1. INTRODUCTION:
The sexual abuse of children and adolescents is being increasingly recognised as an area of concern in paediatrics. Essential to the diagnosis is an awareness of the problem and a knowledge of its manifestations.

The following guidelines aim to provide a sensitive and thorough clinical and counselling service for child and adolescent victims of sexual abuse. Although it details the collection of medico-legal evidence, the interests and comfort of the victim remain the prime concern. Great understanding and empathy is required.

2. DEFINITION:
The generally accepted definition is that of Kempe (1978) who defines childhood sexual abuse as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles".

3. PRESENTATION:
Sexual abuse includes rape, indecent assault, carnal knowledge and incest. For definitions of relevant terms, see Appendix 1.

The more subtle presentation of child sexual abuse are listed in Appendix 2.

NOTE:

i) The assailant is more likely to be someone in the family or who is well known to the family.

ii) Chronic sexual abuse is common with incestuous assaults.

iii) A child should be believed even when there is little supportive evidence.

Prevention of sexual abuse of children includes consideration of the sexual exploitation of children for commercial gain as in child pornography and prostitution, and for 'ideological' gain as is seen in the activity of paedophilia.

*FOOTNOTE: These guidelines are modelled on those used by the Sexual Assault Clinic, Queen Victoria Medical Centre and conform with the recommendations of the N.H. & M.R.C. Statement of the Care of the Child Victim of Sexual Abuse, October, 1980, prepared by the Australian College of Paediatrics, and the Victorian Police protocol for the examination of patients presenting in connection with allegations of sexual abuse.
4. **INTERVENTION:**

An integrated approach to child sexual abuse, incorporating complementary elements of the three interventive areas - criminal, protective, treatment - should be embraced.

For philosophies and values underlying interventive approaches, see Appendix 3.

Conviction of the assailant may be an important aspect of the intervention strategy but should not be pursued in isolation.

5. **CORROBORATION:**

The Evidence Act (1958) Section 23 provides that children under the age of 14 years may only provide sworn evidence if the court is satisfied that he/she understands the nature of the oath. Unsworn evidence is accepted but, in practice, carries less weight. Further, Section 23(b) of the Act dictates that the accused cannot be convicted unless the unsworn evidence is corroborated by other material evidence. In this respect medical evidence is crucial.

6. **MANAGEMENT GUIDELINES:**

6.1 **Preamble:**

Management strategies may depend on the nature of the abuse. Rape or indecent assault may be accompanied by physical violence, with immediate involvement of police, gynaecologist, surgeon and social worker. On the other hand, incest may be expressed in a covert and secretive manner with little or no clinical evidence of assault.

Notwithstanding the fact that there is some common ground, rape-indecent assault and incest will be considered separately.
6.2 RAPE-INDECENT ASSAULT:

Immediate crisis care in Emergency/Adolescent Services:*

A team approach, similar to that described for the child at risk in Emergency is used. If the victim is 12 years or older, the physician and nurse in Adolescent Services may become involved.

6.2.1 TEAM MEMBERS:

- Child abuse team social worker.
- Triage Nurse.
- Charge nurse in Emergency/Adolescent Services.
- Registrar in Emergency/Adolescent Physician/Police Surgeon.

6.2.2 DURING OFFICE HOURS:

(a) ALLEGED SEXUAL ABUSE - TELEPHONE REQUEST FOR ASSESSMENT FROM POLICE SURGEON OR OTHER OUTSIDE AGENCY:

i) Switchboard will direct calls to Social Work Department.

ii) Child Abuse team Social Worker

- Notifies Triage Nurse to direct child and accompanying adults to Adolescent Services.
- Notifies Emergency Registrar/Adolescent Physician and Emergency/Adolescent Nurse.
- Obtains WRITTEN CONSENT if possible from parent or guardian, using the sexual abuse proforma sheet (See Appendix 4).

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"FOOTNOTE: In some instances, a sexual assault may be discovered following admission. The Ground Floor facilities for examination and collection of specimens would also be available for such cases."
- Assesses immediate emotional needs of victim and family.
- Obtain and documents a history of the assault and activity post assault. (This may be done in conjunction with the Emergency Registrar/Adolescent Physician).

