Suspected Child Sexual Abuse

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DR HARLEY GOLDBERG (*Third-Year Resident, Family Medicine*): The patient is a 13-year-old girl, whose care began with a family physician in an outlying community. She was initially seen by this physician in November of 1987 with complaints of 5 weeks of fatigue, intermittent fever, and chills, which were sufficient to keep her out of school. She was treated at that time with amoxicillin. She was seen again in February of 1988 with myalgias, some sinus drainage, and fatigue. She again had missed school for several weeks. A diagnosis of a possible viral syndrome was made and a second course of amoxacillin was prescribed. On February 19 the patient was given a home tutor to help her catch up from prolonged school absences for the same complaints. Three days later, her records reported a negative Monospot and moderate lymphadenopathy, and she was given a short tapering course of prednisone. On February 29 she returned to her physician with essentially the same complaints. On March 7 the severity of these symptoms seemed to be increasing with added problems of nausea and dizziness. The patient and family felt that there was a physical illness involved for which a more thorough investigation was required. Results of a chemistry panel, thyroid function tests, and a complete blood count were all normal. In April these same complaints were again reported, and the family physician entertained the possibility of endogenous depression. Antidepressants were offered and refused.

On April 15 the patient was referred to the Oregon Health Sciences University (OHSU) Pediatric Outpatient Clinic. A fairly extensive history revealed that she had no pleasurable activities and spent most of her time watching television. She was not seeing her friends, though she occasionally talked with them on the telephone. She denied any other stresses, sibling rivalries, or family difficulties as well as any sexual contact. She said that she was attracted to boys but had no boyfriends. She claimed that when she was healthy, she was a good student, getting A's and B's, and that she basically felt comfortable with herself. The remainder of the examination was unremarkable. The assessment at this time was an endogenous depression. Recommendations included establishing rapport with the patient and bringing the entire family back for follow-up. Follow-up never occurred. The patient returned to the care of her private family physician.

In early June she complained of sweats and chills, occasional vomiting, shortness of breath, drowsiness, fatigue, and intermittent nasal congestion. On August 1 the father called the family physician saying that his daughter was "close to her deathbed," groaning, crying, refusing to eat. At that point, referral was made to OHSU Department of Family Medicine, and contact was made with the attending physician on the inpatient service, Dr Eric Wall.

DR ERIC M. WALL (*Associate Professor, Department of Family Medicine*): The family physician I spoke with was obviously very frustrated and requested hospital admission for a multidisciplinary assessment. The physician had approached the family with a diagnosis of depression and felt that the father in particular was resistant to a psychiatric label for the child's problem. He incidentally added that he had received a confidential letter, in April, from an aunt of the patient who said that when she—the aunt—was a teenager, she had been sexually abused by the father of the patient. The contents of this letter were not revealed at the time of the patient's pediatric outpatient visit. I asked whether the physician felt there was any suggestion that the patient had been sexually abused, and he admitted that this was a strong diagnostic possibility.

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After consulting with a number of colleagues both within and outside our department, I recommended that if the physician strongly suspected sexual abuse, he should contact the Children's Services Division (CSD) in the county in which the family was living and at least explore any other potential avenues for evaluating the child. He called me back several days later and said that after exploring these options, CSD felt that there was not enough to go on to evaluate this child's situation. In fact, I later learned CSD had carried out an independent investigation of this child prior to this time. He again requested our help here in trying to sort out the problem with the patient. As there was no other means of access to her for a comprehensive evaluation, she was seen in the Family Practice Center by one of the faculty. That physician also felt that the child's complaints warranted inpatient investigation.

DR GOLDBERG: The patient's past medical history was unremarkable; she had no known allergies, nor was she taking any ongoing medications. Her family history involved some maternal family hypertension, obesity, and diabetes. The father had previously been hospitalized for pancreatitis and was told that he had adult-onset diabetes. The cause of the pancreatitis was unknown, according to the father. Menarche had started for the patient at 12 years of age (1½ years earlier), and she reported a regular menstrual cycle every 28 days lasting 3 to 4 days. She denied sexual activity of any kind.

