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Recognizing child sexual abuse

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10

Summary

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The prevalence of child sexual abuse (CSA) is high¹ and the consequences can be severe²⁻⁴. Unfortunately, CSA remains unrecognized in the majority of cases⁵. In the introduction (**Chapter 1**) we delineate the most important difficulties in the assessment of alleged CSA. First, children are often restrained to disclose CSA due to various reasons, such as fears, shame and linguistic or verbal limitations. Second, most symptoms are non-specific for CSA. Third, signs of penetrative trauma at anogenital examination are often absent. Fourth, until other transmission routes have been excluded, diagnosing a sexually transmitted infection (STI) in a child is not conclusive for CSA. To improve recognition of CSA, more knowledge on the wide variation of psychosocial and physical complaints in CSA-victims is needed. We aimed to increase knowledge regarding the symptoms and behavior which can be displayed in children who experienced CSA. In this thesis we investigated the diagnostic value of different aspects in the psycho-medical evaluation of alleged child sexual abuse (CSA). In part I (**Chapters 1-5**) we pursued the pediatric assessment of alleged CSA, whereas part II (**Chapter 6-8**) reports on the psychosocial and physical complaints, the sexual behavior and sexual knowledge in children involved in the Amsterdam Sexual Abuse Case (ASAC).

Part I

Chapter 2 is a summary of the most important recommendation from the Dutch guideline 'Diagnostics in alleged child sexual abuse [Diagnostiek bij (een vermoeden van) seksueel misbruik in kinderen]'⁶. This is the first Dutch guideline for pediatricians on CSA and the diagnostic approach in these children. In this manuscript we describe the steps for pediatricians to take in evaluating CSA (e.g. differentiating between acute and non-acute situations, history taking, physical examination and testing for sexually transmitted infections). Additionally, we address the need for cooperation with other disciplines like the police, child protection services and psychological care.

In **Chapter 3** we investigated the diagnostic utility of the Child Sexual Behavior Inventory (CSBI) to differentiate between sexually abused and non-abused children. Although CSBI-total scores were significantly higher in CSA-victims compared with non-abused children (in case-control settings), research in a clinical setting (among children with alleged CSA) is limited and showed disappointing results. Based on the systematic review of the available literature we concluded that the CSBI should not be used on its own to differentiate between sexually abused and non-abused children. The CSBI can be used to systematically assess children's sexual behavior as a part of the pediatric assessment of alleged CSA.

We retrospectively studied the clinical profiles of 236 children assessed for alleged CSA by a multidisciplinary team (consisting of a pediatrician, social worker and child behavioral specialist) at an Academic Children's Hospital in Amsterdam (AMC), the Netherlands (**Chapter 4**). In almost half of the cases the mother was the person suspecting CSA. Physical complaints were reported in 59.7% of the children. However, we found no significant difference between children in whom CSA was either considered highly suspected or proven versus children in whom suspicion was lower.

Of the 236 children assessed for alleged CSA only one child showed signs of penetrative trauma (a laceration of the hymen), this girl was seen in the acute situation. Yet, in 18.6% ($n=44$) of the children concerning behavioral reactions during the anogenital examination were noted, such as anxiety (9.8%, $n=23$), shyness (2.9%, $n=7$), uncooperative behavior (2.9%, $n=7$), theatrical behavior (1.7%, $n=4$) or other concerning behavioral reactions (1.3%, $n=3$). In only 2.9% STIs were found and 0.4% of the children tested positive for pregnancy.

CSA was highly suspected or proven in over a third of the children. In cases of conflict divorces, CSA was significantly less often highly suspected or proven.

A total of the 33 interviewed children (18.3%) gave a disclosure of CSA most likely by an adult person. We found that in the children who gave a disclosure during the child interview, CSA was considered significantly more often proven or highly suspected based on the entire assessment (91% vs. 16%, $p=0.000$). A child's disclosure of CSA is considered valuable by involved professionals in the assessment of alleged CSA.

In a scoping review (**Chapter 5**) we aimed to give an overview of the definitions and instruments used, and of two important design aspects, the selection of cases and controls and the use of blinding in published comparative studies investigating the association between CSA and functional somatic symptoms (FSS). In the included studies we found that a considerable amount of relevant information was not reported, and we found a wide variety in study designs, definitions, origins of samples, methods and instruments used for data collection. Rarely the outcome assessor was kept blind to the determinant. Comparability of samples was often low or information on this aspect was insufficient. To be able to interpret the results of studies performed to generate knowledge on the association between CSA and FSS, there are four key-elements which are important: the used definitions, determination of outcomes, the selection of cases and controls, and keeping the outcome and determinant blind for the assessors. Unfortunately, the diversity in methods used in studies on this subject makes it impossible to combine prevalence rates quantitatively and to compare results between studies. To make valid comparisons on the

association of CSA and FSS, it is required that researchers use adequate study designs and methods, and develop internationally agreed definitions, 'core sets' of instruments to determine and rule out CSA and FSS for research purposes.

Part II

In 2010, a day-care center employee and babysitter in Amsterdam sexually abused dozens of young children. Many very young children, mostly boys, were considered possible victims in what was called the Amsterdam Sexual Abuse Case (ASAC)—the largest confirmed CSA case in history⁷. The ASAC is a unique case, due to its large scale, the predominance of young boys, the confessing and convicted perpetrator, the high level of evidence, and detailed documentation available about the abuse. Child pornographic images were decrypted in police investigations, and the employee admitted CSA of 87 children. Parents of 20 children decided against pressing charges, and the day-care worker was convicted for abusing 67 children.

