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Practice Tool

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Dartington

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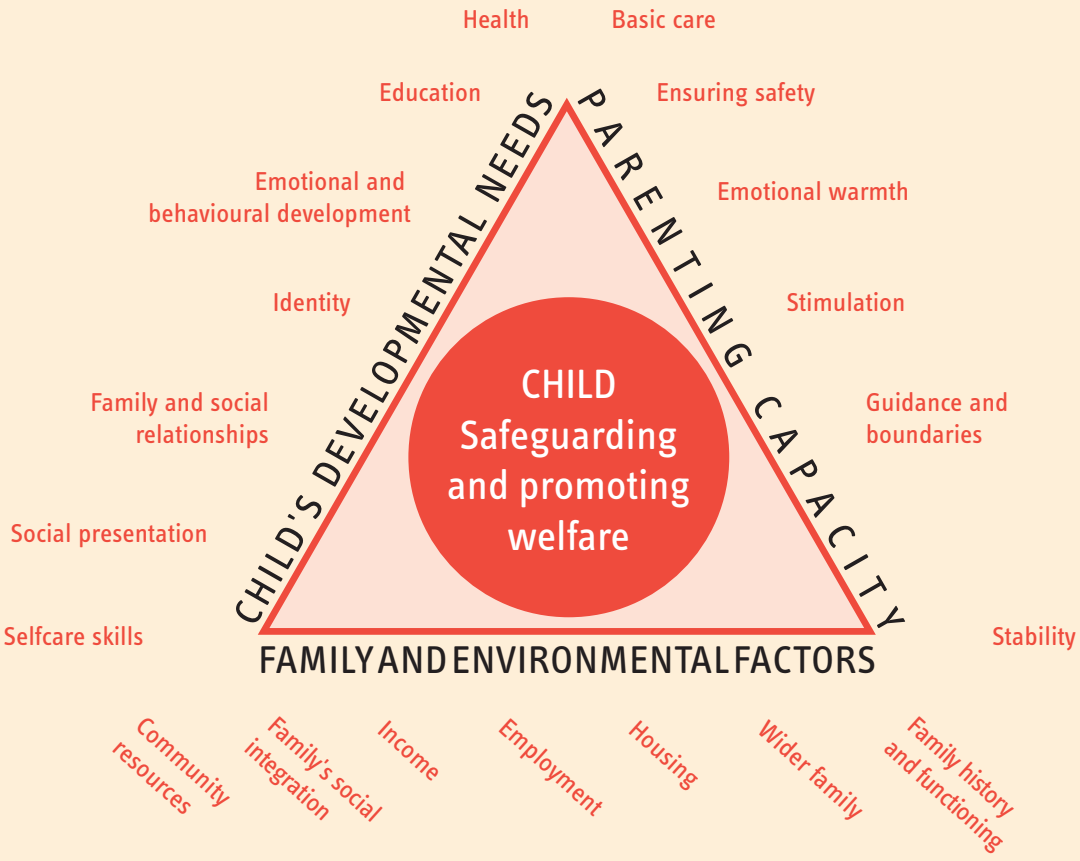
Introduction

This resource is designed to support practitioners to use research evidence to structure their thinking in relation to intra-familial child sexual abuse (IFCSA). Where a case is open to children's social care it may be that:

a) There are concerns about IFCSA, but no physical evidence to verify sexual abuse is occurring/has occurred nor has a child told someone about abuse.

b) A child protection case (involving any form of maltreatment) is being 'stepped down' but concerns about IFCSA remain.



The resource is designed to be used alongside assessment activities structured by the *Framework for the Assessment of Children in Need* (Department of Health, 2000). The focus is on practice with children who are already receiving statutory intervention for other issues (such as neglect or physical abuse) as this engagement provides a prime opportunity to improve the identification where children may also be experiencing sexual abuse within the family.

The idea is to use this alongside existing assessment processes, either while doing an assessment (to focus an analysis in relation to this issue) or when reviewing information that has already been gathered.

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

The three core sections address:

1. Risks and vulnerabilities associated with IFCSA.
2. Indicators (signs) associated with IFCSA.
3. Factors that may protect children against IFCSA.

The presence of risk/vulnerability factors and/or indicators does not mean that a child is currently experiencing, or has experienced abuse. Risk factors or indicators are not 'predictors' of child sexual abuse (CSA) they are factors that have been shown through research to be associated with CSA (i.e. a relationship has been established between that factor or indicator and CSA). They should be used cautiously; sections one and two will help you to think about how they may be interpreted. **The final section** offers suggestions on social work responses to support children and safe parents/carers.

Terms and definitions

Throughout this resource, where the acronym CSA is used, it refers to all forms of sexual abuse that would fall under the statutory definition of CSA:

... forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Department for Education (2015)

Intra-familial child sexual abuse

The Children's Commissioner for England's (CCE) inquiry defined CSA in the family environment as:

... sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member. Within this definition, perpetrators may be close to the victim (e.g. father, uncle, stepfather), or less familiar (e.g. family friend, babysitter).

CCE (2015)

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Some research looks at CSA in general - including both extra- and intra-familial perpetrators. In discussing these studies, we refer to CSA. Where the research relates specifically to intra-familial CSA, the acronym IFCSA is used.

Policy and practice context

CSA is a complex social problem which often occurs alongside other forms of abuse, victimisation and adversity. One form of CSA, child sexual exploitation (CSE) has been the focus of public concern in recent years (Beckett et al, 2017; HM Government, 2017), raising awareness of a previously neglected area of safeguarding. However, this has come at the expense of attention to sexual abuse in the family environment (Allnock et al, 2015; Smith et al, 2015). Various initiatives set out to redress this imbalance, including:

- The CCE inquiry to investigate (CSA) in the family environment (Horvath et al, 2014; CCE, 2015).
- The establishment of the Centre of Expertise on Child Sexual Abuse, which aims to support system-wide change by identifying, generating and sharing high quality evidence on all forms of CSA - **www.csacentre.org.uk**

The CCE inquiry estimated that perhaps one in eight children abused in the family environment come to be identified by professionals, with the remainder unknown to protective services. Those who come into contact with statutory services are typically first identified from the age of 12 but the abuse for many will have started when they were much younger (Smith et al, 2015).

