

SEXUAL ABUSE – CLINICAL CASE SCENARIOS

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Sexual abuse occurrences are not rare: the estimated incidence is one in five girls and one in ten boys. Sexual abuse is difficult to diagnose since there may be no physical findings on the patient's exam to confirm the diagnosis. It is also a difficult to discuss with victims and their families. In this article the authors present typical clinical scenarios which may be encountered in pediatric practice.

Key words: Child ▪ Sexual abuse ▪ Diagnosis

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Introduction

Sexual abuse is a difficult subject to discuss. Often the occurrence of sexual abuse is shrouded in secrecy and feelings of loyalty to family or friends. Sexual abuse does not happen infrequently and is estimated to occur in one in five girls and one in ten boys.

Typically the victim knows the perpetrator very well. The abuse that takes place may have occurred once or over months or years. There are many different forms of sexual abuse, ranging from the sexual exposure of pornography to the physical act of intercourse. One of the most challenging aspects of sexual abuse, in stark contrast to physical abuse, is that there may be no physical findings to corroborate a child's report of sexual touching. A typical scenario is the school age child who can give a very credible disclosure about sexual abuse and has a normal ano-genital exam (1).

The sexually abused child presents a challenging clinical experience. This is a child who will likely need a special investigative interview, counseling services for themselves and

Received: July 13, 2008

Accepted: July 27, 2008

Pedijatrija danas 2009;5(2):172-177

family members and a medical examination. In many areas of the United States, including the state of Kentucky, there are child advocacy centers established to provide these comprehensive services. This allows for the child and family to come to one child friendly site for their special clinical needs and attempts to avoid duplication of services. Related to the child advocacy centers is the concept of the local multidisciplinary team or MDT. This team is composed of law enforcement, prosecutors, social services, therapists, educators and health care providers who meet on a regular basis in a confidential milieu and review the management of all sexual abuse cases in a designated county or region.

In the following case scenarios the reader of this article has designated the imaginative role of a physician who is examining the patient.

Case 1

Casey is an eight year old female who sees you for her belly pain. She has been reporting that her belly has bothered her for the last six months. She has not had any change in voiding or stooling. She has not had any vaginal bleeding or pubertal changes. A complete blood count and chemistries were normal. She has had an abdominal x-ray and an endoscopy both of which were negative. Her mom occasionally gives her an antacid that seems to provide temporary relief. Casey's mom brings the child back to you for a follow up exam. Her mom states that she is doing fine in school but she seems more withdrawn and quiet. She is more withdrawn every time she returns from visiting her grandfather. When mom asks what did she do at grandpa's, she states »nothing« and keeps watching television. You ask Casey's mom if you could have some time alone with Casey to talk for a few minutes and she agrees. In a one to one discussion, you talk to Casey about safety and touching. You ask Casey

if anyone touched her in a way that makes her feel uncomfortable. Casey says, »Yes, my paw-paw (reviewer's comment: paw-paw is jargon for grandfather) touched my privates but he told me it was a secret and not to tell anyone or he would go to jail.«

Case 2

Jimmy is a ten year old male who comes to your office based on a request from law enforcement. Jimmy's adult male school teacher is being investigated for allegations of sexually touching boys. You talk to Jimmy's parents who state he has been doing ok medically. His grades have dropped from As to Bs and Cs but he is now more involved with sports, which explains the change in grades. He has made no disclosure to his parents. His behavior at home has been appropriate. They deny any concerns regarding advanced sexual knowledge or behaviors. You decide to speak with Jimmy privately. Jimmy denies anyone touching his body inappropriately. If anything like that happened he states he would tell mom and dad. He thinks his teacher is 'pretty good' but otherwise has no other comments about him. You notice as you speak to Jimmy that he seems uncomfortable, he states »I don't know« to several of your questions, he has poor eye contact and frequently looks away. His physical exam is normal with the exception of an oval shape, 3mm in length, tan macule on the anterior mid shaft of the penis. The next day you receive a call from his father, who states the investigators brought pictures found on the alleged abuser's computer and wanted them to identify Jimmy. There were images of Jimmy's face and genital area, and the family verified it was him in the photos. When Jimmy was confronted with the photos, he cried and was afraid he would be punished. The teacher had told him he would be in 'big trouble' if he told anyone about the pictures.

Case 1 and 2 Discussion

Children who are being sexually abused may have no symptoms or very vague symptoms. Casey presents as having non specific abdominal pain with no known etiology. She seems withdrawn but otherwise doing ok. Jimmy presents as having a slight drop in grades but perhaps easily attributed to his additional involvement in sports. If the children had symptoms they may present with other nonspecific complaints such as new onset of wetting or stooling incontinence, constipation, painful urination, bleeding or discharge. Behaviorally, they might have increased sexual knowledge, be acting out sexually toward other children, not sleeping or eating well, or having other mental health issues such as depression, or anxiety (2).

Both children have clearly decided not to spontaneously disclose information about their sexual abuse. There are many reasons a child may not disclose including loyalty, guilt, fear, ignorance, punishment, or loss of rewards, to name a few possibilities. Boys may not disclose as easily as girls because they may feel they should have been able to protect themselves. Additionally, children are taught to respect and listen to adults without question so it could be very difficult for the child to challenge that teaching. It can be very helpful for the interviewer to have some one to one time with the child to provide privacy, establish rapport, talk, reassure and answer the child's questions.

Typically the child who is experiencing sexual abuse will have a normal exam. This is understandable: anatomically the hymenal orifice is not readily accessible, anogenital mucosal injuries can heal within days, and the touching could occur non-injurious, or there could be sexual exposure but no touching. Also it should be considered there is some give to the anal opening considering the caliber of stool that a child can pass or at the hymenal opening where children can

place foreign objects inside the vagina without damaging the hymenal tissue. The female teenager has the added benefit of maturation which thickens the tissue and allows for more stretch thus nullifying the myth that the doctor 'can tell' if a female has had sexual intercourse. In fact, abnormal exams may occur as infrequently as five percent of all cases seen (3, 4).

