Sexual Assault

Victimization Across the Life Span
A Clinical Guide

G.W. Medical Publishing, Inc.
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To Bernadette Toner, whose tireless efforts in assisting me with both my academic and administrative responsibilities made it possible to effectively organize the massive effort it takes to produce a scholarly publication such as this. Bernadette's attention to detail was invaluable for getting everything done and her heart for all who suffer trauma was a consistent confirmation of the necessity of this work.

— APG

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— EMD

To my husband, David Kenty, whose love and support have shown our daughters what a relationship should be.

— JBA

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FOREWORD

Sexual assault is broadly defined as unwanted sexual contact of any kind. Among the acts included are rape, incest, molestation, fondling or grabbing, and forced viewing of or involvement in pornography. Drug-facilitated behavior was recently added in response to the recognition that pharmacologic agents can be used to make the victim more malleable. When sexual activity occurs between a significantly older person and a child, it is referred to as molestation or child sexual abuse rather than sexual assault. In children, there is often a "grooming" period where the perpetrator gradually escalates the type of sexual contact with the child and often does not use the force implied in the term sexual assault. But it is assault, both physically and emotionally, whether the victim is a child, an adolescent, or an adult.

The reported statistics are only an estimate of the problem's scope, with the actual reporting rate a mere fraction of the true incidence. Surveys of adults show as many as 18% of all women in the United States have been the victim of an attempted or completed rape over the course of their lives. The incidence of male victims is lower because of the reluctance of boys and men to report their victimization.

The financial costs of sexual assault are enormous; intangible costs, such as emotional suffering and risk of death from being victimized, are beyond measurement. Short term, there are healthcare consequences, such as unwanted pregnancy, sexually transmitted diseases, serious emotional upheavals, inability to carry out normal daily activities, decreased productivity, and, in some cases, loss of life. Longer-term disabilities can be both emotional and physical. It is well documented that survivors of sexual abuse have a much higher incidence of serious and chronic mental health problems than control populations of nonabused patients. Posttraumatic stress disorder, depression, suicidal ideation, and substance abuse are all over-represented among abused groups in case-control studies. Chronic physical symptoms, such as pain syndromes (pelvic, abdominal, chest, myalgias, headaches) and various somatization disorders, are reported in a wide variety of peer-reviewed medical specialty journals.

This book is the first to bring together the best information available concerning sexual victimization across the entire lifespan. Recognizing the radical differences required in approaching child, adolescent, and adult victims, the chapters are organized to present information from the medical and mental health literature specific to the various age groups. Victim and perpetrator characteristics are described. Most importantly, those who provide care for these victims and who handle the disposition of the perpetrators are given specific information to help them carry out their roles most effectively. This book offers information for all who care for the victims—the crisis hotline staff, law enforcement personnel, prehospital providers, specialized detectives, medical and mental health staff, specialized sexual assault examiners, and counselors. The information is as current, accurate, and specific as it can be in a rapidly evolving field. It will fill a need in many venues where sexual victimization is seen and care is given to victims.

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FOREWORD

Sexual abuse is not just an epidemic — it is at pandemic proportions. In the United States, perhaps 20% to 25% of adults sustain some form of sexual abuse during their childhood. These numbers are somewhat higher or lower in other countries, but certainly do not vary by a factor of even 5. With such a high percentage of the world having been sexually abused, it may be legitimate to ask, is sexual abuse a "normal" behavior? Similarly, what is sexual abuse and why does it exist?

Anthropologically, concepts of appropriate sexual behaviors with young humans incorporate both biologically and culturally derived premises. Biologically, prepubertal animals are not frequent targets for sexual activity. This relative taboo is reasonably ubiquitous across species. Males and females of a given species usually wait until they achieve sexual maturity before they engage in sexual activity. This is utilitarian in that effort is not wasted on a non-reproductive member of the species. Besides olfactory, behavioral, and other cues that the individual is mature (and receptive), there are visual indicators of immaturity that seem to inhibit adults of most species. However, once having achieved sexual maturity an individual is fair game. Through most of human history, this biologic distinction of maturity has also apparently held. When the human life expectancy was a mere 30 years, however, one could not wait until the late teen years to begin reproduction.

In more recent historical times (and within certain cultures), a cultural overlay has developed that acknowledges a "delayed" maturity. Thus the age of consent is more likely to be 16 years or so, not age 10 or 11 years when some girls are having their first menstrual period. The concept especially derives from the notion that children need prolonged education and parental nurturance before they should have to compete with the adult population and its risks. The adult is supposed to ignore the development of secondary sexual characteristics (biologic maturity) and focus on chronological age with a somewhat arbitrary cutoff (e.g., what is the difference between a 15-year-old and a 16-year-old?).

Both the biologic cutoff and the chronological cutoff are respected by most adults in society. Yet some overlook the cultural cutoff and some even ignore the biologic cutoff (i.e., have sex with young children). For the latter, this is a violation of both cultural and biologic taboos.

Another biology-related taboo is having sex with close kin. The genetic implications could not have been consciously appreciated by humans through most of history, nor by some species, which also abide by this taboo. Yet nearly all human cultures respect the incest taboo—a sign of a relative biologic underpinning for this behavior. Nevertheless some adult humans also fail to respect this distinction and commit what we consider incest.

Views about appropriate and inappropriate sexual activity with younger humans have been codified into law and society as sexual abuse crimes. These are crimes about sex and reflect the perpetrator's sexual drive. While sexual drives help to maintain the species and are overall a necessary biologic imperative, sexual abuse incorporates biologically useless activity (i.e., sex with biologically immature children) and/or activity that is culturally shunned. In some instances the perpetrator may "love" the child and perhaps be the better caregiver. Yet the violation of taboos elicits a strong reaction by most members of society—reflecting a lack of concern for the child's well-being and trampling of the society's biologic and cultural ideations.

What can be done about this? One option would be to ignore the abuse. Yet this historically has not been done if the act becomes known, and it fails to meet the

developmental needs of children. Another option would be to mount an aggressive prevention campaign aimed at potential perpetrators before they commit sexual abuse (primary and secondary prevention). This has not been done to any significant extent as yet. The third option is what most of this book is about—identifying sexual abuse when it has occurred and providing the types of interventions that might minimize its impact. We can treat the child and treat and/or incarcerate the offender. Considerable progress has occurred in the last three decades that enables us to better understand, identify, and intervene with child sexual abuse. The results of this progress are reflected in the state-of-the-art descriptions within this volume. These approaches make a real difference in children's lives and help us to respect the boundaries we place on sexual activity with our young.

One unanswered question remains: When will we as a society care enough about our children to make the substantial efforts required to implement the very best in primary, secondary, and tertiary prevention for our children? Until this becomes a cultural imperative of its own, we will continue to need books such as these, and the misery of lost childhoods will contribute to a sordid reality. Let us hope that some future generation can appreciate the brilliance of the work portrayed herein, but is also able to view child sexual abuse as an extinct historical oddity.

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PREFACE

What is sexual assault? It is a crime of violence, where the assailant uses sexual contact as a weapon, seeking to gain power and control. Often youths and adolescents are disproportionately targeted, although sexual assault can occur at any age. Sexual assault is also an act of opportunity. Particularly vulnerable populations include children, especially young females, and individuals who are less able to care for themselves, such as the homeless or physically or mentally handicapped persons. Their vulnerability and ease of manipulation makes them prey.