In the Emma Children's hospital of the AMC, an emergency outpatient department (OPD) was set up to examine 130 possible victims of CSA involved in the ASAC (of whom 54 were confirmed victims). Children were referred to the AMC if there was a strong suspicion of CSA (the child was currently (or previously) visiting a day-care center where the perpetrator worked), or the perpetrator currently (or previously) worked as a babysitter at the child's home; or when a child was a confirmed victim of CSA (identification of the child via encrypted pornographic images detected by the police or the perpetrator gave a confession).

In a mixed method study, we analyzed the psychosocial symptoms (**Chapter 6**) of 125 children with confirmed or strongly suspected CSA, and the interpretations given to symptoms by independent clinical experts, who were blinded for the police information. Secondly, we examined whether experts were able to identify confirmed victims of severe CSA.

We identified four themes among the psychosocial symptoms: problems concerning emotions, behavior, toilet training, and development, whether or not associated with the daycare center or the perpetrator.

Clinical experts identified signs of post-traumatic stress disorder (PTSD), regression in continence skills (not otherwise explained), and problems triggered by exposure to the perpetrator or the abuse location as concerning symptoms for CSA. Less concerning symptoms were designated as worrisome if they were numerous and there was no clear explanation for these non-specific symptoms.

For many confirmed victims the experts had no to low concerns for CSA. We strongly believe that this is not a reflection of poor judgment by the experts, but a reflection that many of the children who are abused do not show psychological problems, neither physical injuries. Out of the 32 children who experienced oral copulation and/or anal/vaginal penetration, 12 of the 15 children who were scored as “not-worrisome – somewhat worrisome” did not show any psychosocial problems in their medical files.

At the same time, many children without confirmed CSA still showed problems leading to concerns for CSA among the experts. It is possible that there were victims of CSA among these children, or that they witnessed CSA in other children, as most of the abuse took place at the daycare center or at home in the presence of other children or siblings.

This led us to the conclusion that it is difficult for experts to identify confirmed CSA victims. Thus, the assessment of suspected CSA should be over time and multidisciplinary.

Subsequently, in **Chapter 7**, we investigated: (A) what types of sexual behaviors and knowledge were reported by parents of young children assessed for CSA; (B) in what cases such behaviors and knowledge were worrisome; and (C) how such children responded verbally and non-verbally during child interviews. In this mixed-methods study, we identified themes from (1) the parent reports: sexual behavior (e.g. self-stimulation, touching others, imitation of sexual acts), fears and anxiety with regard to sexuality, and sexual utterances (sexual slang, references to sexual acts); and (2) the child interviews: behavioral reactions (avoidance, distractive behaviors), emotional reactions (anger, aggression), and verbal reactions (conspicuous utterances, refusal to talk about specific subjects). In 37% of the children the sexual behavior and knowledge was deemed worrisome or very worrisome. We advised clinicians who assess children for CSA to include sexual behavior problems and sexual knowledge in their medical history.

In **Chapter 8** we analyzed the physical complaints, physical examination and outcomes of laboratory tests for sexually-transmitted infections (STIs) and pregnancy, in the 54 confirmed victims (predominantly preschool boys) of CSA, using mixed methods: descriptive analysis of physical complaints, physical exams and the results of STI tests from medical files combined with a qualitative analysis on expert’s interpretations of physical complaints and children’s behavior during physical examination.

Physical complaints were reported in 50% of the children, of which gastrointestinal and anogenital complaints were most common. Abdominal pain and constipation were reported in 22% of the confirmed CSA victims. These findings however, were considered as nonspecific for CSA.

None of the children showed CSA-specific genital signs at physical examination. Most prominent finding during physical examination was a deviant behavioral response (anxiety, withdrawal, too outgoing) in 28% of the children ($n=15$). In children who experienced anal/vaginal penetration clinicians reported significant more behavioral reactions compared to children who did not experience anal/vaginal penetration (47% versus 19%, $p=.041$). According to our experts especially behavioral changes observed related to the anogenital examination were considered to be most worrisome.

None of the children tested for STIs were found positive for HIV, Hepatitis B and C, syphilis, chlamydia or gonorrhea. Ten children were found to be IgG positive for herpes simplex virus, but in none of the children genital herpes was reported.

Deviant behavioral reactions during physical examination were the most prominent finding. We recommend precise observation of a child's behavior during physical examination.

In **Chapter 9** we discussed the diagnostic evaluation of alleged CSA. A complete assessment, in case of suspected CSA, exists of: medical interview and child interview (parents and child separate and together) with special attention to the child's development and behavior (problems), psychosocial situation and physical complaints, the child's mental health and the child's trauma history; anogenital examination should be done in all cases of alleged CSA. The examination should be documented by photo or video graphically. Recent research suggest that videography, may be the preferred method; and testing on STIs (NAAT on vaginal swabs or urine samples for chlamydia and gonorrhea, and vaginal cultures for *Trichomonas* are the preferred tests). The assessment should be done multidisciplinary by experienced professionals. Health care professionals who care for children need to know how child protective agencies and law enforcement are organized. In case there are concerns about a child's safety the appropriate authorities should be alarmed.

Abbreviations

AMC	Academic Medical Center, Amsterdam
ASAC	Amsterdam Sexual Abuse Case
CSBI	Child Sexual Behavior Inventory
CSA	Child sexual abuse
FSS	Functional somatic symptoms
NAAT	Nucleic acid amplification tests
OPD	Outpatient department
PTSD	Post-traumatic stress disorder
STI	Sexually transmitted infection