CHILDHOOD SEXUAL ABUSE

THE RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL EXPERIENCE

1986-1988

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(Date)

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SUMMARY

This retrospective descriptive study reviews sexually abused children who presented to the Child Abuse Team at the Red Cross War Memorial Children's Hospital (RCWMCH) between 1 January 1986 and 31 June 1988. During this period 365 children were referred to the Child Abuse Team, of whom 357 were entered into this study. 297 of these were cases of confirmed sexual abuse.

There were 48 male children and 123 children under 6 years of age. Most children were victims of a single episode of sexual abuse with only 13,7% presenting following repeated abuse. More serious forms of sexual abuse, rape or sodomy, were common, accounting for 60% of the cases. Over 70% of the children had physical signs to substantiate their claims of having been sexually abused. Sexually transmitted disease was a common finding, being present in 15,6% at presentation.

All children were accompanied to hospital by an adult, usually a parent. 60% of the children presented directly to RCWMCH. A delay between abuse and presentation was common, only 42% of the children presenting within 48 hours of having been abused. Physical problems frequently required management. Very few children received more than crisis intervention for their

emotional state and only 20% needed any form of intervention to ensure their safety.

Only 1% of cases involved a female abuser. In general the age of the abuser was older than previously reported with 18,6% being under 20 years of age. The relationship between abused and abuser was similar to that described in the literature, as was the reaction of the family against the abuser. 27,4% were prosecuted and of those that appeared in court 74,5% were convicted.

Further comparison of the following sub-groups of abused children are presented: male and female, young and old, intrafamilial and extrafamilial abuse, a single episode of abuse and repeated abuse.

CHAPTER 1 - INTRODUCTION

BACKGROUND

Although child abuse had been recognised for many years[1], it was only in 1962 that Kempe[2] highlighted it as a major problem of childhood. It took a further 15 years before sexual abuse of children was added to the list of childhood problems, when Kempe described the sexual misuse of children as one of the major hidden problems of childhood[3]. Since this disclosure professional and public awareness of the condition has increased to such an extent that in many reports cases of sexual abuse now outnumber those of physical abuse or neglect.

Superficially sexual and physical abuse of children appear very similar. There is, however, one fundamental difference that has a significant effect on attempts to determine the prevalence of sexual abuse. The definition of physical abuse is based on the observed consequences of the abuse. In contrast, "sexual abuse is defined on the basis of facts related by the child victim or a close adult which are not necessary confirmed by a physical examination"[4].

Two methods have been used to determine the prevalence of sexual abuse of children. The first determines the

frequency of child sexual abuse by surveys of adults. The second reviews children referred for evaluation and treatment following disclosure of sexual abuse. Both methods are imperfect and reported prevalence rates show large discrepancies which reflect differences in the research method as well as the definition of sexual abuse applied by the researchers.

In 1953 Kinsey reported that 24% of females have sexual contact with adults before they turn 14 years old[5]. Russell[6] showed in 1983 that in San Francisco 28% of females claimed to have experienced some form of sexual abuse by 14 years of age. In the United Kingdom 12% of females and 8% of males claim to have been sexually abused before the age of 16 years[7], whilst in Australia 13% of adults recall sexual experiences with adults before the age of 12 years[8].

As indicated above, the prevalence of sexual abuse in childhood, varying between 12% and 28%, is high when surveys are undertaken in an adult population. When one reviews the cases presenting for evaluation and treatment following sexual abuse the numbers are not as large but still remain significant. Over the past two decades there has been a steady increase in the number of cases presenting for help. In the late 1970s the American Humane Association reported that of all cases of child abuse and

neglect 6,5% concerned sexual abuse[9]. A few years later in 1978 15% of all substantiated cases of child abuse were sexual[10]. By 1988 the picture in the USA had changed markedly and Marshall[11] reports that sexual abuse now accounts for 51% of reported cases of child abuse and neglect seen at his hospital.

The children at greatest risk have been identified as those who come from dysfunctional families[12], those with pre-existing neurological or behavioural problems and those who have already been sexually abused[13, 14]. De Jong, Emmett and Hervada[13] report that in their experience 3,5% of victims of sexual abuse will have been abused previously and 7% will have pre-existing neurological or behavioural problems. Tilelli et al[14] report figures of 7% and 11% for the same predisposing factors respectively.

In all reports of sexual abuse of children females form the majority of victims. The number of male victims ranges from 10% to 23%[4, 11, 13, 14, 15, 16, 17, 18] and the proportion of male victims is increasing.

The ages of the victims range from 2 months to 20 years. The mean age reported depends to a large extent on the upper age limit set for inclusion into the study and this varies from 6 years[19] to 20 years[17]. Consequently the mean age of the victims has little relevance unless comparing

children in the same sample or samples with similar age ranges. Some studies report the mean age for female victims to be younger than that for male victims[4], whilst others report the opposite[15, 17].

Very little is known about the means by which sexual abuse comes to light. Mian et al[19] report that 53% of sexually abused children under 6 years of age spontaneously disclose the fact that they have been sexually abused. Looking at a wider age range, Reinhart[18] reports that disclosure occurs spontaneously in 39% of cases and in response to prompting by a suspicious authority figure in a further 21%. In 23% of cases in his report clinical findings and/or prevailing circumstances were highly suspicious of sexual abuse, but no confirmation of these suspicions was forthcoming. A minority of cases, 12%, were revealed by a third party who either witnessed the abuse or was also involved in the abuse. Finally in a small number of cases clinical records did not document the method of disclosure.

It is obvious that spontaneous disclosure of sexual abuse is not the norm. Furthermore, whatever form the disclosure eventually takes there is often a delay between the abusive incident and presentation to medical personnel or a child protection agency. De Jong et al[15] found that 56% of victims presented to hospital within 24 hours of having been sexually abused. In a younger age group Mian et al[19]

found that 50% of their patients presented within 48 hours of having been sexually assaulted. 31% presented to hospital more than a week after either a single incident or the onset of repeated incidents. Various explanations have been provided for the often long delay between onset of sexual abuse and either disclosure or presentation to the hospital. These include dysfunctional families, fear or confusion on the part of the child and the accommodation syndrome described by Summit[20].

In 1983 Summit described the stages through which many children pass following sexual abuse as the child sexual abuse accommodation syndrome. The initial stage is a feeling of helplessness, which is followed by coercion to secrecy. As abuse continues entrapment leads to accommodative behaviour by the child. This may take the form of assuming the role of spouse. This is followed at some stage by either spontaneous convincing disclosure or unconvincing disclosure of the abuse, with later recantation in the face of disbelieving authority figures.

Some children will present to a hospital department or child protection agency on their own. In the report by Tilelli et al[14] 47% of victims presented to hospital unaccompanied. This appears to be an exception and most children, between 40% and 75%, are accompanied by their parents[4, 11, 14, 15]. The police may also be involved at

this stage and from 13,7% to 25% of victims will be accompanied to hospital by the police[4, 15]. Other individuals may also be involved, including other family members, neighbours or social workers, but in general they comprise a minority of the people who accompany the victims to hospital[14].

The nature of the sexual abuse covers a wide spectrum and various classifications have been described to encompass all possibilities.

Reinhart[18] described five categories of abusive acts:

1. Noncontact acts which did not involve direct physical contact between the perpetrator and the victim, e.g. exhibitionism and child pornography.

2. Orogenital contact involving direct contact of the mouth with the other person's genitalia, with the child in either role.

3. Genital contact where the victim's genital area comes into contact with the perpetrator's hand, genitalia or any other object.

4. Anal contact includes any contact with the perianal area of the victim by the perpetrator.

5. Anal penetration involves entry into the anal canal of the victim by the perpetrator's penis, finger, or any other object.

Russell described a less specific classification with only 3 categories[6]:

1. Very serious sexual abuse. This includes penile-vaginal or penile-anal penetration or attempted penetration, fellatio, cunnilingus and analingus.

2. Serious sexual abuse. This category includes simulated intercourse, digital penetration and touching breast or genital area while unclothed.

3. Least serious sexual abuse. Experiences with an exhibitionist, kissing or touching clothed breasts or genitalia.

Modifications of one or other of these two classifications have been used in most reports in the literature. The proportion of very serious sexual abuse ranges from 5%, 13%, 29%, 40% to 68%. A similar range of 4,5% to 51% is reported for least serious acts of sexual abuse, while serious sexual abuse accounts for a narrower range between 24% and 42%[4, 7, 14, 16, 18, 19]. Some of these reports

describe only the more serious forms of abuse, while others will list each type of act so that one case may fall into more than one category. In most reports there are some cases where the exact nature of the abuse is not known either because the child is unable to or refuses to verbalise the abusive event or the information in the medical records is not detailed enough. To further complicate comparisons of these reports is the inclusion of only substantiated cases of sexual abuse in some reports, whilst others include suspected cases or cases with sexually transmitted diseases without confirmation of abuse by the child.

Apart from Bentovim, Boston and van Elburg who described the epidemiology and sequelae of repeatedly abused children[21], most reports include an unselected sample with reference to the frequency of the sexual abuse. In most reports a single abusive episode is the rule, with 12-32% of victims being subject to repeated abuse[4, 7, 15]. However Spencer and Dunklee[16] report the opposite, with 53% of the victims in their experience being subjected to repeated abuse.

The abuse may occur at any time of day or night and is more common during summer[15]. The place where the abuse occurs is varied, the single most common place is the home of the victim, with between 19% and 36% of episodes occurring

there[4, 13, 17]. The home of the perpetrator is another common place.

Examination of sexually abused children on presentation to hospital may reveal no clinical findings or may show fairly characteristic features. In general the majority of victims will show no abnormalities on physical examination. Marshall et al[11] report that 71% of victims show no physical signs. This includes 48% of those victims who give a detailed description of penetration occurring during the sexual abuse. Irrespective of the age of the victim, only 24% to 34% show physical signs[4, 11, 14, 15, 18, 19], although one report by Spencer and Dunklee[16] disputes this and describes 68% of victims have some physical evidence of abuse occurring. Physical signs include features of general trauma, more specific acute genital or anal trauma and features of chronic sexual abuse. Sexually transmitted diseases are uncommon, only 1,5%-13% of victims will present with these[4, 11, 13, 14, 15, 16, 22]. In adult victims of rape the incidence of sexually transmitted diseases is generally higher, but averages 11%-12%[23, 24]. Until recently there has been a great deal of confusion about the significance of sexually transmitted diseases presenting in children[25]. It is now accepted that gonorrhoea, 1^{o} syphilis, condyloma accuminata and other sexually transmitted diseases occurring in a child are evidence of sexual activity and, until otherwise proven,

sexual abuse must be considered the most likely cause[22, 26, 27, 28].

The incidence of pregnancy associated with sexual abuse is dependent on the upper age limit for the sample. Dube and Herbert[4] reviewing children under 12 years of age found a 1% incidence and De Jong et al[15] a 1,5% incidence of pregnancy in their sample of children under 16 years. These figures are very similar to the 1,5% of women who become pregnant following rape[24,29].

The psychological consequences of childhood sexual abuse are well recognised and according to Oates[30] depend on the type and frequency of abuse, the age of the victim and relationship between the victim and the perpetrator. In the short term Mannarino and Cohen[31] found that 69% of children manifested psychological problems following sexual abuse[31]. These included sadness, anxiety, clinging behaviour, nightmares, bedwetting and inappropriate sexual behaviour. Most of these symptoms are representative of a post-traumatic stress disorder. Mian et al[19] found that in the younger age group 30% had behavioural problems following their abuse. Long term consequences also exist and most information comes from studies of adult populations who had been abused as children. Baker and Duncan[7] report that 4% of adults remember the experience as pleasant, 42% recall no adverse consequences following

abuse, and 54% claim the abuse had a damaging effect on their lives. In 10% of cases the victims felt these effects were permanent. Fromuth[32] found that a sample of adult women abused as children tended to be more promiscuous and more likely to be sexually assaulted as adults but had no permanent psychological effects. Finkelhor[33] states that sexual abuse victims tend to have lower self esteem and male victims have a fourfold increase in likelihood of becoming adult homosexuals. In general, over half the victims of childhood sexual abuse will show no psychological sequelae. However it is important to recognise that the abuse may have a significant effect on the individual's childhood. It is also important to recognise that the family as well as the child may experience problems following the disclosure of sexual abuse of one of the children. Mannarino[31] found that in 19% of the families the family structure broke down within six months before or after disclosure of the abuse. Bentovim et al[21], in a sample referred for family therapy, report that 87% of the families needed family therapy and subsequently 50% of them broke down, leading to a divorce in 30%. They also found that the outcome improved if the family all concurred that abuse had taken place.

What is known about the perpetrator? Almost all sexual abuse is by males. The proportion of female perpetrators is small, ranging from 1% to 4%, with an additional 1% to

2% of children being abused by both male and female perpetrators[4, 15, 18, 21]. A single perpetrator is also the rule, although up to 32% of children may be abused by more than one abuser, either on a single occasion or during repeated episodes of abuse[4, 7, 15, 18]. Tilelli et al[14] report that in a multi-ethnic community inter-racial sexual abuse is extremely rare. All age groups may be responsible for abuse with 20% to 50% of perpetrators being 20 years old or younger[4, 15, 16, 18]. In fact in De Jong's series[15] 10% of children had been abused by children under the age of 12 years. It is important to note that to exclude normal explorative sexual behaviour of the younger child from being included as cases of sexual abuse many authors include an age difference of two to three years between the abused and the perpetrator in their definition of sexual abuse. This proviso may be appropriate when considering the younger child but may lead to masking of some true cases of sexual abuse when considering the adolescent victim.

