when the abuse is finally disclosed (McCann, Voris, & Simon, 1992). Finally, the low incidence figures for male victims of CSA reported in the research literature and by legal and social organisations may also be attributed to the problem of definition highlighted above.

Recovered versus False Memories

The past decade has seen a proliferation of reports of childhood sexual abuse based on memories that emerge in adulthood (Melchert & Parker, 1997). However, there has been considerable controversy regarding the emergence of recovered versus false memories, and in particular the use of hypnosis to access and process such memories. Some argue that the prevalence of early CSA may be underreported because retrospective memories of early abuse can be dissociated or repressed from memory (Briere & Conte, 1993; Davies & Frawley 1994). Others believe that some childhood sexual trauma can be forgotten and emerge later in adulthood (Chaffin, Lawson, Selby, & Wherry, 1997; Herman & Schatzow, 1987; Williams, 1995).

For example, Feldman-Summers and Pope (1994) asked a national sample of psychologists whether they had been sexually abused as children and, if so, whether they had ever forgotten some or all of the abuse. Both sexually abused and non-abused subjects reported to have experienced a period of forgetting the events in their childhood. The most frequently reported factor correlating with recall of CSA was being in therapy. Approximately 50% of participants who reported forgetting also reported corroboration of the abuse, and reported forgetting was related to severity of the abuse.

There are those who contend that instances of delayed recall of traumatic memories are predominantly falsely remembered events (Wakefield & Underwager, 1992) which may be falsely created in response to various sources of suggestion, including books, the media, and some therapists who use highly suggestive memory recovery techniques such as hypnotic age regression and guided imagery (Bottoms & Davis, 1997; Lindsay & Read, 1995). For example, in surveys of certified therapists in the United States and Great Britain, 14.7% used techniques such as hypnosis and dream interpretation to help patients recall CSA. Harold (1996) states that it is important to recall memories of CSA for effective treatment. The assumption relating to patients who deny a history of abuse is that these patients have hidden memories of CSA.

Epstein and Bottoms (1998) reported that, prior to entering therapy, 31% of participants had only partial memories of abuse that existed before participating in any therapy. Three percent of participants had no memory of sexual abuse before entering therapy and subsequently recalled such memories during therapy.

Critics of repressed or recovered memory do not deny the possibility that actual abuse could be forgotten and then later recalled in adulthood. Instead, they argue that there is little scientific evidence supporting the classic psychoanalytic concept of repression (Lindsay & Read, 1994) and that common cognitive processes may account for forgetting and subsequent recall of childhood sexual abuse (Epstein & Bottoms, 1998). In fact, the validity of repressed memory theory has been questioned and the outpouring of memories has been considered as “false memory syndrome” (Yamini, 1996). For example, Ney (1995) argues that clients can be convinced that they have a memory of a traumatic event that never actually happened to them.

Both sides in this debate suggest that repressed or recovered memory is a wide spread phenomenon, with one side of the debate asserting that the recovered memories are genuine, and the other side maintaining that they are false. Neither of these two arguments is supported by scientific evidence. Research into recovered or repressed memory is still in its infancy, and therefore prevalence rates are unknown.

The clinical and legal implications of embracing false memories of CSA are serious. Individuals have come to believe that they have suffered terrible CSA that never actually occurred. Innocent individuals have been falsely accused of having perpetrated CSA and convicted of crimes they never committed. On the other hand, maligning the credibility of victims who actually experienced abuse and thereby contraindicating their clinical recovery and legal retribution is an equally troubling prospect. Professionals in the field of CSA must develop diagnostic procedures to minimize the likelihood of creating a false memory in CSA victims.

One of the most difficult problems for investigators of CSA is deciding whether or not a child's accusations are truthful. There are indications that false accusations of incest and other forms of sexual abuse by children are relatively rare, usually ranging between 2% and 8% (Corwin, Berliner, Goodman, Goodwin, & White, 1987; Everson & Boat, 1989; Goodwin, Sahd, & Rada, 1982; Jones & McCraw, 1987). However, others advocate that false allegations are relatively frequent (Benedeck & Schetky, 1987) leading most professionals in the field of CSA to treat accusations with suspicion.

