Advances in Psychiatric Treatment (1998), vol. 4, pp. 108–118

Cycles of abuse: a case study

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This study is presented to encourage recognition and early intervention with cycles of physical, sexual and emotional abuse, both within institutions (whether the family, hospital, residential care, residential schools or penal institutions) or within the community at large.

The role of the individual may change within this cycle as they move through their own life course, moving from vulnerable victim to powerful perpetrator or at times being locked in to both roles. Above all, practitioners need to remain alert to the possibility that the origins of the presenting symptoms of the subject, young or old, male or female, able or with disability, may lie in past or current abuse and will have wide ramifications not for just the individual but those on whose lives he or she impacts (Glaser & Frosh, 1993).

The individuals

Shirley	Mother of perpetrator John and of victim Dawn.
James	Father of perpetrator John.
Muriel	Sister of Shirley.
Bernard	Shirley's second husband and father of victim Dawn.
Lorraine	Second wife of James.
John	Adolescent perpetrator and child of Shirley and James.
Dawn	Child victim and child of Shirley and Bernard.

The generations

Shirley, the biological mother of both victim and perpetrator, was the youngest of four children. Shirley was only 10 when her own mother died. She was then reared by her father, a strict disciplinarian, and her oldest sister, Muriel. Material standards in the home were high. She was encouraged in early adolescence to retain the dependency needs of a child. Aged 16, she became pregnant to an 18-year-old, James, recently released from borstal, sentenced for grievous bodily harm when intoxicated. Shirley wanted to keep her baby. Her father disowned her and insisted that she left home but Muriel stayed in contact. James wanted to parent his child and provide for Shirley.

James, the biological father of John, was reared from the age of five, together with his older brother in residential care, following a history of severe physical neglect by their parents. Their social worker had described the boys parental home as a 'Neanderthal pit'. The boys were left unfed and locked in a cupboard for hours on end.

John, the son of Shirley and James, was a full-term normal delivery. Post-partum, Shirley developed a 'reactive' depression which was unaddressed. During the first six months of John's life, James took on much of his day-to-day care. James was in continual dispute with the benefit agencies and survived financially through petty offending, for which he eventually received a short prison sentence. Shirley was now able, with support from her sister, Muriel, to parent John. Muriel was openly critical of John's father and the relationship between John's mother and father deteriorated. The father's alcohol misuse escalated and usually while drunk, but sometimes sober, he subjected Shirley to verbal and physical abuse, both hitting and humiliating Shirley in John's presence or earshot.

Aunt Muriel became more involved in John's parenting and encouraged John's mother to leave James. Social services were involved and remained so intermittently. Knowledge and awareness of domestic violence was kept within the family.

John's mother met and married Bernard, her second partner, and six months later became pregnant. John's stepfather, an unassertive man,

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https://doi.org/10.1192/apt.4.2.108 Published online by Cambridge University Press

attempted to parent John. In return, John was difficult with him, challenging his role as a father. John's mother and stepfather had an open sexual relationship within the home.

John demonstrated antisocial behaviour in the home, school and the local community. His stepfather Bernard was exasperated and attempted physically to chastise his now adolescent stepchild. John retaliated in kind.

Shirley and Bernard adopted a line of least resistance with John, focusing their attention on the special needs of their daughter Dawn. Bernard distanced himself from domestic responsibilities by working longer and longer hours. Aunt Muriel had a serious fall and Shirley started to care physically for her sister, leaving daughter Dawn in the care of her son John after school.

Comments

Family violence and abuse almost never occur in isolation and are inextricably linked with events, situations and states that can by themselves lead to deleterious consequences. A history of family violence and abuse is a concommitant feature of many people seeking treatment (Staples & Dove, 1996). The likelihood of a clinician encountering past or current abuse is overwhelming and it therefore behoves all mental health professionals to be familiar with the field of inter-generational transmission of violence. Over 30 years after Curtis (1963) called attention to the inter-generational transmission of violence, our knowledge of long-term consequences of abusive home environments continues to inform practice. The relationship between childhood abuse and later abuse, delinquency or violent behaviour may lie in more subtle manifestations of emotional damage, severe anxiety, withdrawal or suicide, and difficulties presented in social, educational and vocational settings. Ultimate outcome may depend on a variety of factors including not only the nature and severity of the abuse, but also the age of the child when abuse occurred, the characteristics of the perpetrator, the characteristics of the child and the child's perception of the event (Spatz-Widom, 1989; Dodge *et al*, 1990; Browne, 1993; Yoshikawa, 1994; Kazdin, 1997; Bailey, 1997).

