Nottinghamshire and Nottingham City
Safeguarding Children Boards
Multi-Agency Practice Guidance

Sexual Abuse of Children and Young People

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Contents

Index		Page
1	Introduction	04
2	Identification and Impact	06
3	Acting on Concerns	10
4	A Theoretical Framework for Understanding Sexual Abuse	16
5	Supporting Survivors of Sexual Abuse in the Long Term	19
6	Children and Young People who Sexually Harm	20
7	Assessing Parental Responses to Child Sexual Abuse	23
8	Adults who Sexually Abuse	25
9	Professional Issues when Working with Sexual Abuse	28
10	Frequently Asked Questions	30

Appendices:

A	Decision making in the degree of concern attached to the behaviour of 5-10 year olds – Tony Cavanagh Johnson	32
B	Suggested responses to adolescent sexual behaviour work – Ryan and Lane (1991)	35
C	Sentencing Options for adults who sexually abuse	37
D	References	40
E	Reading List	41
F	Resources	42

Chapter 1
Introduction

1.1 The purpose of this practice guidance is to provide information for staff in all agencies to help them to recognise the warning signs of sexual abuse, to clarify what action should be taken and to build their confidence to do something about it.

1.2 This guidance should be read in conjunction with the "Inter-agency Guidance on the Assessment of Children In Need and the SCB's Child Protection Procedures"

1.3 The definition of sexual abuse in the SCB's procedures reads:
"Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery, or oral sex) or non-penetrative acts. They may involve non-contact activities, such as involving children in looking at, or in the production of pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways."

1.4 Historically there has been significant denial within societies surrounding the sexual abuse of children.

1.5 Sexual abuse knows no barriers. It can happen in all cultures and communities and is not acceptable in any. It can happen to all children regardless of race, culture, gender, class or disability.

1.6 Equally, perpetrators come from all backgrounds including those in a professional or trusted role (see SCB Procedures).

1.7 Some children are abused and exploited for commercial gain e.g. children involved in prostitution, the production and use of abusive images of children; the use of the internet both to produce and distribute abusive images or as a means to contact and groom children; and the trafficking of children for sexual exploitation. These forms of commercial sexual exploitation are dealt with in separate practice guidance (the Tip of the Iceberg Nottinghamshire County SCB and Safeguarding Children from Sexual Exploitation- Nottingham City SCB).

1.8 Child sexual abuse often happens in secret and most victims tell no one. It is reported that eight out of ten victims know their abuser. The abuser is usually a family friend, neighbour, a member of the child's family or someone working with children: he or she may be someone the child knows and loves.

1.9 People who abuse children are often very skilled at building trust with the child and their parents or carers, and abuse may take place for years with no one being aware of it. Because children are rarely able to tell about abuse we, as adults, need to protect them.

1.10 However, recognising the behaviour of people who sexually abuse children is not easy, either because we do not know what to look for or because our suspicions are so disturbing that we push them to the back of our minds.

1.11 It is only in recent years that we have come to appreciate the true scale of sexual abuse of children. The secrecy surrounding child sexual abuse is evident in that it is estimated that only a quarter of children who are sexually abused tell somebody about it. Of those who do report the abuse they are experiencing, most tell a family member or friend. Not all of these come to the attention of professionals in the first instance.

1.12 The harm which sexual abuse causes to children can be profound, not just to their emotional and physical development, but to their trust in adults, especially if their abuser is someone they love. The sooner the abuse is identified and the child is effectively safeguarded, the sooner the healing process can begin. Professionals from all agencies can be involved in supporting the family and safeguarding the child.

Chapter 2
Identification and impact

2.1 Sexual abuse involves physical, emotional and intellectual abuses of the child. It is characterised by betrayal of sexual innocence and trust, fear, silence and deception. Identifying sexual abuse is a challenging task for workers in a society that continues to deny its occurrence.

2.2 Children and young people you are working with may tell you that they are being sexually abused or they may show signs that they are currently, or have in the past, experienced sexual abuse. Children may not talk about being sexually abused for many reasons.

2.3 Practitioners should be mindful of the additional vulnerabilities of disabled children who may be more vulnerable physically and may have greater difficulties communicating with adults about the abuse.

2.4 Working Together (DfES 2006) states that:
"Disturbed behaviour including self-harm, inappropriate sexualised behaviour, sadness, depression and a loss of self esteem, have all been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism or bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and his or her feelings of self worth."

How Does Sexual Abuse Occur?

2.5 The following paragraphs describe elements that are common to patterns of abusive behaviour but are by no means exclusive of others.

Engagement or Entrapment or Grooming

2.6 The abuser initiates contact, offers something 'positive' to the child, which can include emotional rewards and which is later used as a reward/bribe etc. This is a planning stage for the abuser- but the child may not be aware that anything is wrong.

Sexual Interaction

2.7 The abuser begins some form of sexual activity – usually progressing from mild to serious forms – which may include:

- Showing pornographic images
- Kissing/touching
- Undressing
- Masturbation
- Oral sex
- Rape

Secrecy

2.8 Once the abuse has begun the adult often imposes secrecy with threats that can keep children quiet until adulthood or all their lives. These can include that:

- They won't be believed
- They or family or friends will get hurt
- The family will break up
- The abuser will kill themselves etc.

Disclosure

2.9 Under certain conditions a child may disclose or the abuse may be discovered. All disclosures result in a crisis because of threats about the secret getting out and because of the actual consequences of disclosure for family members.

2.10 **Suppression**
If family members dismiss the story or blame the child the disclosure may be withdrawn and the child may remain fearful of the abuser – or support the abuser.

Identification of child sexual abuse

2.11 Sexual abuse can impact on children in many different ways, both in the short and long term.

2.12 Some of the ways that children survive sexual abuse can become like habits that are hard to break, even when the abuse has stopped. They can be seen as ways that children may try to get some control over their life. These may include:

2.13 **Physical Symptoms:**

a) Stress related: headaches, digestive disorders, skin problems, menstrual problems, sexual problems, weight loss/gain.
b) Sleep problems – a lot/not enough/nightmares.
c) Eating problems – anorexia/bulimia/binge eating.
d) Substance/alcohol misuse.

2.14 Sexual abuse may occur with physical abuse and should always be considered, particularly where there is:

- bruising around the knees, thighs or genital area
- bite marks on the breasts and abdomen may suggest sexual abuse, as may signs of trauma in the mouth.
- pregnancy in a child, or a sexually transmitted infection is very likely to indicate sexual abuse.

The following symptoms **can** occur in sexual abuse, but also have many other medical causes. A medical opinion should be sought to try to determine the possible cause:

- Vaginal bleeding
- Vaginal discharge (although this is common in children)
- Anogenital warts
- Vaginal itchiness/ soreness
- Rectal bleeding.
- In boys penile discharge, bleeding or rectal bleeding.

2.15 **Emotional Symptoms**

a) Depression
b) Dissociation
c) Flashbacks and associated distress
d) Feelings of powerlessness
e) Fearfulness/anxiety
f) Need for control / anger or angry behaviour.

2.16 **Intellectual impact**

a) Negative messages about themselves – low self worth, guilt, indifference, powerless.
b) Negative messages/learnt responses to men/women/families/sex/love.
c) Dissociation/stress related concentration problems/memory loss.
d) Poor school attendance/truancy/ deterioration in attainments.

2.17 **Behavioural signs**

a) Prostitution, promiscuity/sexual avoidance.
b) Running away/risk taking behaviour.
c) Lying/secrets.
d) Hurting others physically or sexually.
e) Self Harm

2.18 **Social issues**

a) Attachment issues – fear of intimacy, dependency.
b) Role reversal as the child meets adult needs.
c) Lack of trust.
d) Anticipated victimisation in relationships.
e) Withdrawal from social interaction.
f) Challenging behaviour creates peer problems/school problems.

2.19 **Dissociation**: describes a way that children and adults can cope with serious trauma. It is a psychological way of the mind cutting itself off from an intolerable experience and can be understood as a survival strategy. The effects of this behaviour can include:

- The child denying experiences that have happened.
- The child appearing to be in a trance or day dream.
- The child being unusually forgetful, loses things or gets lost.
- The child experiencing rapid changes in behaviour, personality and abilities.
- The child talking to him/herself as 'she or he' or use different names.
- The child appearing to have two or more personalities or may have imaginary friends who s/he says are responsible for things that s/he has done.

Sexual Development

2.20 Sexual exploration is part of the normal developmental process for most children. In the main, children should be supported to develop age appropriate sexual behaviours.

2.21 However, there may be other behaviours that may indicate that the child or young person has been or is being sexually abused or is at risk of sexual abuse.

2.22 Children whose behaviour falls into concerning categories will need to be referred to LA children's social care in order that it can be considered whether an assessment needs to be carried out or any appropriate protective action taken in accordance with the SCBs Procedures. See also SCB Practice Guidance on Safeguarding Young People at Risk of Sexual Exploitation/the Tip of the Iceberg.

2.23 The following table contains a guide on sexual development. Appendix A offers more detailed guidance on normal and sexually deviant behaviours across developmental ages.

