Child sexual abuse: the emergence of new “disease”

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Disclosure

• Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.

• I do not intend to discuss an unapproved/investigative use of commercial products/devices.
A historical & developmental perspective on medicines discovery of a “new disease”

- What were the forces which created an environment to facilitate this discovery?
  - 1962 C. Henry Kempe, MD paper: *The Battered Child Syndrome* in Pediatrics paved the way
  - 1978 Kempe paper: Sexual abuse another hidden pediatric problem, *Pediatrics*
  - Parallel developments in social work, mental health, rape crises movement, law
  - AAP Section on CAN formed in 1989

“Finally we cannot neglect the fact, that at a time which was particularly full of intellectual and technical ferment, medicine also benefited from a more favorable climate for observing reality and spreading of new ideas”

15th & 16th centuries, Zanobbiu
A historical & developmental perspective on medicines discovery of a “new disease”

- What happens when a new “disease” is discovered?

“Public admiration is mixed with suspicion, as expenditures and expectations rise, simultaneously with calls for regulation and accountability”

Pellegrino 1979
A historical & developmental perspective on medicines discovery of a “new disease”

• Describing a new clinical entity
  - observations of clinical cases by individual physicians
  - grouping of cases with similar symptoms into classes leads to recognition of clinical entities
  - pursuit of treatment modalities
  - evaluation of therapeutic efficacy The disease of sexual victimization

“ The scientist takes off from the manifold observations of predecessors, and shows his intelligence, if any, by his ability to discriminate between the important and the negligible, by selecting here and there the significant stepping stones that will lead across the difficulties to new understanding. The one who places the last stone and steps across to the terra firma of accomplished discovery gets all the credit. Only the initiated know and honor those whose patient integrity and devotion to exact observation have made the last step possible”

Zinsser, 1940
A historical & developmental perspective on medicines discovery of a "new disease"

- Physicians begin to conduct examinations of alleged child sexual abuse victims
  - motivated by desire to understand the medical sequel to sexual abuse
  - grapple with the interpretation of findings
  - search for ways of improving visualization
  - searching for ways to preserve and objectively document observations

- Wading into unchartered waters
  - Any physician examining a child for sexual abuse in decades of the late 70’s and early 80’s was a pioneer
    - few colleagues to validate observations
    - minimal literature to guide physicians
    - no diagnostic criteria
A historical & developmental perspective on medicines discovery of a “new disease”

- Child protection and law enforcement communities seek alliance with medicine
  - doctors share observations amongst colleagues and develop study groups sporadically around country
  - doctors share observations with colleagues at increasingly frequent conferences on child abuse
  - doctors show willingness to learn from colleagues in child protection, mental health and law

- Core of “Experts” surface
  - Requisites to becoming an expert
    - Willing to examine a patient who is alleged to have been sexually abused
    - Overcome genitaphobia
    - Developing working knowledge of sexual victimization and willing to take history from child victim
    - Willing to enter the lions den to defend basis on which diagnosis is based
A historical & developmental perspective on medicines discovery of a “new disease”

Genitalia are placed under the microscope

“Where the telescope ends, the microscope begins. Which of the two has the greater view”
Victor Hugo, 1830
Medical history in child sexual abuse

Obtaining a medical history and integration into the formulation of a medical diagnosis
Making the diagnosis

“The fruit of healing grows on the tree of understanding. Without diagnosis there is no rational treatment. Examination comes first, then judgment, and then one can give help.”

-Carl Gerhardt, 1873
“the patient who comes to us has a story that is not told, and which as a rule no one knows of. Therapy only really begins when we understand that wholly personal story. It is the patient’s secret, the rock against he is shattered. If I knew his secret story, I have the key to the treatment. The doctor’s task is to find out how to gain that knowledge.”

-Carl Gustav Jung, 1961
What is the gold standard for the best outcome following an investigation?

- Prosecution?

- Therapeutic?
Not the first step in making the diagnosis!
Who is this man?
What is his relevance to medicine?
Q: Why do you rob banks?

A: Because that’s where the money is.

Sutton’s Law: The idea of looking for the obvious, before going further a field, when diagnosing.
What is more likely to provide clarity and certainty to what a child might have experienced?

