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Child Sexual Abuse: Implications for Public Health Practice

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CHILD SEXUAL ABUSE: IMPLICATIONS FOR PUBLIC HEALTH PRACTICE

Few public health problems are so hidden and yet have such pervasive impact on the public domain as child sexual abuse. From the community clinic to the Supreme Court, from the day care center to the prison system, sexual victimization of children weaves throughout our social fabric, often unseen -- even denied -- but ever present.

Child sexual abuse has been found to occur in families of every racial and ethnic background and at every income and educational level. It is difficult to determine accurate proportions for these demographic variables because estimates are often based on the number of reported cases. These may exclude middle and upper-middle income families seeking the help of a private physician, who is less likely to report a case of child abuse (despite legal obligations).

Because public health programs and services tend to provide care to middle- to low-income segments of the population, emphasis on issues which are more common to this group will be featured in this Technical Information Bulletin.

Historically, child sexual abuse has been seen as a social service and law enforcement concern. More recently, however, attention has begun to focus on the legitimate preventive and therapeutic roles of other professionals, especially health professionals. Child sexual abuse is truly a multidisciplinary and multisystems problem, requiring concerted, cooperative intervention by professionals in the health care, judicial and law enforcement, social service, mental health, and educational fields and systems.

Over the past several decades, public sentiment has supported increased provision of public health services for mothers-to-be, mothers, and children. This can be seen in the establishment of programs for children and adolescents, family-centered care in hospitals, maternity and infant care projects, and perinatal programs, to mention but a few. Despite this general trend, and the well-documented impact of violence against children on their short and long-term physical and mental health, the public health field has been slow to identify abuse as a legitimate public health issue. Particularly in the area of sexual victimization, public health involvement has been limited primarily to investigation of

sexually-transmitted diseases in children, rather than a more comprehensive approach. Public health professionals need to assume a greater role in terms of epidemiological and other forms of research, public policy formulation, case identification and management, preventive intervention, program planning, and health care education.

DEFINING CHILD SEXUAL ABUSE

A fundamental problem in addressing child sexual abuse is defining precisely what this term means. This subject is especially difficult because definitions can vary from jurisdiction to jurisdiction, as well as from profession to profession (e.g., definitions developed by law enforcement personnel are directed at somewhat different concerns than those of health professionals).

In addition, there is wide variation in the behaviors that constitute sexual abuse, including such acts as fondling, rape, oral or anal sodomy, incest, pornography, and prostitution, and there is often little or no physical evidence to clarify precisely what has occurred. Further, the circumstances surrounding an incident of suspected abuse are often complex and raise difficult questions, such as: "Is it abuse if a child apparently did not resist?" or "How can parents and others distinguish between normal sexual curiosity and abuse?" Finally, child sexual abuse generates intense feelings among all involved, and each professional's training, experience, and levels of sensitivity and awareness influence how cases are defined, recognized, and managed.

Despite the difficulties, each public health and voluntary agency must establish an operational definition to serve as the primary screening mechanism for case identification. At Childrens Hospital National Medical Center in Washington, D.C., the Division of Child Protection has developed a definition that incorporates both clinical and legal elements of case identification; it has proven to be both inclusive and flexible. According to this definition, child sexual abuse is:

- sexual assault involving physical force in which a child is the victim;

- sexual contact or interaction between a child and another person of any age in which the child's participation has been obtained through undue means such as threats, bribery, coercion, or similar tactics;

- sexual contact or interaction between a child and an adult or other person, even with the free cooperation of the child, when such activity is inappropriate to the age and level of maturity of the child.

THE SCOPE OF THE PROBLEM

The true incidence of child sexual abuse is not known. The problem is a crime and a social taboo; it is a phenomenon that all involved frequently want to keep hidden. However, available studies clearly indicate that sexual victimization of children is a widespread national problem. It has been estimated between 250,000 and 500,000 children are sexually abused each year.[1] Finkelhor,[2] Russell,[3] and others have conducted retrospective studies that suggest that as many as one in every five girls and one in every ten boys are sexually victimized in some way prior to their 18th birthday.

