

CONSTRUCTING RISK: PSYCHOLOGY,
MEDICINE AND CHILD WELFARE

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In this paper, we examine the increasing theoretical and practical importance of 'risk' and 'risk factors' in applied psychological and medical settings. We argue that 'risk' has become relatively disentangled from individual persons, and has come instead to reside in a statistically-created hybrid of the personal, the social and the economic. To illustrate this theoretical point, we discuss the use of a medical technique in suspected cases of child sexual abuse: while 'risk' is a powerful instrument for thought and action in modern society, in the case we discuss it has met with much resistance, and ultimately can be refused in favour of older theoretical models such as dangerousness.

In the recent sociological literature, the idea that we live in a 'risk society' has become the occasion of much theoretical and empirical research (see, for example, Beck 1992; Douglas 1992). Although this theoretical paradigm has yet to make much of an impact on psychology, we suggest that in the applied field of psychology which we might term the psychologico-medical, the notions of 'risk' and of 'risk factors' have come to play increasingly important roles in practical interventions and in theoretical orientations (Castel, 1991).

Psychology and medicine are, perhaps, the two most important discourses which regulate the life of the child in modern society (Hacking, 1991; Rose, 1993). In particular, the problem of child welfare has been a fertile ground for psychological and medical expertise to invent theories, diagnose ailments, and propose solutions. Our paper takes as its topic the increasingly debated topic of child sexual abuse, and examines the way in which psychology and medicine have changed the ways we understand the child and its family, and how we **conceptualise** the right of experts to make 'appropriate' interventions (Armstrong, 1983). In brief, we argue that there has been an attempt to make the concept of 'dangerousness' in relation to the child sexual abuser more amenable to scientific knowledge and intervention by way of its reformulation as a variety of 'risk factors'. In this way, concepts such as 'suspicion' can be rendered scientifically knowable and tractable. However, the professional 'turf war' that has taken place in relation to child sexual abuse has made **the** diagnosis of risk problematic; a series of resistances to scientific technique shows how such techniques are fundamentally social.

Our strategy for beginning this inquiry is to analyse the use of, and to explore the controversy surrounding the use of, Reflex Anal Dilatation (RAD) as a diagnostic sign of child sexual abuse. This controversy was seen very clearly in Britain in the Cleveland Affair (Report of the Inquiry into Child Abuse in Cleveland 1987, 1988), during which the sign of RAD was the focus of so much of the **furor**. However, this sign has had a long and previously uncontroversial medical history, especially in medico-legal attempts to ascertain the existence of adult male homosexual relations. There is, then, something interesting and puzzling in the apparent need to reassess the reliability and validity of this sign, and in its rejection as a valid indicator of sexual abuse by many commentators on the case. In the first part of the paper, we explore these debates and comment on the similarities and differences in the deployment of this sign in cases of child sexual abuse and in cases of adult homosexual acts. We then make use of this material to argue that the elimination of ‘dangerous individuals’, using a probabilistic ‘risk’ model is likely to be refused. The use of forensic techniques to diagnose familial pathology cannot operate simply in terms of this new language of risk. We suggest that the relation between ‘science’ and family welfare is complex, and **this** complexity is exacerbated by competing forms of expertise.

Before continuing, we offer a number of disclaimers. We are not trying to assess the various types of reliability or validity of **RAD** as a sign of child sexual abuse, or to offer a moral judgment on its use, or to comment upon the worth of various professional roles. Nor are we in any sense suggesting a moral equivalence between homosexual acts and the actions of a child sexual abuser. It should also be clear that our attempt to describe some factors in the construction of the child sex abuser is not an attempt to legitimate a set of practices we regard as intolerable. Rather, we are trying to investigate the historical deployment of a scientific technique, within psychological and medical expertise, as a starting point for thinking about risk and the psychologico-medical.

