

Accumulating experience in a child abuse clinic

F. P. R. de Villiers, M. A. Prentice

Objective. To examine the patient profile encountered in the first year of operation of the Child Abuse and Neglect Clinic of the Transvaal Memorial Institute.

Design. Record review of all cases presenting to the Clinic from May 1988 to April 1989.

Results. Females comprised just over 80% of the 227 patients. Sexual abuse was the presenting complaint in 89.8%. Most were young, 7% under 3 and 55% under 10 years of age.

Almost one-third of the boys and 5.0% of the girls had chronic signs of anal abuse. Of the girls 56% had signs of chronic and 10% signs of acute vaginal abuse.

Where the certainty of sexual abuse was high, 60% of the girls and 45% of the boys had suffered penetrative abuse.

The perpetrators were almost invariably known to the child; biological family members accounted for 38% of perpetrators, and if all relations are included (biological, step and 'common law'), family members were the perpetrators in 66% of cases. Strangers were the perpetrators in only 7% of our cases. The majority of perpetrators were male.

Behaviour problems were recorded in 73% of cases. Many different problems were noted; the most common were school problems (21%), masturbation (19%), 'clingy' behaviour (12%), and withdrawal or depression (11.5%).

Conclusions. Certainty of diagnosis should be specified. We use four categories: proven, highly suspected, unproven but still suspected, and no abuse. For sexual abuse we also differentiate between penetrative, non-penetrative, 'type uncertain' and no abuse.

Training of other health personnel in child abuse management is now a priority in our setting.

S Afr Med J 1996; **86**: 147-150.

Child abuse is accorded a great deal of exposure in the lay press in southern Africa, resulting in the recognition of more cases. The increased recognition of the problem and improved exposure in the media may also be interrelated. Since the early 1960s, when Kempe¹ used the phrase 'battered baby' to bring home the horror of this problem, we have increasingly realised how common child abuse is. Since the 1970s we have also recognised that sexual abuse

Child Abuse and Neglect Clinic, Transvaal Memorial Institute for Child Health and Development, and Department of Paediatrics and Child Health, University of the Witwatersrand, Johannesburg

F. P. R. de Villiers, M. B. CH.B., M. MED., PH. D. (Present address: Department of Paediatrics and Child Health, Medical University of Southern Africa, PO Box 221, Medunsa, 0204)

M. A. Prentice, R. N.

occurs frequently, not just in America and other countries, but also in southern Africa.^{2,3}

The Child Abuse and Neglect Clinic

In response to the above the Child Abuse and Neglect (CAN) Clinic was started at the Transvaal Memorial Institute for Child Health and Development (TMI) in May 1988, initially once a week but, since January 1989, twice weekly. Cases of chronic abuse, particularly where the child's life is not in danger, are booked to attend the non-racial CAN Clinic.

A team approach has been adopted. The team consists of medical doctors who are skilled in the examination of abused children, registered nurses, social workers and psychologists. The patients and accompanying adults, usually parents, are interviewed by the social worker.

A medical history is taken, followed by a complete physical examination of the patient, which includes examination of the anus and genitalia. Relevant laboratory tests are done.

A case conference is attended by all team members. Decisions are made about issues such as the diagnosis, the need for referral of the child and/or the family to social work agencies, psychologists or other counsellors, the desirability of removing the child from its present environment, the protection of the patient from the perpetrator, and follow-up of the case.

Methods

Data were abstracted from files of those patients who had attended in the first year of the clinic's operation (May 1988 - April 1989). Confidentiality was maintained, since the investigators handling the data were part of the child abuse team. The study was approved by the University's Committee for Research on Human Subjects (Ethics Committee).

* Demographic data, information about the type of abuse, and details of symptoms and signs were recorded. The anal and vaginal examination findings were classified as follows: signs of chronic abuse, signs of acute injury, uncertain physical signs, and no abuse. The types of abuse were categorised as follows: penetrative sexual abuse, non-penetrative sexual abuse, sexual abuse (type uncertain), physical abuse, emotional abuse, and neglect.