Depending on the particular study, between 17 and 25 percent of all victims are boys. Children in all age ranges are sexually abused with a surprising percentage of infants and toddlers being the targets; some studies suggest as many as 12 to 15 percent of all child victims are three years of age or younger. Rogers and Thomas[4] have found that infants as young as three months have been the victims of sexual assault. With reference to incidence, age and sex distribution, and the relative frequencies of different kinds of sexual victimization, study findings vary considerably. This is largely due to differences in intake procedures, local legal practices, and study designs.[4] However, the fact remains that tens of thousands of children are at risk for a wide range of trauma-related infirmities of an acute or chronic nature: sexually transmitted diseases, depression, phobic reactions, and a host of other adjustment and mental health disorders.[5]

MATERNAL AND CHILD HEALTH ISSUES:

Maternal and child health practice encompasses both preventive and ameliorative public health concerns that span the broad spectrum of promoting health in these groups. Therefore, professionals in this field should have a good working knowledge of child sexual maltreatment, including historical and cultural factors, current trends, medical and psycho social therapeutic issues, and the legislative base that authorizes federal funds for intervention. This knowledge makes it possible for maternal and child health professionals to keep abreast of program needs and trends in the field, to identify what resources are needed to expand and enhance current programs, and to locate specialized consultation and advice available to the community. Federal legislation provides funds for the National Center for Child Abuse and Neglect, Office of Children, Youth and Families, Department of Health and Human Services, which is mandated to compile statistics, disseminate information on activities and research on child abuse, and to fund innovative treatment and prevention models. Other federal agencies have legislatively mandated responsibilities in this area, including the Department of Justice, the National Institute of Health and the National Institute of Mental Health. Additional sources of support for public or private health efforts addressing this problem are frequently available at the state or local level.

Early intervention is an essential first step in treating all forms of child sexual abuse. Cost to the community, as well as treatment time for the family, increase when intervention is delayed. The concepts of primary, secondary, and tertiary prevention are applicable to child sexual abuse. Primary prevention aims at keeping the situation from occurring and may involve special theatre programs (such as "Touch", and "Hugs and Kisses"), books, and school-based curricula created for school age children to learn about self-protection and safe communications. Secondary prevention requires the earliest possible identification of cases, and the prevention of recurrence of the problem. Many of the hospital-based child abuse programs focus on crisis intervention and usually provide secondary prevention of child sexual abuse. Most tertiary measures involve the removal of the child and/or extension of some form of community mental health services for long-term treatment of the offender and other family members.

The public health worker has two broad options for prevention: to provide direct intervention or to provide a very indirect approach by educating the public about this issue. The specific approach tries to eliminate certain problems in our society, such as inadequate and poor housing facilities, poverty or unemployment, all of which may contribute to abuse and sexual victimization. That the proportion of the population living in poverty is related to poor health care systems and poor health measure in a given area, is well established. The indirect public health approach might involve a strong policy commitment of public health agencies to develop strategies for incorporating sexual abuse prevention programs into the community.

VULNERABLE FAMILIES

Specific factors may make some children more vulnerable to sexual abuse than others, and direct prevention services should be aimed at children and families displaying these traits. For example, it is estimated that each day over 800,000 children are left alone at home while their parents are at work. There are at least another 1.8 million children return to an empty house after school, according to the 1980 census report. The problem of unattended children has been getting worse as more mothers enter the work force. According to the U.S. Department of Labor, in 1940 only 8.6 percent of mothers with children under 18 years of age were in the paid labor force; in the 1980's, this figure has swelled to 65 percent.(6)

Even more critical is the trend regarding mothers with young children. The Children's Defense Fund (CDF) reports that today 42 percent of mothers with children under the age of three, and 54 percent of mothers with children aged three to five, are in the paid labor force. CDF predicts that by 1990 at least 50 percent of all preschool children and 60 percent of all school age children will have mothers working outside the home. Unfortunately, child care agencies have not picked up where mothers, relatives, and friends have left off.(6) Inadequate child care poses a high risk situation for sexual victimization of children.

Conversely, day care facilities have recently come under attack as a haven for widespread sexual abuse of hundreds of children. However, out-of-home care for children is not a recent phenomenon. For centuries, children have been cared for by others whenever a parent has been unable to provide care. This may involve not only day care programs, but also foster placement, group homes, and other third party arrangements.

Since parents are primarily responsible for the welfare of their children, they must be encouraged to carefully investigate the quality of any person or center that is to provide care. They should also be encouraged to make unannounced visits to these facilities in order to observe the interaction between the child and the caregiver.

Local and state health departments should establish, monitor and enforce regulations that promote licensed day care, screening of potential caregivers for criminal records and complaints of child maltreatment, training of child care workers, and investigation of complaints of abuse.

Other children with social risk factors include those born to single parent families, those whose mothers and fathers are divorced or separated, those families with mental illnesses, those families below the poverty level, and those having a history of abusive parents.