Who commits these acts? While there is no classic profile of an offender, child sex abusers tend to be males who are known to the child's caregivers, and 80% of the women who are assaulted know their attackers as well—they are their ex-husbands, their stepfathers, their boyfriends, and other friends or relatives. Men may also experience victimization.

To protect victims from these offenders will require a change in the attitude of society toward its most vulnerable members. Society must value these individuals before anything will be done. Education plays a key role in accomplishing this change in attitude. This book was prepared with the goal of disseminating the information required to bring about change, to better protect and care for victims of sexual assault. Written for healthcare professionals and other mandated reporters, Sexual Assault Across the Life Span offers a complete approach to the topic. The problem is defined, all aspects are explored, and treatment and interventions are outlined. Victim characteristics are explored, especially those seen in children. But most importantly, useful information is offered to those who provide care for these victims and those who handle the disposition of the perpetrators. We see the problem through the eyes of many professionals: physicians, paramedics, law enforcement personnel, the judicial system, social workers, and people who work with children. This covers everyone from the crisis hotline staff, to police and law enforcement personnel, to prehospital providers, to specially trained detectives, to skilled medical staff, to trained sexual assault examiners, to rape crisis counselors. Finally, the text offers information on programs that are in place or are under consideration to aid in the prevention of sexual assault.

Knowledge gives us the power to intervene, and this book offers current, accurate, and specific data concerning the problem of sexual assault. With the information at hand, we can become empowered and participate in effective interventions to prevent sexual assault as well as care for its victims.

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G.W. Medical Publishing, Inc.
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Our Mission

To become the world leader in publishing and information services on child abuse, maltreatment and diseases, and domestic violence. We seek to heighten awareness of these issues and provide relevant information to professionals and consumers.

A portion of our profits is contributed to nonprofit organizations dedicated to the prevention of child abuse and the care of victims of abuse and other children and family charities.

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Chapter 1

Overview of Child Sexual Abuse

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Historical Perspective

The sexual abuse of children has been discussed in writings dating back to the late 19th century. Freud (1961) publicly noted in 1896 that many of his patients with hysterical illnesses had a history of a sexual experience in their childhood. He thus theorized that hysteria was a direct result of childhood seduction. Unfortunately, he supported this seduction theory for only a short time, and by 1905 his belief had shifted. He renounced his previous views and stated that the sexual events recalled by his patients were unconscious fantasies rather than real events. He claimed that his patients' memories of sexual abuse were merely projections of their own desire for the parent of the opposite sex. Freud's adoption of this oedipal theory was a setback to the widespread acceptance of child sexual abuse because it caused others to question the existence of the problem as well as its psychologic effects (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995b).

Over the next sixty years, child sexual abuse did receive occasional mention but almost always as it related to incest. Most of Freud's followers questioned the impact of sexual experiences on children as well as the role the children played in these activities. Between 1920 and 1950, investigators conceded that family members did sometimes involve children in sexual activities but that this contact did not have a damaging effect on the children (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995a). Furthermore, some proposed that these experiences may even have had a beneficial effect on the children involved. Children were characterized as active participants in the sexual activities, often being labeled as the initiators of their own seduction (Bender & Blau, 1937).

Key Point:
Sexual abuse of children is not a new problem, but has only been accepted as a bona fide problem deserving professional attention since the 1970s.

In 1953 Kinsey et al. published the results of their study, which revealed that sexual abuse was indeed common in childhood. Even though they showed that almost 10% of women admitted to being sexually abused before age 18 years, their results received little attention (Whetsell-Mitchell, 1995a). It was not until the release of the landmark paper of "The Battered Child Syndrome," in 1962 that the medical profession began to take notice (Kempe et al., 1962). In 1971 the first child sexual abuse program was opened in San Jose, California. The Child Protective Movement began to campaign for legislation that would confront the problem of child sexual abuse on a national level. In 1974 the Child Abuse Prevention and Treatment Act was passed, which "mandated mental health professionals and educators to assist in the detection and reporting of child sexual abuse" (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995b).

The publication of "Sexual Abuse, Another Hidden Pediatric Problem" by C. Henry Kempe (1978) forced the healthcare community to address the importance of the diagnosis and treatment of child sexual abuse. Works in the early 1980s focused on the child as the victim and the offender as the initiator. Blame

was put on the offender, not the child (Sgroi et al., 1982). At the same time, the publication of books by survivors of child sexual abuse and the release of television movies on the topic brought the issue of child sexual abuse to the public forefront (Whetsell-Mitchell, 1995b).

DEFINITION

The characterization of child sexual abuse is subject to interpretation on multiple levels. Institutional, societal, medical, and legal terminology all differ in their definition or emphasis. It is impossible to find a single universally accepted definition. Child sexual abuse encompasses a wide spectrum of activities ranging from the less serious to the more serious. Sexually abusive actions may or may not involve direct contact with the child. Kempe defined sexual abuse as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles" (Kempe, 1978). Most legal definitions emphasize certain elements such as the age of the perpetrator and victim, description of specific acts or categories of sexual abuse, and who is considered a mandated reporter. The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 provided a federal legal standard that all states were mandated to follow to be eligible for funds for child abuse programs. This act defined sexual abuse as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct" (Child Abuse Prevention and Treatment Act, 1974). All 50 states have written statutes regarding sexual abuse based on this standard, but many differ in the specific wording. A child, in almost all instances, is defined as a person under age 18 years. Exceptions are made when that person is married. Certain laws are more specific with regard to the age of the perpetrator and victim when specific sexual acts are involved. Most statutes emphasize the discrepancy between the ages of the perpetrator and the victim. These laws also take into consideration the developmental level of the abused child. For purposes of reporting and involving specific legal agencies, laws distinguish who is considered a caretaker or guardian of the child. The involvement of a caretaker in the abuse necessitates the involvement of the local child protective services agency, as well as law enforcement. When the alleged perpetrator is considered a child, intervention may be limited to child protective services alone. When the assailant is unknown, unrelated, or not considered to be someone involved in the care of that child, the abuse may be a purely criminal case.

Key Point:
Sexual abuse is a term that covers a broad range of developmentally inappropriate sexual behaviors that span both contact and non-contact type activities.

Sexual abuse encompasses a large variety of actions. Whereas all states include a provision for rape or intercourse, some states use general terms in defining actions that constitute sexual abuse, while others are far more specific. The degree of detail can be crucial in certain cases; for example, medical and legal definitions do not require actual vaginal entry to occur for an act to be considered rape (Kempe, 1978). Genital fondling, oral-genital, genital-genital, and anal-genital contact are generally recognized forms of sexual abuse. The perpetrator does not need to have direct physical contact with the child for sexual abuse to occur. Exhibitionism, voyeurism, and viewing, producing, or distributing pornography are included under most definitions. Exposing a child to sexually explicit material or acts is also considered abuse. Laws making the use of computers and the Internet in producing, compiling, possessing, or disseminating child pornography a crime had been instituted by 27 states and the District of Columbia as of December 31, 1999. Violations are included under the heading of sexual abuse or sexual exploitation of children. Other laws address the use of computers to seduce or attract children with the intent of sexual misuse. The failure to protect a child is an important component of many definitions of child abuse and is relevant to sexual abuse when a caretaker is aware that such abuse is occurring and takes no action to stop or prevent it.