REFLEX ANAL DILATATION: THE USE OF A SCIENTIFIC TECHNIQUE

Reflex Anal Dilatation (RAD) as a technique of forensic medicine became a national talking point in Britain after “Cleveland”. Essentially, the technique involves an anal examination of the child and an assessment of whether the anus exhibits an abnormal dilatation reflex. The presence of this reflex is taken as an indication that the anus has become used to experiencing penetrating objects. Much of the controversy around the Cleveland affair stemmed from the use of this technique on children, when there were no grounds for suspecting sexual abuse. While **the** use of this technique, (also sometimes known as the ‘0’ sign, reflex relaxation of the anus, and the lateral buttock traction test), has become infamous in the context of child sexual abuse, its history as “a sign” is perhaps less familiar. It had been known for some time as an indicator of homosexual acts, with a large number of publications in the 1950s and 1960s referring to it. However, it is worth pointing out that these reported observations were exclusively clinical, and we can find no evidence of scientific attempts to evaluate its validity or reliability until “Cleveland”. The technique seems to have developed from a series of procedures in forensic pathology and forensic medicine, dating from about a hundred years ago, which stressed the importance of the examination of the anus where there was suspicion of homosexual acts. Polson, Gee, and Knight (1985) cite work by Ambroise Tardieu (1819-1 879) on anal signs of sodomy. The importance of anal signs is unquestioned in the medico-legal literature, and when RAD

becomes a standard forensic technique, it is an unproblematic clinical sign (see, for example, Paul, 1975).

Reflex anal dilatation was initially reported as a possible sign of homosexual acts. In more recent times, Feigen (1954) reported the results of proctological examinations of fifty homosexual prison inmates and eighteen 'private patients' who admitted to having practised or were presumed to have practised passive sodomy. Feigen included in his battery of tests a digital examination. He found that in thirty cases from the fifty prison inmates **there** was a "possibly diagnostic sign" where, as "the examining finger entered the anal canal, there was a sudden, brief contraction of the sphincters.. . immediately followed by pronounced relaxation of the musculature of the anal canal, which then appeared widened" (p. 81). The same sign was said to be present in the majority of the males in the private patient group. Gancz (1962) described how in the "majority of homosexuals.. . when the cheeks are separated.. . the sphincter, almost as a reflex, dilates and a central hole appears when the folds separate. A normal sphincter would resist the insertion of the finger **while** the anal sphincter in the homosexual dilates almost in a reflex manner" (Gancz 1962, p. 263). Mant (1960, p. 243) and Fatteh (1962) also refer to this dilatation of the sphincter. The recommendations of Paul (1975) state **that** in 'normal' tests, when the buttocks of a person are gently separated while in a standard position for examination of the anal region (**left** lateral or knee-elbow position differences in the sign elicited in these positions), there is a **refle** contraction of the external anal sphincter. If the buttocks remain separated the sphincter relaxes to its original tone but does not gape open. However, in people who have experienced repeated anal intercourse, when the buttocks remain separated and the sphincter relaxes, there is gaping or dilatation, Gee (in Polson et. al, 1985) **points** out that though a "lax anus... is not of itself sufficient proof [of buggery] ", a "widely gaping anal canal has of itself great significance" (p. 488). While 'widely gaping' is not the same as 'dilatation' - the latter being very much a dynamic sign - the strong weight attributed to gaping is relevant here. Fatteh also lists a patulous anus without radial folds or relapse of the rectal mucosa as significant.

It is necessary to comment that in relation to the problem of the diagnosis of homosexuality, **RAD** was only one of a battery of objective scientific techniques which aimed unequivocally to provide evidence of unnatural practices. **RAD** could be used as a sign in cases of alleged homosexual rape, but, importantly, it could also be used in attempts to secure convictions where no complaint had been made by any of the parties involved - for example, in cases in the armed forces. A contemporaneous diagnostic tool which tried to do the same job with regard to the detection of an otherwise invisible danger was the gag reflex test; the persistent fellationist was thought not to exhibit the reflex of gagging when objects were introduced into the mouth and throat (see Cornsweet & Hayes 1946, Gioscia, 1950). In summary, then, medical techniques such as RAD and the gag reflex test were used to adjudicate on the presence of a category of person - the homosexual; in **this** way, the medical and the psychological were closely linked, as medical information was used to make inferences **beyond** the purely medical domain and into the area of lifestyle, sexuality, and the law.

