

Child Sexual Abuse

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What if you were asked to see.....?

1. An infant with anogenital irritation after coming home from the babysitter's house.
2. 2 ½ y/o boy he humped his mother's leg and said "I'm doing it to you."
3. 3 y/o girl that said her Daddy hurt her tutu.

What if?

4. A 12 year old girl because she has vaginal bleeding and a + pregnancy test.
5. A 13 y/o girl after she told her aunt that her step-father molested her, but now she tells you nothing happened.

Do you know what to do?

Which of these cases are sexual abuse?

If you suspect child sexual abuse, what do you do next?



Overview

- Review medical and legal definitions of child sexual abuse (CSA)
- Explain the progression of CSA
- Describe behavioral manifestations of CSA
- List the diagnostic features of CSA (Hx, PE, lab tests, forensic evidence)
- Review management of CSA

Definitions of CSA

- Sexual Assault
- Inappropriate Sexual Contact and Activities

Definitions of CSA

- Child Sexual Assault:
 - Physical force or psychological coercion is used to engage child in sexual contact +/- penetration
 - Acute incident
 - Rape model
- Inappropriate Sexual Contact and Activities

Definitions of CSA

- Inappropriate Sexual Contact / Activities
 - Caregiver engages child in activities that:
 - The child cannot comprehend
 - Are advanced for child's developmental stage
 - Go against societal norms.
 - Child is unable to give informed consent to sexual activity;
 - Legal age of consent varies by state.

Inappropriate Sexual Contact / Activities

- Sexual contact or interaction between a child and another person of any age;
- Child's participation obtained through:
 - threats
 - bribery
 - intimidation
 - enticement or
 - coercion.

Legal Definitions of CSA

Offense	Type	Explanation
1 st degree felony	Rape	Intercourse when the person is forced or incapacitated or when the person is < 13 y/o
2 nd degree felony	Statutory Sex Assault	Intercourse, child < 16 and other person ≥ 4 yrs older, unmarried
2 nd degree felony	Aggravated indecent assault	Genital / anal penetration with part of other person's body child < 13 y/o, or < 16 and other person is ≥ 4 yrs older, unmarried

Legal Definitions of CSA

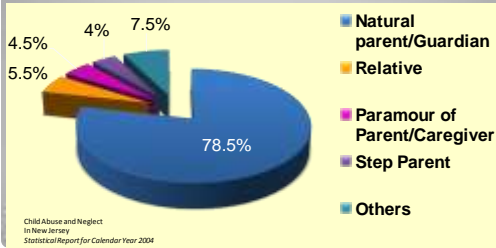
Offense	Type	Explanation
1 st degree misdemeanor	Indecent assault	Touching of intimate body parts for the purpose of arousing or gratifying sexual desire, in either person child < 13 y/o, or < 16 and other person is ≥ 4 yrs older, unmarried
1 st degree misdemeanor	Indecent assault or exposure	Person exposes his or her genitalia and the person knows or should have known that other persons present were < 16 y/o

What Activities Constitute CSA?

- Contact sexual abuse:
 - Touching
 - Penetration
 - Other contact: fondling / sexual kissing
- Non-contact sexual abuse:
 - Exhibitionism
 - Voyeurism
 - Involvement verbal sexual propositions
 - Pornography
- Legally, most CSA cases are:
 - Aggravated indecent assault
 - Indecent assault



Perpetrators of CSA



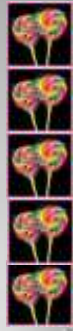
Longitudinal Progression of CSA

(understanding helps with questioning)

- Engagement
- Sexual interaction
- Secrecy
- Disclosure
- Suppression

Engagement

- Access and Opportunity
"He would give me a bath when no one else was home."
- Enticement
"He gave me lots of candy and said, 'OK, now we're friends, I gave you candy.'"
- Deception
"This is because you are my special girl!"
"If you let me do this, I won't touch your sister"



Sexual Interaction

- Progressive sequence - variable rate
- Interaction consistent with developmental age
- Exposure→fondling→oral / anogenital penetration
- *Most perpetrators have little intent to physically injure the child*