The victim

Dawn, John's 'sister', the only child of Shirley and Bernard, was a forceps delivery, 'blue baby', born with the umbilical cord around her neck. She required neonatal intensive care, and her parents were told that she may not survive. A placid baby, her mother accepted without question Dawn's slow development. Aunt Muriel had concerns and accessed professional services. Community paediatricians kept Dawn under review. Dawn received speech therapy and physiotherapy, but her motor coordination remained poor and she was diagnosed as having a mild learning disability.

Dawn was able to be maintained in a mainstream school (not previously attended by John), which offered comprehensive special needs teaching support (assessment by an educational psychologist). Dawn remained an affectionate, compliant, uncomplaining child who unquestioningly followed the directions of others. She was fond of John but had been told he was 'a naughty boy'. Dawn's mother Shirley usually maintained close contact with school.

Comment

People with learning disability have increased vulnerabilities including greater dependence on other people for personal care, an imbalance of power between the carer and person being cared for, and difficulties in communicating. They may lack sexual knowledge and assertiveness skills (Brown & Craft, 1989).

In children with limited ability to communicate and with limited comprehension of the acts against them, it is essential to be aware of the possible psychological manifestations of abuse. The most significant indicator is likely to be a change in personality or behaviour, such as an increase in sexual interest, an avoidance of males or an ambivalence generated within the victim. Behavioural disturbances can include aggression towards the self or others, withdrawal, sleep disturbance, loss of skills and reduced level of functioning. Abuse should always be considered as a possible differential diagnosis in a child or adult with a learning disability, male or female, who presents with psychiatric difficulties (Royal College of Psychiatrists, 1996a,*b*).

The perpetrator

John's earliest memories were of witnessing his father's violence towards his mother. He recalled hearing her screams as he lay on his bed trying to shut out the sounds, with a pillow over his head. He also held happy memories of going fishing with his Dad as a young child. These were 'special'

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days. John disliked maternal aunt Muriel who 'bad-mouthed' his father.

While his father was serving a prison sentence, Aunt Muriel collected the eight-year-old John from primary school one day, took him to her home and announced that his mother had left his father. Angry, upset and confused John cried himself to sleep. Three days later his mother collected him, took him to a new home and introduced him to a stranger, his stepfather, Bernard.

John took his anger, fear and frustration out on his stepfather. When his stepsister, Dawn, was born, he felt excluded, abandoned and rejected. He directed his anger towards his mother and aunt Muriel.

In infant school he was taunted by other boys because they had found out his real father was in prison. His sadness evolved into anger and he retaliated by physically bullying younger children. In junior school he gained a reputation as a good fighter. John 'took on' teachers verbally and his mother was frequently called to his school. Still in junior school he started to truant with older boys, shoplifting from a local market, and in the evenings 'hanging about' on the streets, glue-sniffing and setting minor fires with his friends. John, still under the age of criminal responsibility (10 in England and Wales) was frequently returned home by the police.

John held inside him anger and sadness, and resolved to make contact with his 'real' father. To his surprise, his Mum did not stop him. His father had remarried and had two young children. Initially John's father and new partner, Lorraine, encouraged him to visit their comfortable home, but then John perceived a change in their attitude. His father had let him down and John attributed blame on to his father's new wife, Lorraine.

Now in secondary school, John had received three cautions for property- and vehicle-related offences and had short-term non-statutory intervention from a local youth justice pilot project for young offenders. His attitude remained one of anger and resentment, believing most of his peers held hostile feelings towards him.

He reached puberty at 12, was absent when 'sex education' was given at school, regarded sex with ambivalence, disgusted at the memories of witnessing his mother and stepfather having sexual intercourse when he was aged seven or eight. However, he was aroused by the sexually explicit and violent videos kept in the family home.

