

Advocating for Alaska's Children

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CHILD SEXUAL ABUSE

- **“...contact or interaction between a child and an adult when a child is being used for the sexual stimulation of that adult or another person. Sexual abuse may be committed by another minor when that person is either significantly older than the victims or when the abuser is in a position of power or control over that child.”**
- *National Center on Child Abuse and Neglect*

Children's Advocacy Centers

- Comprehensive
- Child-focused
- Team approach
- Reduce trauma:
 - Fewer interviews
 - Non-invasive exam
 - Welcoming environment

What are the functions of a CAC?

- Forensic Interview
- Medical exam
- Psychosocial evaluation
- Referral for services
- Mental Health Intervention
- Advocacy
- Coordination of agency interaction and services

Goals of a CAC

- Reduce re-traumatization of child
- Identify risks, needs for the child and family; referrals for community resources
- Coordination and better access to information by team members
- Improve prosecution rates with better evidence and information
- Improved relationships amongst professionals

What holds the Center together?

- Multi-disciplinary Team

- Law enforcement

- Child Protection

- Prosecution

- Mental Health

- Medical

- Advocacy

- CAC

Other community need: Tribes, schools, DJJ....

Doing business differently

- Team work is: Collaboration, communication, sharing knowledge and resources, building relationships and trust . Listening to everyone's view.

Protocols

- The hardest thing you'll ever do!!!
- Guides the Team through the process of the investigation.

What is the Truth?

- Alaska: 4X the National average for child sexual abuse
- 95% of the time, the child knows the offender
- The typical child sex offender molests an average of 117 children, most of whom do not report the offense.
- It is estimated there are 60 Million survivors of childhood sexual abuse in America today.
- Children with disabilities are 4 times more vulnerable to sexual abuse than their non-disabled peers.
- There is a 3% chance that an offender will be caught for an incident of sexual abuse.

Mandated Reporting

- Easy to say
- Hard to do.....

- Repercussions?

Child Abuse **RISK FACTORS**

- **poor self esteem**
- **isolation**
- **poor parent-child relationships**
- **poor relationships between parents (DV)**
- **absence of a protective parent (SA)**
- **presence of non-biologically related
male in home (SA)**
- **alcohol / drug abuse in home**

Patterns/Sexual Abuse

- **Child is likely to know perpetrator.**
- **High majority of perpetrators are in position of trust and supervision of child.**
- **Victimization is likely to be gradual process of befriending, seduction, and then coercion into silence.**
- **Rarely any witnesses to the abuse.**

Disclosure

- **Children rarely report.**
- **1 in 10 children**
- **Preschoolers more likely to disclose accidentally and adolescents to disclose purposefully.**

Common triggers for disclosure:

- **child recently exposed to perpetrator**
- **sexualized behavior or statement**
- **educational awareness**
- **influence of peers**
- **anger**
- **child gains distance from perpetrator**

Disclosure

- In a study by Lawson and Chaffin (1982), 28 children ages 4-12 were identified as sexually abused by testing + for an STD.
- Only 43% of these children disclosed at the first interview
- Caretaker's belief/disbelief is very important: 63% disclosure vs. 17%.
- “Without the STD, the abuse of many children would likely not have been even remotely suspected by professionals.”

Sorenson and Snow(1981)

- 116 cases of confirmed sexual abuse:
- 11% were able to disclose at the first interview
- 79% initially denied or were tentative
- 22% recanted
- 93% finally confirmed their abuse

Forensic Interview

- Introduction
- Role
- Perception: why does the child think they are here?
- Establish rapport/assess developmental levels
- Truth vs. lie
- Reintroduce the abuse topic
- Body Parts Inventory
- Obtain Details
- Close of Interview

SIGNS THAT A CHILD MAY BE BEING SEXUALLY ABUSED

Sudden fear of a particular place or person

Extreme mood swings, unexplained depressions and excessive crying

Moodiness and withdrawal from normal family activity and affection and the opposite,

Extreme clinginess to a “safe” family members and extreme fearfulness when separated from that person

Sudden changes in personality

Behavior and other problems in school (grades dropping, etc)

Running away from home

Secretiveness

Indicators

Telling lies

Suddenly has money (from unexplained source)

Self-destructive behavior

Hyperactivity

Fear of the dark and fear of going to bed (new demands for a night light)

Problems with sleep – can't sleep, nightmares, bedwetting, sleepwalking, etc.

Changes in eating habits

Unexplained stomach upsets and aches

Difficulty at bath time

Changes in bathroom or toilet-training habits

More Indicators

- Regressive behavior such as thumb sucking or signs of dependency that were earlier outgrown**
- Inappropriate displays of affection and sexual “acting out”**
- Use of sexual terminology not normal to age level of peers**
- New names for body parts**
- Unusual interest in sexual matters**
- Sudden acting out—aggressive or rebellious behavior – against siblings, or other family members, with friends, violent play with dolls and other toys**
- Hurting animals**
- Fire starting**

Children seldom tell directly with words, but they may “show us with Signs

No one symptom or indicator is seen as diagnostic but a whole picture must be developed (an investigation) to determine whether a child is being sexually abuse.

