

# DSHS Grand Rounds

Oct. 15

## **Child Sexual Abuse: Are We Looking the Wrong Way?**

**Presenter: Nancy Kellogg, MD, Professor and Division Chief of Child Abuse, Dept. of Pediatrics, Univ. of Texas Health Science Center - San Antonio**



# Logistics

Registration for free continuing education (CE) hours or certificate of attendance through TRAIN at:

<https://tx.train.org>

Streamlined registration  
for individuals not requesting CE hours  
or a certificate of attendance

1. webinar: <http://extra.dshs.state.tx.us/grandrounds/webinar-noCE.htm>
2. live audience: sign in at the door

For registration questions, please contact Laura Wells, MPH at  
[CE.Service@dshs.state.tx.us](mailto:CE.Service@dshs.state.tx.us)

# Logistics (cont.)

**Slides and recorded webinar available at:**

<http://extra.dshs.state.tx.us/grandrounds>

## Questions?

There will be a question and answer period at the end of the presentation. Remote sites can send in questions throughout the presentation by using the GoToWebinar chat box or email [GrandRounds@dshs.state.tx.us](mailto:GrandRounds@dshs.state.tx.us).

For those in the auditorium, please come to the microphone to ask your question.

**For technical difficulties, please contact:**

GoToWebinar 1-800-263-6317(toll free) or 1-805-617-7000

# Disclosure to the Learner

## **Requirement of Learner**

Participants requesting continuing education contact hours or a certificate of attendance must register in TRAIN, attend the entire session, and complete the online evaluation within two weeks of the presentation.

## **Commercial Support**

This educational activity received no commercial support.

## **Disclosure of Financial Conflict of Interest**

The speaker and planning committee have no relevant financial relationships to disclose.

## **Off Label Use**

There will be no discussion of off-label use during this presentation.

## **Non-Endorsement Statement**

Accredited status does not imply endorsement by Department of State Health Services - Continuing Education Services, Texas Medical Association, or American Nurses Credentialing Center of any commercial products displayed in conjunction with an activity.

# Introductions



David Lakey, MD  
DSHS Commissioner  
is pleased to introduce our  
DSHS Grand Rounds speaker

# Child Sexual Abuse: Are we looking the wrong way?

Nancy Kellogg, MD  
Professor and  
Division Chief of Child Abuse  
Dept. of Pediatrics  
Univ. of Texas Health Science  
Center - San Antonio



# Learning Objectives

Participants will be able to:

- Describe the incidence and prevalence of child sexual abuse.
- Discuss disclosure patterns among victims of sexual abuse.
- Describe evidence base for detecting and interpreting physical evidence of sexual abuse/assault.
- Examine ethical issues involved in working with abused children.

# **Child Sexual Abuse: Are we looking the wrong way?**



- **How common is it?**
- **What are the clinical presentations of sexual abuse?**
- **How, why and when do children disclose abuse?**
- **What are the physical symptoms?**
- **What are the emotional/behavioral symptoms?**
- **How can we help victims and their families?**
- **How can we improve detection of sexual abuse?**

# How common is it?



- Prevalence: 26.6% of 17 yo girls and 5.1% of 17 yo boys report being sexually abused/assaulted during their lifetime(2011)
- Most vulnerable: girls>boys, ages 7-13 (but large jump from age 15 to 17 in 2011 study)
- Risk factors:
  - Children who do not live with both parents
  - Children whose parents are divorced
  - Children who live in homes with parental discord or domestic violence

