CHALLENGING CASE: BEHAVIORAL CHANGES

Erica: A Question of Sexual Abuse*

CASE

Erica, 20 months old, is brought to the office of her pediatrician by her mother who is concerned about the possibility of sexual abuse. She describes her daughter’s behavior as unusual during the past 2 weeks. At first, she thought Erica was experiencing abdominal pain when she pointed to her abdomen. Gradually, it became apparent that she was pointing to her vagina with the utterance “ooh.” Erica’s mother noted that she seemed more withdrawn and less animated when left alone. However, she remained interactive and responsive with her mother, and there were no separation problems when leaving her at child care each day.

About 1 week later, while alone with her mother, Erica said, “Daddy...play” several times. When her mother inquired what she and her daddy played, Erica took her mother’s hand, went to her parents’ bedroom and pointed to their bed. At the same time she pointed to her vagina and said, “Daddy...play.” Her mother, who appeared surprised and alarmed, thought Erica was imagining something. When her mother asked Erica about “Daddy...play” the following day, Erica repeated the bedroom scene. This event, coupled with Erica’s atypical quiet periods of play, gave her mother reason to believe that she may have been sexually abused.

Erica’s mother asked her pediatrician three questions: “Could my daughter make up such a story?” “If it is true, what do I do now to prevent it from happening again?” and “Will it harm my child for her life?”

Dr. Martin Stein

Behavioral problems among children that are an outgrowth of family and societal violence have become a standard part of pediatric practice. Maltreatment of children is not new. Literature, art, and a broad range of historical documents record violence and neglect directed toward children for many years. Recognition of childhood as a distinct developmental stage, the sociopolitical reform movements of the late 19th and early 20th centuries, and dramatic medical reports of abuse by bold pioneers of pediatric radiology1 and medicine2 created an environment in which recognition, management, and prevention of child abuse and neglect are an important part of medical practice.

The case under discussion reminds us that many cases of maltreatment, especially sexual abuse, present to the pediatrician as a cluster of behaviors reported by a parent that only suggest abuse. An understanding of normal behaviors at a particular developmental age guides the diagnostic process. But the limitations of this approach soon become apparent. Knowledge about confounding factors, such as subtle family violence, marital discord, alcohol and drug abuse, and parental histories of abuse, are critical to formulating a diagnosis. Yet this kind of psychosocial database may be unknown to the pediatrician when confronted with potential child abuse. The process of information gathering to make an informed decision requires communication skills, knowledge about child development, risk factors and family dynamics, and an ability to accept, at least initially, a respect for uncertainty.

Joyce Adams, M.D., Associate Professor of Pediatrics at the University of California, San Diego School of Medicine, provides a perspective to the initial evaluation from the point of view of a general pediatrician. Dr. Adams has conducted several studies that delineate physical findings and behaviors among abused children. Robert Wells, Ph.D., Associate Professor of Pediatrics and Psychiatry at the University of California, San Francisco School of Medicine, approaches this case from the point of view of a child psychologist. His emphasis on developmental expectations and family function complements Dr. Adams’ commentary.

REFERENCES


Dr. Joyce Adams

This case would cause anxiety and uncertainty for most pediatricians. Do the words “Daddy...play” said while pointing to the parent’s bed constitute a history of molestation? How far should the pediatrician go in questioning the child? Should a genital examination be performed? The pediatrician needs to ask these questions and develop at least tentative responses as he or she begins to address the mother’s concerns.

More information is needed about the family to determine whether the child’s words and actions might be cause for suspicion of abuse. Do the parents live together? Has the child seen either parent nude? Does the father play physically active games with his

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daughter, such as frequent tickling or wrestling games? Is it possible that the child might have surprised her father while he was lying on his bed masturbating? Have the parents noticed the child masturbating herself? Has the child ever observed the parents during a sexual encounter? Was the mother herself sexually abused as a child, an experience that may be associated with a heightened awareness about the possibility for abuse?

