Thesis For The Degree Of Doctor Of Philosophy (Ph. D.)

Female child sexual abuse

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1. Introduction and Objectives

Child sexual abuse has been and continues to be a social and diagnostic challenge. Child sexual assault is an especially serious, frequent and unacceptable form of ill-treatment that has major social relevance in many societies. In the past decades child sexual abuse has got into the centre of medical and criminal practice because of its frequency, serious detrimental impact and lifetime aftermath of the victim. Contrary to popular belief, majority of sexual assaults happen on multiple occassions, mostly caused by intrafamiliar perpetrator. Child abuse comes to our attention almost exclusively when a personal tragedy happens.

In Hungary shocking and specific cases had got publicity in the past few years. The task of health care professionals dealing with child sexual abuse, is difficult and multiple, needs skill, delicacy and circumspection. The recognition of maltreatment is complicated, due to difficult assessment, complex signs of abuse, hardship of evaluation, vocational isolation and judgement of sexual maltreatment as a taboo subject. However, maltreatment includes physical and emotional abuse and neglect, I am dealing particularly with sexual abuse, assault in my work.

While in many societies medicine has been involved in the diagnosis, treatment and management of sexual abuse in children and adolescents for more than 20 years, Hungary is in a disadvantegeous position, no population-based Hungarian data are available. The known and explored cases cover only the minority of sexual abused victims. This is only the tip of the iceberg, the child sexual abuse passes along the world as a „mute epidemic", Hungary is not an exception, either. At the same time, professionals dealing with children have insufficient and inadequate knowledge about sexual molestations, characteristics of the victims and perpetrators, recognition and treatment of the crimes and about the possible ways of rehabilitation of the victims. Most criminologists agree that abuse against women is the least well-documented type of crime.

Knowledge of the exact number of sexual assaults and the establishment of an appropriate medical and legal approach to child sexual abuse should be a medical, social and national requirement. The aim of my work is to gather information about the child sexual abuse cases in Hungary in order to support the fight against sexual maltreatment; to summarize the results and to draw the conclusion. We rupture the issue being a taboo subject and design the future tasks as well.

My objectives were the following:

1. Review the definition, types of child sexual abuse, mainly the rape.
2. Introduce the prevalence and occurrence of sexual maltreatment with the data of selected countries in the world, comparing to the domestic situation.
3. Review the case notes of patients, who were examined at the Adolescent Gynecology Outpatient Clinic of the Department of Obstetric and Gynecology, Medical and Health Science Center Debrecen, between 1996-2001. Data were extracted from the files of those of these patients who had allegedly been exposed to sexual abuse, and the characteristics of the victims and crimes, the condition and causes of maltreatment were studied.
4. Summarize the medical and multidisciplinar treatment of the victims, and the possible ways of the diagnosis and therapy.
5. Discuss the personal, social, medical and legal consequencies of sexual abuse.
6. Outline the prevention of sexual assault, the medical and legal approaches and the future tasks.

2. Patients and Methods

2.1. Patients

The case notes of sexually abused girls under 18 seen at our clinic at the University of Debrecen, Medical and Health Science Center, Department of Obstetrics and Gynecology between 1st January 1986 and 31st December 2001 were followed up. This is the only department in Hajdú-Bihar county (inhabitants: 700,000) to which adolescent gynecological cases are referred. During the first 10 years of our examination peroid the data were analysed retrospecively, and after 1996 the data of the patients were collected prospectively. Data were extracted from the files of those of these patients who had allegedly been exposed to sexual abuse, the crime and circumstances were examined, and the results of the legal proceedings were also analysed. The criminal, judical and medical records were continuously monitored and compared.

2.2. Methods

Guidelines for standard management, including the definition of child sexual abuse and the purpose and procedure for the examination, were elaborated in detail at the Department of Obstetrics and Gynecology of Medical and Health Science Center, Debrecen. Characteristic features of cases evaluated in our analysis include: age and education of the victim, age and occupation of the perpetrator, family relationship between victim and perpetrator, frequency of abuse, type and place of assault, season of the year and time of day when the abuse occurred, family relationship between victim and person accompanying her on presentation at the clinic. The time interval between admitted assault and clinical inspection was also recorded. Elicitation of the full medical and social history and the examination was also performed in the same manner in each case. The examination was performed by a member of our adolescent gynecology team. All cases were managed in the same setting and with the same time-scale according to the standard guidelines. The medical treatment was performed in conformity of the injury, also according to the standard guidelines.

Adequate recording the *history* – due to fortuitous legal consequencies – is extremely important, and it is the centerpiece of the medical evaluation for suspected sexual abuse. We documented the story word by word, disclosed by the child and by the parent or caretaker. It is important to achieve the trust of the patient and to convict her, that we would like to help. We should establish creditibility with the child by showing interest and telling her that other

children with similar problems have been helped. We used words that were familiar to the child, we repeated some of the questions during the examination to make sure the youngster understood what parts of the anatomy were being questioned. The history, written in the child's words, should include such details as time, place, circumstances, others present, and resistance. Leading questions were avoided, we remained nonjudgemental.

