

Recognising Child Sexual Abuse

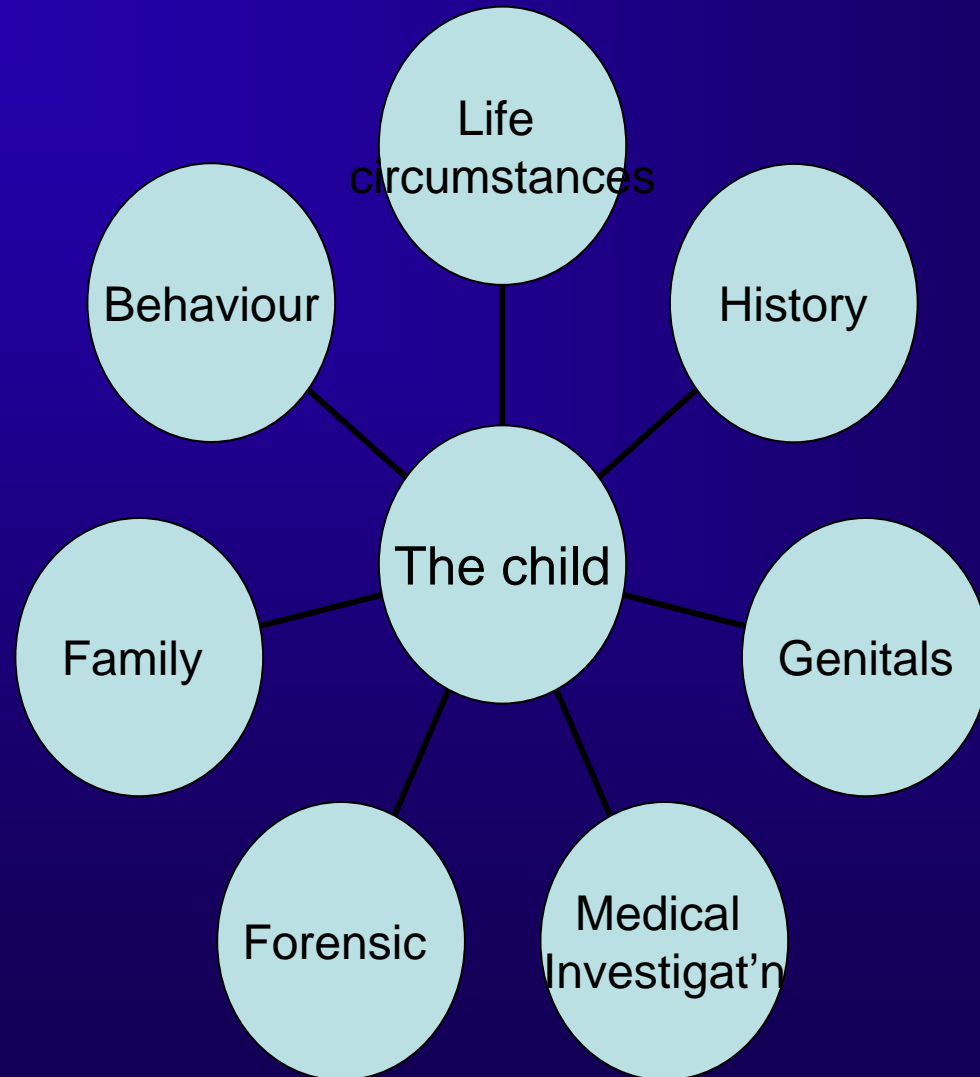
Evaluation of the Evidence-Base

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Recognising child sexual abuse



What is evidence?

- Theory?
- Observation? Anecdote
- Pattern recognition?
- Publication? Peer reviewed journals
- Statistics – how sophisticated?
 - Precisely WHAT is the connection $A \rightarrow B$

What is evidence?

- Consensus? Position statements
- Hypothesis testing?
- Challenges to beliefs (just one unicorn?)
- Assumption / fact / circumstantial evidence / speculation
- Concrete vs 'soft' – scientific vs psychological
- NHMRC levels of evidence

NHMRC levels of evidence

Table 1. Designations of levels of evidence* according to type of research question (including tablenotes)

