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Why Cleveland Still Matters: Connections with a New Era

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Abstract

This chapter explores the lasting impact of 1987 Cleveland child abuse crisis in the UK in which 127 children were diagnosed by two paediatricians as having been sexually abused. It highlights how this resulted in tensions, misunderstandings and stresses in the interface between the public and the child protection system, and persistent challenges of creating and sustaining a successful multidisciplinary approach to intervention and protection. It argues that the experience in Cleveland provided unique information about the effects of intervening in child sexual abuse, especially where children are trapped in silence and only come to light by way of a proactive intervention. These children remain difficult to help and the best way of intervening remains contentious. The authors challenge the ethos that leaves sexually abused children vulnerable in the face of investigative and evidential hurdles and suggest ways forward.

Keywords: Child sexual abuse, Cleveland, medical diagnosis, child protection, dilemmas of intervention

1. Introduction

'We have learned during the Inquiry that sexual abuse occurs in children of all ages, including the very young, to boys as well as girls, in all classes of society and frequently within the privacy of the family. The sexual abuse can be very serious and on occasions includes vaginal, anal and oral intercourse' ([1], p.243).

The lasting legacy of the 1987 Cleveland child abuse crisis, in which a medical diagnosis of sexual abuse was made in 127 children, is that Cleveland became a shorthand for difficult issues in child protection, with widely differing meanings, often informed by media rather than professional debate. It was a pivotal point, which has influenced attitudes, policies and politics ever since. The subsequent Butler-Sloss Inquiry [1] left unresolved issues in child protection and had the effect of stifling debate about the dilemmas facing professionals in the field and the communities in which they work. The key issues from Cleveland remain relevant to child protection today. We argue that after Cleveland, what had been a proactive approach to protecting children who were being sexually abused became reactive, focusing only on those children who can disclose abuse, rather than the majority who are trapped in silence, especially the very young whose abuse can only come to light via an adult advocating in their behalf. The critical role of medical diagnosis in advocating for the latter group was effectively ended in the furor which led to the Butler-Sloss Inquiry. The Inquiry failed to grasp the nettle of the problems of protecting these most vulnerable children.

Because the professionals involved in Cleveland were unable to speak publicly, this created an information gap, and powerful myths were generated, influencing both public and professional perceptions; for example that all children seen by the paediatricians were screened for abuse; that a diagnosis of sexual abuse was made on the basis of a single sign (anal dilatation); that the diagnoses were discredited and that children were removed from home for the flimsiest of reasons. Although Butler-Sloss refuted them all, the myths became solidified and entrenched and continue to profoundly affect our society's approach to tackling the reality of child sexual abuse. In 1987, despite the context of increasing awareness and increased willingness to intervene, the management of child sexual abuse was based on a limited understanding of its dynamics and what would happen when attempts were made to bring it to light. There is now a much stronger evidence base, which should inform politicians, professionals and others responsible for making decisions and taking the field forward.

Although the very complex issues involved are now better understood, intervening remains difficult and professionals have inevitably become more anxious and more aware of the risks they take when entering this field. The Butler-Sloss Inquiry addressed but unwittingly increased this struggle. One of the legacies of Cleveland has been professional anxiety, creating a risk-averse climate which has contributed directly to subsequent child abuse tragedies [2]. Professionals, too, are affected by conflict between the need to know and the distress of hearing unspeakable truths.

We argue that the knowledge and understanding gained in Cleveland could have produced positive changes and greater continuity in child protection practice and that this opportunity was lost. The tensions created left an eternal argument about the facts of Cleveland, and continuing failure by the child protection system to tackle the real scale of the problem. The subsequent clampdown on accurate information about the crisis made it difficult for other practitioners to verify the real issues and led many to question whether authoritative interventions based on advocacy for the child are tenable in a social climate which unconsciously supports the denial of the extent of child abuse.

2. Background: the Cleveland crisis and the inquiry process

The Cleveland child abuse crisis had its origins in a seminal paper by Leeds paediatricians Drs Hobbs and Wynne [3], which identified anal abuse as a potentially common childhood syndrome. The medical diagnosis by Drs Higgs and Wyatt of sexual abuse in 127 children in Cleveland placed unprecedented pressure on the resources of police and social services and inter-agency co-operation was stressed to breaking point. A public outcry of disbelief, fuelled by the media and one local MP, led to a major public inquiry [1]. Of the 121 children reviewed by the Inquiry, 27 were under the age of 3 with the youngest under a year old, presenting a uniquely difficult investigative challenge. In the absence at that time of any agreed procedures for intervention into child sexual abuse, procedures designed for other forms of abuse were followed: this involved removing some children from home. This action fuelled the controversy.

