‘I just wanted someone to ask me’: when to ask (about child sexual abuse)

Geoff Debelle [1], Robin Powell[2]

Listening to a child is a paramount activity, yet, the ‘silence is defeaning’.[1] The importance of hearing the voice of the child or young person who is traumatised, and the importance of justice to survivors, cannot be overstated. This applies particularly to survivors of child sexual abuse (CSA) where report of maltreatment might well influence the legal process. The article by Marchant *et al*[2] notes that imprecations to health professionals to listen and hear the child’s voice are not accompanied by explanations on how to do this ‘practically, well or safely’. They provide guidance on how to do this, through expertise gained through Triangle Services for Children, an independent organisation enabling children and young people to communicate, especially in legal proceedings. The authors use the ‘Opening Doors’ framework that ‘draws on what is known about children’s memory and children’s testimony’. One author (Ruth Marchant) died in December 2018. She was an experienced forensic interviewer who brought considerable expertise and humility to bear, particularly with very young children.[3]

There is potential difficulty in how a paediatrician might enable a child to tell their story and how that might impact on the child’s need for justice that is duly recognised by the authors of this timely and important paper. This commentary provides both paediatric (GD) and legal (RP) insight into this tension. This will inevitably reflect the situation within England and will reflect the situation in other jurisdictions.

The authors of *Opening Doors* have ‘reframed’ the term ‘disclosure’ for reasons that, within the ‘Opening Doors’ framework, and with its specific meaning in the legal system, seem valid. This article will adopt ‘report of maltreatment’ which is used in HM Government guidance instead of ‘disclosure’.

CSA is associated with adverse effects on physical and mental health that, without effective intervention, can have severe, lifelong consequences. These include anxiety, depression, poor self-esteem, feelings of despair, conduct disorder, functional somatic symptoms, drug and alcohol misuse, eating disorders,[4–6] self-harm and suicidal behaviour,[7] and sexually harmful behaviours, particularly in male victims.[8] These adverse effects are worsened by cumulative trauma,[9 10] particularly when there is polyvictimisation from other adverse childhood experiences.[11] An important mediating factor is post-traumatic stress disorder (PTSD) or complex PTSD, particularly in girls, with conduct disorder being more prominent in boys.[12 13] Symptoms of PTSD include anxiety, intense crying, excessive clinginess, fits of rage, somatic symptoms such as abdominal pain, trouble falling asleep or night waking, panic attacks triggered by exposure to say, the perpetrator, feeling ‘jumpy’, regression in continence, and social isolation.[14] In addition, complex PTSD may manifest as negative self-worth, a greater sense of disconnectedness and emotional dysregulation such as extreme anger.[15]

Prompt report of of CSA is associated with better outcomes.[16] It helps to prevent revictimisation and allows the survivor earlier access to evidence-based, cost-effective interventions such as trauma-focused cognitive behavioural therapy that have resulted in significant reduction in PTSD symptoms.[17 18] However, many survivors never tell.[19] Those that do tend to ‘disclose’ to a non-abusing parent, peers or teachers but not to health professionals.[20] Absence of report of maltreatment is reflected in the huge gap between the frequency of sexual abuse obtained from self-report measures (7.6%) and informant studies during childhood (0.4%),[21] a discrepancy that cannot be accounted for by study characteristics alone. A number of studies have investigated reasons for delayed report of maltreatment.[19 22] These include fear of not being believed, fear of consequences for themselves and others, guilt, self-blame, low levels of family support, and intrafamilial abuse, and, particularly germane to this commentary, lack of opportunity to ‘disclose’; they had not been asked. Young people were communicating that something was not right but were unable to articulate this verbally.

In this respect, McElvaney[19] noted that ‘questions did not need to be about sexual abuse per se but rather questions prompted by the young person’s psychological distress’; to set the right context, ask after the child or young person’s well-being. Yet, many of the symptoms of PTSD are age-appropriate, non-specific and without a clear symptom pattern to guide clinicians; in one study, about a half of confirmed cases of CSA did not display any recognisable symptoms of PTSD or complex PTSD.[23] Even more difficult for a paediatrician in a busy outpatient clinic is the recognition of non-verbal cues, facial expressions of shame (gaze eversion) and disgust, and the ‘more polite smiles’ of those children who have not disclosed.[24] In acknowledgement of these difficulties, screening for PTSD symptoms in children where there is concern about hidden trauma or adverse childhood experiences has been advocated by some authors[12] but others caution against this.[25] (This issue is beyond the scope of this editorial.)