His behaviour at school was such that referral to an educational psychologist was seriously considered. He had twice been suspended, and truanted for three days a week. He was placed 'on report' in school and his disruptive, bullying behaviour and truanting subsided in response to the input of his male year tutor, with whom he had a good relationship. He discussed the difficulties he had with other boys and teachers but never discussed family life. At age 14, John listened to the boasting of the sexual exploits of his classmates. He was rebuffed by a girl in his class whom his 'mates' said 'fancied him'. John felt increasing resentment towards his stepsister, Dawn, who received yet more attention. He was left to look after her after school while his mother went to 'see to' his aunt Muriel, whom he disliked intensely.

Comments

Juvenile sexual offending constitutes a substantial health and social problem. There are high rates of behavioural and emotional problems among abusers, combined with substantial history, in many cases, of neglect and emotional and sexual abuse. Assessment and treatment of adolescent offenders has been powerfully influenced by experience of adult offenders. It is, however, essential to consider the origins of sexually abusive behaviour within a developmental model (Vizard *et al*, 1996). A significant proportion of adult offenders first experience arousal to children during adolescence (Longo & Groth, 1983). Studies indicate that between 30 and 70% of young abusers have been sexually abused. In a significant proportion of young abusers aggression plays an important role in the sexual act, which represents an abuse of power, not just the conscious sense of anger, sense of grievance and resentment for and to the victim, often a family member, but an expression of anger towards the rejecting families, anger displaced instead on to the fragile victim (Dolan *et al*, 1996; Bailey, 1997).

Investigation

Process of protection and justice

Dawn was noted by her class teacher to have bruising to her face. Asked about this she told her teacher she 'bumped into the door'. The teacher noted the details and child's account in her records deciding no further action was required. Two months later Dawn's teacher found her crouched in the corner of the cloakroom rocking to and fro. Initially non-communicative, Dawn looked up at the teacher and said "My fanny hurts, he hurt, I didn't like it – I'm naughty". Dawn's teacher immediately informed her headteacher, who reviewed the available information and contacted Dawn's mother with a request for her to come down

https://doi.org/10.1192/apt.4.2.108 Published online by Cambridge University Press

to school that morning. The headteacher contacted local social services and the educational psychologist already involved with Dawn.

Later that morning a discussion meeting with the headteacher, class teacher, social worker and telephone liaison with the educational psychologist took place (the school nurse was on leave). Mother, Shirley arrived and comforted her daughter and was informed of events. The mother spontaneously reported that Dawn had been unsettled of late, was not sleeping at night, and was 'rocking' like she used to when she was a toddler. Shirley had been preoccupied with caring for her own sick sister and had had to leave Dawn in John's care. She said that they had to understand that John was 'difficult and naughty' but was 'not like that'. Shirley remained tearful and upset, seeking reassurance that Dawn would be alright, she was compliant with the decision that the social worker should take Dawn to hospital for full medical examination.

Dawn was seen and examined by the on-call paediatrician for suspected child abuse cases, in special facilities where her mother could observe through a one-way screen. Physical examination revealed recent bruising across the lower back, hymen no longer intact and evidence of penetrative sexual activity, with vaginal bruising and anal tears. Samples were taken for DNA testing. The probable ongoing child protection process was explained further to the mother, as was the need for an interview with Dawn to be recorded on video-tape by specially trained police officers at the family support unit. Shirley remained distressed saying John had always been difficult but not himself of late. She said that she should not have left Dawn with John but no harm could now come to Dawn and she just wanted to take her home. Two days later Dawn had a video-interview with police officers in the presence of a child care social worker with specialist knowledge of children with learning disability (Department of Health, 1992*a*).

Throughout the interview Dawn referred to 'him doing it hurt me', 'killing my bunny rabbit', 'hit me', 'must not tell', while rocking to and fro. She was at times tearful, with her head bent and crouching. She could give no sense of sequence, nature, frequency or type of abuse. She mentioned the name John on eight occasions.