Incest, or sexual relations between persons closely related by blood, is a category of sexual abuse that carries with it a different level of psychosocial problems, prognosis, and family dysfunction. Incest includes sexual relations with members of adoptive families and stepfamilies. For the purposes of reporting and meeting a legal definition of sexual abuse, the terms are the same.

Sexual play occurs between young children of similar developmental levels and frequently involves viewing or touching. Sexual play or exploration is considered a normal part of childhood development and curiosity. The distinction between sexual play and sexual abuse is not always clear. Most definitions focus on the discrepancy in age between the two participants, the level of control or authority the older child holds over the younger one, the degree of coercion, and the actual activity involved.

The variation in the definition of child sexual abuse and the wide spectrum of activities covered within these definitions lead to confusion in the minds of mandatory reporters. Those who have a responsibility for the welfare of children should be familiar with their own state statutes. Statistics regarding the incidence of child sexual abuse are also highly dependent on the definition used.

Scope

The true magnitude of child sexual abuse is unknown. Incidence rates are based on reports filed with central agencies or cases that otherwise come to the attention of professionals. These rates are generally considered to underestimate the actual number of cases of sexual abuse because they are subject to substantial underreporting. An unknown number of cases are never disclosed or detected. Other cases are disclosed by victims but never reported to authorities. Prevalence statistics are based on surveys of adults regarding childhood experiences of sexual abuse. These studies have their own set of limitations, including variations in study definitions and methodology.

In 1993 the US Department of Health and Human Services conducted the Third National Incidence Study of Child Abuse and Neglect (NIS-3). The findings were based on a nationally representative sample of community professionals and included children who were reported to child protective services agencies as well as those who came to the attention of other professionals. The estimated number of sexually abused children in 1993 was 217,700, a rate of 3.2 cases/1000 children (Sedlak & Broadhurst, 1996). This was almost a two-fold increase from NIS-2 figures from 1986, which reported 119,200 cases or 1.9 cases/1000 children.

The National Child Abuse and Neglect Data System (NCANDS) collects and analyzes data from reports made to individual state child protective services agencies on an annual basis. In 1998, 48 states reported a total of 99,000 cases of child sexual abuse for an overall rate of 1.6 cases/1000 children. Female victims had a higher rate (2.3/1000) than male victims (0.6/1000) (US Department of Health and Human Services, 2000).

Prevalence studies report much higher rates of child sexual abuse. A national survey conducted in 1985 by the Los Angeles Times Poll included a random sample of 2626 American men and women over age 18 years. Some form of child sexual abuse was reported by 27% of women and 16% of men. One third of victimized women and 40% of victimized men never disclosed the incident to anyone (Finkelhor et al., 1990).

In a survey of a random sample of 930 adult women in San Francisco, Russell (1983) reported that 38% experienced at least one form of sexual abuse before age 18 years. Less than 10% of cases were ever reported to the police.

Several obstacles limit the ability of current research to provide truly reliable numbers regarding child sexual abuse. Victims seldom disclose episodes of sexual

abuse for reasons discussed later in this chapter. This fact is supported by the low disclosure rates found in adult surveys. Furthermore, cases that are disclosed or eventually recognized by others are not always reported. A broader awareness of child sexual abuse and the passage of mandated reporting laws have resulted in a higher reporting rate. The consistent percentage of reports that are substantiated suggests that this increase reflects actual cases rather than a higher number of unfounded cases.

Despite improved reporting, physicians and other mandated reporters fail to report all cases of sexual abuse (Kempe, 1978). Barriers to reporting are substantial and well documented. In one study fewer than half of the physicians surveyed stated they would report all cases of sexual abuse that came to their attention (James et al., 1978). A study of mandated reporters also found dramatic inconsistencies in reporting practices among pediatricians (Zellman, 1990). The most common reasons provided for not reporting sexual abuse were a perceived lack of sufficient evidence, concern that a report would disrupt the patient-physician relationship or would be harmful to the family, and distrust of the local child protective services agency.

Most practitioners and mandated reporters, as well as the general public, concede that child sexual abuse represents a significant problem in the United States (Tabachnick et al., 1997). Still, the misperception exists that "Child sexual abuse happens, but not in my neighborhood." This belief is contradicted by substantial evidence showing sexual abuse is not related to socioeconomic status or race (Feldman et al., 1991; Finkelhor, 1993; Hymel & Jenny, 1996; Kempe, 1978; Leventhal, 1998; Sedlak & Broadhurst 1996). As a result of misperceptions, the threshold for reporting potential cases remains unacceptably high. The estimated rate of child sexual abuse in the United States is equal to the rate of asthma in childhood, which is considered one of the leading medical disabilities in this age group and an affliction routinely diagnosed and treated in the average pediatric practice (Future directions, 1998).

A different set of potential biases influences prevalence statistics. Recall bias may affect the quoted prevalence in these studies in several ways. False childhood memories overestimate the true prevalence of child sexual abuse, while denial, repressed memories, and a continued unwillingness to disclose these traumatic events give an underestimate of the actual prevalence. Critics point out that many surveys are conducted among select populations limited to college students or specific geographic regions. This limits the ability to extrapolate results to the general population. The definition of sexual abuse, the acts that constitute sexual abuse, and the age at which such acts occur differ between studies.

Key Point:
A number of incidence and prevalence studies have been done over the past several decades and, despite their scientific limitations, both types of studies demonstrate that children in our society are at risk for sexual abuse.

Despite these limitations, comparative numbers between most studies remain consistent, and experts agree that approximately 20% of women and 9% of men experience some form of inappropriate sexual contact during childhood (Hymel & Jenny, 1996; Kerns et al., 1994). There is a wide discrepancy between the actual number of cases of child sexual abuse and the number of cases reported to authorities.

Child protective services agencies have noted a continued rise in the number of reported cases of child sexual abuse since the 1970s, when these numbers were first recorded. Researchers disagree as to whether this reflects improved recognition and reporting of cases, an actual increase in the occurrence of child sexual abuse, or both. The paucity of data before 1980 makes definitive conclusions difficult. To date there is no firm evidence that the rate of sexual abuse has, in fact, increased (Feldman et al., 1991; Leventhal, 1998).

The most recent data from the National Child Abuse and Neglect Data System and the Annual Fifty State Survey shows an actual decline in reports of child sexual abuse beginning in the early 1990s. These studies show a 26% reduction in child

sexual abuse reports and a 30% decline in the number of substantiated reports in the period from 1992 to 1998. It is not clear whether this decline represents a true decrease in the incidence of sexual abuse or changes in the policies or definitions used to tally these numbers. Jones and Finkelhor (2001) offer several possible explanations for the decline. Several theories are currently being investigated. The basis for this trend will have significant implications for future interventions.

Not all cases of reported child sexual abuse result in criminal charges. Cases are selectively prosecuted. This may depend on the particular acts involved in the case, the age of the child, and the age and relationship of the perpetrator. A high number of cases prosecuted end in guilty pleas, and 60% to 90% of cases that go to trial result in convictions (De Jong & Rose, 1991; Martone et al., 1996; San Lazaro et al., 1996). Some reports show that three fourths of perpetrators convicted of child sexual abuse were sentenced to jail time (Martone et al., 1996; San Lazaro et al., 1996). All 50 states include laws requiring convicted sex offenders to register with the local law enforcement agency.

