

# *Margaret's Secret*

## Facilitator's Guide

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**Topic:** Sexual Abuse

### **Abstract:**

Children who have been victims of sexual abuse are often seen by their primary care clinician. Sometimes, the child has made a specific disclosure. More often, he or she may present with nonspecific genitourinary complaints, behavioral difficulties, or a positive response to screening questions. Medical clinicians are often part of a multi-disciplinary team assessing the possibility of child sexual abuse and need to be comfortable with taking a history, performing a physical examination, selecting laboratory tests, and managing the medical aspects of care. They should also know how to take appropriate steps to ensure the child's well being and safety. This case presents the story of Margaret, a 5-year old child with genitourinary complaints and behavioral difficulties who, as it turns out, has been sexually abused by a male relative.

### **Goal:**

To give clinicians a basic understanding of primary care office management of child sexual abuse.

### **Objectives:**

By the end of this session, learners will be able to:

1. Discuss the signs and symptoms of child sexual abuse.
2. List the important elements of the history and physical exam when sexual abuse is suspected.
3. Discuss the indications for filing a report of suspected child abuse to a child protective agency and what an investigation may involve.

**Prerequisite Case:** "The Father's Hand Print" (Child Physical Abuse)

### **Related Case:**

"The Silent Cry" (Neglect)

"The Burning Issue" (Sexually Transmitted Diseases)

### **Themes:**

Child Development and Behavior



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**Key Words:**

Child abuse, sexual; physical examination; enuresis; vulvar disorders; vagina; genitalia

**Bright Futures Core Concepts:**

While all of the Core Concepts are included in each case, this particular case can be used to highlight communication, partnership, advocacy, and prevention/health promotion.

**Materials Provided:**

- Facilitator's Guide
- 3-part Case Narrative: Part I, Part II, Epilogue
- Handout #1: Important Information on Child Sexual Abuse
- Bibliography

**Facilitator Preparation:**

Facilitators should check child protection statutes and the reporting mechanism for their own state. Facilitators may want to have copies of the reporting forms as handouts. This case is best taught **after** the complimentary one on child physical abuse, "*The Father's Handprint*."

At the end of the guide we have included a section entitled, "**Independent Learning/Prevention Exercises**," that will further stimulate group and individual education on this topic.

**Suggested Format for a One Hour Session:**

**We anticipate that case facilitators will modify implementation of the case session to best fit their educational setting and learners. For detailed recommendations on case facilitation, please see the chapter entitled, "A Brief Guide to Facilitating Case-Discussion," found in *The Case Teaching Method; and Growth in Children and Adolescents* (book 1 of this series).**

**Introduction:** Sexual abuse can be defined as the engaging of a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and that violate the social and legal taboos of society. There were an estimated 3.1 million reports of child abuse in the U.S. in 1996 of which 1 million were substantiated. Of these, 9% involved sexual abuse. The actual number of child abuse cases is estimated to be three to four times higher than the number of reports.

According to the *Bright Futures Guidelines*, clinicians should ask screening questions regarding abuse as part of routine care. Parents should be asked: "*Have you ever been worried that someone is going to hurt your child? Have you ever thought your child might have been abused?*" In an interview with an older child or adolescent, the clinician might ask, "*Has anyone ever touched you in a way you didn't like?*" Parents or teachers may notice significant behavioral changes. In this case, Margaret's unwillingness to be alone with her uncle, her behavioral regression (resumption of bedwetting) and her anxious, withdrawn presentation are all concerning.

Children who have been sexually abused may present with nonspecific anogenital complaints, such as a vaginal discharge, vulvar irritation, perineal erythema, or genital pain without objective physical findings. Many people mistakenly believe that a medical examination can determine whether or not sexual abuse has occurred, when and how often a child has been abused, and whether penetration has taken place. In fact, most genital examinations in prepubertal children who have been abused are normal. Clinicians must understand the importance of a thorough history and *properly* conducted child interview. A child's clear statement that he or she was sexually abused and details of the abuse are often the most important evidence of abuse.

**Open the Discussion: Introduce the case title and the session goal. Explain that this will be an interactive case discussion and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.**

### **Part I**

Margaret is a 5-year old girl who comes to your office for evaluation of genital discomfort and bedwetting. Her mother reports that she has noticed some vulvar irritation during the last week and that Margaret has been wetting the bed for the past two weeks after having been fully toilet trained. She tells you that Margaret has had no vaginal discharge or bleeding, and has otherwise been healthy.