• Medical history
• Physical examination
• Laboratory tests
• Forensic evidence
The Medical Model of Diagnosis: tried and true

- Understanding pathophysiology of a disease entity
- Understanding the clinical expression of a disease
- Developing clinical skills in eliciting medical history
- Formulation of a preliminary diagnostic impression
- Physical examination to confirm diagnostic impression
- Use of diagnostic tests to augment physical examination
Diagnosing and Treating Physician: applying concept to child sexual abuse

- What does this mean in practical terms
  - one of the important exceptions to hearsay
- How does one establish this relationship
- Documenting child's understanding of relationship
The Nuts & Bolts of the Medical History

So what's new?
Obtaining & documenting the medical History: principles

- Non leading, non suggestive developmentally appropriate interaction
- Medical history obtained whenever possible independent of caretaker
- Verbatim record of questions asked and child’s response
What is more difficult?

- Making sense of a child’s history
- Interpreting the physical findings

It depends!!!!

Both take considerable skill and the ability to recognize that there are limits to how definitive one can be.
What is more difficult?

- Few clinicians are skilled in obtaining medical histories regarding sexual victimization
  - How two’s of asking questions in non-leading and not suggestive manner not well developed
- Medical documentation in CSA is generally inadequate
  - Written and visual documentation frequently incomplete

Child Sexual Abuse: Definition

• Sexual assault involving physical force when the child is a victim - the rape model

• “Sexual contact or interaction between a child and another person of any age in which the child’s participation has been obtained through undue means such as threats, bribery, intimidation, enticement or coercion”

• “The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, to which they are unable to give consent or that violate the social taboos of family roles.”
Why a medical examination?

To assess and address the medical and psychological impact of suspected sexual abuse

- Abnormality
- Normality

*Every suspected child victim deserves the opportunity to have a comprehensive medical evaluation by a skilled and knowledgeable clinician*
Components of a Diagnosis

- Medical history/verbal evidence
- Medical evidence of injury
- Sexually transmitted disease
- Forensic evidence
Dynamics of Victimization: Contextual framework

- 1. Engagement
- 2. Sexual interaction
- 3. Secrecy
- 4. Disclosure
- 5. Suppression
Disclosure

- Planned disclosure
- Accidental disclosure
- Elicited disclosure
Disclosure Phase: Accidental

- Neither the child nor the perpetrator prepared to share secret
- Revealed because of external circumstances
  - Sexually stylized behaviors
  - Spontaneous age inappropriate statements
  - Observation by a third party
  - Ano-genital trauma
  - Sexually transmitted disease
  - Pregnancy
Disclosure Phase: Purposeful

- Conscious decision to tell
- Reason for disclosure
- Child’s expectation
- Planned intervention
Disclosure details

• Most kids never tell about those kinds of experiences why did you decide to tell?
• What do you want to happen now that you told?
• Most kids find it difficult to tell about those kinds of experiences what made it so difficult for you to tell?
• How do you feel now that you told?
• If you could say something to the person who did that what would you want to tell them?
• Whose idea was it to do this stuff?
Telling is like 'Spring Cleaning'.
Not much fun & A lot of hard work!
But it feels Great!!
When it's done!!
Engagement Phase

- Access and opportunity
- Enticement
- Deception
Engagement

• Who was the person(s) who did something that just didn't seem ok?
• How do you know this person(s)?
  – What were the circumstances that allowed access? Caretaking role of individual?
• Where did this happen the first/subsequent/last time(s)?
Engagement

• When was the first/last time something happened?
  - With young children who cannot provide specific date’s questions then try to relate an experience to an important life event such as a birthday, starting or ending school, a family trip, before or after a holiday help narrow the time.

• How often did it happen? Why did it stop?
Sexual Interaction Phase

- Progressive sequence - variable rate
- Interaction most consistent with child's developmental age
- Exposure - fondling - oral genital - penetration
- *Most perpetrators have little intent to physically injure the child*
Sexually Abusive Behaviors: The Spectrum

- Genital exposure
- Observation of a child
- Kissing
- Fondling
- Masturbation
- Fellatio
- Cunnilingus

- Penile penetration of vagina and/or anus
- Digital penetration of vagina and/or anus
- Vulvar coitus
- Pornography
Sexual interactions and progression

• Did the person who did this have name for what he/she was doing?
  – Coercion, deceit, threats, rewards and/or bribery
• What was the first thing the person did that just didn't seem ok?
  – Details of the first inappropriate sexual interactions and the progression of the sexual contact over time.
Sexual interactions and progression