On the day of disclosure a decision was taken that Dawn could not return home if John was present. John's mother contacted John's natural father, James, who offered to take John, but the social worker pointed out that James also had young children in his home. James became angry and hostile towards the social worker, whom he accused of making false accusations against his son. He arranged for his wife, Lorraine, and daughters to stay with friends, and it was agreed as a temporary measure that John could stay with him.

Subsequently the police visited James's home to explain why they wished to question John. James was verbally aggressive, John was quiet and sullen. At the police station John was cautioned, questioned and charged, under the Police and Criminal Evidence Act 1984, with a solicitor and his father present. John remained sullen and silent apart from 'no comment' responses. James was hostile towards the police. John was formally charged with the rape and buggery of his stepsister together with a charge of actual bodily harm. He allowed himself to have blood and other bodily samples taken. Despite protests from the solicitor, he was held in the cells overnight and appeared in the youth court the following day. Agreement was reached for placement with remand foster parents with dusk-to-dawn curfew (see Box 1).

At the convened child protection conference on both Dawn and John one month after services were alerted, concerns were expressed by the social worker and the child psychiatrist who had been asked by the general practitioner to see Dawn urgently because of concerns about her level of withdrawal and lowered mood state, and thus the necessity for therapeutic intervention. Heated debate ensued between the professionals, the chair raising concerns that John's legal advisors had raised strong objections to Dawn being given any treatment that might influence her subsequent reporting of events in criminal proceedings. The child psychiatrist, in turn, reiterated the paramount need to meet and deal with Dawn's current considerable emotional and psychological

Box 1. The child protection process

- Family violence and abuse almost never occurs in isolation
- Investigation is only the start of the process of child protection and family support
- Child protection conferences follow on from stages of recognition, referral, strategy, discussion and investigation and provides opportunity to evaluate information gathered during investigation plus additional information brought to conference, and to assess degree of risk to the child if registration of the child(ren) is necessary to formulate a child protection plan
- Parental participation is beneficial
- Decision to register a child rests ultimately on the conference chair

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difficulties. Monitoring of her mental state was to continue and non-verbal therapies were to be used to help her start to come to terms with her evident traumatisation, whatever its origins. Unusually, her parents, Shirley and James, were only allowed into the second half of the conference. Dawn's father, Bernard, was too distressed to attend, her mother was quiet and unquestioning, John's father was belligerent, questioning the right of the conference to have excluded them from part of the meeting.

Decisions on risk and registration were finally reached. Little time was spent on looking at John's needs as a child under the Children Act 1989. John was placed with remand foster parents; his foster father was an ex-probation officer. He remained angry and at times out of control, thereby placing himself at risk of a secure care remand. However, he gradually started to respond to the time and attention given to him. He was frustrated that he could not return to school. He liked his foster father who reminded him of his year tutor at school. The foster father was careful to set clear boundaries concerning confidentiality in the event of John starting to talk about his offences.

One week later John returned home drunk telling his foster father he had raped his sister. The following morning John gave his foster parents the same information and asked for help saying "this thing is eating my insides away". His foster parents arranged for him to see his solicitor to whom he admitted to sexual and aggressive acts against his stepsister.

Discussion ensued between John's legal advisors and the Crown Prosecution Service. Guilty pleas were accepted to the charges of rape and attempted buggery. The youth court deemed the charges too serious for them to deal with and the matter was committed to the Crown Court, where John was convicted but his sentence was adjourned to allow the recommendation contained in the pre-sentence report prepared by the youth justice worker to be carried out; that is, a full psychiatric assessment to assist in risk assessment, disposal and treatment issues.

John was assessed over six sessions by an adolescent forensic mental health team: psychiatrist, art therapist and clinical nurse specialist. An accumulation of factors unfolded during the course of assessment:

(a) *Inherent to John* – his temperament, hostile attributions, sensitivity, thoughts, aggressivity, impulsivity and evolution of anger and sadistic thoughts and acts combined with his internal sadness, self-depreciation and generalised anxiety.

(b) *Family factors* – early witnessing of violence, sexual activity *in vivo*, reinforcement at a later time through video images, rejection, parental breakdown, inconsistent parenting; role of female carers, and interaction with his vulnerable female sibling.