The perception that memories of CSA are frequently fabricated is rooted principally in early Freudian theories. Initially, Freud thought that the origin of a variety of neurotic symptoms including hysterical neuroses could be traced to early sexual traumas experienced by young girls perpetrated by their fathers. By 1897, however, Freud renounced this “seduction theory” in favor

of “drive theory” and “Oedipal complex”. Many current psychoanalytic writers believe that Freud’s shift in focus from seduction theory to Oedipal theory served to minimise the role of actual CSA in the etiology of neurosis and psychopathology (Krull 1986; Lerman, 1988; Masson, 1984; Miller, 1984) and, in the early 1980s, a child-centered philosophy of “believe the child” or “children never lie” emerged (Faller, 1984; McCarty, 1981).

Today it is known that false allegations occur most often in the context of custodial or visitation-access disputes (Furniss, 1991; Ney, 1995). Everson and Boat (1989) assert that about one third of all reported allegations in a custody dispute context might be false. In cases where allegations are deemed false, they are more likely to emanate from adults or involve misinterpretations of the child, rather than deliberate fabrications (Berliner & Conte, 1993). It has been suggested that the rates of false allegations of CSA in custodial disputes have risen (Everson & Boat, 1989; Green, 1992; Jones & McGraw, 1987; Theonnes & Tjaden, 1990; Wood, Orsak, Murphy, Cross, 1996), however actual prevalence rates are unknown. These issues are accentuated if the child in question has special needs.

Special Needs

There is ample evidence that the prevalence of CSA is high for children with developmental disabilities and that these children constitute a particularly vulnerable group of people with regard to CSA (Dunne & Power, 1990; Brown, Stein, & Turk, 1995). It is difficult to know how prevalent abuse is among people with developmental disabilities because of the limited number of studies and the underreporting of abuse to proper authorities. However, in the last twenty years estimates have been substantiated that children with developmental disabilities are sexually abused at a rate 4 to 10 times higher than that of children in the general population, and prevalence rates vary from 3% to 70% (Baladerian, 1990). The difficulties in ensuring accurate disclosure and preventing false memories are heightened in special needs children and the percentage of false allegation rates made by people with developmental disabilities remains unknown (Ahlgrim-Delzell & Dudley, 2001).

As is true with the majority of CSA victims, the perpetrators of children with developmental disabilities are most likely to be family members or people known to and trusted by the victim, such as teachers, residential care providers, and aides (Baladerian, 1990). In fact, it has been reported that as many as 99% of perpetrators were well known to and trusted by their victims with developmental disabilities (Baladerian, 1990).

Children with developmental disabilities commonly have communication difficulties, leading to an increased vulnerability, and may be less able to defend themselves, have less knowledge about their own bodies and what may be considered as normal sexuality, and finally but most importantly, they may be dependent upon the abuser. These are circumstances that an adult may misuse, and thus severely developmentally disabled children constitute the real risk group (Hoggs, Campell, Cullen, & Hudson, 2001). Males with developmental disabilities appear to be more susceptible to abuse in general (Zirpoli, Snell, & Lloyd, 1987), whereas females with developmental disabilities appear to be more susceptible to CSA (Ahlgrim-Delzell, & Dudley, 2001).

Difficulties in disclosure may be attributed to several factors. First, the child may not be able to verbally communicate. Like all victims of CSA, children with developmental disabilities will give non-verbal signals when they have been a victim of CSA, such as loss of appetite, sleeping problems, crying, nightmares, rage or introverted behaviour. When such behaviour

occurs, caretakers of children with developmental delays generally link these to bullying, wrong medication, fear of future hospitalization, or even view the behaviour problems as 'symptoms' of the disability (Kvam, 2000). Consequently, sexual assault is not disclosed until it is much more obviously evident.

In 43% of cases involving disabled children, compared to 11% of cases involving non-disabled children close family and/or guardians knew about the abuse but did not acknowledge the sexual abuse because the child had a disability (Kvam, 2000). One reason for this may be that CSA may be regarded as less severe for a child with developmental delays and therefore is ignored for longer. However, there is ample evidence that psychological reactions of people with developmental disabilities are similar if not more pronounced than in typically developing children (Cruz, Price-Williams, & Andron, 1988; Tharinger, Horton, & Millea, 1990).

