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Problems in diagnosing and treating children – victims of sexual abuse, including legal aspects

Problemy w diagnozowaniu i leczeniu dzieci - ofiar molestowania seksualnego z uwzględnieniem aspektów prawnych

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STRESZCZENIE

PROBLEMY W DIAGNOZOWANIU I LECZENIU DZIECI - OFIAR MOLESTOWANIA SEKSUALNEGO Z UWZGLĘDNIENIEM ASPEKTÓW PRAWNYCH

Wprowadzenie. Najczęstszym źródłem informacji o przemocy seksualnej są ofiary. Należy pamiętać, że dzieci rzadko wprost ujawniają wykorzystywanie seksualne, a objawy zależą od czasu wykorzystywania seksualnego, relacji ze sprawcą, rodzaju czynności seksualnych oraz czynników związanych z rozwojem dziecka. Oczywistymi konsekwencjami wykorzystywania seksualnego dzieci są urazy ciała: infekcje układu moczowo-płciowego oraz urazy zewnętrznych narządów płciowych. Niezależnie od tego konsekwencje psychiczne są poważniejsze niż urazy fizyczne.

Cel pracy. Celem pracy było przedstawienie problematyki dzieci wykorzystywanych seksualnie z uwzględnieniem diagnostyki i terapii ofiar przemocy.

Wnioski. Skutki wykorzystywania seksualnego dziecka to oprócz urazu fizycznego również zaburzenie prawidłowego rozwoju psychoseksualnego. Zadaniem lekarzy, personelu pielęgniarskiego, pedagogów i psychologów jest sprawne i pewne rozpoznanie przestępstwa, umożliwiające wszczęcie działań terapeutycznych i postępowania sądowego.

Słowa kluczowe: ginekologia młodzieńcza, wykorzystywanie seksualne

ABSTRACT

PROBLEMS IN DIAGNOSING AND TREATING CHILDREN – VICTIMS OF SEXUAL ABUSE, INCLUDING LEGAL ASPECTS

Introduction. The most frequent source of information on sexual violence are the victims. It should be borne in mind that children rarely disclose sexual abuse directly, and the symptoms depend on how long they have been sexually abused, the relationship with the perpetrator, the kind of sexual activities, and factors related to the child's development. The obvious consequences of child sexual abuse are body injuries: genitourinary tract infections and injuries to the external genitalia. Notwithstanding, the psychological consequences are more serious than the physical injuries.

Aim. The study aimed to present the problem of sexually abused children including diagnostics and therapy of victims of violence.

Conclusions. The effects of sexual abuse of a child include, in addition to physical trauma, also the disruption of proper psychosexual development. The task of doctors, nursing staff, educators, and psychologists is to efficiently and confidently identify the crime, enabling the initiation of therapeutic activities and legal proceedings.

Key words: adolescent gynaecology, sexual abuse

INTRODUCTION

Child abuse is a serious social problem in Poland, and throughout the world. New cases of this phenomenon are constantly being revealed, not just in pathological communities. Lew-Starowicz et al. [1] state that 81% of the perpetrators of sexual violence had grown up in complete families, irrespective of the social group, level of education, financial situation, and awareness that Polish law provides a system of punishments for perpetrators of sexual violence. In view of the above, professionals working with children can find themselves in a "reveal situation", where a child tells about their experiences of sexual abuse.

The World Health Organisation (WHO) defines child sexual abuse as follows [2]: "*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. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.*

This may include but is not limited to:

1. *the inducement or coercion of a child to engage in any unlawful sexual activity;*
2. *the exploitative use of a child in prostitution or other unlawful sexual practices;*
3. *the exploitative use of children in pornographic performance and materials*".

Taking into account the Criminal Code, in 2016 1,000 children under the age of 15 were victims of the crime under Art. 200 of the Criminal Code (sexual intercourse with a person under 15 years of age), the offense under Art. 200a (grooming) and an offense under Art. 202 (sharing pornographic content to a minor and recording, importing, and possessing pornographic content with the participation of a minor under 15, respectively 285 children, right 2 thousand children. However, it should be noted that the statistical data of this phenomenon is underestimated due to the lack of disclosure and informing the law enforcement authorities [2].

AIM

The aim of the work is to show the problem of sexually abused children, including diagnostics and therapy of victims of violence.