Level	Intervention [§]	Diagnosis ^{**}	Prognosis	Aetiology ^{†††}	Screening
I*	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies
II	A randomised controlled trial	A study of test accuracy with an independent, blinded comparison with a valid reference standard, ^{§§} among consecutive patients with a defined clinical presentation ^{††}	A prospective cohort study ^{***}	A prospective cohort study	A randomised controlled trial
III-1	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)	A study of test accuracy with an independent, blinded comparison with a valid reference standard, ^{§§} among non-consecutive patients with a defined clinical presentation ^{††}	All or none ^{§§§}	All or none ^{§§§}	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: <ul style="list-style-type: none"> • Non-randomised, experimental trial [†] • Cohort study • Case-control study • Interrupted time series with a control group 	A comparison with reference standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst untreated control patients in a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: <ul style="list-style-type: none"> • Non-randomised, experimental trial • Cohort study • Case-control study
III-3	A comparative study without concurrent controls: <ul style="list-style-type: none"> • Historical control study • Two or more single arm study [‡] • Interrupted time series without a parallel control group 	Diagnostic case-control study ^{††}	A retrospective cohort study	A case-control study	A comparative study without concurrent controls: <ul style="list-style-type: none"> • Historical control study • Two or more single arm study
IV	Case series with either post-test or pre-test/post-test outcomes	Study of diagnostic yield (no reference standard) ^{††}	Case series, or cohort study of patients at different stages of disease	A cross-sectional study	Case series

Body of evidence assessment matrix

Component	A	B	C	D
	Excellent	Good	Satisfactory	Poor
Volume of evidence	several level I or II studies with low risk of bias	one or two level II studies with low risk of bias or a SR/multiple level III studies with low risk of bias	level III studies with low risk of bias, or level I or II studies with moderate risk of bias	level IV studies, or level I to III studies with high risk of bias
Consistency	all studies consistent	most studies consistent and inconsistency may be explained	some inconsistency reflecting genuine uncertainty around clinical question	evidence is inconsistent
Clinical impact	very large	substantial	moderate	slight or restricted
Generalisability	population/s studied in body of evidence are the same as the target population for the guideline	population/s studied in the body of evidence are similar to the target population for the guideline	population/s studied in body of evidence different to target population for guideline but it is clinically sensible to apply this evidence to target population*	population/s studied in body of evidence different to target population and hard to judge whether it is sensible to generalise to target population
Applicability	directly applicable to Australian healthcare context	applicable to Australian healthcare context with few caveats	probably applicable to Australian healthcare context with some caveats	not applicable to Australian healthcare context

* e.g. results in adults that are clinically sensible to apply to children OR psychosocial outcomes for one cancer that may be applicable to patients with another cancer

Discipline-specific view of evidence

Sociology

- systems theory
- ecological models (Garbarino 1997, Belsky 1980)

Psychology

- Epidemiology
- Research – observation + hypothesis testing
- Statistics
 - analysis of variance
- Interpersonal relationship dynamics – eg attachment theory



Discipline-specific view of evidence

Medicine

- Epidemiology
- Allegation
- Behaviour
- Injury
- Investigations eg infection
- Forensic evidence



"For the last time - don't throw him in the air so roughly!"

Discipline-specific view of evidence

Criminology

- Epidemiology
- Profiling
- Confessions

Judicial law

- Witness credibility
- Weighing of opinion
- Decision regarding guilt = interpreted as 'proof'
- Decision regarding with whom child has contact



What IS the evidence?

- Sociological
- Epidemiological (risk factors)
- Allegations – true or false?
- Behaviour (sexualised or nonspecific)
- Injury evaluation
- Investigations (including infection)
- Forensic
- Criminal – confessions
- Judicial – court judgements



"That's not what I meant when I asked you to 'wind the baby' ! "

Sociology

Conceptual framework

- Ecological model
 - Feminist theory
 - Family violence
 - Courtship violence / intimate partner violence
- Observation and interpretation
 - Witnessed phenomena seem to 'fit' the model, therefore is seen as valid
 - Philosophy and theory
 - Sociology – power and politics
 - The family as a system
 - Evolution of child rearing practices
 - Societal beliefs and attitudes
 - Case examples
 - Narrative
 - Anecdote



Psychology

- Epidemiology
 - Observation
 - Definition of CSA
 - Statistics – descriptive vs search for ‘causal relationships’
- Human behaviour
 - Attachment (good, poor and the factors that influence)
 - Aggression
 - Disinhibition
- Research - sexually abused children
 - Case control studies
 - Abused vs not abused (Freidrich)

Psychology

- Cultural
 - OK sexual behaviour varies in different countries (Larsen)
- Gene-environment interactions
 - MAO I gene and aggression in males (Poulsen)
- Descriptive studies
 - Cross sectional vs longitudinal
 - Retrospective vs prospective
 - Case control,
 - General population to specific
 - Recidivism rates – what factors modify, mediate or exacerbate?

