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Research Paper

# Identifying and Dealing with the Problem of Childhood Sexual Abuse

Medical Science

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## ABSTRACT

*Child sexual abuse (CSA) typically includes unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse. Anyone who is a survivor of sexual abuse, is likely aware that the trauma of the abuse can last a lifetime. Flashbacks of feelings or events can arise at any given moment for abuse survivors. Dentist's role emerges as the one attending to all the dimensions of the patient's presentation and management apart from the diagnosis and treatment of the oral pathobiology.*

**Introduction**

Child sexual abuse (CSA) typically includes unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse. CSA can vary along a number of dimensions including frequency, duration, age at onset, and relationship of victim to perpetrator. However, the most common dimension used to define CSA is type of abuse. Three categories are commonly reported in the literature. Noncontact abuse encompasses a range of acts and includes inappropriate sexual solicitation or indecent exposure. The two other categories are contact abuse, which includes touching or fondling, and intercourse, which includes oral, anal or vaginal intercourse.[1,2] It also includes exposing a minor to pornography or to the sexual acts of others, sexual exploitation which is an adult victimizes a minor for advancement, sexual gratification or profit for example, prostituting a child and creating or trafficking in child pornography and sexual grooming-social conduct of a potential child sex offender who seeks to make a minor more accepting of their advances for example in an online chat room.

Anyone who is a survivor of sexual abuse, is likely aware that the trauma of the abuse can last a lifetime. Flashbacks of feelings or events can arise at any given moment for abuse survivors. Children who have suffered from abuse are shown to have trouble dealing with activities involving discomfort. Any circumstance that represents a loss of control, fear, helplessness, or even pain can be overwhelming and emotionally disturbing. The disease outcomes range from depression, panic disorder, post-traumatic stress disorder (PTSD), alcohol abuse/ dependence, drug abuse/dependence and suicide attempts, eating disorders.1 Today it has ended up to be one of the most high profile crimes outlawed in every developed country. Since 1970's the sexual abuse of children and child molestation has increasingly recognised as deeply damaging to children and thus unacceptable to the society as a whole.

**Frequency of sexual abuse**

The widespread prevalence of child sexual abuse has been reported in several countries, thus highlighting the social importance of understanding the nature and scope of this problem.[3] The first published study dedicated specifically to child sexual abuse appeared in france in 1857 entitled: medical-legal Studies of Sexual assault (Etude Medico-Legale sur les Attentats aux Moeurs) by Auguste Ambroise Tardieu, the noted French pathologist and pioneer of forensic medicine.[4]

Finkelhor (1994)[5] reviewed the prevalence studies on child sexual abuse from the 1970s to the 1990s. Although the literature included in his review is extremely variable in its scope and quality, he concluded that sexual abuse was reported in all of the studies; specifically, he confirmed a history of sexual abuse in at least 7% of females and at least 3% of males, with a range of up to 36% of women in Austria and 29% of men in South Africa. However recent statistics confirm that approximately 20-25% of the women and 5-15% were sexually maltreated when they were children. Most sexual offenders are acquainted with their victims, approximately 30% are relatives of the child, most often fathers, uncles or cousin, around 60% are other acquaintances such as friends of the family, babysitters or neighbours; strangers are the offenders in approximately 10% of sexual abuse cases. Most child sexual abuse is committed by men; women commit approximately 14% of offenses reported against boys and 6% of offences reported against girls. However it must be understood that all these are just numbers, though shocking and alarming, it doesn't really depict reality. It is a multifaceted phenomenon having roots in both mental and psychological disorders as well as in the problems of the family institution, stemming from other social problems including economic crises, unemployment, and various addictions.[6]

**Law regarding child sexual abuse**

An adult's sexual intercourse with a child below the legal age of consent is defined as statutory rape based on the principle that a child is not capable of consent and that any apparent consent by a child is not considered to be legal consent.

The United Nations Convention on the Rights of the Child (CRC) is an international treaty that legally obliges states to protect children's rights. Articles 34 and 35 of the CRC require states to protect children from all forms of sexual exploitation and sexual abuse. This includes outlawing the coercion of a child to perform sexual activity, the prostitution of children and the exploitation of children in creating pornography. States are also required to prevent the abduction, sale or trafficking of children. As of November 2008, 193 countries are bound by the CRC (Child Rights Information Network. Convention on the Rights of the Child. Retrieved on 26 November 2008), including every member of the United Nations except the United States and Somalia.

The number of laws created in the 1980 and 1990s began to create greater prosecution and detection of child sexual abusers. During the 1970s a large transition began in the legislature related to child sexual abuse. In the United States Megan's Law which was enacted in 2004 gives the public access to knowledge of sex offenders nationwide.7 In recent years a notable educational program is the Prevent Abuse and Neglect through Dental Awareness (PANDA) Coalition, organized by Lynn Douglas Mouden. PANDA which began with the model program in Missouri in 1992 is now in 34 states in the United States and has 2 coalitions in Romania.[8] New York State for example requires all dentists to complete a 2 h course in the identification and reporting of child abuse as a condition of a relicensure. Not only in America but also in Japan have been made efforts in the urgent move to tackle this problem.

