Pediatric and Adolescent Sexual Abuse

It’s Real, How Do We Deal?

Speakers

• Charlotte Brown, MD: Pediatric Hospital Medicine
• Carrie Lind, MD: Pediatric Hospital Medicine
• Mary Romano, MD, MPH: Adolescent Medicine
• Hollye Gallion, RN, MSN, CPNP: Our Kids Center
• Leanna Dugan, RN, MSN, CPNP: Our Kids Center
Disclosures

All speakers have no relevant financial relationships to disclose.

Learning Objectives

• Recognize the Frequency and Impact of Pediatric and Adolescent Sexual Abuse
• Learn to Recognize, Diagnose and Manage Pediatric Sexual Abuse
• Discuss Sexual Abuse Management Models and Barriers to Care
• Discuss Mandatory Reporting
• Discuss Child Sex Trafficking
Definition

“Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.”

Sexual Abuse vs Sexual Assault

<table>
<thead>
<tr>
<th>Sexual Abuse</th>
<th>Sexual Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child is used for sexual stimulation of the perpetrator or an observer</td>
<td>Attempted sexual touching of another person without their consent</td>
</tr>
<tr>
<td>Includes both touching and non-touching behaviors</td>
<td>Includes sexual intercourse (rape), sodomy (oral-genital or anal-genital contact), and fondling</td>
</tr>
<tr>
<td>Sexual abuse can include acts that would be considered sexual assault</td>
<td>May result from use of force, threat of force or from victim’s inability or refusal to give consent</td>
</tr>
</tbody>
</table>
Sexual Abuse vs Sexual Play

<table>
<thead>
<tr>
<th>Sexual Abuse</th>
<th>Sexual Play</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involves people of different ages and genders</td>
<td>Children of same developmental age and gender</td>
</tr>
<tr>
<td>Activities inconsistent with developmental level</td>
<td>Mutual agreement to participate</td>
</tr>
<tr>
<td>Elements of coercion, force, secrecy</td>
<td>Causes feelings of guilt</td>
</tr>
<tr>
<td>Increased likelihood of physical injury</td>
<td>Typically does not cause physical injury</td>
</tr>
</tbody>
</table>

Epidemiology

- **Retrospective Incidence**
  - Finkelhor et al., 2005

- **Retrospective Prevalence**
  - Dolen & Scannapieco, 1999
  - Finkelhor, 1994
  - Gorey & Leslie, 1997
  - MacMillan et al., 1997
  - Pereda et al., 2009
Epidemiology

Perpetrators are usually male and often trusted adult acquaintances.

Epidemiology

- Does not discriminate by age, race, gender or SES
- 50% of rape victims are under 18
- 34% of pediatric victims are under age 12
Risk Factors

- Female sex
- Being unaccompanied by an adult
- Poverty
- Physical or cognitive disabilities
- Previous sexual victimization
- Teen runaways/ Incarcerated
- Parent mental illness or with drug or alcohol dependency

Presentation

- Behavioral changes
- Medical complaints: genital or anal trauma or bleeding, STI, pregnancy, dysuria, enuresis, recurrent UTI, chronic constipation, vulvovaginitis, headaches, encopresis, bruises to the palate
A Pop Quiz

• Can virginity be determined by examining the hymen?
  No

• Which is more common – anal or vaginal injury?
  Vaginal (.5% vs. 5-30%)

• If the sexual abuse occurred over a year ago, is there a need for a medical exam?
  Yes

• Does hymenal injury occur more often in young children or adolescents?
  Adolescents
She tells two years later

Family struggles with the truth

She has a forensic interview and a medical exam- disclosure/details are a little different each time.

Exam is 2 years after the last contact there is no rape kit

Medical exam is “normal” although she described multiple episodes of penile-genital and penile-anal penetration over 2 years.

Eventually there is a trial with an Acquittal

WHAT REALLY HAPPENS

WHAT PEOPLE EXPECT

She tells right away

Family believes and is protective

She provides clear exact details-consistent each time she is questioned

She undergoes a forensic medical exam within 24 hours of the last sexual contact

There are physical findings and DNA on the rape kit analysis

There is a jury trial with a conviction

You Are the Beginning of a Lengthy Investigation
Obtaining a History

- History from *parent or caregiver only* (child not present in room)
- Who (victim and perpetrator information)
- What (type of sexual contact)
- When (date/time of event; ongoing?)
- Where (jurisdiction)
- Medical history (PMH, ROS)

Do I REALLY need to talk to the child? (No.)