NOTE:
1. Presumptive consent may be tested in court.
2. The sexual abuse proforma may become legal evidence. Statements made by the victim may be admissible in court. Therefore, take care that all written statements are objective, accurate and legible.

iii) EMERGENCY/ADOLESCENT NURSE
- Sets up Victoria Police Sexual Offences Examination Kit in the Adolescent Services Examination Room.
- Assists with examination, collection of specimens and processing of evidence.
- Assists other team members in responding to victim’s emotional needs.

NOTE: DO NOT HAVE VICTIM UNDRESS UNTIL JUST BEFORE EXAMINATION.

iv) EMERGENCY REGISTRAR/ADOLESCENT PHYSICIAN
- Completes history taking.
- Obtains written consent to a complete medical examination, including pelvic examination and to the disclosure of the findings.
- Notes date, time and place of examination and the name of the witness to the examination.
- Performs a careful general examination (Section 6.2.4); this should include examination of clothing, general emotional status and an overall search for stains, bruises and lacerations.
- Examines area involved in sexual assault; note should particularly be made of the state of the hymen, bearing in mind the wide variation in appearance of the normal hymen.
- Assesses the need for genital examination, especially vaginal examination which is not always necessary.
- Documents findings carefully on the sexual abuse proforma sheet and accompanying traumagram (Appendix 4).
Assesses the need for Laboratory Investigations (Section 6.2.5) and Forensic Tests (Section 6.2.6).

Ensures that forensic evidence is handled correctly (see Section 6.2.7).

Assesses need for admission; this may be indicated to ensure immediate protection for the child while further assessment is carried out.

Considers treatment for physical injuries.

NOTE:

(a) The police surgeon may be consulted for advice without the case being reported to the police for prosecution purposes.

(b) A decision to involve the police in "non-police" cases should be made in consultation with the receiving physician if admitted. If not admitted, the consultant in Ambulatory Paediatrics or Adolescent Medicine should be involved.

b) ALLEGED SEXUAL ABUSE - PRESENT TO TRIAGE DESK:

(i) Triage Nurse

- Notifies child abuse team social worker, emergency registrar/adolescent physician and emergency charge nurse/adolescent nurse.
- Escorts victim and accompanying adults to adolescent services.

(ii) Duties of social worker, registrar/physician and nurse - See (a) (i), (ii), (iii).

c) ALLEGED SEXUAL ABUSE - PRESENTS TO RMO IN EMERGENCY OR GENERAL CLINIC

(i) R.M.O. notifies Emergency registrar and charge nurse.

(ii) Emergency registrar notifies child abuse team social worker.

6.2.3 AFTER HOURS

Switchboard will direct all calls to Triage Desk. Triage Nurse records telephone conversation and notifies Emergency registrar (or Admitting Officer if after 2300 hours) and charge nurse.

Charge Nurse in Emergency notifies duty child abuse team social worker.
If the child does not present, the U.R. should be delivered to the Social Work Department.

6.2.4 MEDICAL EXAMINATION

(i) General Points:
- The doctor who first communicates with the patient following sexual abuse has a great responsibility. His or her attitude to the victim is important.
- Prior to examination, it is most important to explain the impending procedure, and to continue this explanation as the examination continues.
- Once an appropriate atmosphere is obtained, a careful examination is performed.
- AT ALL TIMES DELAY SHOULD BE AVOIDED.
- For forensic purposes, gloves should be worn at all times.
- For court proceedings, there is a need for corroborative physical evidence. Where it is uncertain whether court proceedings will take place, or where a decision is being made about whether to prosecute, the need for such physical evidence needs to be balanced against the possible psychological trauma involved.

(ii) GENERAL EXAMINATION
- Note appearance and emotional state of the victim.
- Clothing must be removed in the presence of the doctor and a witness. This should be done with discretion and delicacy.
- The victim should undress on a piece of paper to avoid loss of small particles, fibres and hairs. The paper should then be folded in on itself and placed in a bag.
- Note appearance of clothing, especially stains and damage. Avoid any further damage to clothing during inspection or removal and place in identified separate packages.
- Indicate which items were worn during the offence, removed before the offence and not replaced, removed before the offence and replaced afterwards.
- If a tampon or sanitary towel was used after the offence, this should be submitted.
- Note condition of the face, mouth, throat, head, limbs, thorax, abdomen and buttocks. Specify and indicate on traumagram any abnormalities, bruises, abrasions, bite marks, etc.
(iii) **EXTERNAL GENITAL EXAMINATION**
- Note presence of semen, blood, mucus, lubration, etc., on vulva.
- Note any abnormalities and any pain or tenderness in mons, labia majora and minora, introitus, posterior fourchette, hymen, urethra, clitoris, inner thighs, perineum, perianal skin and anus.