The Inquiry's remit did not include establishing whether or not the children had in fact been abused, which was addressed in a parallel process in the High Court. An independent expert panel set up by the Regional Health Authority concluded that in at least 75% the diagnosis of CSA had been correct. The Inquiry had access to the report of this panel but chose not to publish this conclusion. In consequence the public perception, led by a small group of aggrieved parents, a local MP and

consistently biased reporting in the media, was that the diagnoses were incorrect and the cause of the crisis was overzealous intervention by professionals.

At the very point at which professionals were trying to get to grips with dealing with the new phenomenon of children presenting via a medical route, the situation went beyond their control. The local MP made allegations in the House of Commons of 'collusion and conspiracy' (subsequently dismissed by Butler-Sloss) and the Inquiry effectively interrupted all ongoing work. The method of the Inquiry, which, despite its statement to the contrary, was adversarial rather than inquisitorial, was unsuited to the elucidation of a highly complex and sensitive issue such as CSA. This resulted in polarisation and a lack of balance, and encouraged the media to represent the professionals as being wholly wrong and the parents as being entirely innocent, creating a public misconception that has endured ever since.

3. A unique opportunity at the heart of the matter

Professionals in Cleveland were presented with a new opportunity to intervene protectively where children were experiencing the most serious forms of child sexual abuse. Some of the children were able to disclose. For some, disclosure was prompted by the medical examination. Others were identified as having been abused but were unable to say anything about what was happening to them. These children, who were trapped in the silence inherent in the dynamics of the abuse, came to attention through a medical 'window', a diagnosis based on previously unrecognised signs and symptoms. The two paediatricians Drs Higgs and Wyatt have analysed the children's presentation and medical findings and described dilemmas for the doctor [4]. The children who came to attention in this way, via an adult or alerting signs and symptoms rather than purposeful disclosure, then posed an enormous challenge for the professionals as to how to intervene to protect them. We term them 'Group B', in contrast to those who can make a disclosure and assist in an investigation, whom we term Group A.

In the case of children in Group B the identity of the perpetrator is likely to be unknown. Butler-Sloss identified but did not resolve this key dilemma and its relation to the question of removal from home. Removal from home, though fraught and controversial, facilitated disclosure for some children. Paediatricians in Leeds reported a similar pattern, commenting 'We know many children never describe their abuse, others only after months in the safety of a foster home. Children left at home may be threatened and never feel able to disclose, and without some sort of admission from the child professionals are increasingly anxious about taking any action. Yet it may be only by removal of the child from the abuser that the child can develop the confidence to tell' [5].

A theme of the Butler-Sloss Inquiry [1] is that children would normally disclose except for 'rare occasions when an abused child does not choose to tell' (p.207). The tenor of the report equates non-disclosure with no abuse. Rather than recognising how difficult and unlikely any disclosure is, particularly for young children, the report emphasised the risks of trying to assist children by interviewing them in more facilitative ways, such as asking them directly. Expert evidence to the inquiry warned that interviewers can create bias, interviews themselves could be abusive, and that children can lie and fantasise about abuse.

The importance of the medical diagnosis for such children was overridden by the idea that the 'gold standard' for the diagnosis of child sexual abuse was disclosure by the child. This reliance on disclosure as the prime route to diagnosis was accompanied by the discrediting of the medical diagnosis, which was based

on a constellation of signs including reflex anal dilatation (RAD). At this time the evidence base for medical findings in child sexual abuse was small, allowing scope for wide disagreement between professionals, which then deterred paediatricians elsewhere from working with child sexual abuse. More recent research [6] suggests that medical findings can in fact make a very important contribution to the diagnosis of child sexual abuse and that anal dilatation is a highly significant sign. The Inquiry missed this unique opportunity to evaluate this vital issue at the heart of the crisis.

The way the Cleveland crisis was handled had long term negative effects over the succeeding decades, and we believe that knowledge and experience about children in Group B has been lost. Such children have become largely invisible, and even when they do come to light, they remain difficult to help because the best way of intervening remains contentious.

4. The medical diagnosis: was it mistaken?

Since 1987 more research has been carried out into the medical signs that the Cleveland paediatricians described [7]. Despite this, the diagnosis of child sexual abuse has become more complex and uncertain. Very little has been added to the evidence base about anal abuse in children, few cases are documented, and paediatricians are still not all in complete agreement about some of the signs that were detailed by Hobbs and Wynne [3].

Although there is still not a complete consensus on this matter the current evidence-based guidelines for doctors [7] conclude that the so called 'controversial' sign of anal abuse used in Cleveland is one of the most statistically significant findings that can be relied upon in the diagnosis, along with most of the other signs and symptoms that the Cleveland paediatricians found.

After Cleveland the changed perceptions of the medical diagnosis soon became apparent. The Social Services response changed and although there were the same number of child protection case conferences, fewer children were placed on the register, fewer taken into care, and there were fewer criminal convictions. Campbell [2] explores the way in which the expert medical consensus that there was no wholesale error of diagnosis was kept from view, and how it was known that scapegoating the Cleveland paediatricians would undermine the paediatric role elsewhere.