- Acute vs. nonacute abuse
- Gather your history from the parent, don’t interview child
- There will be at least 2 other investigative interviews
- If you do talk to child, you may be asked to testify about that hx in court 2 years later
If you must...

- ALWAYS interview alone
- Assess developmental level
- Ask open-ended, nonleading questions
- Use quotes and document well!
- More necessary in adolescents (consensual hx)
- Confidentiality?
- Evidence Collection Kit specifics

Forensic Medical Exam

- What Is It?
- Who Needs One?
- When
Who needs an exam?

- Child describing:
  - Penetration
  - Genital, oral, anal contact with another person’s genitalia or mouth
- Delayed/non-verbal children
  - (less than 5 years)
- Children w/ symptoms for STD
- Anogenital pain and/or bleeding

Is this a 3am exam? (<72-96 hours)

- Anogenital bleeding or injury
- Forensic evidence possible
- STI & pregnancy prophylaxis (adolescents)
- Psychological distress
Medical Exam Components
Team Approach
Medical hx from parent & child
Pre-exam prep
Head to toe physical
Colposcopy
Digital photo documentation
STD testing/prophylaxis
Gold standard, confirmatory
Evidence collection
Peer review
Court testimony

The Colposcope
Exam Techniques

- Never restrain
- Position (supine frog leg, lithotomy, PKC)
- Labial separation & traction
- Hymen evaluation
  - Cotton swab manipulation
  - Saline
- Speculum (adolescent only)
- Anal (Supine knee-chest)

Evidence Collection Kit
Evidence Collection Kits

- Additional history specific to rape kits
- Body fluids exposure
- Nongenital injuries
- Use of force
- Activities that alter evidence
- Alternative Light Source
- Swabs specific to contact and age

Let’s jump right into a little anatomy
Female Anatomy 101...

- Mons pubis
- Clitoris
- Urethra
- Posterior fourchette
- Labium minora
- Labium majora
- Hymen
- Vaginal opening
- Perineum

Unestrogenized vs. Estrogenized
Like a clock...

Hymenal Variations
Hymenal Tags, Bumps & Mounds

Hymenal Injury
Acute Injuries

Hymnal Bruising

Vaginal Wall Petechiae

Use of cotton swab to reveal injury
Non-acute Transection at 7

Non-acute Transection at 7
Anal Injury - Foreign Body

Anal Injury – Foreign Body

[Image of anal injury and foreign body]
Findings Diagnostic of Abuse

- Pregnancy
- Semen on forensic specimen or wet mount
- STIs (GC, CT, HIV, trichomonas, syphilis)
- Anogenital trauma
  - Hymenal injury (acute or healed)
  - Vaginal laceration
  - Deep perianal laceration

Exam “Findings”

- Almost ALL exams are “normal”
- 6% females have findings diagnostic of trauma
- Acute exams: 25-35% females have finding
- <1% have anal injury
- 2% have STDs
Why are they normal?

- Type of contact
- “Delayed” disclosure
- Definition of penetration

So, Exactly What Must Be Penetrated for Penetration to Occur?
The Exam Cannot:

- Always determine if sexual abuse occurred  
  (95% of children evaluated at Our Kids have normal genital exams.)
- Determine exactly when or how many times abuse occurred
- Determine virginity

So, Where is the Evidence?