Has the child’s behavior changed in other ways, such as nightmares, fearfulness of others, attempts to touch the genitals of children or adults, or repetitive kissing with an open mouth? These problems have been found to occur more frequently in sexually abused, compared to nonabused, girls.1 Has the child complained about painful urination or painful bowel movements? Is toilet training in process, so that the child has more access than usual to her own genitals?

Children are sexual beings. They explore their own genitals and discover that they can touch themselves to bring about pleasurable feelings. By parent report, 54% of nonabused girls ages 2 to 6 years will touch their own private parts when at home.2 When Erica points to her genitals and says “ooh,” this activity may represent such a discovery consistent with the exploratory nature of her age. Without other information, it should not raise a concern about sexual abuse.

Should the pediatrician interview the child about possible inappropriate sexual touching?3 Adequate development of receptive language is critical; limited expressive language development may not preclude information gathering. A few questions might be useful in sorting out the concern expressed by Erica’s mother. With a child of this age, questions during the physical examination may be the most productive. While conducting a physical examination in a non-threatening manner, the physician can ask the child, “Show me your...” for a variety of body parts, working down to the “belly button” and then determine whether the child has a name for her genitalia. Then the physician could say: “Now I need to check your pee-pee (privates, che-che, etc.) to see if you have any bumps or owwies there.”

If the clinician has made it a practice to check the external genitalia on all girls by separating the labia and looking at the hymen when they have a complete physical examination, an appropriate knowledge of the range of normal appearances of the hymen and contiguous anatomy will be achieved. If not, the normal reddish appearance of the vestibule and the normal distensible hymen in a girl of this age who is relaxed, lying on the examination table, or in mother’s lap or the normal slight dilation of the anus in a child who has stool in the rectal vault, or a number of other normal or nonspecific findings may cause alarm.4 If the pediatrician is not experienced at meticulously observing genitals or ani, an attempt to assess the normalcy of the hymen and other structures may be both frustrating and inaccurate at a critical clinical moment. A brief, external genital and anal examination to look for bleeding, bruising, rashes or discharge should be done, however; these physical signs are more apparent to an examiner.

In the case of Erica, if the child has not shown any sexually explicit behaviors or any sudden emotional or behavioral changes other than periods of quiet play and if the genital examination is normal, I would not be suspicious of abuse. According to the American Academy of Pediatrics guidelines, behavior changes in the absence of a clear history of abuse and with no physical or laboratory findings, usually leads to a low level of concern about abuse.5 Erica’s mother can be reassured that, although we may not know what she meant by “Daddy... play,” there is no need to jump to the conclusion that the child has been molested. She should be watched for any additional changes in her behavior. The mother might be encouraged to ask the father what he thinks the child might be talking about, but abuse accusations are highly toxic to a marital relationship and in this case are probably not warranted.

All of the questions Erica’s mother asked are based on the assumption that the child has, in fact, been molested and that it will be possible to arrive at “the truth” by some means or another. Unfortunately, with a very young child, finding “proof” that molestation occurred is the exception rather than the rule. Most children giving a history of molestation will not have definitive medical findings,6 and unless there are eyewitness reports of the child being molested or photographic evidence of the molestation or unless an alleged perpetrator confesses to molesting the child, it will not be possible to “prove” that the abuse occurred.

So what can a pediatrician to do? In the case of Erica, my suggestion would be to ask the mother why she thinks Erica’s words and actions are suspicious for abuse. If there is more to the story than she initially presented, the physician may want to consider making a report to child protective services to arrange for the child to be interviewed and examined by a specialist. If the sole reason for the mother’s suspicions are based on the facts stated in the case, the pediatrician can examine the child and reassure the mother that everything looks fine and that most likely nothing sexual has happened to the child.