5. The resulting backlash

Since 1987 society has tried to come to terms with the nature and extent of what can now be understood as an 'iceberg' of child sexual abuse. Ongoing secrecy and denial creates a backlash that can be driven by perpetrators, victims, professionals, politicians and the wider society which hampers the best efforts to understand and intervene effectively to help child victims. At the same time, it can be argued that there is far greater acceptance among the wider public of the reality of child sexual abuse, influenced by the courage and integrity of survivors who have come forward to bear witness to their experiences. In our opinion, a Cleveland-type crisis was an inevitable stage of a process whereby professional awareness advanced; but we argue that this took place in a context of impunity for perpetrators and public ignorance of the reality, and the Inquiry was an exercise in containment of the problem. We can now see how the media backlash used the disagreements between professionals to discredit them.

6. The legal system

The adversarial way the legal system dealt with the cases tended to place the families and the authorities in an oppositional rather than a co-operative relationship. This contrasts with countries like France, where the legal system is founded on a more inquisitorial approach. This in turn influenced not only the media and public perceptions, but also the climate for change and the pattern of the services which developed.

The controversy that developed around the medical diagnosis was only one aspect of the difficulties faced in the courts. The investigative process and methods, particularly around efforts to try and facilitate the children to disclose any abuse, was all subject to intense critical attack on the grounds that the process itself was traumatising and damaging to the children. These opinions served to fuel the criticism directed at the interviews in Cleveland, and influenced subsequent recommendations that interviews with children where abuse was suspected should not be in any way directive.

7. Perpetrators: a missing element of the Inquiry

The Inquiry had only a limited remit in respect of addressing the dynamics of child sexual abuse; the nature of abusers and the reasons for sexual abuse of children; the effectiveness and appropriateness of the strategies used once the problem has been identified; and the response of societies and the agencies to those who abuse.

At the time of Cleveland we did not fully appreciate the power of perpetrators, in particular the nature of the threats and other techniques they commonly use to ensure secrecy. For example, an adult survivor, who had been referred to one of the editors via a Child and Adolescent Mental Health Service as a teenager revealed that as a child of 6, she was abused by her father in his car on her way to hospital following a broken arm to make sure that she kept quiet about his ongoing sexual abuse. Children who are dependent on their abusers are often trapped in secrecy, so that abuse by family members and caregivers is unlikely to be revealed spontaneously.

In a climate where very little attention is paid to detecting and intervening effectively with perpetrators, opportunities for protecting children are correspondingly lost. We believe that this was the case in Cleveland. The media storm that gathered and vilified the professionals was exploited by perpetrators and allowed them to hide under the umbrella of being part of 'innocent families.' A specialist colleague working with sex offenders found indications that, post-Cleveland, some perpetrators had changed their behaviour, anal abuse now being seen as reducing the risk of conviction [8].

Unlike the doctors, social workers and psychologist whose actions were scrutinised in detail by the Butler-Sloss Inquiry, the omissions and failure of the police and legal system were subject to less stringent criticism. The successful scapegoating of the health and social services left an unbalanced system where intervention with perpetrators did not go hand in hand with intervention for the child and family.

8. The wrong kind of Inquiry?

We argue that, because the remit of the Cleveland Inquiry was not to focus on what actually happened to the children, the facts were never established and no-one outside the situation could really grasp the reality of the situation. A valuable opportunity to develop new ways of understanding and grasping the problems for

abused children was lost. Indeed, the intervention of the Inquiry had the effect of hindering rather than fostering effective joint working.

The advocates who believed that children had been abused were treated as the bearers of an unwanted message. The impetus was to remove the key figures from post. Those who did remain were largely disempowered. We have given a personal and professional account of this experience [9].

There is still a real climate of fear among professionals. Many paediatricians have left the field or are reluctant to enter it, some having been subject to a series of attacks.

9. Enduring myths

Members of the community produced a leaflet to refute the myths, raise awareness and counteract the media distortion and resultant scapegoating of those who were trying to bring the real problems to light [10]. Commentators have referred to lessons not being learned, but in our view the problem is more that any useful learning is impossible without an informed debate. Whilst this reflects the general difficulties for the public in accepting the reality of child sexual abuse, we think this may also be a reflection of the crucial absence at the centre of the Inquiry report. Without knowing whether or not the children had been abused, most observers have been unable to make their own judgement about whether the child protection professionals intervened appropriately; whether what happened was in itself unnecessarily damaging to the children; and whether they were in need of protection and whether they received it.