"*Has Margaret been going to the bathroom more frequently than usual?*" you ask.

"*No, not that I'm aware,*" her mother replies.

"*Does she ever need to go to the bathroom, and then only a few drops of urine come out?*"

"*No.*"

"*Does Margaret every say that it hurts her when she goes to the bathroom?*"

"*Yes, sometimes,*" her mother says.

"*Has she had any accidents during the daytime?*"

"*No, just at night.*"

"*Have there been any changes in Margaret's behavior?*" you ask.

Margaret's mother appears distressed and she asks to speak to you alone. Margaret is reluctant to leave the room without her mother but finally accompanies your assistant to the play area.

Margaret's mother tells you that, for the past week, Margaret has seemed unusually anxious. She has been reluctant to leave her mother's side and cried about going to school. The teacher reported that Margaret seems withdrawn, and somewhat hesitant about joining in activities that used to be her favorites. You find out that the family returned two weeks ago from a visit with Margaret's aunt and uncle. Three days into the visit, Margaret refused to stay alone with her uncle stating to her mother that "*I don't like Uncle Bob.*" Margaret's mother found these statements concerning but when she asked further questions, Margaret refused to elaborate.

You check back in your notes and find that up to this point, Margaret's behavior and development have been entirely normal.

**Following this reading, ask all participants "*So what do you think about this case? What would you like to get out of this discussion today?*" List agenda items on a blackboard or flipchart. Then use the questions below to guide the discussion. Remember that the key to successfully leading a small group is *facilitation of the discussion* rather than lecture. Draw as many participants as possible into the discussion. Allow silences while group members think about questions. Present**

**material from the discussion guide only when needed to complement or redirect the group discussion.**

**Guiding Questions for Discussion:**

**What additional historical information would you like from Margaret's mother?**

It is important to determine if there have been any recent changes in the family, which may have led to Margaret's behavioral difficulties. Parental conflict, financial stresses, a death in the family, a new baby, a recent move, or starting a new school can all contribute to behavioral dysfunction in children. Given the history of vulvar irritation, you should get more information regarding the use of any new soaps, lotions, or bubble-baths as well as whether Margaret has been wearing any tight-fitting clothing such as leggings or leotards. The new onset of urinary incontinence at night may also contribute to vulvar irritation. You should also elicit further history regarding other areas of Margaret's functioning. Ask questions about appetite, sleep pattern, relationships with peers, school function, and the presence of separation anxiety. While impairments in these areas are not specific for child sexual abuse, knowing about these difficulties can help you advocate for appropriate psychological support whatever the cause. Rectal or genital pain or bleeding, infection with a sexually transmitted disease, sexualized behaviors or precocious sexual knowledge are all associated with child sexual abuse. Exposure to explicit television or Internet sexual scenes may also cause sexualized behavior, but any child exhibiting such symptoms should be thoroughly evaluated so that sexual abuse can be reasonably excluded.

**What is on your list of differential diagnoses for Margaret's genitourinary and behavioral complaints?**

The differential diagnosis of vulvar erythema includes nonspecific vulvovaginitis (due to hygiene and/or irritants), specific vaginitis (e.g. Group A streptococcal infection), a sexually transmitted disease (gonorrhea, chlamydia, trichomonas), or a vaginal foreign body. The absence of vaginal discharge argues against a specific vaginitis, STD or foreign body. Margaret's enuresis could be the result of a neurologic disorder, urinary tract infection, or diabetes. A new onset urinary tract infection could explain the vulvar erythema and incontinence, but is likely to be associated with daytime symptoms and unlikely to be associated with behavioral symptoms. The behavioral difficulties could be due to a psychological disorder, such as anxiety or depression. Margaret's profile of genitourinary and behavioral symptoms can certainly be seen in child sexual abuse, although they are not specific for this diagnosis.

**What steps should you take next?** Always perform a careful history and a physical exam. Avoid tainting the interview with leading questions and defer detailed sexual abuse and disclosure interviews to experts unless you have been specially trained. The parent interview should be conducted separately from the child, and the child should be interviewed separately from the parent if possible. Clinicians must set aside adequate time to conduct these interviews, and interruptions must be avoided. The anogenital exam is best performed in the context of a complete physical exam. The vulva and hymen may be well visualized in the supine frog leg position. If the edges of the hymen cannot be assessed or there is bleeding or discharge, the knee-chest position is useful to

examine the contours of the hymen and to examine the vagina. Children who are reluctant to have these areas examined will often feel more comfortable sitting on their parent's lap or beside their parent (or other supportive person) on the exam table.