- Questions that elicit specific details surrounding sexual interactions with a focus on signs and symptoms that may have medical significance and provide insight into the potential for physical injury or contracting an STD.
  - When that (insert specific) happened how did that feel?
  - Effect feelings/body or both?
  - If physical discomfort bother while/after or both?
  - Every feel that sensation before/again?
  - Notice anything that made you know you were hurt?
  - Clean afterward?
Idiosyncratic Historical Details:

- Body image concerns
- Age inappropriate descriptions of sexual activities
- Post fondling dysuria
- Post sodomy burning
- Excited utterance
It is hard to write on paper feelings that have building up for so long. When I was still in my home the things my father said and did to me are unforgiveable. He made me feel ugly, unworthy of anybody’s love except for his. I got to the point where I didn’t want to look at myself in the mirror and I didn’t want others to look at me either because I felt that they thought the same way. I remember thinking “was I bad, did I do something to deserve this?” I blamed myself. I tried to be the perfect daughter in hope that he would treat me like a daughter. I feel no love for him because everything I believed a father should be was taken away and turned into filth. He tried to control me like a robot. I didn’t want to believe that a daddy could do this to his little girl. All I want is for him to feel the shame I felt. I never want to see him again.
Secrecy Phase

- Primary task of perpetrator
- Eliminates accountability
- Enables repetition
Secrecy Phase: continued

- Child persuaded or pressured to maintain secret through:
  - Rewards
  - Embarrassment
  - Fear of punishment
  - Fear of abandonment or rejection
  - Threats
- Elicit statements made to the child regarding secrecy, threats, intimidation and/or child's perceived consequences
  - Did the person who did this want you to tell?
- *Anticipatory guidance: substitute surprises for secrets*
1 In the Bathroom
2 My Dad, big strong, nice.
3 He rubbed my privet,
4 I felt scared,
5 He said "don't tell."
Dr. Finket,

I want to thank you for checking my child. I feel relieved knowing that she is fine and being able to trust her school.

I wasn't completely honest with you. I'm sorry, but when you asked me if I was abused child, I didn't want my boyfriend to know, not even my husband knows. This is something I thought I'd take to my genie, my older brother messed me up mentally a long time ago, I guess memories will always haunt me. Is this why I'm so frightened for my daughter. I constantly worry, I'm afraid she won't tell me, just like I never told my parents, either through threats or for feeling ashamed. She is so helpless, she can't talk very well all I have to go on is her actions, I don't even want her to go through the filthy feelings I've felt, how can I protect her?
Suppression Phase

- Limits access, interaction and information
- Increasingly abusive verbal threats by perpetrator
- “Ganging up” on child to recant
- Perpetrator undermines credibility of child
Dear Diary,

How the Hell will my uncle lie about kicking my vagina now to one believe me. My mom thinks I'm lying, my mom thinks. I'm lying. Everyone thinks I'm lying. If people think, I will commit suicide.
Components of a Diagnosis

- Verbal evidence
- Medical evidence of injury
- Sexually transmitted disease
- Forensic evidence
Examining the Child Victim

- Preliminaries
  - Obtain historical details of the alleged events
  - Clarify additional information to be obtained
  - Develop rapport and trust of child
  - Explain the purpose of the examination
  - Tell the child what will happen
  - Determine the child’s names for body parts
  - Encourage the child to ask questions
  - Assess the cooperativeness of the child
  - Child selects adult ally to be present during the examination
  - Encourage child to participate in “head to toe “ examination
Immediate Examination: Criteria

- Age inappropriate sexual contact within 72 hours
- Genital trauma within 72 hours
- Possibility of a sexually transmitted disease
- Possibility of pregnancy
Deferred examination criteria

- Disclosure of age inappropriate sexual contact greater than 72 hours
- *Uncooperative child*
Examination room
Factoid:
- Children are born without hymens
- Children lose their hymens
- Hymens are injured during gymnastic and horseback riding

Fact:
- All children are born with hymens except in rare congenital disorders
  - Ambiguous genitalia
  - Distal vaginal agenesis
  - Transverse vaginal septum
Factoid:

- The transverse hymenal orifice diameter is valuable as a sole indicator of sexual abuse.

Fact:

- The transverse hymenal orifice diameter has minimal utility in making the diagnosis of child sexual abuse. Early studies by Cantwell that suggested a measurement > 4 mm as predictive has not been born out in further studies.