(c) *Social* – verbal bullying, physical retaliation, socialised antisocial behaviour, offending, inadequate systems response, possible rescue point – role of school tutor.

(d) *Opportunity* to offend sexually provided to him.

Sadistic thoughts emerged in non-verbal sessions. Although he minimised the sadistic component to his offence, he did have insight into the impact on his victim, with associated guilt, shame and remorse, but attributed blame to significant adults, his mother and dominant aunt. John always referred to her as "that bitch I hope she dies". He could not share his sense of rejection and abandonment by his father. In the last two sessions he was able to share his sadistic intentions towards his sister had the abuse not been disclosed when it was.

In the meantime, Dawn needed continual reassurance that she did not have to go and see the "judgeman" in court, "she was not naughty and it was not her fault John had gone away". As she responded to non-verbal therapy her symptoms of post-traumatic stress disorder started to reduce as did her regressed behaviour. The child mental health team worked in tandem with social services to support both Dawn and her parents. By this time her mother was taking antidepressants prescribed by her general practitioner.

In view of the seriousness of the charges John was prepared for a custodial disposal (Section 53 (ii) Children and Young Person's Act 1933) and liaison by a youth justice worker with the Home Office took place to identify a secure care bed. The youth justice worker, the adolescent forensic mental health team and the local National Society for the Prevention of Cruelty to Children group treatment programme for young offenders formulated a detailed treatment plan and risk-management strategy for John, asking the court to consider a three-year supervision order with condition of psychiatric treatment and attendance at an abusers' programme. The judge, in an unusually long judgement, made clear his reasons for allowing a community disposal – the local newspaper reported "young sex fiend walks free".

John was fortunate in securing a long-term foster placement in a neighbouring town, with a new school, and responded well to individual psychotherapy followed once he had dealt with his own role as a victim in a sex offender cognitive–behavioural treatment programme group. A

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youth justice worker worked in conjunction with the clinical nurse specialist, and with time and patience it was possible to help John's biological father James start to come to terms with the acts of his son. He had to accept that his son was a sexual perpetrator and also to deal in turn with his own negative rearing experiences. His wife Lorraine reported the benefit this brought to their relationship and family functioning, helped additionally later by anger management training offered to John's father by the adult forensic psychology services. During John's three-year supervision order his general delinquent activity decreased and he began to face issues concerning his future, such as relationships with females, in particular his future partner and his likely parenting skills together with the realities of being a 'schedule one' offender (see Box 2). With the agreement of all parties there was regular liaison between the teams treating both victim and perpetrator. However, John's stepfather Bernard remained hostile towards John. His mother renewed contact with John and there was partial reconciliation.

Meanwhile, Dawn could not cope with mainstream secondary school and was transferred to a special day school. At the age of 14 she presented with social withdrawal and regressed behaviour. This was attributed to discussion about possible contact between Dawn and John as part of a healing process. Six months later two other female adolescents at her school made allegations of sexual abuse by an older male pupil who was subsequently dealt with in the criminal courts.

Box 2. Managing risk – bringing about safe change

Original assessment – the global picture of the young person which includes
Situation in which the behaviour occurs
Specific triggers
Quantification (frequency, intensity, severity) of the behaviour
Cognitive, emotional assessment – examines perceptions, thoughts, feelings associated with the behaviour
Treatment interventions offered in small steps with continued monitoring

Multi-agency interventions are likely to reduce risk, but need to encompass all aspects of the young person's life such as
Living situation
Peer interaction
Family interaction
Psychological
Physical
Education/avocational/vocational
Offence specific
Dependency level

Comments on the process

Government guidance on child protection (Home Office *et al*, 1991) states that all those working in the health field have a commitment to protect children and that their participation in inter-agency procedures is essential if the interests of children are to be safeguarded. Because of concerns, in particular surrounding confidentiality, doctors have expressed concerns about participating fully in child protection work. To address these concerns the Department of Health, British Medical Association and a conference of Medical Royal Colleges drew together further guidance for doctors working with child protection agencies (Department of Health, 1995*a*).

