# Child Sexual Abuse
# A Brief Overview of
## WHO Guidelines for the Medico-legal Care of Victims of Sexual Violence

**Pacific Police Development Program**

**Global Justice Solutions**

# Definition

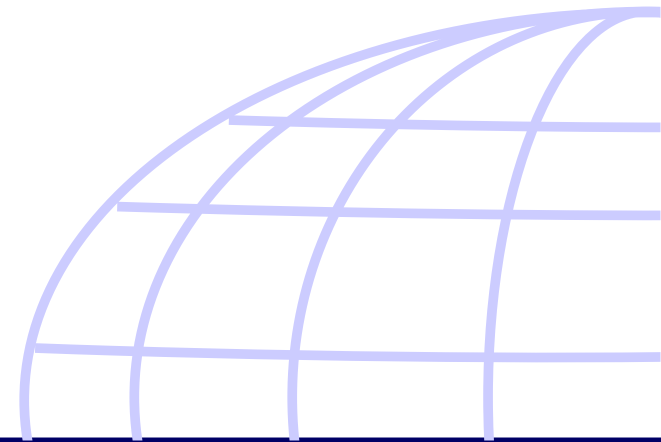
1999 WHO Consultation on Child Abuse Prevention stated that:

"Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.

Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person."

May include:-

- Inducement or coercion of the child to participate in unlawful sexual activity
- Exploitative use of child in prostitution or in pornographic materials



# Dynamics of Child Sexual Abuse

- **Dynamics are quite different to adult sexual abuse**
- **Physical force is rarely used**
- **Child is often confused by manipulative *grooming* behaviours**
- **Abuser is often a trusted care-giver**
- **Occurs over weeks or years with gradual increase in the degree of sexualisation of the abuse**
- **About a third of cases are intra-familial**
- **Paedophiles are people who prefer sexual contact with a child rather than an adult**

# Risk factors for victimisation

- Female gender
- Unaccompanied children or those in adoptive or foster care, step-children
- Intellectually or physically disabled children
- Previous sexual abuse
- Poverty, social isolation
- Parents who are unable to protect due to alcohol or substance abuse, mental illness

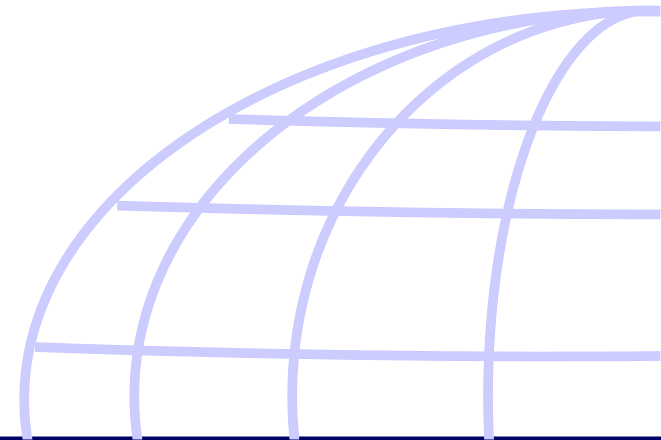
# Dynamics of disclosure

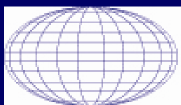
- Disclosure rarely happens close to the time of the event
- Child frightened by threats such as ‘I will kill you/your mother’
- Child concerned that she/he will not be believed and hints at disclosure may be dismissed by adults
- Disclosure may occur after a physical complaint and may occur over a period of time
- Disclosure may be to mother, peer or teacher – but mother may also be subject to similar abuse from the same perpetrator

# Physical and Behavioural Indicators

- **Raise concern but do not prove abuse**
- **Use caution in over interpreting these indicators**

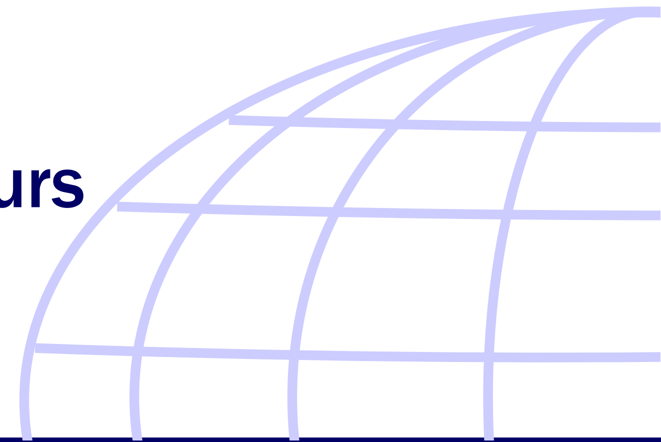
- **Physical indicators such as**
  - Unexplained genital injury
  - Bedwetting or faecal soiling beyond usual age range
  - Anal pain and injury
  - Sexually transmitted infection
  - Recurrent bladder infections
  - Pregnancy





# Behavioural indicators

- Regression in behaviour, school performance
- Acute traumatic response such as clinging behaviour
- Sleep disturbances
- Eating disorders
- Depression, poor self-esteem
- Inappropriate sexualised behaviours
- Social problems



# Genito-anal injuries

- Rare as sexual abuse rarely involves physical force
- A genital examination with normal findings does not preclude the possibility of sexual abuse
- In the vast majority of cases the examination will neither confirm nor refute an allegation of sexual abuse
- The amount of force used will be the determining factor and many signs will be absent or nonspecific

# Genito-anal Injuries

- Female adolescent victims of sexual assault are less likely to show signs of acute trauma or evidence of old injuries than pre-pubescent girls.
- During puberty, the female genital tissues, especially in the hymenal area, become increasingly thick, moist and elastic due to the presence of estrogen and therefore stretch during penetration.
- Furthermore, tears in the hymen may heal as partial clefts or notches that will be very difficult to distinguish.
- Minor injuries will heal almost immediately.
- Signs of major trauma are very rarely observed.

# Outcomes

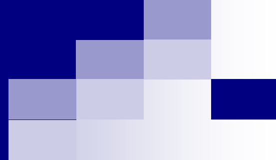
- Physical disorders and pregnancy
- Psychological disorders such as depression, anxiety, suicidality and post traumatic stress
- Social difficulties including relationship problems, sexual difficulties and substance abuse
- Re-victimisation as adults

# When to examine

- If last contact was more than 72 hours previously and the child has no medical symptoms, an examination is needed as soon as possible but not urgently.

- If last contact was within 72 hours and the child is complaining of symptoms (i.e. pain, bleeding, discharge), the child should be seen immediately.

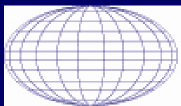
- The examination should be conducted by an experienced paediatrician if the child is pre-pubertal



# Medical history and forensic interview

Regardless of who is responsible for the medical history and the forensic interview, the two parts of the child's evaluation should be conducted in a coordinated manner so that the child is not further traumatized.

It is vital that the doctor and police have a cooperative and coordinated response.



# References


- Wells D (editor) *Guidelines for Medico-legal Care for Victims of Sexual Violence*, World Health Organisation, 2003.
- Hazelwood and Burgess (editors), *Practical Aspects of Rape Investigation : A Multi-disciplinary Approach,* CRC Press, Florida, 2009.