It is not the purpose of this paper to review and evaluate these techniques further, but rather to acknowledge that our understanding of them is now embedded in the context of a scientific debate about the worth of the sign - a debate provoked by "Cleveland" and child sex abuse

but not, we would stress, by previous use of RAD in the identification of homosexual acts and homosexuals. As we develop our argument, we shall suggest that this controversy tells us something about the problems of risk management in family life. While a consensus about the utility of risk management in the case of homosexuality existed in the 1950s, there was no challenge to the objectivity of scientific technique or the good practice of a highly regarded group of professionals. When the technique was relocated to put familial relationships under the microscope, the turf war that ensued was such that scientific technique and professional expertise were carefully **scrutinised** and ultimately reassessed.

CLEVELAND: REDEPLOYMENT OF A SIGN

In January 1987, Dr Marietta Higgs, one of the central figures in the use of RAD as a sign, became a consultant **paediatrician** in the South Tees Health District, joining a team that included Dr Wyatt, who was also to become one of the central figures in the controversy. Dr Higgs had become familiar with the technique and the use of the sign as a possible indicator of child sexual abuse through the work of Dr Wynne at Leeds (see also Hobbs & Wynne, 1986). In 1986, while in her previous post in Newcastle, Dr Higgs (using RAD as part of the diagnostic procedure) had 'diagnosed' two children as having been sexually abused. The subsequent use of this technique in the Cleveland Affair gave rise to fears of 'overdiagnosis'. As the controversy raged on and the value of the sign became a matter of some importance (see Campbell, 1988 for a more detailed discussion of the affair). As we have made clear in the above section, there was very little rigorous scientific evaluation of the sign of RAD, or controversy over its significance, when it was used as a possible indicator of homosexual acts between adults. Yet, since "Cleveland", and the transfer of the technique to the analysis of child sexual abuse, there has been an explosion of scientific inquiry into this issue, even though the worth of physical signs in identifying child sexual abuse is acknowledged by many to be very limited (see for example, Kerns, 1981). Interestingly enough, however techniques of vaginal examination of young girls, as detailed in, for example, Cantwell (1983) and White, Ingram, and Lyna (1989), seem to have caused little controversy and seem to be regarded as providing compelling evidence of sexual abuse.

The debate has continued over the form of the sign and over variations in terminology (for example, whether dilatation as a term should refer to opening of the internal sphincter, rather than the external sphincter - see the Cleveland Report, (Report of the inquiry into child abuse in Cleveland, 1987, 1988, p. 190)); whether or not the sign can be caused by other factors apart from experiences of anal penetration, such as chronic constipation (see, for example, Clayden, 1988); the positive predictive accuracy of such signs (Paradise, 1989); and, perhaps most importantly, the general notion of 'normal' variation (see McCann, Voris, Simon, & Wells, 1989). Its reliability has also been assessed by the doctors at the centre of the introduction of the technique, Hobbs and Wynne (1989). We suggest that even if these debates were to be resolved to the satisfaction of the professional community (so satisfying the Frye rule of the legal process - Scott, 1989) this would not be sufficient to explain the status of the sign in use. It is not, we argue, a case of 'science reaching its limits or of 'science being an inadequate framework'. Instead, we suggest that the case of RAD highlights science as inextricably woven into other processes, from which it cannot be abstracted. We do not think it is possible to separate out science in general, and medicine and psychology in particular, from our consideration of this case. We do not, for example,

wish to **characterise** these disciplines as power-broking, machiavellian practices (Campbell, 1988). Medical and psychological practices are part of a constellation of services which operate around the family and which constitute part of the social domain which administers to it.

