Management of sexual abuse

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In the United Kingdom we are witnessing the beginning of an explosive epidemic of reported cases of the sexual abuse of children. A similar epidemic started 10 years ago in the United States. There is little doubt that this has arisen because of greater public and professional awareness and willingness to intervene in a problem that has been well known for generations.^{1 2}

Recent research on both sides of the Atlantic has shown that as many as one in three to one in 10 children—boys and girls—are sexually abused in some way during childhood or adolescence. This research has recently been well reviewed.³

While professional awareness is increasing, so too is denial—still the major obstacle in effective intervention. It is true that professionals are often ill equipped to manage sexual abuse in children and are learning to cope only slowly. There are also many difficulties—medical, social, and legal—in this complex area.

Paediatricians have developed skills in the diagnosis and management of physical abuse (non-accidental injury), as well as neglect, and failure to thrive. It seems natural, therefore, that they should also become involved in the management of sexual abuse, using their own skills in addition to the new forensic skills needed.

We would like to see paediatricians become increasingly concerned, and children interviewed and examined in hospitals or health centres, and not in police stations where they have been examined in the past.

For paediatricians to become involved is logical, because the complex nature of the symptoms of the sexually abused child implies that many children will present with undisclosed abuse—with genital or anal symptoms, psychosomatic, emotional, or behavioural complaints—and because of problems in development or educational attainment. Paediatricians deal daily with these problems and will increasingly recognise the sexually abused child who presents in this way, for wherever there are children there is sexual abuse of children, and sooner or later the paediatrician will find him or herself confronting a problem which is suspicious or diagnostic of sexual abuse. Confidence in the process of management will encourage intervention on behalf of the child.

Preparing the ground: the multidisciplinary system⁴

Multidisciplinary cooperation is mandatory in treating this, and other forms of abuse. The professional disciplines usually will be medicine, social work, the law, and the police. Most cases will require support for the child and family, including help from psychologists, child psychiatrists, and social workers. Others include school nurses, health visitors, nursery workers, teachers, and youth workers. Care workers, including foster parents and residential home staff, must also participate in planning for the individual child. Court and probation officers, and those concerned with the perpetrators (including judges and magistrates) are vital links in helping the child. Of the professional workers focusing on the child, the paediatrician and the child's guardian ad litem have major roles.

The nature of sexual abuse within the family often leaves the child unprotected by the mother, and others may have to take responsibility for the child. For the paediatrician to become accepted within the professional network that manages these children he or she will need to develop links and contacts, preferably before handling too many cases. In Leeds a multidisciplinary monthly meeting was organised in 1982 so that interested professionals from all these groups could discuss a number of important issues concerning the response to sexual abuse that would be made in Leeds.

The issues were:

- 1 The definition of sexual abuse, including the use of a common language and fluency with sexual vocabulary. Overcoming the usual inhibitions about discussing sexual matters and sexual abuse was a major goal.
- 2 The development of clear management plans for definite and suspicious cases.
- 3 The development and use of new and existing procedures in cases of child abuse, including case conferences and registration.
- 4 The diagnosis, including medical examinations, collection of evidence, and interviews.
- 5 The further management of the child and family.
- 6 The response to the abusers/perpetrators.
- 7 The cost and staffing and the need for additional resources.

8 A multidisciplinary training programme. The working party reported to the local area review committee, the multidisciplinary forum which carries responsibility in each area of the United Kingdom for dealing with child abuse.

We consider that each area will need to establish a small working group to formulate local policy and procedures. The police were included in all our discussions, but it is vital that a policeman with sufficient seniority to influence force policy attends. In our case we were unsuccessful, and the officers who attended were usually of the rank of inspector.

Paediatrician's role

There are five main areas in which the paediatrician must play a part: diagnosis and reporting; obtaining legal advocacy for the child; counselling and help for the child and family; participation in management through case conferences and reviews; and training

Table Principal indicators of sexual abuse*

Presumptive indicators:

- Direct report from child
- Sexually transmitted disease
- Pregnancy
- Genital or anal trauma

Possible indicators:

Preschool—

- Inappropriate or excessive sexual interest, masturbatory activity
- Genital or anal inflammation, discharge, bleeding, or pain (also apparent pain on sitting or walking)

Non-specific behaviour and clinical symptoms:

Preschool—

- Excessive clinging
- Sleep disturbance
- Encopresis or enuresis
- Abdominal pain, headaches
- Sudden changes in behaviour

School age—

- Decrease in performance
- Truancy
- Enthusiasm for attendance even when ill
- Conversion hysteria
- Anxiety, depression, obsession
- Change in appetite
- Sleep disturbance

Adolescence—

- Antisocial behaviour
- Truancy, running away
- Depression, poor self-esteem
- Drug abuse
- Self injury or overdose
- Promiscuity or prostitution
- Anorexia or obesity
- Overt concern about pregnancy
- Adoption of mother role

*This list is not exhaustive, and some seriously abused children will show none of these indicators, effectively concealing the abuse.

personnel and developing services. Contact with secondary care physicians (in addition to the usual ones with primary care doctors working in general practice and the child health service) are important in child and adult psychiatry, paediatric surgery, genitourinary medicine, and occasionally pathology and gynaecology.