Another high-risk situation involves homeless families and children residing in over-crowded housing units. The tight rental market and exclusionary practices have forced the lowest income families into conditions of sub-standard housing. Prevention programs specifically focused on families in housing units will increase public awareness of the problem and encourage neighborhood safety programs.

Parent education programs provide a valuable resource to meet the needs of both parents and others in the community. These programs offer specific instructions on normal growth and development patterns relating to healthy sexual development of children, and help adults recognize signs and symptoms of child sexual abuse.

In spite of its prevalence and seriousness, most children receive little or no information about this problem and are not taught effective techniques for protecting themselves. A child may receive vague warnings about not talking to strangers, but the reason for this prohibition is usually left unsaid. It is well documented that most sexually victimized children are abused by someone they know. Children need help to understand what is meant by sexual abuse. They must be taught to protect themselves from being abused, and they must become acquainted with sources of support and help if they are being abused or become abused in the future. This information can be presented in community prevention programs.

Health care organizations can support such community-based prevention programs. These may include: a) school prevention programs, where health care professionals and/or parent groups can regularly visit schools to reinforce children's safety from sexual assaults; b) community or parent groups' hotline systems, where "at risk" families or children can reach out for immediate consultation or help; and c) providing child sexual abuse information in other community mental health centers such as rape crisis centers and battered women shelters.

In addition, professional societies can be of considerable assisstance in a variety of ways. They play an important role in professional education and in setting and raising standards through journals, publications, and technical statements.

HOW CASES ENTER THE PUBLIC HEALTH SYSTEM

Because child sexual victimization may be presented to a public, private, or voluntary agency in a variety of ways, the process of identification and prevention can become complicated. Three common situations often bring this problem to the attention of a medical or public health worker.[8] First, a specific allegation of abuse or molestation may be made; either the child or parent will state that sexual molestation has occurred and they are seeking medical and emotional support. Second, a mother or another individual may have a vague sense that something has happened, leading her to suspect sexual abuse. She may not have a clear

rationale for the basis of the suspicion, and approaches the health center expecting to gain greater clarification. For example, a mother may notice her seven-year-old daughter demonstrating precocious sexual knowledge or seems preoccupied with sexual issues. The child may have just returned from a visit with another relative, suggesting to the mother "something has happened." During a routine well-child examination, she raises her concerns about the possibility of sexual abuse. A third common situation occures when the child either comes to the health clinic for a routine visit or has a complaint which may be unrelated to sexual abuse or molestation. These children may present genital irritations, changes in behavior, acting-out behavior, common childhood difficulties, or similar findings. Upon a careful assessment and investigation of the issue, sexual abuse may be disclosed as the underlying source of the initial complaint.[8]

Although estimates vary, most clinical service programs report between 40 and 80 percent of identified cases involve intrafamily child sexual abuse, most routinely father-daughter incest.[9] [10]

Intrafamily sexual abuse involves a network of pathogenic behavior. The dynamics of incest produce additional stress through ambiguous and often ambivalent emotional reactions on the part of all family members. The situation often reflects extreme role confusion and inappropriate family boundaries, which in turn can lead family members to experience social isolation and a sense of entrapment. As a category, intrafamily child sexual abuse has proven the most difficult to address in terms of primary, secondary, and tertiary prevention.

Any assessment of a family in which child sexual abuse has occurred must include simultaneous examination of the professional, institutional, and community resources and responses that impact on the family. Rather than looking simply at "intrafamily" functioning in cases of child sexual victimization, it is imperative to examine the ecology of the family's living environment and the impact of external stressors upon the family.

COMMUNITY HEALTH TEAMS

The responsibility for verification and enforcement of state laws prohibiting sexual victimization of children has been given to the social service system and the criminal justice system. This means that police, prosecutors, medical professionals, and individuals from child protective services must function in a cooperative manner.

A comprehensive community-wide child sexual abuse program involves a variety of disparate organizations reflecting a broad spectrum of theoretical constructs, alternative models, and assorted intervention strategies. Needless to say, conflict between the agencies and systems involved is virtually inevitable. Conflict tends to cluster around four issues:

1. The differences in the purpose and focus of each system's intervention as viewed from the perspective of what is best for the child;

2. The effectiveness of each system's intervention, specifically the limits (legal, bureaucratic, financial, and personnel) upon its agencies' abilities to respond to all the problems posed by the victimization, the tasks they have chosen to focus upon, the expertise of their professionals, and the clarity and feasibility of their procedures;

3. The tension between sharing information (about the child with other systems so that they may pursue their functions in a coordinated manner) and preserving the privacy and confidence of the child victim and his or her family;

4. The problem of resolving competing interests.

These challenges are difficult to resolve and the likelihood of frequent interagency conflicts can be disappointing, frustrating, and cause hostility between professionals.