Age range	Developmental tasks	Sexual behaviours	Concerning sexual behaviours associated with traumatic sexualisation
Pre-school 0-5 years	Curiosity, physical exploration of self and environment	Masturbation, looking at and touching others' bodies	Excessive or compulsive masturbation. The child cannot be distracted. The behaviour is associated with distress or aggression
Primary School 6-10 years	Social activity and games with peers. Intellectual interest in self, others and environment	Masturbation, looking at others' bodies, sexual exposure of self to others, sexual fondling of peers or younger children in play.	Excessive or compulsive masturbation. The child does not respond to the social rules around masturbation. Sexual preoccupation. Initiating sexual activity, i.e. sexual exposure of self or sexual fondling with much older children or adults. The behaviour is associated with distress
Pre-adolescence 10-12	Developing a sense of individual identity and independence. Forming and maintaining friendships	Masturbation, sexual exposure and fondling with peers. Growing sense of self as sexual being growing sexual interest in others (same and opposite sex)	Not responding to social rules around masturbation. Initiating sexual activity: • outside peer group or where obvious power imbalance exists • With sadistic or ritualistic elements • Associated with distress or aggression • Sexual preoccupation or compulsive sexual behaviour
Adolescence 13-18	Developing individual and social identity. Practising intimacy with peers "falling in love"	Masturbation, simulated adult sexual behaviours with others (same and opposite sex) Penetration and intercourse.	Excessive or compulsive sexual behaviours. Self neglecting sexual behaviours. Involvement in sexual activity: • where obvious power imbalance exists including prostitution • With sadistic or ritualistic elements • Associated with distress or aggression

Chapter 3
Acting on concerns

Consent and Confidentiality

3.1 It is usually expected that prior to sharing information between agencies, including making a referral to LA children's social care, wherever possible a professional will discuss their concerns and the action they plan to take with the parents unless there is a suspicion they are perpetrating or supporting the alleged abuse.

3.2 In the case of concerns about young people it would also be expected that wherever possible the young person would be informed about the action the professional intends to take.

3.3 However, this may not always be appropriate in the case of sexual abuse as this may jeopardize subsequent Police/LA children's social care investigations as:

- One of the parents may be the perpetrator of the abuse and may therefore have the opportunity to dispose of forensic evidence or interfere with witnesses
- The parents may know the perpetrator and may alert them to what the child has said.

3.4 As a result agencies are advised not to discuss the referral with parents prior to contacting LA children's social care unless it is clear that they are not the perpetrator or are not implicated in any way. Subsequent discussions should identify the earliest opportunity for informing the parents and the person who is most appropriate to undertake this task.

3.5 If a child has medical symptoms that may be suggestive of sexual abuse, but there has been no disclosure, the Paediatrician on call for child protection is available for advice and should be contacted via the named nurse, child protection office or hospital switchboard.

Identifying Concerns

3.6 Children may be exposed to the risk of being sexually abused as a result of concerns about adults whom they have contact with. This includes:

- Parents being convicted for sexual offences, particularly against children
- Parents having connections with people with sexual offences against children, especially in the extended family
- There having been previous allegations of sexual abuse by the child or others regarding adults who the child has contact with
- Parents accessing indecent images of children on the internet
- Additional relevant factors from a parent's background or current behaviour.

3.7 Working Together (DfES 2006) states that:

"A proportion of adults who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic violence and discontinuity of care. However, it would be quite wrong to suggest that most children who are sexually abused will inevitably go on to become abusers themselves"

3.8 If any agency identifies any information to indicate any of the above they should inform LA children's social care in order that the concerns can be assessed and decisions made to ensure that the child is adequately safeguarded.

3.9 Race and culture will be a significant context to children's experience of sexual abuse. Racism and discrimination will affect a child's ability and choices about communicating about abuse, including issues such as loyalty to family and community, and fear/mistrust of white authority and issues around immigration status.

3.10 Similarly, disability will be a significant context of a child's experience of sexual abuse. It may increase vulnerability in terms of;

- A child being dependent on others for physical care
- A child's reliance on specific forms of communication
- Misconceptions and prejudices about behaviours and physical relationships of disabled children.

Allegations from Children and Young People

3.11 For many reasons outlined in chapter 2 children can find it very difficult to tell someone directly about the abuse they are experiencing. However, there will be times when children tell professionals who are working with them that they are being sexually abused and it is important that professionals are confident about how to respond.

3.12 It may be that the child is talking about sexual abuse that occurred to them sometime previously and from which they have now been safeguarded. This could be established from the agency's records or by consulting with LA children's social care.

3.13 If this is the case then you are free to allow the child to speak and to support them in the process of recovery. Important things to consider are:

- Are you certain that the child is not making a new allegation?
- Why is the child talking about this now?
- What would they like from you?
- How can you make the time to listen?
- Are you the right person to support them with these issues or can you identify a more appropriate person?
- Focus on reassuring the child that they are doing the right thing by talking about what has happened.

3.14 It maybe, however, that a child is communicating for the first time that they have or are being sexually abused or are making a new allegation.

3.15 In this case it is important that you respond to them in ways which:

- Reassure the child that they will be supported
- Are clear about with whom you will have to share the information.
- Help them to understand what will happen next
- Do not jeopardize any subsequent child protection investigation or criminal investigation.

3.16 Children may hint at what is happening to them to see how you respond before they decide whether or not to tell you more, and there may be a need to clarify what they are telling you.

3.17 Inquire into what the child is telling you but do not keep revisiting it, e.g. by way of a number of different staff members. **It is important not to cross-examine the child about what they are telling you.** If a decision is made that the child needs to be formally interviewed by police and LA children's social care as part of a joint investigation the child will have to repeat everything.

3.18 Allow them to give you sufficient detail so that you can determine what to do next, but **do not interrogate** (such as by asking who/what/where/when/how questions) **or use leading questions** (is/has) that could be interpreted later as having put ideas into the child's head.

3.19 As soon as reasonably practicable, ideally the same day, make a note of what the child has told you verbatim and date and sign the record. If appropriate involve the child/young person in this with you to confirm an accurate record of what they have told you. It is important to record what the child says and not your interpretation.

3.20 The important thing is to stay calm and reassuring so that the child doesn't interpret your response as disbelief or anger. Ensure that you offer the child support but do not be unrealistic about the role you will play.

3.21 Some helpful things to say to the child may include:

- It was brave of you to tell me
- I am sorry that this has happened, you've done really well to tell me about it
- This has happened to lots of children, some never tell and keep it a secret, you were very brave to tell
- Are you worried about what will happen now you have told me?
- We will have to tell someone else about this, there are people who have special jobs to help children when this happens.

When Children Disclose to Parents / Carers

3.22 Children may choose to tell a parent that they are being sexually abused and in turn the parent may seek help and support from a professional in any agency. The professional must inform the parent of the need to take further action by notifying LA children's social care in order that the matter can be fully investigated and the child, as well as any other children who may be at risk, effectively safeguarded.

Responding to Concerns about Behaviour

3.23 Professionals often become concerned from the behaviours a child may be exhibiting that they are being sexually abused.

3.24 When this occurs, in the absence of the child making a clear disclosure of abuse, it is often difficult to know what action should or could be taken next.

3.25 The following can assist with decision making in these cases:

- How serious is the child's behaviour? Does it indicate that the child is at risk of significant harm (e.g. involving themselves in sexual exploitation, self harming behaviour, crime, going missing, drug use or other serous risk taking behaviour) such that child protection procedures should be followed and a referral made to LA children's social care

- Does the child's behaviour indicate that they may be a child in need, i.e. is their health and development being significantly impaired, such that an assessment should take place
- Would the child benefit from other support services that can be accessed by the person who identifies the concern.

3.26 In order to determine whether the above actions are appropriate it is important to:

- check agency records to establish what information is known about the child and their family
- speak to other colleagues within the agency who are working with the child and may also have concerns
- keep careful records of the child's behaviour in order to identify patterns or changes
- ensure that the child has access to someone whom they appear to trust and appear comfortable talking to
- seek consultation from another agency that has expertise in this area (e.g. NCH No28 sexual abuse project).

3.27 Children should not normally be asked directly whether or not they have been or are being sexually abused as this will jeopardize any criminal investigation. There are occasions, however, when it might be appropriate, as a result of a child's behaviour being of such great concern to consider asking them directly whether they are being sexually abused. This decision should only be made by the police and LA children's social care, taking into account the views of other agencies.

3.28 If sexual abuse is confirmed or suspected referral should be made to LA children's social care immediately in order that they can begin enquiries and consider the need for an investigation under Section 47 of the Children Act 1989

3.29 Where there is reasonable cause to believe that significant harm has taken place LA children's social care will arrange a strategy discussion to plan the subsequent enquiries to include:

- How the child will be interviewed
- Whether a medical is needed
- When the parents will be informed.

Medical examination of children and young people who may have been sexually abused.

