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**Recognizing child sexual abuse**

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## The guideline “Diagnostics for (alleged) sexual abuse in children”

De richtlijn “Diagnostiek bij (een vermoeden van) seksueel misbruik bij kinderen”

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## Summary

Pediatricians are often confronted with (alleged) sexual abuse in children. Confirming or excluding child sexual abuse (CSA) knows many challenges and requires careful evaluation by trained professionals. This also involves the expertise of forensics, child protective services (CPS) and consulting an expert in infectious diseases on prophylactic treatment for human immunodeficiency virus (HIV). Examining alleged CSA requires multidisciplinary, and often transmural, collaboration. All the above complicates diagnostics in alleged CSA. This paper discusses the most important recommendations concerning diagnostics in (alleged) CSA as discussed in detail in the guideline published by the Dutch Pediatric Society (Nederlandse Vereniging voor Kindergeneeskunde, NVK) <sup>1</sup>.

## Introduction

Pediatricians are regularly asked whether a patient could be sexually abused. CSA is more prevalent than many physicians think. It is estimated that about one third of the Dutch children between 0-18 years of age (41% girls, 23% boys) becomes a victim of some kind of sexual violence <sup>2</sup>.

### What is considered CSA?

In the following situations we speak of CSA:

- Children up to 12 years old: any sexual contact, both penetrative as fumbling, whether or not combined with force or violence (with the exclusion of sexual play between children below the age of 12, who are of the same age (< 3years difference) and developmental level).
- Children between 12-16 years: any sexual contact, both penetrative as groping, in principle whether or not combined with force or violence, unless it concerns a voluntary relation between sexually equal partners of about the same age.
- Children between 16-18 years: any sexual contact, both penetrative as groping, with: force/violence; gifts of money or goods; a perpetrator with a special character (parent, teacher, caregiver, etc.); prostitution or working for peepshows; coercion to have sex with someone.
- Children <16 years: if pornographic images are displayed or if the child is present while others have sexual contact, or if appointments are made with the child with the purpose to have sexual contact.
- Children <18 years: if pornographic images are made of the child or another type of sexual exploitation (like prostitution) takes place.

With 'force and coercion' we also mean the psychological coercion in a dependency relationship between a minor and an adult.

### Differentiating between acute and non-acute settings

The first question a clinician has to answer in cases of alleged CSA is whether this child needs to be evaluated acutely. This is relevant for acute somatic or psychiatric help and/or to find possible traces at forensic investigation. Acute evaluation needs to be considered in the following situations: the last sexual contact was up to seven days ago; there is genital pain, genital blood loss or injuries; there are severe psychosocial symptoms such as suicidal or self-injurious behavior or suicidal thoughts.