The *physical examination* included 'top-to-toe' examination, identification of any injury. We searched the signs of physical maltreatment on the whole body surface of the child: notation of hematomas, contusions, bruises, edema, abrasions, lacerations, bite marks, and other evidence of struggle, such as hair and skin beneath the fingernails or scratches. These were documented on the dot in a written report.

The *gynecological investigation* included the assessment of sexual development, identification of any injury with special reference to colposcopic appearances of the introitus and the hymenal ring. The careful inspection of the perineum was achieved by all means, noting bleeding, hematomas, lacerations, hymenal transections, vulvar erythema, condyloma acuminata, and any evidence of dried secretions. The child was carefully examined in a supine position, in frog-leg position, incidentally in her mother's lap; in a supine position, in knee-chest position, and in case of adolescent cases in lithotomy position. The photodocumentation of the recorded cases did not happen.

The followings also belonged to the examination: diagnosis of a possible pregnancy by urine test or ultrasound, collection of forensic evidence (sperm, saliva, clothes, other trace evidence). We looked for sperms in four places: introitus/ hymenal ring, vaginal canal, endocervical os and the anus. The initiation of any surgical treatment and prophylactic arrangements (prophylactic antibiotics of sexually transmitted diseases, emergency pills, tetanus anatoxin) followed afterwards. We analyzed the difference between child sexual abuse and rape, emphasizing the diagnostic difficulties. Our observations were documented during the first and follow-up presentations at the outpatient clinic. The findings were archived and distributed in response to official request. Results of the legal proceedings were also analyzed.

3. Results

In the 16 years between 1986 and 2001, we treated 209 girls under 18 years of age who were seen at the Adolescent Gynecology Outpatient Clinic of the Department of Obstetrics and Gynecology, University of Debrecen. In 86 of these cases (41%) the perpetrator was known to the victim, while in 70 (34%) a stranger was found to have been guilty of the assault. In 53 of all cases (25%) a family member was accused of the act. Forty-seven percent of these sexually abused girls were aged between 11 and 14 years; the youngest victim was 18 months old. One hundred and fifty-seven of the victims were students; 2 were mentally retarded girls; 9 were pre-school children; 17 were working; and 24 were unemployed. A relatively high proportion of the intrafamiliar abuses (25%) were committed by victims' father (44%) or stepfather (40%).

We found that in more than one-fifth of the cases (21%) sexual abuse had occurred on multiple occasions. The characteristics of the crimes can be seen on Table 1. On looking at the timing of individual cases, we found that child sexual abuse occurred mostly in the afternoon or evening and during the summer or winter when children are on holiday from school.

We also looked at the location of the abuse. Twenty-three percent of abuses had occurred at home. We present the distribution of accompanying persons by family/social relationship. In most cases, the victim was escorted to the hospital by her mother or a police officer. According to the history given by the victim and the person accompanying her at presentation in the clinic, the sexual abuse included vaginal penetration in 80% of the cases, sexual perversion in 20%, and physical injury in 32% (Table 1.).

Table 1 Characteristics of sexual child abuse cases

Characteristics	Category	Number of cases	%
Occurrence	Multiple	44	21
	Single	165	79
Type	Coitus	169	80
	Sexual perversion	40	20
	Physical abuse	66	32
Forensic evidence	Presence of sperm	38	18
	Pregnancy	1	0,5
Diurnal occurence	Morning	16	8
	Afternoon	87	42
	Evening	42	20
	Night	64	30
Seasonal occurence	Spring	14	7
	Summer	123	59
	Autumn	31	15
	Winter	41	19

Analysis of the time interval between the abuse and gynecological assessment showed that 101 victims (48%) were able to get immediate emergency care, while 35 girls (17%) visited the clinic within 72 hours and 73 (35%) victims were examined more than 72 hours after the abuse.

Physical examination of the victims focused on the following points: identification and surgical treatment of the signs of injury on the perineum and on the external structures of the female genitalia, collection of forensic evidence, sampling from the lower genital tract for sperm identification. Ultrasound examination was also performed in order to rule out the possibility of pregnancy. One pregnancy was diagnosed. Injury occurred in 66 cases (31 %), two of them required surgical treatment. The presence of sperm was confirmed in 38 cases.

During the 16-year period, legal proceedings followed the abuse in 127 cases. The number of perpetrators who were sentenced was 56 (27%). Twenty-nine of them were found

guilty on charges of rape, four on charges of sexual perversion, and 23 on charges of illegal sexual intercourse.

4. Discussion

In the past 30 years, a large number of reports have summarized the results of numerous studies and research connected to child sexual abuse and of the accumulating clinical experience. Child sexual maltreatment is no longer „another hidden pediatric problem" as Kempe stated in 1978. Twenty years ago the diameter of the hymenal opening played a determining role in the verification of maltreatment, nowadays this method seems to be out-of-date. The reduction of the number of physical findings diagnosed on the victims is conspicouos. The percent of physical signs on abused victims was 50% in 1980, 20% in 1990, and 10% in 2000. The explanation is due to the attendance of numerous studies based on a whale of victims. A great number of specialized referral centers developed a significant expertise in evaluating abused children in a qualified and non-traumatizing manner. As a result of the summarized experience and the development of recognition the physical findings of abused and non-abused children have been systematized.

