TREATMENT IN PSYCHIATRY

A Need for Improved Detection of Child and Adolescent Sexual Abuse

Fatima Masumova, D.O.

"Meghan" is a 13-year-old referred by her endocrinologist for depressed mood and history of cutting herself. She is interviewed separately with her mother's permission. She reports feeling depressed for most of the past year. She has daily thoughts of suicide, which are increasing in intensity, and on at least one occasion has tried strangling herself. At age 11, her stepfather allegedly touched her breasts. After a consultation with the hospital's legal department, this case was reported to child protective services.

CHILD SEXUAL ABUSE STATISTICS

Unfortunately, "Meghan" is just one of the many teenagers who suffer abuse from a family member. It is estimated that approximately 15% of girls in their teenage years and 6% of boys ages 2–17 experience genital touching and/or penetrative sexual abuse. Most cases of child sexual abuse are often unidentified, with possibly as much as 95% not being disclosed to authorities (1). Child sexual abuse does not usually happen in front of witnesses, and the only available statistics consist of the cases disclosed to child protection agencies or law enforcement. Of 551 cases of child sexual abuse reports over a 12-month period, 34% did not constitute sexual abuse, 2.5% were erroneous concerns made by children, and 1.5% of these were false allegations (2).These statistics indicate a need for further study of child sexual abuse and improvement in recognition of the symptoms by medical personnel.

CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME

The child sexual abuse accommodation syndrome model, developed by psychiatrist Ronald C. Summit, M.D., may explain why children often do not report sexual abuse incidents or withdraw their complaints. The syndrome is composed of the following five categories: secrecy (not disclosing the abuse for multiple reasons, including intimidation); helplessness (children are intrinsically powerless and unable to protect themselves against adult intrusion); entrapment and accommodation (children have to endure the circumstances and learn to survive); delayed, unconvincing disclosure (often in adolescence, when the minor is able to overcome anxiety and confront the abuser); and retraction (usually due to guilt and lack of support from family members). Reportedly, this suggestion is based on statistically validated assumptions and observations made in community consultation practice and is endorsed by experienced professionals, as well as victims (3). The child sexual abuse accommodation syndrome model cannot be used to prove whether victims' statements are reliable or whether the defendants are guilty; however, when acknowledged during legal proceedings, it may explain the victim's counterintuitive behavior following the abuse (4).

ASSOCIATED SIGNS AND SYMPTOMS

It has been suggested that child sexual abuse differs from physical abuse in that it is associated with more long-term problems for the victims. In many cases, child sexual abuse is associated with multiple psychiatric disorders, including but not limited to depression, anxiety, and suicidality (5). More recent data indicate that different forms of child abuse have similar psychiatric and behavioral effects (6). Women and men who were victims of child sexual abuse had 2–4 times and 4–11 times higher odds of suicide attempts, respectively, compared to nonabused adults (7). Recognized short-term symptoms of child sexual abuse vary based on a child's age range. Patients between ages 2 and 6 present with higher rates of inappropriate sexual behavior, have lower intellectual abilities, often display signs of post-traumatic stress disorder (PTSD), and have more depression, anxiety, and social withdrawal compared to nonabused children. Patients between ages 7 and 12 are more likely to have depression, anxiety, PTSD, and suicidal ideation, as well as inappropriate sexual behavior and sexual aggression. Adolescents (ages 13–18) commonly present with depression, anxiety, PTSD, and lower self-esteem and are more likely to have suicidal ideation and complete suicide (8).

CHILD ABUSE SCREENING

Use of screening in the pediatric setting is one proposal to improve child abuse discovery. It has been recommended that a child sexual abuse screening tool should not be classified as a screen of "proof" of child sexual abuse but rather a simple prompt to do a more thorough examination of the child (9). A prospective intervention cohort study on children in seven emergency room departments, conducted in 2008–2009 in the Netherlands, determined that detection of all suspected child abuse would likely increase if systematic screening and emergency department staff training were implemented. Based on previous literature review, the researchers used a screening checklist called the "Escape form," which consisted of six questions for all types of abuse and

was completed by the emergency department nurse. Using this checklist, the investigators were able to show a positive effect on the screening rate for child abuse (10). In regard to screening specifically for child sexual abuse, some researchers have concluded that screening is potentially helpful in both nonproblematic and suspect pediatric populations. A 2006 study in Brazil resulted in development of a five-question screening test to identify child sexual abuse. The questions were focused on signs of behavior changes, physical signs and symptoms, such as genital/anal injuries, and sexualization symptoms (11).

