Recognizing child sexual abuse

An unrelenting challenge

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General discussion
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In this thesis we studied the diagnostic value of different aspects in the psycho-medical evaluation of alleged child sexual abuse (CSA) and we assessed the pediatric assessment of alleged CSA (part I). Subsequently, in part II, we focused on the psychosocial and physical complaints, the sexual behavior and sexual knowledge, and the outcomes of the physical examinations in children involved in the Amsterdam Sexual Abuse Case (ASAC).

In part I we delineate that it is difficult for clinicians to recognize CSA in children as in most cases there is no disclosure, often there are only non-specific symptoms (assuming that there are symptoms), often anogenital examination is not contributive and tests for STIs and pregnancy are negative. Therefore, in the Dutch guideline, it is recommended that alleged CSA is assessed systematically by multidisciplinary teams with expertise in CSA. The Child Sexual Behavior Checklist (CSBI) is an instrument to assess sexual behavior in children but cannot be used on its own to distinguish between sexually abused and non-abused children. When evaluating the outcomes of the assessment of alleged CSA at the outpatient department (OPD) we found that children's disclosures of CSA are a valuable part in the evaluation. While reviewing studies on CSA and functional somatic symptoms we found that a considerable amount of relevant information was not reported, and a wide variety in study designs, definitions, origins of samples, and the methods and instruments used for data collection. The diversity in methods used in studies on this subject makes it impossible to combine prevalence rates quantitatively and to compare results between studies.

Among the 125 children included in the ASAC-study (part II) we found that many proven victims of CSA show no psychosocial symptoms, worrisome sexual behavior or knowledge, or signs at anogenital examination.

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.

Among the 125 children included in the mixed method study on sexual behavior and knowledge, we found worrisome or very worrisome sexual behavior or knowledge in 37% of the children.
And even though, anogenital findings specific for CSA are often lacking, deviant behav-
ioral reactions during physical examination were reported significantly more frequently
in children who experienced anal/vaginal penetration. Precise observation of a child’s
behavior during physical examination is recommended.

Based on the outcomes of our studies we were able to make recommendations for clinical
practice and future research in the field of CSA. These will be discussed in the following
paragraphs.

**Recommendations for clinical practice**
There are many barriers that withhold professionals to investigate suspected abuse and
CSA, such as insufficient experience in discussing and/or investigating suspected abuse,
fear to damage confidence between patient and professional, fears for a legal con-
sequences, and fears for possible aggression. Nevertheless, this should not withhold
professionals to investigate suspected CSA.

**Indications for pediatric examination for alleged CSA**
Referring every child with psychological or unexplained physical symptoms for CSA-eval-
uation, is impractical. Clinicians who care for these children need to be aware of the
diverse and non-specific psychosocial and physical symptoms which can be displayed in
CSA-victims and should be alerted by other signs or symptoms matching with CSA. If
other signs and symptoms are noted, which are consistent with CSA, direct referral for
further evaluation is required. Examples are a disclosure of CSA, anogenital injury not
explained by an accident, pregnancy without a history of consensual sexual contact with
a peer, and/or an STI not explained by non-sexual transmission. Other examples where
referral is appropriate are: children diagnosed with a PTSD, without explanatory event;
children showing atypical behavioral problems without explanation or atypical sexual
behavior; or children showing age-inappropriate sexual knowledge. One needs to keep in
mind that absence of symptoms concerning for CSA never excludes CSA, and that most
symptoms are non-specific; thus other causes need to be considered.

**Systematic and multidisciplinary assessment**
Since diagnosing CSA is so difficult, it is important that alleged CSA in children is eval-
uated multidisciplinary and systematically. The assessment should include a medical and
psychosocial history, physical examination (including anogenital examination), child inter-
view (with focus on a child’s sexual knowledge and behavior, and other psychologic or
psychiatric symptoms) and testing for STIs.
A multidisciplinary team should at least have the availability of medical and psychological expertise. Clinicians involved need knowledge of the facts on symptoms related to CSA and other types of maltreatment, age-appropriate child (sexual) development, physical symptoms and (normal) anogenital anatomy. Wallace and colleagues have shown that a multidisciplinary approach can be effective in evaluating child abuse 9. Furthermore, the American Academy of Pediatrics recommends that pediatricians “seek a second expert opinion in cases of CSA when the child’s anal or genital examination is thought to be abnormal” 10. We would prefer to extend this advice to include multidisciplinary consultations in all cases of confirmed or suspected CSA.