The relationship between the abused child and the perpetrator is of paramount importance with respect to the interval between abuse and disclosure and the subsequent sequelae to the child and family. The age of the victim has a marked influence on who is most likely to abuse the child. Mian et al[19] showed that in the younger age group 87% of victims will know their abuser. This finding is

supported by other reports[4, 15]. In the entire childhood population 4% - 61% of victims of sexual abuse will be abused by strangers unacquainted with the child or family[4, 7, 11, 14, 15, 16, 17, 18]. Male victims and older children are more likely to be abused by strangers[4, 15, 17], probably because they spend more time outside the home environment. Conversely intrafamilial sexual abuse is more frequently seen in younger children (up to 60% of the children seen by Mian et al[19] were victims of incest) and female victims[17]. The frequency of intrafamilial abuse ranges from 14% - 60%[4, 7, 11, 13, 15, 16, 17, 18, 19, 34] and when one looks at those victims of repeated abuse this figure increases to 75%[21]. In cases of incest there is a greater likelihood of a delay in disclosure of the abuse and 55% of victims will reveal the abuse after a single episode compared to 97% of victims of extrafamilial abuse[15]. Finally in 1986 Friedrich et al[35] reported that the degree of psychological disturbance in victims of sexual abuse increased the closer the relationship between the victim and the perpetrator.

The consequences for the perpetrator of childhood sexual abuse vary tremendously. Figures from the national reporting system in the United States of America[10] indicate that no action at all is taken in 16% of cases and in only 4% of cases were criminal charges laid. Charges are more likely in the age group where the victim is 7-12 years and

in cases of extrafamilial abuse, 31% of cases versus 23% in cases of intrafamilial abuse. In contrast Mannarino and Cohen's experience[31] saw criminal charges laid against the perpetrator in 56% of cases and Dube and Herbert[4] report that in Canada just over 34% of cases proceed to court. In Bentovim et al's[21] experience with repeatedly abused children, 75% of whom were involved in cases of incest, 61% of cases proceeded to court with 90% of the presumed offenders being found guilty. Sentences varied from suspended sentences to five years imprisonment. Of those offenders who were imprisoned, 15% returned to their families on their release from prison.

There are always at least two people involved in each case of childhood sexual abuse, each with their own claims. As sexual abuse is defined according to the report from the child or an adult witness, whom are we to believe? The child stands to lose a significant amount of emotional and physical stability following disclosure and is later subject to a varying amount of pressure from disbelieving authority figures. The perpetrator is also at risk of significant emotional, social and legal sequelae following disclosure of the abuse and is very likely to lie and disclaim any involvement. Faller[36] feels that in the balance children very seldom make up stories about sexual abuse and all claims should be taken seriously. Eckenrode et al[37] reviewed all cases of suspected child abuse and

neglect reported to the central register in New York State, U.S.A., over a six month period. 40% of the cases of sexual abuse were subsequently proven. The figures were similar for all race groups, higher when the victim was female and the older the child the more likely the chance of subsequently proving the claim. In their experience with over 200 cases of sexual abuse Marshall et al[11] saw five cases where sexual abuse was reported maliciously during a family or neighbourhood dispute and nine cases where parents were unduly concerned and had misinterpreted physical signs in their children as evidence of sexual abuse. No other reports mention the number of falsely reported cases of sexual abuse.

When looking at traditional Third World societies child abuse is rare. Fraser and Kilbride[38] from Kenya attribute this to the extended family situation and strong clan structure providing positive input into child care. When these factors are eroded the likelihood of child abuse increases. Le Vine and le Vine[39] writing about sub-Saharan Africa support these claims and Loening[40] experienced only 20 cases of child abuse and neglect in Durban over a one year period with no cases of sexual abuse. Berrington et al[41] reviewed the records for Coronation Hospital in Johannesburg where 23 cases of child abuse were seen over a five and a half year period. Only two of these involved sexual abuse. Recent experience in South Africa has shown

childhood sexual abuse to be more common than previously recognised. In 1988 227 children were seen by the child abuse team at the Transvaal Memorial Institute for Child Health and Development, 96,5% following sexual abuse[51]. In Alexandra[52] 66 children were seen in 1988 following sexual abuse. This represents 67% of the abused children seen at the clinic during that year. Whilst at Baragwanath in 1988 the majority of abused children were victims of childhood sexual abuse[53]. Eldemire[42] has reported from Jamaica on 33 cases of sexual abuse presenting over a one year period. These cases excluded 104 girls less than 14 years of age who were treated for sexually transmitted diseases. This represents 1,3 cases per 10,000 children. There were three male victims and ages ranged from 2-16 years. All abuse was intrafamilial and involved rape or sodomy. One third of the children had a genital discharge, five had gonorrhoea, two were pregnant and three had evidence of acute physical trauma. Disclosure of the abuse was by the victim or guardian in all but one case. The majority of guardians placed the safety of the child as their major concern and were not concerned with prosecuting the offender.

To date there have been two reports from Red Cross War Memorial Children's Hospital (RCWMCH) dealing with childhood sexual abuse. In 1982 Westcott[43] reported on 20 patients seen over a six month period. Four of the victims

were male. The ages range from 2-12 years. The abuse included rape, incest, indecent assault and two cases of peer experimentation. Two children had sexually transmitted diseases, whilst six children had no findings at all on physical examination. In 65% of the cases the perpetrator was known to the victim. As part of the management 60% of the children were admitted to hospital.

In 1988 Jaffe and Roux[44] reviewed all cases that had presented at RCWMCH during 1985. There were 88 cases of sexual abuse representing 38% of all children seen by the Child Abuse Team at the hospital. Sexual abuse was confirmed in 53% of cases and suspected in the rest, 17% of these being children with sexually transmitted diseases. 90% of the victims were female and ages ranged from 10 months to 13 years, with a peak from 4 to 6 years. One quarter of the children were raped, one quarter indecently assaulted, one quarter involved in incest and the remainder either had sexually transmitted diseases or were subject to attempted rape. On examination only 9% of the children had no findings. Abuse took place in the victim's home in 25% of cases, with the abuser being known to the victim in 58% of cases. In 44% of the cases the victim presented directly to RCWMCH, the remainder were referred by general practitioners, other hospitals, social welfare agencies or the police. Following the abuse five children needed

referral to a psychiatrist and 20 families laid criminal charges against the perpetrator.

STATUS QUO AT RCWMCH

At present at RCWMCH the Child Abuse Team consists primarily of the hospital social workers assisted by two paediatricians, one surgeon and a clinical psychologist. Abused children may be identified by any service in the hospital and once the child's physical needs have been met he or she is then referred to the social worker on call. The social worker is then responsible for investigating the circumstances of the abuse, providing short term emotional support and long term liaison with social welfare services outside the hospital or psychiatric clinics when indicated. All cases are presented at a weekly meeting of the Child Abuse Team, when additional input may be provided. Since the identification of abused children and the initial management of their physical state is dependent on a wide spectrum of medical practitioners with varying degrees of insight into the problem no uniform management has been provided.

In view of the recent Cleveland debacle in the United Kingdom[45, 46], increased awareness of childhood sexual abuse in South Africa and the recent implementation of the

Child Care Act No 74 of 1983, the management of sexually abused children presenting to RCWMCH needed to be reviewed.

AIM

The aim of this study was to describe the pattern of abuse, the presentation to and management of sexually abused children seen at RCWMCH over a two and a half year period.

Following increasing public awareness of childhood sexual abuse and an increase in the number of abused children seeking help an in-depth assessment of the RCWMCH experience is needed to facilitate improvements in the management of these cases. This has not been provided by the two previous studies from this hospital and this study has attempted to rectify this.

OBJECTIVES

The following objectives were used to fulfil the above mentioned aims:

1. Describe the demographic features of sexually abused children seen at RCWMCH.

2. Describe the method of presentation of these children to RCWMCH by:

2.1 Identifying the agency that referred them to the Child Abuse Team at the hospital.

2.2 Identifying the method of disclosure by the child of having been abused.

3. Describe the nature of the abuse with respect to:

3.1 Type

3.2 Time

3.3 Place

3.4 Clinical findings on presentation to hospital

3.5 Perpetrator.

4. Compare the following sub-groups to identify any patterns or risks associated with such groups:

4.1 Male and female victims

4.2 Preschool and school-going victims

4.3 Victims of intrafamilial abuse and extrafamilial abuse

4.4 Victims of one episode of abuse and victims of repeated abuse

5. Describe the management of the child in terms of:

5.1 The child's physical state

5.2 The child's emotional state

5.3 The child's safety

5.4 Action taken against the perpetrator.

CHAPTER 2 - METHODOLOGY

A retrospective descriptive study was undertaken. All children who were referred to the Child Abuse Team of RCWMCH from 1st January 1986 to 30th June 1986 inclusive, who were considered by this team to have been sexually abused, were considered for the study.

Both the hospital folder and social worker's records for each child were reviewed. Those cases which fulfilled the following definition of sexual abuse were entered into the study.

Sexual abuse was defined as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give their informed consent to and that violate the social taboos of family roles"[3]. To distinguish normal sexual exploratory behaviour from sexual abuse an age difference between abused and abuser was also included so that the abuser had to be two or more years older than the abused. It is important to note that, unlike physical abuse where the definition is based on the observed consequences of the abuse, sexual abuse is defined on the basis of facts provided by the child or a witness to the event and not necessarily confirmed on physical examination[4].

No age limits were set for exclusion from the study. An upper age limit of 13-14 years was implied because of the policy at RCWMCH of not treating patients over this age.

Data from these sources was entered onto a computer compatible proforma to facilitate analysis. The data extracted included:

1. Demographic features of the sexually abused children:

   Age This refers to the age of the child at the date the abuse occurred. In the event of repeated episodes of sexual abuse the age has been calculated to the date of presentation to the Child Abuse Team. The age of each of those children whose records did not record a date of abuse was also calculated to the date of presentation to the Child Abuse Team.

   Sex

   Race

   Address.

2. Method of presentation of these children to the Child Abuse Team:

2.1 Date of presentation

2.2 The relationship to the child of the person who accompanied him/her to hospital

2.3 Who referred the child or family to the Child Abuse Team.

2.4 To whom at the hospital the child was initially referred

2.5 How it was revealed that the child had been sexually abused. Revelation of sexual abuse was divided into five groups:

a. Spontaneous disclosure by the victim of having been sexually abused

b. Prompted disclosure - report of abuse by the victim in response to questioning by a suspicious adult

c. Unintentional with confirmation - details of sexual abuse were initially disclosed by another individual (second victim, a witness

or the perpetrator) and subsequently acknowledged by the child

d. Suspicion without disclosure or confirmation - children with sexually transmitted diseases or unusual or promiscuous behaviour where sexual abuse is considered by the Child Abuse Team to have occurred but this is not acknowledged by the child

e. Unknown - inadequate data in the hospital folder or social worker's records to determine the method of disclosure.

3. Features relating to the act of abuse:

3.1 Date of abuse:

Four groups were defined:

a. Exact date of abuse known

b. Month and year known but not the actual day

c. Repeated episodes of sexual abuse

d. Unknown - no record of the date of sexual abuse in hospital records or sexual abuse suspected but not confirmed.

The date of abuse was recorded for groups a. and b. only.

3.2 Time of incident:

Morning	06h01 - 12h00
Afternoon	12h01 - 18h00
Evening	18h01 - 20h00
Night	20h01 - 06h00

3.3 Place where abuse occurred:

Victim's home
Perpetrator's home
Neighbourhood, including school
Elsewhere
Unknown

3.4 Act of abuse, classified as follows:

a. Non-contact - no direct physical contact between victim and perpetrator (exhibitionism, child pornography)

b. Orogenital - direct contact of the mouth with the other person's genitalia, with the child in either role

c. Genital contact - contact with the victim's genital area by the perpetrator's hand, genitalia or any other object and, in the case of female victims, without vaginal penetration

d. Anal contact - any contact with perianal area of the child by the perpetrator without penetration of the anus

e. Sodomy - entry into the anal canal of the victim by the perpetrator's penis, finger or other object

f. Rape - Sexual intercourse or attempted intercourse with a minor, with or without their consent

g. Unknown - sexual abuse is suspected without confirmation by the victim or no record of the nature of the abuse in the hospital folder or social worker's records.

3.5 Evidence of physical injury according to the following groups:

a. Nil

b. General injuries

c. Genital trauma

d. Anal trauma

e. Evidence of sexually transmitted disease.

3.6 Details of the perpetrator(s) of the abuse:

Number

Age

Sex

Relationship to victim

4. Management of the problem:

4.1 Management of the physical state of the child

4.2 Management of the emotional state of the child

a. Acute crisis intervention refers to intervention by any social workers for a period up to two weeks after presentation to the Child Abuse Team

b. Short term counselling refers to any intervention by social worker, psychologist or medical practitioner for psychological or emotional problems for a period of up to three months after presentation to the Child Abuse Team at RCWMCH

c. Long term counselling refers to any intervention by social worker, psychologist or medical practitioner for psychological or emotional problems for a period greater than three months after presentation to the Child Abuse Team at RCWMCH.

4.3 Action taken to ensure the safety of the child

a. Nil

b. Family therapy

c. Child relocated - permanent removal of the child from his/her family and placement in foster or alternate care

d. Family relocated

e. Child removed - temporary removal of the child from the home until circumstances improve

f. Unknown - insufficient data to determine whether or not any measures were taken to protect the child.