Why are we failing to identify so many children who are experiencing this type of abuse? Of those identified, why are we failing to notice them at earlier stages?

- CSA that occurs within the home is usually hidden and can often be obscured by 'normal' parenting activities and behaviours.
- IFCSA is very difficult for children and young people to talk about; many do not seek help for years.
- Social care practitioners may lack the knowledge and skills to recognise and respond confidently (Martin et al, 2014).
- IFCSA may be obscured when other issues are the focus of child protection plans and direct work (CCE, 2015; Martin et al, 2014).

The scale of IFCSA

Estimates from general population studies are likely to under-represent the numbers of children and young people who have experienced or are experiencing sexual abuse. The most recent UK study of prevalence found that 24.1 per cent of respondents aged 18 to 24 reported having experienced *contact and/or non-contact* sexual abuse in their childhood or adolescence, while 12.5 per cent reported *contact only* child sexual abuse (Radford et al, 2011).

It is even more difficult to establish the scale of IFCSA. Using the broad definition of abuse in the family environment referred to above, the CCE estimated that two-thirds of all CSA is likely to be attributable to abuse 'in and around the family environment' (CCE, 2015).

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Poly-victimisation

Poly-victimisation is defined as the experience of multiple victimisations of different kinds - in *different domains* of a child's environment - such as sexual abuse, physical abuse, bullying in school, witnessing community violence or being exposed to family violence (Finkelhor et al, 2005).

The emphasis here is on *different kinds* of victimisation, rather than multiple episodes of the same kind of victimisation. There is no consensus about any numerical threshold that might be used to identify a child as a poly-victim – is it, for example, five or ten different types of victimisation that classify a child as a poly-victim?

- Research suggests that the greater number of victimisations experienced, the greater the impact on children's mental health and wellbeing (Finkelhor et al, 2011).
- When a child experiences *any* type of familial maltreatment, the risk for experiencing *any other* type of abuse or victimisation rises (Radford et al, 2011).

The concept of poly-victimisation raises the possibility of adopting a 'contextual safeguarding approach' in relation to IFCSA. Developed by Carlene Firmin to address adolescent risk *outside* the family environment, the approach encourages practitioners to consider all spheres of children and young people's lives and to avoid siloing locations/contexts of harm.

In relation to IFCSA this approach is noted by practitioners as potentially helpful in making earlier links to organised family abuse. Access contextual safeguarding materials and connect to a network of practitioners at **www.contextualsafeguarding.org.uk**

Cumulative and interacting risk of harm

The risk raised by exposure to multiple family vulnerabilities is cumulative - a greater number of vulnerabilities is associated with increased risk to children's wellbeing, mental health and safety (Davidson et al, 2008). Evidence from the analysis of Serious Case Reviews suggests that parental issues to be alert to in safeguarding children include:

- Domestic abuse, mental health, drug and alcohol misuse (combined or singly).
- Parents' own adverse childhood experiences.
- Involvement or history of crime (especially for violence).
- Patterns of multiple consecutive partners.
- Acrimonious separation.

Sidebotham et al (2016)

Child sexual abuse and children with disabilities

Disabled children are a particularly vulnerable group, with a higher incidence of abuse than among their non-disabled peers (Reiter et al, 2007; Sullivan and Knutson, 2000). Poor recording of disability on case records makes it impossible to understand the prevalence / incidence of IFCSA among disabled children and challenging to understand their particular needs (Allnock et al, 2009 and 2015; CCE, 2015) but children with disabilities may face issues such as:

- dependency on multiple carers
- impaired capacity to resist or avoid abuse
- communication barriers
- in some cases, an inability to understand what is happening to them or where to go to seek help (Miller and Brown, 2014; Sidebotham et al, 2016; Warrington et al, 2017).

Sexual abuse by siblings

Sibling sexual abuse is more common (possibly three to five times more) than sexual abuse perpetrated by other family members (Monahan, 2010). We also know that adolescents who sexually offend usually do so first within their family (Miranda and Corcoran, 2000).

The most common, but not the only, pairing of sibling sexual abuse is evidenced to be brother-sister (Kreinart and Walsh, 2011; Carlson et al, 2006; Welfare, 2008). Adolescents who sexually abuse younger children may select females, males or both as victims (Tidefors et al, 2010). Early onset of harmful sexual behaviours within the family environment may present risks to children in the wider family or community, known as 'victim crossover' (Allardyce and Yates, 2013).

Peer group information capture

Firmin et al's (2016) 'peer group information capture form' is designed to inform assessment of young people who have been abused by a peer and could be a useful template in a case of sibling sexual abuse where victim crossover is a concern, in cases of technology-assisted abuse or where there may be a concern that an adult may be abusing a child within the family and other children in the wider community.

www.contextualsafeguarding.org.uk/assets/documents/Extract-1-Towards-a-Contextual-Response-to-Peer-on-Peer-Abuse.pdf

Technology-assisted abuse (online child sexual abuse)

Practitioners cannot afford to view 'offline' and 'online' abuse as distinct spheres in children's lives. Perpetrators in the family environment may use technology as part of their abuse (Hamilton-Giachritsis and colleagues, 2017) and professional curiosity about a child and family's online activity may reveal helpful information about abuse that is occurring across these spheres.

Images and/or written communication provide a potential source of evidence, whereas with contact abuse we are often reliant on children to communicate that abuse has occurred. Research finds that online abuse it is at least as harmful as contact CSA. There are particular dynamics that compound this, for instance the relative permanence of images and the ability to use images to coerce and threaten children (The Canadian Centre for Child Protection, 2017).

Research in Practice has produced a publication on the topic, *Online abuse - recognition and response: Frontline Briefing* (Randall, 2017):
www.rip.org.uk/online-abuse

The impacts of child sexual abuse

The impacts of CSA are likely to reflect an individual child's developmental stages and needs (Fisher et al, 2017) and any protective factors around them that support their resilience. It may also be that impacts do not emerge until they grow older. When CSA occurs alongside other forms of abuse or victimisation, it may well be difficult to disentangle impacts specific to CSA from impacts specific to other forms of adversity, or the interaction of a number of such experiences.

Views from practitioners

Children and young people who have experienced sexual abuse may have experienced the kind of sexual responsiveness that is associated with physiological arousal to stimulation. Moreover, some children and young people's perceptions of the abuse will be intertwined with affection, 'love', pleasure and being made to feel 'special'.