The first diagnostic step – professional history

A conversation with a child should be held in a place in which the child feels safe and can move about freely. It is recommended that the conversation is accompanied by some form of play activity (e.g. drawing, buildings blocks). It is important that nobody and nothing disturbs the conversation, as people coming into the room, phones and noise can result in the child's withdrawal, as well as a sense of danger, embarrassment and awkwardness. If the child wants to talk in the presence of a person close to them, the child should be allowed to do this. The most important thing is that the child feels safe and free, including children with disabilities [3].

During this conversation it is worth saying: *I believe you. You are not responsible for what happened. It was not your fault. It is very good that you told us about this. A lot of children have similar problems. We will try to help you. We want to help you.* Open questions should be adjusted to the child's age, and „yes" or „no" questions should be avoided. The following questions should not be asked: *Why didn't you tell us about this earlier? Why weren't you shouting? Why didn't you run away?* – they sound like accusations and the children usually do not know answers to them. It should be strongly emphasised that while taking a history from the child, common names of persons, genitalia and sexual behaviours should be agreed. Due to the child's young age or problems with verbalisation of what happened, we can ask them to show what it looked like (e.g. using dolls). At the end of the meeting it is worth praising the child, thanking them for talking, asking if they would like to ask any questions and find out anything in order to confirm their conviction that it is good that they told us about what had happened.

Another important problem can be symptoms indicating sexual abuse (bleeding, dirty panties, pain in the genital area, bruises, abrasions on inner thighs, pregnancy), or somatic acute symptoms requiring immediate medical intervention (injuries to the external and internal genitalia – the vulva and perineum: perineal tear in the midline from the vaginal mucosa to the rectal mucosa (the vaginal vestibule and the rectum as one post-traumatic space)).

Other emotional symptoms that can indicate child sexual abuse include significant avoidance of men, running away from home, suicidal attempts, failure at school, psychiatric problems, depression, and excessive age-inappropriate masturbation [4]. Psychological symptoms also encompass low mood, fear (children can be afraid of going to school, school problems, poor relationships with peers), a sense of guilt, night terror, nightmares, psychomotor hyperactivity, concentration difficulties, as well as eating disorders (anorexia, bulimia) and psychosomatic disorders (headaches, vomiting and nausea) [5-9].

On the basis of experiences in working with sexually abused children, a four-level classification of sexual abuse symptoms was developed. It is presented in Table 1.

Tab. 1. Classification of sexual symptoms

Classification of sexual abuse symptoms		
Level I	Direct communication	Children talk about their experiences, they are able to indicate them on themselves; this can be confirmed by a noticeable sign on the body, e.g. haematoma, bruising, semen stain
Level II	Indirect communication	Children experience anxiety and tension, undertake sexual themes in their plays, and respond to erotic stimuli in an unusual way
Level III	Signs of acute injuries	Sleep disorders, bedwetting, eating disorders, crying, school problems
Level IV	Signs of chronic (cumulative) stress	Psychosomatic disorders, depression, isolation, suicidal attempts

The division of symptoms into acute, chronic, certain and doubtful, seems to be useful

I. Acute, requiring immediate medical intervention:
   1. Injuries to the external and internal genitalia:
      a) the vulva and perineum: perineal tear in the midline from the vaginal mucosa to the rectal mucosa (the vaginal vestibule and the rectum as one post-traumatic space);
      b) haematomas in the hymen region;
      c) injuries to the anal region: bruising, cracks in the skin around the anus
   2. Injuries to other parts of the body: mouth and oral cavity (bruising and petechial haemorrhages on the palate), lower and upper limbs
   3. Bite injuries
   4. Ulcers and wounds in the course of sexually transmitted diseases

NOTE: It should be strongly emphasised that a child can be afraid of telling the truth about the circumstances of the injuries, and that the person who comes with the child wants to hide the truth (e.g. a mother who knows the perpetrator and wants to protect him), the circumstances of injuries given by the mother and the child are unlikely and incoherent "… she fell down on the bike frame, the carpet-beating rack, the edge of the table, a tree branch etc. …"

II. Chronic:
   1. Psychoemotional disorders in the foreground
   2. Calm and confident behaviour of a child during a gynaecological examination (This attitude should raise the gynaecologist's suspicions as children who have not been sexually abused are usually afraid of this examination)
   3. Hymenal defect (the lesion locations refer to clock face hours): absence of the hymen below a hypothetical horizontal line between 3 and 6 o'clock, defect or healed rupture, usually at 6 o'clock
   4. Permanent dilatation of the anus up to 1.5 cm in diameter

NOTE: During the physical and gynaecological examination, 50-90% of patients show no lesions, indicating another type of sexual abuse, e.g. sexual touching, oral intercourse. After 3 months there may also be no traces of vaginal intercourse.