- It begins, almost always, with the words of the child.
Lichen Sclerosis

Labial Adhesions
Failure of Midline Fusion

Initial exam

2 ½ months later

MVA

Accidental Injury

Accidental Injury
Evaluation for STIs

- STIs documented in 4 to 14% of adolescent and adult victims of sexual assault.
- Rates in children are not well established.
- Risk is dependent on multiple factors:
  - Regional variation in prevalence
  - Age of assailant
  - Type of sexual contact
  - Frequency of contact

Evaluation for STIs in Children

- Testing should be done but no recommendation for presumptive treatment
- Low prevalence
- Low risk of ascending infection
- More reliable follow up
Evaluation for STIs in Adolescents

- ALL adolescent/young adults should undergo STI testing AND be given presumptive treatment
  - High prevalence of previous, asymptomatic infection
  - Concerns for follow up
- Most likely to be positive secondary to assault if done within 72 hours of assault
- “Shield laws” prevent sexual history, previous infections from being used as evidence in an assault

Evaluation for STIs

- STI testing before prophylactic treatment
- Nucleic Acid Amplification Testing (NAAT) is preferred method
  - Certain jurisdictions only accept culture results
- Test multiple sites for Gonococcus and Chlamydia:
  - Vaginal, urethral, ano-rectal, pharyngeal
Evaluation for STIs

- Vaginal testing for *Trichomonas vaginalis*
  - NAAT (preferred), rapid antigen or wet mount (least preferred)
- Syphilis testing with RPR
- Hepatitis B testing if victim is not known to be fully immunized

HIV Screening

- Patient needs to be counseled that test will only indicate infection in the last 6 months.
  - NOT infection acquired from assault
- Repeat testing should be done at 1 and 6 months.
Empiric Treatment

- ALL adolescent/young adult patients should be offered empiric treatment
- Treatment provided for GC, Chlamydia and Trichomoniasis
- Children should be treated if infection or symptoms present

Empiric Treatment

- Children < 45kg
  - Chlamydia: Azithromycin 20 mg/kg/day orally, 1 dose daily for 3 days
  - Gonorrhea: Ceftriaxone 25–50 mg/kg IV or IM in a single dose, not to exceed 125 mg IM
  - Trichomonas: Metronidazole 15mg/kg/day divided TID.
- Hepatitis B vaccine if not fully immunized
  - HepB Immunoglobulin if assailant is HepB positive.
Empiric Treatment

- **Adolescents/Children > 45kg**
  - **Chlamydia**: Azithromycin 1g PO X 1
  - **Gonorrhea**: Ceftriaxone 250mg IM X 1
  - **Trichomonas**: Metronidazole 2g PO X 1
- **Hepatitis B** vaccine if not fully immunized
  - HepB Immunoglobulin if assailant is HepB positive
  - Consider HPV Vaccination if not yet started or series incomplete

HIV Post-Exposure Prophylaxis (PEP)

- Not universally recommended
- HIV transmission risk from a single assault is unknown
- MOST beneficial if started within 72 hours of assault
HIV Post-Exposure Prophylaxis (PEP)

- Risk factors:
  - Local prevalence
  - Serological status of assailant
  - Repeated assault/multiple perpetrators
  - Oral/Vaginal/Anal trauma
  - Genital lesions on victim/assailant

- Combination therapy recommended
  - No specific regimen recommended

- Consider ability for adherence
  - Duration (28 days of treatment)
  - Dosing regimen
  - Need for close follow up
HIV Post-Exposure Prophylaxis (PEP)

- Consult local Infectious Disease expert
  - Clinician Consultation Center at UCSF (1-888-448-4911)
  - FREE consultation/recommendations if local expert not available
- Well-tolerated and minimal risk given short course of treatment

HIV Post-Exposure Prophylaxis (PEP)

- Offer 3-5 day supply is possible
  - Many pharmacies do not carry
- Follow up in 3-5 days.
  - CBC, CMP, HIV Antibodies
  - Repeat labs again at 2 weeks (peak SE)
Follow-Up

- 1-2 weeks
  - Sooner if HIV PEP is given
- Repeat GC/CHL testing if no treatment was given.
- Syphilis and HepB testing
  - Allows antibodies to develop
  - 6 weeks, 3 months, 6 months
- HIV testing
  - 3rd generation testing (most tests) for antibodies; positive within 3-12 weeks.
    - Repeat testing 6 weeks, 3 months, 6 months
  - 4th generation testing for antigens AND antibodies; positive within 2-6 weeks.
    - Repeat testing at 4 weeks and 3 months

Emergency Contraception

- Pregnancy testing should be performed in all post menarchal/pubertal females
- Repeat pregnancy testing in 2 weeks whether or not EC was taken
Emergency Contraception