REFERENCES
Dr. Robert D. Wells

When first confronted by a history that may suggest sexual abuse, the clinician should carefully avoid premature haste in drawing a conclusion and should proceed by obtaining data that will assist in determining whether reasonable suspicion of abuse is present. In the case of Erica, it is possible from the information presented either to believe that she was indeed molested by her father or to wonder if her mother misunderstood her comments about “Daddy...play.” Anxiety among clinicians when confronted with such a case is predictable because mistakes of over or under suspicion can have grave consequences for the family.

Given her young age and her complaints of abdominal or pelvic pain, a complete physical examination is indicated, and a urinalysis to rule out a urinary tract infection is essential. In the vast majority of cases of true molestation (with or without penetration), the genital examination is unremarkable. The examination should be done with careful preparation of the young patient. Forensic samples should be taken, and the examiner should have experience assessing young children for sexual abuse. If the primary care physician does not feel adequately trained, a referral should be considered to a sexual abuse clinic, where a colposcopic evaluation can be done.

The mother should also be interviewed without her child present to discuss the presence of other behavioral signs suggestive of sexual abuse. Sudden emotional or behavioral changes can be indicative of sexual abuse. Erica’s quiet periods are apparently her only change in behavior. Other important signs to ask about are fearfulness of being left with a particular person, withdrawal, and an increased sexual interest and knowledge. It is important to realize that these signs are relatively rare in nonabused, nontraumatized children but may be completely absent in 30% of those who have been sexually abused.

It also would be important to learn more about the parents’ relationship and whether there is marital stress and the possibility of separation and divorce. It is important to note that the greatest frequency of false allegations of child abuse occur in the context of contested custody. The mother may also be asked if she has ever worried about her husband’s sexual behavior with other minors.

Given Erica’s young age, she should be interviewed by a trained sexual abuse clinician. Initially, rapport should be established, and open-ended questions about “Daddy...play” can be asked. If Erica has difficulty describing his actions, anatomically correct dolls can be introduced to help her localize and act out the events that transpired. All of this should be carefully but obtrusively videotaped for later review. The video tape is useful to rule out examiner bias and undue pressure to confess to particular actions. If legal action is taken, the tape may also be introduced into evidence and may, under ideal circumstance, limit the number of times Erica will need to tell her story to attorneys. Young children, especially toddlers, are susceptible to leading questions, and once the story is solidified, it will often be re-told over and over again. It is critical to avoid introducing information to young children that they themselves have not yet offered because young children may be susceptible to suggestion in these situations.

Once the information from the parent interview, the child interview, and the physical examination is available, the clinician must determine if a child abuse report should be filed. This is based on one’s belief that a reasonable suspicion exists that molestation did in fact occur. This decision can be aided by determining if another professional with similar training would come to the same judgment. If a reasonable suspicion is present, the clinician must file a report with the proper authorities. If a reasonable suspicion does not exist, the parent will need to be further counseled, and a follow-up appointment for the child is advisable to carefully maintain appropriate vigilance. Recent studies have shown that individual clinicians vary widely in their decision making regarding the need for mandated reporting. As this decision carries extreme consequence, it must be carefully thought out, and all evidence should be considered.

As for the mother’s questions: “Could my daughter make up such a story?”: It appears that her daughter had said nothing more than “Daddy...play” and pointed to the bed and her pelvic area. It is possible that he was tickling her on the bed and this might, under today’s climate of epidemic sexual abuse worries, lead the mother to believe that her husband sexually abused his daughter. If Erica goes on to describe fondling, oral genital stimulation, or digital or genital penetration, these disclosures would be very unlikely to occur without sexual exposure of some sort or direct coaching. However, it is not unusual for a young child to express vague statements that, in turn, parents overreacted to and then go on to anxiously question the child with direct information. Young children may agree that various things have happened in an attempt to satisfy the questioner.