Secrecy: Primary Task of Perpetrator

- Eliminates accountability
"She enticed me by sitting on my lap."
- Persuaded to keep quiet
 - Rewards
 - Embarrassment
 - Fear of punishment
 - Fear of abandonment or rejection
 - Threats
- Enables repetition
- *Secrets vs. surprises*

Disclosure

- Accidental: activity observed; unusual child behaviors or comments
 - Sexually stylized behaviors
 - Spontaneous age inappropriate statements
 - Observation by a third party
 - Anogenital trauma
 - Sexually transmitted disease
 - Pregnancy
- Purposeful: Education programs; child wants it to stop

Suppression

- Limits access, interaction and information
- Increasingly abusive verbal threats by perpetrator
- "Ganging up" on child to recant
- Perpetrator undermines credibility of child
- **Do not discount a disclosure because a child recants.**

Observed Behaviors in all Types of Abuse

- Developmental regression
- Habit disorders
- Sleep and appetite disturbances
- Behavioral extremes
 - Acting-out behaviors
- Anxiety
- Fears

Behaviors Seen in All Types of Abuse

- Poor peer relationships
- School problems
- Depression
- Low self-esteem
- Self-mutilation (Cutting)
- Running away
- Substance abuse
- Promiscuity

Summary: Behavioral Manifestations

- Non-specific behaviors predominate²
 - No behaviors are proof of sexual abuse
- Sexually acting-out behaviors are suggestive of abuse (except masturbation)
 - child asks others to do sex acts,
 - puts mouth on sex parts,
 - tries to have intercourse



Long-term Sequela

- Adverse Childhood Events (ACE) Study
 - Retrospective cohort
 - 1995 to 1997
 - 17,337 adults in San Diego, CA
 - Dose response relationship between ACE and ↑ risk for leading causes of death in adults.

Felitti VJ, Anda RF, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med* 1998;14:245-258

Other ACE Analyses: Long-term Consequences of CSA

- Contact CSA: 16% males, 25% females
 - Men reported female perpetration of CSA ~ 40% of time,
 - Women reported female perpetration of CSA 6% of the time.
- Compared to no CSA, CSA victims:
 - Are twice as likely to report attempted suicide
 - Have a 40% increased risk of marrying an alcoholic
 - Have a 40-50% increased risk of developing marital problems

Dube SR, et al. Long-term consequences of childhood sexual abuse by gender of victim. *Am J Prev Med*. 2005 Jun;28(5):430-8.

Presentation for Medical Care

- Genital/anal complaints or injuries
- Disclosure/discovery of inappropriate sexual contact
- Behavioral changes
- STI or pregnancy

Diagnosing CSA

- Historical features:
 - Key to making the diagnosis most times
- Physical exam:
 - <5% cases have PE findings
- Lab evidence: STIs
- Forensic evidence

History: Parent

Separate child from parent (if possible)

- Nature of inappropriate contact. } Lab tests, prophylaxis, forensic evidence collection
Were body fluids exchanged? } →
- Caregivers? Who was alone with the child when incident occurred? Suspected perpetrator? } → Is this child safe to go home?
- Last time something happened? → Exam, forensic evidence post-exposure testing and treatment
- Symptomatic? → Exam, lab tests

When to Obtain History from Child

- Child has expressive capabilities (ask parent)
- Unexplained injuries
- Parent says child disclosed, details unclear (who, when, type of activities—enough to plan management)

History Tips: Child

- Establish rapport; make child comfortable
- Verbatim record: write questions asked / child's response
- Establish terminology—words used for genitalia / buttocks?
- Open ended questions "What happened?"
- Let child say what she has to say.
- Never ask: "Are you sure?"

Historical Features Suggestive of CSA

- Parent: Child demonstrates specific sexually reactive behaviors
- Child: Makes specific statements re: progression (engagement, sexual interaction, secrecy)
- Parent or Child: Descriptions of inappropriate sexual activities

Idiosyncratic Details Provided by Child

- Circumstances
- Descriptions of sights and smells
- Descriptions of physical signs and symptoms related to the event⁵

There are people specially trained to obtain detailed CSA histories from children that are legally admissible in court.