The physical examination at admission revealed a pale, listless child moaning intermittently and crying that she was unable to move. One could, however, move her limbs, and she was able to stand and walk after considerable encouragement. Other than mild anterior cervical lymphadenopathy, the remainder of the physical examination was unremarkable. A gynecologic examination was not performed at admission, in view of the anticipated examination with Dr Mary Steinberg, the late hour, and the available male examiner. Her laboratory tests included a complete blood count, sedimentation rate, and chemistry profile, the results of which were normal.

As the differential diagnosis of biomedical illness became quickly exhausted, consultations were obtained with Dr Kate Commerford, from our own department; Dr David Holladay from the Department of Child Psychiatry; and Dr Mary Steinberg from the Department of Pediatrics, who in our institution is most experienced in the evaluation of suspected child sexual abuse. The course is summarized by the evaluations of each of these individuals, and I would like to ask each of them to present his or her perspective at this time.

DR KATE COMMERFORD (*Psychologist, Family Medicine*): My initial contact with the patient was on the first morning of her admission. She was lying in bed, pale and lethargic as has been described. She was very difficult to interview, appearing to be wary of my questions and guarded in her answers. The patient completely denied any family or personal problems. She was unable to be specific about her interests or daily activities. She said that she liked to do outdoor things but was unable to describe what these were. She was unable to talk about specific activities of her life either before or since the onset of her illness. She had been out of school since November, so she had been mostly housebound. She described herself as honest, friendly, outgoing, and active.

In an effort to gather additional information about the patient and her family, a genogram was constructed (Figure 1). The identified patient has one male sibling 3 years younger than she. The patient's parents married in 1970, had a brief separation in 1971, and have continued to be married to this day. The mother's only health problem is hypertension. Although the mother's father is now sober, she grew up in an alcoholic family. The mother supports the family by working full time as a receptionist in a health facility.

The patient's father is the second of five children. He is a former Marine who is obese, weighing 270 pounds, and has adult-onset diabetes mellitus and a history of pancreatitis. His father died in 1984 of bone and other cancers, and his mother has a metastatic cancer. The father is not employed and has not been working for at least as long as the patient has been out of school. The father formally worked cutting wood, and his explanation for not working anymore was that "the truck broke." The father and mother both denied alcohol use. The mother and two children are Catholic; the father is not but attends some Catholic functions with them. The younger brother of the patient was described as hyperactive, though this could not be confirmed.

One thing that came up during the interview was that the patient would wake up at 5 AM to do her hair. While trying to determine whether this early morning awakening might be associated with depression (it was not), it was discovered that the family's sleeping arrangements were a bit unusual. The patient's father sleeps with her brother in the parents' bed, the mother sleeps downstairs in the son's room, and the patient is also downstairs in her own room. The explanation given was that the father snores and would otherwise keep the mother from sleeping. The parents also said that the son did not like to sleep alone.

When asked whether they had ever had those sleeping arrangements with the patient, both parents denied that she ever slept with her father. During the interview, the father did most of the talking. I felt that it was important to specifically ask whether either of the parents thought that the patient had been sexually abused. Both denied it, as did the patient when she was asked with neither parent present. The mother's response was that she did not think