4.1. The definition and the types of child sexual abuse

Child maltreatment occurs, if someone causes injury, pain, suffer to the child, or does not incapacitate a crime against the child, or does not report the maltreatment to the authority. Main types: physical, emotional, and sexual maltreatment, and neglect.

Physical maltreatment: all injuries caused by a physical contact with the child, bone fracture, spank, stripe, beat, kick, shake („shaking baby"), lug, burning, scalding, strangulation, chilling, poisoning.

Emotional maltreatment is the imposition of the emotional life of the child, which has major, harmful emotional and psychological consequencies. As the followings: excessive expectations from the child, requirement of school achievements in excess of the child's ability. Other attributes: to develop a feeling in the child, that she/he is not beloved, redundant, wicked; to cause permanent fear and anxiety, to criticize the child, utilization of the child emotionally and/or somatic.

Neglect: in case of the parent or caretaker does not ensure the adequate care and well-being of the child. This includes all instances in which the major needs of the child are not met, regardeless of cause. Major needs includes adequate food, shelter, protection; clothing health care, education, and the emotional needs of love and nurturance. The focus is on the

child' needs, rather than on parental behavior. Neglect also means: the delay of medical attendance, non-delivery of immunization, the lack of the respect of education.

Sexual abuse is a complex medical and social problem that manifests itself in a variety of ways, and is best defined using a synthesis of several definitions. Sexual abuse, sexual maltreatment, sexual misuse and sexual exploitation are all synonyms referring to a dominant or more powerful person involving a dependent, developmentally immature child or adolescent in sexual activities for that dominant person's own sexual stimulation or for the gratification of other people, as in child pornography. The essential components of the definition of sexual abuse involve the child's developmental immaturity and inability to constent, and the perpetrator's betrayal of the child's trust. In intrafamilial sexual abuse, the involvement of the child in sexual activities violates the social taboos of family roles.

Certainly the definitions determined by *legal categories* are not equal to the categories defined in *medical* practice. In order to support the previous statement, we should refer to the definitions used by the updated penal code:

- *Rape*: „If someone coerces another person in order to engage coitus with force, or threat against life or bodily fear, or uses someone's incapability to self-defense to utilize coitus, commits a crime, and can be found guilty. The penalty ranges from 2 to 8 years. If the victim is under 12 years of age, or the perpetrator is the victim's caretaker, educator, attendant, the penalty ranges from 5 to 10 years".

- *Act of indecency*: „If someone coerces another person in order to engage sexual perversion with force, or threat against life or bodily fear, or uses someone's incapability to self-defense to utilize coitus, commits a crime, and can be found guilty. The penalty ranges from 2 to 8 years. If the victim is under 12 years of age, or the perpetrator is the victim's caretaker, educator, attendant, the penalty ranges from 5 to 10 years". *Sexual perversion* includes all pornographic acts, excluding coitus, which is used for sexual stimulation.

- *Illegal sexual intercourse:* if someone achieves coitus with a person under the age of 14, or sexual perversion with a person under the age of 14, commits a crime, and the penalty rate is from 1 to 5 years.

Criminal adjustment emphasizes the tolerance of the victims, in case of the above mentioned statements of facts criminal procedures can be initiated by the request of the victim. In case of under 18 years of age, the procedure can be inchoated by the parent, caretaker or the guardian.

From the point of view of the aim of the perpetrator and the social consequencies, the sexual abuse cases can be devided into *commercial and non-commercial abuses*. The commercial sexual abuse includes prostitution, children pornography, internet crime and

white-slave traffic. The non-commercial group includes the intrafamilial abuse, and the sexual maltreatment in children institutions. There are dissimilar tools and motivation in the background of the acts, but the aftermath of both groups are equal: impairment, intimidation of the child, and permanent harmful effects.

From the point of view of the *type* of the activities, the sexual assaults can be devided into touching and non-touching abuses. The activities in the non-touching group include: exhibitionism, inappropriate viewing of the child, allowing the child to view inappropriate sexual material, taking sexually related photographs of the child. If someone makes, keeps or deals with pornographic pictures, videotapes of a person under the age of 18, commits a crime, and the penalty rate ranges to 3 years. The touching type of abuse consists of sexualized kissing, fondling, masturbation, digital or object penetration of the vagina and the anus; and oral-genital, genital-genital, and anal-genital contact. Types of sexual abuse: rape, sexual perversion, and illegal sexual intercourse, associated with physical abuse. Rape is commited usually against girls (90%), but the number of boy victims increases (10-20%).

We have to specify the difference between *rape* and *child sexual abuse*. The perpetrators of *rape* are mostly strangers, single act occurs. The use or threat of force is usually involved, so the majority of rapes is associated with physical abuse. The victim presents acutely with obvious findings, and immediate examination can be performed. These cases are followed by accusations and legal proceedings. These crimes are well-documented and can be followed up precisely.