“If it is true, what do I do now to prevent it from happening again?” If her father did indeed molest her, a charge of abuse should be filed. Intra-familial incest between a biological father and daughter is relatively rare; most perpetrators are nonrelative males residing in the home. Sexual abuse of 20 month olds certainly occurs but is also somewhat rare. Most pedophiles are quite compulsive and driven. If, indeed, Erica’s father molested her, the risk for repeat victimization is significant. In cases in which these concerns are brought to the attention of a physician, it is not unusual for parents to separate and courts to order supervised visitation by the suspected parent. This allows improved safety for the child, and the parent and child do not lose the healthy aspects of their relationship.

“Will it harm my child for her life?” Predicting future behavior is very difficult and complex. Most of the literature on long-term sequelae is derived from adult victims seen in psychiatric settings. This tends to increase the extent to which prior abuse is
considered to be a potent source of disruption and cause of subsequent psychopathology. In contrast, follow-up studies of children evaluated for abuse find that a significant proportion become symptom free. In addition, most individuals have very little active memory recall for events that occurred before the age of 4 years. If the abuse was relatively non-bizarre or complicated by extreme physical trauma or emotional abuse, it is likely to be forgotten by the child but not by the mother. Perhaps the most accurate, best prognosticating factors are the extent to which Erica was previously well adjusted, her temperament, the ability of her parents to maintain structured and predictable family functioning, and her parents’ ability to cope with this extreme stressor. The most accurate answer a clinician can give is that for this particular child, it is hard to say if this event will harm her. In all likelihood, it does not have to; children are quite resilient. Most reassuring will be a plan to continue to carefully assess Erica to determine her functioning and a willingness to refer for psychological interventions if indicated.

For the health care provider, this case can rarely be resolved to everyone’s satisfaction. There are essentially three possible conclusions: (1) there is strong evidence of abuse, and a child abuse report is filed; (2) the evidence is not significant enough to reach reasonable suspicion; or (3) there is clear evidence that abuse did not occur. In most cases, the health care provider must tell the parent the worst of these possibilities: “We don’t know.” This leaves the parent in a significant quandary regarding her spouse. Has she spoken with him about her concerns and Erica’s comments? Would she leave him? Does she herself believe that Erica is safe or unsafe in his care? How can she come to trust him or to learn not to trust him? These are the tough questions that arise when the evidence is insufficient.

Clearly, the best scenario is that there is clear evidence that abuse did not occur. Perhaps a urinary tract infection is found, and the father’s explanations of his “play” appear completely open and appropriate. Even then, abuse cannot be completely ruled out. It is very rare that a clinician can determine that abuse definitely did not occur. In my practice, I have found it helpful to show parents the list of normative sexual behaviors that were found among nonabused children. When the concerning behavior was found among a large proportion of nonabused children, I have found that this is very comforting for parents and helps reassure them. When a behavior is of low frequency, it also suggests the need to take their concern as potentially more serious. Erica’s concerning behavior is not of a sexual nature and thus does not appear on the list.

In the last scenario, reasonable suspicion is met, and a report is made to the proper authorities. This typically creates a significant crisis for all members of the family. The father may be removed from the home and may be incarcerated. The family may go into significant debt with legal fees. Erica may be subjected to repeated interviews and additional exams. If the mother does not appear to be cooperating with Child Protective Services and is seen as the ally of the perpetrator father, Erica and the other children can be removed and placed in foster care. Unlike earthquakes or other natural traumas, this will be a family secret that will isolate the family from friends, neighbors, and extended relatives. Even if the charges against the father are eventually dismissed or he is found innocent, his reputation may be indelibly harmed.

These are the cases that we wish our colleague handled while we were at a conference. They are extremely difficult and emotionally unsettling to all involved. The best advice is to see this as a difficult surgical procedure with a low probability of success but one in which there are no other options. Consider yourself an extremely well trained and thoughtful person and try your best to follow appropriate guidelines to “do no harm.” The initial assessment and management of Erica and her mother will require considerable skills, knowledge, and sensitivity.