Diagnosis

Diagnosis traditionally follows case history, examination, and in some cases laboratory investigation. Most children are seen as outpatients, although brief admission to hospital may be necessary for further investigation and protection in selected cases where the circumstances are not clear.

Children should be seen in comfortable and pleasant surroundings, with space and toys. Plenty of time should be allowed but there is rarely enough, most of it being taken up in discussion and counselling. Children are often talked to away from parents, and the layout of the room should take this into account, avoiding the need for parents to return to a general waiting area.

The case history should include an enquiry for common symptoms of abuse and the other conditions in the differential diagnosis. Details of any disclosure should be recorded and the child helped to discuss with the doctor what has happened. Notes are best made concurrently or immediately afterwards, if possible. Defence lawyers and judges often check on this point. We always attempt to obtain as much information as possible from other agencies before seeing the child to build a complete picture.

Types of referral

Referrals follow direct disclosure by the child, or suspicion of abuse by a relative or caregiver, or by an unrelated third party who may be a professional. The reason for referral by a professional may not have been explained to a parent, and this can lead to difficulties in the consultation. Children who are relatives or friends of an abused child, or who have been in contact with a known offender, are also referred. In general, frank and honest discussion of the possibility of sexual abuse is the best policy. Sometimes, however, the doctor may wish to feel his way gradually, to see what information emerges, and approach the subject of sexual abuse indirectly ('sometimes I see children who are wetting because someone has molested them—I always need to check with every child with this problem whether that could have happened to them').

Alternatively, the doctor may wait to discuss sexual abuse until after the examination, investiga-

tion, or at a subsequent follow up appointment after other diagnoses have been excluded.

Premature action or discussion about sexual abuse can be distressing and threatening to the family. This may result in the family withdrawing and 'pulling down the shutters' in a way that adversely affects future management and follow up. If suspicion is unresolved it may be better to develop a plan for supervision and follow up with others working with the child and family, thereby maintaining the concern at a professional level.

Talking to children

Much of the evidence in cases of sexual abuse comes from the child's history. Most paediatricians enjoy talking to children, but may feel uncomfortable talking to children about sexual matters in general, and few doctors would be able to talk about sexual abuse without feeling upset. Our former teacher, Dr Michael Buchanan, said, 'with all this talk of sex you would have to be an icicle to be unmoved'.

The approaches vary and there is no single ideal method. Some lawyers, judges, and policemen suggest that you can talk to children as though interviewing an adult, as well as avoiding leading questions. All who work with children know that this is impractical and that it can be confusing and unrealistic to a child. Direct questions such as 'has anyone touched your tuppence?' will be necessary. Long interviews must be avoided, and time spent gaining a child's confidence is more productive than repetitive and exhausting cross questioning.

Common sense dictates that the child should be allowed to describe in detail what has happened in their own way, but to help the child it is necessary to reassure the child constantly that they have not done wrong, that it is right to tell, and that you will help them with the consequences of disclosure. The methods of communication will vary according to the child's developmental level and skills. Verbal disclosure may be too difficult for some children who have been told to keep quiet. Other methods include the use of anatomically correct dolls, ordinary dolls, drawing, or direct demonstration by the child using their own or someone else's body. There are no firm rules about the use of any of these materials and flexibility of approach is the key to success. Children use a wide, and sometimes comical, sexual vocabulary and it is important to check what this is, and to use it onself in talking with the child.

Disclosure may be made before, during, or after the examination and sometimes follows months or years after the event. Children may indicate they have a secret, cannot talk to you, or say 'I can't

remember' or 'I was asleep'. It is important that this is noted and communicated in reports so that work can be done to help the child to disclose later.

Evidence is accumulating that fictitious reporting of sexual abuse by children is uncommon,^{5 6} usually confined to disturbed adolescents, and that children cannot and do not fantasise about specific sexual activities. Children should, therefore, usually be believed.

