The child as a victim of sexual abuse

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'Child sexual abuse does not result in the development of a syndrome of specific symptoms, but rather is a life event or series of events that will produce a broad range of behaviours in child victims.'

Kuehnle 1998[1]

A significant number of children are being sexually abused, often by those least suspected of being offenders – that is, family members or friends. Many of these children will pass through the hands of a local doctor more than once, well before they disclose their abuse or show clinical manifestations, which may be symptoms of genital injury or nonspecific behavioural changes.

The nature of child sexual abuse

Child sexual abuse includes all forms of sexual activity from oral, genital and anal contact by, to or with a child to non-touching abuses such as exhibitionism, voyeurism and using a child for pornography.

There is a popular misconception that penile penetration into the vaginal canal plays a major part in the sexual abuse of prepubertal girls. The relative dimensions of the adult penis and prepubertal introitus suggest that this is unlikely (see box on page 62). Digital penetration is probably the most common cause of injury, but simulated intercourse and cunnilingus are also reported by children. The diameter of the adult male finger is sufficient to significantly damage the prepubertal hymen. This is not the case with anal digital penetration, given the distensible nature of the anus, and less likely with digital penetration of the oestrogenised vagina.

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The abuse of boys by fellatio is not a common presentation, but it is difficult to assess whether this is because it causes less physical injury and is, therefore, less symptomatic, or whether boys report less frequently. A recent study of children who were examined following allegations of sexual abuse found that most (95%) had normal genital examination findings.[3]

How common is it?

For several reasons, including a lack of reporting, the incidence and prevalence of child sexual abuse is extraordinarily difficult to quantify. The most vulnerable victim from the point of view of an offender is the one who is too young to talk. Moreover, child sexual assault victims who are old enough to talk usually don't, and the assault is rarely witnessed. Sexual assault results in very few specific physical signs and symptoms,[4] and even when physical evidence exists, a child's ignorance about sexual acts or fear of detection can delay presentation, with consequent loss of evidence.

The most conservative estimates indicate that 1 to 3% of children experience serious forms of intrafamilial and extra-familial sexual abuse often involving a chronic, repeating and frequently escalating, pattern of abuse. From retrospective studies (which depend on anecdotal and confessional evidence), it is more commonly claimed that one-third of girls

and one-sixth of boys will experience a sexually abusive experience before they are 18 years old.[5]

Even if the most conservative estimates are true then every school and medical practice is likely to contain current child victims or survivors of childhood sexual abuse.

Establishing the facts

Establishing the facts in cases of child sexual abuse is not a task for the inexperienced. Even where young children are perceived to be accurate historians, they may have little or no understanding of phrases like 'in the vagina'. Indeed, an interviewer's fixation on the degree of vaginal penetration betrays a rationale related more to adult rape than to what is harmful or undesirable from a child's perspective. Simulated penile intercourse by an offender rubbing in the vulval area of a small girl with little or no vaginal penetration can cause pain and injury. Similarly, intracrural frottage, cunnilingus and fellatio can cause pain and injury in children.

Efforts to establish a correlation between genital injury and childhood sexual abuse are fraught with methodological problems. Legal confirmation of sexual abuse is sometimes used to establish a population of children where genital findings can be compared with those from children in whom it is assumed no abuse has taken place. However, most charged offenders plea bargain, obtaining a lesser charge, and too few perpetrators confess to sexual assault to allow scientific analysis of the correlation between observed injury, or its absence, and legally confirmed assault. Estimates vary, and the best figures do not rest on what can be deemed scientific evidence, except in the circumstances of recovered pornographic videotapes. Even with videotapes, sexual events that have gone before such as 'grooming' (the gradual preparation of a child for penetration, e.g. gradual dilation of the vaginal introitus) remain unknown.

The low number of convicted child sexual abusers should serve to increase clinical vigilance on behalf of children who are being abused.

The GP and child victims

When sexual abuse is under suspicion, it is not the place of the GP to examine the genitals in detail or question the child. The GP's role lies in dealing with the presentation of parents or carers with a child who has disclosed sexual abuse either

A common misconception in the sexual abuse of prepubertal girls

The size of the vaginal opening in a prepubertal girl and the relative dimensions of the adult penis suggest it is unlikely that penile penetration is common in the sexual abuse of young girls given the limited degree of damage documented in most studies. Digital penetration is probably the most common cause of injury.