(iv) **VAGINAL (SPECULUM) EXAMINATION**
- Not always necessary: active vaginal bleeding from an unidentified site and a history of penetrating vaginal injury are indications for vaginal examination in pre-pubertal girls.

If indicated by the history, examine the rectum.

6.2.5 **FORENSIC SPECIMENS** (Forensic Science Laboratory)

(i) **Swabs and Smears** - For spermatozoa, semen, blood.

Sites: Vulval.
Upper vaginal.
Anal, rectal, oral (if indicated).

Procedure:
- Label sterile swab tubes and ground part of slides provided, indicating name of victim and type of swab.
- Take direct smear and examine for motile spermatozoa.
- Air dry and place in slide-carrier.
- Take direct swab, allow to air dry and replace in labelled tube. **DO NOT PLACE THESE SWABS IN TRANSPORT MEDIUM.**

**NOTE:**
If obvious seminal staining of skin or history of ejaculation onto skin, a dry swab (moistened with sterile saline if stain is dry) should be taken.

(ii) **BLOOD:** 15ml venous blood:-

5ml - plain tube  ) store at 2-6deg.C.
5ml - sequestrine tube  " " "
5ml - baseline VDRL (to lab.), see later.

(iii) **SALIVA:**
- Victim licks envelope provided and saliva is allowed to air dry.
- Seal and label envelope.

(iv) OTHER EXHIBITS: Stray hairs, dirt, grass, seeds, etc.
- Place in clip-shut plastic bags provided, label and seal.
- Note location from which the debris is taken.

6.2.6 LABORATORY INVESTIGATIONS

(i) Blood - Baseline VDRL.
(ii) Swabs - N. gonorrhoeae from upper vagina, urethra, (oral, anal swabs if indicated).
- Smear on glass slide and place in Stuart's Transport medium.

6.2.7 HANDLING OF FORENSIC EVIDENCE

It is important for future legal proceedings that the continuity of evidence of specimens, exhibits, etc., be maintained. These should be handed to the attending police officer if police involvement occurs at the time of the examination, or retained in a refrigerator, after being air dried, in the doctor's possession until being handed to a police officer.

A certificate should be written stating that they have been handed to the 'named' police officer at a certain date and time. This can be incorporated in the medical report.

6.2.8 PROPHYLAXIS FOR STD

This is not recommended. A definite diagnosis should be made before treatment is commenced.

6.2.9 PREGNANCY PROPHYLAXIS

This should be considered and discussed in any post-menarchal female victim. The decision should rest with the consulting physician.

Recommendation: Eugynon - 2 tablets stat.
- 2 tablets 12 hours later.
- (Failure Rate 0.2%).

It should be agreed that if the victim becomes pregnant on this, termination will be undertaken because of the potential teratogenic effects.
6.2.10 ADMISSION

A decision will be made whether or not the victim requires admission by the Emergency registrar and child abuse team social worker. If there is any doubt, notify the consultant on-call for Ambulatory Paediatrics. The receiving consultant is notified of the admission.

If the child is not admitted, the consultant on-call for Ambulatory Paediatrics must be notified. Follow-up and counselling will then be the responsibility of the child abuse team social worker and the consultant.

On admission, further evaluation and documentation is carried out and counselling begun. A case conference will then be convened (see child abuse protocol) and follow-up arrangements made.

6.2.11 FOLLOW-UP AND COUNSELLING

(i) Medical review at 2 weeks:--
- General.
- STD, especially N. gonorrhoeae treatment if indicated.
- pregnancy test (serum) where appropriate.

(ii) Medical review at 6 weeks:--
- General.
- Repeat VDRTL.
- Pregnancy Test (urine).

(iii) Periodic review for counselling.

IMPORTANT NOTE:

The above guidelines are complete and cover almost every contingency. The doctor must use common sense and discretion in their application.