**Distribute Part II of the case and have participant(s) read it aloud.**

**Part II**

You obtain further history. Margaret's mother denies that Margaret has been using any new soaps, bubble baths, or lotions. Margaret has never had prior urinary tract infections. There have been no recent psychosocial stressors in the home. Up to this point, Margaret had been doing well at school. There have been no changes in Margaret's appetite, but she has recently had problems falling asleep.

You find Margaret in the playroom and invite her back into the exam room. As you re-enter the room, your nurse informs you that Margaret's urine is negative for leukocyte esterase, nitrites, and glucose. You have Margaret's mother sit next to her on the exam table. She tolerates the general physical examination well. The neurological examination is normal. Margaret becomes somewhat anxious during the genital exam. Margaret's anal area and hymen appear completely normal. She has slight vulvar erythema. No discharge is present. You end the exam just as Margaret begins to cry, "*I don't like people to touch me there.*"

**What do you think about the physical exam findings?** Most victims of sexual abuse have normal or nonspecific anal and genital exams. Therefore, a normal or nonspecific exam does not rule out the possibility of sexual abuse. Positive physical findings of sexual abuse occur in only 3-16% of victims. The healing process may quickly obscure any evidence of genital or perianal injury. Clinicians should be explicit in noting the physical findings of the genital examination. The hymen should be described in as much detail as possible, and the presence or absence of scars and bruises should be recorded. Most sexual abuse in young children involves fondling or vulvar contact with no resulting trauma and a normal hymenal examination. There are a number of good references with color plates depicting normal and abnormal hymeneal and vulvar findings (see references # 10-12). Several classification systems have been proposed for physical findings in child sexual abuse (see references #8 and 9). Findings suggestive of hymenal penetration include a scar or fresh laceration of the posterior fourchette and a hymenal transection or bruising. Definitive and specific findings are more common in children who reported genital-genital assault than in those who reported digital contact. Remember that both perpetrators and victims may report "vaginal penetration" when *vulvar* coitus has occurred.

**Distribute Handout #1. Ask participants to review Table 1: Classification of Anogenital Findings in Children with Suspected Sexual Abuse and allow a few minutes for discussion.**

**What laboratory tests should be performed if you are concerned about sexual abuse?** The presence of a sexually transmitted diseases (STD) is used by physicians, social service agencies, and the criminal justice system as a means of identifying children who may have been sexually abused. However, STDs are uncommon in asymptomatic children and occur in only 2-15% of sexually abused children. If the rates of STDs in the local adult community are high, the child is more likely to acquire a STD. Some STDs

have a long incubation period and/or an asymptomatic carriage rate, which may lead to a delay in presentation. The most likely STDs to be encountered clinically are: human papilloma virus (presenting as warts), *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, herpes simplex virus, syphilis, and Human Immunodeficiency Virus (HIV).

**Ask participants to review Handout #1, Table 2: STDs in 1538 1-12 Year Old Children Evaluated for Sexual Abuse (1981-1991) and allow a few minutes for discussion.**

Because positive cultures are uncommon in asymptomatic prepubertal children, selective testing is appropriate. Consider testing for sexually transmitted diseases when a child discloses genital-genital, oral-genital, or anogenital contact; if you see an anogenital discharge, bleeding, or another abnormality on physical exam; or if the child discloses sexual contact with a person who has a history of an STD. Furthermore, any child who is found to have one STD should be tested for others (e.g., genital warts should trigger testing for syphilis, etc). Adolescent victims should be tested and treated for STDs even if they are asymptomatic. In contrast, treatment in prepubertal children is initiated on the basis of a positive culture. HIV prophylaxis protocols are evolving, but are applicable only for acute assaults (<36 hours, possibly 72 hours).