3.30 Medical examinations are usually done at the request of the Police and LA children's social care as part of a Section 47 enquiry. They should be performed by experienced staff, who are trained in the examination of children and in forensic examination. In Nottingham and Central Notts, these examinations are performed jointly by Senior Paediatricians and Police Surgeons, available 24 hours on call. (see SCB procedures) The discussion about whether an examination is indicated and its timing should include the paediatrician and / or the forensic examiner where there is uncertainty about whether a medical examination is indicated, such as when a referral has been made by a doctor following an examination finding, the Police and / or LA children's social care should seek advice from the paediatrician on call for child protection.

3.31 The purpose of the examination is to provide any medical treatment and health advice that may be required for the child and also to provide a Forensic report for the Police. The examination will involve a careful history and examination. Good practice requires a permanent record (still photographs or video) of the genital/ anal findings to be made. Ideally the examination should follow the video interview.

3.32 If there is a likely risk of sexual abuse then it is important to exclude sexually transmissible infections and possibly give hepatitis B vaccinations or even HIV post exposure prophylaxis in an acute situation when this is deemed appropriate.

Supporting Parents / Carers Following Disclosure

3.33 Finding out that your child has been abused is a traumatic experience for parents. Parents will respond in a variety of ways depending upon the context of the abuse and their own coping strategies. A parent's response to disclosure or discovery is crucial to the child's well-being and recovery.

3.34 Most parents are shocked and upset and act immediately to protect their children from further harm. However, if the abuser is within the family and there are established attachments to them the trauma and personal cost for the non abusing parent can be significant and affect their ability to respond in the best interests of the child.

3.35 Where a child has talked to their parent about the abuse the parent needs to be advised to:

- Stay calm, control their own feelings and aim to comfort, soothe and reassure their child
- Remain consistent with discipline and routine
- Allow the child to talk about the abuse if they need without cross examining them in any way.

3.36 Professionals working with the family should be mindful of the need to support parents following such disclosures. Disclosing abuse may bring heightened risk to the child.

Speaking to children about the abuse.

3.37 It is often the case that the police may wish the parent not to speak to the child about the offence prior to the video interview and trial. However, parents should be advised to allow the child to speak if the child needs to but not to cross examine them about what has happened, only to respond in a matter of fact way that reassures the child that they have done the right thing, that they are safe now and what will happen next.

3.38 If the case does not proceed to court, attention must be paid to how the young person is informed.

3.39 The Young Witness Support Project offers support and preparation for young people attending court.

3.40 A local protocol confirms that children can receive therapy prior to a criminal trial but any decision about this must be made by CPS and the police in conjunction with LA children's social care and /or the therapist as such therapy could impact on the criminal trial.

Complex or Organised Abuse

3.41 Complex or organised abuse can occur both as part of a network of abuse across a family or community, and within institutions such as residential homes or schools. Such abuse can be profoundly traumatic for the children involved and the investigation of complex abuse can be time consuming and require specialist skills.

3.42 Working Together (2006) defines complex (organised or multiple) abuse as: "abuse involving one or more abusers and a number of related or non related abused children and young people. The abusers concerned may be acting in concert to abuse children, sometimes acting in isolation, or may be using an institutional framework or position of authority to recruit children for abuse."

3.43 Where any professional suspects a complex abuse situation a discussion must take place with LA children's social care in order that a strategy meeting can be considered.

3.44 Each investigation of complex abuse will be different, according to the characteristics of each situation and the scale and complexity of the investigation. Each situation requires thorough planning, good inter-agency working and attention to the welfare needs of the child victims or adult survivors.

Historical Abuse

3.45 Cases of abuse may come to light a long time after the event. However, they may raise concerns as a result of the alleged victim still living in the setting where the incident occurred or the alleged perpetrator still being linked to the setting or employment role or otherwise being in contact with children.

3.46 Where any professional learns of abuse that has taken place historically, which doesn't appear to have been investigated or which indicates that children may currently be at risk, LA children's social care or the police should be contacted in order that enquiries can be carried out and any relevant child protection or criminal aspects pursued.

Abuse Using Information and Communication Technology

3.47 A child may talk about something they have seen or have been involved with on their computer/television at home that indicates they have been exposed to indecent images of children or that they know of the existence of such material at home.

3.48 In this event the Police should be contacted immediately, without the parents being notified, in order that this can be investigated.

3.49 The Police will contact LA children's social care in order that an assessment of the children can be undertaken.

Chapter 4
A theoretical framework for understanding sexual abuse

4.1 Angela Brown and David Finklehor's 'Traumagenic Dynamics' model offers a way of understanding the impact of childhood sexual abuse. They describe four elements:

- Traumatic Sexualisation
- Stigmatisation
- Betrayal
- Powerlessness

4.2 Below is an outline of how the model can be used to understand children's experience of and responses to sexual abuse. The **dynamics** section outlines how sexual abuse works and what the abuser does; the **psychological impact** section lists possible ways a child is affected by this abuse; the **behaviour section** offers some of the things you may observe children and young people doing as a consequence of the above.

Traumatic Sexualisation

4.3 A child's normal sexual development is inappropriately shaped and their normal behaviour may become sexualised by the experience of abuse.

Dynamics

4.4 The abuser exchanges attention and/or affection for sex;
The abuser transmits misconceptions about sexual behaviour and sexual morality;
The abuser rewards the child for sexual behaviour inappropriate to their developmental level;
The abuser sexually distorts the child's healthy need for love and care;
Family, community and society eroticise children (explicitly expressed through child pornography and the cultural sexualisation of children) and withhold appropriate sex education.

Psychological Impact

4.5 The child becomes inappropriately aware or preoccupied with sexual issues;
The child associates sexual or intimate activity with negative memories and feelings;
The child confuses giving and receiving love and care with sex;
The older child or adolescent experiences confusion about sexual identity and sexual norms.

Behaviour

4.6 Any sexual behaviour outside the range of normal sexual development:

- Sexual preoccupation or compulsive sexual behaviour
- Aggressive sexual behaviour
- Seeking attention through sexualised talking, touching and invitations to touch
- Self neglecting sexual behaviours.

Stigmatisation

4.7 A sense of shame and responsibility is communicated to the child through the experience of sexual abuse and is then compounded by negative responses from family, community and society.

Dynamics

4.8 The abuser explicitly denigrates the child;
The abuser directly blames the child for the abusive acts;
The abuser tricks the child into feeling responsible for the abuse – as an active or passive participant;
The abuser pressurises or tricks the child into keeping the abuse a secret;
The abuser keeps the child isolated from peers.

4.9 The family or community reacts:

- With shock and disbelief
- By blaming the child
- By stereotyping the child as damaged goods
- By reinforcing the secrecy.

Psychological Impact

4.10 The child feels bad, dirty, guilty, ashamed and abandoned;
The child experiences a sense of difference from others, especially peers;
The child develops a negative self image and low self esteem;
The child experienced themselves as damaged or unworthy.

Behaviour

4.11 The child isolates themselves from others;
The child harms themselves;
The child attempts suicide;
The older child or adolescent uses alcohol or drugs excessively;
The older child or adolescent becomes involved in criminal activity

Betrayal

4.12 An adult purposefully violates a child's needs, expectations and trust of adult care.

Dynamics

4.13 The offender manipulates the trust and vulnerability of the child;
The offender violates the child's expectation that adults will provide care and protection;
The offender looks out for their own interests, disregarding the child's well being.
The family, community and society fail to provide support and protection.

Psychological Impact

4.14 The child experiences an extreme loss of security, both physical and emotional;
The child experiences confusion around whom and what is safe or trustworthy;
The child feels frightened, distressed, angry, hostile and rejected.

Behaviour

4.15 The child is excessively clingy and dependant;
The child avoids contact, isolates themselves, is hostile or aggressive;
The child is unable to judge the trustworthiness of others;
Self neglecting or risk taking behaviour;
The older child or adolescent experiences discomfort in intimate relationships.

Powerlessness

4.16 A child's sense of will, effectiveness and mastery over themselves and their environment is continually undermined through the experience of sexual abuse.

Dynamics

4.17 The offender invades the child's body;
The offender uses force, threats or tricks;
The offender maintains the threat of repeated abuse or harm;
The offender ensures that the child has no control over the abusive situation;

4.18 Family, community or society disbelieve and fail to take the child seriously.
Society's failure to take the child's experience seriously is echoed in the judicial system's failure to support, protect or compensate children and adults with regard to the experience of sexual abuse.

Psychological Impact

4.19 The child feels anxious or frightened;
The child has a heightened sense of impending danger (real or imagined); the child experiences a lowered sense of their own efficacy in the world;
The child identifies them self as victim;
The child has a need to control;
The child identifies themselves with the perpetrator.

Behaviour

4.20 The child becomes depressed;
The child experiences nightmares (often sexualised), phobias, eating or sleeping disorders;
The child remains vulnerable to subsequent victimisation;
The child asserts their power inappropriately, i.e. bullying, generalised aggressive behaviours (perhaps sexualised).