In India, the laws dealing with sexual offences do not specifically address child sexual abuse. The Indian Penal Code, 1860, does not recognize child abuse. Only rape and sodomy can lead to criminal conviction. Anything less than rape as defined by the law, amounts to 'outraging the modesty' of the victim. The word 'rape' is too specific; this does not even include abuse on 'boys'. There is no comprehensive law on child sexual abuse. For a girl

child, Section 375 (rape) and Section 354 (outraging the modesty) are generally used, which are highly inadequate, as they do not cover the forms of sexual abuse borne by children. For lack of any specific section for boy children, Section 377 (unnatural offences) is presently being used for cases of child sexual abuse of boys. This is an area of great concern.. However, to improvise on the present scenario, The Protection of Children from Sexual Offences Bill, 2011 has been passed in May 2012.[9] The Bill seeks to protect children from sexual abuse with provision for setting up special courts for speedy trial and stringent punishment including life sentence for committing sexual assault on minors under the age of 16.

**Signs and Symptoms**

Dentist's role emerges as the one attending to all the dimensions of the patient's presentation and management apart from the diagnosis and treatment of the oral pathobiology. However for a dentist to play its role optimally in identification of such cases, it is important to recognise the signs.

Oral cavity : The oral cavity is a frequent site of sexual abuse in children. The presence of oral and perioral gonorrhoea or syphilis in prepubertal children is pathognomonic of sexual abuse.[10] When gonorrhea or syphilis is diagnosed in a child, the case must be reported to public health authorities for investigation of the source and other contacts. A multidisciplinary child abuse evaluation for the child and family should be initiated.[11] Pharyngeal gonorrhea is frequently asymptomatic. Therefore, when a diagnosis of gonorrhoea is suspected, lesions should be sought in the oral cavity, and appropriate cultures should be obtained even if no lesions are detected.[12] Moreover, human papillomavirus infections may be transmitted sexually through oral-genital contact, vertically from mother to infant during birth or horizontally through, nonsexual contact from a child or caregiver's hand to the genitals or mouth.[13] Although, human papillomavirus infection may result in oral or perioral warts, the mode of transmission remains uncertain and debatable. Unexplained injury or petechiae of the palate particularly at the junction of the hard and soft palate may be evidence of forced oral sex. Other signs visible are: Bruises, lacerations, abrasions, oral mucosa torn from gingival, darkened or non-vital teeth, trauma to the lip/tongue and other soft tissue injuries.

If a victim provides a history for oral-penile contact, the buccal mucosa and tongue can be swabbed with a sterile cotton-tipped applicator and then the swab can be air dried and packaged appropriately for laboratory analysis. However, specialized hospitals and clinics equipped with protocols and experienced personnel are best suited for collecting such material and maintaining a chain of evidence necessary for investigations.

Other signs: Patterned injuries such as finger, ligature, burn marks or marks possibly caused by a belt, strap or cord. Multiple bruising, loss of hair (hair pulling) or injuries to the ears should also raise suspicion.[14] A child with either a history of multiple injuries that resemble to an identifiable object or unexplainable fractures of bones and varying colours bruises accompanied with a caregiver's explanation non-compatible with clinical data may arise suspicions for preceded sexual assault. Moreover a delay in seeking care for the injury or reluctance to discuss about the accident as well as a general difficulty to cooperate with the child's custodian and a tendency of disorientation from the real problem also should arise suspicion.

However, the researchers have to bear in mind few conditions which may be completely irrelevant to sexual abuse; but are part of the general dental or medical history of the child; and have to be taken into consideration. For example, systematic diseases (e.g., leukaemia, osteogenesis imperfecta), common injuries as well as the Sudden Infant Death Syndrome (SIDS), The Mongolian Spot a discolouration in the lower back and buttocks, back of the legs and/or shoulders of the child, Cao gio signs caused by rubbing or scratching the child's skin with a coin producing a dramatic ecchymosis that is usually localized in the intracostal spaces of the back or parallel to the Spine- and Moxibustion-circular burn like lesions on the skin of the child.[6]

Bite marks: Bite marks are probably the most frequent expressions after a child sexual abuse. They are defined as the distinctive tooth patterns in a wound that may have forensic or legal implications. Its shape can give useful clues about the person who caused it and may lead to the implication or exclusion of an individual under investigation. Acute or healed bite marks may indicate abuse. Bite marks should be suspected when ecchymoses, abrasions or lacerations are found in an elliptical or ovoid pattern. It's remarkable that bites produced by dogs and other carnivorous animals tend to tear flesh whereas, human bites compress flesh and can cause abrasions, contusions and lacerations but rarely avulsions of tissue.[4,12]

Behavioural changes: This may range from being quiet and withdrawn to acting out and being uncooperative. In addition they may face difficulty in keeping dental care appointments as some experiences in the dentist's office may trigger unpleasant memories of the abuse experience and such victims may skip dental care/appointments.