In the Netherlands expertise on CSA can be found in the centers for sexual abuse (in Dutch: ‘Centra voor Seksueel Geweld’, CSG) and the national expertise center on child maltreatment (in Dutch: ‘Landelijk Expertise Centrum Kindermishandeling’, LECK). The CSG provides medical, psychological and legal help for all victims of sexual abuse (both children and adults) who were abused up to and including seven days prior. The LECK is an expertise center where forensic, medical and pediatric expertise are integrated. The LECK can also be consulted for cases in whom the abuse was more than seven days ago. The highest level of evidence for CSA is forensic evidence (for example DNA-traces) or CSA recorded on child pornographic images (photographs or videos). However, in most cases this kind of evidence for CSA is lacking. The second best reference standard is therefore a multidisciplinary assessment combining forensic, pediatric and psychosocial evaluation of a case. We need to keep in mind that the diagnostic value of this multidisciplinary approach is uncertain.

Medical history

Physical complaints

There is scientific evidence that CSA is associated with poor health outcomes in later life 3,11-16. Physical complaints were reported frequently in our studies (50-59.7% 17,18). However, so far, the physical complaints reported in our studies were nonspecific for CSA. Our systematic review on the association between FSS in children and CSA showed a too wide variety in studies. Based on current literature, no firm conclusion on the association between CSA and FSS could be drawn.

Psychosocial symptoms

Numerous studies have reported associations between childhood sexual abuse and psychological and psychiatric disorders in adults, such as substance abuse, self-injurious behavior, post-traumatic stress disorder (PTSD), and (sexual) behavioral problems 2,7,19-28. Several previous studies have likewise found that children exhibit many different, and widely varying, symptoms. So far, no specific pattern of psychosocial symptoms that
indicates CSA has been identified in young children. A number of factors appear to be associated with increased distress after CSA: specific aspects of the abuse (nature, frequency, duration, severity, and relationship with perpetrator), environmental factors (how safe is the child?), and the child’s character. These could be explanations for why certain children manifest problems and others do not.

The absence of a clear pattern in symptoms makes the interpretation of psychosocial symptoms difficult. When evaluating psychosocial symptoms less concerning for CSA in young children, we need to take into account possible triggers, the total number of reported problems, and whether there are other possible explanations. A combination of multiple less concerning psychosocial symptoms can raise concerns if there is no other plausible cause.

Many of the children who are abused do not show psychological problems, neither physical injuries, which is in line with our findings. Since some CSA-related symptoms may take time to develop, it would be wise to monitor such problems in children over time.

**Post-traumatic stress disorder (PTSD)**

In adults a history of CSA is associated with PTSD. Finding signs of PTSD (intrusion and avoidance) in our sample was not surprising. Approximately one quarter of children develop PTSD after interpersonal traumas such as CSA. However, the review of Alisic and colleagues (2014), included only one sample with preschool children younger than four years of age. The clinical manifestation of PTSD differs in young children, older children and adults. A child’s developmental stage must therefore be taken into account when evaluating PTSD. In general, the rates of PTSD in preschool children appear to be lower than those in older children exposed to trauma, and three third do not develop PTSD. This may be because young children are relatively protected by cognitive and perceptual immaturity or because the criteria themselves are not developmentally sensitive enough. Studies have shown that children with PTSD show significantly more developmental regression, such as continence skills regression, than children without PTSD who experienced the same trauma. Perhaps signs of such regression in young children could also be interpreted as signs of PTSD. Literature on the prevalence of PTSD after CSA in very young, preschool children is lacking.

**Sexual Behavior**

In a comprehensive review by Kendall-Tacket et al, 1993, which also includes young children (<6 years of age), sexual behavior problems in 28% of the CSA-victims was found. However, this study is based on older data, possibly a review of more recent research could bring new insights.
Although sexual behavior problems are more often reported in CSA-victims than in non-abused children, there is no single specific sexual behavior that is indicative of sexual abuse. Other origins of developmentally inappropriate sexual behaviors, including physical abuse, family violence, and other types of maltreatment, are known to be possible. Nevertheless, evaluating a child's sexual behavior is recommended as part of the assessment for alleged CSA in children and therefore it is important that pediatricians who do evaluations of alleged CSA are aware of normal, developmentally appropriate variations in children's sexual behaviors.