The Degree Of Impact Of Sexual Abuse

4.21 The impact of child sexual abuse can be short term or extend into the long term – depending upon pre-existing factors such as attachments and resilience, the nature of the abuse and upon the response of others to the abuse. Other factors include:

- The **relationship** between the victim and the abuser. The closer the relationship, the higher the risk of trauma and the greater the possibility that the young person's ability to trust will be damaged.
- The **age** of the young person when the abuse began and the **length of time** that it occurred. An ongoing abusive relationship that begins at an early age is potentially more damaging to the young person.
- The type of sexual activity involved in the abuse. Sexual acts or activity involving no physical contact seem to be less traumatic.
- The degree of force used to coerce the young person. Violence increases the trauma for the young person.
- How others responded to the young person's disclosure. If the young person was not believed, was blamed, or was shunned by others, the trauma increases.
- The support available to the young person following the disclosure. Lack of support increases the trauma and feelings of loneliness, helplessness and unworthiness.

4.22 These factors may have different significance for every young person. All sexual abuse is harmful and each young person experiences a different sense of pain or trauma.

4.32 It is important to remember that signs and symptoms may be very difficult for adults to read. Equally children may not show any signs or symptoms of being sexually abused.

Chapter 5
Supporting survivors of sexual abuse in the long term

5.1 Professionals may be involved in working with survivors of sexual abuse in many different contexts. This may be a known or unknown element of the professional's intervention. For example, professionals may be involved with:

- Children who have been sexually abused in the past and continue to experience individual or family difficulties such as conflict and rejection, youth offending, subsequent sexual or violent trauma etc
- Children living in local authority care who need to understand their history and may have ongoing emotional or behavioural issues associated with the abuse and associated traumas.
- Young people or adults who access support with problem drug or alcohol misuse.
- Adults within mental health, criminal or voluntary sector support contexts.
- Parents seeking support with their children who may have themselves been sexually abused

Childhood sexual abuse can have serious long term emotional, behavioural and social effects which are outlined by the Finklehor and Brown model.

These effects might lead children, young people and adults to seek or avoid professional attention. It might be helpful to consider that all professional interventions with survivors of sexual abuse should seek to **readdress the traumagenic dynamics**, for example:

In order to readdress or reduce traumatic sexualisation it is important to offer:

- Safe touch, affection and attention
- Clear messages about bodies, boundaries and sexual development
- Normal developmental experiences
- Language to describe experiences

In order to readdress or reduce stigmatisation it is important to offer:

- An understanding of their own survival and coping strategies
- Clear, specific and positive messages of worth
- Understanding and clarity about issues of responsibility and blame in the past and present
- Valuing, consistent relationships

In order to readdress or reduce the sense of betrayal it is important to offer:

- Safe relationships, safe touch and attention
- Trustworthy adults
- Clear boundaries about roles and responsibilities of adults and professionals
- Re-establishing and maintaining rules

In order to readdress or reduce the sense of powerlessness it is important to offer:

- Appropriate choices and control
- Openness and information about what has happened and will happen
- Negotiation of boundary and safety issues

Chapter 6
Children and young people who sexually harm

6.1 This is an area of work where there has been a significant shift in opinion over the past ten years about how problems should be addressed. In the early nineties, when awareness about the extent of the involvement of the under 18's in sexually abusive behaviour was growing, there was a prevailing belief that professionals should be extremely worried by such behaviour. This view was heavily influenced by the then recent research coming out of the USA on adult sex offenders which revealed entrenched patterns of sexually abusive behaviour which had an addictive quality.

6.2 Research on adolescent sex offenders over the past decade has presented a different picture, suggesting that youngsters are much less likely than their adult counterparts to re-offend sexually. The large majority do not progress into being adult sex offenders. They seem much more able to learn from their mistakes and move on, rather than be locked in repetitive cycles.

6.3 Home Office crime statistics for 1997 give the total number of offenders (all ages) convicted or cautioned for sexual offences as 6,400 of whom 23% were between the age of ten and 21yrs. Various retrospective studies suggest that between 25-35% of all alleged sexual abuse involves young, mainly adolescent perpetrators.

6.4 Clearly any assessment of a reported incident of sexual behaviour needs to take into account the degree of concern caused by the behaviour. Common sense comes into play here, but Appendices A and B give some guidelines for this.

6.5 Appendix A comes from the work of Toni Cavanagh Johnson and assists decision making in the degree of concern attached to the behaviour of 5-10 year olds. Appendix B lists suggested responses to adolescent sexual behaviour and comes from Ryan and Lane's work. Note that the issue of power needs to be taken into account with this age group especially, and that power is not simply a question of age and size.

6.6 Any assessment should take into account where the sexual behaviour lies on a continuum starting with experimental, co operative acts through to those which are compulsive and violently imposed.

Where does this behaviour come from?

6.7 A history of being abused is a key feature of those youngsters who sexually harm others. However, this abuse does not necessarily need to have been sexual in nature and some studies show that an emotionally abusive environment is more prevalent as a characteristic. Indeed one of the greatest risk factors is being a victim or witnessing domestic violence. Discontinuity of carer is frequently noted.

6.8 There is no bias suggesting any particular racial group is more likely to sexually abuse. Youngsters with learning difficulties are over-represented in this group and various explanations have been put forward for this e.g. more likely to be caught, more vulnerable to being abused, social isolation etc.

Multi-Agency Working

6.9 In order to ensure that all young people who engage in inappropriate sexual behaviour are assessed fully and any decision about criminal action takes into account a young person's welfare needs a multi-agency meeting should be held in relation to the young person at an early point. (see SCB Procedures).

6.10 These meetings will consider the young person's needs in light of the allegations made, including their need for safeguarding, and any potential child protection or criminal action and will put together a holistic plan to address the needs of a young person in the light of any alleged offending.

What should an assessment involve?

6.11 There has been a growing awareness that youngsters need to be assessed holistically and that a single-minded focus on the sexual behaviour (an influence from work with adult sex offenders), is not an appropriate way of completing your assessment. The Assessment Framework Triangle provides an adequate model for this with attention being paid to such issues as:

- Parents' response to the sexual behaviour supportive/dismissive/ denied etc.
- The child's sexual development – pre or post pubertal?
- Origins of sexual knowledge
- How is the behaviour viewed in the family's culture?

6.12 An extremely useful tool for assessment appeared in 2001 arising from the work of Print, Morrison and Henniker and is known as the AIM assessment (Assessment and Intervention Model). This assesses the behaviour causing concern according to a high/medium/low rating, but then looks at the individual's strengths along another dimension high/medium/low and evaluates the degree of risk posed and suggests next steps based on the information obtained.

Working with Parents of Young People who have Sexually Abused Siblings

6.13 Where a child has sexually abused another child in the family an investigation under S47 of the Children Act will have been carried out and the case will have been considered at a multi-agency meeting (Initial Child Protection Conference or other).

6.14 If the young person is considered to be dangerous, and cannot be trusted to be alone with siblings at all, they would not have been allowed to live at home. In some cases, where the evidence is inconclusive and the behaviour is denied by the child, or where the risk is deemed to be manageable, the young person may still be living in the household. In these cases the situation will need ongoing assessment and monitoring.

6.15 The young person whose behaviour has raised concerns should be offered a programme of work to address their behaviour e.g. through the Youth Offender Team, or through Child and Adolescent Mental Health Services.

6.16 Parents in this situation face the difficult task of how to cope with the needs of both children. The victim, who wants the abuse to stop, but still cares for the brother or sister causing the abuse, can feel divided loyalties. They may want to protect their sibling. Sexual abuse is not less painful because the abuser and the victim are related. Indeed it is likely to have gone on for much longer before being detected. Awal and Saunders' research suggested that most victims of young people who abuse are siblings, extended family members, friends or neighbours.

6.17 Parents will need to look at changing the way the family operates, altering the environment in order to protect all children affected by abuse – even those children in the family who have not been victimised will be affected by the undertones associated with abuse.

6.18 Parents can do things to reduce the risk of repetition:

- Try to create a culture of openness in the family.
- Ensure all children have appropriate sex education.
- Take away the opportunities a child has to abuse within and outside the home, e.g. restrict contact with younger or more vulnerable children.
- Encourage respect for privacy within the home – own bedroom where possible, privacy in bathroom.
- Cut back on situations that might encourage young people to think about abusive sex, e.g. violent or abusive sexuality on TV, film. Internet etc.

6.19 Simon Hackett's book 'Facing the Future', from which the above points are taken, is a useful reference. The 'Stop it Now' campaign suggests the following points to parents to ensure the safety of the children in the household:

- Be aware of the warning signs which indicate that a sexual interest in one of your children might be developing.
- Talk to your child and listen to what they have to say.
- Demonstrate to the child that it is all right to say 'no'.
- Set and respect family boundaries – ensure privacy in personal activities.
- Take sensible precautions about whom you choose to take care of your children.

Aims of Intervention

6.20 These can be summarised as:

- The protection of victims
- The prevention of further offences
- The development of self control.