RAD was transferred from the domain of homosexuality to a domain which was regarded as entirely separate and conceptually distinct - the internal (sexual) relations of the family. As a consequence of this redeployment a new set of inter-professional disputes were aroused. During Cleveland (and after), the refusal of the legal system to accept the sign of RAD as a reliable indicator of child sexual abuse resulted in a crisis for medical expertise and an opportunity for psychologists to stake a claim to 'interpret' the bare medical evidence. Such a response - the complexification of the issue, the competition between different forms of expertise, and the rhetorical argument that scientific failure is an indicator that more and better science is needed - is typical of the scientifico-legal controversies which enter the public domain (Wynne, 1982). No doubt the increased scale of the application of the technique of RAD was also a spur to an intensified concern with its validity.

TRANSLATING TECHNIQUES: MAKING THE CHILD SEXUAL ABUSER VISIBLE

The health sciences, for the past one hundred years, have been called upon to give us techniques for making the dangerous homosexual visible - partly because they held the promise of putting an end to secrecy. In particular, their objective has been to try to show us the place on the body where, unarguably, secret acts are made to speak out and reveal themselves to the scientific observer. It is, perhaps, unsurprising that a translation of these techniques to the area of suspected child sexual abuse was attempted.

For both homosexuality and child sex abuse, (though for different reasons) secrecy and the need to 'see beyond' has played a central role. Indeed, **Summit** (1983) identified secrecy as a necessary precondition for child sexual abuse, when perpetrator and victim know one another well. Secrecy requires that social agencies develop means of seeing these acts - 'windows' - as many of the people involved with Cleveland termed them (Higgs, 1991). The project of making child abuse visible, of ending the secrecy and collusion of the pathological family unit, may have commenced in the early 1960s with Kempe's work (see, for example, Kempe, Silverman, Steele, Droegemueller, & Silver, 1962), but the work on the creation of child sex abuse as a distinct medico-legal category began in earnest much later, from the mid 1970s. By referring to this 'act of creation' we do not, of course, mean that child sexual abuse did not happen before this time. What we are suggesting is that prior to the **1980s**, there did not exist the same resources for categorising such behaviours. The category of the child sexual abuser only came into being once lawyers, social workers, politicians, medics, journalists, academics, and members of the 'general public' began to use it in their various practices.

The NSPCC figures during the 1980s evidenced an explosion of child sex abuse cases. As these emerged, it became apparent that the 'bad apple' theory of abuse was an unsatisfactory explanatory device (although it is one yet to be entirely removed from popular and professional consciousness). The creation of a new dangerous act and a new dangerous individual - **child** sex abuse and the child sex abuser - was a scientific venture embarked

upon (with varying degrees of caution) by both professionals and the media. While methods to diagnose this could have been gathered from a range of disciplines, a number of factors suggests that medicine was well placed to play a dominant role. Medicine's claims to scientific **rigour** and its prestigious position as a profession, gave credibility to assertions from medical authorities. The use of the concept of diagnosis and the 'objectivity' of physical signs in previous work on child physical abuse (e.g., Kempe et al., 1962) and in 'successful' identification of dangerous individuals in general gave particular urgency to the search for physical signs that would be indicative of childhood sexual abuse. The strong hope was that medicine, rather than, say, psychology, could again provide certain answers. In this context, the work of two **paediatricians** from Leeds, Chris Hobbs and Jane Wynne, was almost bound to attract considerable attention.

FAILING TO TRANSLATE THE TECHNIQUE

What sets apart the use of the technique of **RAD** in the cases of homosexual acts and in the case of child sexual abuse, then, is a difference in its reception in the latter case as an objective scientific test. In both cases, the same technique did the same job - identify anal penetration and allow an inference to be made about the presence of a dangerous individual - but in the latter case, the claims of one group of experts to 'science' and scientific explanation began to be challenged. Why was the translation of this technique refused?