• Plan B:
  - Progesterone only regimen
  - 2 pills each containing 1.5 mg of norgestrel taken AT THE SAME TIME
  - Prevents pregnancy by inhibiting ovulation and decreasing tubal motility
  - Failure rate of 0.14% if taken within 1 hour of unprotected sexual activity
  - Over the counter ($40-$50)
  - Can taken up to 120 hours after unprotected sexual activity

Emergency Contraception

• Ella:
  - Ulipristal
  - By prescription only
  - Progesterone receptor modulator
  - Can taken up to 120 hours after unprotected sexual activity
  - More effective than Plan B > 72 hours
Emergency Contraception & Obesity

- Clinical trials BMI >30
  - Pregnant 3x more often than those with a lower BMI
  - Better with Ella
  - Efficacy wanes BMI >26
  - Ella had some increased efficacy up to BMI > 35

Drugs/Alcohol

- Alcohol or drug use immediately prior to assault is reported in 50% of victims > 12 years of age
- Alcohol is the most common substance used.
  - Up to 80% of assaults
  - Alone or in combination
- Cannabis is the 2nd most common drug found on toxicology screen
  - Up to 30% of assaults
  - Alone or in combination
Drugs/Alcohol

• “Date rape drugs” rarely found on toxicology screen
  - Flunitrazepam (Rohypnol/Roofies)
  - Gamma hydroxybutyrate (GHB)
• Do not show up on typical drug screen so must request if high suspicion

Psychological Support

• Victims at risk for short and long term mental health sequelae
  - PTSD, depression, anxiety, substance use, eating disorders, criminal behavior
• Younger age of first consensual intercourse
• Pregnancy
• Repeat sexual victimization
Psychological Support

- Evidence that trauma informed mental health services decrease negative emotional response and maladaptive coping strategies that may develop
- Trauma informed mental health services changes the fundamental question from “What’s wrong with you?” to “What happened to you?”

Child Sex Trafficking

- May encounter in any medical setting
- Victims seldom self-identify
- Validated screening tools are lacking
- Can contact national resources
  - National Human Trafficking Resource Center Hotline
  - Polaris Project
  - Shared Hope International
  - National Center for Missing and Exploited Children
### When to Suspect Child Sex Trafficking

<table>
<thead>
<tr>
<th>Initial Presentation</th>
<th>Historical Factors</th>
<th>Physical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child accompanied by domineering adult</td>
<td>Multiple STIs</td>
<td>Evidence suggestive of inflicted injury</td>
</tr>
<tr>
<td>Child accompanied by unrelated adult</td>
<td>Previous pregnancy/abortion</td>
<td>Tattoos (sexually explicit, of man's name, gang affiliation)</td>
</tr>
<tr>
<td>Child accompanied by other children and only one adult</td>
<td>Frequent visits for emergency contraception</td>
<td>Child withdrawn, fearful</td>
</tr>
</tbody>
</table>

### When to Suspect Child Sex Trafficking

<table>
<thead>
<tr>
<th>Initial Presentation</th>
<th>Historical Factors</th>
<th>Physical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing demographic information</td>
<td>Chronic runaway behavior</td>
<td>Signs of substance misuse</td>
</tr>
<tr>
<td>Chief complaint is acute sexual or physical assault or</td>
<td>Chronic truancy or problems in school</td>
<td>Expensive items, clothing, hotel keys</td>
</tr>
<tr>
<td>Chief complaint is suicide attempt</td>
<td>Hx of sexual abuse/ Physical abuse</td>
<td>Large amounts of cash</td>
</tr>
</tbody>
</table>
When to Suspect Child Sex Trafficking

<table>
<thead>
<tr>
<th>Initial Presentation</th>
<th>Historical Factors</th>
<th>Physical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child is poor historian or disoriented</td>
<td>Involvement of CPS or juvenile justice</td>
<td>Poor dentition or obvious chronic lack of care</td>
</tr>
<tr>
<td></td>
<td>Significantly older boyfriend</td>
<td></td>
</tr>
<tr>
<td>Lack of medical home or frequent ED visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Who Can I Ask For Help?