History: Key to Diagnosis

- Obtaining the history
 - Separate parent from child
 - Ask open-ended questions
 - Establish who, what, when
 - Record questions and answers verbatim.
- Diagnostic features
 - Idiosyncratic details re:
 - Circumstances
 - Sights, smells and other observations
 - Temporally related urogenital symptoms and signs



Physical Exam

- > 95% of SA victims have unremarkable exams.
- Greatest chance to identify injuries if examined < 72 hrs after contact.

Physical Exam: Healing Injuries

- Heppenstall-Heger (1997) Few residua
- McCann (2007): Rate of injury resolution
 - 113 pre-pubertal, 126 post-menarchal girls
 - Petechiae: 48 hrs pre-menarchal, 72 post-menarchal
 - Abrasions / mild submucous hemorrhages: 3-4 days
 - Blood blister: 34 days
 - Most lacerations healed without evidence of trauma!

Rate of Healing Non-hymenal Injuries

- McCann (2007)
 - Petechial lesions: resolution by 24 hrs
 - Abrasions: < 3 days
 - Bruises: 2-18 days
 - Sub-mucosal hemorrhage: 2-18 days
 - Labial hematoma: 30 days

When to do a Physical Exam

- Anogenital sx or signs (or other complaints)
 - + / - hx of sex abuse
- Time-limited circumstances:
 - < 72 hours since incident; may need forensic evidence collection, urine drug test, PEP
 - Chance of identifying acute injuries

Physical Exam: Extra-genital Trauma

- Evaluate for injuries at other sites:
 - Mouth
 - Ears
 - Neck
 - Skin
 - Musculoskeletal
 - Infants: assess neurologic status

Extra-genital Trauma Associated with CSA

- Choking:
 - Marks on neck
 - Facial petechia
 - Subconjunctival hemorrhages
- Mucosal Injuries
 - Frenulum tears
 - Intraoral lesions
- Restraint marks

When Not to do a Physical Exam

- >72 hours since incident:
 - Consider type of contact described*
 - Asymptomatic
- ≤ 72 hours:
 - No contact described
 - Fondling over clothes
 - Asymptomatic or
 - If can immediately refer to a specialized center for CSA

**Keep in mind timeline for healing anogenital injuries

PE: Normal ♀ Anatomy

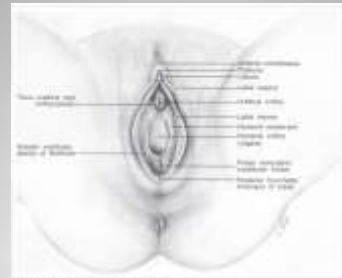


Figure 10-1. External Female Genital Anatomy.

Physical Findings in CSA

- >95% of time, NO physical findings
- Physical indicators:
 - Bruises and abrasions of:
 - Genitalia
 - Perineum
 - Perianal area
 - Arms, legs, wrists and ankles (from tethering)
 - Neck, palate and oral mucosa
 - Sexually Transmitted Infections
 - Rectal abnormalities (lacerations)
 - Hymenal abnormalities (transections)
 - Pregnancy



Lab Tests: STI Testing and the Pre-pubescent Child

- Symptoms of STI
- Has infection that could be sexually transmitted, even with no hx of sexual abuse
- Suspected perp has STI
- Suspected perp is at high-risk for STI (i.e. multiple sex partners, hx of STI);
- Sibling, other child, or adult in household has a STI

Kellogg N and the Committee on Child Abuse. *Pediatrics* 2005; 116 (2): 506-512

Lab Tests: STI Testing and the Pre-pubertal Child

- Patient or parent requests testing
- High community prevalence of STIs
- Evidence of genital, oral, or anal penetration
- Evidence that ejaculation is present (focus screening to anatomic sites of infection based on pts history)

Lab Testing: Adolescents

- STI universal screening is recommended for all sexually active teens; test for pregnancy
- Focus screening to anatomic sites of infection based on patient's history