Results

In the first year 227 patients were seen — females comprised just over 80% of this total. Table I presents the type and certainty of abuse.* A large number of the children were young; 7% were under the age of 3 years and 55% under the age of 10 years. Physical abuse was the presenting complaint in only a small number of patients (3.5%), while 15 patients (6.6%) suffered both physical and sexual abuse. In the overwhelming majority of our cases the complaint was of sexual abuse; 84% of the boys and 91% of the girls (89% of all patients) presented in this way. The sexual abuse recorded varied, including fondling of the

body, fondling of the genitalia, forced observation of pornography, forced observation of intercourse, mutual masturbation, and vaginal, anal or oral intercourse.

Table I. Type and certainty of abuse

	Age (yrs)						Total
	< 10		10 - 16		> 16		
	F	M	F	M	F	M	
Proven							
Sexual	31	5	48	7	10	7	108
Non-sexual	7	0	1	0	0	0	8
Highly suspicious							
Sexual	23	3	6	1	1	0	34
Non-sexual	5	1	0	1	0	0	7
Unproven	26	9	12	2	1	1	51
Non-sexual	1	2	1	0	0	0	4
No abuse	7	4	1	1	1	1	15
Total	100	24	69	12	13	9	227

Owing to the nature of most cases of abuse — coercive rather than pure force — the findings on medical examination were often not conclusive.

It was noted whether the history, physical examination, child's behaviour during examination and laboratory investigations corroborated each other. Certainty of diagnosis category was assigned by the clinician, and confirmed or modified by the case conference. Deciding into which category to classify a particular patient is not always easy, however (these categories are *medically proven abuse*, *unproven but highly suspected abuse*, *unproven but still suspected abuse*, and *no abuse*).

Type of abuse is subclassified as sexual or non-sexual abuse. Sexual abuse is divided into penetrative (oral, vaginal or anal) and non-penetrative types. Sometimes the type of sexual abuse inflicted is unclear, necessitating the third category of sexual abuse, 'type uncertain'. Non-sexual abuse, in turn, is subdivided into physical abuse, emotional abuse or neglect. Sometimes a child had been abused in several ways.

Findings at physical examination

The findings where sexual abuse was either medically proven or highly suspicious are presented in Table II. Approximately a third of boys had chronic anal signs. This contrasts with the much lower figure (5.0%) in girls. No child in this series had signs of acute anal penetration. Of the girls 56.3% had chronic vaginal signs and 10.1% acute signs; in 25.2% of cases the significance of the vaginal signs was uncertain. A very small proportion — 7.6% — had no vaginal signs at all. This contrasts with the 50.0% of boys who had no anal signs.

Table II. Findings on physical examination*

	Girls				Boys (anal)	
	Vaginal		Anal			
	No.	%	No.	%	No.	%
Chronic signs	67	56.3	6	5.0	7	31.8
Acute signs	12	10.1	0	0	0	0
Uncertain	30	25.2	11	9.2	4	18.2
No signs	9	7.6	101	84.9	11	50.0
No examination	1	0.8	1	0.8	0	0
	119	100.0	119	100.0	22	100.0

*Only patients in the proven and highly suspicious groups are included.

* Tables with classification of cases by sex, age, certainty of diagnosis and perpetrators are available from the first author.

Table III provides a summary of sexual abuse in the proven and highly suspicious categories. Almost 60% of the girls (v. 45.4% of boys) suffered penetrative abuse. Almost one-third of the girls and 45.4% of the boys suffered non-penetrative abuse. In less than 10% of the children the type of sexual abuse was uncertain. Approximately 10% suffered more than one form of abuse. (This includes the non-sexual types.)