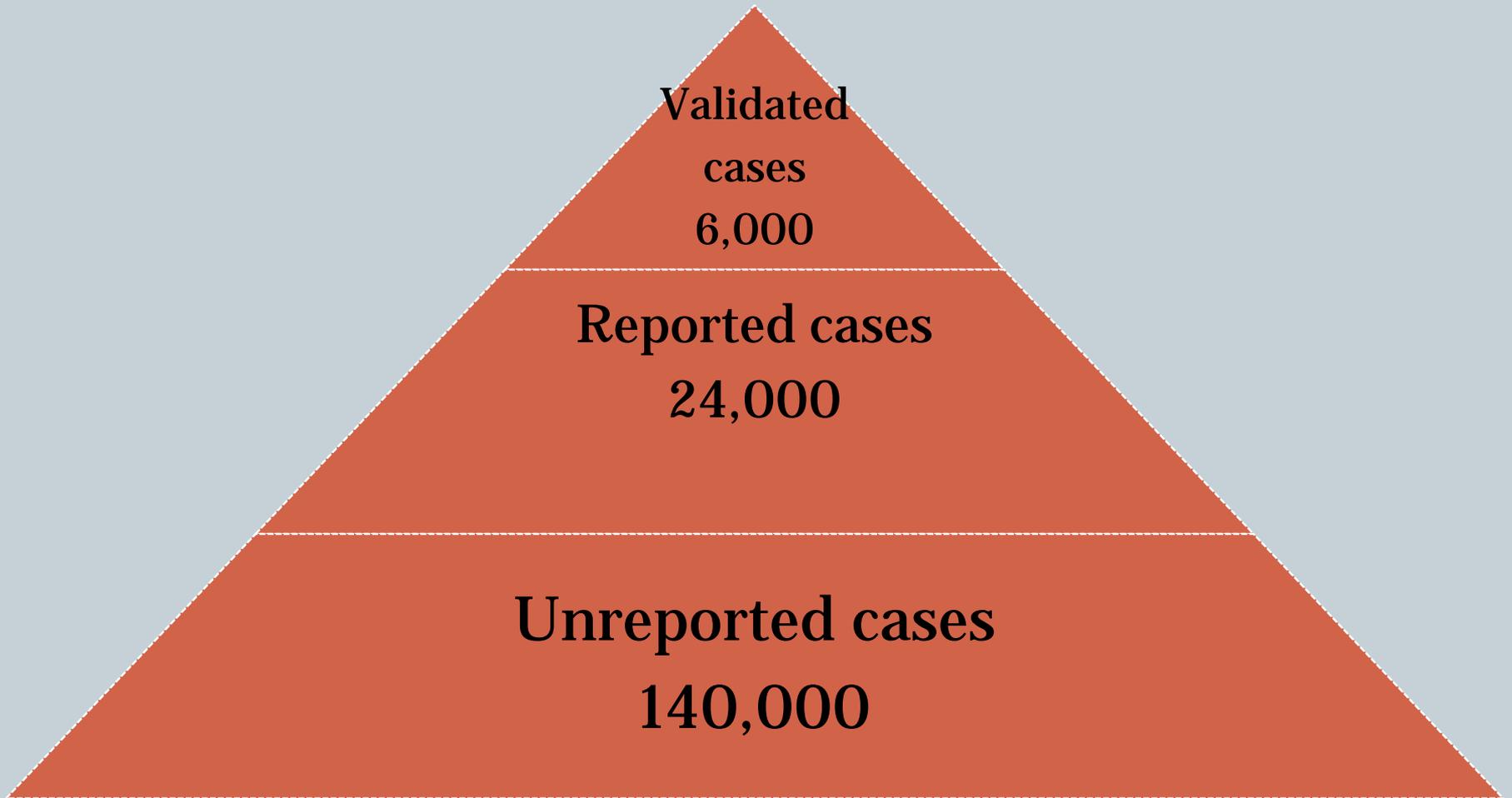
(Finkelhor et al, 2014; Humphrey & White, 2000;Crimes Against Children Research Center)