The media has been vilified as well as praised for its role in the area of child sexual abuse. Some experts argue that the increasing use of graphic images contributes to the problem. Movies and television have been accused of showing increasingly sexually explicit images. Advertisements have been accused of exploiting children by depicting them in adult, sexually stimulating poses and situations. The Internet has made possible on-line sharing of child pornography. Sexual predators have used the Internet as a means to gain access to young children. Highly publicized cases of child sexual abuse have increased public awareness and contributed to widespread recognition of the issue. In one survey, over 90% of respondents reported having seen or heard a news media report during the previous year regarding child sexual abuse (Tabachnick et al., 1997). A Dutch study demonstrated the ability of a mass media campaign to increase the rate of disclosure by sexually abused children by over 300% (Hoefnagels & Baartman, 1997).

False accusations or the fear of such complicates the investigation of reports. False allegations of sexual abuse are an uncommon, but existent, feature of custody battles. The American Bar Association reports that relatively few custody disputes involve sexual abuse allegations (Nicholson & Bulkley, 1988). One literature review found sexual abuse allegations were involved in only 2% of custody disputes, and only 8% to 16.5% of these were false (Penfold, 1995). One report found that 11 of 551 reported cases over a 1-year period involved false allegations of sexual abuse (Oates et al., 2000). These included three cases in which the allegation was made in collusion with a parent. In a survey of New York State teachers, 56% reported knowledge of a false allegation of abuse made against a teacher in their school district (Anderson & Levine, 1999). Differentiating false allegations from true cases can be exceedingly difficult, because most sexual abuse cases tend to be based on circumstantial or hearsay evidence. Investigators are faced with the difficult choice between the potential prosecution of an innocent person versus the devastating situation of not believing a victimized child and providing protection from future abuse. A detailed evaluation of each case by an experienced investigator seeking inconsistencies in the story or evidence that a child's responses have been coached is often necessary.

VICTIMS

Extensive research has been done on sexual abuse victims. The main conclusion from the literature is that there is no classic profile of a sexually abused child. Finkelhor (1993) states that "no identifiable demographic or family characteristics of a child may be used to exclude the possibility that a child has been sexually

abused. Some characteristics are associated with greater risk…none of these factors bear a strong enough relationship to the occurrence of abuse that their presence could play a confirming or disconfirming role in the identification of actual cases." Although it is important to consider every child as a possible victim of sexual abuse, some consistencies have been established in the research.

Most literature has focused on females as the victim of sexual abuse. This is in part because female victims account for more than three times the number of male victims in reported cases of child sexual abuse (Finkelhor, 1993; Guidry, 1995). This discrepancy exists partly because of a boy's increased reticence to admit that he was a victim of sexual abuse. Although female victims are much more highly represented in the literature, the number of male victims is greater than once believed. A collaboration of eight studies revealed that girls are 2.5 times more likely to be victims of sexual abuse than boys (Finkelhor & Baron, 1986). It is imperative that healthcare workers acknowledge the problem of child sexual abuse and not overlook the potential victimization of any child, male or female.

Key Point:
Both boys and girls are at risk for sexual abuse, with male victims, on average, being younger than female victims.

Most experts agree that the risk for sexual abuse is highest during preadolescence, with a smaller peak in the early school-age years (Finkelhor, 1993; Nieves-Khouw, 1997; Pierce & Pierce, 1985). Pierce and Pierce (1985) demonstrated that sexually abused boys are, in general, younger than their female counterparts. The male victim averaged 8.6 years (mode = 7 years) and the female 10.6 years (mode = 14 years). Another study quoted a median age of 7 years for male victims and 10 years for females (Nieves-Khouw, 1997).

Although the number of reported cases of child sexual abuse shows a larger percentage of children from lower socioeconomic groups, the epidemiologic research to date does not support this. Similarly, race and ethnicity do not seem to be risk factors for abuse. Overall, no demographic feature has been identified to increase the risk of child sexual abuse (Finkelhor, 1993).

Conversely, certain victim and parenting characteristics have been associated with child sexual abuse. Studies show that most children who become victims of abuse have a tendency to be easily controlled. These children may be physically or mentally disabled and often have needs for love and belonging that are not being met at home.

In general, children living without one or both of their natural parents are at an increased risk of being abused. Females who live apart from their mothers or are not emotionally close to their mothers are at increased risk of sexual abuse (Finkelhor, 1982). Abused males were more likely to live with their mothers and have no father figure in the home (Pierce & Pierce, 1985). The single most important risk factor, for both females and males is the presence of a stepfather in the household (Finkelhor, 1982, 1993; Pierce & Pierce, 1985; Whetsell-Mitchell, 1995a). Other parenting impairments that pose a greater risk of abuse include a mother who is ill, disabled, or extensively out of the home. Substance abuse, parental conflict, or violence in the home are also risk factors for abuse (Finkelhor, 1982, 1993; Finkelhor & Baron, 1986; Whetsell-Mitchell, 1995a). Children of adolescent parents, foster parents, or parents who were sexually abused themselves are often at increased risk of abuse. Finally, siblings of abused children are at increased risk of being abused themselves (Herendeen, 1999).

OFFENDERS

Much has been written on the epidemiology and psychopathology of child sex offenders, but one thing remains constant: there is no classic profile of an abuser. Studies have shown that child sex abusers are usually older men. However, one fourth to one third of male perpetrators are reported to be adolescents (Leventhal,

1998). Women have been found to be offenders in up to 5% of cases involving female children and 20% of cases involving male children (Guidry, 1995). Most often, the perpetrator is well known to the child. Male family members, such as the father, stepfather, and uncle, are the most common offenders (Guidry, 1995; Nieves-Khouw, 1997). Children living with a stepfather are at substantially greater risk of being abused than those living with a biologic father. Stepfathers molest girls more often than boys. However, biologic fathers reportedly molest a similar number of girls and boys (Kendall-Tackett & Simon, 1992; Leventhal, 1998; Pierce & Pierce, 1985; Whetsell-Mitchell, 1995a).

Key Point:
No all-encompassing profile has emerged for describing sexual abuse perpetrators.

Incest is one of the most commonly reported types of abuse. It has been suggested that the occurrence of incestuous abuse may match or even exceed the incidence of physical child abuse. Experts agree that between 75% and 90% of incest victims are female children. Sexual contact between father and daughter and between stepfather and daughter is encountered most frequently (Guidry, 1995). Father-son abuse is revealed less often because it involves two social taboos: the incest taboo and the homosexual taboo. Mother-son abuse is a rare occurrence (Pierce & Pierce, 1985). Models of the incestuous family have been elucidated and typically involve a family in which multiple stressors exist. The father-daughter model illustrates many characteristics of the incestuous family (Justice & Justice, 1979). There is parental conflict leading to absence of sexual relations between the father and mother. The father longs for a source of physical intimacy, often looking to his daughter for comfort and love. The daughter may be depressed and withdrawn and have a poor self-image. She, too, yearns for attention and affection and may be happy to fill a need in her father's life. The mother feels completely dependent on her husband, to the point of being powerless. She subconsciously suggests and allows her daughter to assume her role of wife. She abandons her husband and daughter both emotionally and physically and finds a way to be increasingly absent from the home (Guidry, 1995).