Lab Tests to Consider

- Urine HCG
- HSV Viral cx, typing
- Serology: RPR, HIV, Hepatitis B
- Wet prep for Trichomonas and BV
- Trichomonas culture
- PAP for HPV (not recommended anymore for <21 yrs--2009)
- Other:
 - UA, Urine culture, if symptomatic
 - CBC, LFTs, BUN and Creatinine if starting HIV PEP
 - Test for date-rape drugs:
 - ketamine
 - gamma-hydroxybutyrate
 - flunitrazepam
 - alcohol

Gonorrhea and Chlamydia Testing

- Cultures: Gold Standard for Court
 - Gonorrhea:
 - Vagina
 - Urethra
 - Oropharynx
 - Anus
 - Chlamydia:
 - Vagina
 - Meatal discharge, not urethral
 - Oropharynx not recommended
 - Anal
- OR
- 2 FDA-cleared NAATs for GC / Chlamydia testing is OK (PCR, TMA, SDA)

When to Collect Forensic Evidence (FE) from Children

- Christian et al (2000) 273 children
 - > 90% with + FE were seen w/in 24 hrs of assault
 - Most FE (64%) found on clothing / linens
 - > 24 hours, all FE from clothing / linens
 - Genital injury / hx of ejaculation: ↑ likelihood of + FE
 - Some + FE was not anticipated by child's hx

When to Collect Forensic Evidence (FE) from Children

- Thackeray et al (2011) FE including DNA
 - 3 children with + body samples collected > 24 hrs
 - 1 had salivary amylase / DNA 54 hrs later, nl PE
- Girardet et al (2011)
 - Yield for + body samples low after 24 hrs, but still retrieved DNA evidence up to 95 hours later.

When to Collect FE

- As soon as possible after an assault.
- Collect FE even if:
 - > 24 hours since assault, despite lower yields
 - The history is not clear b/c of child's age or level of consciousness
 - PE is normal
- Be sure to collect clothing / bedding
(Remember to dry all samples)

Lab Tests and Forensic Evidence Collection

- Test all sexually active teens: STIs, pregnancy, drugs (if suspected date-rape)
- Test children in selected circumstances for STIs
- Collect FE
 - Body, up to 72 hrs since last contact (consider more)
 - Linens and clothing



Management

- If suspect CSA, report to Child Protective Services.
 - Pennsylvania: (800) 932-0313
 - Collect all information needed (see CY-47)
 - Call 911, Special Victims' Unit. Report and inform if need to collect linens or clothing

Management in ED?

- Consider using a screening tool to triage patients—reference #9
 - Still need to consider case by case
 - Think about mental health needs

Management

- STI prophylaxis for teens,
 - GC, CT, Trich prophylaxis,
 - Hep B vaccine, if not previously vaccinated
 - HIV PEP not recommended. Offer if high-risk perp or requested by family and < 72 hrs since event
- Emergency contraception (120 hours)
- Acute events:
 - Need follow-up testing for HIV and syphilis at 6 weeks, 3 months and 6 months

Management

- Non-acute: Still needs full evaluation
 - Refer to specialized center
 - Phila. Children's Alliance will do forensic interviews with police and DHS, but not med eval
- Assess child's safety before discharging.
- Refer for psychological therapy (child / family)

Summary

- Define CSA
- Longitudinal Progression of CSA
- Behavioral Manifestations
- Diagnostic Features
- Management

Cases

1. Infant presents with anogenital irritation after coming home from babysitter. (see pictures)

Cases

2. 2 ½ y/o boy brought to the ED after he humped his mother's leg and said "I'm doing it to you."
3. 3 y/o girl is brought to the ED because she said her Daddy hurt her tutu.

Cases

2. History from child: "Uncle XXX came in the bathroom. I was naked. I said no-no, you get out of here. He touched me right here." With what? "His hand." Last contact was > 1 week ago.
3. Mother-in-law rushed in with child. Child told Dr. it happened when Daddy put her in the carseat.

Cases

4. A 12 y/o girl presents to the ED because she has vaginal bleeding. Her pregnancy test is positive.
5. A 13 y/o girl is brought to the ED after she told her aunt that her step-father molested her, but now she tells you nothing happened.

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Thank You! Questions?



Please feel free to contact me if you have questions.

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