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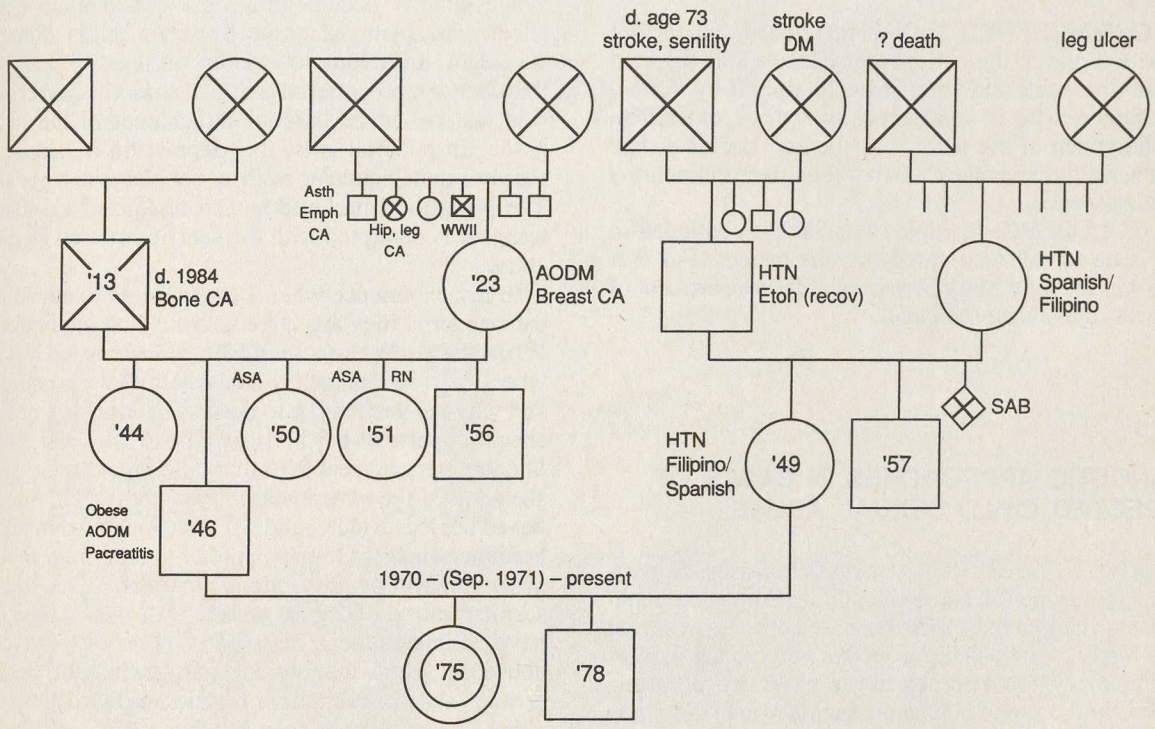

Figure 1. Genogram for identified patient. Asth—asthma, emph—emphysema, CA—cancer, DM—diabetes mellitus, AODM—adult-onset diabetes mellitus, HTN—hypertension, etoh—ethanol abuse, ASA—alleged sexual abuse by patient's father, RN—registered nurse, SAB—spontaneous abortion.

that the father had abused the daughter because she "trusted" both of them.

The patient scored 6 on the Beck Children's Depression Inventory with 19 and above indicating depression in children. She clearly denied any symptoms that would go along with depression. The Minnesota Multiphasic Personality Inventory (MMPI) was also administered, and the adolescent norms were employed in scoring. This administration of the MMPI appeared to be valid, with results indicating someone who is very defensive. One of the most significant aspects of this patient's profile is the presence of a "conversion V." An individual with a "conversion V" is thought to be converting personally distressing problems into more socially acceptable ones. In other words, the patient's results suggest psychological problems are being converted into somatic complaints. Also of importance in the MMPI results is the lack of elevation on scales 6, 7, 8, and 9 (paranoia, psychasthenia, schizophrenia, and hypomania), which are typically quite elevated for adolescents. These scales contain items that acknowledge the confusion, anxiety, hypersensitivity, personal discomfort, and fear of social exposure that are typical of the adolescent period. The patient's scores on these scales were quite low and contribute to the interpretation of defensiveness on the MMPI.