The barriers which often develop result from misunderstandings about roles, responsibilities, and capabilities among professionals; ignorance and misunderstanding about information requirements and procedures, and the presence of policies, procedures; and guidelines which preclude cooperation between agencies.

Several community strategies address these problems. These approaches include: establishing multi-system, multi-agency task groups; participation in multidisciplinary training programs for each of the systems; exchanging technical assistance; and providing consultation in individual cases with professionals from other agencies. To a great extent, the success of the involved agencies efforts depends on the degree to which the systems are able to tailor intervention to the needs of the given community.

GENERAL PRINCIPLES OF MEDICAL MANAGEMENT

In management of cases of child sexual abuse, the clinician must remember that determining whether or not sexual assault has occurred is a legal matter and not a decision for the health professional. The clinical responsibility is to ensure that the child receives all necessary care.

Whenever possible, the initial contact person should be specially trained in working with these cases. A social worker should act as liaison with any family and friends who accompany the child, counseling them about the acute needs of the child for sympathetic understanding and cautioning them against anger or guilt. A member of the clinical team should determine who, if anyone, of those accompanying the child should be present during the examination. Consideration should be given to the circumstances of the case and the child's wishes. The police should not be present during the examination and should interview the child only when the clinician has determined that it is appropriate. It should be noted, however, that many times the child has already related his/her account to the police, and additional questioning by the clinical team may simply intensify an already upsetting situation.

The clinician should explain to the victim and the legal guardian the need to collect evidence, and also explain in detail how this will be done. Even when there is no plan to prosecute, permission to collect evidence should be sought because uncollected evidence is irretrievable. The possibility of obtaining positive results is time limited (up to 72 hours after the assault). The public health professional should explain about giving consent, including the purpose of the

various forms, and obtain necessary consents (consent for treatment, consent to collect evidence, and consent to the release of information). The right to withdraw consent at any time should also be explained. In addition, the clinician should affirm the confidentiality of the medical record and of any evidence collected.

Because health departments are obliged to report all intrafamily sexual abuse cases (and, in some states, other sexual molestation of children) to the authorities, parents should be advised before the fact that a report is being made. The information to be transmitted should include the victim's name, birthdate, sex, address, parent's name and address, phone number, type of assault, date and time of assault, and the extent of any injuries.

INTERVIEWING THE CHILD AND PARENTS

The interviews should precede the medical examination or else be initiated as part of it. In the case of very young children, pertinent facts may be obtained from the parents/guardians or from the police.

The interviewer should try, whenever possible, to interview the child alone. The child's version of what happened should be obtained independently from that of the parents. It is especially important to refrain from having the child present during the adult's description of what transpired to avoid undue influence on the child and later allegations of collusion.

In the case of very young children, the parents may be the only source of information. The public health worker should obtain information about:

- any suspicious or unusual changes in the child's behavior, (including reluctance to interact with a particular peer, family member, relative, or friend); and
- baby-sitting arrangements and other people who may have regular access to the child.

In approaching the child, the interviewer should try to convey a relaxed, unhurried attitude. The child will quickly sense if the interviewer is anxious, uncomfortable, hurried, or ill at ease, and will be affected accordingly.

The interviewer should help the child feel at ease prior to discussing the sexual incident(s). "Zeroing-in" on the topic of the sexual abuse should be avoided prior to establishing a relationship.

The interview with the child is best conducted in a comfortable setting where there is a choice of toys to suit the child's developmental stage, items that can help the child communicate about the incident. An important objective of this interview is to give the child the opportunity to tell others about what has happened and to express the feelings and thoughts he or she may be finding overwhelming.

If possible, anatomical dolls should be used to determine the child's knowledge and language related to body parts (if this has not already been determined), as well as details of and reactions to the alleged sexual abuse. Other toys, such as a doll house and puppets, can be used to learn about family structure and relationships. The child should be supported in expressing whatever feelings and concerns he or she may have personally or in relation to his or her family. Engaging the child in role playing, writing a personal journal, story telling, drawing pictures, or playing with various toys can yield much information.