Conversely, the perpetrators of *child sexual abuse* are individuals, who the children know, trust and love, mostly family members, fathers or stepfathers. Multiple occurrence is a classified category among these cases, force is not used, so the paucity of physical findings is normal. Frequently it does not involve physical contact sufficient enough to produce physical sequale. Therefore the „absence of evidence is no evidence of absence" (of abuse). In cases of sexual abuse, the perpetrator has authority and power over the child ascribed by his or her age or position and is thus able, either directly or indirectly, to coerce the child into sexual complience. These types of abuse often assume the phantasm of the cooperation of the child. The child does not want to get involved in sexual activities, which the child can not understand because of developmental immaturity. The child only seeks the love of the adult, who misuses the child's trust. The proof of the crime is extremely difficult, and the family keeps it quiet. In these cases the first examination is delayed, no legal proceedings are initiated. Because of underreporting, the actual number is probably much higher.

4.2. The prevalence, frequency and the causes of child sexual abuse in selected countries of the world, and comparison with the Hungarian situation

In order to adjuducate the domestic situation correctly, we have to overview the international statistics. In the United States, looking specifically at the data of DHSS (Department of Health and Human Services) in 1998: 903,000 children were known by the child protective services to have been victims of maltreatment. 103,845 children were known to have been sexually abused. The sexual abuse victimization rate is 1,5‰. Children aged 12 to 15 years old had an incidence rate of 2,1 ‰, this is the highest risk group. The rate for sexual abuse of females was 2,3 ‰, of males was 0,6 ‰. In Australia 37-41% of the women reported to be sexually abused during her lifetime. Twenty-five percent of the victims are under antidepressant treatment. In Canada 13%, in Germany 20,1%, in the United Kingdom 20% of the women have suffered from sexual molestation. A recent study has found a 19% prevalence among adolescents in Switzerland. In the north European countries the prevalence is a bit lower, in Norway 17%, in Sweden 13%, and the prevalence is higher in Spain: 22%.

Unfortunately, so far, there are no summarized data of child sexual abuse in Hungary. Although there are unique case reports published. In Hungary the first article reporting child sexual abuse was published by Antoni, and followed by numerous studies (Bognár, Bodánszy, Osváth). Velkey was the first to design a retrospective study in Borsod county, among 170,000 children. The frequency of child maltreatment was recorded 5,7%. In 1994 Éva Barkó tried to design a similar survey. Four thousand questionnaires were sent to pediatricians, general practitioners, children's homes, children's wards in hospitals, day nurseries, kindergartens, teachers, nurses. She wanted to gather information about such cases in the children suppliers' practice. Not more than 250 answers had been sent back, 39 answers were negative. The 6,25% answer rate shows the uninterested approach of the profession. What can be expected from the laymen, if the health care professionals are so disinterested?

In 1999 the child protective service made a questionnaire survey. Seventeen institutes answered, and child sexual abuse was reported from all places. Eighty-two percent of the reported 138 victims were girls, 35% were between the ages of 13-14 years. Intrafamilial abuse occurred in 66% of the cases, the perpetrator turned out to be the father in 43%, and the stepfather in 35%. The type of abuse was fondling in 35%, vaginal penetration in 22%, oral contact in 15%. These can be considered only particulars.

Why do not we have domestic, overall data of evidence value?

This has several reasons: in Hungary child sexual abuse cases are hidden, hard acceptable and considered to be a taboo subject. Because of the lack of information and the small number of trained health care professionals, the family can not turn to anybody to get some help. In case of intrafamilial abuse, the mothers' fear losing their homes, their possessions, so it is more practical to convince the jury, that the victim has „found out" the story, because the penalty of father can cause the family a poor financial situation.

The other reason of the paucity of adequate number and quality of forensic evidence is the diagnostic difficulties of sexual abuse. Frequently the majority of the crimes does not involve physical abuse, with multiple occurrence and long-lasting runoff. This interprets that normal findings range from 23-91% during the examination among sexually abused children.

The explanation of the specially low rates of proved cases in Hungary (5-6% vs. 20 or > 20 %) is the nature of the abuse itself.

- Just think about the non-touching types of sexual abuse!
- The constant threats of physical abuse and the limited anatomical knowledge of the victim inhibit a precise statement.
- The difference between medical and legal word usage makes the accurate documentation and rapid legal proceeding difficult. Touching the genitalia in order to engage in sexual intercourse with a child but without penetration is counted as a complete crime in judical practice.
- As delayed disclosure is typical for abuse, the examiner will frequently be unable to document any residual trauma or signs of previous trauma after a certain amount of time has elapsed. It has been confirmed that a single incomplete hymenal rupture can heal in 9 days and a complete rupture in 24-30 days after the trauma. In a recent study, only 2% of 192 girls with a history of vaginal penetration had physical signs (hymenal transsections, perforation)
- In order to complete the above mentioned, the unpreparedness of the health care system, the lack of free information flow and the lack of the obligation of case reporting also explanate the low percent of reported cases.

In Hungary the majority of sexual maltreatment cases remain hidden.