III. Certain, direct:
   1. Pregnancy
   2. Sexually transmitted diseases (STDs) [10-11]
   3. Semen in the vagina
   4. Hair, blood, saliva, skin cells (in the vagina, oral cavity or under the victim's nails) that according to molecular DNA analysis do not belong to the victim

IV. Unjustified, doubtful, misleading to an inexperienced physician [7]

Procedures in cases of alleged female sexual abuse

Parents/Guardians, who have doubts whether the child has been sexually abused, pay a lot of attention to the result of the medical examination and would like to start the diagnostic process with a gynaecological examination. This is associated with overestimating this examination and considering it ultimately reliable, particularly in the face of the results of the psychological observation, which are difficult to comprehend for the family. For this reason, a physician should devote more time to meet the expectations of the child, mother, and the public prosecutor's office or the police.

The suggested order of procedures is as follows:
1. Medical history
2. Gynaecological examination
3. Taking colour photographs of the lesions: these photographs should be taken with a 35 mm camera equipped with a large-focal-length lens and flashlight in such a way that the photographic documentation is complete and does not distort the real image. Irrespective of the photographic documentation, the physical symptoms should always be presented in drawings.
4. Notifying the Public Prosecutor's Office or the police of the offence prosecuted ex officio (pursuant to Article 304 of the Code of Criminal Procedure).

Information obtained on the basis of a history taken from the mother and child, the child's physical examination, and additional examinations, should be included in the protocol drawn up by the physician. Using the specially designed questionnaire improves the documentation effectiveness.

Physical diagnosis – the principles

1. We examine the child's overall condition for other diseases: we examine the skin of the entire body, palpate the head, listen to the back, the heart etc.
2. While examining, we talk to the child and make contact, trying to minimise the fear of the examination.
3. We first look for the signs of sexual abuse on other parts of the body.
4. We examine the genitalia at the end.

The principles and techniques of the gynaecological examination

1. Age-appropriate explanation of the purpose of the examination.
2. Placing the child on a gynaecological chair or on a bed with the legs extended in a "frog-leg" position and joined soles of the feet.
3. Participation of a small child's mother in the examination, close to the child's head and holding their hand. In the case of a teenager, the examination can be performed without the mother present (upon the victim's request).
4. Examining the skin of: the lower abdomen, the medial surfaces of the thighs, the buttocks, the anus, the perineum, the labia majora, and the mucous membranes of the rectal opening, clitoris, labia minora, and the vaginal wall.
5. The examination should be conducted gently, using a warm bivalve vaginal speculum designed for children (No. 1, No. 2).
6. Viewing the vagina with a colposcope, using a magnifying glass and an immunofluorescent lamp for the detection of semen.

7. Wiping the mucous membranes and the skin with 1% solution of toluidine blue – detecting microinjuries (disappearing after 48 hours).
8. Taking vaginal swabs (carefully, not touching the hymen) and other places for possible contact with semen. During this procedure, the child can hold the swabs to reduce anxiety and improve wellbeing.
9. In the course of the examination photographs should be taken for medical and court documentation.

NOTE: In the case of fresh extensive injuries and wounds, performing the examination following the above 1-6 principles can be impossible. The examination should be then performed under general anaesthesia in an operating theatre using specialist equipment (vaginoscope, cystoscope or ophthalmoscope).

Victims of sexual abuse in the legal aspect

Article 197 of the ACT of 6 June 1997 of the Penal Code clearly specifies that "§ 1. Anyone who, by force, illegal threat or deceit, subjects another person to sexual intercourse is liable to imprisonment for between two and twelve years.

§ 2. If the offender forces another person to submit to another sexual act, or to perform such an act in the manner specified in § 1, he or she is liable to imprisonment for between six months and eight years.