Psychosocial/Emotional repercussions

Depression

Anxiety

Lower self-esteem

Easily agitated or unsettled behavior

Hurting themselves, attempting suicide

Loss or reduced trust in friendships, family

Poor social skills

Blame themselves for negative events

Feeling different from their peers

Feeling “Too much” or overly guilty and/or shame

See themselves as helpless and life as “dangerous”

See their body as damaged

Eating disorders such as obesity, bingeing and self-induced vomiting

Factors effecting how well children recover:

- ✓ Supportive parent/caregiver!
- ✓ The extent of the abuse, number of times it happened and how severe it was,
- ✓ Relationship to the offender.

Child on child sexual abuse: What We Know

- There is a continuum of children's sexual behaviors
- There are children who "molest"
- Challenge is sorting out sexual behavior that is natural and healthy and when it is an indication of some sort of distress.

Sexual Behavior Presentation & Child Psychological Orientation

- Normal Sexual Exploration : Giggly or silly about sexuality
- Sexually Reactive: Shame, guilt, anxiety regarding sexuality

Sexual Behavior Presentation & Child Psychological Orientation

- Extensive Mutual Sexual Behaviors: Anxiety/guilt/shame and ho-hum attitude and does not understand the concerns regarding the sexual behavior
- Children Who Molest: Volatile very aggressive and anxious features. Rage, fear sadness jealousy

What might contribute to a child's sexual behavior moving beyond natural and healthy?

- Children may be confused by what they see on TV, videos, magazines, movies, the Net
- Do not receive adequate supervision
- Live in homes with little sexual privacy
- Have been used to meet an adult's emotional and/or sexual needs
- See parents act in sexual ways after drinking/drug use

Contributing Factors, cont.

- Live in places where sex is paired with violence
- Have been physically and/or emotionally abused and/or neglected
- Have been observed or photographed naked for others
- Sometimes children's sexual behavior is attempt to diffuse confusion, tension, anxiety

Assessment of Sexualized Behavior with Children

Dimensional Criteria

Distinguishing Problematic Sexual Play vs. Age Appropriate Sex Play

- **Difference of Age Greater than 3 years**
 - Consider
 - Chronological Age
 - Developmental stage of both children
- **Size Difference**
 - Even at same age, height and weight can prove to be a threat or bullying tactic

Distinguishing Problematic Sexual Play vs. Age Appropriate Sex Play

- Status
 - Disparity of Power
 - Is one child a babysitter, caretaker, authority?
- Type of Sexual Activity
 - Developmentally expected for age?
 - How sophisticated is the act/play?
 - Mutual play or initiated/coercive play by one party
- Dynamics of Sexual Play
 - Is the Play spontaneous, laughter, joy, embarrassment?
 - Is the play focused on themes of dominance, coercion, threats, and force? Or does the child seem agitated, anxious, fearful?

CACs/MDTS around the State

- ❖ Fairbanks *“Stevie’s Place”*
- ❖ Anchorage *“Alaska CARES”*
- ❖ Wasilla *“The Children’s Place”*
- ❖ Juneau *“SAFE”*
- ❖ Bethel *“Tundra Women’s Coalition”*
- ❖ Nome *“Kawerak Child Advocacy Center”*
- ❖ Dillingham, Nitaput
- ❖ Kotzebue MDT in progress
- ❖ Kenai Peninsula, Haven House
- ❖ Cooper River Basin
- ❖ Kodiak MDT in progress

In Alaska: Best Practice

HB 53 now is AS 47.17.033:

- Requires sexual abuse investigative interviews to be videotaped
- And should be done at a CAC if there is one available to the investigator.

Medical Evaluation for Child Sexual Abuse

The “Intact Hymen” & other Myths

- **Kids always tell**
- **Kids tell everything the first time**
- **The exam will tell**
- **The exam is traumatic & invasive**
- **If the exam has no forensic value, it has no value**

What do we know about exam findings?

- The majority of children with a history of sexual abuse have ***normal examinations***
- Children's injuries heal amazingly well and quickly
- There are many findings that mimic abuse

Why are most exams normal?

- Delay in disclosure
- Delay in seeking evaluation
- Rapid healing
- Types of abuse
- Elasticity of vagina, hymen, anal sphincter
- Child perception of events

Why don't kids tell?

1. Children are vulnerable.
2. Children usually have a relationship with the perpetrator.
3. Child may not perceive as “abusive.”
4. Children are often groomed for sexual abuse.