6.3 INCEST

As previously stated, incest tends to be expressed in a covert manner. Collusion between the assailant and other family and extra-familial members is not uncommon.

Even when the abuse is detected, the family may continue to resist professional intervention.

It is paramount, therefore, to both increase our awareness of the problem (Appendix 2) and to commit ourselves to an integrated management strategy (Appendix 3).

6.3.1 HISTORY

It is difficult for a child to recall the dates upon which
offences took place as they may have occurred over a prolonged period. It is therefore useful to establish that an offence took place within a certain time of an identifiable event (e.g. birthday).

Children who give a history of incest should be believed even when there is little supporting evidence. In fact, the abuse is often more extensive than the victim admits.

6.3.2 EXAMINATION

It may be unnecessary, even contraindicated, to rigorously pursue the procedures outlined above. Again, common sense, discretion and the comfort and interests of the victim must prevail.

It should be noted that frequently there is an absence of trauma or clinical signs of abuse.

6.3.3 INVESTIGATIONS

As a minimum, where sexual contact is thought to have occurred, a high vaginal swab for N. Gonorrhoeae should be taken. However, investigations may well be non-contributory.

6.3.4 ADMISSION

All cases of alleged or suspected incest should be admitted unless there are clear cut reasons why this is inappropriate. If there is any doubt discuss with consultant on-call for Ambulatory Paediatrics. (This is not meant to imply that removal of a child from the family is the definitive step in therapeutic intervention. Appendix 3).

6.3.5 COUNSELLING

NOTE: For the following assume father-daughter incest.

A crisis intervention model, appropriate for the needs of most victims of sexual assault is usually not adequate in cases of incest where the special characteristics of intra familial abuse need to be acknowledged.

Individual, family and, at times, group therapy of a supportive rather than confronting nature should be undertaken. Although the revelation of the incest may be a symptom of the family disintegration, it is important to 'engage' the whole family rather than to be left working with the excluded child or adolescent. (This may be very difficult, especially if the father has left or is in jail).

Again, the integrated approach to intervention, embracing criminal, protective and treatment areas, is emphasised (Appendix 3).
Individual counselling should help the victim to function at an age appropriate level. This may involve helping her to establish peer contacts, re-defining her role within the family, and discussing with her the accepted norms of sexual behaviour.

Family therapy should consider what conditions are both necessary and sufficient in the family to make incest occur. The core of the problem may not be found within the family system— the family dynamics and pattern of relationships may be the 'effect' and not the 'cause' of incestual abuse. It is therefore important to consider such questions as: what does father bring into the family from his family of origin? (agents such as alcohol that disinhibit impulse control are important in this context).

It is important that such counselling be performed by experienced members of the therapeutic team. This should be discussed at the initial case conference and follow-up arrangements made.

Dr. G. Debelle.

Dr. A. Carmichael.

October, 1984.
APPENDIX 1

DEFINITION OF RELEVANT TERMS

RAPE:

Rape has no absolute definition in law but has been accepted in Common Law as:-

"Sexual intercourse by a male against a female without her consent, with or without the use of fear, force or fraud".

It has now been extended statutorily by definition in The Crimes (Sexual Offences) Act 1980, amending Act 9509, to include:-

"Rape" Includes the introduction (to any extent) in circumstances where the introduction of the penis of a person into a vagina of another person would be rape, of -

(a) the penis of a person into the anus or mouth of another person (whether male or female); or

(b) an object (not being part of the body) manipulated by a person (whether male or female) into the vagina or anus of another person (whether male or female) - and in no case where rape is charged is it necessary to prove the emission of semen; and

For the purposes of this Act, an act of sexual penetration is -

(a) the introduction (to any extent) of the penis of a person into the vagina, anus or mouth of another person of either sex, whether or not there is emission of semen; or

(b) the introduction (to any extent) of an object (not being part of the body) manipulated by a person of either sex into the vagina or anus of another person of either sex, otherwise than as part of some generally accepted medical treatment

For the purposes of this Act, both -

(a) a person who introduces his penis or an object into the vagina, anus of mouth of another person; and

(b) the other person -

shall be deemed to take part in an act of sexual penetration.

The four components required for a conviction are:-

12
(i) Proof of Penetration
This need not be complete.
It does not necessarily require rupture of the hymen.
It does not require ejaculation.
Swabs and smears may help prove penetration.