Nevertheless, as sexual behavior problems are frequently reported among children in whom CSA is suspected it is important that a systematic assessment follows.

**Sexual knowledge**

Possibly, age-inappropriate sexual knowledge in children might be a better indicator for CSA than sexual behavior. On the whole, young children have very little sexual knowledge. They only possess certain basic knowledge of genital differences, gender identity, sexual body parts, and non-sexual functions of the genitals. Knowledge of pregnancy, birth, reproduction, and adult sexual behavior is very limited and decreases in that order. Younger children generally know less than older ones.

There are several reasons why age-inappropriate sexual knowledge may be a more useful discriminant for assessing CSA than sexual behavior. Sexual knowledge can be more objectively measured, measurements need not depend on caregivers’ observations, and although the extent of knowledge may depend partially on the extent of experience, knowledge of sexuality is likely to be less dependent on abuse-related variables. Although, there could be a multitude of reasons why sexual knowledge differs between children, such as differences in parental-provided sex education, exposure to sexual-related information from peers and siblings and exposure to sexuality via media. These limitations would limit the conclusions that could be drawn from an assessment indicating age-inappropriate sexual knowledge.

To be able to express sexual knowledge, children need to have a certain level of speech development. However, clinicians need to keep in mind that young children might be talking, but they still do not have the words to express their experiences. For example, young children do not know words like ejaculation and might describe ejaculation as peeing, a word they do know.
Chapter 11

Child interview
The first step for a professional is to tell a child that it is okay if the child talks to you, about anything. It might be helpful if parents tell the child before the interview that it is alright to talk to the interviewer.

Secondly, professionals should not hesitate to ask about traumatic experiences of the child, and get to the point. Carefully observe the child’s behavior during the interview; a child might say ‘no’ while his body language tells you the opposite.

Children’s reports of CSA are extremely important, maybe even the most important, in any abuse case, whether or not a physical or laboratory finding is present \(^{53}\), as there are almost never any eyewitnesses of the abuse. Fears, shame and linguistic or verbal limitations can withhold children from disclosing CSA. Hence, an important part of the assessment in cases of alleged CSA is the child interview. It is necessary that children are carefully interviewed by skilled professionals trained to interview children about possible abuse \(^{50}\) separated from the parents to avoid parental influence on the child’s statements \(^{10}\). The positive and negative predictive value of abuse disclosure are strongly influenced by the way children are interviewed \(^{54}\). Approaching the child at his own level in terms of development, readiness to disclose, culture and language \(^{55}\), using free recall (open ended) questions and so called “How” questions (which are likely to elicit evaluative information), and avoiding misleading and direct questions (as they generally increase false positive rates, especially in younger/preschool children) are some key elements \(^{10,54,56,57}\).

Anogenital examination
Besides a medical and psychosocial history, and the child interview, the physical examination is an integral part of the assessment. However, most genital injuries in CSA heal with little or no residua, unless the injuries are severe. When children are physically examined more than 72 hours after the last abuse, physical signs specific for CSA, are only found in a small minority of cases, 4 to 5\% \(^{58,59}\). This corresponds with our findings \(^{17,18}\).

Physically examining children for alleged CSA requires training and special skills. Interpreting anogenital findings is difficult and only limited number of signs indicate penetrative trauma. Genital examinations should always be documented photo or video graphically. This allows clinicians to consult (forensic) experts without burdening a child with additional examinations.

Considering the fact that findings at physical examination indicative for CSA are very rare in children, it is important to carefully observe the child’s behavior during the examination. We found that deviant behavior during anogenital examination might be a good
indicator of CSA. Especially sudden behavioral changes observed during the anogenital examination, such as anxiety, panic attacks or shutting down, and ‘too easy and outgoing’ reactions seem important. Though this topic is not yet studied extensively, some other studies found that non-abused children do not perceive the anogenital examination very distressing. In children examined for alleged CSA it appears that significantly more stress was reported by older children (12 years and above). Whereas other studies found that anogenital exams are not re-traumatizing or perceived as ‘strongly negative’. However, anxious feelings prior to the examination seem to increase anxious behaviors during the examination. Knowledge of preschool children’s perceptions of the anogenital examination and the best way to prepare these children is lacking.