10. Ongoing denial and failure to connect

Thanks largely to the courageous efforts of survivors, there is an emerging narrative of widespread abuse in a large range of settings such as children's homes, football clubs and custodial institutions. Over time there has been greater awareness of the real extent of sexual abuse as the numbers of victims in large scale cases have increased. For example, an inquiry in Rotherham U.K. [11] gave a conservative estimate that 1400 young girls had been sexually exploited over a 16 year period from 1997 to 2013.

A major independent inquiry into child sexual abuse in the UK (IICSA) has identified and is addressing broader cultural, structural, financial, professional and political themes, and the importance of social and political narratives in tackling child sexual abuse [12].

From Cleveland to Rotherham the negative treatment of the messengers has continued. IICSA's remit includes an examination of the extent to which the deliberate investment in concealment is a factor in the many emerging cases of past abuse in organisations and institutions. Many of these cases are accompanied by allegations that those with a duty of care were aware of the abuse and either did not act, or covered it up.

11. Social work practice: was the refocusing policy helpful?

The post-Cleveland 1989 Children Act profoundly changed the way that child protection professionals could access abused children hidden within families. Rather than being led by the needs of children, the underpinning of the act was

political, reflecting the view that state intervention in family life was to be avoided wherever possible. Early intervention, effective child protection, and prevention have been casualties of that ideology.

The Children Act 1991 had the over-riding purpose of keeping families together by encouraging local authorities to work with them. During the 1990's it was argued that too many families were drawn into the child protection system. To counter this, the criteria for entry to that system were revised so that the majority of families where children might be at risk would receive supportive family intervention. In effect, this raised the threshold for child protection.

Rather than making child abuse increasingly visible as had been happening in the previous decade, it became laudable to reduce the numbers on the child protection register.

Refocusing the debate in the 1990s placed assessment of risk and inquiry rather than investigation, at the heart of child protection policy in the U.K. [13]. We find it telling that the term 'child protection' has been replaced with 'safeguarding'. We prefer the earlier term, which implies a more pro-active approach and intervention to protect or stop abuse [14].

12. The jigsaw approach

In Cleveland we saw the medical intervention as creating a window of opportunity, through which light could be shone on a problem that might otherwise remain hidden. For Group B children, especially those who were pre-verbal, this was potentially the only way their plight would be recognised. The medical 'window' by which possible abuse is identified by physical examination, has since given way to a 'jigsaw' approach, in which medical evidence is just one of several pieces gathered from several sources [15]. This development has improved our recognition of the factors associated with sexual abuse, for example domestic violence. However, it is bound to be detrimental for children in cases where the medical evidence is the only piece of the jigsaw available. The Royal College of Paediatrics and Child Health (RCPCH) [7] confirmed this approach: 'The child's story of what happened, together with the child's demeanour and emotional response whilst describing what took place, is the single most important factor in coming to a diagnosis'. This leaves many Group B children without a paediatric route, and few will now come to paediatric attention without having first made an alerting comment. The Ministry of Justice guidance for criminal investigations includes a section on the medical examination, making the comment that 'children who do not allege penetration should not receive unnecessary medical examinations' [16]. It assumes that the child will be Group A, that is, will already have disclosed.

Despite the existence of guidelines for doctors, very few children are now referred to the child protection system as a result of a paediatric examination.

13. Why the disclosure process creates difficulties for investigations

We know that disclosure is a process rather than a single event. This is why it does not fit the requirements of evidential interviewing and the court. In response to Cleveland's children we developed the concept of a 'continuum of disclosure' on which children, particularly those in Group B, are highly dependent on external factors, especially the presence of an adult to advocate on their behalf [17].

Although still a contentious issue in the courtroom, since 1987 the problems of such children including delayed disclosure, active withholding, traumatic amnesia

and not being believed have been well documented in research and practice [18]. A review by London et al. [19] of the evidence for the child sexual abuse accommodation syndrome [20], concluded that children who disclose in an informal setting are often able to give an account in a forensic interview, and that children are likely to disclose after an intervention such as a medical examination. This echoes what we saw in Cleveland: some children disclosed abuse only after being taken into care following the medical diagnosis, and, despite increased internal pressures, managed to tell once in a safe place. Out of a sample of 40 children seen by the psychologist because abuse was suspected or confirmed, nine disclosed shortly after the medical examination, whilst still in hospital ([17] Figure 5.2 p. 124).

It is now better understood that the process of disclosure is a dynamic one of the child balancing the need to tell with the need to contain the secrecy. This creates a pressure within the child which any successful intervention must understand and respect, giving some control over when and to whom the child or young person will be able to speak out. For the most part, and particularly in older children, nondisclosure is not a passive non-disclosing experience, but rather an active withholding of information. This has enormous implications for policy, particularly for investigations.