Figure 1. Flow diagram - acute situations

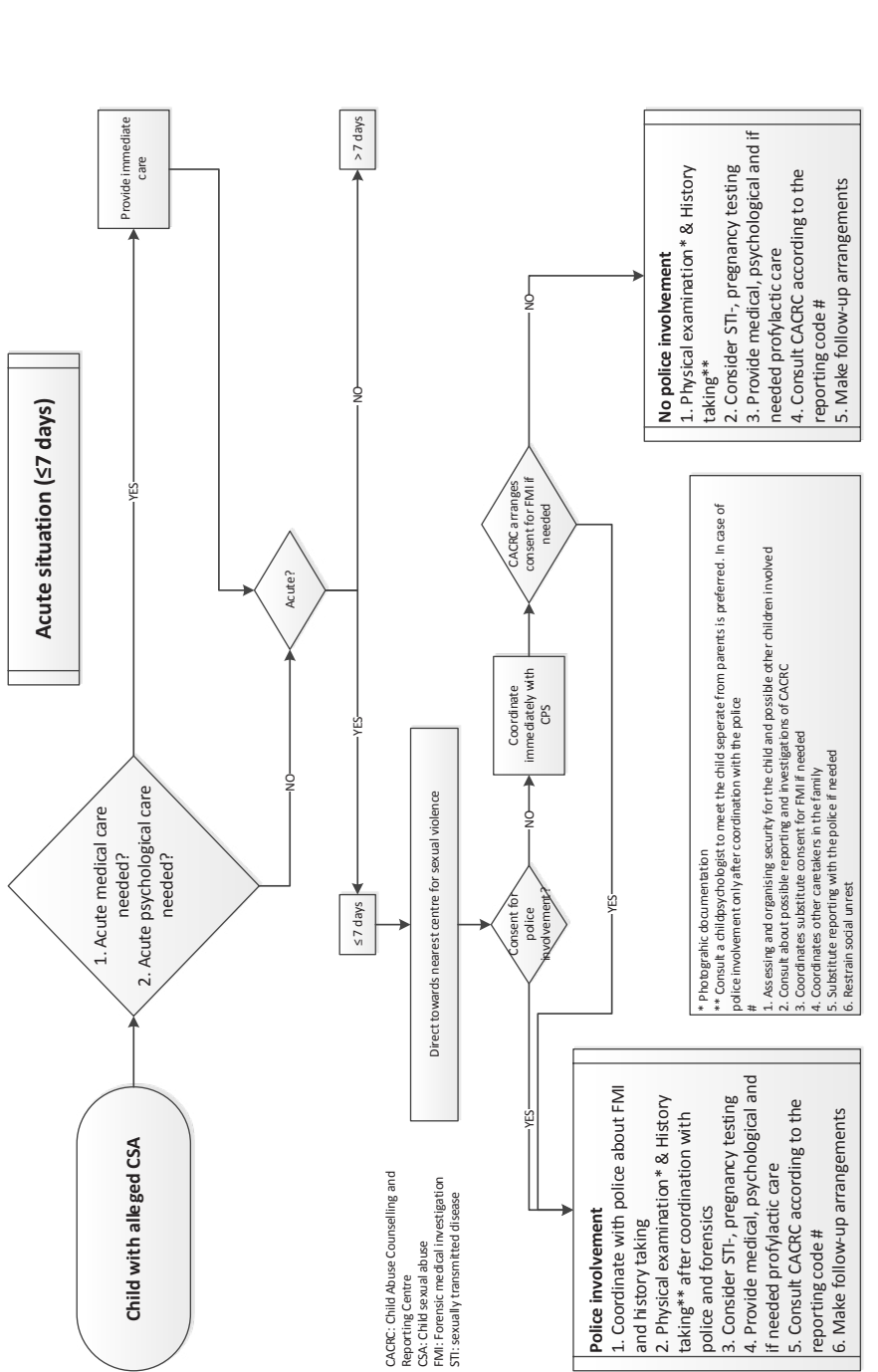
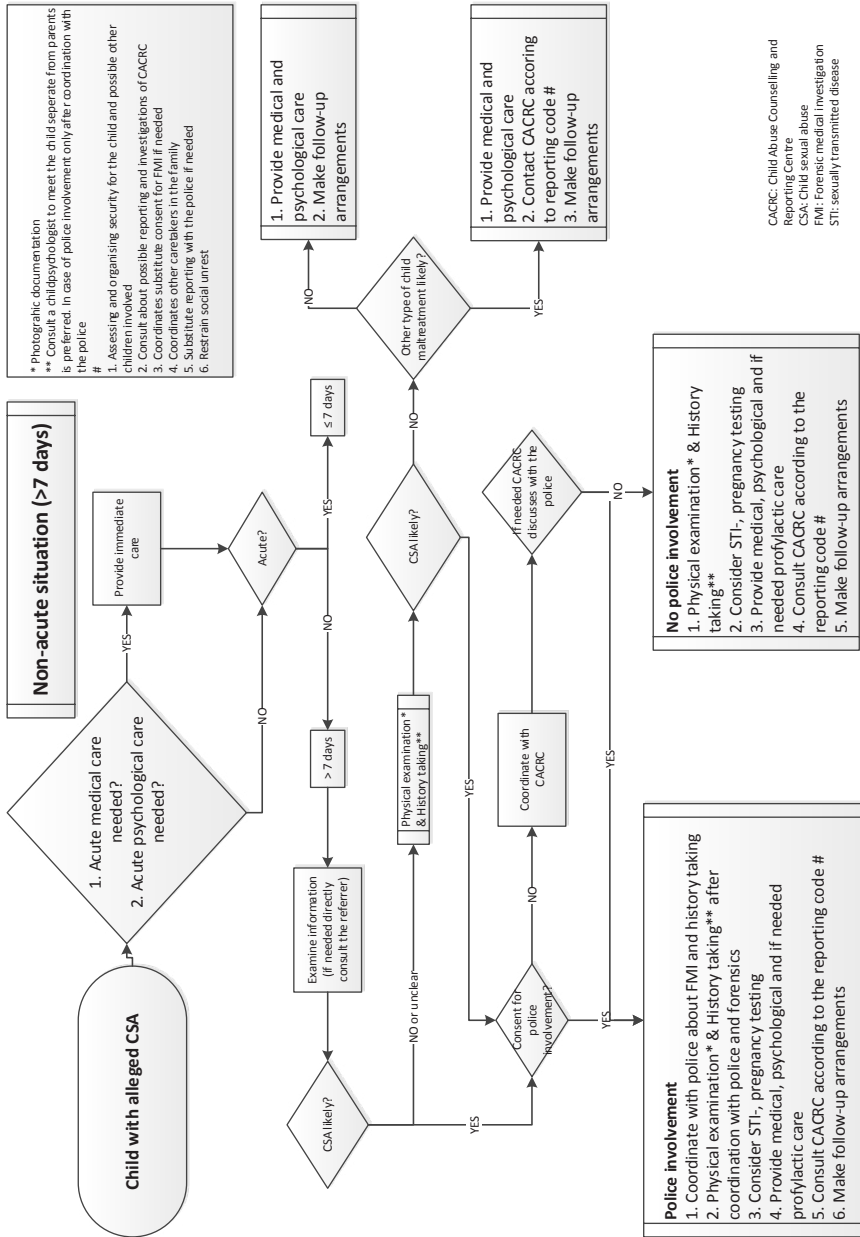