4.4 Action taken against the perpetrator of the sexual abuse

a. Nil - no action taken

b. Intended - in these cases the family had indicated to members of the Child Abuse Team at RCWMCH that they would lay a charge against the perpetrator. However no record of a charge could be found at any police station.

c. Charged - open. This refers to those cases still being investigated by the Police.

d. Charged - closed. This refers to those cases which have been closed as unsolved by the Police or where the Attorney General has refused to proceed to court or where the family have subsequently withdrawn the charge.

e. Court - convicted. This refers to those cases which went to court with the conviction of the perpetrator.

f. Court - dismissed. This refers to those cases which went to court and the presumed abuser was found not guilty.

g. Court - outstanding. This refers to those cases awaiting a court hearing or where the hearing is still in progress.

h. Unknown. No record in either the hospital folder or social worker's records of what action was taken against the perpetrator.

i. Other. This refers to those cases where the perpetrator was dealt with within the family or the community or those cases where the perpetrator was referred for psychiatric treatment.

5. Comparison of subgroups:

The following subgroups were identified for comparison to reveal particular high risk groups with respect to patterns of abuse, mode of presentation or management.

5.1 Male and female victims

5.2 Preschool and school-going victims.

Preschool children were defined as those 5 years of age or younger at the time of abuse. School-going children were defined as those over 5 years of age at the time of the abuse.

5.3 Intrafamilial and extrafamilial abuse

Victims of confirmed sexual abuse were divided into two groups according to their relationship with their abuser.

Intrafamilial abuse refers to those children abused by members of their own family, namely a parent or step parent, sibling, grandparent, uncle, aunt or cousin.

Extrafamilial abuse refers to those children abused by anyone not included above.

Children abused by their mother's consort, who was not their father, were included in the group of extrafamilial victims. In his review of the 1970 and 1980 Population Censuses Simkins[54] showed that in 1980 45,6% of White females were married and only 1,2% were living with their consort; 25,7% of Coloured females were married and 3,9% living with their consort; 37,3% of Asian females were married and 0,7% living with their consort and 23,3% of African females were married and 3,3% living with their consort. The figures for Coloured and Asian females living with their consort had not changed from 1970 whilst that for White females had increased from 2,5%. In the light of these findings it is probable that the mother's consort does not co-habit with her and does not function as a member of the family. For the purposes of this study he was therefore classified as an extrafamilial perpetrator.

5.4 Single episode of abuse and repeated abuse

Repeated abuse refers to children abused on more than one occasion by one or more abusers.

Single episode of abuse refers to those children abused during a single episode irrespective of the number of abusers.

PROCESSING OF DATA

Processing of the above data was undertaken by the researcher on a Bondwell personal computer.

Statistical analysis and interpretation was done by the researcher.

ETHICS

The protocol was submitted to the Ethics and Research Committee of the University of Cape Town and approval was granted.

CHAPTER 3 - RESULTS

During the period 1 January 1986 to 30 June 1988 863 children were referred to the Child Abuse Team at RCWMCH; of these 365 (42,3%) were for suspected sexual abuse. Hospital records and social worker notes were available for 362 of the 365 children. On reviewing these records three children had been seen on two separate occasions for separate episodes of sexual abuse and in two cases the history did not fulfil the criteria for a diagnosis of sexual abuse. There were therefore 357 records entered into the study.

The results of the study will be presented in six sections: general data, followed by comparisons of male and female victims, preschool and school-going children, intrafamilial and extrafamilial abuse and repeated abuse with a single episode of abuse. The final section will deal with the abuser. When comparing the data for two groups this has been presented twice, initially as a table to provide the basic data and then in two pie charts to facilitate comparison of the two groups.

General data

Figure 1 shows the number of cases of child abuse seen at RCWMCH from January 1985 to June 1988, as well as the proportion of children who were sexually abused. During the

study period 42,9% of all children referred to the Child Abuse Team had been sexually abused. There was a steady increase from 38% in 1985 to 45,3% in 1988. During the same period there was very little change in the number of children attending the outpatient departments at the hospital.

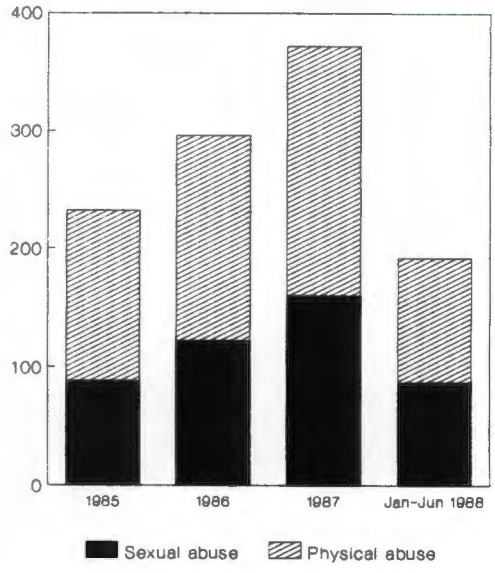

Fig. 1. Child abuse at RCWMCH

Table 1. Attendances to RCWMCH outpatient sections from Jan 1985 to Dec 1987

	1985	1986	1987
MOPD	141 399	147 051	131 930
SOPD	37 425	38 599	41 952
Trauma Unit	11 899	11 568	12 362
Total	190 726	197 218	186 244
Difference		+6 942	-10 974
% difference		+3,4	-5,5

Table 1 shows there was an increase in outpatient attendance of 3,4% from 1985 to 1986 but a decrease of 5,5% from 1986 to 1987. This contrasts with the steady increase in cases of sexual abuse during that period.

Figure 2 provides a breakdown of the sex of the victims. There were 48 male victims of sexual abuse representing 14,8% of male child abuse victims and 5,5% of all victims of child abuse. This number also represents 13,4% of all victims of childhood sexual abuse. 309 female children were seen. This comprised 57,2% of female child abuse victims,

35,8% of all child abuse victims and 86,5% of all victims of childhood sexual abuse.

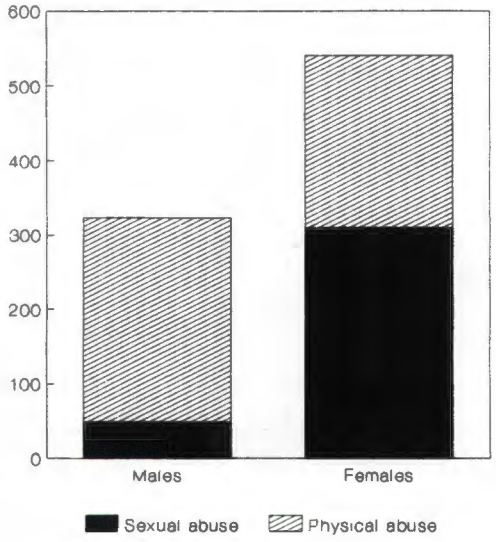

Fig. 2. Sex of child abuse victims seen at RCWMCH Jan 1986 - June 1988

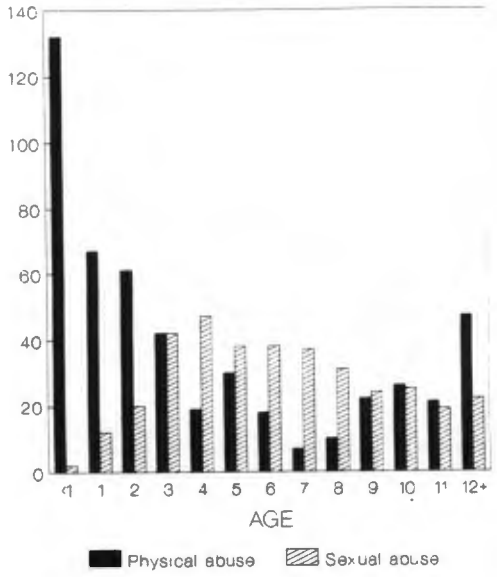

Fig. 3. Age of child abuse victims

The age of the children is presented in Figure 3. The range was from 10 months to 13 years and 10 months with a mean of 6,8 years. Physical abuse was the most common form of abuse in children under 3 years of age. From 3 years to 8 years of age sexual abuse was commoner, with a peak at 4 years. After 8 years of age there was a decline in the number of sexually abused children and an increase in cases of physical abuse.

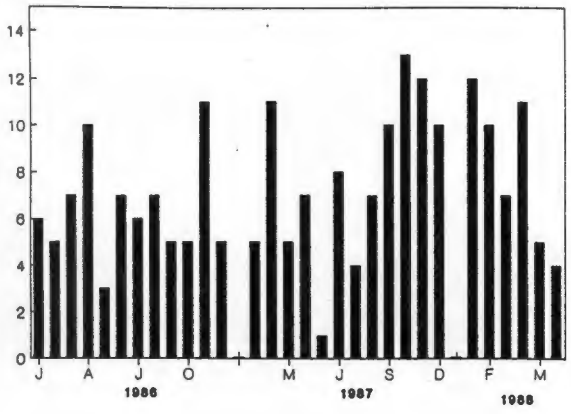

Fig. 4. Distribution of cases by month

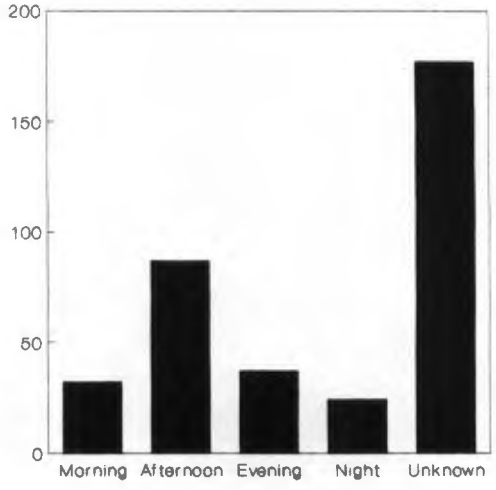

Fig. 5. Time of day that abuse occurred

The month and time of day when the abuse occurred is shown in Figures 4 and 5. Cases of unconfirmed or repeated abuse have not been included here. The monthly number of cases ranged from 1 to 13 with no seasonal variation or obvious relationship to school holidays. Where recorded most cases occurred during the afternoon although the time of abuse is unknown or not recorded in the majority of cases.

The method of disclosure by the child that he or she had been sexually abused is shown in Table 2. In reviewing the records no indication of how the abuse came to light was found in 27,8% of cases and a further 20,7% were cases of suspected abuse not confirmed by the child. In almost half the cases, 43,4%, the children spontaneously or with prompting revealed that they had been sexually abused. The

remaining cases came to light when a third party witnessed the abuse or was also involved.

Table 2. Method of disclosure of abuse

	Number	%
Spontaneous	64	17,9
Prompted	91	25,5
Unintentional	29	8,1
Suspicion	74	20,7
Unknown	99	27,8
Total	357	100,0

Table 3. Frequency of abuse

	Number	%
Once	226	63,3
Repeated	49	13,7
Unknown	82	23,0
Total	357	100,0

Table 3 shows the number of times the children were abused. The majority of children, 63,3%, were abused once only. In 23% abuse was either never confirmed or no record was found of how often it occurred.

The type of sexual abuse to which the children were subjected is listed in Table 4. For each child only the most severe form of abuse has been listed. Rape, including incest, was the most common form of abuse followed by manipulation of the victim's genitalia and sodomy. In 19,8% of cases the nature of the abuse is unknown. These cases include 36 children with sexually transmitted diseases (STD) who did not confirm that they had been abused.

Table 4. Nature of abuse

	Number	%
Non-contact	2	0,5
Orogenital		
Anal contact	4	1,2
Genital contact	66	18,5
Sodomy	39	11,0
Rape	175	49,0
Unknown	71	19,8
Total	357	100,0

Table 5. Place where abuse occurred

	Number	%
Victim's home	100	28,0
Abuser's home	57	16,0
Neighbourhood	69	19,3
Elsewhere	24	6,7
Unknown	107	30,0
Total	357	100,0

Most incidents, 47,3%, occurred in the victim's home or neighbourhood. The abuser's home was the setting in 16% of cases and no record of where the abuse occurred could be found in 30%.

Tables 6 and 7 show where the patients presented initially. 214 children, or 59,9%, presented directly to RCWMCH, the majority of these to the Trauma Unit although a significant number also presented to MOPD or specialist clinics. The specialist clinics concerned were primarily the gynaecology and dermatology clinics, although a few cases were identified at the neurology and allergy clinics. The remaining 143 cases presented to the agencies listed in Table 6 and were then referred to the services at RCWMCH shown in Table 7. Of all the sexually abused children 49,5% are referred to the Child Abuse Team of the hospital via the Trauma Unit.

Table 6. Place of initial presentation

		Number	% (Total)
RXH:	Trauma unit	120	33,6
	MOPD	33	9,2
	Sp clinic	37	10,4
	SOPD	19	5,3
	Wards	5	1,4
	Total	214	59,9
Other:	SA Police	47	13,2
	GP	29	8,1
	S W Agency	20	5,6
	Hospital	19	5,3
	School nurse	11	3,1
	Other	17	4,8
	Total	143	40,1
Total		357	100,0

Table 7. Service at RCWMCH to which outside patients were referred

	Number	%
Trauma Unit	57	40,0
Social Worker	19	13,2
Psychologist	4	2,8
OPD	36	25,1
Other	27	18,9
Total	143	100,0

No children came to hospital unaccompanied. Mothers were the most frequent person to accompany the child to hospital. Table 8 shows that 8,7% of the victims were brought to hospital by someone other than a family member.