During the interview, it is important to determine the child's level of understanding of human anatomy and what terms he or she uses to identify organs and functions. The interviewer should use the child's own terminology if he or she is too young to use conventional terms. Diagrams, pictures, or dolls may help the child illustrate or act out what occurred. The child's account should be recorded in his or her own words, using quotes.

When eliciting information about the offender, the interviewer should avoid a "whodunit approach" by not dwelling too heavily on the identity of the offender. Lastly, the professional interviewing the child and family should be cognizant of his/her personal reactions, avoid being judgmental about the information supplied, and avoid projecting his/her own feelings.

Appropriate and sophisticated interviewing is absolutely essential for effective intervention. More comprehensive discussion of the interviewing process may be found in Thomas[12] or in Sgroi.[13]

THE PHYSICAL EXAMINATION

The medical evaluation should be performed by a physician experienced in the treatment of sexual abuse. The patient may be accompanied by a sympathetic staff member (nurse or social worker), parent, family member, or friend who can offer emotional support. The medical history and examination should be performed in the usual manner with special attention to specific evaluation of sexual trauma and collection of required data and specimens. Full explanations of every step in the examination are necessary. In the very young child, explanations are more easily done during a procedure than in advance.

Based on the history of the assault, the genital examination may be limited to visual inspection. The extent of the examination will be determined by the examiner. Several factors should be kept in mind:

- If the child was assaulted more than 72 hours prior to the exam, specimen collection may not yield sperm or semen, but an examination for medical purposes is still indicated.

- If, on visual inspection of the perineum of a female child the hymen is intact, the introitus is atraumatic, and there is no evidence of genital trauma, a speculum exam may be deferred. However, a cotton-tipped applicator should be passed through the hymeneal ring to obtain forensic specimens and a culture for gonorrhea.

- If anal sodomy is suspected in a male or female child and visual inspection reveals an absence of blood, lacerations, fistulas, or other anal trauma, and if the digital rectal exam is negative and the stool is gram negative, no further rectal examination is required. Specimens should be obtained with a cotton-tipped applicator both for evidentiary purposes and for Neisseria gonorrhoeae (GC) culture.

- If the history reveals loss of consciousness, drug and/or alcohol ingestion, or age or communication factors result in a lack of clairity regarding specifics of the incident, then specimens should be obtained from all sources.[14]

If the primary care physician finds that there are significant physical injuries, or feels that the child is in imminent danger of further abuse, the child should be transferred to an acute care medical facility in the community. A court order may be required if the parent or legal guardian objects.

In all cases, a treatment plan should be developed to address the possible problems associated with sexual assault, including the need for prophylaxis against gonorrhea, syphillis, tetanus, lice, and pregnancy.

A follow-up plan is necessary. The circumstances in each case determine what should be included. The plan may include:

- An appointment for a repeat pregnancy test in 8 weeks (or 2 weeks via blood test if necessary)
- A repeat the Venereal Disease Research Laboratory (VDRL) test in 8 weeks, and/or
- An appointment for other indicated medical services, e.g., x-rays, suture removal, wound check, etc.

The primary care physician should be responsible for making the appointments, and explaining the need for them to the child, parent, or appropriate agency.

The public health worker should contact the victim within two to three days after the incident to ascertain whether further support is needed.

More detailed discussion of the medical examination and corroborative evidentiary considerations may be found in a variety of sources.[14] [15]

COMMUNICABLE DISEASE CONTROL

The actual incidence rate of sexually transmitted diseases (STDs) in children is currently unclear. However, numerous studies have documented the strong correlation between STDs and child sexual abuse. In 1981, the Centers for Disease Control recommended that any sexually transmitted infection in a child should be considered as a possible abuse case until proven otherwise. Recognition and comprehensive management of STDs in children require the public health professional to

have a thorough understanding of both clinical and child protection issues. It is mandatory in all 50 states and the District of Columbia that health providers report suspected cases of sexual abuse perpetrated by a parent, guardian, or caretaker.

Much has been written about the epidemiological approach to case-finding in communicable disease control and its correlation to child sexual abuse. In one study involving 36 cases of gonococcal infection in children under 12 years of age, 244 individuals identified as either sexual contacts, household members, or nonhousehold members who had close access to the child were examined. Of the 244 persons, there was an infection rate of 18.4 percent. Known sexual contacts were found in 21 of the 36 cases; ten (46.6 percent) were found to have the infection in Neisseria gonorrhoeae.[17] Given the difficulty of obtaining detailed epidemiological contact data from either the child or the parents, it is strongly recommended that persons identified as household members or close contacts be screened for gonorrhea.