DR DAVID HOLLADAY (*Third-Year Resident in Child Psychiatry*): When we went to interview the patient, we found her lying on the bed engaged in a lively sort of discussion that quickly changed after we introduced ourselves. She immediately looked quite ill, and it appeared she was trying to show us how sick she was. What was most remarkable was her denial of any and all problems. She was not very pleased to talk with us, although she was cooperative throughout the interview. We looked for obvious evidence of psychosis or major depression, which was not present. She was able to laugh spontaneously,

and her thoughts were clear and coherent throughout the interview.

DR COMMERFORD: Dr Wall mentioned that an aunt had written one of the patient's physicians and reported that she (the aunt) had been sexually abused by the patient's father, who is approximately 5 years older than she. She stated in the letter that she and her sister had been abused by the patient's father for 4 to 5 years during their adolescence.

DR GOLDBERG: Possible sexual abuse continued to be an issue for all who cared for this patient. For that reason we asked Dr Mary Steinberg of the Department of Pediatrics to evaluate the child.

DIAGNOSTIC APPROACHES IN CASES OF SUSPECTED CHILD SEXUAL ABUSE

DR MARY STEINBERG (*Assistant Professor, Department of Pediatrics*): I am frequently asked to do examinations on children for whom there are concerns of sexual abuse. Many of the children I see are very young. Unfortunately, many reported sex abuse cases are of young children. In the physical examination of young girls, it is often easier to identify signs of molestation. There are some significant differences in the genitalia of prepubertal and postpubertal girls. In young girls the labia majora tend to be much thicker and overlie the introitus more. The clitoris is fairly prominent, but the labia minora are usually very small and attenuated. The urethras generally appear small. The hymenal tissue is generally annular, circumferential, or horseshoe shaped and surrounds a fairly small vaginal orifice. One of the indicators we look at closely is the size of the vaginal orifice. We measure it both horizontally and vertically. For many years it was understood that any prepubertal girl who had a vaginal opening greater than 4 mm had been sexually abused.[1] Since that time, however, it has been recognized that this 4-mm limit is not correct. Depending on the child's age, vaginal openings can go up to 6, 7, or 8 mm, especially in the older girls before they reach puberty. It is important to understand that the size of the vaginal opening is only one part of the examination.

It is also important to look at the appearance of the hymen. Is there a hymen, or has it been completely rubbed away, leaving just a thin rim of rough-edged tissue surrounding the vaginal orifice?

Is there generous hymenal tissue with an irregular notched border? Is there evidence of a healed transection of the hymenal ring? What is the appearance of the posterior fourchette? These additional findings are important to look at in addition to the size of the vaginal opening. When puberty occurs, there is a concomitant estrogen effect. The hymenal tissue becomes thick, fluted, and succulent, and tends to overlap on itself. The posterior fourchette in prepubertal girls is a smooth, coved depression just below the inferior attachment of the hymenal tissue. In pubertal girls, this depression is longer, more narrow, and glandular with a cobblestone appearance. The posterior fourchette has an organized vascular pattern that is disrupted with the scarring caused by chronic abuse.

In my experience when I try to do an examination on teenage girls, they are quite nervous and uncomfortable. When this patient was seen, she was slumped over in her wheelchair. I explained to her what we were going to do and why we were going to do it. I said that we needed to check all parts of her body as part of her total checkup. She was very agreeable to that, and much to my surprise she allowed the examination without a twitch. She easily flexed her legs widely, and with any kind of stimulation of her inner thighs or touching of her genital area, there was no voluntary or involuntary reaction. This response seemed unusual because, again, with most young girls I have examined, regardless of whether they have been abused, it seems that any kind of touching of the genital area causes an involuntary reaction of the patient. I was able to insert a finger deep into her vagina and move her cervix without any difficulty. Her lack of response alarmed me because it was totally unlike any reaction I had seen in other teenage girls who come in for an examination. If I had anticipated her compliance, I would have been prepared to do a full pelvic examination including a colposcopic examination, which is now standard in alleged sexual abuse. I did not have the proper equipment available at the time of this examination. I did take a culture of her vagina for gonorrhea and a fluorescent antibody test for *Chlamydia*. She did have a positive standard vaginal culture for *Gardnerella vaginalis*. It was suggested that she have a follow-up speculum examination for visualization of the cervix and to obtain cervical cultures for *Chlamydia* and gonorrhea, since that type of examination is more reliable in postpubertal females.