4.3. The characteristics of the sexually abused victims visited the outpatient clinic of the Department of Obstetrics and Gynecology, Medical and Health Science Center between 1986-2001, the characteristics of the crimes; the types, circumstances and causes of abuse

To make interpretation of our results possible we have to specify the difference *sexual abuse, sexual assault, molestation and rape*. In the majority of our cases (68%) force had not been used: children were abused by persons they know, trust and love. In 53 case (25%) the person accused of child sexual abuse was a family member and the assault happened at home. In these cases, the first examination is delayed and usually no forensic evidence is found. Multiple occurrence is a classified category among these cases (21%). As delayed disclosure is typical, it was unable to find any residual trauma. Beyond the long time-interval, the most important reason for the paucity of abnormal findings is the nature of the abuse itself. In most cases, the crime does not involve enough physical contact to produce physical symptoms (non-touching or oral abuse, pornographic photos). Special attention is required in the cases in which sexual abuse is carried out by a member of the victim's family. We have seen only 52 cases in which first instances of abuse were reported. The highest frequency was observed between the ages of 11 and 14; the youngest victim was 18 month old. The actual number was probably much higher than 52 because of underreporting. In almost every case, the girl reported constant threats of physical abuse if they spoke about the act. Therefore, such girls are afraid of the consequencies of filing a report, and unfortunately their mother do not become aware of the situation until it is too late. The mothers' fear losing their homes and possibly their children. This is the foundation on which multiple and continuous sexual abuse can continue. Most of these crimes occur during the summer and winter months when children are on holiday from school, without supervision (59% of the cases in the summer, 19% in the winter).

There are *risk factors* that make the children more liable to sexual abuse. The youngster becomes victim easier if: parents are divorced, stepparent exists in the family, the parents are also teenagers, the child is mentally retarded, isolated, busy mother, paucity of knowledge of sex education, risky behaviors – use of drug and alcohol.

Conversely, those children who are the victims of assault or rape perpetrated by strangers (34%) present acutely with forensic evidence. Among our patients, stranger perpetrator was accused of the crime in 70 cases (34%), sperm was found in vulvo-vaginal smears in 38 cases (18%). They had family support – they were brought to the clinic by their

mothers – and immediate examination could be performed. Forensic evidence can be collected within 72 hours after the assault.

Only in 127 cases (60%) of the 209 crimes were legal proceedings subsequently initiated during the 16-year period. Delivery of judgements against the 56 (27%) ultimately sentenced took several years in each of the cases. This low proportion of charges and the long time interval needed for a judgement in the Hungarian legal system do not support prevention.

4.4. Elements of medical and multidisciplinar attendance: the moral of recognition and therapy

During the medical and social history, the patient has to be questioned about events referring to previous sexual abuse in a direct or indirect way. Harmonizing with our experiences, the authors of recent studies agree with each other, that the victims look forward to the questions, in order to discover the possibility of sexual abuse, but these questions are neglected in the majority of cases.

The parents, school teachers and health care professionals play an important role in recognition of such crimes. They have to pay attention to child neglect, the tiny signs referring to suspicious child sexual abuse. The following remarks make the recognition even more difficult: the paucity of somatic symptoms, ambiguous symptoms, the confirmation of suspicion can not be expected from the victim, so the possibility of sexual abuse has to be always kept in mind. The suspicious findings of maltreatment appear in different forms in line with the age of the child; in pubertal age, it is extraordinary difficult to separate normal and deviant behavior. The suspicious findings can be general or specific, may appear at somatic, emotional and behavioral level, or at mixed levels. Immediate professional intervention is needed if the following behavioral signs are detected with the child: sleeping disorders, difficulty in concentration, depression, failure of school performance, inactivity, reticence, distrust, apprehension, premature behavior, runaway from home. The suspicious behaviors of the parents must also be taken into consideration. Our experiences: the parents do not follow the advices given by the nurse or the doctor, the history taken from the parent does not interpret the development of the injury, the child's and the parent's history were different, omission of the visits of the child previously taken to hospital.

We recorded the following physical signs of maltreatment: contusions, abrasions, bruises, hematomas arisen from different time and not typically located; bitemarks, signs of strangulation, signs of burn and scald.

The non specific suspicious signs of sexual maltreatment include the general behavioral signs, mentioned above; the consequencies of sexual assaults, e.g. pelvic, abdominal pain, recurrent dysuria and urogenital infections, the pain and pruritus of the genital organs.

The specific signs are definite: injury and inflammation of the genitalia and anus, gravidity, sexually transmitted diseases.

In order to help the recognition of sexual abuse, we summarize the anamnestic data and the physical findings for assessing the probability of abuse in Table 2.