When the clinical context is right; that is, there is an interaction between the child and clinician that allows a child and young person to feel safe enough to offer verbal or non-verbal cues of distress, the right questions should be asked. Marchant *et al*[2] provide expert advice on how to do this by creating a safe and trusting relationship and then accompanying the child while they tell their story. They argue that current advice to health professionals is proscriptive to the extent that it precludes clinicians from asking enabling questions. They advocate the use of open questioning, thereby avoiding a ‘yes’ or ‘no’ answer and then encouraging the child to continue, without directing their account in any way, by using phrases such as ‘uhuh’, ‘tell me more about that’. They also give a worked example of ‘Opening Doors in action’. This use of open, carefully phrased, non-leading questions is in tune with what adult survivors advocate. ‘Open questions enable communication of your willingness to listen without leading to the answer you are necessarily expecting; it does not invite specific allegations while giving confidence that someone is listening’.[26]

Can this be done without placing the child and their story in jeopardy of being rigorously challenged in the courts? Might the advocates of the accused attempt to challenge and

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devalue a child's story that has been seemingly encouraged, coached or prompted in any way? The child's report of maltreatment is of prepotent importance in the legal system as corroborative medical evidence of abuse is often lacking.[27] Although the child or young person will undergo a formal forensic interview in most jurisdictions (such as Achieving Best Evidence video interview in England) that will be admitted in the courts, the case may not be taken forward if there are underlying concerns relating to the strength or otherwise of the child's report of maltreatment. In many jurisdictions, the attrition rate of CSA cases being brought to the courts is very high.[28] If the child's case does get to court, there is a risk of retraumatisation if they are subject to rigorous and repeated cross-examination.[29] Despite the intervening law reforms designed to improve the experience of child witnesses in court, a recent Australian study found that, relative to their historical counterparts of past decades, contemporary child witnesses are subjected to 'a much broader range of strategies and tactics'.[30]

The current advice to social care, education, health and other professionals is contained in statutory guidance which must be followed by healthcare professionals, 'Working Together to Safeguard Children'.[31 32] The advice is not prescriptive but it does provide a framework for a dedicated named doctor and nurse for safeguarding. Working Together is supplemented by 'What to do if you're worried a child is being abused'[32 32] which is not statutory advice but has been produced to help practitioners identify child abuse and neglect and take appropriate action in response. The advice is:

> If a child reports, following a conversation you have initiated or otherwise, that they are being abused and neglected, you should listen to them, take their allegation seriously, and reassure them that you will take action to keep them safe. You will need to decide the most appropriate action to take, depending on the circumstances of the case, the seriousness of the child's allegation and the local multi-agency safeguarding arrangements in place. You might refer directly to children's social care and/or the police, or discuss your concerns with others and ask for help. At all times, you should explain to the child the action that you are taking. It is important to maintain confidentiality, but you should not promise that you won't tell anyone, as you may need to do so in order to protect the child.

In England and Wales any record made by a medical professional of a report of maltreatment of a child will be disclosed to the defendant in criminal proceedings or the respondent in family proceedings. The same may be true of other jurisdictions. If the report is disputed it is possible that the author of the record will be required to give evidence to be challenged by the defendant or respondent. Any discrepancy, leading question or suggested cause of maltreatment between the initial record taken by the professional and a later investigation may be used by the accused's legal representatives to challenge and undermine the truth of the report of maltreatment in cross-examination of the health professional and of the child.

Thus, there is substance to the advice, 'don't investigate, avoid questions that are leading, don't press the child for information'. However, the contribution by Marchant *et al* is welcome; as an example of good practice, it is thoughtful, thought-provoking and timely. It is written with a passion that reflects the late Ruth Marchant's expertise in the often difficult process of engaging and talking with traumatised children and young people.

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