# Recent trends



- **CPS-substantiated cases of sexual abuse have declined 62% from 1992-2010**
  - 63,000 cases validated in 2010
  - CPS cases involve primarily sexual abuse by family members
- **Decreases also noted in FBI-reported rapes (35%), 3 victim surveys (29-69%), teen births (55%), teen suicide rates (30%) and sex offender re-offense rates (41%)**
- **National Survey of Adolescents showed no change over 10 years**
- **Probably a real decline, but sexual abuse still under-reported**  
(Finkelhor & Jones, 2012)

# Child Sexual Abuse in Texas (2013)



# Other recent trends



- **Increase in juvenile sex offenders**
  - Many involve sexual abuse of young family members
- **Increase in rapes resulting from internet solicitation**
  - 1 in 5 teens that go on-line regularly are approached by strangers for sex  
(Mitchell, Finkelhor, Wolak; JAMA 2001)
- **Increase in drug-facilitated sexual assaults**  
(Schwartz & Milteer, 2000)
- **In a telephone survey of 1560 youth, ages 10-17, 7.1% indicated they had received nude or nearly nude images of others**  
(Mitchell, Finkelhor, Jones & Wolak, Pediatrics 129; 2012)

# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- **What are the clinical presentations of sexual abuse?**
- How, why and when do children disclose abuse?
- What are the physical symptoms?
- What are the emotional/behavioral symptoms?
- How can we help victims and their families?
- How can we improve detection of sexual abuse?

# Clinical presentations



- **History:**
  - Child tells someone
  - Uncommon for abuse to be witnessed
- **Physical symptoms of injury or STD**
- **Emotional/behavioral symptoms**
  - Particularly sexual behaviors

# History from the child



- *More than 90% of the time child sexual abuse is first discovered when the child tells someone (Kellogg & Menard, 2003)*
- *Most children first tell a parent or a friend*
- *More children disclose to professionals (school, clinics, etc.) now than they did 10 years ago (Kellogg & Huston, 1995, Nienow, Kellogg & Nair, 2014, submitted)*

# Why is understanding disclosure important?



- Provides strategies for facilitating disclosures and increasing detection
- Provides guidance for supporting child when he or she is making a disclosure
- Enhances ability to provide ongoing support for the child and family following disclosure
- Opportunities to educate jurors, judges, public so child's history is given appropriate consideration

# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- What are the clinical presentations of sexual abuse?
- How, why and when do children disclose abuse?
- What are the physical symptoms?
- What are the emotional/behavioral symptoms?
- How can we help victims and their families?
- How can we improve detection of sexual abuse?

# Disclosure study



- Analyzed data from 661 children and adolescents presenting for acute (221) and nonacute(440) sexual assault/abuse examinations
  - Average age: 11.6 y
  - 89% female
  - >7% had >1 abuser
  - 30% of abusers were minors; 46% of these were family members/related to the victim

(Nienow, Kellogg & Nair, 2014, submitted)

# Disclosure questions



- “What kept you from wanting to tell right away?”
- “Why did you decide to tell?”
- “How old were you the first time [the abuse] happened?”
- “How old were you the last time [the abuse] happened?”
- “How old were you when you told?”
- “Did anyone say anything to you about telling?”

# Time to disclosure



- **Total sample:**  
mean 1.5 years;  
median 90 days
- **Non-acute  
sample: mean 2.3  
years; median 18  
months**



# Factors impacting time to disclosure (in non-acute group)



- Average delay was almost **2 years** longer for children victimized by **family members** than for those victimized by non-family members
  - If abuser is a parent, children wait 6.5 months longer to disclose than if abuser is another family member
- Average delay was about **1 year** longer for children victimized by **adults** than for those victimized by juveniles
- Hispanic children waited **>13 months** longer on average than African-American children to disclose
- Non-Hispanic white children waited **8.7 months** longer than African-American children to disclose

# Factors impacting time to disclosure



- **The younger the child was when the abuse began, the longer the disclosure time**
  - Children aged 0-5 yrs at onset of abuse waited 1 year longer to tell than children who were 6-10 yrs of age at onset of abuse
  - Children aged 6-10 yrs at onset of abuse waited 2 years longer to tell than children who were 11-15 yrs of age at onset of abuse