Unfortunately, incestuous abuse is a difficult pattern to break. Commonly, the nonperpetrating parent does not believe the disclosure of abuse when it is revealed, thus allowing it to continue. Often, the nonperpetrating parent is physically or emotionally ill and is unable or unwilling to end the abuse. Some nonperpetrating parents fear violence from the perpetrator. Others are afraid of losing emotional or economic support. Pierce and Pierce (1985) reported that up to 15% of nonperpetrating parents actually encouraged the abuse.

Extrafamilial abuse is more common among boys than girls (Kendall-Tackett & Simon, 1992; Leventhal, 1998; Pierce & Pierce, 1985). Boys younger than age 6 years are at highest risk of abuse by family and friends. Boys older than age 12 years have a greater risk of being abused by strangers (Holmes & Slap, 1998). Extrafamilial abuse is two times more likely to be "very serious" (vaginal/anal intercourse, oral sex) than familial abuse (Leventhal, 1998). Pierce and Pierce (1985) showed that perpetrators of male sexual abuse engaged the boys in three or more sexual acts almost twice as often as perpetrators of female sexual abuse. However, the duration of molestation is shorter on the average for male than for female victims (3.9 years vs. 5.6 years) (Whetsell-Mitchell, 1995a). Kendall-Tackett and Simon (1992) propose several reasons for this. Perpetrators of sexual abuse of boys are more likely to be from outside the home, without continued access to the child; male victims sustain more physical injury, bringing them to medical attention sooner; and males are more likely to possess the physical strength to end the abuse.

Fewer than 50% of child sex offenders are mentally ill (Hilton & Mezey, 1996; Pierce & Pierce, 1985). However, the majority have an emotional disorder that prohibits them from forming intimate relationships with partners their own age. Most offenders feel a sense of excitement when anticipating the abuse of a child and experience both emotional and sexual gratification when the act is complete.

Perpetrators often view their abuse of a child as proof to themselves that they have the power to control one aspect of their lives (Hilton & Mezey, 1996). This partly explains the motivation of abusers who have been victims of sexual abuse themselves. The "victim-to-victimizer" cycle is particularly true of adolescent perpetrators and seems most frequently to involve male victims of male offenders. The characteristics of the chosen victim, including age and physical appearance, as well as the characteristics of the abuse often closely parallel the offender's own memory of abuse (Hilton & Mezey, 1996).

To help understand the events leading up to sexual abuse, Finkelhor (1984) proposed a set of four preconditions that must be overcome before the victimization of a child can occur. The first step is arousal, in which the abuser has sexual desires surrounding children. The perpetrator must then overcome his internal inhibitions relating to the abuse of children. This step is facilitated if the perpetrator experienced a traumatic childhood sexual event of his own (Hilton & Mezey, 1996). The offender must then find a way to have repeated physical contact with the child. This explains why perpetrators usually are people on whom the child depends for emotional, physical, financial, educational, or religious support. Finally, the abuser must overcome the child's resistance to the sexual interaction (Hilton & Mezey, 1996).

Key Point:
Finkelhor (1984) has described a set of 4 preconditions that are typically present in cases of sexual abuse. Sgroi (1982) has described a longitudinal model of how sexual abuse typically occurs over time, progressing from nonsexual contact to sexual abuse to the point at which the abuse is discovered.

The strategies employed by the perpetrator to gain the child's trust involve many forms of manipulation (Nieves-Khouw, 1997). This "engagement" is the first step in Sgroi's model, which describes the progression of sexual abuse. The abuser targets the child, and they begin to share nonsexual activities. The abuser may use bribery, including gifts, favors, or privileges to entice the child. He may shower the child with encouragement and compliments. He may use persuasion to deceive the child into believing that they share a special friendship. Over time there is an escalation of activity, with each subsequent interaction becoming more sexual in nature. Once the sexual intimacy occurs, the perpetrator focuses on maintaining the secret. He now uses a different form of manipulation to intimidate the child. Playing upon the child's guilt, he may threaten to stop loving the child. He may use threats of physical harm either to the child or to a family member. He may actually use force or violence. The child feels confused, alone, and betrayed and so perpetuates the secret. This progression of events details the next two steps in model developed by Sgroi et al. (1982): sexual interaction and secrecy (Hilton & Mezey, 1996)

Indicators of Sexual Abuse

The disclosure of sexual abuse, the next stage in the model, may be suppressed for a long time (Sgroi et al., 1982). There are many barriers to disclosure. Children may not reveal a history of sexual abuse because they fear that no one will believe them. Often the child feels guilt and shame surrounding the event and worries about being blamed for the abuse. Children often do not want to get the perpetrator in trouble, and they fear retaliation if they tell (Hilton & Mezey, 1996). For these reasons, children rarely provide a direct disclosure of sexual abuse. When they do, the disclosure may come at any time and to any of a multitude of people. It may occur in a place that reminds the child of the event or in a place where the child feels safe. Children may disclose a history of sexual abuse to a parent at bathtime or at bedtime. It may be made to a sibling to a playmate. The disclosure may be revealed to a teacher or guidance counselor after a sexual abuse prevention program in school. The disclosure may even be confided to the child's physician during a routine health examination (Guidry, 1995; Whetsell-Mitchell, 1995a). More commonly, a nonspecific indicator prompts an evaluation for sexual abuse. A common early warning sign is the use of broad general statements. These statements are used by the child to gauge the response of a trusted listener. Some statements might be relatively general, such as, "Date rape has been a common topic on the news lately." Other examples might be more specific: "Mr. Smith wears

tight underwear." These subtle suggestions should alert the listener to the possibility of sexual abuse (Guidry, 1995; Whetsell-Mitchell, 1995a).

In a literature review, Friedrich (1993) concluded that, overall, the most consistent indicator of sexual abuse in all age groups is the demonstration of sexualized behavior. This is defined as age-inappropriate knowledge of both sexual language and behaviors. Victimized children often masturbate when stressed. They may unknowingly use seductive vocabulary or exhibit sexually aggressive intentions. Younger children may use dolls to portray sexual play, whereas older girls may demonstrate promiscuous sexual activity. Male victims have a high rate of cross-dressing (Friedrich, 1993; Sansonnett-Hayden et al., 1987; White et al., 1988). It is important to note that some sexual behavior is considered normative rather than pathognomonic for sexual abuse. The most frequent normative sexual behaviors appear to be self-stimulating behaviors, exhibitionism, and behaviors related to personal boundaries. There seems to be an inverse relationship between normal age and sexual curiosity and exploration, with the overall frequency peaking at 5 years for both boys and girls, then decreasing over the next 7 years. More intrusive or excessive sexual behavior seems to indicate a psychosocial problem. Some issues to consider include family sexuality, life stress, domestic violence, and sexual abuse (Friedrich et al., 1998).