TABLE 1. Strategies for Evaluating Alleged Victims of Child Sexual Abuse[a]

Interview and examination
Relaxing environment and limited interruptions.
Avoiding suggestive questions.
Videotaping and sharing of information to preserve original report and to limit the number of victim interviews.
Use of anatomically correct dolls and drawings to elicit details.
Noting signs and symptoms associated with sexual abuse.
Noting factors that support the child's credibility.
Mental status examination and, if possible, physical and genital examination by qualified clinician.
Report
Awareness about state ethical and legal requirements and being prepared to testify in court.
Recommendations
If possible, determining whether sexual abuse occurred; making recommendations regarding the child's safety and treatment for the child and family, as well as recommendations pertaining to the offender.

[a] For further details, see the Guidelines for the Clinical Evaluation for Child and Adolescent Sexual Abuse, American Academy of Child and Adolescent Psychiatry (http://www.aacap.org/).

INTERVIEW TECHNIQUES

Despite multiple areas of overlap between clinical and forensic child sexual abuse evaluation, an important distinction between the two is the purpose for which the evaluation is being made. The primary goal of clinical evaluation is to determine whether abuse has occurred and whether the child needs treatment, whereas the duty of the forensic evaluator is to report the findings to a particular agency or court. The American Academy of Child and Adolescent Psychiatry guidelines for child sexual abuse clinical evaluation include the following: ensuring that the victim is evaluated by the least number of individuals and for the least number of times to limit stress on the victim and to prevent confabulation; conducting the interview in a relaxed atmosphere; obtaining thorough developmental, psychiatric, medical, and social history; gathering information from both parents, as well as performing psychiatric evaluation of each parent; bearing in mind the likelihood of false allegations; maintaining a neutral stance during an interview; gathering supporting data from multiple other sources; possibly using anatomically correct dolls to obtain information from a child who cannot verbalize the experience; prompt medical evaluation of the child by qualified physicians for treatment purposes and forensic evidence; and making recommendations regarding diagnostic impression, safety of the child, and treatment (see Table 1). Practice parameters for forensic evaluation of child sexual abuse include additional aspects that should be considered during assessment, such as motivations behind the child's denial or retraction of allegations, an extensive list of reasons behind false allegations of sexual abuse, the child's capacity to testify in court, and more emphasis on collateral information (12, 13). Considering normal sexual behavior in families is also an important issue to keep in mind during assessment (14). The use of suggestive questions was criticized by the jury in the controversial McMartin Preschool Abuse Trial, in which staff members of the McMartin Preschool were accused of child sexual abuse but were later acquitted due to lack of credible evidence. Even short doses of improper interview techniques, such as social influence (e.g., describing to the child what others had supposedly said) and reinforcement (e.g., providing reward for answers), cause significant error rates in children's answers (15).

Some factors that may help distinguish between fictitious and credible accounts include providing a unique detail when describing the sexual abuse encounter, age-appropriate use of words and sentences, emotional response during the interview, child behavior during the period of abuse, and the use of toys and drawing materials (16).

REPORTING CHILD ABUSE

Additional area for improvement is continuous education of physicians and other professionals about child abuse and reporting laws. Statistically, professionals (e.g., doctors, teachers, law enforcement personnel) report child abuse at rates nearly three times that of nonprofessionals (e.g., parents, legal guardians, neighbors) and seven times the rates of anonymous sources (17). Medical personnel alone are consistently responsible for a large portion of sexual child abuse reports; 9.4% of child sexual abuse reports were made by medical professionals in 2006 (18). At the same time, many suspicious cases of abuse are not reported by physicians. A 2008 study found that merely 39 out of 75 clinicians (52%) reported suspected child abuse to child protective services (CPS). Among the factors that influenced physicians in reporting were familiarity with the patient's family, availability of professional resources to discuss the case, projected negative outcome of CPS intervention, and elements pertaining to injury (19). Physicians are required by law to report in good faith all suspected cases of child abuse, regardless of doctor-patient confidentiality. Generally, a report must be made within 48 hours of learning about suspected abuse; however, standards for making a report and penalties for noncompliance vary by state (20).

KEY POINTS/CLINICAL PEARLS

- Sexual abuse affects many children and adolescents worldwide and is associated with many psychiatric problems in victims.
- Regular screening in the medical setting may lead to improved detection of child sexual abuse.
- Continuous education and broad knowledge in child sexual abuse and reporting laws are necessary for early discovery and treatment of affected children.

CONCLUSIONS

Broad knowledge in child abuse and reporting laws, as well as good effort, are needed on behalf of medical providers when interviewing children and teenagers. Required screening for child abuse during each pediatric patient encounter could lead to improved detection rates. However, such screening is hindered by legitimate ethical concerns related to the complexity of proper child sexual abuse assessment. It is important for medical professionals to argue strongly for early detection and treatment of child sexual abuse.

Dr. Masumova is a third-year resident in the Department of Psychiatry at the University of Tennessee Health Science Center, Memphis, Tenn.

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