When STD testing is performed, the CDC recommends (see reference #13) the following: cultures for *Neisseria gonorrhoeae* from the pharynx, anus, and vagina (urethra in males), cultures for *Chlamydia trachomatis* from the vagina and anus, cultures of any ulcerative lesions for herpes simplex virus (HSV), wet mount for *Trichomonas vaginalis*, and inspection of the anogenital and oral areas for human papillomavirus (HPV). Hepatitis B screen (if not immunized), serology for syphilis (RPR, VDRL) and HIV testing should also be considered. Recommendations vary on HIV testing. Experts generally agree that victims who have had exposure to semen, who have symptoms of HIV infection, or who have been abused by a perpetrator who is HIV positive or has another STD should have HIV counseling and testing.

**Ask participants to review Handout #1, Table 3: Guidelines for Making a Decision to Report Child Sexual Abuse and Table 4: Common STDs, and allow a few minutes for discussion.**

**What further steps are indicated at this point?** A careful interview is essential. This can best be performed by a clinician with special training in evaluation and treatment of children who have been sexually abused. A child may disclose sexual abuse during the course of a routine history or physical examination. Should this happen, carefully record the child's disclosure in his or her own words and note whether the disclosure was made spontaneously. You may play an important role as the first professional to hear the child's disclosure of abuse. The medical provider's role in reporting what a child says has a legal stature and is an exception to the hearsay rule in most states.

After an initial disclosure, clinicians may want to consider the following questions while taking a history: "Do you know why you are here today?", "Can you tell me what

*happened?”, “How did it begin? What happened?”, “Did anything change? Where?”, “Where was everyone else?”, “Why tell now? Has anybody told you to keep it a secret?”, “Have you been hurt?”, “And then what happened?”, “What were you wearing?”, “What did the room look like?”* Older children and adolescents may be aware of whether ejaculation occurred. Remember that the first report may not be the first incident.

Clinicians must carefully record in the medical record the wording of each question asked, and the child's specific response. Special care should be taken when abuse allegations occur in the context of a child custody case or divorce. It is generally recommended that the clinician not interview the child by him or herself, as the disclosure interview is best conducted by the most experienced professional possible. If you suspect sexual abuse, you need to file a report on the child's behalf with your local child protective services agency. All clinicians in the United States are required under the laws of each state to report cases of known or suspected child abuse. Failure to report can result in potential prosecution. Statutes generally provide immunity from lawsuits when reports are subsequently unsubstantiated, provided that they were made in good faith. Once a report is filed, child protective services and law enforcement personnel conduct an investigation that usually includes interviews of the child and all pertinent adults. Often a referral will be made for the child and family to receive supportive psychological counseling after the investigation is complete. In Margaret's case, you will probably need more information before filing.

**Distribute the Bibliography page and Epilogue. Ask someone to read the Epilogue aloud.**

### **Epilogue**

You refer Margaret and her family to a psychiatric social worker who has expertise in child sexual abuse. During these sessions, she discloses that her Uncle Bob *“put his finger in my pee-pee and it hurt. He told me it was our secret and not to tell. I don't like him.”* A report of suspected child sexual abuse is filed on Margaret's behalf. Margaret is referred for longer term counseling, and her behavioral symptoms gradually resolve.

You see her back at a follow-up visit in 6 weeks and she appears to be doing well. Her enuresis has resolved.

**Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.**

**Independent Learning/Prevention Exercises:** Facilitators may wish to assign “Independent Learning/Prevention Exercises” to the group, particularly if time constraints hinder the completion of the case. The following list includes suggestions to explore the available community resources that focus on Child Sexual Abuse, as well as other avenues of pertinent interest that can be integrated during or after the session. If the exercise is done in the absence of the facilitator, learners should take notes on their experience, then discuss with a faculty member for feedback.

1. Brainstorm/role play with group: “How to counsel parents in the office setting on ‘keeping kids safe’.”
2. Find what supports/curricula on sexual abuse prevention are in place in local schools and how they deal with disclosure.
3. Visit a crisis center/support group for victims of sexual abuse.
4. Identify treatment programs for adolescent sexual offenders.
5. Interview a victim’s advocate in court and learn about the process.