§ 3 If the offender commits rape: 1) in concert with another person, 2) against a minor under the age of 15, 3) against a descendent, ascendant, adopter, adoptee, brother or sister, he or she is liable to imprisonment for at least three years.

§ 4. If the offender commits rape specified in §§ 1-3, with particular cruelty, he or she is liable to the penalty of imprisonment for at least five years" [12].

According to Polish law, a child under the age of 16 cannot independently exercise the patient's rights to take decisions about diagnostics and treatment. These decisions are taken by their statutory representative (parent or guardian).

A child above the age of 16 but under the age of 18 can independently exercise patients' rights within a given scope, under his or her statutory representative's supervision. A child above the age of 16 has the right to directly participate in taking decisions (in using medical procedures) related to the choice and consent for health services in relation to them [13-14].

In the context of the analyzed problem, it is worth noting that criminal records all over the world report daily crimes related to sexual violence, the victims of which are people of both sexes, of different ages - unfortunately also children. This violence is perpetrated by depraved people. They commit these shameful acts out of various impulses. Child sexual abuse is a relatively new term for a problem that has existed for thousands of years [15].

Prevention of violence and therapy of children and families affected by sexual violence

Prophylactically, all legal guardians of all children should know what „bad touch" means, and how to defend themselves against it. It is important to conduct educational meetings for parents about bad touch, the consequences of molestation, and prevention. The child should have a sense of security. The tasks of doctors, nursing staff, educators, and psychologists are efficient and reliable identification of a crime, enabling the initiation of therapeutic activities and legal proceedings. Professional help from many specialists and close family members or carers is essential. A phased therapy (open door therapy) is recommended, which consists in allowing the child to return to a specialist at various stages of his life. In diagnostic and therapeutic procedures, it is important to empathically understand the young patient and to provide him with support, encouragement, and awakening hope for a better life. It is connected with a good relationship with the patient-victim of violence. The importance of creativity of the specialist conducting therapeutic sessions is emphasized. The therapeutic team should provide legal guardians of child victims of violence with knowledge about the rights of sexually abused persons. Psychological support, empathy, and the possibility of crying out and clearing bad emotions are important at every stage of the therapy. It is important to include individual therapy for the parent as well as group therapy. Facing the issues of violence on the part of the therapeutic team, an open attitude of the helper should be shown: a calm tone of voice, leaving the desk, leaning the body towards the child, and taking care of silence. However, it is not advisable to hug or touch the baby. The goal of therapy is to increase interpersonal skills in relationships with other children and peers. It is important to accompany the child in showing emotions, which are very often suppressed by him. Specialists should help to look for the child's strengths, skills, interests, and signs of independent thinking and acting. It is important to decouple guilt and shame from the children, and then help them name and express their feelings. As emphasized, interdisciplinary cooperation is important. The therapeutic teams include doctors and nursing staff, pychosexologists, school educators, teachers at the school attended by the child, and kindergarten teachers. The child should be treated subjectively - they should know who the helping person is, what their role is, why they talk to the child, how long the meetings will last and what they will consist of (in general), and what is the purpose of psychotherapy [16, 17].

Qui tacet, consentire videtur

The words of Boniface VIII, „Whoever keeps silence seems to allow" can be applied to the epidemic of silence that concerns sexual offenses against children. It is an unpleasant, inconvenient, problematic topic, which is why, unfortunately, in some circles it is believed that it is better not to touch it: it is easier to pretend that nothing has happened, that we do not see, hear or feel what we prefer not to think about. It is worth emphasizing that adults have defense mechanisms that order them to run away, shout, strike and defend themselves to the last

strength in an emergency. In children, these mechanisms are not yet so well developed, especially when the aggressor is a loved one on whom the child depends. Children are silent because of fear of the consequences. They are afraid of losing those they love. They do not want to let them down and disappoint them. Meanwhile, it is wrong if adults choose silence for fear of the administration of justice, family breakdown and shame. The price of the victims' silence is a disturbed life on the physical, emotional and social levels [15].

SUMMARY

The authors of reports on child sexual abuse have been emphasising that the majority of these cases are not revealed either by children or their carers for a variety of complex reasons. Thus, knowledge of the above presented somatic symptoms and changes in the child's behaviour that can indicate sexual abuse is essential in medical practice.

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