

Child sexual abuse and the pediatric dentist

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Child sexual abuse has increased dramatically over the last decade. An estimate of the incidence at the beginning of the 1980s put the number of sexual assaults on children at 300,000 annually.¹ Most authorities agree that these estimates are probably low, due to underreporting as a result of a number of factors:

1. Cultural mores make sexual abuse a stigma for victim, perpetrator, and family and an issue not easily broached.
2. Victims are often young children whose fear, lack of awareness, or lack of language skills make them easy prey and victims who may not be ready or believable witnesses.²
3. Health professionals may be unaware of the signs or symptoms of child sexual abuse.³
4. Child sexual abuse often is hidden with no visible physical manifestations.²
5. Health professionals may be unwilling to report cases of sexual abuse where clear physical evidence is lacking for fear of error, reprisal, or loss of patients.
6. Verification of sexual abuse by physical examination may be beyond the legal extent of practice for many professionals.

One other reason for low reporting is the lack of an accepted definition of sexual abuse. Not all states agree on a legal definition of sexual abuse. Federal statutes define sexual abuse in the context of child abuse and include such acts as child pornography, rape, molestation, incest, and child prostitution. The

TABLE. Signs, Symptoms, Testing for Suspected Child Sexual Abuse

| <i>Condition or Suspected Act</i> | <i>Physical Signs</i> | <i>Etiology</i> | <i>Testing Procedures</i> | <i>Treatment/Action</i> |
|---|---|--|---|---|
| Gonorrhea | Pharyngitis or Tonsilitis or Gingivitis or asymptomatic orally: Conjunctivitis | Neisseria Gonorrhea | Oral swab and culturing on Thayer-Martin® or Transgrow Media® | Procaine Penicillin G and Probenicid or Tetracycline |
| Syphilis, primary | Chancre Lymphadenopathy | Treponema <i>Pallidum</i> (21 days) (Postinoculation) | Dark-field micro- scopy VDRL, RPR, ART serologic tests | Benzathine Penicillin G or Procaine Penicillin G or Erythromycin, Tetracy- cline |
| Syphilis, secondary | Lymphadenopathy Maculopapular rash Mucous patch (Mucous membrane) Condyloma lata (Skin) | Same as above (2-8 weeks postchancre) | | |
| Herpes | Oral and perioral vesicles leading to ulceration | Herpes Simplex Virus Types 1 and 2 | Immunologic differ- entiation of Types I and II | Supportive |
| Venereal warts (Condyloma accu- minata) | Papilloma-like lesions on lip, tongue, palate, gingiva | Papovirus | None suggested | Excision at base of lesion |
| Chlamydia | Conjunctivitis <i>Asymptomatic orally</i> Pneumonia (from oropharyngeal carriage) | Chlamydia Trachomatis | Specialized tissue culture systems | Sulfonamides or Tetracyclines or Erythromycin |
| Orogenital contact | Presence of physical trauma or pubic hair | Oral penetration (with or without ejaculation) | Wet mount micro- scopic examination for motile sperm Air-dried slides of sperm Acid phosphatase Wood's lamp test for fluorescence Swab of area of suspected semen and preserve swab in saline for typing | Supportive |

National Center on Child Abuse and Neglect offers a more general definition of child sexual abuse to include contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person.⁴

Child Sexual Abuse: The Victim

The sexually abused child is most often a female, with the ratio of victimized females to males of 9 or 10 to 1.⁵ Children of all ages are abused sexually, but those in the early teens seem to be most at risk⁴ if mean age can be taken as an indicator. One study of sexually abused children in Minneapolis found the

mean age of victims to be about 11 years.⁶ The victim is more often than not known or even related to the abuser.⁷ This close relationship between victim and perpetrator compounds the problem of reporting, and leads to a victim who may be abused repeatedly. The sexually abused child may or may not be physically abused as well. One study associated physical trauma to about one-third of those children who had been sexually abused,³ while another found about one-quarter of these children with signs of physical trauma.⁸ Some studies have found that boys are more often physically abused in conjunction with a sexual attack, as are older children of both sexes and those victimized by strangers. Recent data also suggests that within the population in general, rural white children

and black children whose mothers are single parents are more prone to be sexually abused.⁹

The psychological profiles of sexually abused children vary widely and appear to have some relationship to age, closeness to the perpetrator, and the type of abuse. An early estimate of the emotional effects of sexual abuse suggested that two-thirds of children who are sexually abused will develop emotional sequelae.¹⁰ Functional disturbances such as retention of feces or frequent masturbation have been noted,¹¹ as have a preoccupation with the genital area,² regression in behavior,⁴ guilt, and anxiety.⁷ A study of 28 children referred to a psychiatric clinic for management of abuse found a history of psychiatric disorders in about half of these children and in more than three-fourths of their families.¹² The closer the relationship between victim and perpetrator, the more likely there will be emotional effects. Incest is the primary example, with these children experiencing significant emotional trauma. Young children often do not suffer long-term effects of sexual abuse, perhaps because they have not identified the act with society's concepts of right and wrong.⁴