While a child's cognitive abilities and developmental and maturation level sometimes cause difficulties in obtaining certain information, (such as providing details about times and places for complicated events), available research demonstrates children as young as four years of age can provide reliable information. Therefore, attempts at gathering such contact information from the child victim are justified. To facilitate data collection, children should be interviewed separately from their parents in a private area of the clinic or health center.

Since young adolescents are also highly vulnerable to victimization, one should not assume that STDs in adolescents are always due to consensual sexual relationships. Information regarding menstrual history, sexual history, and the use of birth control should be obtained.

PSYCHOSOCIAL CONSIDERATIONS

Sexual abuse of a child can produce acute and long-term emotional consequences for both the child and his or her family. To be effective in minimizing these consequences, professionals must treat all concerned with

sensitivity and compassion. The management of every abused child must be individualized. For some children, the experience can be emotionally devastating, while for others it may be less serious. The child's age, degree of comprehension of the abusive act, resulting pain or discomfort, trauma from the subsequent physical examination or interview, and the reactions of others, particularly parents, are important determinants of the overall impact the experience will have on a child. Every effort should be made to minimize potential adverse psychological effects.

Family members, too, require calm, gentle, and compassionate attention. Often the anguish and anger of the family will exacerbate an already difficult situation for the child. Great care should be exercised in the initial dialogue with family members to establish trust and open lines of communication. The disclosure of a child's sexual victimization strains the coping resources of the entire family, and often family members are in a state of crisis when they first encounter the health professional.

Following the initial medical diagnosis and treatment, parents and child should be interviewed by a worker specially trained in the area of child sexual abuse. The mental health goals may include:

- o determining the child's and the family's ability to cope with the immediate situation: dealing with feelings of guilt, fear, anger, disbelief, and physical damage;

- o assessing the impact of the incident on the child, on the immediate and/or extended family, and on their social relations; and

- o establishing a longer range community mental health goal, such as identifying basic life supports for both child and parent(s).

Following an experience with sexual abuse, some children experience little or no reaction while others feel guilt, shame, anger, confusion, and depression. Many child victims display unrealistic fears, anxiety, grief, and a noticeably decreased self esteem.[13] Stress-related reactions may include sleep disorders,

encopresis, enuresis, speech disorders, and regressed behavior. In addition, there is often evidence of inappropriate sex play, excessive masturbatory behavior, hyperactivity, and psychosomatic complaints. Sexual abuse can lead to a decline in academic performance, runaway behavior, drug and alcohol abuse, and even sexual abuse of other children.

When the full assessment of parents and child is completed, a plan for follow-up treatment must be developed and explained to the family. The need for additional services, such as individual, parental or group counseling or psychotherapy, must be determined. Reporting procedures should be carried out and directed to the appropriate agencies -- the local health department for STDs, the police department, or a protective services unit for investigation of the incident.

During the course of the follow-up treatment, the child and/or family might have difficulty resolving problems related to the sexual abuse. Referrals for formal psychological and/or psychiatric evaluations may be necessary to facilitate the desired short- or long-term outcomes. In some cases, it will be necessary to refer family members for substantially longer term treatment to a community mental health (MH) center or similar agency. These programs offer family therapy, specialized programs for incest victims, various forms of group therapy, or individual long-term psychotherapy for pre-existing conditions precluding the successful resolution of the victimization crisis.

A variety of excellent sources addressing the short- and long-term mental health treatment of child sexual abuse victims and their families are currently available.[9 18]

LEGAL CONSIDERATIONS IN CASES OF CHILD SEXUAL VICTIMIZATION

Public health intervention in cases of child sexual abuse proceeds from the traditional physician-patient relationship. In the typical case involving minor children, informed consent is obtained from the parent or guardian, and the confidential relationship between the physician and child patient is extended to permit the physician to share information with the parent or guardian. However, more complex situations arise in these cases necessitating clear procedural guidelines for staff.

For example, most states permit minors of a certain age to provide their own informed consent and impose strict confidentiality requirements if the diagnosis and treatment relate to the patients' sexual behavior or mental health needs. However, if a teenager discloses incest, or participation in molestation, pornography, or prostitution at the behest of his or her parent, guardian, or caretaker, that information must be disclosed to the local child protective services agency (as a result of state laws passed in response to 1984 amendments to the Federal Child Abuse Prevention and Treatment Act).