This may be uncomfortable for some practitioners to contemplate; however, these are valid victim experiences which cannot be ignored. The child may feel guilt or shame that they experienced sexual arousal and this in itself may be a barrier to seeking help because they may feel complicit in the abuse as a result (see Sanderson, 2006).

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Table 1: Impacts of CSA across the life course (Allnock, 2015)

LIFE STAGE	REPORTED IMPACTS
Immediate and short-term impacts	***Physical health impacts***[1] Genital and/or anal injury; tearing of hymen / blood loss (girls); pain in the genital area and painful urination (boys and girls); sexually transmitted diseases (STDs) in small numbers of children. ***Behavioural impacts***[2] Harmful sexualised behaviours.
Medium and longer-term impacts	***Physical health impacts***[3] HIV infection; increased rates of gastro-intestinal, gynaecologic and cardiopulmonary symptoms; higher rates of obesity; more physical health symptoms reported; and poorer self-perceptions of overall health. ***Psychological impacts***[4] Deliberate self-harm; post-traumatic stress disorder; Suicidal ideation/suicide attempts; depression and anxiety; 'borderline personality disorder' (BPD); conduct/anti-social personality disorders; Dissociative identity disorder (DID). ***Educational impacts***[5] Adverse educational outcomes and school adaptation; poorer cognitive, intellectual, performance, and achievement scores; disruptive behaviours at school and difficulties in integrating into peer groups. ***Later abuse and victimisation***[6] Later sexual re-victimisation by other perpetrators; possible link with sexual exploitation. ***Behavioural impacts***[7] Alcohol and other substance abuse including nicotine dependency; risky sexualised behaviours; increased arrest rates for sex crimes such as 'sex trading' (in other words, for money, drugs or shelter) for both women and men. ***Interpersonal relationships***[8] Problematic interpersonal functioning, including intimacy difficulties; and problems in parenting and pregnancy.

[1] *Adams et al, 2007; McCann et al, 2007; Royal College of Physicians, 2008; Birdthistle et al, 2011; Ingram et al, 1986; Atabaki and Paradise, 1999; Woods, 2005; Centers for Disease Control and Prevention, 2010; and see review by Maniglio, 2014*

[2] *Herrenkohl et al, 1998; Putnam, 2003*

[3] *Woods, 2005; Irish, Kobayashi and Delahanty, 2010; Hulme, 2000; Newman et al, 2000*

[4] *Klonsky and Moyer, 2008; Fliege et al, 2009; Maniglio, 2011 and 2014; Chen et al, 2010; Neumann et al, 1996; Paolucci, Genius and Violato, 2001; Beitchman et al, 1992; Jumper, 1995; Putnam, 2003*

[5] *Daignault and Hébert, 2009; Mannarino, Cohen and Gregor, 1989; Paradise et al, 1994; Wells et al, 1997; Dubowitz et al, 1993; Calam et al, 1998*

[6] *Messman-Moore and Long, 2000; Roodman and Clum, 2001; Classen, Palesh and Aggarwal, 2005; Maniglio, 2009; CEOP, 2011; Barnardo's, 2012; Berelowitz et al, 2012; Cockbain and Brayley, 2012*

[7] *Nelson et al, 2002; Min et al, 2007; Paolucci et al, 2001; Arriola et al, 2005*

[8] *Herman, 1981; Jehu, 1988; Westerlund, 1992; Davis and Petretic-Jackson, 2000; Herrenkohl et al, 1998*

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'Disclosure' of abuse

... social workers should be conscious of the fact that the presumption that abuse has taken place can have damaging repercussions for the child and the family. Equally, an abnormally low level of alertness to the possibility of child sexual abuse may deter children from subsequently trusting adults sufficiently to reveal the fact of abuse to them.
MacDonald (2016)

In the context of legal proceedings 'disclosure' is a formal term, used alongside terms such as 'suspicion' or 'allegation' to indicate the status of evidence in a case. In research the term disclosure is used more loosely, to refer to children and young people telling someone about abuse, either directly or indirectly, through verbal or non-verbal means of communication.

As the judgment by Mr Justice MacDonald quoted above underlines, it is vital that practitioners are scrupulous in written language, court reports and cross-examination in the correct use of these terms, as this can have serious consequences for the investigative process. This is in no way at odds with the clear imperative to respond to children and young people's help-seeking with reassurance, recognition and appropriate action and to speak to them in language appropriate to their developmental needs.

A study with a sample of 60 abuse survivors (44 of whom had experienced sexual abuse) found that children and young people try to tell adults in many different ways:

- Some children and young people may try and seek help *indirectly* - for example, they may say to a parent: "I don't want to go to Uncle John's house overnight anymore."
- Children and young people may attempt to seek help in *non-verbal* ways, such as drawing pictures, writing letters or keeping a journal.
- Children may display behavioural signs and indicators. These may be intentional attempts to be noticed.
- Some children *partially* tell others about their abusive experiences. They may, for example, report what they perceive as 'less serious' in an attempt to stop sexual abuse.
- Children seek help through telling for a variety of motivations. They often want the abuse to stop, but sometimes they want to 'test the waters', to seek emotional support, to protect others (for example, siblings) or to seek justice for their abuse.

Allnock and Miller (2013)

Barriers to children and young people's help-seeking may be:

- **Related to the individual child**
  They may not understand what is happening to them, they may not recognise the experience as abuse or lack the vocabulary to describe it; they may feel intense shame and self-blame; they may worry that their response will have terrible consequences for themselves and their family.
- **Relational**
  For example, the perpetrator may threaten or otherwise silence the child; a child may have tried to tell someone previously and received a poor response from a trusted adult or professional.
- **Related to societal and community factors**
  The stigma attached to CSA may prevent help-seeking; a lack of available helping services means children do not know where to seek help.

Allnock and Miller (2013)

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Section One: Risk factors and vulnerabilities associated with child sexual abuse

Risk factors are characteristics or circumstances shown in research to be *associated* with CSA.