A suspicion that child abuse has occurred has a traumatic effect on a family. The overriding need to protect the child while minimising damaging consequences for the family can involve agonising decisions for those professionals working directly in the child protection field, but can and does also draw in any doctor or member of their team who, for whatever the original professional purpose, has contact with any member of the family. The spirit of the Children Act 1989 is that there should be a balance between child protection and family support services. Real benefits can arise if there is a focus on the needs of children and families, rather than just a narrow concentration that starts and finishes with the investigation process. (Department of Health, 1995*b*).

Defining child abuse

Child abuse is difficult to define, yet clear parameters for intervention are required if professionals are to act with confidence to protect vulnerable children. Thresholds which legitimise action on the part of child protection agencies are the most important component of any definitions of child abuse. The aim is to develop the concept of a threshold for defining abuse, to establish the factors that make up the threshold in various agencies and to consider the consequences for children of the thresholds employed in a given set of circumstances. Whether abuse may have occurred, why the professional has reached that conclusion and

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whether areas of doubt remain; what additional information is needed to be certain that there is a case for physical abuse, sexual abuse, emotional abuse, neglect or failure to thrive (Gibbons *et al*, 1995).

Professionals' definitions of issues

Thresholds legitimising action by agencies involved in child protection will be set differently by different professions and the subgroups within them (Farmer & Owen, 1995).

The principles of cooperation and openness between professionals in child protection work have been extended to include the active involvement of parents and children. Government guidance (Home Office *et al*, 1991) makes it clear that parents and, where appropriate, children should be given the opportunity to be involved in all aspects of the process. Medical participation can include preventive work, awareness raising, investigative work, attendance at child protection conferences, ongoing care and the provision of therapeutic services.

In deciding when to share confidential information with medical and non-medical colleagues, the doctor has to determine first of all whether the disclosure of that information is justified, bearing in mind their common law and ethical duties such as the disclosure of information without consent in the public interest (in the best interest of the child) or when required by court order or statute (see pp. 66–69, this issue). Preliminary consultation is not to be confused with strategy discussions and is not the beginning of an investigation. However, when a critical threshold of professional concern is reached, doctors must be prepared to share these concerns with statutory agencies for further evaluation and discussion within a time frame which is not detrimental to the child's interests.

Comprehensive contemporaneous records in whatever form are essential as they are the best evidence of any discussion or consultation. In preparing these, doctors need to bear in mind the person's legal rights to access medical records and reports and the possibility that such documentation may be used in later court proceedings.

A child protection conference follows on from the stages of recognition and referral, strategy discussion and investigation and will form part of the area child protection committee's guidelines on the handling of individual cases. Area child protection committee's have overall responsibility for developing inter-agency policies and procedures.

The child protection conference is not the forum for a formal decision that a particular individual has abused a child but is an opportunity to evaluate information gathered during investigation, to assess degree of risk to the child, to decide on the basis of this information and any additional information brought to the conference, if registration is necessary and to formulate a child protection plan. Parental participation in child protection conferences is beneficial and their participation has a positive effect on the conference proceedings (Hallett & Birchall, 1992). Exclusion in part or whole should be kept to a minimum and should be specifically justified. Wherever possible a doctor should discuss with parents and, if appropriate, the child, before a child protection conference, the content of any report, what information it is intended to give and consent should be sought to disclose personal and medical details. Decision to register a child rests ultimately on the conference chair.

The evidence of children

A child's account of worrying experiences usually emerges slowly and in stages. This is particularly true for children who have been traumatised by abuse.

Children interviewed by the police, are likely to have an expectation of criminal proceedings being taken. The Department of Health (1992*a*) has stated:

> "Children have a right to justice and their evidence is essential if society is to protect their interests and deal effectively with those who would harm them".

Concern has been expressed about the large number of video interviews that take place, while only small numbers are used in the criminal courts (Davies *et al*, 1995).

There remain differing approaches in different parts of the country regarding whether a child can receive therapy that may or does involve enquiring about allegations that have been made, creating real concern and tension between welfare and justice when the child may be suffering from severe psychological disturbance (see pp. 89–95, this issue).