Table 8. Person accompanying victim

		Number	%(total)
Family:	Mother	243	68,0
	Father	13	3,6
	Both parent	32	9,0
	Other	24	6,7
	Total	312	87,3
Other:	Social Worker	6	1,7
	Neighbour	6	1,7
	Childminder	10	2,8
	Other	9	2,5
	Total	31	8,7
Unknown		14	4,0
Total		357	100,0

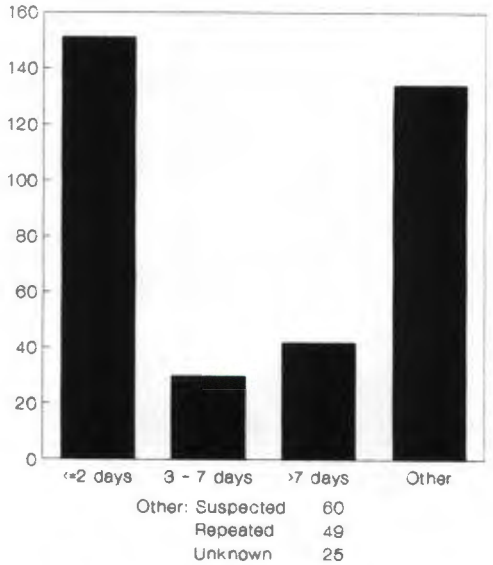

Fig. 6. Interval between abuse and presentation to RCWMCH

The delay between the act of abuse and presentation to RCWMCH is represented in Figure 6. In cases of suspected abuse or those children repeatedly abused it was often not possible to establish when the abuse started and all of these cases have been included in the group where the interval is unknown. The majority of children presented with minimal delay, with 72 arriving at hospital on the day of the abuse. 22 children presented after a delay of at least one month and the longest delay was about 5 years and 9 months.

The clinical findings on examination of these children when first presenting to RCWMCH appear in Table 9. Almost a third of the children had no abnormal findings at all, only 29 had features of generalised assault although 129 children had evidence of acute anal or genital trauma. 56 children had proven sexually transmitted disease, whilst a further 34 had a genital discharge. One child presented with an incidental urethral caruncle and two with urinary tract infections.

Table 9. Findings on presentation to RCWMCH

	Number
Nil	104
Trauma - general	29
genital	103
anal	26
Chronic genital changes	21
Discharge	34
Perianal warts	10
STD	56
Behavioural problems	10
Other	3
Total	396

Table 10. Management of physical state

	Number	%
Nil	213	59,6
EUA	30	8,3
Surgery	23	6,3
STD prophylaxis	90	25,2
Pregnancy prophylaxis	2	0,6
Total	358	100,0

Management of these children can be divided into three groups:

Management of their physical state, shown in Table 10
Management of their mental state, shown in Table 11
Action taken to ensure their safety, shown in Table 12.

The majority of children required no physical management although 14,6% were subjected to a surgical procedure. One quarter of the children were given antibiotic prophylaxis

against sexually transmitted diseases. Only 2 girls, out of 29 who were 11 years or older and victims of rape, received prophylaxis against pregnancy. Almost half the children received no support for their emotional state. These included 41% of the victims of genital contact, 28% of the victims of sodomy, 42% of the victims of rape and 86% of cases of unconfirmed sexual abuse. 20,2% of the children, all victims of more serious forms of abuse, received short term counselling. 7,6% received long term counselling following rape or indecent assault

Table 11. Management of mental state

	Number	%
Nil	173	48,4
Crisis intervention	85	23,8
Short term counselling	72	20,2
Long term counselling	27	7,6
Total	357	100,0

Table 12. Action taken to ensure child's saftey

	Number	%
Nil	287	80,4
Child removed	6	1,7
Child relocated	35	9,8
Family therapy	28	7,8
Family relocated	1	0,3
Total	357	100,0

6 children were temporarily removed from their homes for their own safety and 9,8% permanently removed from their parents. 28 families needed family therapy following the abuse and 1 family moved.

Comparison of victims according to their sex

Of the 357 children 48 (13,4%) were male. The ages of male and female victims are shown in Figure 7.

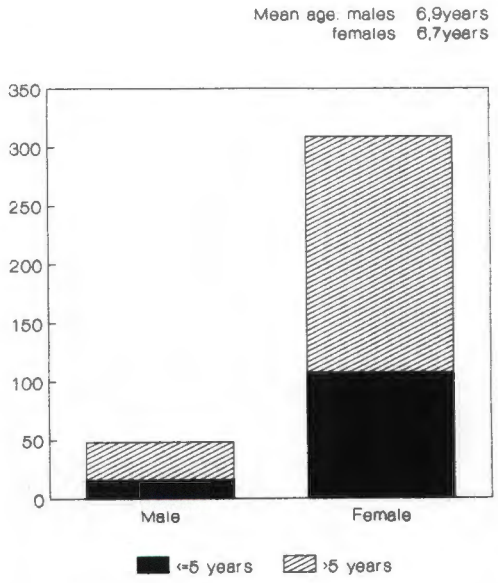

Fig. 7. Ages of male and female sexual abuse victims

16 male victims were 5 years old or younger. This is 33,3% of all males which is very similar to the 34,6% of female victims who were 5 years old or younger. The mean age for males was 6,9 years, for females 6,7 years and for all the children 6,78 years.

Comparison of the method of disclosure is shown in Table 13 and Figure 8. Although males were more likely to reveal their abuse spontaneously or respond to prompting the difference is not statistically significant.

Table 13. Comparison, according to sex of victim, of method of disclosure

	Males	Females
Spontaneous	12	52
Prompted	14	77
Unintentional	3	26
Suspicion	8	66
Unknown	11	88
Total	48	309

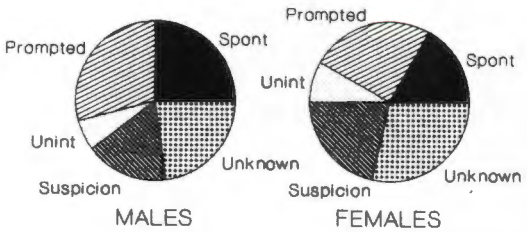

Fig. 8. Comparison, according to sex of victim, of method of disclosure

Comparison of the frequency of abuse, Table 14 and Figure 9, shows females were more often repeatedly abused but not to a significant degree (x^2, $p = 0,06$).

Table 14. Comparison, according to sex of victim, of frequency of abuse

	Males	Females
Once only	35	191
Repeated	2	47
Unknown	11	71
Total	48	309

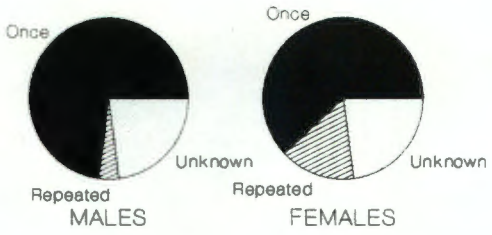

Fig. 9. Comparison, according to sex of victim, of frequency of abuse

Comparison of the nature of the abuse is shown in Table 15 and Figure 10. There was no difference between the two sexes in the severity of the type of abuse.

Table 15. Comparison, according to sex of victim, of nature of abuse

Type of abuse	Males	Females
Non contact		2
Anal contact	3	1
Genital contact	7	59
Sodomy	28	11
Rape		175
Unknown	10	61
Total	48	309

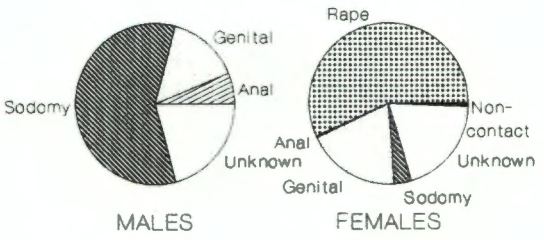

Fig.10. Comparison, according to sex of victim, of nature of abuse

Comparison of the place where the abuse occurred is presented in Table 16 and Figure 11. Female victims were more likely to be abused in their own homes (x^2, $p < 0,001$) and male victims outside the home (x^2, $p = 0,02$).

Table 16. Comparison, according to sex of victim, of place where abuse occurred

	Males	Females
Victim's home	4	96
Abuser's home	4	53
Neighbourhood	18	51
Elsewhere	6	18
Unknown	16	91
Total	48	309

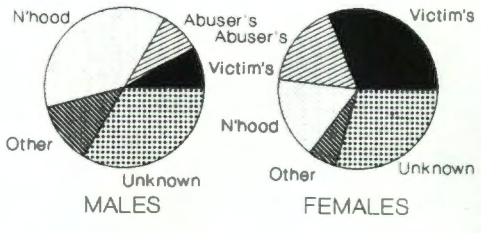

Fig. 11. Comparison, according to sex of victim, of place where abuse occurred

The delay in presentation to RCWMCH following the abuse is compared in Table 17 and Figure 12. Males presented earlier than females with a significantly greater number of males presenting within 48 hours of the abuse (x^2, $p = 0,01$).

Table 17. Comparison, according to sex of victim, of delay in presentation to RCWMCH

	Males	Females
<=2 days	29	122
3 - 7 days	1	29
>7 days	5	38
Other	13	120
Total	48	309

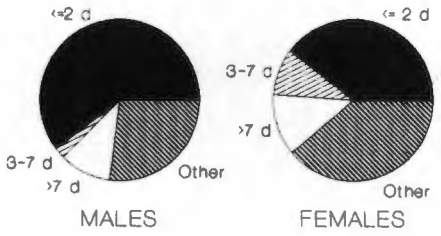

Fig. 12. Comparison, according to sex of victim, of delay in presentation to RCWMCH

A comparison of the findings on presentation to RCWMCH is presented in Table 18 and Figure 13. An equal proportion of male and female victims had no findings on examination. A significantly greater proportion of males had evidence of physical trauma to the genitalia, anus or body (x^2, $p < 0,01$) although there was no difference in the proportion of victims with evidence of nongenital/nonanal trauma.

Table 18. Comparison, according to sex of victim, of findings on presentation to RCWMCH

	Males	Females
Nil	13	91
Trauma - general	7	22
genital	8	95
anal	18	8
Genital changes		21
Discharge	1	33
Perianal warts	5	5
STD	4	52
Behavioural problems		10
Other		3

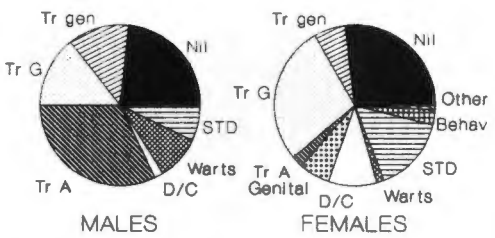

Fig. 13. Comparison, according to sex of victim, of findings on presentation to RCWMCH

Comparing the management of the physical state of the victims, Table 19 and Figure 14, shows that significantly more male victims required surgical intervention (x^2, $p < 0,01$) with 3 children needing colostomies. More female victims were given prophylaxis for sexually transmitted diseases (x^2, $p = 0,006$).

Table 19. Comparison, according to sex of victim, of management of physical state

	Males	Females
Nil	26	186
EUA	7	23
Surgery	10	13
STD prophylaxis	5	85
Pregnancy prophylaxis		2
Total	48	310

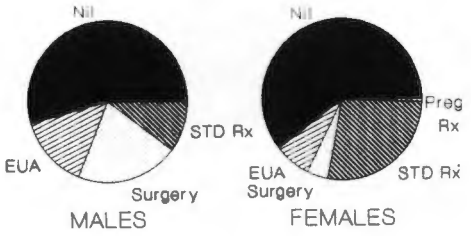

Fig. 14. Comparison, according to sex of victim, of management of physical state

Management of the victim's mental state is compared in Table 20 and Figure 15. Although more male victims received crisis intervention or short term counselling the difference was not significant. More female victims received long term counselling but again this was not significant.

Table 20. Comparison, according to sex of victim, of management of mental state

	Males	Females
Nil	18	155
Crisis intervention	14	71
Short term therapy	15	57
Long term therapy	1	26
Total	48	309

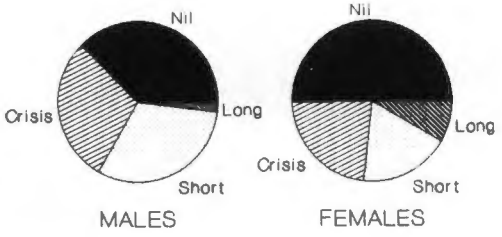

Fig. 15. Comparison, according to sex of victim, of management of mental state

Action taken to ensure the safety of the child is compared in Table 21 and Figure 16 and shows no significant differences between the two groups.

Table 21 Comparison, according to sex of victim, of action taken to ensure safety of child

	Males	Females
Nil	42	236
Child removed		6
Child relocated	2	33
Family relocated		1
Family therapy	3	25
Unknown	1	8
Total	48	309

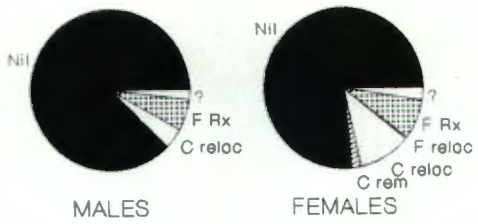

Fig. 16. Comparison, according to sex of victim, of action taken to ensure safety of child

Comparison of the relationship between the abused and the abuser is shown in Table 22 and Figure 17. Female victims were more likely to be abused by members of the family (x^2, $p = 0,05$) and male victims by strangers (x^2, $p < 0,001$).

Table 22. Comparison, according to sex of victim, of relationship of abused to abuser

	Males	Females
Family	5	74
Acquaintance	13	125
Stranger	21	51
Unknown	9	59
Total	48	309

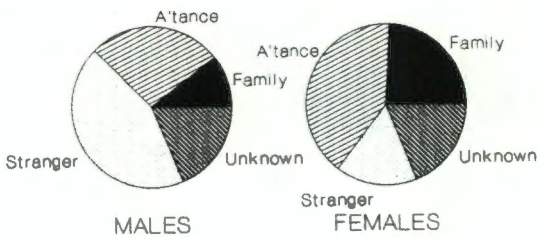

Fig. 17. Comparison, according to sex of victim, of relationship of abused to abuser

The age of the abuser is compared in Table 23 and Figure 18 and shows no significant differences between male and female victims.

