

PRACTICE TOOL

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

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 indicators¹⁶ <ul style="list-style-type: none">> 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 <p>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.</p>	<p>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).</p> <p>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.</p> <p>The views of both children and parents would be important in determining whether there are any particular unexplained injuries or discomfort.</p>

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

¹⁷DeLago et al (2008); Klevan and De Jong (1990)

¹⁸DeLago et al (2008)

¹⁹Klevan and De Jong (1990)

²⁰Royal 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

²¹Delphi 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 indicators²²

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

²²Evidence 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

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

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

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

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

³⁰ ³¹ ³²Wells et al (1995)

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

³⁴Holmes (1998)

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