Child Sexual Abuse: The Perpetrator

The perpetrator of sexual abuse is no longer considered to be the impersonal stranger who victimizes an unknown child. The numbers of sexual assaults by those familiar to the child have increased dramatically. Statistics from 30 states in 1980 showed that parents accounted for more than 90% of caretaker-perpetrators.⁵ Other studies have confirmed that in a large proportion of sexual abuse cases the perpetrator is either related or known to the victim.^{13,14} The type of abuse may characterize the perpetrator. Incest most often is committed by a male parent against a female child. The father may have one of several profiles. He may be abusive or shy and withdrawn; sexual problems with a spouse and alcoholism also can be a part of the profile.¹⁵ Mother-son, or father-son incest is less common, but also indicates psychological pathosis. Sexual abusers tend to be young adults and racially similar to their victims, reinforcing the concept that most sexual abuse occurs between people familiar to each other.⁷

Child Sexual Abuse: The Act

Child sexual abuse includes child pornography, child prostitution, sodomy, oral and anal intercourse, fondling, exposure, and a host of other major and minor acts against children. Sexual abuse may or may not be associated with physical abuse of the genitalia or other areas. Pregnancy or venereal disease may be the sequelae of single or repeated sexual abuse. The act of sexual abuse is rarely a singular event if per-

petrated by someone familiar to the victim, but rather a repeated episode. The violent sexual episode is the exception rather than the rule. In many cases, the abuse may involve repeated fondling of genitalia or other body parts. Penetration in intercourse occurs, but does not account for the majority of sexual acts.^{6,16}

Of interest to dentists is the association of oral findings with child sexual abuse and the frequency of oral invasion in the pattern of child sexual abuse. Oral penetration has been found to occur in varying amounts by investigators. One study of sexually transmitted disease in children found oral penetration occurring in about 10% of abuse cases.¹⁶ Sodomy is a type of sexual abuse noted in a small percentage of cases,⁶ and seems to be an act more likely to be perpetrated on boys than girls. Recent data indicate that oral-genital contact may occur in up to half of sexual abuse cases involving boys.¹⁷ Kissing may be a part of the pattern of sexual abuse and also may be responsible for transmission of infectious disease, though its effect is difficult to quantify.

Venereal disease is a variable finding in child sexual abuse. Available data describe the presence of venereal disease or positive culture at the time the abuse is identified. It is likely much abuse-related venereal disease goes undiscovered. One study of 130 children found 3 to have gonorrhea.³ A summary of other studies shows a range of 0.8¹⁸ to 11.6% for the incidence of venereal disease in sexual abuse.¹⁹ A problem in identifying venereal disease is its variable appearance in the oral cavity and the fact that it may be asymptomatic. Other oral findings in sexual child abuse include laceration,³ and the presence of semen or pubic hair in the oral cavity.²⁰

Child Sexual Abuse: The Role of the Pediatric Dentist

The role of the pediatric dentist in child sexual abuse is not as clear as for other forms of child abuse and neglect. Several factors complicate the willingness and ability of the dentist to identify child sexual abuse or deal with suspicions:

1. Sexual child abuse often occurs without physical findings.
2. The dentist may be unwilling to address the sexual abuse issue because of its volatility and possible negative repercussions.
3. Dentists often are not equipped to do the necessary testing to obtain corroborating data such as the presence of sperm or positive cultures for infectious organisms.
4. Dentists may not be aware of the oral manifestations of venereal disease or other oral sexual lesions.
5. The transient nature of such lesions as oral gon-

orrhoea and intraoral trauma decrease the likelihood of identification and verification of an episode.

The dental literature lacks adequate information to aid the pediatric dentist in approaching the problem of child sexual abuse. Most attention has been given to identification and reporting of physical abuse. Sanger and Bross provide the clinician with some information on child sexual abuse.²¹

The medical literature also provides some help in identifying child sexual abuse. Perhaps the best advice is that a high index of suspicion is necessary to detect sexual abuse.²² Some signs and symptoms of child sexual abuse which might alert a pediatric dentist to consider further evaluation are the following:²⁰

1. A history of sexual assault
2. Physical findings of venereal disease
3. Pregnancy in a child younger than 12 years of age
4. Signs of physical abuse
5. Direct reports from children.²³

A second level indicator which may suggest sexual abuse includes a child's preoccupation with sex or a precocious sexual interest, or indiscrete masturbatory activity. A number of other psychological changes can accompany sexual abuse, but these are varied and numerous and can range from feeding difficulties in infants to promiscuity or prostitution in the adolescent.¹⁵ Nonspecific behavioral associations include social withdrawal and isolation, underachievement, distorted body image and low self-esteem.²³ These observations in identifying sexual child abuse, are speculative at best.

The legal role of the pediatric dentist in child abuse should be clear from the statute of the state in which the practitioner resides. Less clear is the point at which the dentist should suspect sexual child abuse, and pursue collection of medicolegal documentation and begin the reporting process. Perhaps the best approach is honesty, with the interest of the child as primary motivator. For the pediatric dentist who examines a child with clear signs or indications of child sexual or physical abuse, activation of the community's child abuse reporting protocol is the approach of choice. Coincident with this step is informing parents or caretakers of the action and collection of corroborating data. This process is discussed in detail in several places^{20,21} and the individual pediatric dentist should be aware of accepted and mandated practices in his locale.

History taking and examination in suspected child sexual abuse should be done in the presence of another adult to preclude accusations of sexual misconduct against the dentist.²⁴ Physical examination should be confined to areas considered in the purview of the

dentist and should be carried out in the presence of or in consultation with other professionals. Referral for complete examination or corroboration may be in the best interest of all concerned.

The table provides suggested physical signs of child sexual abuse and techniques used in identification and collection of medicolegal documentation.

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