Table III. Sexual abuse in the proven and highly suspicious groups

	Girls (N = 119)		Boys (N = 22)	
	No.	%	No.	%
Proven	89	74.8	18	81.8
Highly suspicious	30	25.2	4	18.2
Penetrative	71	59.6	10	45.4
Non-penetrative	39	32.8	10	45.4
Uncertain	9	7.6	2	9.2
More than one type of abuse	13	10.9	2	9.2

Correlation of certainty of diagnosis with physical signs

The children (6 girls, 7 boys) who had chronic anal signs fell into the proven category and were diagnosed as having suffered penetrative sexual abuse. Of the 67 girls who had chronic vaginal signs, 61 were considered to fall into the proven and 6 into the highly suspicious category; 58 of these cases were diagnosed as penetrative, 8 as non-penetrative and 1 as uncertain sexual abuse. Of the 12 girls who had acute signs on vaginal inspection, 10 were diagnosed as proven and 2 as highly suspicious cases of sexual abuse; of these girls 8 were diagnosed as having experienced penetrative and 4 non-penetrative sexual abuse. Of the 4 boys with uncertain anal signs, 2 were considered proven and 2 highly suspicious cases of abuse; 2 were classified as having experienced penetrative sexual abuse, 1 non-penetrative sexual abuse and 1 uncertain sexual abuse.

Perpetrators

Biological family members accounted for 38% of the perpetrators and, including all relatives (biological, step and 'common law'), family members were the perpetrators in 66% of cases. Friends and acquaintances accounted for 17.7% of cases, and strangers were the perpetrators in only 7%. The majority of the perpetrators were male, but 2 girls and 3 boys were sexually assaulted by females.

Behaviour problems

During the medical history-taking the patients or parents were asked an open-ended question about changes in the patient's behaviour since the abuse started; there was also a specific question about masturbation. In 62 cases (27.3%) no behaviour problems were reported, and in 10 insufficient information was available. School problems, occurring in 48 patients (21%), were the most prevalent. Masturbation was the second most frequent problem cited, with 43 patients (19%) showing inappropriate or public masturbation. Sexual 'acting out' or provocativeness, however, occurred in only 15 (6.6%) of our patients. Other behaviour problems included aggression (10% of patients), 'clinginess' (12%) and temper tantrums (5%). Twenty-six of the patients (11.5%) were

withdrawn or depressed, some (9.3%) avoided people, and there were various feeding (11%) and sleeping (9%) problems. Other behaviour problems occurred less frequently.

Discussion

This was a new facility offering a comprehensive service; possibly patients who previously did not know where to go, or who had had poor service elsewhere, may have flooded the clinic, increasing the number of patients seen in the first year. On the other hand, the existence of a new facility is not instantly known to interested parties, a factor that may have reduced the number of cases seen in the first year. For the first 8 months the clinic only took place once a week, thus reducing the number of patients that might have been seen. Concurrent with the development of the clinic, a telephonic service (Childline) was instituted. Trained counsellors deal with enquiries about child abuse and counsel victims and actual or potential perpetrators. This service publicised our clinic to potential users.

The cases have now stabilised at a slightly higher number than in the initial year; 248 were seen in 1990, 285 in 1991, and 264 in 1992.

An equal sex distribution is expected in cases of physical and emotional abuse, but a female preponderance is likely in sexual abuse.⁶ For example, Winship *et al.*³ found that of 67 sexually abused children in their clinic 58 (86.6%) were girls, while Hobbs and Wynne² found that 243 out of 337 sexually abused children (72%) were girls. In our study, when those with no abuse or incomplete information are excluded, only 8.6% of girls and 10.3% of boys suffered from non-sexual abuse. Of those with sexual abuse, 81.9% (158) were girls, conforming to our expectations.

It may be anticipated that severe physical abuse may occur in infancy and possibly at the 'terrible two's' stage, moderate physical abuse at any age, and sexual abuse in adolescents and older pre-adolescents. No such pattern was evident in our study. For example, 11 of the 12 girls under 3 years of age, 34 out of the 42 in the 3 - 6-year age group, and 35 out of 39 in the 6 - 10-year age group suffered some type of sexual abuse. Only 1 of the 11 physically abused patients was younger than 3 years of age.