6.21 Treatment goals will incorporate these aims but also delve into the areas relevant to the abusive behaviour, such as:

- Enhancing self esteem
- Social skills work
- Sex education
- Victim empathy
- Problem solving skills
- Uncovering effects of trauma
- Controlling impulsive behaviour

6.22 Treatment is offered by YOT and CAMHS teams.

Chapter 7
Assessing parental responses to child sexual abuse

Pre-Disclosure – Assessing Risk Factors

7.1 In situations where there are concerns about a risk of sexual abuse there may be signs in the parents' histories, lives, attitudes and responses to the suggested risk, which indicate an increased vulnerability or potential lack of protection:

- Parents who have previous sexual offences against children
- Parents who have previous involvement in families or relationships where sexual abuse was a concern
- Parents with friends or extended family who have committed sexual offences against children
- Parents with a history of domestic violence or current domestic violence
- Emotional and physical neglect or abuse
- Social isolation of parents or children
- Indecent images of children found in the house
- Extensive and open use of adult pornography – found available in the home
- A vulnerable parent with unresolved issues of sexual abuse and limited coping strategies – which might include dissociation, alcohol or drug misuse.

7.2 Where the alleged abuser is within the family and there are established attachments, the trauma and personal costs to the non-abusing parents can be significant and affect their ability to respond to risk and disclosure. It may be helpful to see parental responses on a continuum of actively protective to actively abusive.

7.3 Table A offers guidance in gathering and analysing assessment information in order to assist judgements about risk and protection and decision making about future action.

Table A

CATEGORY OF PROTECTION	PARENTAL DYNAMICS AND RESPONSES			PROFESSIONAL RESPONSES	
	Family Context	Relationship To Abuse & Abuser	Responses to Disclosure	Protection/ Safeguarding	Support/ Promoting Welfare
ACTIVE PROTECTION	Secure attachment. Good social networks. No other concerns.	No relationship to abuser. Did not know about abuse. No involvement. Terminates relationshi with abuser. Child tells parents.	Believes child, protects from danger. Reports to ssd/police. Assertive with professional. Seeks support.	Initial assessment	Pre-court work. Therapeutic referral/assessment. Support to parent. Liaise with POLICE CPS PROBATION re trial/sentence/DPMU re release.
PASSIVE PROTECTION (Failure to protect)	Secure/ambivalent attachments. Possible learning difficultly. Unsupported. Socially isolated.	Knew and trusted abuser. Did not know about sexual offences. Tricked and groomed. No part in abuse. Child told others/ parents.	Compliant but not appearing to appreciate what has happened and the consequences. Compliant but passive.	Core assessment. Social. Educational. Family support.	Pre-court work. Referral for therapy /assessment. Support for parents. Family support. Liaise with POLICE, CPS, PROBATION, DPMU as above
PASSIVE PROTECTION (Failure to protect & neglect)	Insecure attachments. Inconsistent parenting. Parents own history of abuse – unresolved. Drug/alcohol misuse. Domestic violence. Neglect.	No direct part in abuse. Knows, trusts abuser. Knows about offences. Child tried to tell – dismissed.	Disbelieves. Overwhelmed. Continues to see abuser. Links to own abuse. Intermittent co-operation.	ICPC Core assessment of protective capacity. Assess other safe/ unsafe adults. Secure safety. Liaise with PROBATION.	Pre-court work. Referral for therapy/assessment. Mental health assessment/ therapy for parent. Family therapy.
ACTIVE COLLUSION/ PASSIVE ABUSE (Failure to protect & neglect)	Insecure attachments. Child isolated. Neglect/physical/ emotional abuse.	Knows and attached to abuser, knew about abuse but "blocked it out". Child tried to tell – threatened to maintain secret.	"Disbelieves" child. Describes child as silly, storyteller etc. No co-operation/makes complaints.	ICPC legal planning. Child's safety secured. Criminal proceedings. Assess other safe/ unsafe adults. Liaise with PROBATION, POLICE.	Child witness support for child. Referral for therapeutic assessment. Support for carers. Assessment of offenders.
ACTIVE ABUSE	Insecure/disorganised attachment. Parent changes in presentation. Child isolated. Emotional abuse/may appear OK.	Involved in the sexual abuse either alone or with others in family or wider network. Threats to child to keep quiet.	Denies abuse. Undermines child. Grooms/threatens professional.	ICPC Legal proceedings. Criminal proceedings. Liaise with PROBATION, POLICE.	Child witness support. Referral for therapy/ assessment. Support for carers.

These "categories" are on a continuum and can apply differently to both parents and other family members. Issues of race, culture, gender, ability, class must be integrated in any assessment. Behaviour may change over time and require re-assessment.

Chapter 8
Adults who sexually abuse

8.1 The information in this section provides brief details about characteristics of adult male sex offenders and some guidance for professionals on useful questioning techniques. It is important to recognise that there is no such thing as a typical sex offender; however research has been able to identify some traits that can assist in assessment.

Summary of the Adult Characteristics of Sex Offenders.

8.2 Adult male sex offenders display a number of characteristics, which may predispose them to offend sexually. There is some evidence for deviant sexual arousal, which, even if it is not always present, may be triggered by certain events or mood states. This is accompanied, in many cases, by sexual preoccupation, feelings of sexual inadequacy and by sexual dysfunction.

8.3 Sex offenders also suffer from a number of problems associated with intimacy deficits, loneliness and feelings of inadequacy. Problems with their adult relationships and low self-esteem may contribute to making abusive sex appear to be an acceptable substitute for true intimacy and a legitimate way of obtaining sexual satisfaction.

8.4 Pro-offending thinking involves holding distorted views of self and others – views that can help to disinhibit and make sexual offending appear acceptable to the abuser. Many sex offenders have distortions about women and children – particularly about their sexuality. In addition, some sex offenders have difficulty accurately identifying the feelings and attitudes of others, whereas others show little concern for anybody other than themselves.

8.5 Finally, many sex offenders display poor self-management. Some of these show evidence of impulsive and anti-social lifestyles, showing little concern for others or for the consequences of their actions. Many sex offenders have poor problem solving strategies, tending to use emotion-focused (rather than object focused) means of dealing with problem situations. They are also far more likely than non-offenders to adopt sexual fantasy/behaviour as a coping mechanism when faced with negative affect. This suggests that some sexual offending may be an attempt to meet non-sexual needs with sexual behaviour.

8.6 Individuals who commit sexual offences have been shown to have an identifiable pattern of abusive behaviour, which is reinforced by dysfunctional beliefs and attitudes. Offenders are motivated to offend (e.g. sexual arousal, pro-offending thinking, confusion of sex with intimacy, loneliness and/or anger) and derive some satisfaction from offending; that they do not always have the skills in place that will help them not to re-offend (e.g. deficits in problem-solving, social/relationship, self management skills) and that they requently fail to identify their own risk situations and mood states (e.g. lack of understanding of own cycle and inability to recognise the significance of certain mood states and risk situations).

8.7 Another important factor in sexual offending is 'grooming', both of direct victims and of their families or carers. Sex Offenders may also attempt to groom the professionals involved with them. Grooming is behaviour that causes the victims/families/professionals to believe that the potential abuser is trustworthy and poses no threat. Some examples may include: offering practical or financial help, displaying what could seem to be appropriate interest in children and their needs, and through these means possibly isolating the child/parent or carer from other influences.

Professional Techniques When Assessing Adults Who Sexually Abuse

8.8 **Some General Notes about Questions:**

Facilitative questioning: (Genuine versus dead questions).
Questions that are confrontational, patronising or judgmental will often provoke a hostile response or will encourage the individual to shut down and become less forthcoming. Therefore it is absolutely vital that professionals use questions in a fair, honest, enabling and non-judgmental way.

Wait time. In normal social interaction, people cannot tolerate more than 45 seconds of silence before someone interjects with a comment, no matter how meaningless, in order to break the silence. In sex offender work, however, wait time is essential to any critical thinking activity. Wait time gives people time to reflect and gather their thoughts before responding. It is important that we, as professionals, restrain ourselves from speaking during this wait time.

8.9 **Minimising Resistance**

- Re-frame resistance as ambivalence.
- Do not attempt to force the offender/ alleged offender to agree with you.
- Use the offender's own motivational statements as a way of moving forward.
- Use a style that encourages a process of discovery rather than one that relies solely on didactic teaching.

Types of Questions

8.10 **Socratic Questions.** Socratic questions are those designed to lead the individual to make his own discoveries and insights based upon a series of incremental questions and answers.

Examples:
- Can you help me understand how you came to be alone with the child?
- Can you say a bit more about how the fantasy and masturbation were related to your offence?

8.11 **Open-ended Questions**. This type of question does not allow for a yes or no response, but rather invites an open ended response. These are "Who, what, where, when, why and how" questions).

8.12 **Probing Questions.** Probing questions are simply questions that seek to go beyond the surface level of given information. The forms of the question may be an open question or other type of question, but the context of the question makes it a probing questions.

Examples:
Offender: "I was pissed off".
Worker: "Can you say a bit more about that? What were you angry about? What's happening inside when you are angry? Are you feeling that in your head, in your gut, your heart?"
Offender: "I'm really angry with this group".
Worker: "Can you say more about why you are angry with the group?"

8.13 **Jenkins' Questions: (Invitations to Responsibility).** Jenkins' questions are those types of questions that tend to focus on the individual's sense of responsibility for his actions.