DR GOLDBERG: She did return for a follow-up examination, which was less remarkable. She asked questions that were more typical of a 13-year-old, and she was a little hesitant initially. There was, however, no difficulty in performing the pelvic examination, placing the speculum, or obtaining the cultures. A colposcope was not available but is useful in examinations of suspected child abuse. A handheld magnifying glass may be used with similar effect.

DR DOUGLAS LANGROCK (*Second-Year Resident in Family Medicine*): You mentioned that there is some

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and acquaintances of their teenage daughters. Determination of sexual activity was entirely through self-report.

DR GOLDBERG: The authors stated that for any positive results, they reexamined and retook a history specifically requesting whether the subject was sexually active. None of the subjects on requestioning changed her history.

DR STEINBERG: I think we all have questions about the reliability of self-reported sexual activity. It seems clear, however, that one cannot use the presence of *Gardnerella vaginalis* as an absolute marker of sexual activity. In this patient, the presence of *G vaginalis* is little more than an additional suggestion of sexual activity, especially in the context of historical factors and her clinical presentation.

DR WALL: Is there a possibility that the different reactions to the pelvic examination were due to the sex differences of the examiners? I am also curious about the family's reaction to the psychiatry referral.

DR GOLDBERG: Sex differences could certainly have accounted for the different reactions of this patient. The patient's father consistently refused or was otherwise unable to recognize possible psychological reasons for his daughter's illness. He reluctantly accepted our recommendation that his daughter undergo a psychiatric evaluation.

DR HOLLADAY: We clearly stated to the family that we also were very concerned about the patient's symptoms even though we did not completely understand them. We thought, but did not immediately state to the parents, that much of the history was quite suggestive of sexual abuse. There was a reliable letter and some very unusual sleeping arrangements. There are some dynamics in the parents' histories that were suggestive of some problems. The mother was from an alcoholic family, and we know that she was making a lot of excuses for her husband in the history that we had obtained. The father had his own difficulties. There was much denial of family problems. We did get a history of alcoholism, which is often found in families who have sexual abuse problems.

DR GOLDBERG: In our contact with CSD, the history of the patient's early morning prolonged grooming and the observations by Dr Steinberg and the team of lax pelvic tone as well as absent affect strongly suggested the possibility of pedophile activity. An aunt had notified CSD of her concerns about possible abuse and supplied the history of the patient's father abusing his two sisters. The aunt also reported specifically asking this child whether her father had been molesting her, and the child denied it. Another relative, who happened to be a CSD employee, also had reported concern about abuse of this patient. Because of the denial by the patient, however, the family was not further evaluated by CSD. There was also a history of violent and explosive behavior of the father

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DR WALL: It s very difficult for many medical professionals to deal with issues of child abuse directly. I am wondering how you addressed this issue with the patient and the family.

DR STEINBERG: I asked them directly.

FOLLOW-UP AND DIAGNOSTIC CRITERIA

DR GOLDBERG: The team's recommendations on discharge were that the child return to school as soon as possible and that the family undergo counseling arranged through CSD. In fact, the patient was discharged from our institution directly to CSD to make those arrangements.

DR COMMERFORD: The patient was told she had a conversion disorder that was related to or caused by stress. She denied being under stress and was very upset at that diagnosis. The father was told the same thing.

DR GOLDBERG: What was her diagnosis from child psychiatry?

DR HOLLADAY: Undifferentiated somatiform disorder.

DR WILLIAM TOFFLER (*Assistant Professor, Department of Family Medicine*): Had the decision been made to investigate this further, what would be done?