Table 23. Comparison, according to sex of victim, of age of abuser

	Males	Females
<20 years	12	55
>=20 years	13.	128
Unknown	23	126
Total	48	309

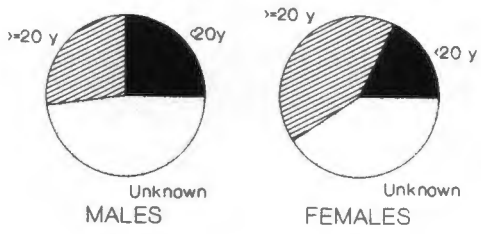

Fig. 18. Comparison, according to sex of victim, of age of abuser

Comparison of the action taken against the abuser is presented in Table 24 and Figure 19. There were no significant differences between the two groups although proportionately more abusers of male children were referred for psychiatric help.

Table 24. Comparison, according to sex of victim, of action taken against abuser

	Males	Females
Nil	17	101
Intended to	13	55
Charged: open	3	20
closed	2	18
Court: outstanding		5
convicted	4	37
dismissed	2	7
Psychiatrist	3	3
Other	1	9
Unknown	3	54
Total	48	309

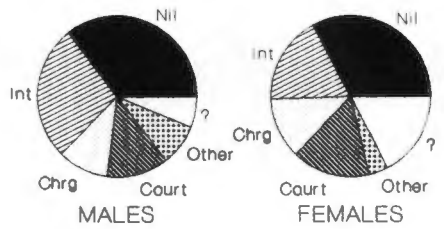

Fig. 19. Comparison, according to sex of victim, of action taken against abuser

Comparison of victims according to their age

The victims were divided into two age groups, the preschool child of 5 years or younger and the school going child over 5 years of age. 123 children (34,4%) were in the group of preschool children. Male victims comprised 13% of the

younger age group and 13,6% of the older group. This is shown in Figure 20.

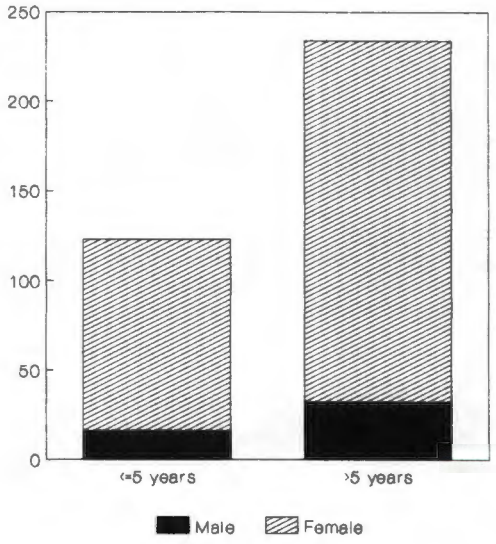

Fig. 20. Sex breakdown of sexual abuse victims under or over 5 years of age

A comparison of the method of disclosure of sexual abuse, according to the age of the victim, is shown in Table 25 and Figure 21. The difference between the two groups in the number of cases of suspected abuse unconfirmed by the victim is significant (x^2, p = 0,001), with more in the younger age group.

Table 25. Comparison, according to age of victim, of method of disclosure

	<=5 years	>5 years
Spontaneous	17	47
Prompted	37	54
Unintentional	10	19
Suspicion	40	34
Unknown	19	80
Total	123	234

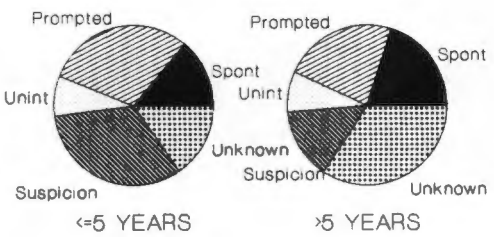

Fig. 21. Comparison, according to age of victim, of method of disclosure

The frequency of the abuse is compared in Table 26 and Figure 22. This shows that signficantly more older children were subject to repeated sexual abuse (x^2, p = 0,01).

Table 26. Comparison, according to age of victim, of frequency of abuse

	<=5 years	>5 years
Once only	74	152
Repeated	8	41
Unknown	41	41
Total	123	234

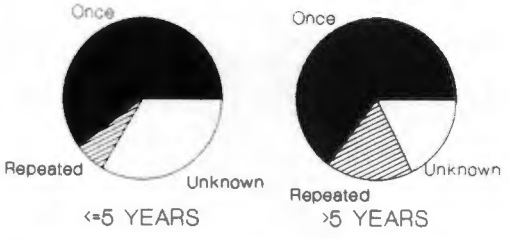

Fig. 22. Comparison, according to age of victim, of frequency of abuse

Table 27 and Figure 23 show a comparison of the nature of the sexual abuse. The difference in number of older children subject to severe sexual abuse, rape or sodomy, was significant (x^2, p = 0,001).

Table 27. Comparison, according to age of victim, of nature of abuse

Offence	<=5 years	>5 years
Non-contact		2
Anal contact	1	3
Genital contact	28	38
Sodomy	13	26
Rape	45	130
Unknown	36	35
Total	123	234

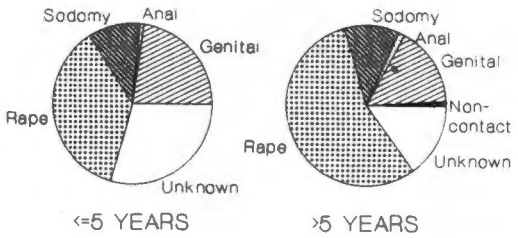

Fig. 23. Comparison, according to age of victim, of nature of abuse

Comparison of the place where the abuse occurred is presented in Table 28 and Figure 24. The proportion of older children abused outside their home or neighbourhood and the abuser's home was significantly greater than the proportion of younger children (x^2, p = 0,01).

Table 28. Comparison, according to age of victim, of place where abuse occurred

	=5 years	>5 years
Victim's home	29	71
Abuser's home	23	34
Neighbourhood	19	50
Elsewhere	2	22
Unknown	50	57
Total	123	234

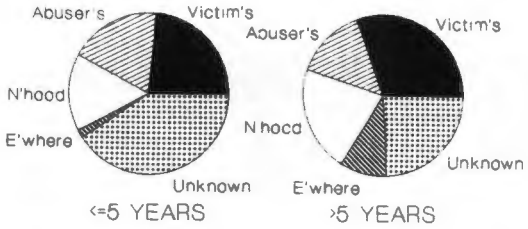

Fig. 24. Comparison, according to age of victim, of place where abuse occured

The delay in presentation to RCWMCH following the abuse is compared in Table 29 and Figure 25. This was similar for both groups.

Table 29. Comparison, according to age of victim, of delay in presentation to RCWMCH

	<=5 years	>5 years
<=2 days	50	102
3 - 7 days	10	20
>7 days	14	28
Other	49	84
Total	123	234

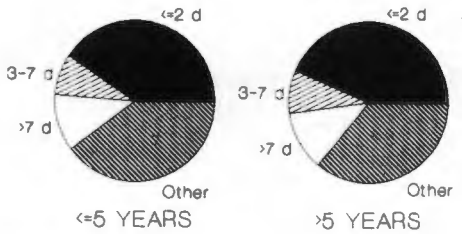

Fig. 25. Comparison, according to age of victim, of delay in presentation to RCWMCH

The findings on examination of the children on presentation to RCWMCH are compared in Table 30 and Figure 26. More older children had no physical findings but this was not significant. Acute trauma was equally common in both groups. However, significantly more younger children had sexually transmitted diseases on initial presention (x^2, p = 0,001).

Table 30. Comparison, according to age of victim, of findings on presentation to RCWMCH

	<=5 years	>5 years
Nil	31	73
Trauma - general	6	23
genital	32	71
anal	9	17
Chr genital changes	3	18
Discharge	14	20
Perianal warts	5	5
STD	31	25
Behavioural problems	5	5
Other	1	2

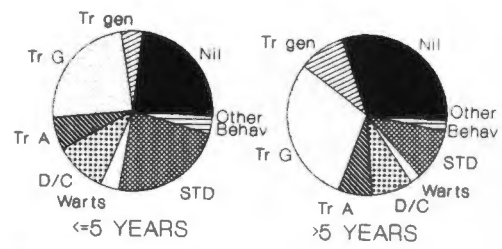

Fig. 26. Comparison, according ot age of victim, of findings on presentation to RCWMCH

Comparing the management of the children's physical condition, Table 31 and Figure 27 show significantly more older children needed no management at all (x^2, p = 0,04), whilst more younger children were given treatment or prophylaxis for sexually transmitted diseases (x^2, p = 0,02).

Table 31. Comparison, according to age of victim, of management of physical state

	<=5 years	>5 years
Nil	64	149
EUA	14	16
Surgery	5	18
STD prophylaxis	40	50
Pregnancy prophylaxis		2
Total	123	235

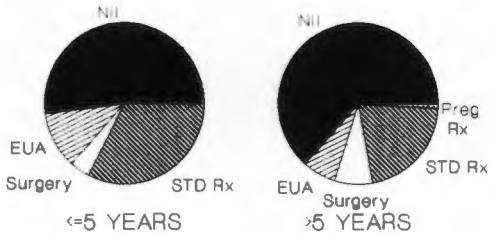

Fig. 27. Comparison, according to age of victim, of management of physical state

Management of the mental state of the children is compared in Table 32 and Figure 28. Significantly more younger children received no intervention (x^2, p < 0,001). An equal proportion in each group received acute crisis intervention but significantly more older children received short term counselling (x^2, p = 0,02) and long term counselling (Fishers exact, p = 0,001).

Table 32. Comparison, according to age of victim, of management of mental state

	<=5 years	>5 years
Nil	82	91
Crisis intervention	24	61
Short term therapy	16	56
Long term therapy	1	26
Total	123	234

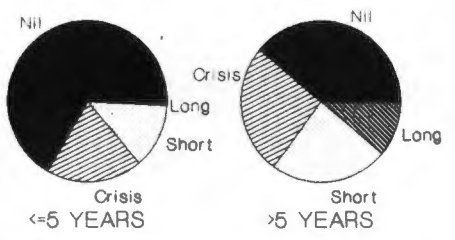

Fig. 28. Comparison, according to age of victim, of management of mental state

Comparing the action taken to ensure the safety of the children in the two groups, Table 33 and Figure 29 show a

significantly greater proportion of older children received some active intervention (x^2, p = 0,001).

Table 33. Comparison, according to age of victim, of action taken to ensure safety of child

	<=5 years	>5 years
Nil	110	168
Child removed	1	5
Child relocated	6	29
Family relocated		1
Family therapy	2	26
Unknown	4	5
Total	123	234

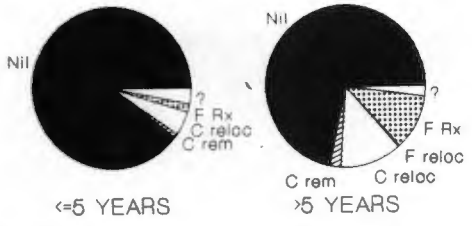

Fig. 29. Comparison, according to age of victim, of action taken to ensure safety of child

A comparison of the relationship between the abused and the abuser is shown in Table 34 and Figure 30. More older children were abused by strangers than younger children (x^2, p < 0,01).

Table 34. Comparison, according to age of victim, of relationship of abused to abuser

	<=5 years	>5 years
Family	24	58
Acquaintance	46	92
Stranger	15	57
Unknown	38	27
Total	123	234

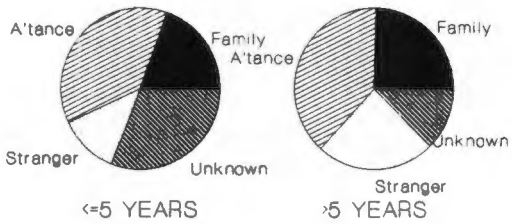

Fig. 30. Comparison, according to age of victim, of relationship of abused to abuser

Table 35 and Figure 31 show a comparison of the age of the perpetrator in each group. The difference in number of young abusers, less than 20 years of age, is not significant, whilst that of older abusers is (x^2, p = 0,002).

Table 35. Comparison, according to age of victim, of age of abuser

	<=5 years	>5 years
<20 years	30	37
>=20 years	35	106
Unknown	58	91
Total	123	234

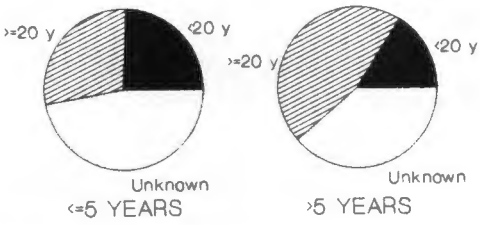

Fig. 31. Comparison,according to age of victim, of age of abuser

Comparing the action taken against the abuser, as presented in Table 36 and Figure 32, shows that in a significantly greater number of cases of young victims no action was taken (x2, p = 0,003).

Table 36. Comparison, according to age of victim, of action taken against the abuser

	<=5 years	>5 years
Nil	64	54
Intended to	10	58
Charged: open	7	16
closed	10	10
Court: outstanding	2	3
convicted	9	32
dismissed	1	8
Psychiatrist	3	4
Other	1	8
Unknown	16	41
Total	123	234

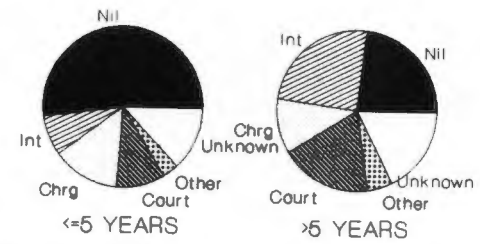

Fig. 32. Comparison, according to age of victim, of action taken against the abuser

Comparison of intrafamilial and extrafamilial abuse

In 62 cases seen by the Child Abuse Team at RCWMCH the team was unable to confirm that the child had definitely been abused. The remaining 295 cases can be divided into two groups - those who were abused by a member of their own family, intrafamilial abuse, and those abused by an outsider, extrafamilial abuse. Those cases abused by the mother's consort who was not the child's father or

stepfather have been included in the group of extrafamilial abuse.