Medical examination findings

Factoid:

• The medical examination is frequently diagnostic of sexual abuse

Fact:

• The medical examination confirms sexual abuse in less than 5% of cases
• The medical examination rarely differs from that of the non-abused child
Medical examination findings

  236 children, normal in 28%, nonspecific in 49%, suspicious in 9%, and abnormal in 14% of cases, 1% abnormal anal

  192 abused children, 4 had transections diagnostic of sexual abuse otherwise non specific
Girls Who Disclose Sexual Abuse: Urogenital Symptoms and Signs After Genital Contact
Cynthia DeLago, Esther Deblinger, Christine Schroeder and Martin A. Finkel

Pediatrics 2008;122:e281-e286
DOI: 10.1542/peds.2008-0430

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://www.pediatrics.org/cgi/content/full/122/2/e281
Symptoms and Signs

• **Girls**
  - 60% described ≥1 symptoms / signs
    - 53% genital pain
    - 37% dysuria
    - 11% bleeding

• **Caregivers**
  - sx / signs
    - 17% genital pain
    - 19% dysuria
    - 4% bleeding
  - 24% sought medical care (n=38)
    - 12% during abuse period (n=19)
IN or ON:
Reconciling discrepancies

Determining the child's perception of their experience
  - use of Ortho anatomic model
Addressing any discrepancy between child's perception and their examination findings
  - educating the judge and jury
IN or ON: Reconciling discrepancies
Anal penetration

Midsagittal View of Anus

Dilation of Anal Sphincter with Downward Pressure by Convex Side of Penis
Medical Diagnosis of Child Sexual Abuse: Healing principles

- Retrospective interpretation of changes in anogenital anatomy
- Understanding healing chronology of acute trauma
- Regeneration of labile cells without residual
- Repair results in formation of granulation tissue - repair
- Appreciate limitations of retrospective interpretation

Clinical Issue: utility of rape kits

Factoid:
- Rape kits are an important component of the evaluation of sexual abuse and likely to result in evidence identification

Fact:
- Collection for seminal products after 24 post contact is unnecessary
- No seminal products collected after 9 hours
- Evidence is more likely to be collected from clothing and linens than the child (64%) 
- Of 273 children < 10 had forensic evidence found when processed through crime lab
- 273 children <10
  - 24.9% + when examined less than 44 hours, 90% of + < 24 hours
  - No positive swabs after 9 hours
  - 64% of evidence from clothing/bedding, 35% of children had clothing/bedding collected

- 80 children & adolescents presenting within 72 hours
  - 16 positive for semen (13 adolescents)
  - No seminal products recovered from any pre pubertal child, when retrieved only + on clothing/bedding
Looking back
Formulating a Diagnosis: basic tenets

- Objectively state the facts
- Do not exaggerate the meaning of a particular finding
- Know the limitations of what can be said
- Do not co-mingle hearsay and clinician obtained history when formulating a diagnosis
- State limitations
- Presume that diagnosis will be challenged
- Make sure that every statement is defensible and rests on sound scientific footings
Formulating a Diagnosis: basic tenets

- Utilize the diagnosis section to explain and educate those who will have access to the report
- Issues for which an explanation can be helpful
  - Why evidence does not exist when history of injury
  - Why evidence does not exist when child states that an object was placed inside them
  - How a child can acquire a sexually transmitted disease without genital to genital contact
PHYSICAL EXAMINATION cont'd

With gentle lateral traction placed on the innermost thighs of this five year old young lady, the labia majora are stretched sideways gently, but not beyond physical tolerance. Once this maneuver is accomplished, it is noted that there is no hymen present and the hymenal remnant is limited to an annular ring surrounding the entrance of vestibule of the vagina. On closer examination within the vagina, one notes stratified epithelium in circumferential arrangement throughout the vagina, signifying the physiological changes accompanying frequent penetration beyond the hymenal ring. Small fan-shaped scars are noted in the area of the posterior fourchette and throughout the vaginal vestibule. In addition, the median raphe stretching from the posterior vaginal vestibule to the anterior anal edge is scarred and excoriated. When one gets to the examination of the anus, it is noted that there are anal irregularities in the rugae and the amount of tension on the external anal sphincter. This too, in this examiner's mind, leads to the conclusion within medical certainty that the anus has been penetrated on a frequent basis, as well. The examination then went on to other portions of the body.

The extremities are within normal limits with a full range of motion. There are no skin rashes noted, except for the marked erythema in the area of the vaginal vestibule and the anus. The back is straight without evidence of kyphosis or scoliosis. No adenopathy is seen. All deep tendon reflexes are 2+ and equal and no abnormal superficial reflexes are seen. There is no nuchal rigidity and the posture is said to be straight.