The large number of young children (55% under 10 years, 7% under 3 years) experiencing sexual abuse in our study is not a unique finding. In Hobbs and Wynne's² series 68% of the children were younger than 10 years and 34% younger than 5 years, while Herbert⁴ reports that 6.3% of her patients were under 5 years, and about half (49.1%) younger than 9 years.

When a child's life is considered to be in danger, or where injuries may heal if an examination is delayed, patients are admitted to one of the hospitals. This may partly explain why physical abuse makes up such a small proportion of the patients at the clinic. Furthermore, overt injuries due to physical abuse are often easy to see, a factor that may urge the doctor to consider admission. In contrast, even when there are injuries in cases of sexual abuse, the patient's genitals are often not examined; such injuries may be missed. Most cases of sexual abuse take place under coercion or threat, and physical force is a less common factor. Many more doctors are prepared to manage cases of physical than of sexual abuse, so that the latter get referred

to our clinic. These reasons contribute to the high proportion of cases of sexual abuse seen in our clinic.

Certainty of diagnosis cannot be established in terms of a simple 'yes/no' classification; several categories are necessary. Ours is a similar classification to that of Herbert,⁴ who also used four categories, 'determined', 'probable', 'uncertain' and 'unfounded'. A higher percentage (14.3%) fell within the 'unfounded' category than in our study. A stricter definition for Herbert's 'determined' category was used, namely that the perpetrator confessed, leading to a low incidence of 8%. The simple dichotomous classification would be preferable, leading to clearer (not necessarily easier) management and follow-up decisions. The law courts are more comfortable with the medical witness if the diagnostic certainty is 100%. Unfortunately, in practice the final diagnosis is rarely absolutely certain, 22% in Herbert's study⁴ and 56% (combined 'proven' and 'no abuse') in ours. A major reason for this is the importance that doctors place on the history, contrasted with legal caveats against uncorroborated or 'hearsay' evidence. The medical findings and the legal findings often disagree. In one study, for example, convictions were obtained in 79% of cases of child abuse where there was no physical evidence, and in only 67% of cases with physical evidence.⁹ Furthermore, there was a significantly lower conviction rate where the children were young.⁹ Convictions seem to depend largely on whether the accused pleads guilty, or whether the child is a convincing witness in court.⁷

Separate penetrative and non-penetrative sexual abuse categories are used because the diagnosis can be made more readily in penetrative sexual abuse and the correlation with sexually transmitted disease is higher where penetrative sexual abuse occurred.^{8,9} It must be noted that some children who suffer non-penetrative abuse show severe psychological sequelae.¹⁰

The absence of acute anal signs in our patients, and the low incidence (10%) of acute vaginal signs, seem to indicate that the abuse was not associated with a great deal of physical force. The high incidence of chronic anal signs in boys (31.8%) and of chronic vaginal signs (56.3%) indicates that most of these children were victims of ongoing abuse. These findings corroborate the fact that the perpetrator was known to the child in all but 7% of cases, and in 66% of cases was a member of his or her family. It is more comfortable to hold the view that strangers are dangerous, while biological family members are not; in the case of sexual abuse this is not true. In Herbert's study⁴ 35% of perpetrators were the biological father and 28% were step-, common-law or foster fathers. In our study biological fathers (22.7%) outnumber any other category of perpetrator. Mothers' boyfriends (11.35%), stepfathers (9.9%), and other biological relatives (15.6%) account for many of the remaining perpetrators of child abuse. As mentioned before, strangers were rarely implicated (7.1%). Females were the perpetrator in only 3.8% of the cases (sex unknown in 9 cases).

In a large study¹¹ 43% of the girls had suffered intrafamilial, 71% extrafamilial and 14% both types of sexual abuse. However, only 11% of the perpetrators were total strangers.