There were 80 children subjected to intrafamilial abuse and 215 to extrafamilial abuse. The age and sexes of the children in these two groups are shown in Figure 33 and Figure 34. In the intrafamilial group there were 6 male victims (7,5%) and 24 children 5 years of age or younger (30%). In the extrafamilial group there were 35 boys (16,2%) and 63 children of 5 years of age or younger (29,3%). The mean age in the intrafamilial group was 7,1 years, similar to the 7,2 years in the extrafamilial group.

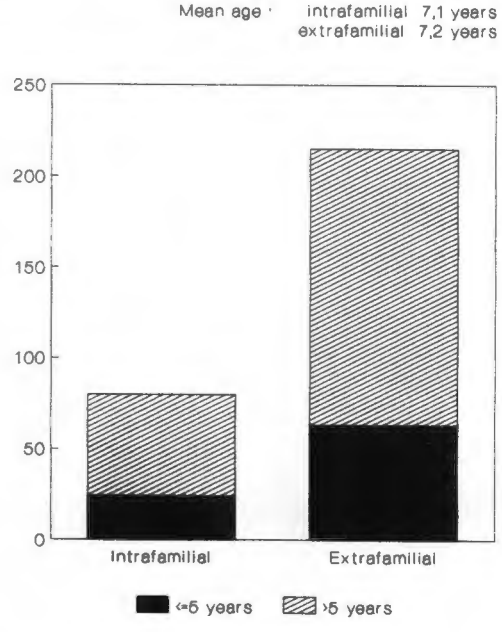

Fig. 33. Age breakdown of intrafamilial and extrafamilial sex abuse victims

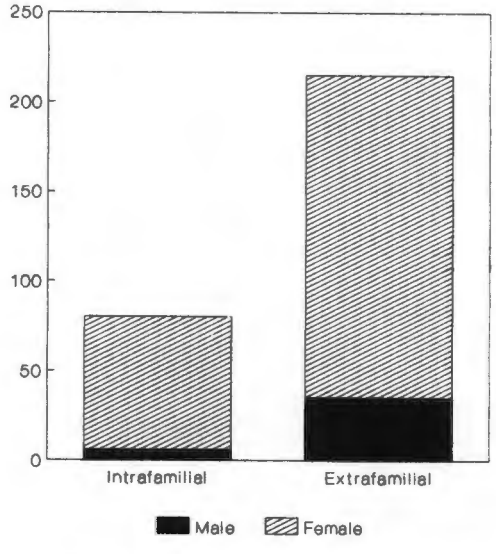

Fig. 34. Sex breakdown of intrafamilial and extrafamilial sex abuse victims

The method of disclosure of being sexually abused is presented in Table 37 and Figure 35. Although spontaneous disclosure was more common in the extrafamilial group the difference was not significant. The difference in prompted

disclosure, which was more common in intrafamilial abuse, is significant (x^2, p = 0,02).

Table 37. Incest and method of disclosure

	Intrafamilial	Extrafamilial
Spontaneous	11	53
Prompted	33	58
Unintentional	12	17
Suspicion	5	7
Unknown	19	80
Total	80	215

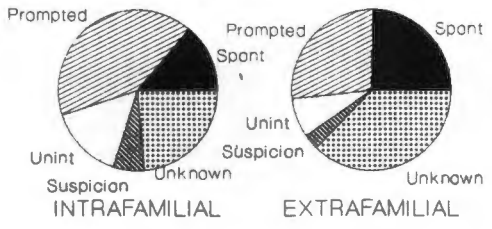

Fig. 35. Incest and method of disclosure

Table 38 and Figure 36 compare the frequency of abuse and show repeated abuse was more common in intrafamilial abuse (x^2, p < 0,001) and a single episode more common in extrafamilial abuse (x^2, p < 0,001).

Table 38. Incest and frequency of abuse

	Intrafamilial	Extrafamilial
Once only	39	181
Repeated	27	22
Unknown	14	12
Total	80	215

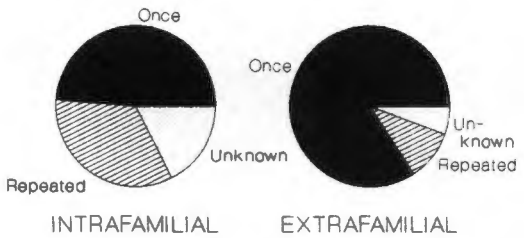

Fig. 36 Incest and frequency of abuse

Comparing the nature of the abuse, Table 39 and Figure 37 show severe sexual abuse, sodomy and rape were significantly more common in children subjected to extrafamilial abuse (x^2, p = 0,04).

Table 39. Incest and nature of abuse

	Intrafamilial	Extrafamilial
Non-contact		2
Anal contact	1	3
Genital contact	21	44
Sodomy	7	29
Rape	42	130
Unknown	9	7
Total	80	215

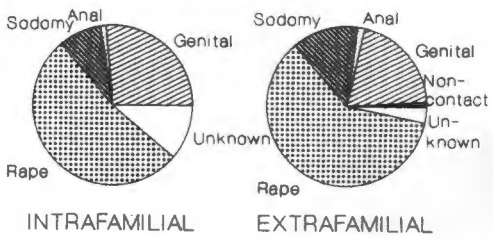

Fig. 37. Incest and nature of abuse

Comparison of where the abuse took place is shown in Table 40 and Figure 38. This shows that victims of intrafamilial abuse were more likely to be abused in their own homes (x^2, $p < 0,001$).

Table 40. Incest and place where abuse occurred

	Intrafamilial	Extrafamilial
Victim's home	53	46
Abuser's home	12	45
Neighbourhood	1	65
Elsewhere	1	23
Unknown	13	36
Total	80	215

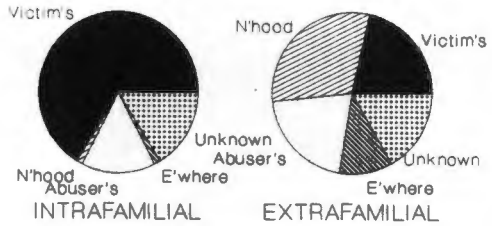

Fig. 38. Incest and place where abuse occurred

The delay in presentation to RCWMCH for the two groups is compared in Table 41 and Figure 39. Victims of extrafamilial abuse presented significantly earlier, within 48 hours following the abuse, than victims of intrafamilial abuse (x^2, $p < 0,0001$).

Table 41. Incest and delay in presentation to RCWMCH

	Intrafamilial	Extrafamilial
<=2 days	20	127
3 - 7 days	5	25
>7 days	13	28
Other	42	35
Total	80	215

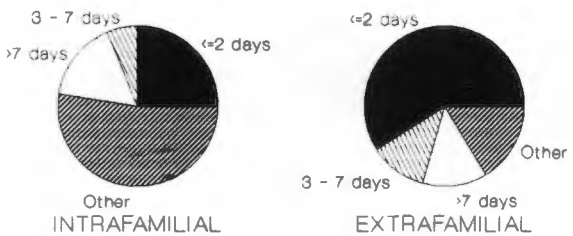

Fig. 39. Incest and delay in presentation to RCWMCH

Comparing who accompanied the child to RCWMCH, Table 42 and Figure 40, shows no significant difference between the two groups.

Table 42. Incest and person accompanying victim to RCWMCH

	Intrafamilial	Extrafamilial
Family: Mother	49	147
Father	1	10
Both parents	6	21
Other	6	13
Other: Social worker	4	2
Neighbour		4
Childminder	5	5
Other	5	4
Unknown	4	9
Total	80	215

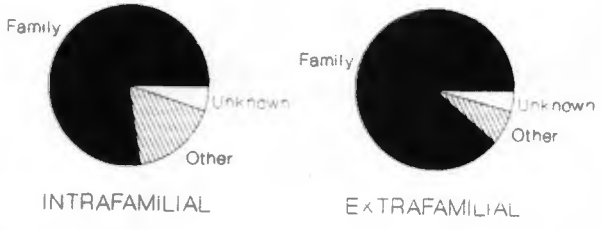

Fig. 40. Incest and person accompanying victim to RCWMCH

Comparing the clinical findings on presentation to RCWMCH, Table 43 and Figure 41, shows that victims of extrafamilial abuse had significantly more features of acute trauma (x^2, $p < 0,0001$). Significantly more victims of intrafamilial abuse had chronic genital changes (x^2, $p = 0,01$).

Table 43. Incest and findings on presentation to RCWMCH

	Intrafamilial	Extrafamilial
Nil	34	68
Trauma - general	3	25
genital	18	78
anal	4	22
Chr genital changes	11	10
Discharge	6	15
Perianal warts	2	1
STD	4	21
Behavioural problems	1	8
Other		2

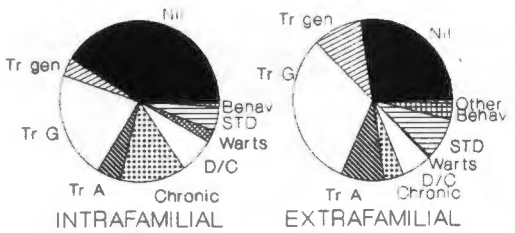

Fig. 41. Incest and findings on presentation to RCWMCH

Management of the children's physical state is compared in Table 44 and Figure 42. This shows that victims of intrafamilial abuse were more likely to require no intervention (x^2, $p = 0,02$) and those of extrafamilial abuse needed more surgical intervention, although this was not significant (x^2, $p = 0,3$).

Table 44. Incest and management of physical state

	Intrafamilial	Extrafamilial
Nil	62	135
EUA	5	20
Surgery	2	18
STD prophylaxis	11	40
Preg prophylaxis		2
Total	80	215

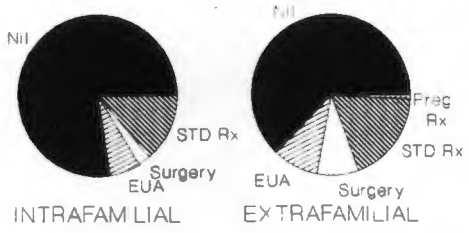

Fig. 42. Incest and management of physical state

Comparing the management of the children's mental state, Table 45 and Figure 43 show more victims of extrafamilial abuse received acute crisis intervention (x^2, $p = 0,05$) whilst more victims of intrafamilial abuse received long term counselling (x^2, $p = 0,02$).

Table 45. Incest and management of mental state

	Intrafamilial	Extrafamilial
Nil	34	81
Crisis intervention	16	69
Short term therapy	18	52
Long term therapy	12	13
Total	80	215

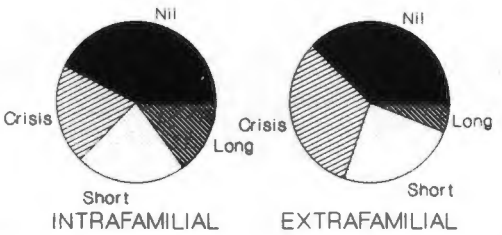

Fig. 43. Incest and management of mental state

Action taken to ensure the child's safety is compared in Table 46 and Figure 44. Fewer victims of intrafamilial abuse received no intervention (x^2, $p < 0,001$). More victims of intrafamilial abuse were permanently relocated (x^2, $p < 0,001$) and more families of victims of intrafamilial abuse received family therapy (x^2, $p < 0,001$).

Table 46. Incest and action taken to ensure safety of child

	Intrafamilial	Extrafamilial
Nil	45	173
Child removed		5
Child relocated	20	15
Family relocated		1
Family therapy	12	15
Unknown	3	6
Total	80	215

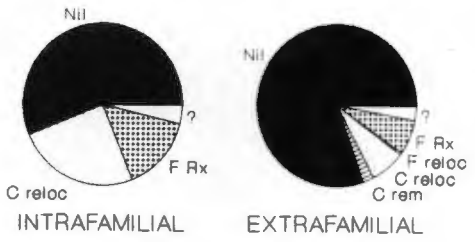

Fig. 44. Incest and action taken to ensure safety of child

Comparisons of the action taken against the abuser are shown in Table 47 and Figure 45. There was no significant difference between the two groups.

Table 47. Incest and action taken against the abuser

	Intrafamilial	Extrafamilial
Nil	18	40
Intended to	12	52
Charged: open	6	17
closed	8	12
Court: outstanding	3	2
convicted	3	38
dismissed	2	7
Psychiatrist	2	5
Other	4	5
Unknown	22	37
Total	80	215

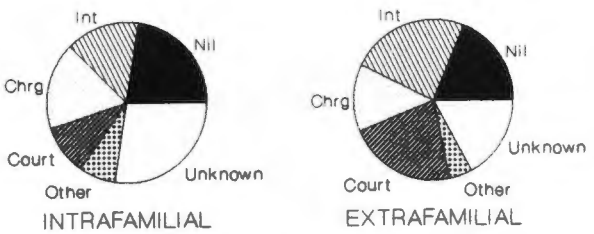

Fig. 45. Incest and action taken against the abuser

Comparison of victims of repeated sexual abuse and victims of a single episode of sexual abuse

In 275 cases an indication of the number of times the child had been abused was present in the hospital records. 49 children were subject to more than one episode of abuse and 226 to a single episode only. Of the 49 children repeatedly abused 3 (6%) were male and 8 (16%) were 5 years old or

younger. In the group abused once only, 35 (15,5%) were males and 74 (32,7%) were 5 years old or younger. The mean age of repeatedly abused children was 8,3 years and that of the others 6,9 years. See Figure 46 and Figure 47.