The Children's Commissioner for England has since confirmed this picture and the barriers to disclosure which result in only one in eight sexually abused children being identified by professionals [21]. The report states that the majority of victims go unidentified because the services that protect them, including the police and social services, are geared towards children self-referring or reporting abuse, although they rarely do so. Longfield concluded that the true scale of child sex abuse in England is likely to be significantly greater than official figures suggest.

Some children will remain unable to say what has happened to them, or will even deny proven abuse, especially when they are very young and the abuse is by a parent or other attachment figure on whom the child depends.

The optimal conditions for disclosure can be summarized as: having someone who will listen, believe and respond appropriately and effectively; having knowledge and language about what abuse is; being able to access help; having a sense of control over the process in terms of anonymity (not being identified until they are ready) and confidentiality (the right to control who knows); being asked directly about any experiences of abuse [22].

14. Group B: the silent majority of victims

We subdivide Group B into children who can be helped to disclose their plight, and can then be protected; and those who remain trapped in silence with no prospect of protection. The narratives of children and adults in group B are often fragmented and unprocessed and may be dissociated from conscious awareness. They present with a high index of suspicion of abuse but depend on a third party for recognition and protection. The children may be very young and without the ability to communicate other than through their bodies and their behaviour.

In the post-Cleveland climate of reactive rather than proactive intervention, some Group B children were nevertheless recognised when they presented to child mental health services [23]. Work with children and young people who came to attention because of symptoms of trauma such as disturbed, sometimes sexualised behaviour, dissociation and self-harming, confirmed our belief that even these children could be helped, by addressing their internal barriers so that the child's experience could be reached. Despite the inadequacies of the child protection system, children with protective mothers could often be enabled to disclose, even without

a protective intervention, provided they were both supported [24]. However, there were very few successful police investigations. Even when abuse was recognised by other means, some children remained unable to disclose.

Our 20-year review in two linked papers [25, 26] observed that changes in the child protection system had been directed only at children in Group A. In our opinion, the dilemma of children in Group B who cannot climb the continuum of disclosure remains unacknowledged and unaddressed, and the loss of the medical window adds to the number who remain unheard. The significance for policy and practice of the concept of Groups A and B, the continuum of disclosure and the role of the medical diagnosis was highlighted by Itzin [27].

15. The importance of disclosures made in informal settings

A focus of the Cleveland Inquiry was on scrutinising formal, forensic style interviewing. However, it is often those caring for children following abuse who receive the most information from the child.

In Cleveland, the social workers recognised the importance of this, and detailed information was recorded in social work files. Foster carers in particular were asked to keep detailed diaries and encouraged to make notes of what the children said, often at relaxed times of day or situations of intimate care such as bath and bed time. These were often spontaneous, unprompted accounts or direct re-enactments of abusive experiences, the significance of which may not have been appreciated or understood by the carers, who may have been very puzzled by the child's statements and actions.

Children's self-disclosure of sexual abuse is often fragmented, since they only reconstruct their experiences through this process. Everyday activities in foster families can be threatening to a child as they may trigger memories of the abuse. On the other hand, these activities can also create a shared frame of reference that facilitates a child to disclose. Because foster carers naturally react strongly to these experiences, an important task for social workers is to guide foster families through the disclosing process and enable them reflect on what the disclosure evokes.

16. The need to be asked and the need to be safe

Nelson [28] explores the need for potential victims to be asked about any experience of abuse. The Children's Commissioner uses the phrase 'enabled telling' in recommending ways that professionals can approach this ([16], p. 39). The majority of survivors who do not disclose until adulthood say they simply were not asked – or not in a way that they felt safe with.

Nelson [28] points out that, in the context of backlash propaganda, being proactive by asking about a history of abuse takes courage on the part of professionals. This applies particularly to the crucial intervention that children need. Fear of putting words into a child's mouth, ideas into their head, or contaminating any evidence, results in denying the child the one thing they need – to be asked directly. We saw in Cleveland that once children were asked in general terms what had happened to them, often by the examining paediatrician who found signs of abuse, some would then be able to tell what had happened. This moved the investigation on for such children if the perpetrator could then be identified. However, this often depended on an immediate intervention to create external safety for the child, and time to allow that to have an effect on the child's inner world, so that safety became psychologically as well as physically real.

Taking a proactive stance requires assuring the child that they will remain safe, and ensuring that this happens. One major aspect of the tragedy in Cleveland was that the professionals acted in the belief that the court would give this assurance. We then had to face the outcome that many of the children were returned home, in our belief to possible further abuse in some cases. Nelson quotes a child protection worker in a high profile case in Orkney, Scotland who said the most distressing part of the whole affair was ‘watching one small girl cross the tarmac to a huge cheering crowd, to her own parents and massed TV cameras... we had failed her, and I will never be able to get that sight out of my mind’ ([28] p. 115). In Cleveland, we remain haunted by an 8-year-old child, who whilst on the return journey to her home, asked her social worker what she should do if the abuse started again.