In CSA cases of children with disabilities who are in institutional care and who are abused by a care worker, institutions have at times tried to handle the situation "in house" (Kvam, 2000), for example, through job termination of the alleged abuser. Oftentimes no formal legal action is taken, the offender will leave the institution, and if no background checks are conducted, he/she can seek new employment in other institutions where they might perpetrate further abuse (Sobsey & Doe, 1991). As a result, rather than protecting children from CSA, some institutions are inadvertently perpetuating the problem of CSA.

Other reasons why CSA is not always reported may be lack of faith in the existing judicial system, the parents' or caretaker's belief that a trial would probably not lead to conviction, and therefore their decision not to further violate the child with a medical examination that may be necessary for criminal conviction. Kvam (2000) stated that :

...convictions of offenders were rare in spite of the chronic and severe nature of abuse... Ironically, many who fail to report abuse indicated that they lacked the faith in the justice system to secure convictions. This appeared to become a self-fulfilling prophecy, as crimes that go unreported cannot be punished. (p. 79).

Assessment Tools

Documenting that CSA has taken place can be extremely challenging, particularly when the current literature indicates that no specific syndrome exists among CSA victims (Berliner, 1991; Berliner & Conte, 1993; Lamb, 1994; Mannarino, Cohen, & Gregor, 1989). Not all sexually abused children show identifiable syndromes in reaction to their sexual victimisation (Finkelhor & Berliner, 1995) and many non-abused children show behaviours that are thought to be indicative of CSA (Kendall-Tackett, Williams, & Finkelhor, 1993). For example, Cohen and Mannarino (1988) and Mannarino, Cohen, and Gregor (1989) suggest that sexually abused children and children with psychiatric diagnoses but with no history of CSA show no significant differences in sexual behaviour (Cohen & Mannarino, 1988).

As reports of CSA have risen dramatically in the last two decades, tremendous attention has been focused on how professionals in the field of CSA evaluate allegations of abuse (Conte, 1992; Corwin & Olafson, 1993), which has subsequently lead to the development of a wide array of assessment tools. The most commonly used assessment methods include interviews (Berliner & Conte, 1993), medical examinations (Cantwell, 1983; 1987; Muram, 1989), human figure and family drawings (Hibbard & Hartman, 1990), the use of fables (Miller & Veltkamp, 1989a;b), the use of anatomically detailed dolls (Boat & Everson, 1988; Britton & O'Keefe, 1991; Jampole &

Weber, 1987; Kendall-Tackett & Watson, 1992; Lie & Inman, 1991; Sivan, Schor, Koepl, & Noble, 1988; Sirnkens & Reiner, 1996; White, Strom, Santilli & Halpin, 1986), direct observations of behaviour or behaviour check lists (The Research Team, 1990), and behaviour analytic procedures (McGlinchey, Keenan, & Dillenburg, 2000).

Interviews

The validity of information obtained in CSA interviews is currently an area of highly visible public, professional, and legal concern. It is generally accepted that a child's interview is a critical source of information (Lamb, 1994). In fact, many professionals believe the child's report is among one of best indicators in deciding whether or not abuse took place (Berliner & Conte, 1993; Conte, 1992; Lamb, 1994).

Assumptions that interview statements are always valid indicators of a history of CSA have been challenged (Rawls, 1994) and there are indications that a child's reports may be "suggestively induced" (Ceci & Bruck, 1993). A semi-structured interview approach is often the preferred method for assessment of children as they are quite flexible. Highly structured formats are inflexible and may not allow for the interviewer to accommodate developmental factors such as attention span and motivation (Wood, Orsak, Murphy, & Cross 1996).

Despite concerted efforts to avoid repeated interviewing in suspected cases of CSA (National Criminal Justice Reference Service, 2004), all too often children still are exposed to repeated questioning to elicit more detailed information. Repetitive questioning by law enforcement and social care professionals and concerned parents may significantly alter or distort a child's original story. Young children may come to believe that because they are asked the same questions repeatedly, their original answers were not correct and they should provide a different response. If so, changes in children's answers, resulting from the social demands of the interview situation, may negatively affect the consistency and accuracy of their reports (Mordock, 2001).