The work of Robert **Castel** (1991) allows us to begin to understand this problem. Castel has suggested that in certain areas of social administration, the notion of dangerousness has recently been undergoing a radical reconceptualisation. He discusses, in particular, the French 'GAMIN' project which aims to break down the aggregate of "dangerousness" into a series of factors. 'GAMIN' is an attempt to register huge amounts of information about children and families; the aim is to adjudicate in cases where there is the presence of risk, as determined by a rationalised checklist of factors. For example, the presence of a particular risk factor (teenage pregnancy, or unemployment, or alcoholism, or other '**factorised**' social evils) can be used to justify intervention by a welfare agency. The whole system is computerised, so it becomes easier to give various weightings to different factors, and alerts agencies to intervene when a family has exceeded a preset level of risk.

It seems to us that an attempt has been made to use the technique of **RAD** as something like a factor in the diagnosis of child sexual abuse. However, a factor is rather like a synecdoche; its purpose is to represent and to indicate a series of problems of which it is only a small part - indeed, in itself, the loss of the anal dilatation reflex is unimportant. What the sign represents is the crucial issue. In the case of homosexuality, such a synecdoche worked - nobody needed convincing that the social evil of homosexuality existed and that its existence was proven by this objective sign, and there was also no professional dispute to disturb the inference from medical sign to psychological and behavioural category. In the case of child sexual abuse, there was a professional and popular resistance to going beyond the sign, to seeing the horror that was implied by the technique. The resistance took the form of disputing the premise; surely **RAD** could not be a reliable indicator of sexual abuse?

While we think Castel's analysis of the reorganisation of the logic of social welfare is extremely important for anyone interested in this area, we would add that it is worth stressing just how quickly techniques of 'governmentality' (Foucault, 1991) are being refined and readjusted, and consequently how many opportunities there are for governmental initiatives to be disputed and derailed. Castel's general point is that the business of spotting danger and risk is undergoing a hyper-rationalisation; however, we suggest that this rationalisation is dependent on professional and popular consensus - even a statistically significant correlation will mean nothing, if this consensus does not exist. In general, then, Castel has argued convincingly for the intrusion of new modes of surveillance. These modes of surveillance operate, not by a consideration of the whole individual or the complete family unit, but by a process of inference from something *infra-individual*: a factor or a sign. We suggest that this transition is bound to be fraught with difficulties. First of all, the use of any 'risk factor' as an indication of dangerousness is reliant on a science of probabilities. Factors may well indicate dangerousness, but they may also generate some 'false positive' cases. There is a general problem here with any such probabilistic system, in that the probabilities are gathered from the consideration of large populations, and these probabilities cannot then be applied logically to individual cases. In some sense, the Cleveland affair **was** about the refusal of the logic of **factorisation**. It was relatively easy to mount a campaign which suggested that using RAD as a 'window' was impossible because of the generation of false positive diagnoses of abuse.

In addition, Castel makes the point that the task of making risk factors visible is one which falls increasingly to executives and administrators, with more and more specialist knowledge and less and less ability to make a judgment on the wider view. While it is possible to read Castel's piece as an indication that the future of risk detection in welfare provision belongs to an executive administrative class, each member of which can deal with a specific **infra-individualistic** element, the experience of Cleveland suggests **that** such a transition may not be easy. Certain forms of expertise may be refused, if they do not appear to connect up with a wider, often common-sense reading of a situation, and with other professional diagnoses. Furthermore, we would suggest that Castel's work cannot be used to provide a model of **how** the health sciences and processes of welfare operate; in the Cleveland affair, the notion of risk factor was put into play, but was ultimately refused **in** favour of a more old-fashioned conception of the 'dangerous individual'. By this, we mean that the weight of evidence of abuse had to be derived - especially in terms of testimony - in relation to a specific person; the judgment of abuse took place at *the individual*, rather *than* at *the infra-individual*, level.

In the Cleveland affair, then, the attempt to rationalise the diagnosis of danger was refused, partly because there was no professional or popular consensus that a causal link between RAD and sexual abuse could be made. We suggest that the operation of scientific technique cannot be seen as a separate domain, above **the** hurly-burly of public debate, **but is enmeshed within** everyday practices and beliefs, and depends upon them for its effectivity and its truth value.