Key Point:
Sexual abuse often presents with nonspecific indicators that fall into 3 categories:
1. physical signs and symptoms
2. behavioral signs and symptoms
3. psychiatric signs and symptoms

There are many other broad, nonspecific indicators of child sexual abuse, and these can be divided into three categories: physical signs, behavioral signs, and psychiatric signs. In terms of physical indicators, few are diagnostic of sexual abuse. The presence of a sexually transmitted disease in a young child, including gonorrhea, chlamydia, syphilis, genital warts, and herpes simplex type 2, is strongly suggestive of abuse (Whetsell-Mitchell, 1995a). Still, fewer than 7% of cultures for sexually transmitted diseases are positive in suspected cases of sexual abuse (Atabaki & Paradise, 1999). The presence of sperm in or on the body or the discovery of a childhood/teenage pregnancy is a strong indicator of abuse, especially if there is no history of sexual interaction with a peer (Whetsell-Mitchell, 1995b). However, it is rare to find such blatant physical signs of assault (DeJong & Rose, 1991). More often the proof of sexual assault is in scars that are not visibly evident (Friedrich, 1993; Guidry, 1995; Whetsell-Mitchell, 1995a). Other broad indicators that may bring a child to medical attention include chronic abdominal pain, enuresis or encopresis, constipation secondary to anal discomfort, recurrent urinary tract infections, vaginal discharge, or the presence of a vaginal foreign body (Friedrich, 1993; Guidry 1995; Herendeen, 1999; Whetsell-Mitchell, 1995a).

Behavioral indicators of abuse are often the first signs noticed by people close to the child. However, these issues are not unique to victims of sexual abuse. They may also be seen in children experiencing other forms of severe stress (Whetsell-Mitchell, 1995a). Some of these behaviors include temper tantrums or running away from home. Children may begin to demonstrate developmentally regressive behaviors, such as thumbsucking or bedwetting. Victims may become fixated on obsessive cleanliness, or they may begin to neglect their bodies. They may engage in self-mutilating behaviors or self-stimulating behaviors such as excessive masturbation. Abused children often exhibit poor school attendance and performance. They may begin to experiment with delinquency or substance abuse. Finally, they may become involved in sexual relationships prematurely (Guidry, 1995; Herendeen, 1999; Hilton & Mezey, 1996; Whetsell-Mitchell, 1995a).

The psychiatric indicators of abuse must also be recognized. Victims of sexual abuse often become victims of depression. This may be exhibited as social withdrawal and the inability to form or maintain meaningful peer relations. Victims experience a profound grief in response to the many losses that they incur after the abuse. These include the loss of innocence and the loss of childhood, the loss of trust in oneself

and the loss of trust in adults. The pain of the abuse may be expressed as a sleeping disorder, with fear of the dark and nightmares preventing rest. Children may adopt changes in their eating habits: anorexia, overeating, or avoiding certain foods, such as milk, which reminds them of semen. Victims may attempt suicide to rid themselves of their psychologic pain (Guidry, 1995; Herendeen, 1999; Hilton & Mezey, 1996; Whetsell-Mitchell, 1995b).

The final stage of the model developed by Sgroi et al. (1982) follows either purposeful or accidental disclosure of abuse. At this time the victim's caregivers and/or the offender attempt to suppress the allegation of abuse to restore the perceived state of peace that existed before the disclosure. This suppression accounts for many of the effects described by survivors of child sexual abuse. The short-term effects can range from physical to psychologic derangements, closely paralleling the aforementioned indicators of abuse. If unrecognized or untreated, these effects can lead to severe long-term issues (Guidry, 1995).

Support Systems

As the issue of child sexual abuse has come increasingly to the national forefront, support services have slowly been increasing. Specialty divisions have arisen in several areas. Special police units are trained specifically to deal with child sexual abuse victims. Social workers receive specialized training to deal with childhood sexual abuse cases. Multidisciplinary child abuse evaluation teams or Child Advocacy Centers consisting of social workers, nurses, and physicians assist in evaluating potential cases. A 1988 survey of 29 pediatric hospitals with accredited residency programs reported that 69% had a designated pediatric sexual assault center (Smith et al., 1988). Protocols have been developed to improve the accuracy and thoroughness of evaluation and the recommended management of the sexually abused child. Legal services for victims are available, including the appointment of a guardian ad litem when necessary.

Even with these expanded services and referral sources, the pediatrician and family practitioner play a key role in child sexual abuse assessment and evaluation. The practitioner is often the person a family feels most comfortable turning to when there are concerns regarding this issue. He or she may be the person to whom a child discloses the abuse. This person must remain vigilant about detecting subtle clues and recognizing signs and symptoms of sexual abuse. The physician is a mandatory reporter of child sexual abuse and must be familiar with local state law with regard to reportable offenses, as well as the process of reporting such suspicions (American Academy of Pediatrics, 1999; Botash, 1994; Kempe, 1978; Kerns et al., 1994). The primary care physician can provide emotional as well as medical support to the child and family. The physician must be familiar with potential resources in terms of referrals and consultants that deal with this problem in the community. The increasing number of reports suggests that a growing number of physicians are willing to consider sexual abuse a possibility. Primary care practitioners can provide parental education through anticipatory guidance. Young children can be taught to discriminate between "a good touch and a bad touch." Families can be alerted to behaviors or physical signs that are cause for concern or be reassured regarding normal childhood play and curiosity. The physician who routinely performs a genital examination continually reviews the normal anatomy and increases the likelihood that abnormal physical findings will be detected. Regardless of the sophistication and specialty resources eventually incorporated into the system, the primary care physician remains a crucial link. The extent of the evaluation performed by the pediatrician or family practitioner depends on the experience and competency of the physician, the availability of adequate time and equipment to perform an appropriate evaluation or obtain forensic specimens, and the accessibility of a referral site for performing the necessary examination.

Key Point:
Sexual abuse is a problem that could affect any child. Therefore, professionals who come in contact with children need to be aware of the problem, need to know how it presents, and need to know what resources exist in their communities to assist in the evaluation and investigation.

Outcomes

Finkelhor and Browne (1985) describe a set of four traumagenic dynamics as a framework for understanding the link between the experience of sexual abuse and its sequelae. ***Traumatic sexualization*** refers to the inappropriate and dysfunctional development of a victim's sexuality as a result of the abuse. These children are burdened with confusion and misconceptions surrounding their sexuality. They have distorted perceptions of sexual activities. They emerge from the abuse with sexual preoccupations, such as compulsive masturbation, sexualized play, sexual aggression, and seductive behaviors. They often suffer from gender identity conflict and may engage in cross-gender behavior. Several studies reveal a high rate of prostitution among sexual abuse victims. Adult survivors tend to question the role of sex in affectionate relationships and often complain of sexual dysfunction or disinterest. For most victims of sexual abuse, sexual contact will forever bear a negative connotation (Cosentino & Collins, 1996; Finkelhor & Browne, 1985; Guidry, 1995). Certain abuse experiences tend to result in more severe traumatic sexualization. Invasive abuse is probably more sexualizing than when the offender just uses the child to masturbate. Older children who can understand the implications of the abuse are more likely to suffer traumatic sexualization than younger victims (Finkelhor & Browne, 1985).

Key Point:
Finkelhor and Browne (1985) describe a conceptual framework that helps explain the damaging effects of sexual abuse on the developing child—the traumagenic model.

A sense of betrayal emerges when victims realize that someone they trusted has caused them harm. This betrayal is often three-fold. First is the betrayal by the perpetrator in the form of manipulations and misconceptions about sex and love. Second is the child's betrayal by her own body. The child is often convinced that if her body responded to the sexual stimulation then she must have somehow wanted the abuse (Bass & Thornton, 1983). The third betrayal, committed by the victim's family, often confounds the other violations. A family who disbelieves the child's allegation or attempts to suppress it further violates the child's trust (Finkelhor & Browne, 1985).