- The presence of particular risk factors may increase a child or young person's *vulnerability* to CSA, but, on their own, should not be taken to indicate CSA is occurring or might occur.
- Risk factors are not *predictors* of CSA. Similar factors are associated with risk for a range of abuse *other* than or *as well as* CSA.
- Risk factors are *cumulative*; as the number of risk factors that are present, the risk of abuse also increases (Finkelhor, 1990).

Identifying risk factors should be interpreted with great care, in context with other evidence such as indicators of CSA (addressed in section two) and protective factors (addressed in section three).

Table 2a sets out the risk factors associated with CSA across four domains:

1) The child

2) The family

3) The community

4) Society

Much of this research is from the USA or elsewhere as there is very little UK research to draw on. Ethnicity is not identified in the evidence as a risk factor for CSA so is not included in this table. In other words, membership of a particular ethnic group has not been found to raise the risk of CSA. UK data on IFCSA suggests that children from all ethnic groups can be at risk, although children from certain ethnic groups are under-represented in data held by statutory services (CCE, 2015).

Table 2b captures evidence from studies with sex offenders about their targeting and grooming of children, which offers insights about characteristics/environments which sex offenders spot and which motivate their choice of victim.

The template in **Appendix A** can be used alongside a child/young person's assessment case file to cross-reference with the information provided in Tables 2a and 2b to help 'build a picture' of evidence.

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Table 2a: Risk factors for child sexual abuse

Risk factors for CSA	Research evidence
Child risk factors	
Age[1]	Risk of CSA (all types taken together) rises with age. We do not have prevalence statistics that tell us whether IFCSA specifically is more common for younger or older children. UK evidence does tell us that, for a significant percentage of victims, IFCSA begins before the age of nine. Most, however, are not identified by authorities until the age of 12 or older. Girls may experience IFCSA at younger ages than boys.
Gender[2]	All of the research evidence in the UK on prevalence (abuse ever experienced) and incidence (abuse experienced recently) reports higher rates of CSA among girls than boys. Boys do experience CSA, however, and may face particular challenges to reporting abuse. Moreover, boys are less likely to be identified by practitioners for a range of reasons. All practitioners should remain alive to the particular needs and challenges of boys in terms of supporting them to speak about their abuse.
Physical and learning impairments[3]	Risk of CSA for disabled children is three to four times higher than for non-disabled children. Disabled children face particular barriers to reporting their abuse, and have been found to be less likely to report and more likely to delay help-seeking than children without impairments.
Single parent[4] **and stepfamilies**[5]	Several reviews find that a single parent family context is a risk. This may partly be due to sex offender strategies which target economic or emotional vulnerability in single parents (often women). It may also be due to the more limited capacity single parents may have to spend time with their children if they combine work with childcare. Supporting single parents both emotionally and practically can strengthen protective contexts around children. Risk of CSA to children may be higher with stepfathers or parents' partners than biological fathers. Potential explanations suggest that where there is less commitment to the parenting role, the risk of abuse may be higher. This by no means suggests that step-parents generally pose a danger to children, but does suggest attention to family contexts and relationships as a source of risk or protection.

[1] *Radford et al (2011); CCE (2015); Smith et al (2015)*

[2] *Bebbington et al (2011); CCE (2015); ONS (2016); Radford et al (2011); Stoltenborgh et al (2015)*

[3] *Hershkowitz et al (2007); Jones et al (2012); Miller and Brown (2014); Sullivan and Nutson (2000); Stalker and McArthur (2012); (Sidebotham et al (2016)*

[4] *Black et al (2001); Finkelhor (1990); McAlinden (2006); CCE (2015)*

[5] *Black et al (2001); Finkelhor (1990); Finkelhor et al (1997); Gordon and Creighton (1988); Marsiglio et al (2017); Mullen et al (1993); Paveza (1988); Putnam (2003); Russell (1984)*

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Risk factors for CSA	Research evidence
Family risk factors	
A parent, particularly a mother, also reporting experiences of CSA[6]	A parent who has experienced CSA in childhood and who has unresolved mental health and wellbeing issues related to past trauma may have reduced parenting capacity as a result. This may impact on their relationship with their child and/or their ability to recognise possible abuse. Supporting a parent who has experienced CSA in childhood to access appropriate therapeutic support may be one way of increasing protective context for children.
Unavailability of mother due to employment outside of the home, disability or illness[7]	A mother's unavailability may leave children isolated and/or on their own, inadvertently providing potential offenders with greater access. Supporting mothers and wider family networks to strengthen supervisory and emotional support may help to increase the protective environment around the child.
Parental neglect[8]	Children who are neglected may be more accessible to potential offenders as a result of supervisory neglect. Neglected children may seek out love and affection elsewhere and therefore be more vulnerable to the attention of others. Supporting parents to increase their capacity to parent may improve the protective context around the child.
Quality of parent-child relationship (particularly mother-daughter relationship)[9]	A child or young person may spend more time away from their parent/home, meaning they become more accessible to potential offenders outside the home. The poor relationship may affect their mental wellbeing and they may seek attention elsewhere. The parent may be unable to adequately communicate with their child and thereby protect them. Working with families to enhance parent-child relationships will support the development of a protective context around the child.

[6] *Black et al (2001); Finkelhor et al (1997)*

[7] *Finkelhor and Baron (1986)*

[8] *Allnock (2015b); Black et al (2001); Finkelhor et al (1997)*

[9] *Black et al (2001); Finkelhor and Baron (1986); Finkelhor (1990); Fergusson et al (1997)*

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Risk factors for CSA	Research evidence
Family risk factors	
Low parenting satisfaction (parents of sexually victimised children report being less satisfied with parenting than parents of children who were not sexually victimised)[10]	Low satisfaction with parenting may manifest in a reduced capacity to respond sensitively to a child, thus disrupting or diminishing the attachment a child makes to a parent/carer. Where this is the case, children may feel more isolated, increasing vulnerability to offenders. A poor relationship may impact on their self-esteem, increasing their vulnerability to grooming strategies. Supporting parents to increase their parenting capacities/abilities may help to increase the protective context around the child.
Family poverty[11]	Internationally, research documents a strong association between families' socio-economic status and the chances that their children will experience child abuse and neglect. The greater the economic hardship, the greater the likelihood and severity of abuse. Poverty is neither a necessary nor sufficient factor. Many children who are not from families in poverty will experience abuse and most children living in poverty will not. Direct and indirect effects of material hardship can interact with other factors to increase or reduce the chances of abuse. These interactions are complex and often circular. For example, poverty increases the risk of mental ill-health and mental ill-health increases the likelihood of poverty. Evidence suggests that individual practitioners and child protection systems currently pay insufficient direct attention to the role of poverty in child abuse.
Community and social risk factors	
Dangerous/violent communities[12]	Dangerous and violent communities have been linked to child sexual victimisation. It may be that this context is associated with family poverty and that poverty is the more important risk factor (i.e. that living in dangerous communities is a by-product of family poverty). Support to children and families that targets their practical and economic needs may help to increase the protective context of the child.