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### **Handout #1: Important Information on Child Sexual Abuse**

**Table 1: Classification of Anogenital Findings in Children with Suspected Sexual Abuse**

Muram's Classification	
Category 1	Normal-appearing genitalia
Category 2	Nonspecific findings: abnormalities of the genitalia that could have been caused by sexual abuse but also are often seen in girls who are not victims of sexual abuse (e.g. inflammation and scratching). These findings may be due to poor perineal hygiene or nonspecific infection (e.g. redness of the external genitalia, increased vascular pattern of the vestibular and labial mucosa, presence of purulent discharge from the vaginal, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora).
Category 3	Specific findings: the presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, procto-episiotomy (a laceration of the vaginal mucosa extending to the rectal mucosa), and indentations in the skin indicating teeth marks (bite marks). The category also includes patients with laboratory confirmation of a venereal disease.
Category 4	Definitive findings: any presence of sperm

(Adapted from Muram D. Classification of genital findings in prepubertal girls who are victims of sexual abuse. *Adolescent and Pediatric Gynecology* 1988;1:151.)

**Table 2: STDs in 1538 1-12 Year Old Children Evaluated for Sexual Abuse (1981-1991)**

<i>Neisseria gonorrhoeae</i>	2.8%
<i>Chlamydia trachomatis</i>	1.2%
Human papillomavirus	1.8%
<i>Treponema pallidum</i>	0.1%
Herpes simplex virus	0.1%

(Adapted from Ingram DL, Everett VD, Lyna PR. Epidemiology of adult sexually transmitted disease agents in children being evaluated for sexual abuse. *Pediatr Infect Dis J* 1992;11:945.)

**Table 3: Guidelines for Making the Decision to Report Child Sexual Abuse**

Data Available			Response	
<i>History</i>	<i>Physical</i>	<i>Laboratory</i>	<i>Level of concern about sexual abuse</i>	<i>Action</i>
None	Normal exam	None	None	None
Behavioral Changes	Normal exam	None	Variable	± Report*, follow closely (possible mental health ref)
None	Nonspecific findings	None	Low	± Report*, follow closely
Nonspecific history by child or history by parent only	Nonspecific findings	None	Possible	± Report*, follow closely
None	Specific findings	None	Probable	Report
Clear Statement	Normal exam	None	Probable	Report
Clear Statement	Specific findings	None	Probable	Report
None	Normal exam, nonspecific or specific findings	+ culture for gonorrhea; + serologic test for syphilis or HIV; presence of semen, sperm, acid phosphatase	Very High	Report
Behavioral Changes	Nonspecific changes	Other sexually transmitted diseases	Probable	Report

\* A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective service agencies.

(Adapted from American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1999;103:186-191)

**Table 4: Common STDs: Diagnosis and Reporting of Sexual Abuse of Children**

<i>Confirmed STD</i>	<i>Sexual Abuse</i>	<i>Suggested Action</i>
Gonorrhea <sup>1</sup>	Diagnostic	Report <sup>2</sup>
Syphilis <sup>1</sup>	Diagnostic	Report
<i>Chlamydia trachomatis</i> <sup>1</sup>	Diagnostic <sup>3</sup>	Report
<i>Condyloma acuminata</i> <sup>1</sup>	Suspicious	Report
<i>Trichomonas vaginalis</i>	Highly Suspicious	Report
Herpes simplex virus type 1 (genital)	Possible	Report <sup>4</sup>
Herpes simplex virus type 2	Suspicious	Report
Bacterial vaginosis	Uncertain	Medical follow-up
<i>Candida albicans</i>	Unlikely	Medical follow-up

<sup>1</sup>if not acquired perinatally, <sup>2</sup>to agency mandated in community to receive reports of suspected sexual abuse,

<sup>3</sup>culture only reliable diagnostic method, <sup>4</sup>unless there is a clear history of autoinoculation

(Adapted from American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1999;103:186-191)

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## **Suggested Readings (Annotated):**

**American Academy of Pediatrics. Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children. *Pediatrics* 1999;103:186-191.** This article presents an excellent overview and includes discussion of the definition of child sexual abuse, how children present to the pediatrician, and the important elements of the history and physical examination, treatment, and legal issues.

**Levitt C. The medical examination in child sexual abuse: a balance between history and exam. *Journal of Child Sexual Abuse* 1992;1:113-121.** This article integrates the physical examination with the process of history taking and emphasizes the importance of a well-documented medical history in the evaluation of the sexually abused child. A discussion of physical findings and the use of the colposcope are also included.

## **Educational Resources on the World Wide Web:**

*American Academy of Child and Adolescent Psychiatry—Facts for Families*. This site provides access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The information sheets on Child Sexual Abuse are #9 and #28.

<http://www.aacap.org/publications/pubcat/facts.htm>