Perhaps the most serious challenge to the accuracy of children's reports of CSA involves the issue of suggestibility. While most experts agree that even young children can provide accurate experimental accounts (Berliner & Conte, 1993; Lamb, 1994, Keenan, McGlinchey, Fairhurst, & Dillenburg 2000), there is considerable evidence to suggest that children are highly susceptible. It is well documented that during certain interview conditions adults, especially those in authority can lead children to report highly persuasive accounts of fictitious events (Ceci & Bruck, 1993) especially between the ages of 4 – 9 years of age (Cole & Loftus, 1987). Young children when interviewed can be susceptible to social pressure to say what they think those in authority want to hear (Ceci, Ross, & Toglia, 1989; Myers, 1996).

Lepore and SESCO (1994) demonstrated how personal biases impacts on the assessment process. They reported that interviewers who were purposely misled about children's experiences prior to an interview elicited more inaccurate information from the children than those who did not receive inaccurate information. Based on the conclusions above, it is evident that interviews alone cannot be relied on as sole indicators of CSA.

Medical Examination

Considerable progress has been made in the last decade in the evaluation of the medical examination of children in suspected cases of CSA (Paradise, 1989). Regardless of this progress,

medical evidence exists in only a fraction of cases (Finkel & De Jong, 1994) providing conclusive evidence in less than 30% of cases (Adams, 1992). This makes CSA one of the most difficult crimes to detect and legally prosecute. Three studies of sexually abused children showed that 77% of CSA victims had normal or nonspecific medical findings. Even where there was strong evidence of vaginal penetration and in cases where the perpetrator had admitted to CSA medical evidence remained inconclusive (Muram, 1989; DeJong & Rose, 1991).

The Committee on Child Abuse and Neglect of the American Academy of Pediatrics (American Academy of Pediatrics, 1991) concluded, "The diagnosis of CSA is made on the basis of a child's history. Physical examination alone is infrequently diagnostic in the absence of a history and/or specific laboratory findings" (p. 256). Strong medical indicators of CSA include urinary tract infections, perineal bruises and tears, pharyngeal infections, venereal disease, and pregnancy in young adolescents. Physicians have recently expressed concern about the overemphasis on, and limitations of, the physical examinations in the detection of CSA (Sinal, Lawless, Rainey, Everett, Runyan, Frothingham, & Herman-Giddens, 1997). One major problem when using medical evidence as an indicator of abuse is that in most cases there are no physical signs, e.g., when the abuse involved touching, fondling, oral-genital contact, or rubbing of the hand or penis against the genital area.

Human figure and family drawings

Drawings have been used as assessment tools, interviewing aids or props, and communication tool in a range of clinical areas (Cohen-Liebman, 1995). Thomas and Silk (1990) found that a child's innermost feelings can be portrayed in drawings and that therefore drawings may be employed as an effective medium of communication. This can be especially true for children whose language is developmentally delayed (Veltman & Brown, 2001) and who therefore may not be able to describe in detail what has happened to them.

While several studies indicate a significant difference between sexually abused and non-abused children regarding the drawing of genitalia, very few sexually abused children draw genitalia. Waterman and Lusk (1993) found that only 7% of a sample of ritualistically abused children drew genitalia, although none of the non-abused children did so. Hibbard and Hartman (1990) reported no significant difference in the drawings of a sample of abused children compared to non-abused children and concluded that the drawing of genitalia is not conclusive for diagnosis CSA.

More recently, Butler, Gross, and Hayne (1995) reported that the opportunity to draw during an interview facilitated 3- to 6-year-old children's verbal reports of a past event up to one month later, especially in response to direct questioning. The effect of drawings on children's recall is not restricted to experimentally contrived events but has been shown to generalise to actual clinical contexts. Gross and Hayne (1998; 1999) found that 3- to 9-year-old children who were given the opportunity to draw and verbally report their emotional experiences reported more than twice as much information as children asked merely to verbally report their experience.

