Psychiatric Bulletin (1989), **13**, 311–315

Correspondence

Assessment and management of sexually abused children

DEAR SIRS

Sometimes guidelines for a group of specialists are not only of great use to those specialists but of considerable value also to their colleagues in other specialties. I found that to be true of the report on 'Child Psychiatric Perspectives on the Assessment and Management of Sexually Mistreated Children' (*Psychiatric Bulletin*, December 1988, **12**, 534–540).

As a paediatrician, I know that some child psychiatrists are heavily involved with child abuse and others barely at all, and I have wondered how the latter group manage to get away with it. Perhaps it is because of the statement on page 535 (ref 2, p. 22) that "child psychiatric intervention is only justified in cases of child sexual abuse where the child and/or the family displays psychiatrist disorder". Do the members of the working party who devised this report only wish child psychiatrists to be involved where there is *gross* overt disorder? Does it not think that there is perhaps some disorder in any family where child sexual abuse occurs?

I would be sad if child psychiatrists only became involved with child abuse when there was gross psychiatric disorder. Child abuse, and particularly sexual abuse, is difficult to deal with and child psychiatrists are in a strong position to deal with it better than most. In the first instance they ought to be better at talking with children and at discerning the truest version of events and helping with the initial disclosure: surely they are better at that than most social workers, police surgeons and paediatricians. Moreover with their understanding of families they must be in a better position to deal effectively with the turmoil that allegations of abuse produce for that family, and they ought to be effective in helping with the conflicting emotions and problems of social workers, nurses and doctors who are struggling to deal with child abuse.

The new committees replacing the former Area Review Committees are not mentioned in the report. I fear that sometimes these committees have not valued the potential contribution of child psychiatrists sufficiently.

In some districts there are three or four paediatricians on the committee but no child psychiatrist. Yet the duties of the committee include reviewing the arrangements for identifying and monitoring suitable training for professionals working with child abuse, and play an important role in bringing together some of the key people from different agencies concerned with child abuse. Child psychiatrists should stake their claim for a least one place on those committees.

Many of us may sigh when we encounter another abused child, and I am sure child psychiatrists must sigh as long and hard as anyone, because the ensuing work and worry will be immense. However, there are many people who recognise the volume of that work load and who wish that child psychiatrists would state more clearly that the only way that they can deal effectively with that work is by having more training posts and more consultant staff. If child psychiatrists do that they will be supported strongly by several allied specialties.

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DEAR SIRS

I read with interest the article on child abuse prepared by the Working Group of Child and Adolescent Specialist Section in the *Psychiatric Bulletin* (December 1988). I found it very readable, informative and of practical help, especially on difficult aspects such as confidentiality and interviewing abused children. Looking at the recent problems experienced by professionals working in the difficult area of child abuse, especially child sexual abuse, the great necessity is seen for a multidisciplinary approach and use of case conferences to facilitate communication between us (Butler-Sloss, 1987). The problem I have experienced is finding the time to attend these conferences as they are usually announced only at short notice and have to be accommodated into an already busy working week. Apparently, we may be able to claim for attending such case conferences unless it is written in our contracts that this service should be provided (Simmons, 1988).

I also found the section on "court work" interesting (Working Group of the Child and Adolescent Specialist Section, 1988). It does seem that child psychiatrists will be increasingly involved in court related work but they have little training in court work unless they have had, like me, the opportunity of accompanying one's consultant to court. The training we do have tends to be acquired when we are actually performing in court. Finally, courts can be very demanding of our time and although the courts state that they do give priority to "invalids and doctors", this does not always happen and we can find ourselves waiting outside court for what seems,

and sometimes is, ages. If the court expects us to attend cases, attempts should be made for us to have priority so that we can find time to see our patients and perhaps, if we are lucky, have lunch.

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SIMMONS, S. (1988) Money briefing. *B.M.A. News Review*, (December).

WORKING GROUP OF THE CHILD AND ADOLESCENT SPECIALIST SECTION (1988) Child psychiatric perspectives on the assessment and management of sexually mistreated children. *Psychiatric Bulletin*, **12**, 534–540.

DEAR SIRS

I welcome the document prepared by the Working Group of the Child and Adolescent Specialist Section on child psychiatric perspectives on the assessment and management of sexually mistreated children (*Psychiatric Bulletin*, December 1988). It is timely, balanced, clear and comprehensive. The one area where I feel further clarification is required concerns the advice that "in exceptional circumstances the psychiatrist may decide that the child's best interests can be safeguarded without breaking confidentiality". I wonder what might constitute such exceptional circumstances and how can the psychiatrist "adopt full responsibility for the child's protection from re-abuse" in such circumstances, without stepping outside of his role?

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DEAR SIRS

We would like to thank Professor Meadow for highlighting the primary direction and point of our document, which was to emphasise the signal contribution we have to make to children in families where CSA has occurred. We have the necessary skills to combine a view of physical, emotional and intellectual problems, child development, experience with children, communicating with children and assessment of children and families; and work and communication with related disciplines. We thought this was clear both from the whole document as well as our conclusions. However, we were primarily addressing our own colleagues not wider groups. Had we been doing so, our paper would have been less concerned with specific practical details and more focused upon our wider role.

The description of child psychiatric services and CSA appears to give rise to some misinterpretation about our role in relation to assessment and diagnosis, treatment and finally wider work. Most of the points which Professor Meadow makes were in fact contained within this section, but it was necessarily dense because we had much to cover in the document. For example, the last sentence of 'wider work by child mental health services' (p. 535) is a reference to the child psychiatrists' involvement in local procedures, and although we did not mention child protection committees, it is clearly that which is meant. However, his point about the child protection committee is well taken and we certainly agree that at least one child psychiatric slot should be mandatory. As for our involvement in treatment services, we recognise a role in relation to the disturbed child and family and not merely the overtly or grossly disturbed child. Under 'wider work' we emphasise the importance of consultation. The only area of work which we have recommended that child psychiatrists are not routinely involved in is the initial investigation of most cases, but again we see an important consultation role. Further, we *do* write ourselves into the initial investigation of complex cases involving very young children, severely disturbed, mentally handicapped and the suspicions arising in complex circumstances such as matrimonial disputes. We also see an important involvement either through consultation or directly in the investigation of institutional abuse where we could bring the degree of objectivity required.

In his last paragraph Professor Meadow makes the case about the work load. It is heartening to see the recognition by a senior paediatrician of the heavy work load that child psychiatrists often are asked to and do undertake. However, we would also note that some of the child abuse work load is not new. There is an increasing tendency for many of the child and family problems that have been dealt with within child psychiatry for many years to be re-assigned to the label of child abuse or sexual abuse.

Finally, while we would advocate a wider role for child and adolescent psychiatrists in CSA (and this has crucial manpower implications), it would be counterproductive to advise them to devote a disproportionate amount of their time to this problem. A balanced view is absolutely essential about the specification of our specific as well as our overlapping roles with other disciplines so that we maintain due respect for these professions' mandates and level of skills.

WORKING PARTY
Child and Adolescent
Specialist Section

Child psychiatry service

DEAR SIRS

T. J. Dyer queries the assumption of the multidisciplinary nature of child psychiatry (*Psychiatric Bulletin*, February 1989). In my view, most medical