- Personnel on call:
  - Child abuse pediatricians
  - Sexual Assault Response Team (SART)
  - Pediatric Sexual Assault Nurse Examiners (SANE-P)
  - MDs and midlevel providers with advanced training

- Jurisdictions often have a preferred site
  - Local health care facility or a child advocacy center
Child Advocacy Centers

Care Models

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-Call 24/7</td>
<td></td>
</tr>
<tr>
<td>Appropriate Medical Treatment</td>
<td></td>
</tr>
<tr>
<td>Improved Access to Mental Health Resources</td>
<td></td>
</tr>
<tr>
<td>Time Saved</td>
<td></td>
</tr>
<tr>
<td>Increased Prosecution Rates</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td></td>
</tr>
</tbody>
</table>
Legal Issues

- All physicians in the US are Mandatory Reporters
- Good faith immunity
- NOT a HIPAA violation

But What About in My State?

<table>
<thead>
<tr>
<th>CAPACITY TO CONSENT</th>
<th>ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>At what age is a person able to consent?</td>
<td>18 years old. Tenn. Code Ann. §39-13-528.</td>
</tr>
</tbody>
</table>
| Does difference in age between the victim and actor impact the victim’s ability to consent? | Yes.
- Mitigated statutory rape is the unlawful sexual penetration of a victim by the defendant, or of the defendant by the victim, when the victim is at least 15 years old but less than 18 years old and the defendant is at least 4 but not more than 5 years older than the victim.
- Statutory rape is the unlawful sexual penetration of a victim by the defendant or of the defendant by the victim when: (1) the victim is at least 13 years old but less than 15 years old and the defendant is at least 4 years but not less than 10 years older than the victim; or (2) the victim is at least 15 but less than 18 years old and the defendant is more than 5 but less than 10 years older than the victim.
- Aggravated statutory rape is the unlawful sexual penetration of a victim by the defendant, or of the defendant by the victim, when the victim is at least 13 years old but less than 18 years old and the defendant is at least 10 years older than the victim.
Take Home Points

• Think about it
• Ask about it
• Know your resources

Resources

• What to Know about Child Abuse: https://www.healthychildren.org/English/safety-prevention/athome/Pages/What-to-Know-about-ChildAbuse.aspx
• Sexual Behaviors in Young Children: What’s Normal, What’s Not: https://www.healthychildren.org/English/ages-stages/preschool/Pages/Sexual-Behaviors-Young-Children.aspx
• Foster or Adopted Children Who Have Been Sexually Abused: https://www.healthychildren.org/English/family-life/family-dynamics/adoption-and-foster-care/Pages/Foster-or-Adopted-Children-Who-Have-Been-Sexually-Abused.aspx
References


References


References


- National Center for Missing and Exploited Children (www.missingkids.com)

- National Child Traumatic Stress Network.

References

- National Human Trafficking Resource Center Hotline (1-888-3737-888)


- Rape, Abuse & Incest National Network (https://www.rainn.org/public-policy-action)

- Shared Hope International (sharedhope.org)

Case Discussion #1

A 15 year old female is admitted to your service for acute alcohol intoxication. She was reportedly found by friends in a parking lot outside the local fair. Her parents were not with her at the time, but they are currently on their way to the hospital.

The emergency department obtained a urine drug screen which is positive for marijuana and a serum ethanol level is 180.

When you come to the room, she appears disheveled and is slurring her speech. She is wearing the jeans she arrived in, and has a gown on over them. She has grass stains and rips in her jeans on her knees. She has dirt under her fingernails and scrapes on her hands. No other visible bruises. She is able to answer some questions but then quickly falls back asleep.
Case Discussion #2

A 7 year old girl is admitted for constipation clean-out. She was brought to the ED for abdominal pain, and was noted to have an excessive amount of stool on abdominal XR along with hx of hard stools. She has not stooled in 5 days. Upon admission, mom mentions that she is concerned for sexual abuse.

Case Discussion #2

Mom reports that her daughter has been spending some weekends at her father’s house, as they have recently divorced. Since she started going there, her daughter has been acting “different”. She seemed more tearful than usual and has been having nightmares. Mom wants her “checked” for sexual abuse.
Questions?