Children respond to these betrayals in different ways. Some children express their betrayal as anger, with risk-taking behavior and delinquency representing attempts at retaliation (Finkelhor & Browne, 1985; Whetsell-Mitchell, 1995a). Other victims suffer from dissociation in which they separate themselves from their bodies and from the world (Briere & Runtz, 1988; Guidry, 1995). Yet other children display excessively clingy behavior in an effort to restore trust and security in their lives. Adult survivors describe a constant search for a redeeming relationship. Often these early betrayals are a lifelong deterrent to successful marriages. Intrafamilial sexual abuse can produce a more severe and long-lasting sense of betrayal than that involving strangers. Furthermore, the degree of betrayal is also related to the family's response to disclosure. A family who minimizes or blames the child for the abuse compounds the child's sense of betrayal. Finally, when an offender is not held accountable for his crime, the victim's sense of betrayal by the legal system and the norms of society is heightened (Finkelhor & Browne, 1985).

Powerlessness develops when a child feels that her will and her desires are continually superseded. In sexual abuse this occurs when the child's body is repeatedly misused or invaded without her consent. This loss of power is intensified with each manipulation to which the child falls victim. Each unsuccessful attempt by the child to end the abuse further magnifies her sense of disempowerment (Finkelhor & Browne, 1985). Many of the effects of sexual abuse are related to the fear and anxiety that stem from this loss of power. Nightmares, phobias, eating disorders, and somatic complaints all result from the excessive anxiety associated with the abuse (Finkelhor & Browne, 1985). ***Somatization*** refers to the preoccupation with bodily dysfunction that many victims of sexual abuse experience (Briere & Runtz, 1988). Some common manifestations of somatization include headaches, nausea and vomiting, heart palpitations, dizziness, fatigue, and

muscle aches (Guidry, 1995; Whetsell-Mitchell, 1995a). Most survivors fear their susceptibility to repeat victimization and express their feelings of helplessness through runaway behavior, self-mutilation, and suicide attempts. Other victims display aggressive and dominating behaviors, often becoming abusive themselves, to compensate for frustration resulting from their powerlessness. If left untreated, many victims develop posttraumatic stress disorder (Cosentino & Collins, 1996; Hilton & Mezey, 1996). Frequent abusive interactions and lengthy duration of abuse both contribute to an increased sense of disempowerment. The use of force, threats, or excessive coercion by the perpetrator all create a greater degree of psychologic trauma. This is also true of a situation in which the child tries to end the abuse with a disclosure and is disbelieved (Finkelhor & Browne, 1985).

Stigmatization, the final dynamic, describes the negative connotations that become a part of the child's self-image after the abuse. This can happen in various ways. First are the demeaning comments made directly to the child by the offender. Furthermore, the pressure from the perpetrator to maintain secrecy sends a strong message of badness and shame to the child. Second, the child may know that this sort of sexual behavior is wrong, and thus, must deal with her own internal stigma of guilt. Finally, the stigmatization may be magnified if the family reacts with disgust or blames the child for the abuse. The victimized child feels different and alone and often associates with other stigmatized groups of society. This may explain why victims get involved with substance abuse, delinquency, and prostitution. Children often tend to alienate themselves from family and friends who may view them as "damaged goods" (Cosentino & Collins, 1996; Finkelhor & Browne, 1985). Their low self-esteem may contribute to the fact that many survivors of child sexual abuse develop multiple personality disorder (Cosentino & Collins, 1996; Guidry, 1995; Hilton & Mezey, 1996). Children who receive support from their families as well as from professional treatment programs often are less stigmatized than those who are made to feel different (Finkelhor & Browne, 1985).

It is well known that child sexual abuse leaves its victims with substantial psychologic trauma. Furthermore, the variability of abuse experiences seems to cause a wide range of outcomes. However, little is known about the effect of different coping mechanisms on the outcome of abuse. Chaffin et al. (1997) studied the strategies used by a group of sexual abuse victims to cope with their abuse, as well as their self-reported abuse-related symptoms. From the data, they developed a model of four coping mechanisms used by victims of sexual abuse and the group of characteristics associated with each. They defined the coping strategies as avoidant coping, internalized coping, angry coping, and active/social coping (Chaffin et al., 1997).

Avoidant coping

Avoidant coping involved distraction, wishful thinking, and cognitive restructuring. Children who received greater social support after disclosure seemed to display more avoidant coping than others. It has been suggested that avoidant coping produces short-term benefits, but long-term problems. Victims who employed avoidant mechanisms seemed to have more negative attitudes and anxieties about sexuality. Their data revealed, however, that avoidant coping was associated with fewer behavioral problems than the other strategies (Chaffin et al., 1997).

Internalized coping

Internalized coping included social withdrawal, self-blame, and resignation. This strategy seemed to be more common in children who received negative reactions from others after disclosure. Their data revealed that these victims displayed more hyperreactive behaviors after the abuse, perhaps leading to the development of post-traumatic stress reactions. Although their study did not differentiate between male and female behaviors, prior research has suggested a distinction (Friedrich et al.,

1986). Female victims seem to display internalized behaviors such as dissociation and depression more commonly than males. Furthermore, they (females) tend to develop phobias, regressive behaviors, and multiple somatic complaints. The research of Chaffin et al. (1997) demonstrated that children rated internalized coping the least helpful of the strategies.

Angry Coping

Angry coping involved the cathartic release of emotions and the tendency to blame others. Abuse situations in which the perpetrator had a more distant relationship to the child seemed to instigate angry behaviors. Similarly, a high frequency of abuse interactions and forceful abuse were noted to be antecedents of angry coping. Older victims seemed to react with anger more often than younger ones. This coping mechanism, termed externalization in other research, seems to be more common in male victims (Friedrich et al., 1986; Sansonnett-Hayden et al., 1987). The data of Chaffin et al. (1997) revealed that this strategy was associated with the greatest number of behavioral problems. Such behaviors include physical as well as sexual aggression used to prove their masculinity. Conversely, females demonstrate a greater tendency toward sexually reactive behaviors, which may put them at an increased risk of revictimization.

Active/Social Coping

Active/social coping consisted of the utilization of the child's problem-solving abilities as well as social support resources. Children who experienced less severe sexual experiences seemed to implement this coping strategy. The data demonstrated that active/social coping was the only strategy not associated with negative abuse-related behaviors. However, this coping mechanism did not produce any measured benefits either, suggesting that this was a neutral strategy (Chaffin et al., 1997).