[10] *Black et al (2001); Manion et al (1996)*

[11] *Bywaters et al (2016); Finkelhor et al (1997); Paveza (1988); Sedlak et al (2010)*

[12] *Boney-McCoy and Finkelhor (1995)*

Table 2b: Perceived vulnerabilities in children: Evidence from studies of sex offenders

Children are never at fault for being targeted by offenders, and these studies serve to remind us of this. While not risk factors per se, the findings point to specific vulnerabilities that sex offenders seek out.

Perceived vulnerabilities in children	Research evidence
Low self-esteem and/or low self-confidence in children[13]	Sex offenders may seek out children with low self-esteem or self-confidence because they believe these children are less likely to tell. Where children do not have their emotional needs met they may be more responsive to grooming strategies by would-be abusers.
Children who are overly trusting of others[14]	Sex offenders report that they seek out children who are overly trusting in order to groom and manipulate them more easily.
Families with 'observable' problems[15]	While 'families with problems' are not often well defined in these studies, research shows would-be offenders targeting families where there has been some breakdown; and targeting single mothers who may be economically stressed and isolated.

[13] *Allnock (2015b); Berliner and Conte (1990); Conte et al (1989); Elliott et al (1995)*

[14] *Elliott et al (1995)*

[15] *CCE (2015); Craven et al (2006); Elliott et al (1995); Leberg (1997)*

Section Two: Indicators associated with intra-familial child sexual abuse

Defining 'indicators'

Indicators of CSA suggest a child is experiencing (or has experienced) actual CSA. However, like risk factors:

- Not all indicators of CSA are distinctive to CSA alone and may signal other problems.
- A child displaying these signs has not necessarily been sexually abused.
- Most cases of child abuse are not identified based on a single indicator but rather on clusters of indicators.
- The *absence* of indicators does not exclude the possibility that abuse is occurring.

Table 3: Indicators of IFCSA

The template in **Appendix A** can be used alongside a child/young person's case file to cross-reference with the information provided in Table 3 below to help 'build a picture' of evidence.

Indicators (signs)	Discussion
Physical indicators[16]	
- Genital pain/soreness.[17] - Genital/rectal bleeding or discharge.[18] - Enuresis (wetting the bed at night).[19] - Particular types of sexually transmitted infections may be indicators of sexual abuse (for example, Hepatitis B, anogenital warts; gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection).[20] - Pregnancy, especially when the identity of the father is concealed; the child is 13 and under; and if there is concern that a child has been sexually exploited.[21] Physical indicators may be a sign of other medical conditions and not necessarily CSA. Alternative explanations should be pursued as well as consideration of CSA where the physical indicators may have no alternative medical explanation or they are outside of 'normal' developmental stages.	The evidence base on physical signs of CSA is limited, partly because of the problems involved in conducting research in this area. Observable signs are relatively uncommon; this might be explained by the timing of examinations in relation to the abuse (NICE, 2009). Where physical signs might be present, they are unlikely to be easily observable by social workers or other support practitioners. Signs of discomfort, however, may suggest there are possible medical problems to be assessed. Discomfort may cause the child to limp, perform poorly at sport, drop out of strenuous play activities or even have difficulty sitting still. Information from other partner agencies such as health, including sexual health, will be beneficial in building a picture. The views of both children and parents would be important in determining whether there are any particular unexplained injuries or discomfort.

[16] *Evidence on physical indicators was drawn directly from the National Collaborating Centre for Women's and Children's Health (NCCWCH) guidelines When to suspect child maltreatmen - **www.nice.org.uk/Guidance/CG89***

[17] *DeLago at al (2008); Klevan and De Jong (1990)*

[18] *DeLago et al (2008)*

[19] *Klevan and De Jong (1990)*

[20] *Royal College of Paediatrics and Child Health (2008); **NICE guidelines direct that sexual abuse should be suspected only in certain cases – for example, under certain ages (13), the guidance directs that CSA should be suspected when there is no evidence that mother-to-child transmission during birth or blood contamination has occurred*

[21] *Delphi Consensus agreement (NCCWCH (2009); NICE guidelines direct that pregnancy between the ages of 13 to 15 should be considered in relation to consensual experimentation and should not automatically be considered CSA*

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Demeanours and behavioural indicators[22]

The indicators listed below are identified in the literature as being potential impacts of CSA. Other demeanours and behaviours not listed here may also indicate CSA. Demeanours and behaviours may not be related to CSA at all. These must be considered in relation to other information to hand.

- Indirect or non-verbal help-seeking. It may not immediately be recognised that a child is trying to tell someone what has happened. A child may say something like "I don't like going to grandad's house" or "I know a girl who..."[23]
- Fearfulness, where there are no other evident explanations.[24]
- Becoming withdrawn/withdrawing communication, particularly where this is a significant change from prior personality/behaviour. [25]
- Low self-esteem.[26]
- Internalising behaviours (this includes a number of internal stresses such as anxiety and depression).[27]
- Externalising behaviours (these represent interpersonal conflict such as aggression, oppositional behaviour and other 'anti-social' behaviours).[28]
- Nightmares.[29]
- Extreme distress.
- Sudden and unexplained behavioural or emotional change.[30]
- Sleep problems, in the absence of alternative explanations.[31]
- Concentration problems.[32]
- Sexual curiosity and knowledge (outside of developmentally appropriate standards).[33] This might include persistent and inappropriate sexual play with peers, toys, animals or themselves; sexual themes in a child's artwork, stories or play.
- Repeated and coercive sexualised behaviours, particularly in boys.[34]
- Dissociation in the absence of a known traumatic event unrelated to abuse; dissociation is a transient state in which the child becomes detached from current, conscious interaction and this detachment is not under voluntary control. A child may appear disconnected or focused on fantasy worlds.[35]