Psychology

- Memory
 - Observations
 - isolated, nonverbal, sensory, motor, and emotional fragments
 - Theoretical constructs
 - Forgetting, Repression, Amnesia, Dissociation
 - Van der Kolk 2001
 - traumatic memory
 - cognitive neuroscience / biology memory storage & retrieval
 - Widom and Morris 1997
 - 58% M and 32% F of 96 subjects not recalled
 - abuse documented 20 years earlier
 - Williams 1994,
 - closer relationship, younger child – not remembered

Medical

- Epidemiology
- Allegations
- Behaviour
- Examination findings
- Investigations
- Levels of evidence NHMRC



Epidemiology- CSA, the facts

- Incidence 1% paediatric population
- Public health research
 - Large general populations -> selected groups
 - Clusters of 'risk factors'
 - Confounders or antecedents?
 - Some populations & higher prevalence of abuse
 - Study of re-abuse rates
 - Identify modifiable factors that reduce vulnerability and promote resilience
- Prevalence
 - F= 12-25%, M=8-10%, <18yo
 - 1 in 4 F, 1 in 7 M during childhood
 - F>M, boys less likely to report
 - Peak risk = 7-13 years (12%M, 18%F between 13-16 yrs- Erickson 1991)
- Risks
 - Less supervision and support
 - Substance abusing / violent home

Epidemiology- CSA, the facts

- Abusers

- Intrafamilial 50 F, 10-20% of M
- Adol F 84% knew assailant (Koss 1987)
- Boys, acquaintances outside home
- 10% female perpetrators?
- ¼ to 1/3 of male offenders = juveniles, most abuse >1 child (Becker 1994)

- Type of abuse

- When by family member, 23% vaginal pen & oral, 41% digital pen touching, 36% over clothes
- When by non-family , more very serious penetrative assaults

Allegations

- < 50 % tell anyone – retrospective studies?
- Most = Accidental disclosures (Sgroi1982)
 - (74% = accidental, Sorenson and Snow 1991)
 - not Bradley and Wood 1996 - 78% full initial disclosure
- Intentional disclosures = delayed
- CSA Accommodation syndrome (a model)
 - Secrecy, helplessness, entrapment and accommodation, delayed unconvincing disclosure, retraction (Summit 1982)
- The process of disclosure (a model)
 - Denial, tentative disclosure, active disclosure, recantation, reaffirmation (Sorenson and Snow 1991)

False allegations

- Custody disputes
 - Wakefield and Underwager 1991 – timing of allegation might suggest fabrication?
 - Parent alienation syndrome (Gardner 1992)
 - No evidence, hotly disputed (Faller 1993)
- Intentionally false / fabrication (tiny %)
 - CIS-98 12% separated cf 4% overall - most = neglect, fa > mo (Bala 2001)
- Misinterpretation
 - by child
 - by parent
 - by professional
- False memory syndrome / recovered memory
 - (induced by therapist?)

Child's Behaviour

- Sexualised behaviour
 - Developmentally average (same age, size and level – Cavanagh-Johnson 1999)
 - Normal range but not due to abuse
 - Concerning for abuse – or just problematic?
 - Cultural influences 'average' and 'OK' behaviours
- Nonspecific behaviour change or disturbance
 - 30% asymptomatic (Kendall-Tackett 1993)
 - Sign of emotional distress (aggression, tantrums, sleep disturbance, appetite change, depression, withdrawal, substance abuse, school problems, self injury,)
 - In context of child's developmental level
 - Common 'normal' behaviour problems (30% 3-8 yo have nightmares, 10% 6 yo wet bed)
- Odd behaviour but due to recognised cause
 - Autism spectrum disorder
 - Intellectual disability
 - ADHD
 - Mental illness

Screening tools

- Freidrich – CSBI = not a diagnostic tool
- Sexual behaviours and PTSD? (Kendall-Tackett 1993)- maybe?
- Dubowitz 1992 – CBCL not diagnostic
- Drach 2001 – sexual behaviour = no help
- Conclusion – not to be used diagnostically to diagnose or exclude CSA

Examination findings

- Pattern of injury on body
 - Defense wounds
 - Age related patterns (intracanal intercourse)
 - Type of alleged abuse - related patterns (penetrative injuries)
- Pattern of injury on genitals
 - Photo-documentation = gold standard
 - 4% findings = diagnostic of abuse (Hegar 2002) eg. Hymenal transection
 - Most children's examination findings are within the normal range
 - Incr. knowledge of variants/ nonspecific abN
 - specialist area of paediatric medical practice in UK and USA