Medical examination^{7 8}

The purposes of this are threefold:

- 1 To make a complete assessment of the child in terms of health, growth, and development, with special emphasis on emotional and behavioural aspects and problems which may or may not be directly linked with abuse.
- 2 To collect and record forensic evidence of the abuse.
- 3 To treat the child—this must be incorporated at every stage.

It is assumed that paediatricians will be experienced in the assessment of the whole child, as in other types of abuse, and the discussion will be limited to a consideration of the forensic and therapeutic aspects.

GENERAL POINTS

- 1 Abnormalities of the anus are found in 40 to 50% of boys and girls, and in 50 to 60% of girls there are vulval abnormalities.
- 2 Note the child's demeanour during the examination. Is he or she angry, passive, cooperative, or frightened? Many children will be unexpectedly cooperative.
- 3 Older children may refuse to be examined and they should be given the chance to return later when they have had time to think about things. It is never justifiable to force a child to be examined. Anaesthetics or sedation are occasionally used to examine children who would like to be examined but who cannot relax, or where there are injuries which need surgical attention (in our experience this is uncommon).
- 4 The use of an auroscope, or simple illuminated magnifier, for examination of the vulva is useful. We note the use of the colposcope to improve the recognition of hymenal scars and tears, with perhaps a 10% improvement in diagnostic rate.⁹ We feel the colposcope is of fairly limited use in diagnosis.
- 5 Photography is extremely useful. Our hospital photography departments have been very helpful, but one of us (CJH) uses a Nikon F301 camera with 105 mm F2.8 medical micro Nikkor lens and

SB15 flash unit to record findings. We would caution the use of photographs alone when a further medical opinion is requested, especially where photographs are not of good quality or do not record the dynamic signs.

Specific aspects include the following:

- 1 Examination for injuries, such as bruises, bites, and love bites or burns; the site of injury—for example, around genitalia, thighs, lower abdomen, and groins; grip marks, which may occasionally be seen on upper arms and knees; and bruising or redness of the perineum.
- 2 Genitalia should be examined carefully. In boys the penis and testes are uncommon sites for injuries, and these have been recorded in only 1% of boys seen. Tears of the foreskin frenulum are occasionally found. In girls the breasts (in older children) may show signs of injury and bites; there may be labial reddening and bruising with extension to perineum; the vulva may show abrasions, tears, bruises, and oedema. There may also be tears of the posterior fourchette and hymen, and the shape and size of the hymenal opening should be recorded. Under 6 years of age full penile penetration of the vagina is unusual and results in tears of the vagina. Dilatation of the hymen (in prepubertal children more than 0.5 cm is a rough guide) may have occurred. Digital assessment of girls after puberty should be made; if intercourse has taken place regularly two fingers may usually be inserted with ease. The anus should be examined with the child in the lateral position and buttocks gently parted. We do not routinely undertake digital or instrumental examination of anus and rectum. Examination of the anus is important,¹⁰ because one third of abused girls and two thirds of abused boys have signs here. There may be reddening and bruising around the anus and loss of the normal fold pattern. Tears are commonly multiple or, if single, posterior. Measure the length and note the position. There may also be dilated veins, either in a complete ring or just an arc, and swelling of the margin of the anus, as well as scars and skin tags. There may also be dilatation of the anus and reflex dilatation on minimal skin traction to the buttocks, and twitching.
- 3 Signs of oral, pharyngeal, vaginal, and anal infection should be sought. In young children small nasopharyngeal swabs are useful, and one should establish with the laboratory which specimens they need to screen for gonorrhoea, chlamydia, and trichomonas. Children find it uncomfortable having these specimens taken so the swabs should be dampened under the tap first: it may only be possible to do two swabs together.

Specific forensic evidence for example, cotton wool swabs, again moistened with tap water—should be taken from skin, mouth, vagina, and anus and tested for spermatazoa and acid phosphatase, which are markers for semen. These swabs must be labelled and handed to a police officer who will send them for analysis. Forensic tests are most useful if done within 48 hours of the last contact, but most physicians working with abused children have noted that they are rarely helpful.

EXPLANATION

Throughout the examination, which begins with a general physical examination, it is important to explain every step and to reassure the child that he or she will be fine and that the symptoms will go. Children are beginning to ask about the possibility of acquiring AIDS and the need for serological testing is likely to increase. Other worries concern pregnancy and 'damage', which they fear may be lifelong. To some girls and families to hear, 'the hymen intact', is extremely helpful. Many boys fear themselves to be homosexual and this can be dispelled.

The child needs to be told that the adult is entirely responsible for the abuse and that he or she is absolved from any blame or guilt. They need to know that they have been believed and that they will be helped. Finally, they need to know that they have acted correctly by disclosing the abuse and by allowing examination, the emphasis being on the child granting permission and thereby having control over his or her own body. All this should be reinforced with the parents.