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REFERENCES


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Precision and certainty in formulating a diagnosis is the rule rather than the exception in primary care pediatric practice. A potential child abuse case, such as the sexual abuse implied in the case of Erica, requires a cognitive shift in the diagnostic process. The clinician may be challenged to move from a position of uncertainty to one of possibility. Traditional mechanisms that usually lead to a diagnosis (pattern recognition, algorithm and hypothesis generation) may be ineffective after an initial assessment. Drs. Wells and Adams provide a guide to managing this period of diagnostic uncertainty by
means of generating several hypotheses based on available data from pediatric, psychological, and child abuse literature.

When confronted with a history like the one given by Erica’s mother, pediatricians usually make use of their developmental knowledge about young children. One might ask two questions: Is a 20-month-old toddler aware of gender differences, and is she capable of describing a sexual event? It is known that gender recognition develops between 10 and 18 months when a child has the ability to recognize a person as a man or a woman. She can even recognize a voice that belongs to a man or a woman. The internal or private belief that “I am a boy (or girl)” occurs between 18 months and 3 years with the consolidation of a gender identity. A specific interest in genitals develops between 16 and 20 months, followed by naming genital parts usually after the second birthday. Approximately one-third of toddlers are either observed or reported to engage in pleasurable genital exploration.2 These developmental observations of gender recognition, identity, and sexual exploration suggest that a 20 month old has the capacity to internalize an experience that is focused on gender and genital differences.

But can a young toddler like Erica use language to communicate effectively a sexual event? To some extent, it depends on a child’s expressive language skills, which are highly variable in output at this age. Dr. Wells points out that, as a result of a toddler’s susceptibility to leading questions, a response may be solidified once told regardless of veracity. This observation reflects a more mature receptive language capacity that provides the toddler with a foundation for understanding language. With limited expressive ability, Erica can follow commands (from a potential perpetrator) and questions (from a clinician). The recognition of limited expressive language skills coupled with more mature receptive skills has led some clinicians to use anatomical dolls in interviewing children during assessments of suspected child sexual abuse. Although a controversial practice, recent literature has demonstrated the value of anatomical dolls during diagnostic interviews conducted by an experienced professional.3 This clinical technique requires special training with appropriate supervision.

Cases such as Erica’s are among the toughest problems faced by an office-based pediatrician. Drs. Adams and Wells highlight several important points for the general pediatrician:

1. Consider physical causes for symptoms and behaviors that imply sexual abuse, e.g., constipation, urinary tract infection, benign causes for vaginitis (less than 5% are secondary to abuse), and rectal fissures.
2. A discordance between actual sexual abuse and specific physical findings is the rule rather than the exception. Dr. Adams points out the few specific findings that are consistent with abuse. Most sexually abused children have normal physical examinations.
3. Prepare a child for a physical examination when sexual abuse is under consideration with a reassuring reminder that “this will be like a regular exam (or check-up).” An internal pelvic examination is rarely indicated.
4. The recognition of abnormal physical signs on a genital examination is strengthened by examining the genitalia of a significant number of normal children.
5. Use a pediatric knowledge of normal development with a focus on language capacity and cognitive aspects of sexual maturation.
6. Consult with a colleague when uncertain. Refer to a center or specialist when a videotaped interview or a complete gynecological examination may be necessary.
7. Reasonable suspicion of sexual abuse requires a report to a child protective service agency and referral to a trained sexual abuse clinician.

A dilemma arises when “reasonable suspicion” either does not exist or the clinician remains uncertain after a complete history and physical examination. Consultation with a colleague or a child abuse specialist may assist the general pediatrician when confronted with this problem. Vigilant observation with frequent follow-up visits (“watchful waiting”), so effective in many uncertain clinical situations, may be appropriate in some cases. It is a strategy that allows a process to unfold or resolve over time. The relationship that grows among the clinician, parents, and child may be both therapeutic and lead to a clearer diagnosis.

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