Examples:

- Would you be prepared to leave this responsibility fully up to your partner and rely on her to deal with it, or do you think it is appropriate that you take the responsibility yourself?
- If you failed to face up to it, and ran away from it or copped out, what would that say about you?
- How did you find the courage to face up to your offending behaviour?

Information Sharing

8.14 There is much information that LA children's social care, police, probation and prisons can share with regard to sexual offenders in order to minimise the risks that such offenders pose. It is important that information is shared in order to best inform decisions taken about both the offender, and victims… existing and potential.

8.15 Non statutory agencies should also seek to apply the same principles as statutory agencies when their staff make decisions about the sharing of information held by their agencies with other or statutory partner agency.

Chapter 9
Professional issues when working with sexual abuse

9.1 Working with families or individuals where there is an issue of sexual abuse can lead to confused, distressed or angry reactions. The Traumagenic Dynamics outlined in **Sections 4.1 – 4.20** can often affect the professionals at both individual and organisation levels. For example:

- The dynamic of traumatic sexualisation can lead professionals to see sexual abuse everywhere - at work home and at play. Intrusive thoughts and images can spoil our own sexual experiences.
- The dynamic of stigmatisation can be generated by the public, interagency or organisational criticism of our work and can lead to an undervaluing of ourselves and others.
- The dynamic of betrayal can reveal itself in feelings of being let down by our system or other systems, by people not doing their job, breaking professional boundaries etc.
- The dynamic of powerlessness can lead us to feel ineffective in our job, unable to help our clients, prevent or punish the crimes, or unable to say "No" to unreasonable organisational or client demands.

9.2 Other aspects of sexual abuse can also infiltrate professional systems. These can include: secrecy, silence, blame, the blurring or breaking of boundaries or rules, denial, dissociation, disbelief.

9.3 **It is important to acknowledge that perpetrators of sexual abuse may try to groom the professionals involved by inviting or introducing the above dynamics and aspects into their relationship with professionals.**

9.4 Dealing constantly with sexual abuse can also lead to secondary trauma and post traumatic symptoms: these include specific or generalised anxiety, sleep or eating difficulties, intrusive thoughts and memories, tearfulness, forgetfulness, loss of hope etc.

All professionals will be affected differently. There are a high proportion of sexual abuse survivors in the caring professions and these workers should seek additional support if working with issues which affect them. Other workers may find particular accounts, images or relationships disturbing.

Without noticing, the professional's usual coping strategies may be increased, for example, alcohol use, smoking, risk taking etc. The cumulative impact of the above effects and coping strategies can result in burnout.

9.5 Although, to some extent, these effects are an inevitable part of the work, it is important that the impact is reduced or redressed through good, safe professional practices. These echo the strategies for re-addressing the impact of sexual abuse outlined in section 5.1 and include:

9.6 **In order to reduce traumatic sexualisation**

- Consistent supervision
- A balance of different types of work.
- Self care and maintenance – both physical and psychological
- Co-working where at all possible

9.7 **In order to reduce stigmatisation**

- Consistent supervision
- Open communication within and between professional organisations
- Co-working where at all possible

9.8 **In order to reduce betrayal**

- Consistent Supervision
- The maintenance of professional boundaries.

9.9 **In order to reduce powerlessness and perpetrator grooming**

- Consistent Supervision
- Co-working where at all possible, particularly with perpetrators.
- Effective internal and external complaints procedures.
- A learning culture which encourages peer support and training.

In terms of maintaining effective professional responses to child sexual abuse, these practices are not luxuries, they are essential elements of safe effective practice and reduce the risk of significant personal impact, sickness and burnout.

Chapter 10
Frequently asked questions

10.1 A six year old child repeatedly asking other children to show him their privates in class, does this mean they're being sexually abused? What should the teacher do??

At six it is not unusual for a child to be interested in their genitals and to show them to other children. However it should be established whether there is any background information to indicate otherwise, for example previous sexual abuse, other concerning behaviours or changes in behaviours that indicate a child may have experienced trauma, contextual information about the family such as contact with adults who may pose a risk to children. In addition the teacher should talk to the child about what they are doing and why.

If there is no contextual information or allegation the teacher should discuss the child's behaviour with their parents and agree a strategy for managing it that ensures the child understands that they should stop doing this. This should be monitored and reviewed.

If there is significant concern as a result of the background information and/or an allegation LA children's social care should be contacted.

The other children who are involved in this should not be seen as victims of abuse unless there is a significant degree of force or coercion.

10.2 A GP working in a drop in project for young people has concerns that a young person may be having a relationship with a much older man. Can the GP share their concerns with the youth worker who has a positive relationship with the young person?

Any multi-disciplinary project should have clear guidelines about consent/confidentiality and information sharing that are clear to staff and publicised to service users.

The GP should talk to the young person about their concerns and obtain more information about the nature of the relationship. They should also identify who could provide the young person with ongoing support and the GP should get the young person's agreement to share information with any others as being relevant. If the young person does not consent to this the GP cannot share their concerns, unless they are clear that the young person is at risk of significant harm in which case they would inform the young person that they needed to contact LA children's social care.

10.3 Is it OK to have physical contact with a child who has been sexually abused? (e.g. as a teacher or foster carer).

Yes. After a child has been sexually abused it is important for physical contact to remain the same by negotiation with the child. The child may need more reassurance about what is happening making the behaviour explicit or involving other people for safety/reassurance.

It is important that children who have been sexually abused have appropriate physical contact but professionals need to take care not to behave in ways which could be misinterpreted. It is also important to remember that children who have been sexually abused may be more vulnerable to further abuse from the adults they are in contact with.

10.4 An early years worker has noticed that a 4 year old child has a greenish looking vaginal discharge. What should they do?

Check the child's file to establish whether there is any information to indicate contextual concerns about the possibility of sexual abuse, e.g. contact with a schedule one offender. If not advise the child's parent to take the child to the GP for medical tests and treatment as required. Further advice should be sought from the named nurse for child protection.

10.5 A ten year old asks the school nurse for a pregnancy test. What should they do?

Ask the child why they think they might be pregnant and information about whom they have had sex with. Check records to see what is known about the child and whether there are any contextual concerns. If there are clear child protection concerns a referral will need to be made urgently to LA children's social care as there may be forensic evidence to be obtained.

If not talk to the child about involving their parents. At 10 the child is very unlikely to be Gillick competent. N.B. Gillick Competence was defined by Lord Scarman, 'as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to enable him to understand fully what is proposed'. Gillick competence refers to the particular child and the particular treatment. If there is a risk of pregnancy action may need to be very urgent to involve parents and appropriate agencies.

Appendix A

Age range	Developmental tasks	Sexual behaviours	Concerning sexual behaviours associated with traumatic sexualisation
Pre-school 0-5 years	Curiosity, physical exploration of self and environment	Masturbation, looking at and touching others' bodies	Excessive or compulsive masturbation. The child cannot be distracted. The behaviour is associated with distress or aggression
Primary School 6-10 years	Social activity and games with peers. Intellectual interest in self, others and environment	Masturbation, looking at others' bodies, sexual exposure of self to others, sexual fondling of peers or younger children in play.	Excessive or compulsive masturbation. The child does not respond to the social rules around masturbation. Sexual preoccupation. Initiating sexual activity, i.e. sexual exposure of self or sexual fondling with much older children or adults. The behaviour is associated with distress
Pre-adolescence 10-12	Developing a sense of individual identity and independence. Forming and maintaining friendships	Masturbation, sexual exposure and fondling with peers. Growing sense of self as sexual being growing sexual interest in others (same and opposite sex)	Not responding to social rules around masturbation. Initiating sexual activity: • outside peer group or where obvious power imbalance exists • With sadistic or ritualistic elements • Associated with distress or aggression • Sexual preoccupation or compulsive sexual behaviour
Adolescence 13-18	Developing individual and social identity. Practising intimacy with peers "falling in love"	Masturbation, simulated adult sexual behaviours with others (same and opposite sex) Penetration and intercourse.	Excessive or compulsive sexual behaviours. Self neglecting sexual behaviours. Involvement in sexual activity: • where obvious power imbalance exists including prostitution • With sadistic or ritualistic elements • Associated with distress or aggression

Decision making in the Degree of Concern Attached to the Behaviour of 5-10 year olds. (Toni Cavanagh Johnson 1998)