Laboratory testing
The last part of the assessment is often laboratory testing for sexually transmitted infections (STI) and pregnancy (when applicable). However, finding an STI does not necessarily indicate CSA. For instance, some infections, Condyloma acuminata or Herpes simplex type 1 or 2 infections, can be spread by both non-sexual and sexual transmission. Therefore additional information is required to interpret these infections. Infections likely to be caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out are gonorrhea, syphilis, chlamydia, HIV (if transmission by blood or contaminated needles has been ruled out), or Trichomonas vaginalis.

Using instruments during the assessment
Measuring sexual behavior
Examining sexual behavior is part of the total assessment of alleged CSA in children. The Child Sexual Behavior Inventory (CSBI), is an instrument used to measure sexual behavior in children. However, based on our review, we found that the CSBI only has a limited ability to distinguish abused from non-abused children in children with alleged CSA. This can be explained by four reasons: 1. The CSBI only screens for symptoms and does not ask about a child’s experiences; 2. Only one third of the sexually abused children have sexual behavior problems, meaning that two third of the abused children do not display sexual behavior problems; 3. There is not one specific sexual behavior that is indicative for CSA, and there are many other explanations for the behavior; and 4. It is likely that there are several cases of suspected CSA in whom the reason for the suspicion of CSA is based on observed atypical sexual behavior. Possibly the CSBI-scores of the entire sample of children with suspected CSA were higher on average compared to the normative population, as was also reported in psychiatric control samples. This is an important point – there could be circularity that is impacting the accuracy of the CSBI in this context. When atypical sexual behavior is the reason for suspecting CSA this may lead to false positive accusations, as there are numerous other explanations for the displayed behavior.
Based on what was published on the reliability of the CSBI in general, the CSBI seems to be a reliable instrument to objectively measure a child’s sexual behavior. However, the CSBI measures sexual behavior observed by a caregiver who answers the questionnaire. The CSBI relies on what is observed (and reported) by the caregiver and is therefore not fully objective.

**Instruments for interviewing children**

As discussed previously, the SKPI is a non-verbal technique which can be used during the child-interview. Unfortunately, until now the SKPI is not a validated tool to differentiate between abused and non-abused children. Research to validate the SKPI is in progress. Until the SKPI has been validated the instrument needs to be used carefully and we should be cautious in interpreting the outcomes.

The administration of non-verbal techniques like the SKPI in abuse interviews has been widely debated. The use of anatomical dolls, for example, is considered to encourage leading or suggestive lines of questioning, as well as over interpretation of a child’s play. However, when non-verbal techniques are employed in accordance with a standardized protocol, using open and non-suggestive questions, they can be valuable instruments, especially in young children with limited verbal abilities. Professionals need to be trained to use such instruments adequately.

Previous research has shown that non-abused children respond with an open-minded and engaged attitude to the interview material. Sexually abused children have been found to show significantly more non-verbal reactions indicative of avoidance of the sexual meanings of pictures.

The American Professional Society on the Abuse of Children (APSAC) has developed guidelines for forensic interviewing of children on abuse. In this interview method the child’s narrative is the central focus. However, forensic interviewing is a specialized skill. Pediatricians and child behavioral specialists need special training before applying this interview method.

**Trauma treatment**

Various studies show that children who were sexually abused have a higher chance on revictimization if they do not receive treatment. PTSD is an important mediator in the process of revictimization. Therefore it is important to prevent PTSD and otherwise treat PTSD adequately. Helping a child to cope with the traumatic experience decreases the chance on psychosocial problems and revictimization. PTSD can be treated adequately using Eye Movement Desensitization and Reprocessing (or EMDR) or Trauma Focused...
Cognitive Behavioral Therapy (TF-CBT)\textsuperscript{22,23}. Unfortunately it is unclear whether all victims of CSA have access to adequate treatment to recover\textsuperscript{24}.