Table 2 Protocol for assessing the probability of child sexual abuse

No evidence of abuse

- Normal examination, no history of abuse, no behavioral changes, no witnessed abuse
- Nonspecific findings with another known or likely explanation and no history of abuse or behavior changes
- Child considered at risk for sexual abuse, but gives no history and has only nonspecific behavior changes
- Physical findings of injury consistent with history of accidental injury, which is clear and believable

Possible abuse

- Normal or nonspecific physical findings in combination with significant behavior changes, especially sexualized behaviors, but child unable to give a history of abuse
- Condyloma acuminata or HSV 1 anogenital lesions in a prepubertal child, int he absence of a history of abuse, and with an otherwise normal examination
- Child has made a statement, but it is either not sufficiently detailed given the child's developmental level, or is not consistent
- Physical findings concerning for abuse, with no disclosure of abuse or behavior changes

Probable abuse

- Child gives clear, consistent, detailed description of being molested, with or without physical findings
- Physical findings suggestive of abuse, with or without a history of abuse and with no history of accidental penetrating injury
- Positive culture (not rapid antigen test) for Chlamydia trachomatis from genital area in a prepubertal child >2 years of age
- Positive culture for HSV 2 from genital lesions
- Trichomonas infection diagnosed by wet mount or culture

Definite evidence of abuse or sexual contact

- Clear evidence of blunt force or penetrating trauma with no history of accident
- Finding sperm or seminal fluid in or on a child's body
- Pregnancy
- Positive, confirmed cultures for Neisseria gonorrhoea from genital, anal or pharyngeal source
- Syphilis aquired postnatally
- Witnessed abuse or cases in which photographs or videotapes show child being abused
- Confession by the alleged perpetrator to the acts described by the child
- HIV infection with no documented means of transmission other than sexual contact

4.5. The personal, social, medical and legal effects of sexual abuse

The notability of sexual maltreatment against adolescents is the extremely wide spectrum of consequencies:

- The harmful effects of the physical abuse range from *somatic injuries* to homocide.
- The sequelae of sexual contact can be an *unwanted pregnancy*, which can be followed by a *criminal abortion*.
- Other outcome is the great number of *sexually transmitted diseases*, which can cause *infertility,* other aquired immundeficiency syndromes.
- Psychosomatic disorders, like *premenstrual syndrome*, or *chronic pelvic inflammation* and pain, usually refer to older victims. Younger victims suffer from *gastrointestinal malfunction*, and *irritable bowel syndrome* more often.
- The emotional effects of sexual maltreatment include nearly all *emotional, psychosomatic, self-destructive, and antisocial behavioral problems*. Many and various studies have highlighted the development of secondary mental health problems: *suicide*, *depression, anxiety, posttraumatic stress, eating and sleeping disorders, chronic brain-fag, drug and alcohol dependency.* The harmful effects of the long-lasting stress are: reduced immunity, chronic diseases, premature labour, high-risk pregnancy. In order to appreciation the cases should be long-term followed up

As a summary, the medical and social effect of sexual abuse is complex, diversified, and incalculable. Child maltreatment puts women's health at extremely high risk, it has also economic impact. It is proved that women with a history of childhood sexual abuse account for significantly higher primary care and outpatient costs than do women without any such history.

The impact and consequencies of sexual assaults are influenced by several factors. We have to underline the relationship against the perpetrator, the degree of the probable cousinhood, the duration and frequency of the crime, the age of the victim, and the positive psychiatric and psychosocial, medical records in the victim's history. We emphasize the adequate awareness, the professional skills and the positive attitude of health care professionals, and the positive or negative effects of medical attendance. It must be kept in mind, that an unadequate examination can cause a more harmful effect on the victim, than the abuse itself. The definition of secondary victimisation means the failure of the child protection system. This includes the interviews of unnecessary numbers, performed by an

unskilled professional during the investigation, during the medical and legal evaluation; and the gratuitously long lasting examination and questioning.

4.6. We summarize the prevention of sexual abuse, the medical and legal approaches and the challenges of the future.

Since the sexual maltreatment may involve serious life-time somatic and/or emotional consequencies, the skilled medical attendance of the victims is not sufficient. Effective intervention includes the reduction of the number of cases, and the prevention.

- It has to be ensured that the victims and potentional victims have the opportunity to get to be informed, to receive assistance, and to achieve anonymous reports.
- The information can be assisted by posters, published handouts, or information sheets available on the internet. A possible way of instruction is the establishment of a free green telephone number, which can be dialled by the children and parents in strictest confidence.
- The health care professionals should pay more attention to the possibility of sexual abuse of the patients at drug-ambulances and at youth psychological outpatient clinics.
- Health educational programs have to be organized for children, parents and teachers. The parents and the teachers have to be trained and informed about the basic characteristics of child sexual maltreatment. The age-group specific proposal of sexual education and prevention of sexual abuse is summarized in Table 3. We consider it important, that the child has to be acquainted with the danger, and should not be afraid of disclosing. The parents' task is the establishment of a direct, above-board connection with their child. The appropriate emotional contact between family members is essential to the successful prevention. Above the responsibility of the parents, the sexual education in an adequate form at schools is also necessary.