Hibbard, Roghman, and Hoekelman (1987) caution that drawings alone should not be over-interpreted and sexual abuse should not be inferred exclusively from drawings alone, specifically because conclusions derived from a child's drawings are based on the subjective interpretation of the individual assessor (Thomas & Silk, 1990). At best drawings should be used as a demonstration aid to facilitate verbal disclosure.

Fables

An alternative methodology that has yielded considerable clinical information has been the use of fables as a means of allowing the child to identify with a particular situation and to generate, through metaphor, their comprehension of the issues involved in stressful life events, such as CSA. As early as 1943, Despert first proposed the use of fables and incomplete stories to evoke children to disclose and talk about various affective themes (Miller, & Veltkamp, 1989a). Today, story-telling techniques are used as projective technique designed for psychiatric assessment of children and adolescents to determine areas of emotional conflict, including physical trauma and CSA (Miller, & Veltkamp, 1995). However, imaginative stories are open to misinterpretation and therefore cannot be used as a sole conclusive indicator in the diagnosis of CSA.

Family Dolls and Anatomically Detailed Dolls (*AD dolls*)

The use of family dolls and the introduction of role-play can enable the evaluator to assess the level and nature of interactions between the child and their parents or siblings (Miller & Veltkamp, 1989a; 1989b). Doll houses and family dolls are commonly employed in therapeutic interventions with CSA victims (O' Connor & Braverman, 1997). However, similar to the use of drawings and fables, interpretation remains problematic and renders assessment through family dolls insufficient for a diagnosis of CSA (Faller, 1984).

Anatomically detailed dolls are used extensively as assessment tools in CSA investigations. Recent work by Everson and Boat (1990) indicates that, in a sample of 223 children aged 2 - 5 years of age who were screened for the presence or absence of CSA, physical touching and exploration of AD dolls genitalia were common behaviours, occurring in over 50% of the sample. Six per cent of the sample demonstrated explicit sexual play in the form of apparent demonstrations of vaginal, oral, or anal intercourse, for example, penile insertion, sexual placement with what is described as "humping" motions, or "mouthing" a dolls genitals.

There are no clear evidence-based guidelines and no consensus among professionals regarding what constitutes normal, questionable, and abnormal doll play (Ney, 1995). While some view anatomically detailed dolls as a symbolic medium through which children can more easily communicate and re-enact events (Everson & Boat, 1994), others fear that exposure to anatomically detailed dolls will promote sexual fantasy and suggestibility (Ceci & Bruck, 1993; Mordock, 2001). Presently, the most reliable use of AD dolls is for demonstration of the child's knowledge of various body parts and to aid verbal disclosure more clearly. In short, there is no scientific evidence that suggests AD doll play provides reliable validity for detection of CSA.

Direct Observations and Behavioural Checklists

In response to the need to identify children who have been sexually abused, many professionals have employed the use of traditional assessment methods, which use behavioural signs that are apparently indicative of sexually abused children. A broad range of behavioral symptoms that have been identified as indicators of sexual abuse in children, include sleep disturbances, nightmares, enuresis, depression, frequent bathing, crying with no provocation, staying indoors, anxiety, and regressive behaviours such as, finger sucking or clinging (Ney, 1995). While these behaviours may well be associated with children who have been sexually victimised, they are common behaviours in children who have experienced general stress or trauma rather than specifically CSA.

The one behavioural sign that may be of some discriminative value in CSA investigations is inappropriate sexualised behaviour. Empirical research suggests that children who have been sexually abused often show an increase in their sexual behaviours (Deblinger, McLeer, Atkins, Ralphe, & Foe, 1989; Friedrich, 1993; Friedrich, Beilke, & Urquiza, 1988; Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991; Gale, Thompson, Moran, & Sack, 1988; Kolko, Moser, & Weldy, 1988; White, Halpin, Strom, & Santilli, 1988). Poole and Lindsay (1998) concluded the following:

