Myths & Realities About Child Sexual Abuse

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• American Academy of Pediatrics Visual Diagnosis of Child Abuse CD-ROM
• Frank Netter series
• The Children’s Place files
• Baldwin/Johnson family

MYTHS

1. Stranger danger
2. Kids always tell
3. Sexual abuse = intercourse
4. The exam will tell
5. The exam is invasive & traumatic
6. If the exam has no forensic value, it has no value
Myth #1
Stranger Danger

Perpetrator characteristics:

• 90% + male
• Juvenile perpetrators (20+%)
• 90+% known to child
• 70% perpetrators have 1 – 9 victims
• 20% have 10 – 40 victims
• Serial child molester: as many as 400 victims in his lifetime

Parent Misperceptions

• I know him/her
• He/she would never do this
• They don’t act afraid of him/her
Myth #2
Kids Always Tell

How Children Tell

- Physical and behavioral signs often the first indicator

Physical Signs:
- Teen pregnancy, especially early
- Genital, anal, urethral trauma, bleeding, or discharge
- Genital infections or sexually transmitted diseases
**Physical Signs (cont.)**
- Recurrent urinary tract infection-type symptoms
- Complaints of pain or itching in genital area
- Chronic or recurrent abdominal, genital, anal, pelvic pain

**Behavioral Signs:**
- Direct statements about abuse
- Behavioral changes
- Sexualized behavior or language inconsistent with age or development
- Appetite disturbances

**Behavioral Signs (continued):**
- Psychiatric problems including conduct disorders; depression; Post-Traumatic Stress Disorder; suicidal behavior
- Sleep disturbances
- Withdrawal or guilt
Behavioral Signs (cont.)

- Temper tantrums, aggressive behavior
- Alcohol and/or substance abuse
- Promiscuity, prostitution
- Enuresis and/or encopresis (bladder/bowel accidents) -- new
- Sexual perpetration to others

What is normal child sexual behavior?

- Exploratory in nature
- Characterized by spontaneity & lightheartedness
- Interest in sex is intermittent & balanced with curiosity about all things
- May leave the child embarrassed but not fearful or anxious

Children who molest:

- Sexual behaviors frequent and pervasive
- Sexuality and aggression closely linked
- Use coercion to gain participation (bribery, trickery, force)
Children who molest:

- Impulsive, compulsive, aggressive quality to many of their behaviors, including sexual behaviors
- Problems in all areas of their lives

Tony Cavanaugh Johnson: "Understanding Your Child's Sexual Behavior: What's Natural and Healthy"

The Disclosure Process

- May tell only after they feel safe
  - Custody issues

The Disclosure Process

- Young children:
  - Accidental more likely
  - Behaviors raise concern
  - Language barriers
The Disclosure Process

- Older children:
  - Purposeful decision
  - May tell out of anger, protection
  - Will tell their friends first

Why don’t kids tell?

- Child may not perceive as abusive.
  - May lack sexual knowledge
  - May lack vocabulary to describe
  - May be disguised as a game
  - 40% of sexually abused children who had been through court process did not appreciate that they were being sexually abused when it first started. (Sas & Cunningham 1995)

Why don’t kids tell?

- Children are often groomed for sexual abuse
- Sexual abuse usually progresses in phases
  - Engagement
  - Harmless touch
  - Sexual touch
  - Secrecy and isolation
Why don’t kids tell?

• Children are often not believed
  – May seek help/understanding at time least likely to get it
    • Adolescent: Rebel or super-achiever
    – Tentative/incomplete disclosure common
      • “Testing the waters”
      – Initial reaction critical
        • In one small study only 17% of STD + children with unsupportive parents disclosed (c/w 43%)

Why don’t kids tell?

• Secrecy:
  – “Everything will be all right as long as you don’t tell”
  – Child given power to destroy family or keep together
    • Guilt, chaos, stress
      – child taken out of home instead of perpetrator
    • Recantation common
      – confirming adult beliefs that children lie about sexual abuse

Why don’t kids tell?