Table 3.Protocol for sex education and abuse prevention in well-child care *

Age	Developmental issues	Prevention plan
Newborn	Complete dependency	Discuss choosing daycare and babysitter
6 month old	Discovery of pleasant feelings associated with genitals	Talk about normalcy of infant genital exploration and self-stimulation
18 month old	Beginning of language development	Encourage parents to teach children normal anatomic terms for body parts and use them.
2,5-4 years	Establishment of gender identity	Identify children with sex role confusion
3-5 years	Increasing independence of child, beginning of oedipal stage, recognition of sexual differences	Encourage parents to give child permission to say „no" to advances, teach children about „private places", reassure parents about normalcy of sexual curiosity and play, encourage parents to give their children straightforward answers about sex.
5-8 years	Developing inreasing independence and accomplishments, beginning school	Discuss safety away from home, encourage parents to teach children safe behaviors, reinforce self-protective behaviors and difference between good and bad touch, encourage children to talk about frightening experiences
8-12 years	Developing sexuality, the time of highest incidence of child sexual abuse	Parental planning for sex education for their children, reinforce personal safety education
13-18 years	Development of adult identity, increasing independence from family, beginning of normal sexual experimentation	Discuss personal safety and risk-taking behaviors (alcohol, drug abuse, hitchhiking), discuss sexuality, birth control and sexually transmitted diseases

* Jenny, C., Sutherland, SE., Sandahl, BB.: Developmental approach to preventing the sexual abuse of children. Pediatrics, 1987; 78: 1034.

- Social collaboration is the primary condition of the successful action against child sexual abuse. The prosperous prevention and definite suppression of the mute pandemic is expected by interdisciplinar, medical, educational, police, legal, and social collaboration.
- The organization of further vocational training has to be pressed. The education of prevention of sexual abuse must exist on all levels of general education.
- The teenagers have to be informed about the old-fashioned and up-to-date methods of rape. The new form is represented by the *party-rape* and party-drugs. The active ingredient of the party-drugs are GHB (gamma hidroxi butirate), gamma butirolacton and 1-4 butanediol. These popular party drugs are perfectly suitable for the perpetrators to rape the victim in a stupefied, incapable of self-defense condition, 15-30 minutes after drinking. The victim does not put up resistance, no physical abuse occurs, no forensic evidence – no grasp marks – are detected. According to their pharmacocinetics, these drugs have short half-life, empty through the kidneys, hence the diagnosis is even more difficult. Certainly not only GHB and its precursors are able to modify the victim's sense, but Rohypnol and Ketamin as well, and regarding the latter, the verification of sexual abuse is almost impossible, because its wild and often sexual hallucination. The most important and referenced way of prevention is the keeping of the old-fashioned warning: „Do not take anything from a stranger!", - of course it is possible to preparate and put drug in an unopened bottle of refreshment.

Our round of duties in the future:

1. The *treatment and rehabilitation* of the abused children should take place in a referred center, on the grounds of uniform protocol.
    - Document the findings: the use of video-colposcopy is highly recommended, because it makes the examination and the sampling visible and bearable for the victim. Besides the registration of the accurate history, photodocumentation is obligatory.
    - The common used examination methods should be completed with the examination performed in prone knee-chest position. This position offers an excellent view of the anus and allows a different perspective of the hymenal membrane and vestibular structures. In this position, the anterior wall of the vagina falls forward and allows the hymen to splay out for easy viewing. Occasionally, the use of saline to „float" the hymen when there is redundancy or cohesiveness of the tissue is indicated.

- The collection of forensic evidence should be supplemented with searching for sperms of the whole body surface – using of the Woods-lamp. The introduction of DNA testing for examination of collected secretion is definitely important.
- Taking the anamnesis should happen in a special room, with the participation of an interview-expert, the interview must be recorded on videotape.
- Multidisciplinary teams including a physician, a social worker, psychologist, psychiatrist, nurse, police officer and a prosecutor are extremely helpful in sorting out the complex issues involved in child sexual abuse cases, including decreasing the number of interviews for the child, identifying the perpetrator, and pressing charges. The team members should meet occasionally, and talk over the ongoing cases. The members and the roles of the multidisciplinar team are summarized in Table 4.

2. *Legal harmonization*: a new law should be created, in order to lay down, that who and how should report the child sexual abuse. In order to engage the legal proceeding less harmful for the victim, the use of the recorded statement should be used during the investigation. The long lasting trials must be shortened, the somatic and emotional defense of the child must be looked after; in view of the prevention of persistent and irreversible psychotic aftermath. This is particularly important, because in the present legal practice the perpetrators usually are at large, so in intrafamilial cases the perpetrator and the victim remain in the same household. This increases the possibility of the repetition of the abuse.
3. *Prospective studies* that follow children into adulthood would provide the best method for understanding the processes and experiences that mitigate or exacerbate abuse effects.
4. Although this thesis has dealt only with girls, boys, too, may be subject to intrafamilial and stranger homosexual and heterosexual abuse; they need the same type of education and meaningful care during childhood as their female counterparts.

In our routine work, in judgement of patients, in our point of view, we have to believe that children and adolescents are not objects. Not only statistical data or issues. They signify the connection between present and future. We can not lose them. It is our common responsibility.