[22]Evidence on demeanours and behavioural indicators is derived from NCCWCH/NICE guidelines as above but also the wider evidence base on impacts of CSA. This is because the literature review carried out for these guidelines was narrow and evidence in relation to emotional/behavioural signs can be found outside of the medical literature

[23]Allnock and Miller (2013); Cossar et al (2013)

[24] [25] [26] [27]Kendall-Tackett et al (1993)

[28]See Finkelhor and Browne (1985); Gore-Felton et al (2001); Kendall-Tackett et al (1993)

[29]See Finkelhor and Browne (1985) (NCCWCH/NICE guidelines direct that other causes for nightmares should be considered first)

[30] [31] [32]Wells et al (1995)

[33]Kendall-Tackett et al (1993); Wells et al (1995)

[34]Holmes (1998)

[35]Macfie et al (2001); Eisen et al (2002); Collin-Vézina et al (2005)

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

- Non-suicidal self-injury (self-harm which includes cutting, scratching, picking, biting, tearing skin, pulling out hair or eyelashes and taking prescribed medications at higher than therapeutic doses).[36]
- Suicidal ideation/attempts.[37]
- Hypervigilance, which involves being in a constant state of arousal. A child may appear tense, 'on edge' and may demonstrate hostility, especially if they feel threatened.[38]
- School adaptation may be suffering (for example, arriving late at school or leaving early; non-participation in school activities or performance is falling).[39]
- Poor or deteriorating relationships with peers.[40]
- Substance abuse.[41]
- Experiencing (CSE); the evidence suggests that prior CSA may be a risk factor for CSE. If a child you are working with has experienced CSE, you may wish to consider prior childhood experiences.[42]

The Brook Sexual Behaviours Traffic Light Tool - **www.brook.org.uk/our-work/category/sexual-behaviours-traffic-light-tool** - can help you to make decisions about certain behaviours and whether they are concerning. The tool differentiates between behaviours that may be seen as normal in very young children but in older children may be more concerning, and vice versa.

[36] *Glassman et al (2007); Weierich and Noch (2008)*

[37] *Martin et al (2004)*

[38] *See Finkelhor and Browne (1985)*

[39] *Daignault and Hébert (2009)*

[40] *Calam et al (1998); Mannario et al (1989)*

[41] *Tonmyr et al (2010)*

[42] *Berelowitz et al (2012)*

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Section Three: Protective factors associated with intra-familial child sexual abuse

A protective factor is a characteristic associated with a lower likelihood of experiencing IFCSA or which reduces the level of risk a particular risk factor presents on IFCSA. The existence of a protective factor does not rule out that abuse has taken place. Protective factors can be targeted and strengthened in direct work with children and families.

The template in **Appendix A** can be used alongside a child/young person's case file to cross-reference with the information provided in Table 4 below to help 'build a picture' of evidence.

Table 4:

	Protective factors[43]
Child protective factors	> Good health, history of adequate development. > Above-average intelligence. > Hobbies and interests. > Good peer relationships. > Positive school experiences: academic, sporting or friendship-related. > Good and mutually trusting relationships with teachers. > Development of skills, opportunities for development and mastery of tasks. > Positive disposition. > Active coping style. > Positive self-esteem. > Good social skills. > Internal locus of control (a belief that one can control their own life). > Balance between help-seeking and autonomy.
Parental/family protective factors	> Secure attachment; positive and warm parent-child relationship. > Supportive family environment. > Household rules/structure; parental monitoring of child. > Extended family support and involvement, including caregiving help. > Stable relationship with parents. > Parents have good coping skills. > Family expectations of pro-social behaviour. > Higher levels of parental education.

[43] *These protective factors are based on a number of extensive reviews of protection and resilience, including Butchart and Kahane (2009); Krug et al (2002); Marriott et al (2014); Newman (2004)*

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

	Protective factors
Social/environmental protective factors	> Adequate parental income. > Social support for mothers; particularly around birth to ease perinatal stress. > General social support through links with other parents, local community networks and faith groups. > Access to healthcare and social services. > Consistent parental employment. > Adequate housing. > Good schools.

Using this tool to reflect on team practice:

1. Distinguishing risk factors, indicators and protective factors

Using the definitions above, reflect on how these are defined and what makes them different from one another.

This activity takes around 15 minutes.

2. Working with specific risk factors, indicators and protective factors associated with CSA

> Print off and cut into strips the risk factors, indicators and protective factors identified above and shuffle so they are mixed up.
> Working in groups, practitioners sort what they think are risk factors, indicators and protective factors, and whether they relate to the ecological levels indicated in the tables (for example, child-level, parent/family-level or social-environmental protective factors).

This activity takes around 30-45 minutes and can generate considerable debate and critical reflection.

3. Facilitated discussion

Guide discussion around exercise 2, focusing on:

> practitioners' experience of the activity
> interactions between risk and protective factors
> the role of professional judgement in relation to using this resource.

When we have used this exercise in workshops attendees have shared important insights around the contextual nature of risk factors, indicators and protective factors which highlighted the necessity of professional judgment and knowledge about the child and family.

Section Four: Social work responses

Building knowledge, skills and confidence

Communicating with children

Children, young people and adult survivors of abuse want someone to notice when things are not right and the responsibility lies with practitioners to hear and understand what children may be trying to say. Managers should ensure their staff are appropriately trained and have access to resources to support them to listen to - and hear - children.

- Triangle and the NSPCC produced a video, 'Two Way Street', to help practitioners build confidence and skills in communicating with disabled children who do not use speech or language: www.youtube.com/watch?v=IiymMEeaj7U&feature=youtu.be
- Keep informed about local or national helping services that can support children where CSA is a concern such as the NSPCC Hear and Now Project: www.nspcc.org.uk/services-and-resources/childrens-services/hear-and-now

Trauma-informed approaches

Rather than viewing trauma as a clinical label or 'condition', this approach considers trauma in a holistic way, as a common, expected outcome of exposure to dangerous and threatening circumstances. A trauma-informed approach includes:

- Recognising signs/symptoms of trauma (as identified in section two of this resource).
- Acknowledging the impact of traumatic experiences.
- Actively seeking to avoid re-traumatisation.
- Integrating an understanding of trauma in organisational policy and practice.