While the sexually abused children studied exhibited significantly more indicators of emotional and behavioral disturbance that did comparison groups of 'normal' children, when compared to non-sexually abused children receiving psychiatric services only one discriminating variable emerged. These studies empirically support the growing impression among clinicians that overt sexual behaviour, inappropriate for age, is an indication of sexual abuse. (pp. 488-489)

Overtly sexual behaviour includes open and compulsive masturbation, precocious sex play, sexualised play with dolls, seductive behaviour and age-inappropriate sexual knowledge (Dubowitz, Black, Harrington, & Verschoore, 1993; Chaffin, Lawson, Selby, & Wherry, 1997; Gale, Thompson, Moran, & Sack 1988; Wells, McCann, Adams, Voris, & Ensign, 1995). Sexual aggression, that is, coercing others to repeat and re-enact the sexual victimisation, is considered to be among the most salient indicators of CSA (Cosentino, Meyer-Bahlburg, Alpert, Weinberg, & Gaines, 1995; Friedrich, Beilke & Urquiza, 1988; Gale, Thompson, Moran, & Sack, 1988; Kolko, Moses, & Weldy, 1988; Yates, 1991).

The Children's Sexual Behavior Inventory (CSBI) (Friedrich, Grambsch, Broughton, Kuipers, & Beilke, 1991) reflects an attempt to clearly define and operationalise sexualised behaviour so as to allow for a discrimination between sexually abused and non-abused children. Friedrich and colleagues used this inventory with a sample of 276 children (aged , 2-12 years) with a confirmed history of CSA and a sample of 880 non-abused children of the same age. Friedrich (1993) suggested that the CSBI demonstrated greatest sensitivity for classifying sexualised behaviours in 2-6-year old males (0.92), and the lowest overall sensitivity for 7-12 year-old females (0.70), who had a confirmed history of CSA. Behaviours such as "puts mouth on sex parts, asks to engage in sex acts, masturbates with object, inserts object in vagina/anus, imitates intercourse, imitates sexual sounds, and French kisses" were among some of the more powerful discriminating behaviours (Friedrich, Eeilke, & Urquiza (1988). Cash (2002) examined the frequency of sexual behaviour among a sample of preschool children and confirmed that levels of sexualised behaviours on the CSBI as well as levels of sleep disturbance significantly differentiated "probably abused" from "probably not abused".

The CSBI represents a promising line of research however, like other traditional diagnostic indicators of CSA, it is difficult to draw firm conclusions. As noted by Lamb (1994), familial and cultural factors may influence what is defined as sexualised behaviour, thus making it extremely difficult to define a standard for what constitutes overtly sexualised behaviour. Exposure to certain television shows may be responsible for the presence of sexualised behaviour rather than direct sexual victimisation. In conclusion, while the presence of inappropriate sexualised behaviour in children may provide some evidence that CSA has occurred, and may point to a need for further investigation it cannot be relied upon solely in the diagnosis of CSA.

Behaviour Analytic Procedures

Inspired by Rawls (1994), Keenan and colleagues (McGlinchey, Keenan, & Dillenburger, 2000; Keenan, McGlinchey, Fairhurst, & Dillenburger, 2000) initiated the development of behaviour analytic procedures that avoid a range of the problems with traditional diagnostic procedures. Their work builds on procedures developed within the stimulus equivalence paradigm (Sidman & Tailby, 1982) that have been used to explore complex behaviours such as concept development (McGuigan & Keenan, 2002) and creativity (McVeigh & Keenan, 2002). In general, these procedures entail training participants using a matching-to-sample discrimination procedure and then testing responses to new combinations of stimuli. The general logic of the procedures can be seen in a related study by Watt, Keenan, Barnes, and Cairns (1991). Although not a study on CSA, the procedure was designed to address a question that is relevant to the goals of assessment in CSA. Put simply, the study investigated whether it was possible to distinguish between two groups of subjects in terms of prior social learning. Participants were trained to match three traditionally Northern Irish Catholic names (stimuli A1, A2, & A3) to three 3-letter nonsense syllables (stimuli B1, B2, & B3), and subsequently to match these nonsense syllables to three traditionally Protestant symbols (stimulus C1, C2, & C3). When arbitrary stimuli are used in match-to-sample training like this the result is the establishment of three 3-member equivalence classes (i.e., A1B1C1, A2B2C2, & A3B3C3). In the Watt et al study, however, there was a departure from the traditional equivalence assessment procedure. Normally the stimuli from class C would be used as samples and the stimuli from class A only would be used as the comparisons from which a selection is made. During their equivalence testing phase, Watt et al presented participants with Protestant symbols (class C) as the sample stimuli but the comparison stimuli were two of the Catholic names employed during training (class A) and novel Protestant names (N1, N2 or N3). The inclusion of socially loaded stimuli as novel stimuli in the testing procedure disrupted equivalence responding in twelve of the nineteen Northern Irish subjects; they selected the novel Protestant stimuli (either in N1, N2, or N3) in the presence of the Protestant sample stimulus (C1, C2, or C3 respectively) instead of the expected A1, A2 or A3 stimuli. In other words, these participants failed to demonstrate the expected laboratory-induced equivalence responding. In contrast, all of the English subjects responded equivalently by selecting the Catholic names in the presence of the Protestant symbols. The general conclusion from this study is that pre-experimentally established social relations were incongruous with the experimentally induced discriminations and thus controlled participants' performance on the equivalence test. These results have been replicated using a number of different social experiences and participants, including children (McGlinchey & Keenan, 1997).