Natural and Expected	Of Concern	Seek Professional Help
Asks about the genitals, breast, intercourse, babies.	Shows fear or anxiety about sexual topics.	Endless questions about sex. Sexual knowledge too great for age.
Interested in watching/ peeking at people doing bathroom functions.	Keeps getting caught watching/ peeking at others doing bathroom functions.	Refuses to leave people alone in bathroom.
Uses "dirty" words for bathroom functions, genitals and sex.	Continues to use "dirty" words with adults after parent says "no" and punishes.	Continues use of "dirty" words even after exclusion from school and activities.
Plays doctor, inspecting others' bodies.	Frequently plays doctor and gets caught after being told "no".	Forces child to play doctor, to take off clothes.
Boys and girls are interested in having/ birthing a baby.	Boys keep making believe he is having a baby after month/s.	Displays fear or anger about babies or intercourse.
Shows others his/her genitals.	Wants to be nude in public after the parent says "no" and punishes child.	Refuses to put on clothes. Exposes self in public after many scoldings.
Interest in urination and defecation.	Plays with faeces. Purposely urinates outside bowl.	Repeatedly plays with or smears faeces. Purposely urinates on furniture.
Touches/rubs own genitals when going to sleep, when tense, excited or afraid.	Continues to rub/ touch genitals in public after being told "no". Masturbates on furniture or with objects.	Touches/rubs self in public or in private to the exclusion of normal childhood activities. Masturbates on people.
Plays house, may simulate all roles of mummy and daddy.	Simulates intercourse with other children with clothes on. Imitates sexual behaviour with dolls/ stuffed toys.	Simulating intercourse whilst naked. Intercourse with another child. Forcing sex on other child.
Thinks other sex children are "horrible" or have "wee wees". Chases them.	Uses "dirty" language when other children really complain.	Uses bad language against other child's family. Hurts other sex children.
Talks about sex with friends. Talks about having a girl/ boy friend.	Sex talk gets child in trouble. Romanticises all relationships.	Talks about sex and sexual acts habitually. Repeatedly in trouble with regard to sexual behaviour.
Wants privacy when in bathroom or changing clothes.	Becomes very upset when observed changing clothes.	Aggressive or tearful in demand for privacy.
Likes to hear and tell "dirty" jokes.	Keeps getting caught telling "dirty" jokes. Makes sexual sounds, e.g. moans.	Still tells "dirty" jokes even after exclusion from school and activities.
Looks at nude pictures.	Continuous fascination with nude pictures.	Wants to masturbate to nude pictures or display them.
Plays games with same-aged children related to sex and sexuality.	Wants to play games with much younger/older children related to sex and sexuality.	Forces others to play sexual games.
Draw genitals on human figures.	Draws genitals on one figures and not another. Genitals in disproportionate size to body.	In drawings, genitals stand out as most prominent feature. Drawings of intercourse, group sex.
Explores differences between males and females, boys and girls.	Confused about male/female differences after all questions have been answered.	Plays male or female roles in a sad, angry or aggressive manner. Hates own/other sex.
Takes advantage of opportunity to look at nude child or adult.	Stares/sneaks to stare at nude persons even after having seen many nude persons.	Ask people to take off their clothes. Tries to forcibly undress people.

Decision making... (cont.)

Natural and Expected	Of Concern	Seek Professional Help
Pretends to be opposite sex.	Wants to be opposite sex.	Hates being own sex. Hates own genitals.
Wants to compare genitals with peer-aged friends.	Wants to compare genitals with much older or much younger children or adults.	Demands to see genitals, breasts, buttocks of children or adults.
Interest in touching genitals, breasts or buttocks of other same-age child to have child touch his/hers.	Continuously wants to touch genitals, breasts, buttocks of other children. Tries to engage in oral, anal or vaginal sex.	Manipulates or forces other child to allow touching of genitals, breast or buttocks. Forced or mutual oral, anal or vaginal sex.
Kisses familiar adults and children. Allows kisses by familiar adults and children.	French kissing. Talks in sexualised manner with others. Fearful of hugs and kissed by adults. Gets upset with public displays of affection.	Overly familiar with strangers. Talks/acts in a sexualised manner with unknown adults. Physical contact with adult causes extreme agitation to child or adult.
Looks at genitals, buttocks, breasts of adults.	Touches/ stares at the genitals, breasts or buttocks of adults. Asks adult to touch him/ her on genitals.	Sneakily or forcibly touches genitals, breast, buttocks of adults. Tries to manipulate adult into touching him/her.
Erections.	Continuous erections.	Painful erections.
Puts something in own genitals/rectum due to curiosity and exploration.	Puts something in own genitals/rectum frequently or when it feels uncomfortable. Puts something in the genitals/rectum of other child.	Any coercion or force in putting something in genitals/rectum of the other child. Anal, vaginal intercourse. Causing harm to own/other genitals/rectum.
Interest in breeding behaviour of animals.	Touching genitals of animals.	Sexual behaviours with animals.

Appendix B - Ryan and Lane (1991)

Suggested Responses to Adolescent Sexual Behaviour Work.

Power

In abusive situations the power of the abuser is used to deny the victim free choice. Some of the principle elements of power differential in sexual relationships can be summarised as follows:

- Age, gender, race and culture
- Physical size/ strength
- Significant different levels of cognitive functioning
- Invested authority (e.g. baby-sitting, school prefect)
- Self image differential
- Arbitrary labels (e.g. such as leader in games)

Adolescent Sexual Behaviours

Applying the above framework of consent and power allows us to define adolescent sexual behaviours in terms of whether they are acceptable/ normal, require limited intervention/ further assessment ore are clearly abusive and require treatment. The following categorisations are examples of adolescent sexual behaviours adapted from those developed by Ryan and Lane (1991):

Normal Behaviours

- Explicit sexual discussion amongst peers, use of sexual swear words, obscene jokes
- Interest in erotic material and its use in masturbation
- Expression through sexual innuendo, flirtations and courtship behaviours
- Mutual consenting non-coital sexual behaviour (kissing, fondling etc.)
- Mutual consenting sexual intercourse.

Behaviours that suggest monitoring, limited responses or assessment

- Sexual preoccupation/anxiety
- Use of hard core pornography
- Indiscriminate sexual activity/ intercourse
- Twinning of sexuality and aggression
- Sexual graffiti relating to individuals or having disturbing content
- Single occurrences of exposure, peeping, frottage, obscene telephone calls.

Behaviours that suggest assessment/ intervention

- Compulsive masturbation if chronic or public
- Persistent or aggressive attempts to expose other's genitals
- Chronic use of pornography with sadistic or violent themes
- Sexually explicit conversations with significantly
- younger children
- Touching another's genitals without permission
- Sexually explicit threats.

Behaviours that require a legal response, assessment and treatment

- Persistent obscene telephone calls, voyeurism, exhibitionism or frottage (rubbing up against someone)
- Sexual contact with significantly younger children
- Forced sexual assault and rape
- Inflicting genital injury
- Sexual contact with animals.

Sgroi's assessment methodology underlines the developmental perspective and highlights the use of secrecy:

"does the sexual behaviour initiated by a child fit into anticipated developmental norms with regard to ages of the participants, participants and id sexual behaviours? Did the child who initiated the sexual behaviour do so openly or furtively? With concern about discovery or disregard being detected? Were other participants bribed or threatened? What did the victim think would happen if she or he told others?" (Sgroi, 1989)

Children's Sexual Behaviour

Ryan (1991) defined the range of sexual behaviour of children into 4 categories:

"Normal" – includes; genital or reproduction conversations with peers, exploratory games, imitating seduction (kissing or flirting), occasional masturbation, sexual language or jokes with peers.

"Yellow Flag" – (some concern) – includes: preoccupation with sexual themes or masturbation, displays of inappropriate sexual knowledge, sexually explicit conversations with peers, attempts to expose other's genitals, mutual or group masturbation, simulated foreplay with toys or peers.

"Red Flag" – (high concern) – includes: sexually explicit conversations with significantly younger children, touching genitals of others, repeated or chronic genital exposure or masturbation, simulate intercourse with toys, peers or animals.

"No Question" – (clearly abusive) – includes: oral, vaginal or anal penetrations of dolls, children or animal, touching another's genitals using force, simulated intercourse with peers with clothing off, any genital injury not explained by an accidental cause.

Appendix C - Sentencing options for adults who sexually abuse

Once a perpetrator enters the criminal justice process, it is often the responsibility of the Probation Service to undertake a risk assessment. This may be done at the Pre-sentence stage if a court orders a report prior to sentencing, but a report is not always requested by a court. For example there are occasions when a prison sentence is given at the time of conviction, without a pre-sentence report being requested.

A Pre-sentence report will include; analysis of the offence(s), relevant information about the offender's circumstances, an assessment of the risk he or she poses and a proposal for sentence. This initial risk assessment forms the basis of any future work that will be undertaken with the offender.

Whilst men who commit sexual offences have much in common with one another, it is recognised that there is no detailed model of the sexual offending process that is applicable to all. The Probation Service use 2 main tools in their assessment of risk with sexual offenders, these are used both in custodial and community settings;

Thornton's Risk Matrix 2000 is an actuarial assessment tool based on static factors..

There has been much research that makes clear the factors that are the best predictors of future sexual offending. This work informs the Risk Matrix 2000 (RM 2000) This static risk predictor is used by Police, Prisons and Probation in their work. The factors that are most predictive are:

***Age at point of risk – the younger the greater the risk.**

***Number of sexual convictions – the more the greater the risk.**

***Number of other convictions – the more the greater the risk.**

***Relationship history – higher risk if he has never been in a 'living together' relationship of more than 2 years.**

***Victim factors – higher risk if victims are currently or have been male or strangers (not known 24hours prior to offence)**

***Offence factor – higher risk if there is now or ever has been any non-contact sexual offence.**

Offender Assessment System (OASys) is a joint prison and probation system which, when complete, contains detailed information about an offender's needs and risks. Information contained in the first 13 sections includes details of the offence(s), offending history, and a range of 'social factors', for example accommodation, employment, lifestyle & associates. A whole section is dedicated to Risk, both risk assessment and risk management. There are several sections which raise questions about risks the offender may pose to children. LA children's social care may be contacted at this point by the OASys assessor (usually a Probation or Prison Officer) in order to get up to date information about known children who may be at risk from the offender.