CHILDREN'S SERVICES DIVISION (CSD) OFFICIAL: In our county, we would have made the report to the sheriff's office, and the deputy sheriff would have gone out with a protective services worker. Typically, we would have tried to arrange a structured interview with the child away from the parents.

In juvenile court, conviction for child sexual abuse is determined by a preponderance of the evidence suggesting abuse has occurred and identifying the perpetrator. If abuse has been found to occur, but the perpetrator has not been conclusively identified, the judge would have to decide whether the child could remain in the family.

BECKY MERRITT (*Social Worker, Department of Family Medicine*): Has the father been known to law enforcement agencies prior to this time?

CSD OFFICIAL: Yes, there have been a lot of problems with the father. I have experienced very explosive, violent behavior in the contact I have had with him. He is a dangerous individual who is very intimidating.

After the patient's evaluation, we felt that the best strategy was to try to help this family deal with their many problems. They were referred to two private family therapists, and reluctantly agreed to follow through with these referrals.

DR WALL: Can you summarize what happened when the girl was discharged?

DR GOLDBERG: This case illustrates many of the difficulties in management of suspected child and adolescent sexual abuse. For a diagnosis to be established, overt physical evidence, or disclosure by the abused, or admission by the perpetrator must be present. *Sexual abuse* is defined as the involvement of children and adolescents in sexual activities they do not understand on the basis of their developmental level, to which they cannot give consent, or that violate the social taboos of family or society.[3] In the event that a diagnosis cannot be definitively established, the appropriate course of action will depend on the circumstances of the case.

Following discharge, the family reported to Children's Services Division of their county and began interviews with a family therapist. During this time the parents took the child for further medical evaluation. The father obtained access to records that commented on the confidential letter revealing a purported history of multiple sexual abuses by the father. The father then became physically threatening to the family. Armed, he disrupted the house and reportedly threatened to kill his entire family and himself. Because of these occurrences, the children were taken into custody, and at a shelter hearing, the judge ruled there was reasonable cause to keep the children in care until wardship could be determined.

While in foster care, the patient reportedly improved her school attendance and social behavior, and her somatic complaints diminished. These symptoms recurred only after contact with the father and during a subsequent hearing. Although there were many other suspicious events and behaviors by the father, he passed a two-

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question polygraph, and at a later hearing, the children were returned to the family.

The child's failure to disclose information and her continued denial that anything had happened is not unusual. When neglect, prolonged abuse, or violence is involved, children do not usually disclose the events unless they perceive themselves as safe from the perpetrator.

The management of suspected sexual abuse is dictated by the particular social situation. Often the mother is torn between the alleged perpetrator and the child. Family crisis and disruption may occur. Stages of reaction may include grief-like responses of shock, disbelief, anger, bargaining, and acceptance.[4] The physician may well become the object of the family's anger. Prolonged psychotherapy is helpful, and disclosure need not be made to initiate therapy. Therapy may be individual or group. Family assessment is also important, but family therapy, if the perpetrator is a family member, may be contraindicated.

In all states, suspected child sexual abuse must be reported to a designated authority. The reporting physician is protected from prosecution, and only suspicion of abuse is required to warrant notification. Determination of guilt is a decision reached only in the court system.[5]

References

1. Cantwell HB: Update on vaginal inspection as it relates to child sexual abuse in girls under thirteen. Child Abuse Negl 1987; 11:545–546
2. Bump RC, Buesching WJ III: Bacterial vaginosis in virginal and sexually active adolescent females. Evidence against exclusive sexual transmission. Am J Obstet Gynecol 1988; 158:935–939
3. Schecter MD, Reberge L: Sexual exploitation. In Helfer RE, Kempe CH (eds): Child Abuse and Neglect: The Family and Community. Cambridge, Mass, Ballinger Publishing, 1976
4. Berkowitz CD: Sexual abuse of children and adolescents. Adv Pediatr 1987; 34:275–312
5. Morris JL: To report or not to report. Physicians' attitudes toward discipline and child abuse. Am J Dis Child 1985; 139:194–197