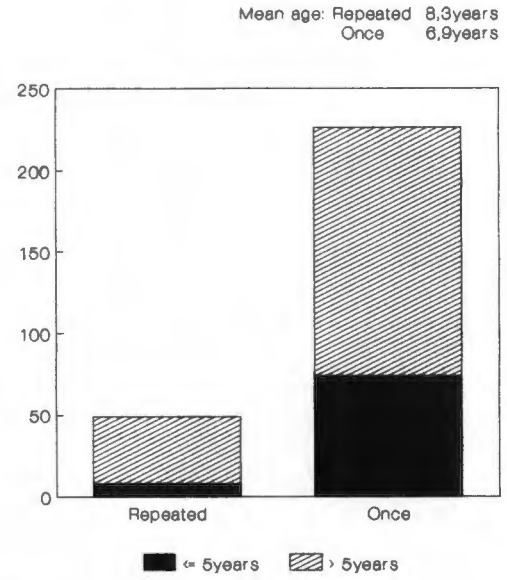

Fig. 46. Comparison, according to frequency of abuse, of age of child

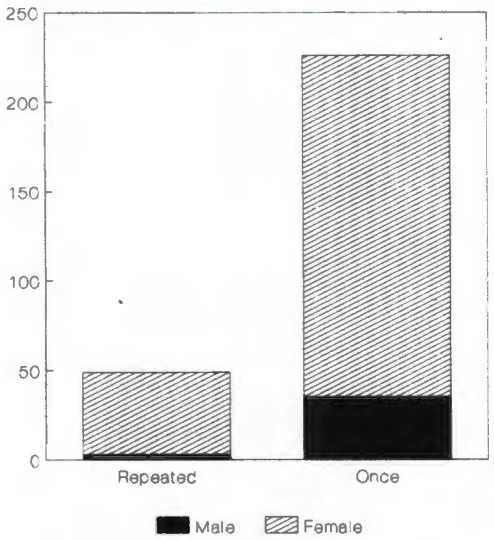

Fig. 47. Comparison, according to frequency of abuse, of sex of child

A comparison of the method of disclosure of sexual abuse for repeatedly abused children and children abused once only is presented in Table 48 and Figure 48. There was no significant difference between the two groups.

Table 48. Comparison, according to frequency of abuse, of method of disclosure

	Repeated	Once
Spontaneous	5	55
Prompted	17	64
Unintentional	7	19
Suspicion	2	11
Unknown	18	77
Total	49	226

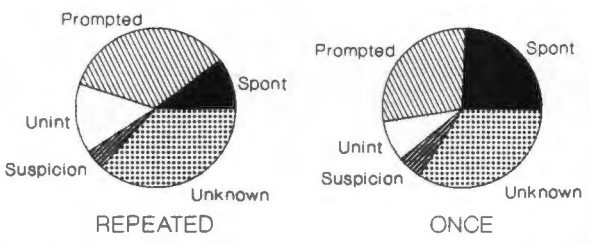

Fig. 48. Comparison, according to frequency of abuse, of method of disclosure

Table 49 and Figure 49 show a comparison of the type of abuse that occurred. Again there was no significant difference between the two groups.

Table 49. Comparison, according to frequency of abuse, of nature of the abuse

	Repeated	Once
Non-contact		2
Anal contact		4
Genital contact	12	47
Sodomy	5	32
Rape	30	133
Unknown	2	8
Total	49	226

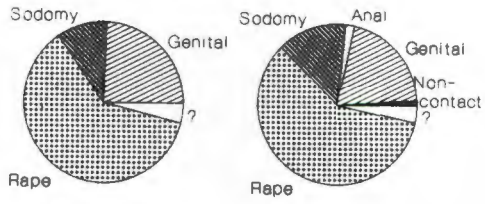

Fig. 49. Comparison, according to frequency of abuse, of nature of abuse

Comparing the clinical findings of the two groups on presentation to RCWMCH, Table 50 and Figure 50 show that an equal proportion in each group had no findings at all. Evidence of acute trauma was more common in children abused once only (Fisher's exact test, $p < 0,001$), whilst chronic genital changes were more common in repeatedly abused children (Fisher's exact test, $p < 0,001$).

Table 50. Comparison, according to frequency of abuse, of findings on presentation to RCWMC

	Repeated	Once
Nil	14	75
Trauma - general	2	27
genital	5	94
anal	1	24
Chr genital changes	17	2
Discharge	5	4
Perianal warts	2	1
STD	3	13
Behavioural problems	1	5
Other		2
Total	49	226

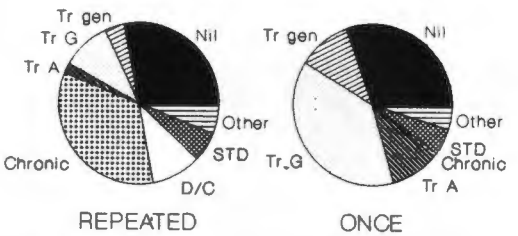

Fig. 50. Comparison, according to frequency of abuse, of findings on presentation to RCWMCH

Comparison of the management of the children's mental state is shown in Table 51 and Figure 51. More victims of a single episode of abuse received crisis intervention

(Fisher's exact test, p = 0,01) and more victims of repeated abuse received short term counselling (x^2, p = 0,01).

Table 51. Comparison, according to frequency of abuse, of management of mental state

	Repeated	Once
Nil	16	87
Crisis intervention	8	75
Short term therapy	19	48
Long term therapy	6	16
Total	49	226

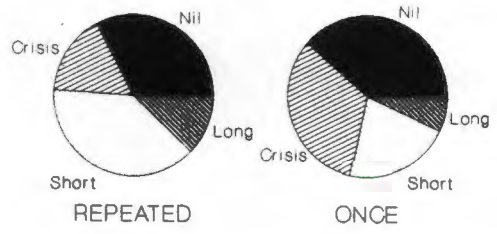

Fig. 51. Comparison, according to frequency of abuse, of management of mental state

The action taken to ensure the safety of the children is compared in Table 52 and Figure 52. More victims of repeated abuse received active intervention to ensure their safety (x^2, p < 0,001).

Table 52. Comparison, according to frequency of abuse, of action to ensure safety of child

	Repeated	Once
Nil	26	180
Child removed	1	4
Child relocated	11	19
Family relocated		1
Family therapy	8	16
Unknown	3	6
Total	49	226

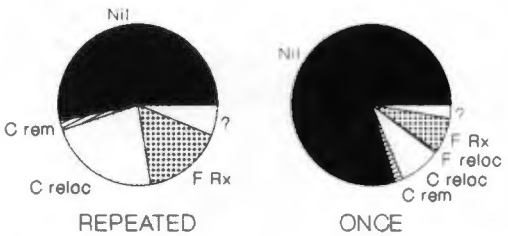

Fig. 52. Comparison, according to frequency of abuse, of action to ensure safety of child

Comparing the relationship between the abused and the abuser, Table 53 and Figure 53, family members tended to be responsible for repeated abuse (x^2, p < 0,001), whilst strangers were responsible for single episodes of abuse (Fisher's exact test, p < 0,01).

Durrheim

Table 53. Comparison, according to frequency of abuse, of relationship of abused to abuser

	Repeated	Once
Family	27	39
Acquaintance	17	113
Stranger	5	64
Unknown		10
Total	49	226

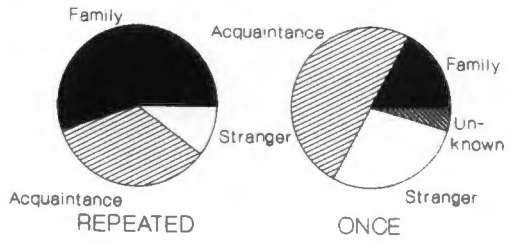

Fig. 53. Comparison, according to frequency of abuse, of relationship of abused to abuser

Finally, the action taken against the abuser is compared in Table 54 and Figure 54. In almost half the cases of repeated abuse no information was available regarding action against the abuser.

Table 54. Comparison, according to frequency of abuse, of action taken against the abuser

	Repeated	Once
Nil	7	49
Intended to	8	53
Charged: open	2	21
closed	3	17
Court: outstanding		5
convicted	4	36
dismissed	1	7
Psychiatrist		6
Other		5
Unknown	21	27
Total	49	226

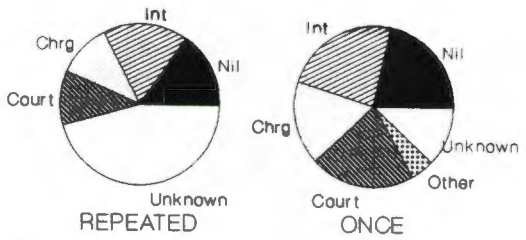

Fig. 54. Comparison, according to frequency of abuse, of action taken against abuser

The abuser

Of the 357 records reviewed 60 cases involved suspected sexual abuse which was never confirmed, therefore no information was available regarding the abuser. In the remaining 297 cases information about the abuser was recorded in most of the notes.

The majority of the abusers were male, although 3 cases involved female abusers only and one case involved both male and female abusers. See Table 55.

Table 55. Sex of abuser

	Number	%
Male	285	80,0
Female	3	0,8
Both	1	0,3
Unknown	68	18,9
Total	357	100

Table 56. Age of abuser

Years	Number	%
<10	2	0,6
10 - 14	30	8,4
15 - 19	35	9,8
>=20	141	39,5
Unknown	149	41,7
Total	357	100,0

The ages of the abusers are shown in Table 56. In most cases this was unknown but in 67 cases the abuser was under 20 years and in 2 cases under 10 years of age.

Table 57 shows the number of abusers involved in each case, either during the same episodes or over a number of occasions. As can be seen, most cases involved a single abuser.

Table 57. Number of abusers.

	Number	%
Single	257	72
Two or more	32	9
Unknown	68	19
Total	357	100

The relationship between the abused and the abuser is shown in Table 58. Acquaintances were the most common abusers, then family members, and strangers the least common.

Table 58. Relationship of abused to abuser

	Number	%
Intrafamilial:		22,1
Father	35	
Sibling	3	
Grandparent	5	
Uncle/Cousin	35	
Aunt	1	
Acquaintance:		38,7
Neighbour	57	
Family friend	36	
Parent's consort	10	
Lodger	11	
Childminder	7	
Peer	17	
Stranger	72	20,2
Unknown	68	19,0
Total	357	100,0

Table 59. Action taken against abuser

	Number	%
Nil	118	33,1
Intended to	68	19,0
Charged:		12,0
Open	23	
Closed	20	
Court case:		15,4
Outstanding	5	
Convicted	41	
Dismissed	9	
Psychiatrist	7	2,0
Other	9	2,5
Unknown	57	16,0
Total	357	100,0

Finally the action taken against the abuser is shown in Table 59. In over half the cases no action was taken at all. Criminal charges were laid against the abuser in 27,4% of cases, with 15,4% appearing in court. 74,5% of those appearing in court were found guilty and sentences varied from fines, corporal punishment or suspended prison terms to 10 years imprisonment. 7 abusers were referred to psychiatrists and 9 were dealt with by the family or community, these cases involved primarily the younger abusers.

CHAPTER 4 - CONSTRAINTS

There are two main problems with this study. Firstly it is a retrospective review of folders and hospital notes. Secondly tracing the action taken against the abuser is incomplete.

In a retrospective study the data entered into the study depends on the data recorded in the patient's records and this is often incomplete. Although individual records may have been incomplete, when one considers individual items in the study data was available from over 70% of the records for all items. As this is a descriptive study this has not negated the value of the information obtained. In addition all reports on childhood sexual abuse in the literature are either retrospective reviews or combinations of retrospective and prospective studies and therefore also have an incomplete database. This means that where comparisons have been made with the literature any difference identified may be exaggerated or reduced because of the incomplete data on both sides.

Determining what action, if any, had been taken against the abusers was extremely difficult. Families could often not be traced and the researcher then had to rely on what the hospital records reported as their intentions. Although co-operation from the numerous police stations in the Cape

Peninsula was very good, it was extremely difficult to confirm whether a charge had been laid or not, the reasons being the charge could have been laid at any police station and the police documentation records the name of the individual laying the charge and not that of the victim. As a result the 19% of families reported as intending to prosecute the abuser may indeed have done so but the researcher was not able to confirm this. In addition the researcher was unable to find any evidence of any intentions on the part of the family for a further 16% of cases, which have been included in the category "unknown".

CHAPTER 5 - DISCUSSION

Apart from previous studies from RCWMCH and Jamaica, there is no information available about the epidemiology of sexual abuse in the developing world. All comparisons between this and other studies will therefore be a comparison between sexual abuse in a developed country and that in a setting with both developed and developing components.

Over the thirty month study period there was a steady increase in the total number of abused children seen by the Child Abuse Team. The increase in sexually abused children was slightly greater than that of physically abused or neglected children and rose from 38% of the total number of abused children in 1985 to 45,3% in the first six months of 1988. Over the same period there was no comparable increase in the attendance to the RCWMCH outpatient departments. Although this would suggest that the increase in sexually abused children must be due to an increase in the incidence of the problem, this is unlikely. More sexually abused children are now seeking help and increased awareness by both parents and medical staff has resulted in better identification of these children and more appropriate management including referral to the Child Abuse Team. Krugman[47], Marshall[11] and Eckenrode et al[37] report a similar increase in the number of sexually abused children presenting for help.