THE FAMILY: NODAL POINT OF LIBERAL GOVERNMENT

The account given by Donzelot (1979) of the role of the family in practices of liberal government is helpful at this point in our discussion. **Donzelot's** account aims to sidestep

thinking of the family in purely functional, political terms, and refuses to think of the family as a purely private space with its own internal mores and modes of organisation. Rather, he wishes us to understand the family as a relay of different and varied forms of power. Forms of family life are in turn produced by the various strategies which target the family, either as a whole, or in terms of its individual members. Thus, for example, one of his arguments is that a certain intensification of family life is made possible by a series of strategies which aim to guarantee the health of children in families, as well as by strategies which give a privileged position to the mother in terms of the educational and hygienic government of the family.

It seems to us that Donzelot makes two crucial moves which help us understand the modern family and its relation to welfare strategies. First, he makes it clear that we can no longer understand the family as a prop for patriarchal or capitalist relations - the various strategies which play on the surface of the family are too heterogeneous and too anonymous for such a reading; second, he disrupts a simple notion of the family as a 'private' sphere, as if 'public' concerns stopped at the threshold of the family home - for example, he details how the modern family is no longer an autonomous unit, outside the public sphere and governed by the patriarch, but a unit which has been 'opened up' to a variety of forms of inspection and scrutiny. Donzelot's first move enables us to be suspicious of explanations of the fate of RAD in terms of a reaffirmation of the privacy of the family and the power of the father within the family. His second move allows us to analyse how the family is constituted and maintained in terms of strategies which comprehend it as simultaneously public and private. It is precisely this oscillation between the family as a public institution and as a private institution which allows child welfare to operate and which provides conditions of possibility for the reproduction and evolution of the familial unit (see also Ashenden, 1994).

The main argument, then, is that the family is simultaneously a public and a private institution. There are, clearly, many departments of existence where the family is allowed its own internal economy; and there are, just as clearly, many others departments where public intervention is legitimate and expected. The family is caught up in the criss-crossings of these public/private strategies. It is, in fact, a site of constant tension for this reason (think of the contrasting claims of 'child welfare' and 'parents' rights' in the Cleveland affair, for example, which work through contrasting notions of the family as public and hence fair game for interventions, and the family as private and thus as inviolable). One might note here a general tension in forms of liberal administration - one must govern effectively, but one must not govern too much.

If we return to our example with these observations in mind, we can begin to make sense of the rather complex picture presented to us after Cleveland. First of all, in the case of the use of RAD as a diagnostic technique in the case of suspected homosexual acts, we suggest that the lack of controversy stems from a general consensus about homosexuality as a public danger. The idea of homosexual acts as part of a private domain was certainly not absent, but it is precisely because the public health consequences of homosexuality were taken to be so severe that no controversy about an invasion of privacy ensued. It is worth noting that there is also a public/private tension in interventions into homosexual acts, but in the recent past at any rate, these interventions have been recuperable within the logic of liberalism, precisely because the public dangers have been taken to outweigh rights of privacy.

Consequently, a generalised logic of dangerousness has been employed to oversee a set of techniques to make the homosexual knowable and administrable within public health discourses. The Wolfenden Report was one such example of a governmental strategy which was able to come into being because of scientifico-technical devices, like **RAD** and the gag reflex test, which made homosexuality visible. Homosexuality, then, was **targetted** as one of a series of dangers which required public intervention. The work of inference **that** needed to be done from the sign to the dangerous act and dangerous individual was carried out easily and smoothly, and the value of 'science', in the shape of medical and forensic technique, was undisputed.