As another example, a child may be brought to a clinic by the police or child protective services agency for a medical examination. In an emergency situation, the officer or caseworker has authority to provide informed consent; in non-emergencies, however, the state law may require the informed consent of the parent. For this reason, health professionals should know and understand the pertinent laws in their jurisdiction.

A major policy issue in public health is how best to balance traditional physician-patient confidentiality with the need to reduce sexual molestation of children (and the concomitant incidence of sexually transmitted diseases). According to the law in every jurisdiction in the country, health professionals must report children who have been identified as sexually molested by a parent, guardian, or caretaker. Most of these reports must be made to the child protective services agency and/or the police department.

Most state laws do not require physicians to report cases of sexual molestation if the alleged offender is not in a parental or caretaking role. (The 1984 amendments to the Federal Child Abuse Prevention and Treatment Act added employees of residential facilities and staff persons providing out-of-home care to the category of persons considered responsible for the child's welfare, and thus reportable to the local child protective services agency.) However, it is possible for a clinic or hospital to adopt its own policy of reporting all cases of sexual molestation.

Some public health clinics send all reports of prepubertal children with STDs to the child protective services agency for investigation; this is an excellent procedure to follow unless state law prohibits it (a

legal advisory opinion should be sought). If the agency maintains confidentiality for all contacts in STD investigations except for those identified as contacts with children, an appropriate balance is reached that furthers both important public purposes: patient-physician confidentiality and child protection.

The experience of most professionals in child welfare is that sexually molested children are better protected if the case results in court proceedings -- either a criminal prosecution or a family court child abuse/neglect proceeding. However, for such proceedings to succeed, it is crucial that health care providers be trained to:

- identify medical and behavioral evidence of sexual molestation;
- accurately document it;
- collect and safeguard any specimens and other tangible evidence in a manner that precludes an allegation that someone tampered with it; and
- testify.

Training should also include special emphasis on the process of child development, including dynamics that can cause children to be hesitant, confused or inaccurate in their testimony.

The ability to identify, collect, and document evidence is especially important. While only one state (Nebraska) requires evidence in addition to the child's testimony to sustain a criminal conviction, any state appellate court can overturn a jury's guilty verdict if the trial record indicates that there was insufficient credible evidence to prove guilt beyond a reasonable doubt. To prevent this, prosecutors tend to demand some evidence that supports the child's account before they will agree to file charges. Having the participation of the local district attorney in formulating protocols and training programs for health professionals help overcome this problem.

The need for the health professional's testimony highlights the importance of documentation and record-keeping. When a child presents a history of molesta-

tion, that history should be recorded because it is usually admissible (as an exception to the rule against hearsay evidence). All findings and laboratory reports should be recorded as contemporaneously as possible with the examination of the child. Statements made by the child, the parents, and others involved should also be recorded as verbatim as possible. Specimens for laboratory tests should be handled in an unbroken chain of possession with an accompanying record of possession; they should be secured in an area of limited access until all legal proceedings have ended.

Legal intervention can also impact on the short- and long-term mental health treatment needs of the child and family. The experience of going through a trial can be very stressful for children. Currently, in a typical case, a child may have to repeat his/her account of the molestation numerous times: to police and/or child protective services workers, to physicians, to prosecutors, to a grand jury, in court at a preliminary hearing, and at trial. Health care professionals have been in the forefront of child advocacy groups demanding changes in legal procedures to minimize detrimental effects on child victim/witnesses. As a result, a number of states have enacted legislation to permit the child to be videotaped while relating the account to the investigator, and to admit the videotape into evidence if the child is unavailable to testify at trial. Another innovation involves the use of closed circuit TV to permit the child to be in a room other than the courtroom while testifying. This avoids the unfamiliarity and formality of the court's physical setting and the possibility of psychological intimidation by the defendant.

However, such innovations may not be permissible under state and federal constitutional protections of the rights of defendants. Therefore, prosecutors are reluctant to use them if they increase the risk of a successful appeal and the necessity of a retrial. For example, a defendant has the right to confront and cross- examine witnesses against him. Unless he and his lawyer were present at the videotaping and could cross-examine the child, and unless the child is actually unavailable to testify at the trial (because of geographical distance or acute psychiatric trauma), the use of the videotape in lieu of the child's testimony may be illegal. While the U.S. Supreme Court has not

yet ruled on some of these innovations, there may be state supreme court decisions that determine the legality of particular innovations in each jurisdiction, and these should be well researched.