# Factors impacting time to disclosure (in non-acute group)



- Children with a history of abuse involving penetration delayed disclosure **no longer** than children who did not have a history of penetration
- Boys did not wait any longer than girls to tell
- Average delay in disclosure for children who were **threatened** by the abuser was **109 days** longer than for children who were not threatened
  - Overall, only 29% were threatened



“I didn’t want to tell because when I told the first time [I was abused], it ruined everything. It took all my mother’s happiness away.”

- Lauren, age 14, sexually abused from 3 to 6 by mother’s boyfriend, then sexually abused from ages 11 to 14 by her stepfather

# “Why didn’t you tell?” - Major themes



- Fear of consequences
- Incapacitating feelings
- Lack of opportunity or person to tell
- Told not to tell
- Didn’t think/know it was wrong



# Fear of consequences (52%)



- **Child or others threatened by abuser (explicit or implicit)**
  - “I thought it would hurt my mom, and that’s the only reason I didn’t tell because if I let him do it to me he didn’t hurt my mom”
- **Fear of consequences to self or others, including abuser**
  - “I was scared of being punished”
  - “I didn’t want him to get in trouble”
- **Fear of how others will react, especially parents**
  - “I didn’t want to hurt mom’s feelings”
  - “I was afraid no one would believe me”
- **Among theme groups for nondisclosure, this group waited longer than any other group to disclose**

# Incapacitating feelings (22%)



- Abuse generated uncomfortable feelings
  - “I felt guilty, no disgusted is the right word”
  - “I was ashamed and embarrassed”
- Avoidance/denial
  - “I don’t like thinking or talking about it”
- Unspecified fear
  - “I was scared”

# Lack of opportunity or person to tell (7%)



- **Didn't know who/how to tell**
  - “I didn't know how to say it, how to tell mom and dad that a person we trusted hurt me”
- **Lack of prior protective response**
  - “I didn't think mom would do anything. He would get drunk and beat her and he would leave but she always took him back, so what was the point?”

# Told not to tell (5%)



- “He said to keep it a secret”
- “I pinky promised not to tell”



# Didn't think/know it was wrong (4%)



- **Consensual**
  - “It was my decision”
  - “I didn't tell him no”
- **Didn't know it was wrong**
  - “He would do it so much I thought what we were doing was something normal”
  - “At first I didn't know it was wrong”

# “Why did you tell?” - major themes



- **External factors (56%)**
  - Found opportunity or person to tell
  - Witnessed/rescued/someone else told
  - Needed help from others because of physical, psychological or behavioral symptoms or concerns
- **Internal factors (44%)**
  - Pressure cooker
  - The right thing to do
  - Felt safe

# External factors



- **Found opportunity or person to tell**
  - “The night before my grandma was talking about something similar that happened to her when she was little”
  - “The doctor asked me”
- **Witnessed/rescued/someone else told**
  - “Mom walked in”
  - “My sister told my mom”
- **Needed help from others because of physical, psychological or behavioral symptoms or concerns**
  - “I kept waking up crying and screaming”
  - “I was worried I had an STD/was pregnant”

# Internal factors



- **Pressure cooker (most common disclosure reason)**
  - “I wanted to get it out-it was like a soda can, just shaking and shaking”
- **The right thing to do**
  - “Just knowing that if I didn’t [tell], other people could get hurt and he would get away with it”
  - Shortest disclosure time of all external/internal factors
- **Felt safe**
  - “I told because my mom left him”

# Partial and non-disclosures



- **Partial disclosures are statements that exclude certain types of abusive acts or minimize the frequency of such acts.**
- **Non-disclosures are denials or refusals to answer questions about abuse despite strong evidence that abuse has occurred**
- **Partial and non-disclosures are more common with:**
  - Family member perpetrators
  - Children who blame themselves
  - Children who think they may lose their family or who protect the abuser
  - Younger children
  - Shy/reticent/slow-to-warm-up children

# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- What are the clinical presentations of sexual abuse?
- How, why and when do children disclose abuse?
- **What are the physical symptoms?**
- What are the emotional/behavioral symptoms?
- How can we help victims and their families?
- How can we improve detection of sexual abuse?