(ii) Proof of Identity
Medical examination may assist in providing evidence
for grouping of semen, contact tractes, hair
characteristics, etc.

(iii) Lack of Consent
(a) The presence of injuries consistent with the story of
the complainant that she struggled, fought, etc.
(b) Nail clippings and scrapings can produce evidence of
skin or blood from an assailant following a struggle.
(c) Frequently consent is not given, but there is no
evidence of a struggle or other injuries because the
victim has submitted to rape by virtue of threats and
intimidation. The law recognizes the difficulties of
accepting this situation as allegations of sexual
assault are easily made and have been shown difficult
to disprove. It is therefore important that a Doctor
should give an objective opinion on the patient's
mental/emotional state as well as physical findings.

(iv) Guilty Intent
It is necessary to prove that the accused had the
intent to commit rape. This may involve psychiatric
argument in Court. The medical and legal aspects in
this type of examination are intertwined and it is
important that Doctors should understand some of the
basic necessities of the law.

CARNAL KNOWLEDGE:
Carnal knowledge consists of having vaginal intercourse with a
girl who does not consent but who, because of her age, is deemed
to be unable to give her fully informed consent, in Victoria, the
'age of consent is 16 years. Any charge relating to intercourse
with a girl under 10 years is likely to be carnal knowledge,
rather than rape, as in the former case it is unnecessary to prove
absence of consent.

ASSAULT:
A use of violence, or a threatened use of violence against another
person is assault. If consented to, there is no offence.

If more than a trivial injury is caused in the assault, the
offender can be charged with assault occasioning actual bodily
harm.
INDECENT ASSAULT:

Technically, indecent assault consists of an assault coupled with an act of decency. This covers a very wide area from the most serious forms of indecent assault to touching another person's genitals.

INCEST:

Incest consists of having intercourse with one's mother, sister, daughter or granddaughter, or with the equivalent relations if one is a girl. Consent is no defence.

Father/daughter (including step-father/step-daughter) relationships are the most frequently reported. Incest between siblings is also common. Only a small number of incestuous relationships occur between mother and son.
APPENDIX 2

PRESENTATIONS OF CHILD AND ADOLESCENT SEXUAL ABUSE
(N.H. & M.R.C. Statement, October, 1980)

(a) Unexplained emotional disturbance and/or psychosomatic symptoms in childhood, particularly when preoccupation with sexual matters, or predominance of sexually based behaviour, is present.

(b) Persistent or unexplained vaginal discharge, vaginal or rectal foreign bodies.

(c) Preoccupation of older children with symptoms based on their genitalia or perianal regions.

(d) Pregnancy in girls particularly when less than 14 years.

(e) Venereal disease in children less than 14 years.

(f) Inadequately explained genital or perianal trauma.

(g) Physical abuse or emotional abuse or neglect in young children and infants should alert the professional to the possibility of concurrent sexual abuse.

(h) Physical abuse or unexplained symptomatology in children of multiproblem families, particularly when drug and alcohol abuse are problems.

(i) Children who give a history of incest or sexual abuse should be believed even when there is little supportive evidence.

(j) Suspected or proven sexual abuse of other family members should alert the professional to the likelihood of sexual abuse in all family members.

(k) Non-specific symptomatology of an emotional or psychosomatic nature in girls required to act as housekeepers or mother substitutes.

(l) Repeated absconding from home in adolescent girls.
APPENDIX 3

PHILOSOPHIES AND VALUES UNDERLYING INTERVENTIVE APPROACHES

In contemporary theory and practice, three different approaches to the understanding of, and intervention in, Child Sexual Abuse can be discerned.

The process of clearly identifying these approaches is of importance, since one's philosophical approach, in turn, determines the strategies one adopts in intervening in the abuse situation.

Moreover, the parties to a sexually abusive relationship may come into contact with a variety of professionals. Each may adopt a different approach according to their professional role and orientation.

(i) Child Abuse as a Criminal Offence

Within this approach, emphasis is placed upon securing a conviction against the assailant.

There is very little attention provided to the child, unless there is evidence of severe psychological or physical trauma.

This approach is associated with Law enforcement and Criminal Justice systems.

A recent Queensland Survey indicated that in all cases, in the study, where legal action was brought against the assailant, no counselling was provided for the victim.