Working with parents

The issues and terminology of parental engagement, 'resistance' and 'disguised compliance' raise complex questions for reflective practice.

'Resistance' is often a sign that the parent is not feeling heard, respected or taken seriously, or not yet ready to consider implementing what may seem to us like an obviously needed change (Miller and Rollnick, 2013). Parents may be reluctant to engage for many reasons, including:

- Intentional deception - minimising/denying abuse and neglect.
- Previous negative social work experience.
- Oppression, discrimination and disadvantage within which child protection intervention is experienced as further oppression.
- Shame and stigma.
- Ambivalence about the ability or need to change.
- Conduct of the social worker.

(Laird, 2013; Forrester, 2012; Shaheed, 2012)

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

There is no simple formula. The work requires resilient and supported practitioners with time and space to work with 'respectful uncertainty' (Laming, 2000), applying critical evaluation to any information they receive and maintaining an open mind.

Motivational interviewing (MI) breaks down the concept of 'resistance' to explore how parents respond to workers, prompts practitioners to reflect on their own behaviour and role, and offers skills and communication strategies.

'Authoritative practice' is described as a worker aware of their professional power and using it judiciously while interacting with sensitivity, empathy and willingness to listen. Respecting parents' autonomy and dignity while recognising their primary responsibility is the protection of children from harm (C4EO, 2010).

Recommended authoritative practice:

- Don't accept excuses or parental assertions that they have changed or will change their behaviour.
- Establish the facts and gather evidence about what is actually occurring or has been achieved, to keep objective sight of what is happening.
- Chronologies can be used to provide evidence of past parenting experience, including possible former instances of 'disguised compliance' and to analyse parenting history. The information can then be considered in relation to current parenting capacity and to gain a fully documented picture of the family environment.
- Record the child's perspective and situation. This will help to retain focus on the child and can also help to ensure that important information does not become lost.
- Assess parents' capacity to change.
- Focus on outcomes rather than process, so that attention cannot be deflected by good intent or an appearance of participation. Identify and establish clear, understandable and measurable outcomes that are consistent with the child's needs and development. Take action when outcomes are not achieved within agreed timescales.
- Low threshold for concern: parents can expect to be challenged about poor parenting and further harm to their children.
- Focus maintained on the child. Risk assessment is seen as a key mechanism for achieving this and ensuring that parents are clear about concerns.

(Tuck, 2013)

PRACTICE TOOL

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Working with a child when there are concerns about abuse but they have not spoken about it

- Establish the facts. Create succinct, clear chronologies and case notes.
- Work to open up space for the child to share. Confidence and trust need to be built - do not expect children to open up about their experiences immediately. Make it clear that you are ready to listen and to help. Safety, security and privacy are crucial in establishing trust, as is keeping children informed - in developmentally appropriate ways - about what is happening.
- Listen. Do not assume all experiences are the same. Be aware that children may not have the words to describe what has happened to them.
- Keep your support child-centred. Build a bond, ask what they like and build in activities. Set out agreements about how you will work together and the boundaries of confidentiality. Include them in the decisions that affect them.
- Understand the child's support network. Identify early on who they trust - ask the child directly. Quickly implement home and school safety plans.

Where risk factors for IFCSA are evident but CSA cannot be evidenced, work with children and parents/families might usefully focus on strengthening protective factors and limiting and addressing identified risks:

- Targeting particular components of a parent-child relationship may improve them. Brief interventions - for example Promoting First Relationships (Kelly et al, 2008) - are low cost, can be delivered in the home and are designed to address key relational components understood to impact on parent-child relationships, such as maternal sensitivity (Valentino, 2017).
- Where lack of parental supervision is an issue families could be supported to strengthen parental capacity in this area and/or draw on wider networks of (safe) significant others who can assist.
- Where a child is displaying low self-confidence or self-esteem, work can focus on building their resilience.
- Harmful sexual behaviour (HSB) should be explored and addressed comprehensively. If the needs of children who have displayed HSB and have also been victims of abuse or trauma are not addressed, it is unlikely that interventions for HSB will be effective. Evidence suggests that any intervention should be holistic, strengths-based, proportionate, multi-agency and resilience-focused.

The NSPCC and Research in Practice have published a framework for responding to HSB:
www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework.pdf

The Sex Offenders Treatment Services Collaborative (youth sub-group)[44] at the University of Kent offer a collection of resources for use with children and young people with learning difficulties who display HSB:
www.kent.ac.uk/tizard/sotsec/ySOTSEC/Documents/Website%20resources/RL2015.doc

[44] **www.kent.ac.uk/tizard/sotsec/ySOTSEC/resources.html**

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Responding when a child speaks out about being abused

A swift and appropriate response is central to a child's ongoing safety and recovery and to the child and family receiving the help they need. Refer to practice guidance for your organisation and to national guidance which states:

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.

DfE (2015)

Listen

- Give the child your full attention in a suitable space free of distractions.
- Be calm, patient and reassuring - allow them to be heard.
- Let the child take their time, go at their own pace and use their own words.
- Don't ask questions that may imply the child is at fault (for example, "Why didn't you say something sooner?").
- Do not ask leading questions (questions which imply or contain their own answer). This could be prejudicial and contaminate criminal evidence.

Reassure

- Tell the child they did a good/right thing in telling you what's been happening.
- Tell them that you are treating the information seriously.
- Reassure them that they are not at fault.

Respect

- Don't make promises you cannot keep - manage their expectations.
- Acknowledge their bravery and strength.
- Tell them what you plan to do next.
- Explain that in order for them to be safe you will need to report their experience to someone else.
- Do not confront the alleged perpetrator.

Adapted from Australian Institute for Family Studies (2015)
www.aifs.gov.au/cfca/publications/responding-children-and-young-people-s-disclosures-abu

Document the exchange as soon as possible using the child's exact words and report according to your organisation's guidance immediately.

Criminal justice and child protection processes are inter-related but there are often competing demands from each process. The substantiation of a suspicion of abuse requires a different level of proof in the family and criminal courts, but evidence put forward in the CCE (2015) report suggests that the criminal burden of proof is often given primacy in joint investigations.