• Children are vulnerable
• Child usually has a relationship with the perpetrator
Why don’t kids tell?

• Helplessness:
  – Children expected to be obedient and affectionate with adults entrusted with their care
  – Same source for love/affection and fear/pain
  – No option but to accept/survive
  – “Stranger danger” fallacy

Other reasons children may not tell:

• Embarrassment and shame
• Avoidance coping
• Fear of consequences
  – Threats to self, parent, siblings, pets, etc.
  – Getting in trouble
  – Perpetrator getting in trouble

Cross Cultural Issues Affecting Disclosure

• Language barriers
  – Includes differences in body language
• Impact on family, tribe, village
• Distance from/lack of resources
• Distrust
• “Normalization” (and resignation)
Working with cross cultural issues
- Understand and respect potential barriers
- Develop local relationships
- Respect cultural differences
  - Be aware of our own cultural biases
- Use trained translators where needed

Parent Misperceptions
- My child would tell me
- I would know

Myth #3
Sexual Abuse = Intercourse
What Are Sexual Offenses Against Children?

“Nontouching” sexual offenses include:

- Indecent exposure/exhibitionism
- Exposing children to pornographic material
- Deliberately exposing a child to sexual acts

“Touching” sexual offenses include:

- Fondling
- Making child touch adult’s sexual organs
- Any penetration of a child’s vagina or anus – no matter how slight, by any object that does not have a valid medical purpose
“Sexual exploitation” is also an offense and includes:

- Engaging a child or soliciting a child for the purpose of prostitution
- Using a child to film, photograph, or model pornography

What are the differences between rape and child sexual abuse?

- **Rape:**
  - Acute
  - Violent
  - Forensic and physical evidence present
  - Victim may be seen more quickly
  - Victim more likely to be viewed as competent historian by virtue of age

Differences, continued

**Child sexual abuse:**

- Chronic
- Nonviolent USUALLY
- No or limited forensic and physical findings
- Victim rarely seen acutely
- Accuracy of history questioned
- Developmental issues
Myth #4
The Exam Will Tell

What the medical exam CAN’T do

- Tell exactly what caused the injury
- Tell when the injury occurred once it has completely healed
- Tell how many times it happened
- Tell who did it (unless forensic or DNA evidence)

How does the medical examiner help the team?

- Assist with developmental issues with interview
- Perform comprehensive medical evaluation
- Identify and document any findings
- Gather forensic evidence if present
- Perform diagnostic testing
- Provide an assessment and interpretation of symptoms and findings
How does the medical examiner help the team?

• Answer questions
• Provide expert witness testimony
  – Why the exam is normal!
• Health care provider often viewed as neutral or positive by child and family
• Child may disclose or clarify during exam
• Help assess the child’s safety
• Make recommendations for treatment, referrals, etc.

What do non-medical folks need to know?

• Have realistic expectations of what the exam may or may not show
• Understand basic exam terminology, techniques
• Know when the child needs an exam (urgency/triage)
• Know who to call/consult for exam decisions
• Prepare and support parents and child through the exam process
  – Reinforce NOT TRAUMATIC

What do we know about exam findings?

• The majority of children with a history of sexual abuse have normal examinations
• Children’s injuries heal amazingly well and quickly
• There are many findings that mimic abuse
Why are most exams normal?

- Delay in disclosure
- Delay in seeking evaluation
- Rapid healing
- Types of abuse
- Elasticity of vagina, hymen, anal sphincter
- Child perception of events

Myth #5

The Exam Is Invasive and Traumatic

Parent Misperceptions

- Sexual abuse exam = speculum
- Child will need to be restrained
Who needs an exam?