Where a young perpetrator admits guilt, full ownership for the offence is unusual. 'Disclosure' of the offence, feelings of responsibility, guilt and shame emerge slowly over time, analogous to the gradual disclosure of the extent of the abuse experienced by the victim, reflecting again the importance of understanding the developmental context for all those involved in the cycle of abuse.

The Criminal Justice Act 1991 encourages all agencies involved in working with young offenders to come together to offer comprehen-

https://doi.org/10.1192/apt.4.2.108 Published online by Cambridge University Press

sive assessment and formulation of both current risk, future risk and capacity of services to bring together a comprehensive treatment package that will safely meet the overall needs of the perpetrator while ensuring offence-specific interventions are successful (see Box 3).

Box 3. The Criminal Justice Act 1991 encourages multi-agency working with the young offenders to:

Offer comprehensive assessment
Formulate both current and future risk
Make a statement of capacity of services to provide comprehensive treatment packages under the spirit of Children Act 1989 and in keeping with guidance principles of the Reed Report (Department of Health, 1992*b*)
Determine the conditions of least security to ensure safety of others
Be as near to child's home area as possible

Breaking the cycle of abuse

In the general population

The 1980s saw a move away from a 'nothing works' towards a 'what works' philosophy. Lipsey & Wilson (1993) and Kazdin (1995) point to the importance of primary population-based preventive intervention, secondary interventions focused on high-risk groups and tertiary treatment-centred programmes – foci that are echoed in the findings of the Audit Commission (1996).

In individual cases

Whatever the treatment model, safe interventions have to be based on an original assessment that has established a global picture of the young person, including the situations in which the behaviour occurs, specific triggers and quantifications of frequency intensity and severity of the behaviour. Cognitive and emotional assessment has to examine perceptions thoughts and feelings associated with the behaviour. Interventions have to be applied with continuous monitoring and evaluation of treatment outcomes on all aspects of the young person's life.

It is important that mental health professionals share their wealth of research knowledge and clinical experience with each other and with other professionals, and strive to inform policy-makers and influence public opinion. Sadly, it is never safe to assume that abuse from within the family, protects the vulnerable victim from abuse outside the family, and that any new information about changed behaviour in victim or perpetrator is carefully assessed.

In breaking the cycles of abuse an overall statement of risk serves as a strong argument for the need to provide services and acts as an important tool in helping to prevent future abuse (Snowden, 1997).

Assessing children and adolescents for court proceedings (Lindsey, 1997) can provide a unique opportunity to influence positively the lives of children and their families and can increase their emotional well-being, however unpromising, difficult and complex the circumstances and whatever the point of entry of the child, forensic, adult, learning disability or other specialist psychiatrist into the process.

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Commentary

Eileen Vizard

The key messages emerging from this paper are the need for early intervention in all cases of known or suspected child abuse, and the necessity for practitioners to remain alert to the possible early traumatic origins of adult symptomatology. These clear messages are amply supported by research (Lindberg & Distad, 1985; Browne & Finklehor, 1986; Briere, 1992; Mendel, 1995; Styron & Janoff-Bulman, 1997). The paper suggests that services for both victims and perpetrators could be identified and provided much sooner if the process is started with an 'overall statement of risk' or risk assessment. Given the connections between child abuse, family violence and various physical, psychosomatic and emotional problems presenting to doctors in all specialities, it is clear that "The likelihood of a clinician encountering past or current abuse is overwhelming" (p. 109). The message here is that all doctors, not just psychiatrists, should be alert to the possibility of abuse in the past history or present symptomatology of their patients.

The generations

A familiar pattern of neglect and physical and emotional abuse across generations is described in the family backgrounds of the people who subsequently became John's mother and father. The absence of any known or documented sexual abuse in the parental or grandparental generations may be because none occurred, or because specific questions about a past history of sexual abuse were not asked. Lack of specific enquiry is an important omission, since research (Kaplan *et al*, 1988) has shown that parents of adolescent incest perpetrators have high levels of victimisation in their own childhoods. Was specific enquiry made among adult family members for any convictions for 'schedule one' offences (sexual or physical) against children inside or outside the family? Follow-up studies

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https://doi.org/10.1192/apt.4.2.108 Published online by Cambridge University Press