17. The role of protective parents

One of the enduring myths of Cleveland has been that children were removed from, and then returned to ‘innocent families’. In fact, many children were quickly returned from interim care situations, subject to conditions imposed by the court, once the perpetrator was known and the child could be protected. If, as was usually the case, the abuse was thought to be occurring within the family, the role of a protective and believing attachment figure was crucial in the process of return. Following the crisis and the lack of an effective child protection system in the 90’s, efforts became more directed at empowering protective parents, mainly mothers, to take action [29]. This was important in itself for healing and strengthening the attachment bonds between the mothers and children, which were often damaged by the dynamics of abuse. We came to realise the importance of the child’s attachment system in mediating the effects of abuse, particularly if the abuse was by a close family member.

In the absence of parallel legal intervention with the perpetrator, this approach only worked if the mothers were empowered to separate themselves and the child from the perpetrator. The voices of protective mothers were rarely heard [2].

18. Do children lie and fantasise about abuse?

This commonly held assumption has been shown to be erroneous in many studies. A report by the Australian Law Commission states: ‘Indeed, research suggests that children may be actually more truthful than adults. Certainly, the research on children’s beliefs about court proceedings implies that children may be more cautious about lying in the witness box than adult witnesses’ [30].

Although children can make false allegations, it is much more likely that in order to avoid breaking secrecy, punishment, and embarrassment they will deny abuse or retract previous disclosures. This is consistent with our model of the continuum along which children move between disclosure, denial and secrecy, according to the situation.

19. The legal system: has anything improved for child witnesses?

The Achieving Best Evidence (ABE) [16] protocol used in the UK is based on good research about how best to help children tell. It allows for more specialist interviewing with children deemed to be disturbed or otherwise vulnerable.

However because the guidance allows only a reduced number of interviews it is difficult for interviewers to establish rapport with the child and take account of the level of trauma in creating memory problems and confusion. In our view this is unhelpful even for children in Group A who are ready to talk about what has happened, making it far less likely that they will give a full account. To avoid influencing the evidence, interviewers became wary of giving kindly reassurance, or any indication that they believe the child.

The use of carefully structured, supportive interviews can facilitate children who are reluctant to tell and indeed, some children will only tell if they are asked. Nelson ([28], p. 40) comments that the ABE protocol, which requires the child to give a more or less free narrative account, can be seen as a classic example of defensive responses and reactions to the backlash, and does not fit well with children's own feelings, difficulties and reactions.

Although we now know that children can accurately recall and give accounts of abuse, are no more suggestible than adults, and can provide evidence that ought to be acceptable, we also know that they are unlikely to give such information spontaneously. Testifying in court will also be very stressful and likely to create further trauma. Studies have shown [31] that to help them give a fuller account children benefit from support to reduce stress: this will not undermine or reduce the value of the testimony but in fact will enhance the child's ability to recall and give an account of traumatic memories.

20. Support for child witnesses

To provide support to children and non-abusing parents in Cleveland, a specialist therapeutic project was set up and subsequently continued by Barnardo's [32], also piloting pre-trial therapy for children who were to give evidence in court. Not all children who face giving evidence at a criminal trial are given that benefit. In 2017 The Children's Commissioner concluded that 'Overall the lack of consistency or clarity about entitlement and provision of pre-trial therapy appeared to create an additional silencing mechanism, compounding children and young people's sense of feeling repressed from talking about their abuse and delaying their recovery process' ([21] p. 136).

Special measures have been introduced for all children under the age of 16 to have their evidence and cross-examination pre-recorded, although they still face long delays between investigation and trial. Multiple problems still face children and even when cases do reach court, there are long term devastating effects of the whole process. Longfield [21] commented that the vast majority of cases do not progress to this final stage of the justice system.

We conclude that despite the greatly increased knowledge about how to help and support child victims, neither the investigative framework or the courts have become significantly more child-friendly.

21. Developments in understanding trauma and dissociation

Many victims of child sexual abuse become dissociated from the memory of the experience. This is a survival strategy, in which the brain helps the victim bear the ongoing pain and fear via a process of fragmentation which separates mind, body and memory and compartmentalises experiences. This psychological process is the only way that many victims can cope with ongoing abuse, but it means that they

cannot then readily bring the experience back into mind, even in a safe and supportive context. The victim is in effect prevented from accessing protection, and becoming a survivor. We observed the process of dissociation in some of the children in Cleveland but at that time we did not really understand it or know how to help.

While accounts in the clinical literature now shed light on this process in children, [33] the knowledge gained has not been easy for clinicians to apply. The work involved in helping such children is often attacked and misrepresented, especially in court despite a wealth of clinical and research evidence. Dissociation, with its characteristic amnesia, can be a major factor in keeping some children and adults in Group B.