However, in the case of child sexual abuse, interventions into **the** familial unit and into the life of the child had to move between understandings of these domains as public and private. The story of Cleveland is the story of **that** tension. Clearly it is a public **issue**, or **the** children would never have been examined and put into care; and just as clearly it is a private issue, as the refusal of the medical sign, the return of many of **the** children to their homes, and the concern for parental rights, prove. Yet it would be over-simplistic to assert that Cleveland is a story of the victory of the private over the public. The various recommendations of the report and the subsequent review and strengthening of welfare services suggest that it is more the case that a constant entanglement of public and private is played out in the area of family welfare. The 'failure' of **the** liberal administration of the family (and one way or another, we must be talking about 'failure' here - **either we have failed to protect children adequately or we have wrongly intervened into the private domain** - that is, we have either governed too little or too much) is a spur to the constant recalibration of the techniques which measure pathology and normality, and the strategies which these techniques permit. Failure has a crucial place in our analysis, as the failure of administration is not the occasion for its displacement, but the spur to further revamp techniques of government; because it is the failure of the family unit in the first place that provides the pretext for the adjustment and correction of deficiency. Donzelot goes as far as to say that failure is built in to the family mechanism (1979), precisely because the modern family is that which fails, which needs gentle correction and regulation. Without failure, there would be no welfare, there would be no 'social'.

Child sexual abuse stands outside of the logic of risk which has been described by Castel. The attempt to use a 'factor' to indicate a need for intervention **was** a **principle which** was refused by the courts; RAD was **the** weak link in the chain which failed to hold as the debate oscillated between competing forms of professional expertise.

CONCLUDING REMARKS

In this paper, we have addressed the general problem of the knowledge and administration of dangerousness, in relation to child sexual abuse and homosexuality. We have presented this by concentrating on the role of a rather humble scientific technique, IUD, **which** has been used in each of these domains, although **with** differing consequences. We have suggested that the work of Foucault and **Castel** on dangerousness and risk is an important resource for thinking about these problems, and has enabled us to understand how homosexual acts have been made visible and governed. We had suggested that there is a logic of dangerousness, within which homosexual acts have been understood, and a consensus on the dangerousness

of homosexuality has allowed interventionist policies to take place, based, in some instances, on a diagnostic sign. The administration and policing of child sexual abuse has been more complex, because interventions into the familial unit have led to a series of professional disagreements about the validity of 'risk factors'. We have followed Donzelot in seeing the family as a dynamic unit, a unit for the generation of relations of power. No doubt some of the **patterns** we have identified are a subset of the various dynamics at work (some of which are very parochial) in the domains of homosexuality and child sexual abuse. We do not wish to argue for a simple 'correlation' between these two domains, particularly since in the case of child sexual abuse there is a professional 'turf war' going on as to which experts have the prime competence to judge abuse. Psychologists and medicos are two of the most important of these expert groups, and each is ready to step in, if the other's diagnostic and curative techniques come into question.

It might be thought that the rejection of RAD at Cleveland was a blow to the prestige of the medical profession and a restitution of patriarchal authority and the sanctity of the family. What we would suggest is that the continuing problematisation of child sexual abuse, and the ongoing debate about limits and duties of intervention, suggest that the story is not over. The reassessment of RAD, and debates over other candidate indicators of abuse (child testimony, precocious sexualisation, etc.) are part of a process of reconfiguring government, and the constant readjustment of its aims and of its limits. For example, the common reading of the welfare authorities as being rather too interventionist and heavy-handed in the Cleveland affair has, it has been argued, led to an attempt to restore autonomy to the family and its members through devices such as the 1989 Children's Act (Bell, 1993). The family is surely destined to be a prime site for future regroupings of governmental strategies and of resistances to government. Psychology and medicine are destined to continue to play crucial roles in these strategies and resistances.

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AUTHORS' RESPONSES TO REVIEWERS' COMMENTARY ON CONSTRUCTING RISK: PSYCHOLOGY, MEDICINE AND CHILD WELFARE

The paper has little to say about the turf war, social nature of scientific knowledge, or the application of risk factors.

We find this judgment mystifying, as the paper regularly refers to the turf war between different expert groups, and suggests it as a causal factor in the rejection of medical technique. Our detailed discussion of liberalism and the family as implicated in the