# Physical signs and symptoms of sexual abuse



- Uncommon (most victims of sexual abuse have no signs or symptoms)
- Nonspecific (many causes are possible for a given symptom)
- “Signs” are not diagnostic, but rather indicate a need for further history or testing
- The timing of the physical or behavioral symptom may be significant if related to timing of abuse
- About 85% of children referred for sexual abuse evaluations because of physical signs *only* will have conditions unrelated to sexual abuse (Kellogg, Parra & Menard, 1998)

# **Physical signs and symptoms** ***sometimes* associated with sexual abuse**



- Genital or anal pain
- Genital or anal bleeding (excluding menses and anal fissures)
- Ano-genital bumps, blisters or sores
- Genital discharge
- Pain on urination, UTIs
- Enuresis (urinary incontinence)
- Encopresis (fecal incontinence), fecal withholding
- Stress-induced headaches and stomachaches

# Sexually transmitted diseases in children are:



- Uncommon, occurring in fewer than 10% of prepubertal and 10-20% of pubertal patients evaluated for sexual abuse (Gavril, Kellogg, Nair, 2012; Shapiro, Makoroff, 2006)
- Usually associated with no symptoms
  - Possible exception: prepubertal children with gonorrhea
- Detection rates are changing due to increasing use of nucleic acid amplification tests for gonorrhea, chlamydia, HSV and Trichomonas

# Acute sexual assault injuries are....



- **Uncommon in females (10-40%);** (Adams et al 2014), especially uncommon in prepubertal females
- **Rare in male victims (fewer than 5%)**
- **Small (average about 2 mm in size, per injury)**
- **Difficult to find in pubertal females (hidden between folds of hymen)**
- **Most commonly seen in the posterior vestibule in females** (Adams et al, 2001)

# Healed injuries are....



- Rare in females (5-10%; least common in prepubertal children; Heger et al, 2002)
- Extremely rare in males
- Difficult to detect and confirm
- Are *not* more likely with increasing number of penetrations (Anderst, Kellogg, Jung, 2009)
- Are more likely when child reports bleeding but only 20% of females with bleeding and penetration have healed injuries (Anderst, Kellogg, Jung, 2009)

## Most examinations of children and adolescents evaluated for sexual abuse are normal because:



- The type of abuse did not result in observable tissue damage
  - Children often cannot reliably differentiate between contact and penetration

OR

- The abuse/assault did result in observable tissue damage but the injury(s) has healed completely,

OR

- No abuse occurred

# Why “normal” does not mean “nothing happened”



- **Most exams of pregnant females are normal** (Kellogg, Menard & Santos, 2004)
- **Most exams of children with STDs are normal** (Kellogg, Baillargeon, Lukefahr, Lawless, Menard, 2004; Gavril, Kellogg, Nair, 2012 )
- **Many exams of children with acute trauma are normal within a week** (McCann, Miyamoto, Boyle, Rogers, 2007)
- **Many exams of children whose abusers have confessed to penetration are normal**

# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- What are the clinical presentations of sexual abuse?
- How, why and when do children disclose abuse?
- What are the physical symptoms?
- **What are the emotional/behavioral symptoms?**
- How can we help victims and their families?
- How can we improve detection of sexual abuse?