The nature of evidence in sexual abuse

Unlike physical abuse where much of the evidence lies in the injuries and the parents' explanations, in sexual abuse physical evidence may or may not be present and the degree of certainty that may be attached to it may vary. Gross evidence—for example multiple anal tears, reflex dilatation, and dilated veins—may indicate that penetration has taken place and that, in the absence of any other reasonable explanation, sexual abuse has occurred.

Lesser physical evidence is said to be consistent with the allegation of abuse in the statement from the child. Absence of signs is normal in oral abuse or masturbatory activity of the adult by the child, but this clearly does not mean that the child has fabricated the story. Also, as the law stands at present, a clearly given history by a young child (too young to be sworn or affirmed) is inadequate for a prosecution without corroboration.

The dynamic changes in the physical signs caused

by time have not yet been reported, but it is clear that an abnormal anus can return to normal within days, weeks, or months. Follow up examinations are justified and essential to document changes and to distinguish normal anatomical variants or disease from the signs of abuse.

When addressing the mode of transmission of sexually transmitted diseases in children, one is aware of the occasional occurrence of non-sexual transmission. We would say that transmission of gonorrhoea has been by sexual contact—that is, sexual abuse, until proved otherwise. For other infections (herpes simplex type 2, *Trichomonas vaginalis*, venereal warts, and chlamydia) the evidence points to sexual contact being the usual form of transmission and their presence probably indicates sexual abuse. This subject has been well reviewed.¹¹

Therapeutic aspects of the paediatric role

Efforts to intervene effectively on behalf of sexually abused children and to reduce the emotional damage associated with this form of abuse should be incorporated at every stage. Many children have recalled the process of questioning and examination as damaging experiences. This can be overcome by an approach which is responsive to the child's needs. The issue of the sex of the examiner is less important than the sensitivity afforded to the child, but a woman doctor should ideally be available for those children who prefer and request one. Early counselling may be undertaken by the paediatrician who is in a good position to ensure follow up and help for the child and family.

Talking to parents

Abuse perpetrated within the family has special difficulties. The perpetrator may have been named clearly by the child and immediate steps to separate the child from the perpetrator must be taken while further investigation ensues. In other circumstances, when the identity of the perpetrator is not clear, it is probably better to indicate to the parents that there is evidence of sexual abuse and that the child needs protection. A statement that everyone in contact with the child is necessarily under suspicion and that a police investigation is necessary sometimes encourages a reasonable response from the family, although denial of abuse is common. When the abuse is brought out into the open, either by disclosure or by professional intervention, is a dangerous time for the child, and we have repeatedly found that protection cannot reliably be left to the child's mother.

Admission to hospital can be an option while investigation and further talking to the child continues, but access of the perpetrator to the child may continue and ensure that the child remains silent. Immediate admission to a foster home or children's home is an alternative while investigation proceeds, with supervised access to the child. Siblings and other children in close contact should also be seen and examined in every case. It is unusual for abuse to be limited to one child in a family and common for all the children to have been abused.

Reports and responsibility of other agencies

In this country responsibility under the law for the protection of children rests with the social service departments in each area, the National Society for the Prevention of Cruelty to Children, and with the police. All are empowered to take immediate and continuing responsibility for children thought to be at risk. The police also have the responsibility to prevent and detect crime and maintain the rule of law.

Every investigation should involve the police and one of the two child protection agencies. Where a diagnosis is clear, immediate referral to both agencies is the next step for the paediatrician, remembering the need to safeguard other children who may be, or have been, in contact with the perpetrator. Where the diagnosis is uncertain, the paediatrician may have to assess carefully, preferably in informal discussions with the police and social workers, how best to proceed. Increasing cooperation and confidence among agencies, hopefully through joint consultation and working, should foster earlier communication and discussion between people who trust one another to avoid precipitate, hasty, or unwise action on the one hand, or inappropriate delay or inactivity which leaves the child at continuing risk on the other.

A medical report should be written for use by social services. This may contain the sort of information which will be useful in the juvenile court, but a different report in the form of a statement should be written for the police. Police statements should list the symptoms and details of the physical condition as well as the allegations the child has made and whether the physical symptoms are consistent with the child's story. It is important that the doctor expresses an opinion. We find the phrase 'consistent with' is usually appropriate. It is important to keep the family doctor, as well as the other agencies, in touch with what is going on.