Table 4. Roles and Responsibilities of Professional Team Members*

Discipline	Role	Education
Gynecologist, Pediatrician, Adolescent gynecologist	• Identification and reporting of suspected child sexual abuse • Completion of accurate medical evaluation, including history, physical exmaination and collecting forensic evidence • Medical treatment and mental health referral for child and family • Follow-up for high-risk cases • Interpretation of and expert testimony regarding genital examination and forensic evidence • Training of medical and nonmedical professionals on child sexual abuse	Training, knowledge and experience to manage the medical aspects of child sexual abuse
Nurse	• Identification of patients needs • Provision of appropriate services	Knowledge of age-specific features of a healthy child
Social worker	• Careful assessment of family strengths and weaknesses • Team coordination with Child Protection Services, Police, Pediatrician and Nurse	Knowledge of child development, abuse dynamics and legal process and skills at interviewing
Child protective services	• Gathering of reports • Initial assessment • Liasion to other disciplines in investigation • Individualized service plan • Communitiy activities around awareness and prevention	Knowledge of regulatory and legal issues Collaboration skills
Police officer	• Immediate intervention and protection of child • Criminal investigation	Training in child abuse investigation
Prosecutor	Defending child during court proceedings, prevention of harmful consequencies	Special skills
Child advocate	Protection of needs and interests of child in court proceedings	Special skills
Psychologist	Identification of suspected child abuse. Mental health assessment. Interpretation of findings. Assessment of caregivers' degree of risk for further abuse	Knowledge of roles of persons, connected to the child (teacher)

* Giardino, AP., Ludwig, S.: Roles and responsibilities of professional team members In: Finkel, MA., Giardino, AP. (Ed.), Medical Evaluation of child sexual abuse Sage Publications, USA. 2002. Chapter 11, pp. 215-231.

5. Concluding remarks

1. We were the first to perform a population based study among sexually abused girls under 18 years.

2. As a result of examining the characteristics of the victims and the perpetrators, the type and the cicumstance of sexual abuse, we establish:
   - According to sexual maltreatment, the highest incidence of abuse occur between 11-14 ages, this is the highest risk group;
   - In almost half of the cases the perpetrator is a family member, mostly the father or the stepfather;
   - The maltreatment occur more often if the child remains without supervision (afternoon, eveining, off-school times),
   - the sexual abuse caused by a family member occurs mainly on multiple occassions, without any residual trauma or signs of previous trauma, we have to lean on the behavioral changes of the victim or of the accompanying person and on the suspicious physical findings.
   - The immediate, urgent examination, where physical signs and forensic evidence are usually found, refers to a sexaul assault comitted by a stranger.

3. On the basis of our experience we summarized the data of the medical and abuse history and the records of physical findings, which assess the possibility, probability, or definite evidence of sexual abuse.

4. We call attention to the round of duties, which can develop the effectiveness of the recognition of abuse, the medical evaluation, and the pevention in the future.

5. We underline the role of sex education, training, qualification and the importance of changing of our approach to abuse.

6. We point out the imperfection of jurisdiction, and the urgent need for an establishment of adequate, up-to-date legal harmonization of child sexual abuse.

7. We call attention to the medical and social notability of sexual maltreatment among adolescents.

6. Summary

In the past decades child sexual abuse has got into the centre of medical and criminal practice because of its frequency, serious detrimental impact and lifetime aftermath of the victim. In Hungary there has been no population-based study published dealing with evaluation of medical and legal procedures of female child sexual abuse.

During my work I analysed the data of sexually abused girls under the age of 18, who visited the Pediatric Outpatient Clinic of the Obstetric and Gynecology Department of the Medical and Health Science Center in Debrecen between 1986 and 2001. Data were compared with those in international studies. The aspects studied were as follows: characteristics of victims and perpetrators, types and circumstances of the abuse, the frequency and massiveness of injuries and the method of medical service respectively. Legal procedures were also followed up until the end of litigation.

During the study-period 209 girls were reported at the office. The perpetrator was intrafamiliar in 53 cases (25%). The half of the victims (47%) were between 11 and 14 years of age. Majority of them (157: 76%) were students, but kids also occurred. The perpetrator among intrafamiliar cases most often was the victim's father (44%), or stepfather (40%). The abuse had occurred on multiple occasions in one fifth of the cases (21%). The crime happened most often in the afternoon or evening, frequently in out-of-school times, and took place in the victims' home in one fifth of the cases. Vaginal penetration was the type of abuse in 80%, and sexual perversion in 20%, associated with injuries in one third of the assaults. Half of the cases (48%) were immediately cared, 35 girls presented themselves within 72 hours, and in 73 cases (35%) the examination was performed after 72 hours. Pregnancy was identified in one case. Sixtysix victims (31%) were physically injured, two of them required surgical treatment. The presence of sperms was confirmed in 38 cases. During the 127 legal proceedings, 56 perpetrators were sentenced and found guilty on charges of rape, sexual perversion and illegal sexual intercourse.

On the basis of our experience we found, that medical, legal evaluation and social adjudication of child sexual abuse can be considered to be insufficient in Hungary. The diagnostic facilities, the financial and human resources are mostly absent, as well as the skilled health professionals and knowledge of the adults who care after and are responsible for the children (parents, educators) are missing. As a conclusion the various methods of prevention, the possibilities of improvement of diagnostic procedures, and treatment are summarized.

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