“I felt like screaming. It hurt. But it was like I was in a dream. You try to move but you can’t. You open your mouth but there is no sound. You can’t scream when you’re dreaming”

- Sarah, age 15, explaining how she felt the first time her stepfather abused her

# Behavioral indicators that are associated with, but may not be specific for, sexual abuse



- Sleeping difficulties, including nightmares
- Change in eating habits or appetite
- Change in school functioning, either academic or behavioral
- **Sexual behaviors**
- Runaway
- Self-injurious thoughts or behaviors
- Timing of symptoms may be important

# Sexual behaviors in children



- Parent witnesses behavior and wants professional to evaluate child for sexual abuse
- Parent witnesses behavior, asks child where idea came from, and sexual abuse is disclosed
- Sexually abused child engages in frequent, disruptive sexual behaviors and parent/caretaker presents for management

# Definitions



- **What is “sexual behavior?”**
  - Includes solitary behaviors (e.g., touching self)
  - Behaviors that involve others
  - May involve contact or non-contact behaviors, such as talking about sexual topics or viewing nudity
- **What is the purpose of the behavior?**
  - Sexual gratification
  - Self-soothing
  - Curiosity
  - Imitation
  - Attention-seeking
  - Reactive

# Normative sexual behaviors



- Sexual behaviors that are observed in children who do not have risk factors for abuse, and that are developmentally appropriate and expected
- Wide range of prevalence (<1% to 60%) and frequency for each type of behavior (Friedrich, et al., 2001)
- Other terms
  - “Sexualized behaviors”
  - “Sexual play”

# Normal sexual behaviors



- Vary in frequency and type by child's age and development
- Touching own genitals/anus, viewing/touching others, sitting/standing too close are common behaviors in children up to 9 years of age
- Behaviors are transient, occasional and distractable
- Behaviors become more covert as child ages and learns social taboos

# Sexual behavior problems



- Children 12 and younger who “initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks or breasts) that are developmentally inappropriate or potentially harmful to themselves or others.” (Association for the Treatment of Sexual Abusers, 2006)
  - “Developmentally inappropriate” are sexual behaviors that
    - Occur at a greater frequency than seen in normative groups
    - Occur at a much earlier age than would be expected
    - Become a preoccupation for the child
    - Persist/reoccur after adult intervention
  - “Potentially harmful” sexual behaviors involve coercion, or cause physical injury or emotional distress

# Sexual abuse and sexual behavior in children



- Sexually abused children are 2-3 times more likely to display sexual behaviors with greater frequency than children who have not been sexually abused or who have psychiatric diagnoses (Friedrich et al., 2001; Cosentino et al., 1995)
- About 28% of sexually abused children have sexual behavior problems (Kendall-Tackett et al., 1993)
  - Most common in younger children
  - Risk factors (Cosentino et al, 1995; Friedrich et al., 2001):
    - Onset of abuse at a young age (0-3 years)
    - Father figure perpetrator
    - Abuse involving penetration
    - More than one perpetrator
    - Use of force
    - Self-blame

# Problematic sexual behaviors



- Sexual behaviors between children 4 or more years apart
- One child “takes charge” and directs the time, place, type of sexual contact
- Masturbation that is persistently obsessive and difficult to distract
- Sexual behaviors that produce distress and anxiety in at least one child
- Asking adults to engage in specific sexual acts

(Kellogg & COCAN, *Pediatrics*, 2009; Kellogg, *American Family Physician*, 2010)

# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- What are the clinical presentations of sexual abuse?
- How, why and when do children disclose abuse?
- What are the physical symptoms?
- What are the emotional/behavioral symptoms?
- How can we help victims and their families?
- How can we improve detection of sexual abuse?



“I don’t know if my mom believes me. At night, everyone is crying. My mom doesn’t know who to believe, and my little sister and brother cry for their father.”