One innovative method of improving the situation for the child which may not raise legal questions is to use a court-appointed guardian ad litem to represent the child's best interests and to help educate the judge and jury. Health professionals involved with cases of child sexual abuse should cooperate with this individual, who is frequently an attorney, and the prosecutor to prepare for any testimony. However, the health professional is not free to discuss any confidential matters disclosed by the child to the guardian ad litem without the permission of the parent (unless the parent is the suspect, which means that only the guardian ad litem can give permission). Questions about confidentiality should be addressed and resolved prior to the professional's testimony.

CULTURAL AND ETHNIC VALUES

The role of socioeconomic status (SES) as an underlying issue in identification and special treatment needs is controversial. It is well established that the problem of child sexual abuse transcends all ethnic and racial groups. Nevertheless, we are also aware of the disproportionate representation in lower SES families in the reporting system, due in part to their more frequent encounters with public social and health systems.

Although the status of minorities has improved in the past few decades, minorities express concern that they are continuously in a disadvantaged situation in systems' interventions. Knowledge of both cultural and ethnic value systems represent a critical area in the assessment and treatment of these cases. In order to be helpful to families, a worker must be aware of cultural differences and determine familiar, sensitive, and effective interventions. This can be particularly problematic in dealing with issues of violence, sexuality, and family dynamics.

Families active in the public health sector are usually low SES, minority, and multiple-problem families. These families often suffer the added burdens of unemployment, poverty, severe familial medical problems, and/or substance abuse.

We possess a limited understanding of the characteristics, process of identification, effectiveness of intervention, and social dynamics of minority children who are victims of sexual molestation. An assessment of family strength, closeness and attachment issues of minority families is critically needed. In poor minority families, which push toward aspiration and progress, the sexual victimization incident can have a devastating impact. Most minority families need support to transcend the many barriers of the wider society systems. The strong religious orientation of many these families helps to provide a sustaining element in the struggle to cope with the pressures and realities of a hostile environment. The disparity in access to basic supports (health care, employment, education) between minority families and the larger society is widening. This gap extends further when these families need services to deal with sexual abuse. The stresses these families face are sometimes subtle, sometimes overt and very pervasive, and often debilitating when sexual abuse is disclosed. The public health centers in minority communities must incorporate culturally sensitive educational, preventive, and interventive programs.

CONCLUSION

Historically, the field of public health has only tangentially addressed the issue of sexual victimization of children, primarily in regard to control of sexually-transmitted diseases. It has become increasingly apparent that sexual abuse of children is a massive problem with clear public health impact, including both physical and mental health issues, health care resource allocation issues, and public health care policy issues. With the need for increased public health involvement clear, the field of public health is uniquely positioned to influence how we collectively choose to address this health care problem. Public health professional possess expertise in the areas of epidemiology, health care systems networking, primary and secondary prevention technology, and public health care policy formulation, easily adaptable to this problem area. This expertise is also desperately needed to make meaningful progress in addressing the problem of child sexual abuse.

The development and expansion of MCH programs addressing this problem requires a combination of clinical and community expertise. In addition, over 1000

community health centers, most of which are located in low-income areas in the central cities and rural areas, could sponsor programs on the identification, interviewing, treatment, counseling, and legal involvement in cases of child sexual abuse and assault. Each of these facilities should recognize the necessity for forensic laboratory tests and clinical procedures to identify evidence of sexual abuse or assault while such evidence is still detectable. Procedures for cooperation with law enforcement personnel must be developed in order to reduce the conflicts in cooperative service delivery.

Health officers, public health nurses, and public health social workers in agencies and facilities providing services to mothers and children should be required periodically to participate in training programs covering the handling of child sexual abuse cases. Local health workers should participate in multidisciplinary policy and community child sexual abuse treatment teams.

Local public health social workers should sponsor training programs in conjunction with existing social service and law enforcement programs. In addition, local health officers should encourage the development and maintenance of standardized protocols for community-based treatment teams involved in the management of these cases.

School health nurses and public health social workers should disseminate specific information regarding the identification, care, and service needs of the sexually abused or assaulted child. They should also educate the community on child safety and protection within schools and other institutions which care for children. Even though an estimated 50 percent of all abused children are school age, preventive programs for students are seriously limited. There is an obvious need for systematic training of all school personnel, parents, and students.

Effective primary health care involves establishing a standardized approach for early screening of potential health problems and determining individuals of high risk or special needs. There continues to be limited understanding of the characteristics and process of identification and effective intervention strategies for high-risk children. Public health workers are in a strategic position to develop, refine, and implement programs for children who may be potential sexual abuse victims.

FOOTNOTES

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