Some perpetrators of organised abuse deliberately induce dissociative states in order to restructure the victim's personality, installing parts who will comply with the perpetrator's commands and remain amnesic for what has occurred [34]. The many mechanisms used by abusers to frighten, compromise and silence their child victims can be almost insurmountable obstacles to disclosing the experiences even in adulthood. Investigations tend to uncover only a part of what has happened. For example, abuse that is part of an organised network might be missed when a single victim comes forward.

In retrospect, some of the children in Cleveland who had gross physical symptoms of sexual abuse but made no complaint may have been dissociated. Many dissociative adults also fall into Group B. This is especially the case for adults suffering on-going abuse. Both adults and children in Group B lack a coherent narrative of what has happened and, if they get as far as an investigation, struggle to assist. There are cases of the victim then being charged with perverting the course of justice. Alternatively, the adult self can be well aware of the abuse but unwilling to report out of fear of the consequences or because of bad experiences of past failed investigations. These factors may be compounded by so-called attachment to the perpetrator, more accurately understood as a trauma bond. The stakes are high for anyone in this position. A debate is needed about how we view capacity in dissociative victims, that is, whether they have lost the conscious ability to take responsibility for behaviour, actions and decisions. This can be difficult to judge where dissociation causes awareness and mental states to fluctuate. We need to debate our role as advocates, and the mismatch between the victim's needs and the requirements of the legal system.

22. Implications of the nature of organised abuse

At the time of Cleveland the organized nature of much child sexual abuse was not fully understood. The networks of perpetrators who deliberately enter professions such as child care, children's homes, teaching, and other youth work, or who groom those in such positions to procure children for them, have operated largely undetected or within a culture of impunity. In Cleveland we had glimpses of networks that could have been pursued, as did practitioners in Leeds [35]; but the investigative focus was mainly on abuse within families. A look back at NSPCC guidance from the 1990's on investigating organised abuse [36] shows how practice has receded, especially as joint investigations are no longer happening.

The difficulties of police officers investigating this dimension of abuse and the suppression of a piece of research by a UK police team are outlined by Mallard [37]. More than any other group, victims of this form of abuse suffer from 'iatrogenic doubting' [38] which reinforces what their abusers have told them, that they will never be believed.

Abusers formally entrusted with the care and protection of children are especially difficult to recognise. There are a number of examples of convictions of professionals who, over a long period, abused children entrusted to their care: care home workers, such as Frank Beck in Leicestershire, who also gave other adults access to abuse the children; and doctors such as the paediatric oncologist Dr. Myles Bradbury, convicted of sexual offences against boys aged 8 to 17 at Cambridge Crown Court in 2014.

23. The Community response

Members of the community in Cleveland have described how adults in the community can have a role in helping children trapped in silence and supporting professionals who advocate on their behalf [10]. We believe their account of a spontaneous grassroots effort to deal with the uncomfortable awakening to the reality of abuse in its midst is the first of its kind. The members of this group were deeply affected by what they learned.

While lip service has been paid to the role of the community, it has been given little systematic attention. This is reiterated by Nelson and Baldwin [39] who draw on a successful project in Scotland to show how to create 'active bystanders'. Community responses too have been affected by the backlash with its scapegoating of professionals and promoting of unscientific theories of 'false memory'. Nelson [28] analyses the legacy of the backlash in distorting the discourse, marginalising and obscuring the significance of and obscuring the facts especially in high profile cases.

Children and adolescents more often choose individuals within the community, such as protective parents and friends of their own age, to disclose to than professionals. Collings et al. [40] highlight the role played by both children and significant others in the process of child sexual abuse recognition and reporting. Detection by another was found to be more likely as the trigger for disclosure than purposeful disclosure by the child, which was noted in less than 30% of their sample of young people. Adults who work with children, including many in voluntary organisations, are in a position to ask children directly and to become a valuable part of the child protection system, but require support and understanding of what to expect and how to approach the difficulties. The dilemmas about confidentiality and the slow process of gaining a child's trust are now better understood. This knowledge, together with advice from both adult and child survivors, could be harnessed to build up resources in every community.

24. What happened to Cleveland's children?

The 121 children will now be between 33 and 48 years old. Their records were all destroyed by Social Services after the Inquiry, and it is impossible to know about any who came to the further attention of Social services or other agencies following their return home. We have some information about those children who remained in care and were followed up in the Child and Adolescent Mental Health Service (CAMHS) [41]. One, a group B child age 4 with medical findings of abuse, was protected as her older brothers were able to disclose. Once in care she was able to make a successful new attachment to her adoptive parents. Another girl removed from home at 4 years was successfully adopted, but continued to be troubled. Eventually at age 15, when given the

information about her early childhood along with therapeutic help, she made a good recovery. Another was returned home, but later asked to be taken back into care, and was fostered. Her own little daughter was later referred for help and was placed on the child protection register as the child was still at risk within the family in which her mother had herself been abused as a Cleveland child and returned home.