NEUROLOGICAL EXAMINATION:

No formal neurological examination was undertaken at this time because of the nature of the complaint.

Vanessa, 10 month old white female with a given history of sexual abuse. On a full physical examination done on April 11, 1986, physical findings consistent within medical certainty of anal penetration and digital vaginal penetration are found. The basis for these conclusions are as follows: appearance of the vulva and perianal areas with erythema, fan-shaped scarring, anal rugae irregularities, lack of hymen, etc. Based on the appearance of the vaginal orifice, it is doubtful that an erect male phallus was the instrument used to penetrate the vagina, although certainly an adult male finger could have caused the damages noted.
Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

Medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.
Common Case Scenarios

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence)

- Medical history/behaviors are suspicious and/or concerning that child either experienced something inappropriate and/or exposed to something inappropriate and the examination is without physical diagnostic residual.
Less Common Case Scenarios

• A child presents with a concern by a caretaker without historical or behavioral details to support the concern.

• A sexually transmitted disease is diagnosed in a young child, and no explanation for how the child contracted the disease is evident following a complete investigation.

• Upon examination, the clinician identifies a healed injury with no prior suspicion of abuse and for which no historical or behavioral indicators are presented.
Less Common Case Scenarios

• Witnessed inappropriate sexual interactions without physical diagnostic residual.

• Medical findings that mimic sexual abuse upon evaluation are found to be associated with medical conditions and not the result of abuse.

• Concerns arising in family with custody/visitation arrangements in young child requiring genital care.

• A child presents with fabricated or misinterpreted behaviors and/or a history alleging sexual abuse.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

The medical history presented by this 9 y.o. white female reflects her experiencing progressive engagement in a variety of inappropriate sexual activities initially represented to her in a caring and loving context and progressing to utilize treats. Although she did not complain of experiencing any physical discomfort following the genital fondling, oral genital contact or the touching of her uncles genitalia she has expressed a concern which merits attention. She told me that she was worried that she thinks that people can tell that she had to do those disgusting things just by the way that people look at her. She also provided historical details of contact with “icky stuff” coming from her uncles penis placing her at risk for contracting a sexually transmitted disease. I have evaluated her the possibility of such and will initiate treatment and follow-up should anything be positive.
• Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present. cont...

Her physical examination does not demonstrate any acute or chronic residua to sexual contact nor would be anticipated to in light of the her denial of discomfort associated with the contact. Her body image concern is common among children who experience sexual abuse. I do not believe there is any alternative explanation for this child’s history of progressive engagement in sexual activities, threats to maintain secrecy, detailed description of a variety of sexually explicit interactions and concerns about body image other than from experiencing such. The most significant impact of sexual victimization is psychological. She should be seen immediately by a clinical child psychologist to assess the impact of her sexual victimization and develop a therapeutic plan.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.

This 5 y.o white female provided a detailed medical history reflecting genital to genital contact and discomfort associated with such. Although her perception of the genital to genital contact as demonstrated on an anatomic model of the genitalia involved penetration into her vagina, her examination indicates that any genital to genital contact that occurred was limited to the structures of the vaginal vestibule. Following the genital to genital contact she provided a history of discomfort in the form of dysuria. Her review of systems was negative for any alternative explanation for dysuria. The symptom of dysuria temporally related to the genital to genital contact reflects trauma to the periurethral area as a result of rubbing. The trauma incurred to the distal urethra was superficial and has since healed without residual as anticipated.
Diagnostic Conclusion Examples

- Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence)

This 6 year old white female provided a clear and detailed history reflecting her experiencing genital to genital contact and being coerced into placing her mouth on her fathers genitalia. The genital to genital contact was perceived by her to involve penetration into her vagina. She provided a history of bleeding and pain following the genital to genital contact. Although her disclosure of abuse occurred 1 month following the last contact her physical examination demonstrates residual to such in the form of a healed transection of the posterior portion of the hymen extending to the base of its attachment. Cont...
• Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence) cont...

This finding is diagnostic of the residual to the introduction of a foreign body through the structures of the vaginal vestibule, the hymenal orifice and into the vagina. She did not complain of physical discomfort associated with the history of oral genital contact although she stated that the alleged perpetrator peed in her mouth placing her at risk for a sexually transmitted disease.