**Recommendations from victims of CSA and parents of children with CSA**
When developing the pediatric guideline on diagnostics in alleged CSA\textsuperscript{5,75}, we interviewed many victims of CSA and parents of children who were sexually abused. The majority of patients and parents indicated that they had waited a long time before they started to talk about the abuse, even often not before they were adults. After disclosing the abuse they frequently encountered closed doors and had to deal with professionals who did not know how to respond. For most patients and parents it took a long time before receiving the help they needed. Many did not feel heard, believed or supported. During focus group discussions they came up with some important advices for professionals:

CSA can be a blind spot for most people. Professionals need to be open and willing to see CSA and be alert for signals children give. Be aware that CSA exists in many different forms. CSA can be the cause of physical and behavioral problems in a child, be willing to notice the signals. Ask about striking behaviors or physical complaints. Name the signs you notice and that you are concerned. Explain that CSA happens and can cause physical or psychological problems in children. Children might say ‘no’ to direct questions for abuse, but this does not always mean CSA is not happening. Therefore, it is of major importance to come back to this topic at a later moment.

In case of a disclosure immediate professional help with expertise on CSA should be offered. A child’s story should be taken seriously, despite of the content of their story. It is possible that the child thickens the story because he or she is scared not to be believed, or ‘justify’ why he or she did not resist. Unfortunately it happens that the story is not taken serious if a child is caught on a lie.

What to do differs per child. Some children respond best on a direct approach where others close down. There is not one method, question or answer by which CSA can be discovered. In general it is important to create a safe and trusting environment. The child needs to be in charge, for example by deciding who can be present during interviews or investigations. Make time to discuss your concerns and ask again about possible abuse at a later time. Other ways to create a safe environment is by approaching children in a child friendly manner, playful surroundings, games, and icebreakers. Children need to feel that they are being heard and believed. This can be done by involving children during the entire assessment.
A strong emotional response of the professional in reaction to a disclosure should be avoided. As result, a child may think that the professional is not able to cope with the story and stops telling. However, this does not mean that professionals should not show any emotional reactions, they should however, not predominate.

Children are often threatened or scared by the perpetrator to prevent them of disclosing. Children can be scared to lose control or that the threats of the perpetrator become a reality. Discuss clearly with the child about the consequences of a disclosure and try to comfort the child. Often the child and/or the parents feel the need to have a confidential adviser, who can assist them during the entire process. Make time, do what you say and say what you are doing.

**Future research**

To date, a generally accepted, scientifically valid way to diagnose or exclude CSA in young children is lacking. Recognition of CSA needs to be improved, as up to now, many cases of CSA are missed by professionals. We would therefore recommend to focus future research on improving the recognition of CSA in children.

For future research in the field of CSA it is important that researchers develop internationally agreed definitions, and ‘core sets’ of instruments to determine and rule out CSA for research purposes. This would make it possible to interpret the results of studies performed to generate knowledge on associations between CSA physical or psychosocial symptoms and to make valid comparisons.

First, as most psychosocial and physical symptoms are not specific for CSA, we recommend studying risk factors for CSA, whether there are recognizable symptom patterns in children after CSA, and how these symptoms can be measured objectively. Further we need to learn more on how to interpret physical and psychosocial symptoms. Prospective studies on physical and psychosocial symptoms, the outcome of the child-interview, and the anogenital examination (including behavioral observations), could be of value if the data is systematically collected and validated instruments are used where possible. The collected data should be reviewed by experts on CSA, both independently and as a multidisciplinary team (e.g. child-abuse pediatrician and child-behavioral specialist) blinded for the clinical conclusions and police information, if available. Ideally, the clinical samples should include children in whom CSA was proven by police investigations, children in whom pediatric assessment concluded a high suspicion and children in whom CSA is not likely. Such research could provide information to enable early detection of CSA, early recognition of its consequences, and the prompt provision of support.
Until now research has focused on sexual behavior in children. However, as discussed earlier, sexual knowledge is presumably a more objective and more readily measurable indicator compared to sexual behavior. Systematic research on sexual knowledge in children after CSA in comparison with non-abused controls is needed. This can create a better understanding of age-appropriate and -inappropriate sexual knowledge in children. Nevertheless, there are several reasons why sexual knowledge differs between children, for example differences in sex education, exposure to sexual-related information from peers and siblings and exposure to sexual media. If possible, all these factors should be taken into account. Non-verbal techniques such as the SKPI need to be evaluated further in order to create standardized, validated interview techniques for young children who are examined for possible CSA.