OASys then calculates a risk of reconviction for the offenders ranging from Low to High depending on the scores that are inputted for sections 1-13 .Sex Offenders will often score low on measures predicting risk of reconviction, many will be without a recorded previous convictions .However, the risk sections contain detailed information about the current offence and scope to reflect the offender's potential risk of harm. As with risk of reconviction, there are categories for risk of harm. These range from Low to Very High.

Sentencing Options

People convicted of sexual offences receive a wide range of sentences from Conditional Discharges, to terms of imprisonment. This will depend on the court's view of the seriousness of the offence, and the assessment of the risks the offender poses. Any conviction for a sexual offence will lead to the offender being required to sign on the **Sex Offender Register** as follows:

Is sentenced to 30 months or more imprisonment (inc Life)	**An indefinite period**
Is admitted to a hospital subject to a restriction order	**An indefinite period**
Is sentenced to imprisonment for a term of more than 6 months but less than 30 months	**10 years**
Is sentenced to 6 months imprisonment or less	**7 years**
Is admitted to hospital without a restriction order	**7 years**
Is cautioned	**2 years**
Is given a Conditional Discharge	**Duration of the Court order**
Received any other disposal (such as a community order or fine)	**5 years.**

These notification periods apply to offenders over the age of 18, for those under 18 the notification periods of 10, 7, 5 and 2 years are halved.

Offenders required to sign the Sex Offender Register have to notify the relevant police of any change of address and/or periods spent away from their usual address. Breaches of registration carry a maximum 5 year prison sentence. The Dangerous Persons Management Unit is usually responsible for monitoring people subject to registration. They will be interested in any significant information you may have about an offender subject to registration.

Offenders who receive Community Orders will be managed predominately by the Probation Service, although other agencies may be involved (under **Multi-Agency Public Protection Arrangements**) Community Orders can be 'tailored' to meet the specific needs of the offender, and the risks posed by him or her. A Community Rehabilitation Order, for example, could contain a condition that the offender participates in a Sex Offender Treatment Programme (SOTP) this may be managed by the Probation Service or in some cases another agency e.g. the NSPCC. Where an offender is subject to a community order, the Probation Service may be a useful source of information to social workers involved with the offender's family.

If an offender fails to comply with the requirements of a community order, he or she will be breached, which could result in them being re-sentenced, possibly receiving a custodial sentence.

If an offender receives a custodial sentence of less than 4 years he or she will be released automatically at the half-way point. Those serving 4 years or more become eligible to be considered for release on parole at the half way stage. This is not automatic. If parole is not granted the offender is released at the two-thirds point. In both cases offenders are supervised to the three-quarters point of sentence.

Some sex offenders will be supervised until the 100% point of sentence if the judge decided this when passing sentence. This allows for risk management over a longer period of time, and gives further time for offence related work to be undertaken, particularly as this may not have been completed during the custodial element of the sentence.

In Custody

If a perpetrator is sent to custody, the Prison Probation Officer (or designated Child/Public Protection Officer) will often undertake a risk assessment to inform how best to manage the possible risks the individual poses whilst in custody. This may lead to restrictions being imposed, under prison service procedures, such as preventing visits from children and young people under 18, stopping letters and telephone calls being made to young people, or indeed to partners/prospective partners where there are children.

Such restrictions are also applied to unconvicted inmates (i.e. those on remand) who are charged with sexual offences.

The aims of these restrictions are not only to protect existing victims, but also to prevent such inmates from 'grooming' children and 'vulnerable' adults for future exploitation. Whilst the individual is in prison, this relies primarily on communications through letters, visits and 'phone calls.

Approved Visits

If an inmate charged or convicted of sexual offences against children, wishes to receive visits from named Under 18s he or she must apply under the Approved Visits Procedure. For such an application to be considered ,the named children/young person must be the birth child/ren of the inmate , or 'stepchildren' (for these purposes the inmate must have lived with the child/ren , as a 'family', prior to coming into custody.

In all circumstances where an inmate has applied for Approved Visits, the views of the relevant LA children's social care Department will be sought. In some cases LA children's social care will already be involved with the named children, and be able to offer advice on the appropriateness of the child/ren visiting. In cases where the children are not known LA children's social care are expected to undertake a visit to the child/ren and carer, undertake a specific assessment with regards to the appropriateness of visits, and to provide information to the prison about this.

Contact can be at several levels;

Level One - full restrictions apply. No contact with any child permitted

All correspondence and telephone calls will be monitored.

Level Two - contact permitted only via written correspondence. All correspondence and telephone calls will be monitored.

Level Three - contact permitted via written correspondence and telephone. All correspondence and telephone calls will be monitored.

Level Four - no restrictions necessary. May have contact via correspondence, telephone, visits and family visit (if applicable). Routine sampling – reading of correspondence, listening to telephone calls, general observation in visits area.

Appendix D - Refences mentioned in text

Paragraph 4.5

Johnson, Toni Cavanagh, (1998). Understanding Children's Sexual Behaviours – what's natural and healthy. A booklet for use by families, obtainable direct from the author, TCavJohn@aol.com

Ryan G and Lane S, (1991). Juvenile Sex Offending – causes, consequences and correction. Lexington Books

Print, Morrison and Henniker's description of the AIM model is published in;

Calder M, (2001) Juveniles who Sexually Abuse: frameworks for assessment (2nd Edition) Chapter 12, Russell House Publishing.

Awad G and Saunders E B, (1989) Male Adolescent Sexual Assaulters, Journal of Interpersonal Violence, 6, 446-60.

Hackett S (2001) Facing the Future. Russell House Publishing

Resources

Hackett S (2004) What works for children and young people with harmful sexual behaviours. Barnardo's. An excellent and accessible book which covers much of the available research in this area.

Appendix E - Reading list

Breaking Free: Help for Survivors of Child Sexual Abuse
By Carolyn Ainscough and Kay Toon

Breaking Free Workbook
By Carolyn Ainscough and Kay Toon

The Courage To Heal: A Guide for Women Survivors of Child Sexual Abuse
By Ellen Bass and Laura Davis

The Courage To Heal Workbook: for women and men
By Ellen Bass and Laura Davis

Male Survivors: A self help pack
By Survivors Sheffield

Books for partners and families

Allies in Healing: When the person you love was sexually abused as a child
By Laura Davis

Dissociative Identity Disorder

Amongst Ourselves: A self help guide to living with Dissociative Identity Disorder
By Tracy Alderman and Karen Marshall

Self Harm

Making Sense of Self Harm
By Lois Arnold and Anne Magill

The Self Harm Book
By Lois Arnold and Anne Magill

Books for Professionals

Adult Male Survivors of Childhood Sexual Abuse
By Kim Etherington

Surviving Child Sexual Abuse
By Dr Liz Hall and Siobhan Lloyd

Surviving Secrets: The Experience of abuse for the child the adult and the helper.
By Moira Walker

Working with Self Injury: A practical guide
By Lois Arnold and Anne Magill

The above is taken from the DABS National Resource Directory which is available from

DABS 1 Broxholme Lane Doncaster DN1 2LJ

Appendix F - Resources

Childline Midlands
3rd Floor
1A Brook St
Nottingham NG1 1AA
Helpline Number 0800 1111

Incest and Sexual Abuse Survivors (ISAS)
35 Mill Gate
Newark
Nottingham NG24 4UA
Helpline Number 01636 610 313

Nottingham Rape Crisis Centre
30 Chaucer St
Nottingham NG1 5LP
Helpline Number 0115 941 0440

NSPCC
Cranmer St
Nottingham
Telephone 0115 960 5418
Child protection Helpline: 0800 800 500

NCH action. No 28 Child and Family counselling Service
28 Magdala Rd
Mapperley
Nottingham NG3 5DF
Telephone 0115 985 8308

AACCESS House (Formerly Asante Sana)
PO Box 226
Nottingham NG1 5LJ
Telephone 0115 958 0873

RAINS (Ritual Abuse Information Network and Support)
Telephone 01483 898 600

Women's Aid Advice Centre
C/o The Women's Centre
30 Chaucer St
Nottingham NG1 5LP
Helpline 0115 947 6490

Nottingham Counselling Service
32 Heathcoat St
Nottingham NG1 3AA
Telephone 0115 950 1743

Sexual Abuse Project
32 Heathcoat St
Nottingham NG1 3AA
Telephone 0115 958 8859

Prevention of Professional Abuse Network (POPAN)
1 Wyvil Court
Wyvil Rd
London SW 8 2TJ
Telephone 0171 720 1553

United Kingdom Society for the Study of Dissociation
UKSSD
26 Princes St
Norwich
NR3 1AE
Telephone 08707 454726
www.ukssd.org

Young Witness Support Project
Victim Support