It is generally believed that offenders tend to avoid causing significant injury because their interests are erotic and not punitive,[2] unlike in child physical abuse. Moreover, there is a desire to maintain access to the child and ensure the child remains compliant.

The size of the vaginal opening alone is not diagnostic of abuse; however, there are data showing that in prepubertal girls, a transverse vaginal opening diameter greater than 0.65 cm is more commonly seen in children with a history of vaginal penetration.[2]

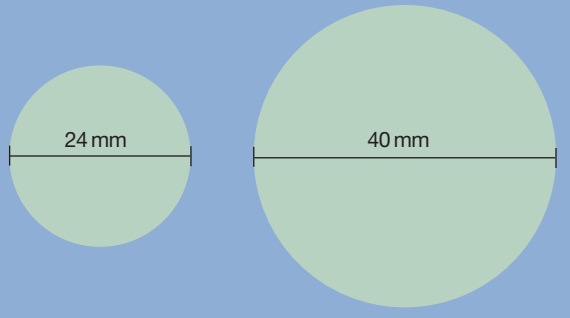


Figure A (above). The average diameter of an erect penis is 24 to 40 mm.

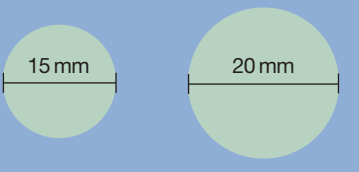
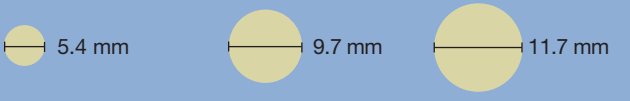


Figure B (above). The average diameter of an adult index or middle finger is 15 to 20 mm.

Figure C (right). The average hymen diameter is estimated to be 5.4 mm in 1- to 5-year-olds, 9.7 mm in 6- to 9-year-olds and 11.7 mm in 10- to 12-year-olds.



to a parent or other party, and being aware of what clinical presentations should raise suspicion of sexual abuse.

History taking when a child has disclosed

Because of the law of mandatory reporting in most States and Territories, children who have disclosed to teachers or school counsellors will usually be referred directly to child protection agencies. On the other hand, parents to whom a child has disclosed are more likely to take a child directly to their own GP or to the nearest doctor.

Child sexual assault produces a wide range of behaviours, not only in victims but also in the adults involved. The behaviours that manifest in the adult are often disturbing to the child as well as to the investigative process. So first and foremost, the GP should reassure all involved that there is time to address the situation without rushing into unnecessary and distressing conjecture.

It is not appropriate for the GP to automatically pick up a phone, refer the case to child protection agencies or make a mandatory report, dismissing the family as quickly as possible. There is a place for careful history taking from the parent, importantly out of earshot of the child, to establish what kind of disclosure took place, as well as any relevant medical history (e.g. a recent straddle injury to the genitals, dysuria or changes in behaviour, such as altered appetite or sleep pattern, enuresis or constipation). Occasionally, the person presenting with the child is a suspected offender – a difficult situation for the doctor, and no less for the child. In this instance, the GP should not discuss or reveal any suspicions, but contact the Department of Community Services (DOCS) to address the issue of ensuring the child's immediate safety.

Suspicious symptoms and signs

Most acute and chronic child sexual abuse manifests in nonspecific, rather than florid, clinical signs and symptoms. Physical symptoms may include vulval or perianal discomfort caused by friction or stretching, and recurrent dysuria from urethral injury. Behavioural symptoms may take the form of sleep disturbances, sexualised play, withdrawal and appetite disturbances – all of which may occur in response to other physical conditions and trauma in general.

If every time a child got a red bottom and a parent became highly anxious, a referral to the child protection agency was made then the system would collapse under the weight of over-referral. Vulvovaginitis caused by inadequate perineal hygiene, pinworms, clothing or scratching is the most common gynaecological condition in female children. Lichen sclerosis is another common condition and may be mistaken for sexual abuse.

On the other hand, when there is chronic discharge from the vagina or anus, or unexplained redness and irritation, abuse cannot be clinically distinguished from infection, and vulval (avoid vaginal swabs in prepubertal girls) or anal swab collection is warranted; consider also whether oral and pharyngeal swabs are indicated. Infections, such as caused by haemolytic streptococcus and *Haemophilus influenzae*, need exclusion as well as a range of sexually transmitted infections (STIs), most commonly chlamydial infection. STIs in children raise strong suspicion of sexual abuse (except for infections contracted congenitally or during delivery); thrush also should be considered suspicious in the prepubertal girl, because it is uncommon in the unoestrogenised vagina. Similarly, *Trichomonas vaginalis* infection should be regarded as an STI in a child. Anal pain or fissures, encopresis and enuresis need careful history taking and the follow up of any persistent abnormal findings.