Evidence given in court, and also the expertise and professional standing of the paediatrician as a witness, will be cross-examined. The evidence should be given in a way which leaves the court to

decide whether the child has been abused. Sexual abuse is what the law says it is; the best approach is to say that the history and examination are consistent with sexual abuse and be prepared to discuss what else they may be consistent with. There are usually few other relevant options, but defence lawyers will raise them. Other doctors may be available to challenge the findings, and it is reasonable to point out to the court that this difficulty is well recognised in these cases.

Case conferences

Case conferences are called following diagnosis but, as long as protective action has been taken, their timing will depend on discussion between agencies. The tasks are broadly similar to those facing case conferences for physical abuse, and children may be registered under the separate category of sexual abuse. We believe doctors should provide both written and verbal evidence to the conference when practically possible.

Treatment for child and family

There are no simple rules as to which child or family will benefit from help. The paediatrician, in conjunction with other agencies, shares responsibility for ensuring that adequate help is offered in the form of individual, group, family, or part family therapy, as appropriate. This work is undertaken by social workers and also within departments of child psychology and psychiatry. The difficulties encountered in treatment are such that a structural multidisciplinary approach, backed by statutory legal measures in some cases, is essential. We have found that there is no place for 'going it alone', although families may wish to encourage doctors not to pass on information to other agencies; we would discourage adopting that approach. Making the vital link from the paediatrician to the helper can be made easier by close working and joint clinics. One of us has experience of working in a family treatment group and the other does a joint clinic with a child psychiatrist. Further follow up visits by a paediatrician are not required in most cases, but children and families should always be encouraged to return to discuss further worries.

Professional needs for support for the people working in this area are met in Leeds by the team approach, and we would suggest that paediatricians do not attempt to tackle this problem alone. Ideally, having two paediatricians, who can call on one another for second opinions and discussion, is recommended. Our team includes social workers and a psychologist who is trained in psychotherapy. Regular

monthly meetings with the others working intensively in child sexual abuse have proved valuable.

Conclusion

There is increasing evidence of the initial and long term harmful effects on children of sexual abuse.¹² On a global scale the scope of widespread abuse, neglect, and exploitation of children is being acknowledged.¹³ Those who are prepared to work on behalf of children will need to be backed up strongly at a personal as well as professional level.¹⁴ Sexual abuse is the abuse of adult power. Not only does the professional need to confront the results of this abuse for the sake of the child, but also on behalf of the power structures in society, the family, and the law, which so often fail to protect and care for children. This personal view sets out our initial conclusions in a new and rapidly expanding field. Everybody who involves themselves in this problem will have to resolve these and many other issues to their own satisfaction.

References

- Hamilton GV. *A research in marriage*. New York: Albert and Charles Boni, 1929.
- Landis C. *Sex in development*. New York: Paul B Hoeber, 1956.
- Peters SD, Wyatt GE, Finkelhor D. In: D Finkelhor and Associates. *A sourcebook on child sexual abuse*. Beverley Hills: Sage Publications, 1986.
- Porter R. *Child sexual abuse within the family*. London: Ciba Foundation, Tavistock Publications, 1984.
- Anderson S. An overview and approach to the management of sexual abuse, assault of children and adolescents as a significant public health problem (less than 2% victim reports prove unfounded). University of Washington, 1979. 113pp. (MPH Thesis.)
- Cantwell HB. Sexual abuse of children in Denver 1979: reviewed with implications for pediatric intervention and possible prevention. *Child Abuse and Neglect* 1981;5:75-85.
- Rape. In: McLay WDS, ed. *The New Police Surgeon*. Northampton: Police Surgeons' Association.
- Paul DM. The medical examination in sexual offenders against children. *Med Sci Law* 1977;17:251-8.
- Woodling BA, Heger A. The use of the colposcope in the diagnosis of sexual abuse in the pediatric age group. *Child Abuse Negl* 1986;10:111-4.
- Hobbs CJ, Wynne JM. Buggery in childhood—a common syndrome of child abuse. *Lancet* 1986;ii:792-6.
- Neinstein LS, Goldenring J, Carpenter S. Nonsexual transmission of sexually transmitted diseases—an infrequent occurrence. *Pediatrics* 1984;74:67-76.
- Browne A, Finkelhor D. Initial and long-term effects—a review of the research. In: D Finkelhor and Associates. *A sourcebook on child sexual abuse*. Beverley Hills: Sage Publications, 1986:143-79.
- Anonymous. Ill-treatment of children. [Editorial.] *Lancet* 1987;i:367-8.
- Summit R. Causes, consequences, treatment and prevention of sexual assault against children. In: Meier JH, ed. *Assault against children, why it happens, how to stop it*. London: Taylor and Francis, 1985:47-97.

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