Child Sexual Abuse can result in both short-term and long-term harm including psychopathology in later life.[15] It can have an impact on psychological, emotional, physical and social aspect including depression, post-traumatic stress disorder, anxiety, eating disorders, poor self-esteem, dissociative and anxiety disorders; general psychological distress and disorders such as somatization, neurosis, chronic pain, sexualized behaviour, school/learning problems and behaviour problems including substance abuse destructive behaviour, criminality in adulthood and suicide.[16]

**Examination and identification**

When it comes to correct assessment of the situation, the dental surgeon has to be quick and vigilant, and needs to observe the child's actions, behaviour, physical movements and verbal communication with others as soon as the child enters the operatory, and see if they are appropriately age-related to the patient. This is to be followed by quick visual assessment of the child's face, head, neck, hands and any other exposed area of the body. The diagnosis of child sexual abuse often is made on the basis of a child's history. Sexual abuse can rarely be diagnosed only on the basis of only physical examination or laboratory findings.[17,18] However, the examination of the involved parts should be done only after gaining confidence and creating a trusting environment.

If the dentist suspects abuse with a young patient then he or she should have another dental staff member also witness the injuries and assist in their documentation. A written description with diagrams can document the locations, shapes, sizes etc., of injuries. Intra-oral injuries might necessitate the need for dental X-rays. The dentist is allowed by the law to obtain X-rays of a child without the consent of the parent when the dentist is diagnosing the case as one of possible child abuse and determining the extent of such child abuse. If there are injuries present such as on the face of the child that lead the dentist to suspect child abuse, it is recommended that photographs be taken of the injuries. A photograph should be taken of the entire face as well as close ups of the individual injuries. The close-up photographs should include some type of scale (ruler) placed near the injury but not covering any part of the injury. X-rays, photographs etc., should be documented. When reporting the suspected abuse, it is recommended that the dentist advise the authorities what documentation of injuries the dentist obtained. X-rays or photographs taken in the dental office may be the only evidence available to authorities. However, if unable to handle, help of a forensic odontologist should be taken.

The scientific community recognizing the catalytic role that a dentist might play in the identification of child sexual abuse runs educational programs in order to familiarize dentists with the potentials of Forensic Odontology. Paediatric dentists and oral and maxillofacial surgeons whose advanced education programs include a mandated child abuse curriculum can provide valuable information and assistance to physicians about oral and dental aspects of child abuse and neglect. The Prevent

Abuse and Neglect Through Dental Awareness (PANDA) organisation has made great efforts to this direction as well and has trained thousands of physicians, nurses, teachers, child care providers, dentists and dental auxiliaries as another resource for physicians seeking information on this issue.[19]

**Reporting of cases**

Reporting suspected abuse is not an accusation of abuse by the reporter, rather help for the child and for the abuser; as both of them require treatment. In every jurisdiction of United States, health professionals are mandated by law to report suspected cases of child abuse and a penalty is to be provided in case of failure to report. In addition, to criminal liability for failure to report, the practitioner could also face a civil lawsuit if there subsequent injury to the child. Considering the legal obligation to report and the statutory protection provided for the reporter, there would seem to be a greater risk from failing to report than from reporting. Reports may be made to the local law enforcement agency or to the local child protective service. When reporting, the reporter should make sure that he has:

- A statement of concern and reasons for suspecting abuse, including any documented evidence, and
- The names, addresses and phone numbers of all involved parties. The immediate and initial report should be made by telephone. The reporter should then follow up with a written report as required.[20]
- Health care professionals who see children should have the telephone number of the reporting agency available.

Unwillingness to report: The most common reason is uncertainty about the diagnosis, fear of litigation, unfamiliarity with symptoms, possible effect on the practice, reluctance to believe one could inflict cruelties on one's offspring and uncertainty about the reliability of the child's account of the injury. A wonder that can prevent a dentist from reporting is, if the child will be taken away from home, but we should all know that this happens, only when the child's life is really in danger.[21]

**Dentist's Responsibility Outlined By The American Dental Association[22]**

- To observe and examine any suspicious evidence that can be ascertained in the office.
- To record, per legal and court rules, any evidence that maybe helpful in the case, including physical evidence and any comments from questioning or interviews.
- To treat any dental or orofacial injuries within the treatment expertise of the dentist, referring more extensive treatment needs to a hospital or dental/medical specialist.
- To establish/maintain a professional therapeutic relationship with the family.
- To become more familiar with the perioral signs of child abuse and neglect and to report suspected cases to the proper authorities, consistent with state law.

**Conclusion**

Childhood abuse can have life-long effects on the victims. It is important for doctors and patients to be aware of this, so the issue of fear can be addressed in the most effective way. As patients and dentists become aware of the connection between abuse and phobia, it will be easier for all parties to work together to improve the doctor/patient relationship. An empathetic dentist and a patient willing to communicate their concerns will make the best medicine for this situation.

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