There is a paucity of literature to date regarding guidelines for the intervention and treatment of child sexual abuse. The first intervention following disclosure is to ensure the child's safety from further abuse. The next intervention involves the family or nonperpetrating parent (Cosentino & Collins, 1996). The goal of family therapy is to facilitate a supportive and protective environment for the child (Cosentino & Collins, 1996). No available data delineate which type of personalized therapy is best for the child. The treatment, however, must be targeted to the appropriate developmental level of each child. Younger children may benefit from play therapy (Hilton & Mezey, 1996). Group therapy seems to be helpful with adolescent victims because it provides peer support and may reduce the sense of isolation and stigmatization that they feel (Cosentino & Collins, 1996; Hilton & Mezey, 1996). However, group treatment may be too threatening initially for some victims. They may be unable to openly discuss their experience or hear others' accounts of abuse in the early stages of healing. For these victims, individual therapy can help them regain trust and begin to achieve control in their lives once again (Hilton & Mezey, 1996). Recent research has focused on the success of directed abuse-specific therapy. Studies comparing abuse-specific cognitive behavioral therapy to nondirective supportive therapy reveal that both groups show improvement in posttraumatic stress symptoms, but those in cognitive behavioral therapy have significantly greater improvement. Furthermore, involving the nonoffending parent in the treatment of their sexually abused children has proved beneficial as well. Parents engaged in treatment describe a greater decline in their children's externalizing behaviors, as well as a greater improvement in their parenting skills. Cognitive behavioral therapy aims to instill in the nonoffending parent an increased level of confidence and encourages them to model appropriate coping mechanisms for their children. Subsequently, their children report a significantly greater reduction in their level of depression (Deblinger et al., 1996). One reason that this treatment modality may be helpful is its utilization of well-established treatment strategies to handle abuse specific symptoms. Furthermore,

the treatment focuses on both amelioration of current symptoms and prevention of later behavioral problems and further victimization (Saywitz et al., 2000). The larger question is whether therapy has a beneficial effect on the well-documented long-term effects of child sexual abuse.

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Chapter 2

Anogenital Anatomy: Developmental, Normal, Variant, and Healing

William J. Reed, MD, FAAP

Medical Embryology of the External Genitalia

Genetic sex is determined at the time of fertilization of the ovum. The early genital system in the human fetus is undifferentiated and bipotential. That is, during the first 12 weeks of embryonic life both male and female primordial tracts are present and develop in unison (Moore, 1982). In the female the cortex develops into the ovary at 10 to 11 weeks, while the medulla regresses. In the male the medulla differentiates into the testis, and the cortex regresses. This gonadal development results from the migration of primitive germ cells to the urogenital ridge near the fetal kidney and adrenal gland. After fertilization, the undifferentiated gonad begins to change with the appearance of the mullerian ducts in the female at 6 weeks gestation. In the male, differentiation is present with the appearance of Sertoli cells at 6 to 7 weeks and Leydig cells at 8 weeks, respectively (Sadler, 1995). This phase of development of dual gonadal ducts then forms the phenotypic external genitalia.

Key Point:
Genetic sex is determined at the time the ovum is fertilized. The early genital system in the human fetus is undifferentiated and bipotential, meaning that during the first 12 weeks of embryonic life, both male and female primordial tracts are present and develop in unison.

The gonadal primordia are influenced by the sex-determining region (SRY) on the Y chromosome. If there is a deletion of the short arm (p-) of the Y chromosome or of the SRY gene, male differentiation does not occur. Deletions of the long arm (q-) of the Y chromosome result in normally developed males with short stature and azoospermia. The presence of an anti-müllerian hormone (AMH) or müllerian inhibitory factor (MIF) produced by the Sertoli cells in the testis causes the müllerian duct system to regress with dissolution of the female pelvic structures, that is, the uterus and fallopian tubes. This MIF is characterized as a glycoprotein whose gene locus has been localized to chromosome 19 (Simpson, 2000). Testosterone produced by the Leydig cells stabilizes the wolffian ducts and through 5-a reductase produces dihydrotestosterone, which virilizes the male external genitalia. The Sertoli and Leydig cell lines and their respective hormones function separately from the morphogenesis of the testis (Bhatnagar, 2000). Specifically, they direct gonadal development as opposed to being products of the testis. Therefore, if a functioning testis is present, the phenotype will be male. Conversely, in the absence of the sex determining region, whether or not an ovary is present, the phenotype will be female (Mittwoch et al., 1993). The uterus, fallopian tubes, and upper vagina will develop independently of the ovary. The female genital tract results from the müllerian ducts, urogenital sinus, and vaginal plate. In the male, the wolffian ducts, the genital tubercle, and the labioscrotal folds form the external genitalia. So, counterintuitively, M becomes female, and W becomes male.

Development of the External Genitalia in Boys

Key Point:
External genital development in boys occurs between 10 and 16 weeks of gestation and does not require high concentrations of testosterone, but does require the conversion of 6% to 8% of the total testosterone to 5-dihydrotesterone.

In boys, external genital development occurs between 10 and 16 weeks gestation and does not require high concentrations of testosterone, but does require the conversion of 6% to 8% of total testosterone to 5-dihydrotestosterone. The genital tubercle continues to grow to form the penis, and the urogenital folds fuse to enclose the penile urethra (Bukowski & Zeman, 2001). The distal head of the penis is the glans penis and the proximal shaft is joined at the corona. The opening of the penile urethra, which may be covered by the foreskin, is called the meatus. Where the foreskin attaches to the corona of the glans penis is termed the frenulum. Laterally, the labioscrotal folds develop and, in the presence of testosterone and 5-DHT, become fused in the midline to form the scrotum. This line may be very prominent on inspection and is referred to as the median raphe. At approximately 11 weeks, the processus vaginalis is present at the internal inguinal ring. It is contiguous with the gubernaculum, which inserts on the mesonephric (wolffian) duct. At 17 weeks the testis is now at the same site and begins to elongate along its vertical axis (Rohn, 1998). This phase of descent is androgen dependent. At 28 weeks the "inguinal scrotal" stage of descent begins. The testis descends into the scrotal sac between 28 and 32 weeks, depending on regression of the gubernaculum. The scrotal content may include fluid from a patent process vaginalis, intestine from a hernia defect, or a discolored and indurated mass caused by torsion of the testis, occasionally seen in breech presentations. The apparent clinical absence of one or both testes requires differentiating between an undescended or absent testis and the more common retractile testis. The spermatic cord and epididymis lie posteriorly to the testis, which is anchored to the scrotum by the gubernaculum, which now becomes a reticular strand.

Testosterone is responsible for the evolution of the mesonephric duct system into the vas deferens, epididymis, ejaculatory ducts, and seminal vesicle. Dihydrotestosterone results in the development of the male external genitalia, including the prostate gland, which arises from the urogenital sinus, and the bulbourethral glands of Cowper. At puberty, testosterone leads to spermatogenesis and the development of the secondary sexual characteristics as well as a five to seven-fold enlargement of the prostate gland, epidydimis, and testes (Moore, 1982).

Anatomic Variations in Boys

During examination of the male from infancy through puberty stage Tanner G5, many variations of normal as well as some previously unrecognized problems may be present. Many of these findings are frequent and easily noted and managed. Others are not so obvious and may be missed. The more common variations in genital findings are discussed throughout the following sections.

Leydig cell aplasia or hypoplasia (Rapaport, 2000) produces a phenotypic female with mild virilization. The testes, epididymis, and vas deferens are present. There is no uterus or fallopian tubes and no secondary sexual changes at puberty. Testosterone levels remain prepubertal, that is, at a serum level defined as less than 10ng/dL (Lee, 2002), but pubic hair can appear appropriately normal as a result of adrenal function. Abnormalities at this early stage also include congenital adrenal hyperplasia with subsequent virilization, or androgen receptor site/enzyme defects (5-a reductase) causing a lack of virilization and incomplete or normal development in the male (albeit eventually a large penis). It may lead to ambiguous genitalia in the female.

Partial androgen insensitivity produces the most common form of male pseudohermaphroditism. This occurs at a frequency of less than one in 20,000 genetic males and is an X-linked disorder with the androgen receptor gene locus at Xq11-12 (Simpson, 2000). All are 46XY and may appear with female genitalia,

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