CHILDHOOD SEXUAL ABUSE

What is childhood sexual abuse?

1) The involvement of a child in sexual activity:
   a) to which he/she does not consent
   b) that he/she does not understand on the basis of their developmental level
   c) that violates the norms of society
2) The involvement of a child in sexual activity where there is an imbalance of power on the basis of age, strength, assertiveness or status

What is meant by sexual activity?

There are 4 classes of sexual activity:
1) Suspected abuse where the signs and symptoms suggest abuse but the child is unable or unwilling to confirm this
2) Mild or non contact abuse – i.e. verbal harassment, exhibitionism or exposure to pornography
3) Moderate or contact abuse – fondling of the breast or genitalia of the child or perpetrator by the child or perpetrator
4) Severe or penetrative abuse – penetration of the mouth, anus or vagina by any object: this may be the consequence of a process of seduction or one of rape

How common is childhood sexual abuse?

1) Sex: 1 in 3 girls and 1 in 6 boys will be sexually abused before the age of 16 years
2) Age: Girls - two age peaks, below 6 years and in the early teens
   Boys - a single peak around 7 - 9 years of age
3) Predisposing factors: children at particular risk are those with behavioural or neurological disorders, those from dysfunctional families and those who have previously been abused

Who does the abuse?

- Most instances of abuse involve a single perpetrator
- Over 95% of perpetrators are male
- Males of any age are capable of abuse – 40% of perpetrators are < 20 years old
- There are 4 possible relationships between the child and the perpetrator
  a) ¼ - unknown as the child cannot or will not reveal this
  b) ¼ - a stranger
  c) ¼ - an acquaintance
  d) ¼ - a family member

How does the abuse happen?

It is important to understand the process so that one can assist the families of abused children to prevent a recurrence of the incident. Finkelhor has described four steps that a perpetrator engages in before abuse can happen:
1) Have a desire for a sexual relationship with a child – nothing a parent can do about this
2) Overcome internal inhibitions – this happens when drinking or using drugs so parents need to more vigilant under these circumstances
3) Isolate the child – major point of prevention – adequate supervision of children
4) Overcome the child by threats and force or bribery and seduction
HOW DO WE MANAGE A CHILD SUSPECTED OF HAVING BEEN ABUSED?

There are 6 basic steps to the management of all forms of child abuse:

1) Suspect abuse
Spontaneous disclosure is uncommon and most cases of abuse come to light about a week after the event. This will be on the basis of what you are told (story of abuse or symptoms suggestive of abuse) or what you see (trauma, infections or pregnancy).

2) Investigate
Three different examinations are required:
1) Social workers need to do a risk assessment to define the social circumstance of the child and his/her susceptibility to abuse
2) SAPS need to investigate a criminal offence
3) Health care workers have two functions:
4) A medical examination to consider all possible differential diagnoses and establish the most likely cause of the complaint. This entails the usual steps of history, examination and special investigations. Examination comprises pubertal assessment and genital examination. NO INTERNAL EXAMINATION IS REQUIRED. Genital examination is to look for evidence of acute trauma (TEARS – tenderness, ecchymoses, abrasions, redness and swelling) or structural changes to the hymen.
5) Medico-legal examination to support the SAPS investigation. This involves collection of forensic evidence using the Sexual Assault Evidence Collection Kit (SAECK) if the child presents within 48 hours of the incident, and recording all clinical findings on a J88 irrespective of the interval between the abuse and the examination.

6) Before any clinical examination, it is essential to obtain consent from the child and the guardian or investigating officer (SAPS 308 Form). A police case number is not required. Without the child’s consent, do NOT proceed with the examination.

3) Validate
For judicial purposes a process of validation is required to assist with the decision to prosecute or not. This does not effect the medical management, but does require medical input in the form of a J88 and crime kit.

On a quiet day, it is worth opening a crime kit and going through its contents and instructions, to familiarise yourself with what you need to do

4) Manage the child
1) Mental status:
   a) Prevent post traumatic stress disorder (PTSD) by debriefing - the earlier the better. This is basically a process of allowing the child to talk about what has happened and how they feel about it.
   b) Recognise PTSD. Warning signs include disturbance in sleep patterns or appetite, separation anxiety, deteriorating school work or general behavioural changes subsequent to the incident.
2) Physical status:
   a) Treatment
      i) Acute injuries
      ii) Established complications – infections or pregnancy
   b) Prevention of complications is feasible if the child presents to the health services within 72 hours of the alleged incident
      i) OVRAL 28th tablets - 2 stat and 2 in 12 hours PO if pubertal development is Tanner stage 3 or more (menarche is irrelevant). Ovral makes children very nauseous so they should also receive metoclopramide 0,15-0,3mg/kg 6H PO for 24 hours
      ii) If the child is HIV negative use - AZT & 3TC as PEP (see Step by Step Guide for Childhood Sexual Assault: Appendix 6, page 45)
   v) METRONIDAZOLE PO for 7 days: <3yrs 50mg 8H; 3-7yrs 100mg 12H; >7yrs 100mg 8H
   v) ERYTHROMYCIN PO for 14 days: 10-15mg/kg 6H

5) Ensure the ongoing safety of the child
Ultimately this is the responsibility of the family, social workers and SAPS. DO NOT admit children to hospital unless this is medically indicated. It is preferable to explain the process of abuse to families to allow them to respond appropriately.

6) Family reconstruction
The family is the child’s primary support system and this needs to function effectively to minimise the trauma to the child and ensure their ongoing well-being.