-Amy, age 10

# What does the mother do when her child discloses abuse?



- **60%: believe and support the child, report promptly to authorities**
- **20%: don't believe the child, don't report**
- **20%: don't know whether to believe the child or perpetrator, delay reporting or "talk" to the perpetrator to try to stop the abuse**

(Kellogg & Menard, Child Abuse & Negl, 2003)

# Assess child's sense of security



- Are they are afraid of anything or anybody?
- Do they think (or know whether) their parent(s) believes/supports them?
- Do they worry about what family members think?
- If the child has fear or senses disbelief, recantation is a risk
- Speak with CPS investigator if concerns are identified

# Assessing parent's degree of support/belief



- Is child in therapy?
- What do they think about the child's disclosure?
  - It is common for investigators to NOT inform the parents of the details of the child's statements while investigation is being conducted
- Provide guidance about “normal” disclosures
  - Partial disclosures are common
  - Many tell friends before telling a parent
- Clarify meaning of a normal exam
  - Most exams are normal, even those of pregnant teens!
  - Normal does not mean “nothing happened”

# Parents need to know...



- Children need to **KNOW** that parents will believe and support them if they disclose
  - Fear of parental response is the single most common reason children don't tell
- Delay in disclosure is common, long, and does *not* mean that children don't love or trust their parents
- Most children are not explicitly threatened by their abuser



# Child Sexual Abuse: Are we looking the wrong way?



- How common is it?
- What are the clinical presentations of sexual abuse?
- How, why and when do children disclose abuse?
- What are the physical symptoms?
- What are the emotional/behavioral symptoms?
- How can we help victims and their families?
- How can we improve detection of sexual abuse?

# Be alert to behavioral changes



- **Mood and temper swings**
- **Withdrawal from friends and teachers**
- **Reluctance to go home or be with someone; runaway behavior**
- **Sexual behaviors that develop suddenly, and are frequent and varied**
- **Signs of sleep deprivation**
- **Hints in personal reflections/essays**
- **Hints in conversations**
- **Concerns voiced by friends**

# Demonstrating care and concern in a non-threatening setting



- Show you are comfortable with the topic of sexual abuse...and bullying, harassment, physical abuse, etc.
- Ask more! Talk about sexual abuse/assault as opportunities/situations arise
- Acknowledge the difficulty children have talking about it, as many worry about family responses
- Outline reasons why disclosure is a good idea
  - Best way to stop the abuse and get help
  - Helps prevent abuse to others
- Give them ways to contact you confidentially

# General Guidelines



- Earn, don't assume, the child's trust
- Be honest, informative, and respectful to the child
- Give the child permission to talk to you about anything uncomfortable, confusing or threatening
- Tell them why you are worried
- Do not “peddle” your suspicions
- Give the child time to think about what you said if disclosure does not occur

# If a child begins to disclose abuse...



- Be open, receptive, and supportive, **NOT** judgmental, skeptical, analytical, shocked, or surprised
- Use open-ended prompts: “And then what happened?”
- Verify information by repeating, not paraphrasing or interpreting the child’s words
- Gather **only** information needed to make a report

# Summary



- The detection of child sexual abuse depends more on what we *hear*, not what we *see*
- Victims are more likely to disclose if they find the right person or opportunity, or because they need help with their physical or emotional health
- Children fear how others, especially parents, will react more than they fear being harmed by the abuser
- Clinicians have opportunities to help children disclose abuse and to help families support children following disclosure

# Questions and Answers



James A. Rogers, MD  
Medical Director  
Texas Dept. of Family  
& Protective Services

Remote sites can send in questions  
by  
typing in the *GoToWebinar* chat  
box or  
email  
[GrandRounds@dshs.state.tx.us](mailto:GrandRounds@dshs.state.tx.us).

For those in the auditorium, please  
come to the microphone to ask  
your question.

# Our Next Grand Rounds

Oct. 22

## **Mystery Shopping in Healthcare Yields "Aha Moments"**

**Presenters: Garrett Craver, Spindletop  
MHMR; David Lloyd, MTM Services;  
Melissa Brown, DSHS; Kellye Mixson,  
RN, DSHS**

