Childhood sexual abuse and family physicians

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Childhood sexual abuse is a serious problem with considerable implications for individual patients and society. Psychological and interpersonal problems are more common among those who have been sexually abused than among those who have not.

Any sexual activity with a child where consent is not or cannot be given is sexual abuse.[1] It is difficult to determine the incidence and prevalence of childhood sexual abuse accurately; however, in an American telephone survey of adults, 27% of female and 16% of male respondents reported being sexually abused.[2] In a similar survey in Ontario, sexual abuse during childhood was reported by 4.3% of male and 12.8% of female respondents.[3] Recent analysis suggests that the incidence of childhood sexual abuse might be decreasing.[4]

Childhood sexual abuse is not often revealed immediately. Even if children reveal the circumstances, abuse might not be reported to authorities. A notable percentage of health care professionals choose not to report cases of suspected abuse of children. This is surprising given the serious implications for the child, the family, other children at risk, and society. Failure to report has been attributed to various factors, most based on individual attitudes. Most people in our society recognize the presence, appreciate the seriousness, and abhor the concept of childhood sexual abuse. Unfortunately, I have often observed people's inability to translate these thoughts into action when they are personally involved (eg, families in a physician's practice, friends, or colleagues). A balanced, thoughtful approach is needed when considering sexual abuse. Emotion and personal attitudes have no place in the equation. Any child can suffer sexual abuse—this problem is not limited by culture or socioeconomic status.

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Value of physical findings

The article by Dr Gary Smith and colleagues (**page 1347**) from Orillia's Regional Paediatric Sexual Assault Program describes their medical approaches to concerns of childhood sexual abuse. As the authors illustrate, physical findings that confirm sexual abuse are rare. Even when children have suffered intrusive physical acts, such as genital penetration, physical findings unique to sexual abuse might be seen in only 2.5% of children.[5] In another large study, results of examinations were normal or revealed nonspecific findings in 96.3% of 2384 children referred for evaluation when concerns of sexual abuse arose.[6]

Dr Smith and colleagues noted the presence of physical findings in 45% (17 of 38) of examinations completed at their secondary regional pediatric sexual assault clinic. Eight of these 17 children had findings considered noteworthy by the examining pediatrician. Six of these were nonspecific findings, including erythema; anal fissures, tears, or tags; and scarring lesions on the back of the leg associated with a finger blister infected with *Herpes simplex* virus type 2.

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One of the noteworthy findings was a "fragmented hymenal rim." This terminology illustrates a recurring problem in past literature relating to medical evaluation of childhood sexual abuse. Until recently, terminology was not standardized, and the importance of certain findings was difficult to determine.

Interpretation of physical findings must be evidence based. The authors noted a notch in the hymen at the 6 o'clock position in one patient. While a notch at this location raises concern over injury from penetration, the specific characteristics of the notch are important to allow opinion about the diagnostic value of the observation. Given these caveats, overall analysis of the data indicated two potential hymen injuries representing 5.3% of the children seen following referral to the secondary centre. While this is in the range of recent experience, the percentage is somewhat higher than other reports and indicates a need for greater detail and clarity about the findings described.

How can examinations help?

The lack of conclusive evidence does not mean that children should not be examined. Children might have medical or psychological needs that must be considered. A variety of physical problems, such as infection or irritation, might benefit from medical evaluation. In addition, examination can be reassuring for children and parents when no worrying physical abnormalities are discovered. These examinations can be planned and completed in a setting that is comfortable for the child.

Timely examination must be considered when forensic evidence might be present. Discovery of forensic evidence, including DNA, has important implications in criminal proceedings. When considering the forensic value of the examination, important areas to explore are the likelihood of the presence of evidence (time since occurrence, intrusive physical acts) and the potential loss of evidence (changing clothes, bathing, using the toilet). Often, bedding or clothing used at the time of abuse is the best source of forensic evidence. The authors discuss approaches to deciding if and when an examination should be done.

Putting examinations in context

As knowledge about childhood sexual abuse expands, it is clear that information provided by the child is the most effective way to determine whether sexual abuse has occurred. While occasionally helpful, medical examinations should not be relied on for corroborating evidence. Investigative interviews should be completed by those with specialized training to ensure accurate and dependable collection of information. The importance of these interviews cannot be underestimated. The legal community generally understands this better than those in medicine; however, investigators might request examinations in the hope of finding corroborating evidence.

The meaning of examinations and the likelihood of findings must be explained to investigators and parents. For example, investigators and parents might be skeptical of the child's information when penetration is reported and no abnormality is found. Penetration is a concept adults understand but young children might not. The degree of entry into genital or anal areas and possible healing of injuries are important factors to consider.

Medical training inadequately prepares physicians for the issues of childhood sexual abuse. A recent American article found that 29% of pediatric chief residents incorrectly labeled the hymen on a photograph of a female child's genitalia. Half of those surveyed thought their training in sexual abuse during residency was inadequate for practice.[7] This is consistent with my experience. Unfortunately, education in family practice offers less opportunity than even pediatric residencies offer to gain adequate knowledge in the area of childhood sexual abuse.

Acting as advocates

Given the limited opportunities for children to report sexual abuse and the frequent involvement of physicians in response to concerns raised, health care professionals need to be prepared to help children and families respond to this important issue. This has resulted in specialization in evaluation of childhood sexual abuse. Many such specialists work collaboratively with other disciplines, illustrating

that a multidisciplinary approach to childhood sexual abuse is the most effective. It is also important for specialist team members to determine and disseminate criteria for referral.

Specialized resources should be used when physicians who are inadequately prepared to respond to the issue encounter indications of sexual abuse. Physicians must consider the child's perspective. Instead of dismissing concerns that have arisen because the physician "knows" the family, physicians should seek advice from those with more experience in this area. This allows concerns to be thoroughly evaluated to either identify sexual abuse, thereby protecting children from further harm, or to eliminate a cloud of suspicion that might be surrounding the family.

Children are vulnerable and are often unable to speak up when they are sexually abused. While examination by physicians will rarely confirm sexual abuse, doctors can be powerful advocates for children by reporting concerns to allow appropriate multidisciplinary investigation and by supporting children and families through the process. Need for and timing of medical examination should be carefully considered. Situations of childhood sexual abuse are often far more complicated than initial impressions suggest.

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