Third, as recommended by the Royal College of Pediatric and Child Health-guideline, there is an urgent need for comparative primary research studies on CSA and anogenital injuries (in both female and male children). However, as anogenital injuries are rare we do not believe that this will increase the number of recognized cases of CSA. Perhaps studying children’s behavioral reactions during examination is more promising. Therefore, research should focus on (normal) behavioral reactions of children during examination and compare children with CSA to non-abused children. It is advised that during the physical examination an observer is present to notice the child’s reactions, preferably a child behavioral specialist. Based on our current knowledge children need to be prepared carefully and age adjusted before the physical examination. Though further research is needed to investigate how young children can be prepared best.

Fourth, the shortage of studies reporting on associations between CSA and physical complaints in children is striking. We recommend that future research should focus on the association of CSA and functional somatic symptoms in young, preferably preschool, children. Ideally a prospective cohort study investigating the association of CSA and functional somatic symptoms in young (preschool) children should be performed.

Fifth, due to the low prevalence of STIs in the pediatric population and the various transmission routes, it is difficult to examine the association between STI in children and CSA. To be able to give clear and valid recommendation large numbers of participants are needed in studies on STIs and CSA.

As discussed in our recommendations for clinical practice, alleged CSA should be examined systematically. Therefore, research should contribute to the development of sexual abuse case protocols to enable clinicians to improve CSA assessments and to simultaneously collect standardized data on CSA assessment for research purposes. The knowledge
gained from such research could additionally be helpful in creating a rating system for psychosocial symptoms that are more concerning or less concerning for CSA.

And finally, as a disclosure of CSA is such an important element we should study how children can be best empowered to talk about abuse and how parents can help their child to talk about sexual abuse. Educating children in schools and through social media might be helpful. This was also one of the recommendations of the experience experts we spoke during the development of the Dutch guideline on diagnostics in alleged child sexual abuse.⁶⁷⁻⁷⁻. 
Conclusions

Confirming or excluding CSA in children is difficult, especially when children are very young, (preverbal age). With our studies we tried to improve the recognition of CSA. The most important conclusions to draw from this thesis are mentioned below.

- We were unable to identify a clear symptom pattern indicating CSA.
- However, evaluating expert opinions showed that there are symptoms which can be considered more or less concerning: PTSD symptoms, regressions in continence and other cleanliness skills were designated by experts as symptoms more concerning for CSA, unless other explaining stressors are present.
- All other psychosocial symptoms may raise concerns for CSA if they are numerous and unexplained.
- We advise clinicians to assess children presenting with sexual behavior problems and age-inappropriate sexual knowledge thoroughly for CSA, but also keep in mind other possible explanations.
- Signs of CSA at anogenital examination, STI and positive pregnancy tests are rarely found. However, observing children’s behavioral responses during anogenital examination might be of value.
- Evaluating alleged CSA should be done systematically, multidisciplinary, and over time, to evaluate a child’s development, and any progression of symptoms.
- So far, there are no validated instruments for the diagnosis of CSA. The CSBI can be used to measure sexual behavior but should not be used on its own to differentiate between children with and without a history of CSA. The SKPI needs to be validated and until then used cautiously.
- Be aware, CSA happens, but this is not always visible. Many victims do not display physical or psychosocial problems. “It's normal to be normal” does not only count for the anogenital examination.
- Children’s disclosures are essential and therefore techniques and instruments to talk with children about abuse should be improved, and children should be empowered to talk about abuse, this might be the only evidence in many cases.
## Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ASAC</td>
<td>Amsterdam Sexual Abuse Case</td>
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<td>CSA</td>
<td>Child sexual abuse</td>
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<td>CSBI</td>
<td>Child Sexual Behavior Inventory</td>
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<td>EMDR</td>
<td>Eye movement desensitization and reprocessing</td>
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<td>FSS</td>
<td>Functional somatic symptoms</td>
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<tr>
<td>LECK</td>
<td>Landelijk Expertise Centrum Kindermishandeling</td>
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<tr>
<td>OPD</td>
<td>Outpatient department</td>
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<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>SKPI</td>
<td>Sexual Knowledge Picture Instrument</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TF-CBT</td>
<td>Trauma focused cognitive behavioral therapy</td>
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References