Moreover, although there is an emphasis on the offender, intervention assumes a punitive approach - usually in the form of incarceration. Counselling is rarely, if ever, provided for the assailant. U.S. data suggests a probable reduction in the recidivism rate where offenders undertake a treatment programme.

In the case of incest, incarceration of the offender, particularly where he is also a family breadwinner, may exacerbate existing family problems, and may engender guilt in the child.

(ii) The Child Protective Approach

Within this approach, the interests of the child are seen as paramount. The bid to protect the child's interest often result in his/her removal from the family.

As child sexual abuse, particularly incest, is thought to arise from broader dysfunctional family dynamics, this approach -
pursued in isolation - is problematic, since it leave the source of the abuse untreated.

Moreover, clinical experiences suggests that the removal of the child, from the family, may actually exacerbate the trauma he/she is experiencing as a consequence of the abuse itself.

(iii) The Family Treatment Approach

This approach sees the problem as lying within the family system. Strategies are aimed at preserving the family unit, and resolving the sexual abuse problem within it.

There is a risk, however, that the safety of the child may be neglected.

This is particularly the case in Victoria, since the family is not compelled by law to attend counselling. Reporting the offender, where he is a member of the family, may result in his incarceration and thus defeat the possibilities of family treatment.

Each of these approaches makes an important contribution to the understanding of, and intervention in, Child Sexual Abuse.

However, it sees none as adequate in isolation. An effective approach, which incorporates complementary elements of all these philosophical understandings and the strategies generated by them, would be one in which:-

* attended to the family, but at the same time provided for the protection of the child.

* preserved the role of the law enforcement and criminal justice systems, yet placed greater emphasis on the treatment of the offender, and allowed for options to be pursued which were less punitive and which minimized family disruption.

* allowed for the removal of the child from his/her home, yet which facilitated the return of the child as soon as practicable and avoided this option wherever possible.

(Background report, Rape Study Committee, Department of the Premier and Cabinet, prepared by Ms. Kim Webster, Lesley Hewitt, Dr. G. Debelle, June, 1984).
PRINCIPLES FOR INTERPERSONAL INTERACTION ON SEX-RELATED ISSUES AND PROBLEMS
James W. Maddock, Ph.D.

I Relationship Aspects

A. Communicate warmth and acceptance - this helps break down emotional barriers which surround this sensitive subject.

B. Respect the person with whom you are working - the bond of humanness which unites you is much stronger than any differences which may exist in your sexual attitudes or behavior patterns; this bond is what makes genuine helping possible.

C. Help the other person save face - without being overresponsible for the other (constantly "bailing him/her out"), it is important to be sensitive to how much personal risk is involved for many people in dealing forthrightly with their own sexuality. If overexposed, they may retreat permanently.

D. Give permission and reassurance continuously - permission to be sexual is a crucial therapeutic variable; reassure that thinking, feeling and talking about sex is OK.

E. Be in charge of yourself and the situation - your own comfort with yourself and with sex is the most effective tool for helping; let the other person know that you know what you want in this situation; this builds confidence and also models responsibility for self; being in charge of the situation also makes it more difficult for the other to "steer clear" of threatening subjects by being evasive.
II. Structure

A. Know what you want to accomplish and have a clear plan for getting there; don't leave too much to chance or behave too randomly; it will threaten the other person.

B. Move from least threatening (for client) to more threatening subjects or areas of concern; this will allow other to "test the water" and reduce likelihood of panic.

C. Do not overload the other with questions or information or suggestions, etc; data is clearest when it is both sent and received in its simplest forms.

D. Use as few formal procedures, e.g. recording, as possible—such procedures interfere with relationship between you and other person; they also cater to paranoid feelings about self-evaluation which surround the area of sex.

III. Process

A. Be forthright and direct when dealing with sex; do not use euphemisms or circumlocutions; directness encourages directness.

B. Assume other person has thought of and done everything sexually, unless there is obvious evidence to the contrary; it is easier to say no than it is to say yes; this minimizes the avoidance of areas difficult to deal with.

C. Avoid suggesting answers; (1) when gathering data from clients, avoid "feeding" possibilities for response to them; this prejudices the answers and makes them less genuine for the other. (2) when dealing with client