Figure 2. Flow diagram - non-acute situations



\* Photographic documentation  
 \*\* Consult a child psychologist to meet the child separate from parents & preferred. In case of police involvement only after coordination with the police

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1. Assessing and organising security for the child and possible other children involved
2. Consult about possible reporting and investigations of CACRC
3. Coordinates substitute consent for FMI if needed
4. Coordinates other care takers in the family
5. Substitute reporting with the police if needed
6. Restrain social unrest

1. Provide medical and psychological care  
 2. Make follow-up arrangements

1. Provide medical and psychological care  
 2. Contact CACRC according to reporting code #  
 3. Make follow-up arrangements

**No police involvement\* & History taking\*\***

1. Physical examination\* & History taking\*\*
2. Consider STI-, pregnancy testing and if needed prophylactic care
3. Provide medical, psychological and if needed reporting code #
4. Consult CACRC according to the reporting code #
5. Make follow-up arrangements

**Police involvement**

1. Coordinate with police about FMI and history taking
2. Physical examination\* & History taking\*\* after coordination with police and forensics
3. Consider STI-, pregnancy testing
4. Provide medical, psychological and if needed prophylactic care
5. Consult CACRC according to the reporting code #
6. Make follow-up arrangements

CACRC: Child Abuse Counseling and Reporting Centre  
 CSA: Child sexual abuse  
 FMI: Forensic medical investigation  
 STI: sexually transmitted disease

In these cases immediate contact should be sought with the nearest center for sexual violence [Centrum voor Seksueel Geweld] (<http://www.centrumseksueelgeweld.nl>), where all needed expertise is present.

In all other cases it is important that the child is examined by a pediatrician with sufficient experience in evaluating alleged CSA, conducting and assessing the anogenital examination. (with knowledge of both normal and deviant anatomy). Figure 1 & 2 display flow diagrams helpful to make the right decisions. When children are presented with alleged CSA in a dependency relationship clinicians need to contact a confidential doctor of Child Abuse Counseling and Reporting Center (CACRC) [Veilig Thuis] in an early stage with the primary goal to seek anonymous advice and in case necessary make a report (according to the Dutch Royal Society of Medicine Reporting code for reporting child abuse [KNMG-Meldcode Huiselijk Geweld en Kindermishandeling])<sup>3</sup>.

### **History taking**

History and psychologic evaluation need to be executed by competent professionals with sufficient experience. Besides knowledge on CSA, knowledge on other psychopathology is also needed (like autism and mental disabilities) and for example on violent divorces. Besides a pediatrician also a child psychiatrist or psychologist needs to be consulted. Be alert for unexplained physical complaints, inappropriate sexual behavior, symptoms of post-traumatic stress, internalizing and externalizing behavioral problems, regression and behavioral problems in general. Not one symptom on its own is sufficient to indicate CSA.