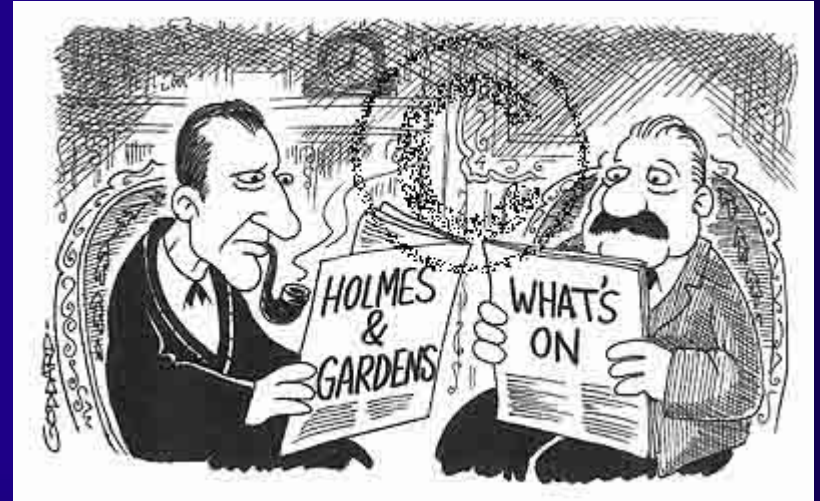
Investigations

- Sperm on microbiol swab / in urine
- Pregnancy
- Sexually transmitted infection (AAP)
 - Gonorrhoea, Syphilis, Chlamydia, HIV = diagnostic
 - Trichomonas, condylomata, genital herpes prepuberty = suspicious
 - Bacterial vaginosis = inconclusive
- Toxicology (drugs, alcohol)
- Other injuries due to abuse (fractures, bites)
- Unlikely to be due to CSA - Pubic lice, molluscum, warts



Forensic evidence

- Offender DNA
- Semen, body fluids
- Suction bruising (love bites)
- Other wounds / injuries
- Debris from crime scene
- Protocols and expertise = essential
- < 72 hours – prompt examination and collection (chain of evidence)
- Clothing and linens = best yield (Christian 2000)
- Other
 - Products of conception
 - Fingerprints



Child Protection

Risk assessment frameworks underpinned by

- Lit review
- Stats

Collate all available evidence

- Epidemiology
- This child's life circumstances
- Cluster of 'risk factors for abuse' – population health
- 'forensic interview' and / or VATE (the story)
- Medical evidence (+ exam and investigations and opinion)

Decision making tools, best practice

Case planning (literature about effectiveness and value)

- More than 'feels right' or theoretically more respectful

Protective intervention

- Aim = alter the trajectory of a child's life – for the better
- Continuum – vulnerability to experiencing abuse
- Welfare and protective intervention = concurrent
- Effective use of community based services to meet child's needs and family's needs



"Child Protective Services here. We understand you're keeping an infant in a manger."

Police

- Criminal profiling - characteristics of offenders
 - Schemas for classifying offenders –
 - interpersonal offenders - lots contact, relationships with children
 - sadistic offenders violent acts lead to arousal
 - Recognise the juvenile offender!
 - 58% adult offenders started as teens (Abel 1985)
 - Median age 14-15 years (Ryan 1991)
 - 49% been sexually abused 19% PA (Johnson & Shrier 1985)
- Confessions = ‘the gold standard’
- Covert video surveillance / ‘nannycam’
- Healthy Skepticism

Police

VATE

- Truthfulness – ask the question
 - Memory – the good, the bad, the suggestible
 - Ceci, Powell
 - Non-leading questions
 - Interview process = standard, accountable
 - Free narrative
-
- DATA
 - Sexual crime rates & regions
 - Conviction rates & types of crimes

Court

- NB. Not guilty does not mean the crime did not occur.
- Differing degrees of certainty in different courts
 - Balance of probability VS beyond reasonable doubt
- Judgement based on careful deliberation
 - current law
 - witness credibility
 - quality of expert and factual evidence
- Probitive vs prejudicial value



Court

- Evaluation of expert opinion
 - Criteria determine who might be ‘an expert’
 - Criteria determine what / how evidence is presented
 - Credibility is important – ‘weight’ of evidence
- Scrutiny of the evidence - cross examination
 - Deliberately challenge the evidence and the expert
- Consensus view vs unique viewpoint
- Daubert

Daubert:

whether the theory or technique in question can be (and has been) tested, whether it has been subjected to peer review and publication, its known or potential error rate, and the existence and maintenance of standards controlling its operation, and whether it has attracted widespread acceptance within a relevant scientific community

Daubert v. Merrell Dow Pharmaceuticals (92-102), 509 U.S. 579 (1993)

Recognising Child Sexual Abuse

The Evidence Base

- We share (most of) the theoretical knowledge
- Some evidence 'arises' from a narrow source (eg interpretation of genital findings)
- All evidence is not equal
- A broad understanding of different types of evidence is required
- Understanding how evidence is gathered and compared increases appreciation of its value /weight
- Recognition
 - Open mind – alert to populations where prevalence is high
 - Suspicion
 - Recognition (ah ha phenomenon?)
 - Question : could it be something else?
 - Evaluate evidence from multiple sources / varying weights
 - Confirm it (substantiation) or exclude it – ie. get it right!