Over the years we have often been asked whether any of the other children can be traced or are likely to come forward to add their voices to the debate. The fact is that we simply do not know what has happened to them or if any have come forward in other settings. IICSA is hearing evidence from many other adult survivors who have previously been silent, disbelieved, or prevented for many reasons from accessing the justice system. So perhaps it is not surprising that the children who were so effectively silenced in Cleveland in 1987 have never spoken out publicly. If they were successfully protected – and despite the difficulties we have described, some were – they may well be getting on with their lives. If they were returned to their families only to experience further abuse, they are never likely to have trusted further attempts at intervention, and to have become casualties of the long-term effects on their mental and physical health. It is possible that some may even have taken the path of becoming perpetrators themselves. So a more apposite question is, why would they ever come forward? And what would they experience if they did?

25. Asking the right questions: what should we do now?

We believe it is necessary to revisit areas of controversy, especially what the public expect professionals to do in respect of children whose bodies carry the hallmarks of abuse but who cannot disclose.

A renewed public and professional dialogue would need to go back to some fundamental unanswered questions and dilemmas. For Group B children, the need for protection might still be paramount to ensure a safe situation to be able to disclose. It's important to mobilise protective adults within the family and give them support and time to absorb what is happening.

It is clear that children who are trapped in silence need to be given time, listened to and also helped pro-actively. In 2015 the Children's Commissioner described precisely the same issues we were grappling with in Cleveland: 'There is a high level of commitment to tackling this issue among professionals working with children. However, statutory services are largely disclosure-led, with the burden of responsibility placed on the victim' ([21] p. 7). 'Some professionals are hesitant to seek information from a child for fear that such actions will be construed as 'leading the victim'. Victims are likely to exhibit some sign or indicator suggestive of sexual abuse, though in some instances this will not always be obvious or conclusive. Proactive enquiry is therefore necessary to substantiate concerns' (op.cit, Conclusions 4–5 p.9).

26. Re-opening the medical window

In 2018 paediatrician Chris Hobbs commented: 'Despite ongoing disputes and insufficient research, the physical signs of Cleveland stand largely undiminished in the eyes of the U.K. medical community. When present, they continue to provide evidence valued by professional and legal authorities charged with the protection of children' [42].

How would we now act in regard to the child if a medical diagnosis was made? If the medical window could be re-opened how would inter-agency planning aim to manage the disclosure process on behalf of the children?

Attaching greater relative forensic weight to the medical component of the jigsaw would assist Group B children, because 'While behavioural symptoms and disclosure are important in medical treatment and child protective services investigation, positive physical findings are associated with a finding of guilt (in the criminal court)' [43] p. 388.

27. A different approach to investigation

Successful intervention with Group B victims, who include silenced adults as well as children, requires someone who will advocate on their behalf, with the primary goal of providing safety as a route to disclosure. The child protection system should be re-orientated to accept the responsibility for asking children and young people about abuse, and for actively reaching out to help and support those who cannot easily tell. The agencies who are vital at the later stages of a protective intervention, i.e. the legal system and the courts, need to understand and accept this reality.

The present legal system is inherently unsuitable for these often very emotive and difficult cases. Because the courts have relatively little experience of Group B children, they would need to traverse a considerable learning curve. How should the present investigative framework change to accommodate these realities? What kind of legal system could really acknowledge and accommodate these complexities? In the end the court is the ultimate arbiter of child protection, and unless the legal system supports this process of change, and accepts the hard-won knowledge and expertise of professionals, we will still fall at the last hurdle: making a case in court.

28. Conclusion

We are left with more questions than answers and there is a need to progress the debate. Yet the insights from research and from survivors will not be heeded unless society as a whole is willing to believe and empower them. Since the problem is presenting on an ever increasing scale to the point of overload, it must be owned by everyone to avoid yet another cycle of discovery followed by suppression. The core way forward for a problem that is endemic in society can only be a change in social and cultural power structures and attitudes towards women and children, as discussed by Campbell [2].

A key question is how watershed moments in the stages of recognition of child abuse can be held in public and professional awareness long enough for real cultural and organisational change to replace the failures of the past. The emphasis has always been on containment via legal and procedural solutions, and blaming of individuals which is of short term value only and of little help to the survivors. Over time, the detailed history gets lost, sometimes including the documentary evidence. Failures to heed warnings, to learn from past cases and to listen to the victims are repeated. What is needed is a concerted and well-funded effort at public and professional education, training and the development of trauma-aware and trauma-specific services. That all of this is possible is shown by the work undertaken alongside the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia [44]. Who will find the courage and provide the political will that Nelson [28] rightly argues is necessary for this kind of action in the UK?

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