There are several validated questionnaires that might be of diagnostic value: Children's Revised Impact of Event Scale, Child Sexual Behavior Inventory, and Trauma Symptom Checklist for Young Children, Trauma experience questionnaire [Schokverwerkingslijst voor Kinderen – kindversie/ouderversie], Adult Attachment Interview and Childhood Trauma Questionnaire.

### **Physical examination**

The physical examination exists of a general pediatric examination, supplemented with a top-to-toe and anogenital examination. The preference is not to end the physical examination with the anogenital examination. The behavioral reaction of the child during the examination needs to be observed and documented. Photographic documentation of the anogenital examination is essential for a proper assessment <sup>4</sup>. Additionally, this allows for the consultation of forensic medical expertise without the need to examine the child again.

Acute evaluation (up to the seventh day after the last sexual contact) needs to be performed as soon as possible, at least within 24 hours, and preferably in the presence of a forensic physician. If the situation allows, collection of forensic evidence by the forensic physician is done before examination by the pediatrician. Collecting forensic evidence can only take place in presence of the police. Obviously, the authoritative parent and (depending on the age) the child itself need to consent with the investigations.

The anogenital examination in prepubertal girls needs to be executed in supine (frog-leg) and knee-chest position. The hymenal edges are very sensitive; touching the hymen needs to be avoided. Examination of pubertal girls can be performed in supine 'frog-leg' position with the use of water moistened swab or sterile Foley catheter (if indicated) as labial separation and/or tractions will be insufficient to demonstrate the hymenal edges. The use of anesthetics needs to be avoided. Assessing for anal dilatation has no value under anesthesia.

In the guideline a detailed description is given on the various anogenital findings and the associations with CSA and other differential diagnosis. In the Dutch Royal Society of Medicine Reporting code for reporting child abuse [KNMG-Meldcode Huiselijk Geweld en Kindermishandeling]<sup>3</sup> it is mentioned explicitly the possibility to consult forensic medical expertise for the interpretation of anogenital findings. Forensic medical expertise can be consulted anonymously. In the Netherlands forensic medical expertise is available among confidential doctors of CACRC, regional trained pediatricians, the Dutch Forensic Institute [Nederlands Forensisch Instituut] and since 2014 the Dutch Expertise Center for Child Abuse [Landelijk Expertise Centrum Kindermishandeling], (LECK, [www.leck.nu](http://www.leck.nu)) this is the only organization where pediatric and medical forensic expertise are combined.

### **Additional investigation**

CSA needs to be considered when sexual transmitted infections (STIs) are diagnosed and other transmission routes and consensual sexual contact (in older children) have been excluded. Consider STI-screening (Table 1): in all children with alleged or confirmed CSA; in children with symptoms that can indicate an STI; unprotected consensual sexual contact in the past; anogenital injuries.

The preference is to test the perpetrator if possible. If STI-testing is indicated testing on multiple locations should be done low threshold (genital (vestibular – girls, urine – boys), oropharyngeal, anal). Inform in advance about the available tests, medium and transportation available in your institute.



**Table 1. Diagnostics for Sexual Transmitted Infections**

Group	Criteria for testing	Immediately
Prepubertal and pubertal girls intolerant for speculum	STI testing need to be considered: <ul style="list-style-type: none"> <li>- In cases of alleged or confirmed CSA;</li> <li>- Symptoms or complaints indicating STI;</li> <li>- Unprotected consensual sexual contact;</li> <li>- Anogenital injury.</li> </ul>	Vestibular swab and/or first catch urine (20 ml): NAAT on CT, Ng; Culture for TV. On indication: Oral swab: NAAT on CT, Ng; Anal swab: NAAT on CT, Ng. Ulcers/blisters swab: NAAT HSV and syphilis and serology for syphilis. In high risk cases: new generation HIV test and serology: HIV, HBV, HCV, syphilis.
Pubertal girls (potentially tolerant for speculum)		Vulvovaginal or vestibular swab: NAAT on CT, Ng; Culture for TV. On indication: Oral swab: NAAT on CT, Ng; Anal swab: NAAT on CT, Ng. Ulcers/blisters swab: NAAT HSV and syphilis and serology for syphilis. Discharge: high vaginal swab (in case speculum is used cervical swab). In high risk cases: new generation HIV test and serology: HIV, HBV, HCV, syphilis.
Boys		First catch urine (20 ml): NAAT: CT and Ng. On indication: Oral swab: NAAT on CT, Ng; Anal swab: NAAT on CT, Ng. Ulcers/blisters swab: NAAT HSV and syphilis and serology for syphilis. Discharge: meatal swab (prepubertal) or urethra tip swab (pubertal): NAAT on CT, Ng.