Behaviour problems are common in abused children,^{4,12} and were found in 58.7% of cases in Herbert's⁴ study and more than two-thirds (68.3%) of our patients. The six most common problems in our study were school problems, masturbation, clingy behaviour, being withdrawn or

depressed, feeding problems, and aggression; each of these affected more than 10% of the patients. School problems generally comprised failure to pass a standard, or placement in a special training institution. The most common problem in Herbert's study, sexual acting out, seen in 20.6% of the children, occurred in only 6.6% of our patients. Behaviour problems are of course common in children who suffer other kinds of stress, especially when there is potential for the family breaking up. The presence of behaviour problems alone cannot be taken as confirming child abuse, but may contribute to the diagnostic picture.

Prevention of recurrence and psychotherapy were considered in each case according to the needs. Where a perpetrator was conclusively identified arrangements were made to remove the child from that person's presence (if this had not already been done). Where the diagnosis was less certain or a perpetrator was not conclusively identified the case was transferred to a social work agency for continuous surveillance. A volunteer worker at the clinic contacted the agencies on a quarterly basis, until satisfactory resolution of the cases occurred.

Therapy was arranged in most cases. The Child, Adolescent and Family Unit of the TMI was used in cases of severe psychopathology. In other cases a variety of agencies and private therapists (psychologists and social workers) were used, depending on the patient's needs and geographical location.

The head of the Clinic is the paediatric director of the TMI and is committed both to the Institute and to the delivery of a child abuse diagnostic and therapeutic service, and several of the clinic members are women who, in addition to liking paediatric work, appreciate a part-time but stable work opportunity. A recurring theme is that the congenial and supportive personalities of the clinic members were such that the atmosphere in the clinic at least partly offset the stresses inherent in the work performed there. These are some of the factors that enabled the clinic to maintain a stable staff contingent.

A great deal of expertise has been amassed in this clinic. The next step that has to be taken is the increased training of primary health care personnel in the management of child abuse, so that it is not only the privileged few children who attend a specialised child abuse clinic who receive expert treatment.

REFERENCES

1. Kempe CH. Child abuse — the pediatrician's role in child advocacy and preventive pediatrics. *Am J Dis Child* 1978; **132**: 225-260.
2. Hyslop J, Howard P, De Villiers F, Wagstaff L. A composite overview of child abuse clinics in Johannesburg. Paper presented at the South African Society for Prevention of Child Abuse and Neglect Conference, Johannesburg, 5 - 6 July 1990.
3. Winship WS, Key JA, Dawes ME, Jacob WAS. Examination of sexually abused children. *S Afr Med J* 1987; **71**: 437-439.
4. Herbert CP. Expert medical assessment in determining probability of alleged child sexual abuse. *Child Abuse Neglect* 1987; **11**: 213-221.
5. Hobbs CJ, Wynne JM. Sexual abuse of English-boys and girls: the importance of anal examination. *Child Abuse Neglect* 1989; **13**: 195-210.
6. De Jong AR, Rose M. Legal proof of child sexual abuse in the absence of physical evidence. *Pediatrics* 1991; **88**: 506-511.
7. De Villiers FPR. The doctor as witness in child abuse cases. *S Afr Med J* 1992; **81**: 520-523.
8. Glaser JD, Hammerslag MR, McCormack WM. Sexually transmitted diseases in victims of sexual assault. *N Engl J Med* 1986; **315**: 625-627.
9. De Villiers FPR, Prentice MA, Bergh AM, Miller SD. Sexually transmitted disease surveillance in a child abuse clinic. *S Afr Med J* 1992; **81**: 84-86.
10. German DE, Habenicht DJ, Fletcher WG. Psychosocial profile of the female adolescent incest victim. *Child Abuse Neglect* 1990; **14**: 429-438.
11. Russel DEH. The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse Neglect* 1983; **7**: 133-146.
12. Ludwig S, Rostain A. Family function and dysfunction. In: Levine MD, Carey WB, Crocker AC, eds. *Developmental-Behavioral Pediatrics*. 2nd ed. Philadelphia: WB Saunders, 1992.

Accepted 16 Oct 1995.