Only pregnancy and the identification of sperm or seminal fluid are absolute proof of sexual contact. Fresh injury to the genitals with obvious bleeding, bruising or evidence of a possible sexually transmitted disease requires urgent investigation, because sexual abuse is the most likely explanation.

Examination

Even in the hands of experts, the medical examination and investigation of child sexual abuse victims is beset by subjective judgement and ambiguous clinical findings. While it is not the place of the GP to examine the genitals in detail, the GP should perform a careful, general examination of the child's body, including the mouth and vulva (the latter without labial traction). This should enable observation of the general emotional affect and of relevant bodily areas, and detection of obvious abrasions, bleeding or bruising. Sometimes a child will unexpectedly and spontaneously disclose abuse while being examined, at which point the doctor involved must record as accurately as possible what the child says, but pursue no direct questioning on the matter. If a suspicion of sexual abuse cannot be excluded, mandatory reporting or referral to the appropriate agency is in order. When doing so, it is important to make it clear to the parents that it is a precautionary move, required in most cases by law, and not a diagnostic conclusion.

Only a minority of cases of child sexual abuse present within hours or days of abuse, allowing definitive forensic evidence to be collected. Early presentation is more likely when the abuse has been intercepted or witnessed. Semen, although rarely found, is more often retrieved from the child's clothing or bedding (even when the clothing and bedding have been washed) than from body swabs.

Children may present with symptoms or delayed disclosure days or weeks after the event, when there can still be physical evidence of recent nonaccidental injury to the genitals. Again, the role of the GP involves reporting and prompt referral to the nearest agency.

Consultant's comment

The abuse and neglect of children is not uncommon and is a cause of preventable mortality and morbidity. It is probable that an individual GP should have cause to suspect child abuse and/or neglect (CAN) on multiple occasions in the course of a career. Family members, caregivers and family friends are commonly responsible. This has implications for the GP because the person presenting the child for consultation may be the offender, or have a vested interest in concealing or minimising the circumstances surrounding the abuse or neglect.

GPs have an obligation to display competency in the identification and management of child abuse and neglect, which are legitimate and important differential diagnoses for a diverse range of childhood and infant presentations. The GP should take a history from the presenting adult, adequate to arrive at the position of suspicion of abuse, but leave the gathering of a detailed forensic history to child protection experts. The GP should examine the child to determine acute medical needs requiring immediate action, but not undertake a forensic examination beyond his or her level of expertise.

As this is a specialised area of medical practice, the development of clinical referral and consultation relationships between an individual GP, who may have limited expertise, and practitioners with expertise in this field is an expectation of appropriate medical practice.

Each State and Territory has specific legislations and regulations in regard to GPs reporting suspicions of child abuse and neglect. Western Australia is the only Australian jurisdiction where reporting is not mandated in legislation; however, in all Australian jurisdictions, protection is given to doctors who make notifications in good faith.

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Further reading

Medical Board of Queensland Bulletin Issue 12, August 2000.

Over to you

Most child sexual abuse probably presents nonspecifically to general practice and escapes detection. In NSW, for example, only 2% of referrals to agencies come from local doctors.

If as a GP your suspicions are raised, consider the possibility that the child in front of you may be a current or past victim of undisclosed sexual abuse. Literature has shown that clinical suspicions of sexual abuse range along a continuum from 'a mere hunch' to 'absolute knowledge', and that this affects the decision to report abuse.[6] Assess the need to report your suspicion, however reticent you may be to precipitate alarm and distress in a child or family. You may be the only doctor who will ever have the opportunity to consider the possibility of sexual abuse in a particular child. The occasion may arise where it is appropriate to ask a child 'Is there anything happening to you that is worrying you or hurting you?' Many adult survivors testify to their distress as children when at the doctor's, they felt so near and yet so far from help.

The GP is a key professional in the area of child sexual abuse. As well as exercising clinical vigilance, encourage parents to teach their children about appropriate behaviour and touch, including that by older siblings. Raising such issues in the home and the surgery allows a nondisclosing, abused and invariably threatened child to know that help is at hand. This is especially so when the victim is not able to ask for help because it is the offender who has brought the child to the doctor. MT

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