In general:

- In cases NAAT is positive for CT and/or Ng a second NAAT in another sequence needs to be performed (preferably from the same sample) and a culture for possible resistance of Ng. On indication repeat after at least 4 weeks;

## Treatment

Prophylactic treatment needs to be considered for: syphilis, if the possible perpetrator is known with a contagious syphilis; hepatitis B: vaccinate, in case a child has not been vaccinated and presents <6 weeks after the last sexual contact; hepatitis B: immunoglobulins, in case the possible perpetrator is positive for hepatitis B-eAg/sAg-positive and the child is presented < 48-72 hours (preferably), but at least within seven days after the incident; HIV: post exposure prophylactics when unprotected anal/vaginal penetration has occurred, risk factors for HIV in the possible perpetrator need to be taken into account, always consult an STI-specialist or (child)infection specialist first; N. gonorrhoea and C. trachomatis are preferred to be treated in case of positive testing.

2 weeks	4-6 weeks	8 weeks	3 months
Repeat swabs as advised under 'immediately'	New generation HIV test and serology for syphilis (in high risk cases and untreated)	New generation HIV test and HBV en HCV (in high risk cases and untreated)	New generation HIV test (in high risk cases)

Repeat swabs as advised under 'immediately'

Repeat swabs as advised under 'immediately'

- Speculum should not be used primarily for STI-testing. In prepubertal girls the use of a speculum is never indicated;
- Consult a local microbiologist about the available tests, medium and transportation and number of swabs needed.

Consider (after consulting a (child) gynecologist) prophylaxis for pregnancy. Per case it needs to be considered whether trauma treatment is needed. When there are no symptoms of post-traumatic stress at the time of the assessment it can be decided to choose for 'watchful waiting'. Clear agreements need to be made about who is responsible for what during the follow-up.

Do not forget to explain parents/caretakers and the child about the medical follow up and also the judicial path.

### Recommendations and bottle necks

In cases of alleged CSA many aspects need to be taken into account: Clinicians and patients can show emotional reactions, the (lack of) findings can introduce insecurity

about the alleged CSA, and there are many logistic challenges. Therefore, it is important that every hospital makes its own protocols based on the guideline. Areas of concern are to include contact information of collaborative partners, such as the nearest center for sexual violence, CACRC, psychologists, microbiologists and centers of expertise for consultation. Clear agreements on collaboration need to be made with various disciplines involved in diagnostics, treatment, and prevention of CSA. Collaborating with other disciplines and caretakers is essential.

## Abbreviations

CACRC	Child Abuse Counseling and Reporting Center
CPS	Child protective services
CSA	Child sexual abuse
CT	Chlamydia trachomatis
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HSV	Herpes simplex virus
HIV	Human immunodeficiency virus
LECK	Landelijk expertise centrum kindermishandeling
NAAT	Nucleic acid amplification tests
Ng	Neisseria gonorrhoeae
STI	Sexually transmitted infection
TV	Trichomonas Vaginalis

## References

- 1 Teeuw, A. H., Vrolijk-Bosschaart, T. F. & Langendam, M. W. [Guideline: Diagnostics for (alleged) child sexual abuse] Richtlijn: Kindermishandeling, Diagnostiek bij (een vermoeden van) Seksueel Misbruik bij kinderen; Nederlandse Vereniging voor Kindergeneeskunde (NVK). (Utrecht, 2016).
- 2 Mensenhandel, N. R. Kinderpornografie – Eerste rapportage van de nationaal rapporteur., (Bureau Nationaal Rapporteur Mensenhandel, Den Haag: BNRM, 2011).
- 3 KNMG - Meldcode Huiselijk geweld en Kindermishandeling. (Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), maart 2012).
- 4 Kurpershoek, J. Forensische foto's van letsel - Een goede foto van letsel bij een slachtoffer van geweld, kan de doorslag geven tussen vrijspraak en een veroordeling. Maar een goede foto maken is nog niet zo eenvoudig. *Blauw 2* (2014).