- New National Children’s Alliance Standard: *All children who are suspected victims of child sexual abuse should be offered a medical evaluation. Medical evaluations should be required based on specific screening criteria developed by skilled medical providers or by local multidisciplinary teams which include qualified medical representation.*

Some Exam Criteria

- Verbal statement of SA by child
- Observation of maltreatment
- History of skin to skin contact
- Concerning symptoms: anal or genital bleeding, pain, discharge
- Safety concerns
- Medical referral for indicators of SA

Other Exam Indications:

- Symptoms out of proportion to history
- Not sure of history (preverbal child)
- Concern best answered by medical provider
  - Reassure child
  - Reassure family
- Remember incomplete disclosures are common
Medical Exam Includes:
• Specific questions about medical history, symptoms, abuse history if necessary
• General physical
  • Evaluate overall health and well being of child.

Medical Exam, continued
• Photographs and/or video recordings of exam
• Collection of specimens (forensic, diagnostic)
• Anogenital exam
  – With aid of colposcope (or other magnification)
  – Different positions

Medical Exam, continued
• External only for pre-adolescent
  – Vaginal speculum, bimanual exam, STD testing for adolescents
• Children have right to say no: "Empowered children are cooperative children"
Anogenital findings may be:

- Normal
- Normal variants (congenital)
- Abnormal but not abuse
  - Infection
  - Accidental trauma
- Abnormal due to abuse
- Abnormal but nonspecific (can’t tell)

Sexual Abuse Exam Techniques

- Evaluation of sexual maturity stage, anatomy, rashes, lesions, evidence of trauma
- Different positions, use of traction help show different areas of anatomy better
- Colposcope helps magnify, illuminate, document

The Hymen: What It Is

- A rim of tissue around the vaginal opening (rarely, covers entire opening)
What It Is Not

- "Intact" vs. "Not Intact"
- Congenitally absent
- Something that requires "breaking" or tearing for penetration to occur ("virginity check")

Normal Genital Exam Findings

Findings documented in newborns or commonly seen in non-abused children

Normal Variants: Examples

- Periurethral or vestibular bands
- Intravaginal ridges or columns
- Hymenal bumps, mounds, tags, septation, notches/clefts (anterior half)
- Linea vestibularis
- Shallow/superficial notch/cleft in inferior rim of hymen
- Congenital variants: crescentic, annular, redundant, septate, cribiform, microperforate, imperforate
Findings commonly caused by other medical conditions

- Erythema (redness)
- Increased vascularity (prominent blood vessels)
- Labial adhesions
- Vaginal discharge (infectious and non-infectious causes)
- Friability (easy bleeding/tearing) of posterior fourchette
- Excoriations, bleeding, vascular lesions

Normal findings in boys

- Hyperpigmentation of circumcision site
- Median raphe (raised dark or light line along penis & scrotum)

Nonspecific male findings

- Infection
- Erythema (redness)
- Eczema
- Accidental trauma
Non-abusive anal findings

- Hemorrhoids, fissures, tags
- Venous pooling
- Congenital:
  - Failure of midline fusion
  - Diastasis ani
- Infection
  - Yeast
  - Strep
  - Pinworms
- Accidental trauma

Myth #6

If The Exam Has No Forensic Value, It Has No Value

Purpose of the Medical Evaluation

- Diagnosis and treatment
- Ensure health and safety of the child
- Find and document acute and healed injuries
- Find, document and collect forensic evidence
- Interpret any findings
Purpose of the Medical Evaluation, continued

- Look for medical conditions that can be confused with abuse
- Evaluate for unmet health needs
  - Medical home, immunizations, counseling
- Normalize the ano-genital area
- Reassurance for child and family
- Recommendations and referrals as needed

Children are different

- Rate of return for evidence from child’s body rapidly diminishes (low yield after 24 hrs., different from adolescents and adults)
- Much higher yield from crime scene (bedding, towels, clothing, etc.)
  - Importance of scene investigation
- Use of sexual assault evidence kits

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