Normal to be normal

- Kellogg et al Pediatrics 2004
- “Normal does not mean nothing happened”
- 36 pregnant adolescents presenting for sexual abuse evaluations
- 2/36 (6%) definitive findings of penetration
- 64% normal/nonspecific
- 22% inconclusive
 - Lack of consensus, unable to determine from photo
- 8% suggestive
 - Deep notch posterior rim, scar

Purpose of the Medical Evaluation

- Evaluate **health and safety** of the child
- **Diagnosis and treatment**
- Find and **document** acute and healed injuries
- Find, document and collect **forensic evidence**
- **Interpret any findings**



Purpose of the Medical Evaluation, continued

- Look for **medical conditions** that can be confused with abuse
- Evaluate for **unmet health needs**
 - Medical home, immunizations, counseling
- **Normalize** the ano-genital area
- **Reassurance** for child and family
- Recommendations and referrals as needed

What are the differences between rape and child sexual abuse?

- **Rape:**

- Acute
- Violent
- Forensic and physical evidence present
- Victim may be seen more quickly
- Victim more likely to be viewed as competent historian by virtue of age

Differences, continued

Child sexual abuse:

- **Chronic**
- **Nonviolent USUALLY**
- **No or limited forensic and physical findings**
- **Victim rarely seen acutely**
- **Accuracy of history questioned**
- **Developmental issues**

Before the Exam

- Explain the exam to parent/caregiver and child
- Discuss photography/recording
- Decide who should be present
- Gain cooperation
- Distraction techniques
- Different strategies for young children vs. adolescents

Medical Exam Includes:

- **Medical history, specific questions about symptoms, abuse history if necessary**
- **Head to Toe Exam**
 - Evaluate overall health and well being of child.

Medical Exam, continued

- **Anogenital exam**
 - With aid of colposcope (or other magnification)
 - Different positions
- **Photographs and/or video recordings of exam**
- **Collection of specimens (forensic, diagnostic)**

Medical Exam, continued

- External only for pre-adolescent
- Children have right to say no:
 - *“Empowered children are cooperative children”*
 - Encourage/allow participation

What About Teens?

- Emergency contraception and sexually transmitted infection testing and prophylaxis available
- Exams for adolescents may be internal
- 13 and up can consent to meds/treatment for reproductive issues

Anogenital findings may be:

- Normal
- Normal variants (congenital)
- Abnormal but not abuse
 - Infection
 - Accidental trauma
- Abnormal due to abuse
- Abnormal but nonspecific (can't tell)

What we can't tell from a Medical Exam

- **When** something happened (signs of healed trauma)
- **What** happened or what caused the injury
- **Who** caused the injury (unless identified from DNA/forensic evidence)

Findings commonly caused by other medical conditions

- Redness
- Labial adhesions
- Discharge: Infectious and non-infectious causes
- Bleeding, birthmarks

Nonspecific male findings

- Infection
- Erythema (redness)
- Eczema
- Accidental trauma

Non-specific Anal Findings

- Infection
 - Yeast
 - Strep
 - Pinworms
- Other factors:
 - Chronic constipation
 - Sedation
 - Neuromuscular condition

Indeterminate Sexually Transmitted Infections

- Genital or anal condyloma – (genital warts or HPV)
- Herpes 1 or 2 in anal or genital area with no other indicators of abuse

Diagnostic of sexual contact

- Pregnancy
- Sperm identified in specimens taken directly from child's body

Findings diagnostic of trauma that could be from sexual contact

- Support disclosure of sexual abuse if given
- Highly suggestive of abuse even in absence of disclosure
 - Unless clear, timely, reasonable description of accidental injury

Healing injuries

- Hard to determine unless acute injury seen in same place
- Perianal scar (rare)
 - Consider Crohn's, accident, medical procedure
- Scar posterior fourchette or fossa
 - Differentiate from linea vestibularis, labial adhesion – normal findings

Certain STD's

- Gonorrhea
 - Confirmed culture outside neonatal period
 - Genital, anus, throat
- Syphilis
 - Perinatal transmission ruled out
- Trichomonas
 - Child older than one
 - ID by culture or wet mount
- Chlamydia
 - Genital or anal
 - Child older than 3
 - Cell culture or other CDC approved method
- HIV
 - Perinatal, blood product, needle contamination ruled out

Assessment for Sexual Abuse =

- History or disclosure by child
(or events were reported / observed)
 - Child exhibits concerning behaviors
 - Child has concerning symptoms
- PLUS
- Medical examination findings
(Normal, Non-specific, Suggestive of Abuse)

Follow-up After Evaluation

- Referrals for Mental Health Services
- **Other referrals based on child/family needs/community/available resources:**
 - * Medical Referrals
 - * Developmental Screening
 - * Housing/Shelter/Food
 - * Other

Thank you for Helping Protect Alaska's Children!

- An investment in Alaska's future is an investment in Alaska's children!