McGlinchey, Keenan, and Dillenburger (2000) argued that using the logic of Watt et al's study "it might be possible to differentiate between abused and nonabused children by examining the extent to which normal equivalence responding can be disrupted by [the inclusion of] socially loaded stimuli" (p. 729). Keenan, McGlinchey, Fairhurst, and Dillenburger (2000) continued this line of research and were able to increase the accuracy in verbal reporting of social experiences. This is a promising line of research, not only because it might lead to reliable diagnostic tools in the area of CSA, but also because it uses well established conceptual foundations related to learning, thus offering parsimony for the development of screening procedures for CSA. In effect, this line of research calls for a return to more basic experimental investigations aimed at assessing the extent to which we can discriminate between children based on prior social experiences. If we can control those experiences, then we should be able to develop assessment procedures that map on to those experiences. This is precisely the goal in the development of screening tests for CSA. What makes it difficult, though, is that the assessment protocol must be designed in a context where we don't know which stimuli are the appropriate stimuli to use. The varieties of abuse and the varieties of locations in which the abuse may have taken place present a significant challenge to the whole endeavour.

Conclusion

Concerns about accuracy of allegations have resulted in an increased interest in the reliability and validity of the CSA assessment process (American Professional Society on the Abuse of Children (APSAC), 1995; Faller, 2003). Inaccurately assessed allegations have serious repercussions for the individuals involved (Bradley & Wood, 1996). Victims of CSA who have been abused may not be taken seriously and may continue to be subjected to abuse and thus exposed to additional unnecessary psychological trauma (Brown, Palmer, and Rae-Grant, 1994; Robin, 1991). It has been said, that one of the biggest factors in false allegations, has generally been the lack of expertise and training of those professionals assigned to conduct the investigation and interview. (Ney, 1995, pp. 27-28).

In response to this it could be argued that investigators must be adequately trained if the systemic response to child abuse is to be effective (Ney, 1995). However, this solution only makes sense if we have effective screening procedures.

In this paper we have highlighted the fact that the key issue in the diagnosis of CSA is that as yet there is no generally accepted, scientifically valid way to determine whether an abuse report is true or false. While traditional assessment methods continue to be used as indicators of abuse, none are conclusive in their utility to reliably diagnose CSA (Berliner & Conte, 1993; Lamb, 1994; Goodman, Emery, & Haugarrd 1998). This point was eloquently expressed by Poole and Lindsay (1998):

The clinical assessment processes which have been used in assessing allegations of sexual abuse have regularly and ambitiously raced ahead of the experimental and empirical foundations which would warrant their use as valid, and reliable methods. (p.15).

Clearly what is needed is the development of covert assessment procedures that are reliable and unintrusive, and that at the same time do not falling prey to the problems associated with traditional assessment methods. This is a difficult research challenge but one that will reap enormous benefits for all concerned.

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