Images as listed in Jimmy's case provide a powerful method of corroborating the victim's report. The commonality of the internet and the millions of users provides easy access and even financial gains for the child pornographer and those affiliates of the »business«. Always inquire of the child if there were cell phones, cameras or any computer involvement that they were aware of at the time. Identifying marks on either the victim or perpetrator could prove to be very important. Any markings or skin changes that are in question should prompt a follow up visit a few days later.

Case 3

You have been asked to see some children who may have been around a sex offender that had moved from another community and did not report his status to the authorities. This man found employment at a day care and is now being investigated for sexually touching a four year old child who attended the day care. One mother brings in her three year old child, Sarah, stating she has been fine. She acknowledges the alleged had done some babysitting for her in the past. She does report that not too long ago, the child had a green discharge but it has since resolved. The child is in diapers and trying to potty train. She has not made any comments that anyone hurt her. Sarah's mother states that the alleged was always very nice to her and her family and doubts he would do anything to hurt the baby. Based on the history

of a discharge you decide to do cultures. You notice that as you culture the child from the vagina and rectum that this toddler has no emotional response and does not resist your examination. The child looks around the room, laying quietly and otherwise allows you to complete the exam. You receive a call from the lab later in the week that her vaginal culture is positive for neisseria gonorrhea. Discussing the situation with the child's mother, she states she can't believe it, there must be some kind of a mistake. She is very tearful and upset, stating she had begun dating this man a few months prior.

Case 3 Discussion

It is not unusual to have a parent who has come to implicitly trust the sexual offender, whether as a family friend or significant other. It is very important to assist a parent who has guilt about allowing the sexual offender into their family life. The sexual offender is typically working very hard to be a sincere friend and all around helper for the family. The goal for the offender is to never create suspicion. In fact, the ultimate goal is that the family would run to the defense of the accused offender because he has been so well loved and trusted.

It is very important to examine the infant and toddler in cases of sexual abuse. These children are particularly vulnerable as they are limited by their developmental lack of speech. In fact any child who is compromised due to a disability should be examined. A child who is compromised by age or disability makes an ideal victim for the offender.

A prepubertal child should not have a discharge. Presence of a discharge or report of a discharge as in this scenario mandates testing for sexual infections. It is important to remember that discharge does not implicitly identify a sexually abused child but it is concerning and should be evaluated. Other

reasons for a discharge could be a foreign body, a bacterial infection such as from stool contamination or from strep group A, candidiasis, fistula, irritant or other dermatological condition (5).

Anecdotally, the child who has been sexually abused may have a myriad of presentations during the examination. The child may be fearful, curious, pleasant, talkative or resist the examination. This child, as a toddler, had no emotional response to the exam. Considering her age of three, total complacency during the exam is unusual. Some clinicians would describe the act of dissociation when examining the sexually abused child where the child does not resist the exam but is clearly not attending to the activity going on at the time. There should at least be consideration that this is how the child eventually coped when being sexually abused.

Case 4

A thirteen year old female, Erica, runs away from home. The police find her and take her back home. They talk with the child's parents, her mom and step-dad. Her step dad states that her behavior has been more and more challenging for the family and they have been arguing quite a bit. He is polite and apologetic for the inconvenience. He agrees that she needs to see a counselor and the police leave. A few months pass and again the child runs away. The police locate her and notice she has some blood on her pants from where she climbed over a fence. They take her to the emergency room. You see Erica in the emergency room and talk to her for a few minutes while waiting for her parents to arrive. You ask Erica »Why are you running away?« and Erica states »My stepdad has sex with me, I have tried to tell my mom over and over but she doesn't believe me. I just can't keep it inside anymore.«

Case 4 Discussion

Parents may not believe the child who discloses sexual abuse. The non-offending parent may be in love with the offender or need the offender's financial assistance. The non-offending parent may be a chronic victim who consistently demonstrates poor judgment in choosing a partner. This parent may be mentally unstable or using substances. The parent may feel that the child is a troublemaker and a liar who manipulates. It is crucial to understand that for their own myriad of reasons, the parent may not believe the child who discloses sexual abuse and therefore is unable to protect their child. When conduct-

ing an interview with the alleged victim and parent or guardian, it is extremely important to keep an open mind about the dynamics of the situation. It is very important to speak with the child on a one to one basis and document accordingly. Also, document if the parent refuses to allow you to speak with the child one to one. Additionally, the Kentucky child advocacy center guidelines request that both a therapist and the physician separately meet and assess the family. Having two professionals with somewhat different clinical perspectives can be very helpful in understanding these often challenging cases (6).

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Additional Suggested Reading

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Sažetak

KLINIČKI SCENARIJI SLUČAJEVA SEKSUALNOG ZLOSTAVLJANJA

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Seksualno zlostavljanje djece nije rijetka pojava: pretpostavlja se da su jedna od četiri djevojčice, i jedan od šest dječaka seksualno zlostavljani. Seksualno zlostavljanje se relativno teško dijagnosticira, jer fizički znakovi pri pregledu često nedostaju. Istovremeno, to je također neprijatan predmet diskusije sa pacijentom i porodicom pacijanata. Autori u ovom radu prezentiraju kliničke scenarije sa kojima se pedijatar može tipično susresti u praksi.

Ključne riječi: Djeca ▪ Seksualno zlostavljanje ▪ Dijagnoza

Primljeno: 13. 7. 2008.

Prihvaćeno: 27. 7. 2008.