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Achieving Best Evidence (ABE) interviews - used by the police to substantiate abuse and maximise evidence for trial - are found to be inconsistent, with delays and shortages of trained intermediaries and ABE-trained social workers to assist with interviews. This has led to concerns that substantiation of abuse is increasingly delegated to the police using the criminal burden of proof. Messages and advice for practitioners include:

- Child protection measures should be independent of the criminal justice outcomes - action taken to safeguard children should not depend on evidence that meets the criminal burden of proof.
- ABE practice guidance recommends that representatives from the police and local authority children's services should be involved as members of the investigating team at minimum. Interviews can be led by police or social workers, provided they are trained in accordance with ABE guidance. www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf

Barnhaus

Research highlights that multiple interviews in the course of the criminal justice process re-traumatise children and young people (Goddard et al, 2015).

Barnhaus provides child-centred and integrated justice, healthcare and ongoing therapeutic social care services under one roof, often in purpose-built, child-friendly accommodation. Evidence shows it is effective in improving justice and therapeutic outcomes for children who have experienced sexual abuse and assault.

Barnhaus in Iceland provides learning for improving the evidence gathered from children whilst reducing additional trauma. Interviews are undertaken in a 'home-like setting'; exploratory interviews are carried out by a psychotherapist trained in forensic interviewing to facilitate the child in telling what has happened to them; a minimal number of interviews take place, reducing the likelihood of degrading evidence; and the service provides guaranteed and rapid access to therapeutic support.

Evaluation of the model indicated that in 2014 80 per cent of interviews occurred within two weeks, allowing the child to receive support immediately. The evaluation also found that the number of perpetrators charged had trebled, convictions had doubled and therapeutic outcomes for children improved (OCC, 2017).

NHS England is currently funding the establishment of two Children's Houses in London: www.nspcc.org.uk/globalassets/documents/conferences/how-safe-2016-presentation-childs-house-model-emma-harewood.pdf

- Provide support, information and advocacy during a criminal investigation or trial. Information on the Victims Code which outlines the specific rights of children can be found here: www.gov.uk/government/uploads/system/uploads/attachment_data/file/476900/code-of-practice-for-victims-of-crime.PDF
- Victim Support's You&Co (2016) produced an interactive courtroom - www.youandco.org.uk/going-court - that can be shared with children and their families to help prepare them for court.
- Children should receive a holistic package of support, tailored to their needs, including therapeutic support to help them recover from their experiences. This includes provision of therapy - when it is the best interests of the child - prior to or parallel to any investigation or court process (CCE, 2015).

Practitioners may be confused about providing a child or young person with access to therapy if there is an upcoming trial and, indeed, there are real concerns for practitioners to consider in balancing a child's need for emotional support with the need to ensure that evidence is not compromised. There is guidance from the Crown Prosecution Service (CPS) outlining what types of therapy can be provided in these contexts. This indicates that the least problematic aspect of pre-trial therapy will focus on improving self-esteem and confidence, often using cognitive behavioural techniques.

Other types of support which are seen as suitable would focus on the reduction of distress about impending legal proceedings and the treatment of associated emotional and behavioural disturbance that does not require a rehearsal of abusive events:
www.cps.gov.uk/publications/prosecution/therapychild.html

Children and young people who have experienced IFCSA often feel an enormous sense of awareness and responsibility for the emotional impact of the abuse on their families (Warrington et al, 2017). Parents and carers of sexually abused children may find it difficult to understand what has happened; may not understand how sexual abuse impacts their child; and may well struggle to cope with their own emotional turmoil upon learning about their child's abuse.

The 'Women as Protectors' service works with mothers who are in contact with a man who poses a sexual risk to children; they have produced a report to guide practitioners in the assessment of a mother's or carer's capacity to protect their child: www.nspcc.org.uk/services-and-resources/childrens-services/women-as-protectors.

Practitioners can also support parents and carers by educating them about CSA, facilitating access to therapeutic support, helping them to better support and responding to their children's needs.

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Checklist for self-preparation	
Question	**Action**
Am I confident that I can respond to a child who tells me or indicates in another way that they have been sexually abused?	Social care teams can 'role-play' scenarios using the checklist above to practice their skills in sensitively hearing a disclosure of abuse.
Have I done all I can to ensure the ABE process is followed?	You should identify the best person to carry out the ABE; you can challenge police about their involvement of intermediaries at the earliest stages and whether a trained ABE social worker should carry out the ABE.
Do I know enough about victim's rights to be able to effectively advocate for them?	Become familiar with the Victim's Code and establish a method for helping children to understand the criminal justice process.
Have I done all I can to minimise the trauma a child can experience within the criminal justice process?	Examine what you can do to minimise the number of interviews a child is subjected to; ensure that the location of assessments and interviews are child-friendly and comfortable.
Am I confident about when a child can receive therapy?	Familiarise yourself with the CPS guidelines on what types of therapy are acceptable and will minimise damage to a criminal trial. Know what types of therapy you can swiftly gain access to on behalf of the child you are working with.
Am I doing enough to support parents and carers?	While assessments should always remain child-focused, examining the needs of parents/carers can contribute to a positive child-focused outcome. Understand where you can refer parents for help, increase your own toolbox of strategies to address their emotional and practical needs and recognise parents as partners in support for children.

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

Appendix A: Intra-familial child sexual abuse vulnerability template	
Child's name/ID	
Domains	**Evidence**
Risk factors, as mapped against Table 2a of this resource.	
Indicators (signs), as mapped against Table 3 of this resource.	
Protective factors, as mapped against Table 4 of this resource.	
Analysis (this should take into account risks, indicators and protective factors).	
Recommendations (possible interventions to minimise risk and strengthen protection).	

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Notes

PRACTICE TOOL

Intra-familial child sexual abuse: Risk factors, indicators and protective factors

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With grateful thanks to
Spencer Bailey, Richard Fountain, Carol Larne and Suzi Moore

Cover image: ©curtoicurto

Research in Practice is a programme of The Dartington Hall Trust which is registered in England as a company limited by guarantee and a charity
Company No. 1485560 Charity No. 279756
VAT No. 402196875
Registered Office: The Elmhirst Centre, Dartington Hall, Totnes, TQ9 6EL

ISBN 978-1-904984-95-5