As expected, the majority of sexually abused children were female. Sexual abuse was also the major type of abuse for all girls seen by the team; 57,2% of abused girls were sexually abused. Boys represented 13,4% of sexual abuse victims. This is similar to the range of 10%-23% reported in the literature[11, 13, 14, 15, 16, 17, 18, 21] and slightly higher than the 10% previously reported from RCWMCH by Jaffe and Roux[44].

The age range was from 10 months to 13 years and 10 months with a mean of 6,8 years. The decrease in the number of children over 8 years of age may be a consequence of the child sexual abuse accommodation syndrome[20]. This range is similar to that found in previous studies from RCWMCH[43, 44].

This age range was determined by the policy of RCWMCH of only treating children up to 13 years of age. Comparison with other studies is difficult as the upper age limit varies from 12 years[4] to 16 years[14, 15, 21] and the mean ages reported vary accordingly from 5,8 years[11] to 11,3 years[14].

In this study young children, 5 years or younger, accounted for 51,7% of all abused children and 34,4% of sexually abused children. This is similar to other studies where younger children, less than 4 years or 6 years of age,

account for one third to a half of sexual abuse victims but over 60% of victims of all forms of child abuse[11, 19].

There was only slight variation in the number of cases seen each month. Apart from June, the autumn and winter months tended to be associated with fewer cases than the warmer months. This trend occurs elsewhere[4, 15]. The increase in the number of cases seen in June may be related to school holidays. However, as most of the mid-year holiday is in July and not June, this is open to question and in general school holidays do not appear to influence the number of cases presenting to RCWMCH.

In most cases no record of when the abuse occurred was available. Where it was recorded most cases occurred in the afternoon (24,4%) or evening (10,3%). Most of these cases were single episodes of abuse and it is possible that creche or school hours play some role in when children are abused, with only 9% of episodes occurring in the morning. Dube and Herbert[4] were unable to report on the time of abuse, but did find that 60% of victims presented to hospital during the day and a further 34,9% before midnight.

Over 43% of the victims revealed spontaneously or on questioning the fact that they had been abused. This is slightly lower than the reported figures of 55%-59%[18, 19]. The reason here is probably a higher proportion of cases

where we have no record of how the abuse was disclosed, 27,8% versus 8%, and a high proportion of cases of suspected abuse, 20,7%.

The frequency of abuse in this series was similar to some published reports[4, 7] with 53%-63% of cases involving a single episode of abuse. However the number of children subject to repeated abuse, 13,7% in this series, was almost half that described by Dube and Herbert[4] and Baker and Duncan[7] but similar to the figure reported by De Jong et al[15]. There is no obvious reason for this as the 23% of cases where the frequency of abuse is unknown is similar to the 22,3% reported by Dube and Herbert[4]. Children subject to repeated episodes of sexual abuse may present to the psychiatry clinics with emotional or behavioural problems, in which case they would not have been referred to the Child Abuse Team or included in this study.

The nature of the abuse shows that a high proportion of children are victims of serious forms of abuse. This is similar to 70% reported by Tilleli et al[14] and far higher than the 29% in Dube and Herbert's experience[4]. This figure of 60% is probably even higher as a large proportion of cases classified as unknown were children with proven gonorrhoea, 10% of the 19,8%. Serious forms of sexual abuse were as common at RCWMCH as in Tilleli's report[14] but not as common as reported by Dube and Herbert[4]. Comparing previous

studies from this hospital Westcott[43] only reported serious forms of abuse whilst Jaffe and Roux[44] found fewer cases of serious abuse, 45%, but much more unconfirmed abuse, 47%. Only two cases of non-contact abuse is extremely low. In comparison, a survey of adults by Baker and Duncan[7] showed only 5% recalled serious forms of sexual abuse, 44% recalled genital manipulation and 51% non-contact forms of abuse. In general children are not brought to hospital unless they manifest problems secondary to the abuse and in this series the major problems were physical. Therefore there were extremely few cases of non-contact sexual abuse referred to the Child Abuse Team at RCWMCH. Older children with emotional or behavioural problems secondary to sexual abuse may present directly to the Child and Family Psychiatric Unit and not be assessed by the Child Abuse Team.

In the majority of cases, 44%, the abuse took place in the home of the victim or the abuser. A further 19,3% occurred in the victim's neighbourhood. This is similar to the experience of others[4, 15], except for Jaffe and Roux[44] who found only 6% of cases occurring in the home of the abuser.

Presentation was directly to RCWMCH in 60% of cases. This is slightly higher than the 47%-54% of patients presenting directly to hospitals in published reports[4, 11]. Of those children who were referred to RCWMCH, 13,2% presented via the police, 8,6% via their general practitioners and 5,3%

via social welfare agencies. In comparison, Dube et al[4] report 22,5% presenting via the police and 12,4% via their own doctor. In reporting on their experience primarily with cases of incest, Bentovim and Boston[21] report that 78% presented via social welfare agencies. Most of the children who were referred to RCWMCH presented to the Trauma Unit or Outpatient Department. The remainder were referred to the hospital social worker, psychologist or specialist clinic.

On arrival at RCWMCH no children were unaccompanied and the majority (87,3%) were accompanied by one or both parents. Dube and Herbert[4] report a similar finding, with 75,5% of children being accompanied by a parent. However in other reports[14, 15] the figure is much lower, 43% and 57%, with up to 47,7% of children arriving unaccompanied. The most likely explanation for this may be the younger age of victims in both this series and the report by Dube and Herbert[4].

Only 42,2% of the children presented to RCWMCH within 48 hours of their being abused, and 11,7% presented after a delay of at least a week. Cases of repeated abuse, suspected abuse or where the date of abuse was unknown have been grouped apart and are unlikely, in view of their symptoms or history, to have presented within 48 hours of the onset of their abuse. This delay in presentation is understandable in the light of the accommodation syndrome

described by Summit[20] and is important to bear in mind when examining the children as it may account for the high proportion of children with a normal examination in published reports. The number of children who presented early is low in comparison to the reported figures of 50%-56% presenting within 24 hours of being abused[15, 19]. There is no obvious explanation for this discrepancy. Socio-economic factors may play a role.

Clinical examination on presentation to RCWMCH showed that a very high proportion of children had obvious signs or symptoms following their abuse. This is a remarkable finding compared to the literature where only 20% to 31% of victims of sexual abuse show some physical evidence[4, 11, 14, 15]. One exception is the report of Rimsza et al[48] who found no associated physical signs in only 23% of their cases. Jaffe and Roux[44] have previously reported an even higher proportion of children with abnormal physical findings with only 10% having a normal medical assessment. Features of non-genital physical trauma was present in 8% of cases, which is similar to the literature. However acute genital or anal trauma was present in 36% of cases, which is similar to the 33% reported by Tilleli et al[14] but far higher than the usual figures of 20%-25%[4, 15, 48]. Features suggestive of long standing, repeated sexual abuse were seen in 5,8% of cases, which is similar to that found by Tilleli et al[14] but much lower than the figures of Eldemire[42] and

Rimsza and Niggemann[48]. Proven sexually transmitted disease, all cases of gonorrhoea, was extremely common and the figure of 15,6% is far higher than the quoted figures of 2%-4%[4, 11, 14, 15]. This, together with acute genital and anal trauma, is a major contributing factor to the high prevalence of physical findings following sexual abuse in this series. However this is similar to the figure reported by White et al[22] and Eldemire[42] in Jamaica. No pregnancies were discovered, but the majority of post-menarchal girls were not followed up to detect a possible pregnancy, so this may well have been missed.

Management of these children was extremely varied. The most likely reason is that, as shown in Tables 6 and 7, the children present initially to a variety of different services at RCWMCH. Although they were all eventually referred to the Child Abuse Team at the hospital, management of their physical state is the responsibility of the doctor who first sees the patient and this Team, primarily the social workers, then take over further investigation into the circumstances of the abuse and supervise further management. Although a protocol for the management of sexually abused children is present at RCWMCH it is not uniformly applied throughout the hospital. Consequently the management varies and probably not all children are referred to the Child Abuse Team.

Almost 60% of the children needed no management for their physical state, 15% needed surgical treatment, ranging from suturing perineal lacerations to three children who required colostomies following rectal tears or abdominal stab wounds. Two girls were given prophylactic treatment for possible pregnancy, whilst 25% received antibiotics for existing sexually transmitted diseases or as a prophylactic measure. In Rimsza and Niggemann's experience[48] 30% of post-menarchal females were given an abortifacient and 27% of all their victims received prophylactic antibiotics. Tilleli et al[14] found that only 13% of girls over the age of 11 years were given an abortifacient. In this study no information is available regarding the number of girls who were post-menarchal when sexually abused. There were 29 girls out of 35 over 11 years of age who were at risk of falling pregnant following rape. The failure to offer an abortifacient to these girls is unexplained.

Management of the emotional or mental state of the individual child showed a more uniform policy as this was undertaken by the Child Abuse Team at RCWMCH. The majority of children received no therapy beyond the initial consultation and a further 44% were given supportive therapy over the subsequent weeks or months. Only 27 children received long term emotional intervention which was provided by a psychologist or child psychiatrist. Comparative figures are not readily available although Tilleli et al[14]

describe that 94% of abused children in their experience received follow up counselling.

Finkelhor[10] reports that the majority of children require some form of active intervention to ensure their safety. He found only 16% required no intervention at all, whilst 17% were eventually placed in foster care. Bentovim and Boston[21] found that amongst children and families referred to them for family therapy 26% of the victims eventually needed to be relocated. It is important to note that 75% of these children were victims of incest. Amongst the children presenting to RCWMCH, a minority needed active intervention to ensure their safety. Six children were temporarily removed from their homes and 35 placed in foster care. One family moved to a new community and 28 were provided with family therapy. No information is available on the effect that the sexual abuse of a child had on the family structure.

The abuser

In most cases seen at RCWMCH the abuser was male. Only four cases involved a female abuser, who in one case was acting together with a male. This is similar to the 1%-4% of female abusers reported in the literature[4, 15, 19, 21].

The exact age of most abusers was unknown. In almost 19% of cases, however, the abusers were under 20 years of age, with the youngest being 9 years old. In general the age of abusers in this series tended to be older than previously reported. Dube and Herbert[4] found 45% of abusers to be less than 20 years old, whilst De Jong et al[15] reported 10% to be under 11 years of age. A possible explanation may relate to the nature of the abuse. Younger abusers may tend to be involved in less serious forms of abuse. If so, the high proportion of serious abuse in this series could account for the older age of the abusers.

In the majority of cases a single perpetrator was responsible. Multiple abusers were involved in 9% of cases, slightly higher than the 6% reported by De Jong et al[15].

The relationship between abused and abuser was similar to that described previously. Strangers were responsible for the abuse in 20% of the cases. This is similar to the figures reported by Dube and Herbert[4] and Bentovim and Boston[21], but less than those of Tilleli et al[14] and De Jong et al[15], which varied from 36%-54%. In 22% of the cases a family member was responsible for the abuse. This falls within the range of 12,3%-75% in the literature[4, 11, 14, 15, 19, 21]. Of interest, however, is the number of cases involving an uncle or cousin as the abuser. In most reports the father was the most likely abuser, followed by a

surrogate father. Acquaintances were responsible for 38,7% of cases. Again this is within the reported range of 22%-52%[4, 11, 14, 15, 19]. In her study Westcott[43] found a similar picture. However Jaffe and Roux[44] reported only 4% of cases involved a stranger and only 26% of cases an acquaintance of the family, with data on the abuser being absent in 43% of cases.

In only 27,4% of cases did the family react to the abuse of their child by prosecuting the abuser. This is a similar proportion to that described by Finkelhor[10], but lower than the range of 34%-61% described in other reports[4, 15, 21, 31]. In Bentovim and Boston's report[21] 90% of those people prosecuted were found guilty and the sentences imposed ranged from a suspended sentence to five years imprisonment. Of the 27,4% of abusers prosecuted in Cape Town only 41,8% were found guilty and sentences varied from corporal punishment, a fine or suspended prison term to ten years imprisonment. Of interest are the number of families who inform the Child Abuse Team of their intention to prosecute but who fail to do so. It is important to recognise that the prime concern of most families is for the well-being of the child and punishing the abuser is only of secondary importance. Eldemire[42] found in Jamaica that only two out of 15 guardians considered that prosecuting the abuser was a priority. Furthermore it is not necessarily in the child's best interest to prosecute the abuser. In cases of incest

subsequent family break-up may be more damaging than the abuse. In other cases the court hearing may be extremely trying for the child and aggravate existing emotional trauma.

Comparison according to the sex of the victim

An equal proportion of male and female victims was 5 years old or younger and the mean age for each sex was similar, 6,9 years for the males and 6,7 years for the females. Comparisons of mean ages according to sex vary with some reports[4, 7] describing the male victims as older whilst an equal number[15, 17] describe the female victims as older.

Female victims were more likely to be abused more than once but this was not significant ($p = 0,06$). The severity of the type of abuse was similar in both sexes. Females were more likely to be abused in their homes and males outside the home ($p < 0,001$). The probable reason is a tendency to allow young boys greater freedom of movement outside the home. Males tended to present to hospital earlier than females with a significantly greater number presenting within 48 hours of their abuse ($p = 0,01$). Males also had more evidence of trauma, both general physical trauma and anal or genital trauma and consequently more of them needed surgical treatment. Both sexes required similar

intervention for their mental state and to ensure their safety.

Females were abused by family members($p = 0,05$) and males by strangers ($p < 0,001$). Again this may reflect the greater freedom experienced by boys. The age of the abuser was similar for both sexes and the action taken against the abuser was also similar.

Baker and Duncan[7] found that females were more likely to be abused more than once. However Reinhart[18] found no difference in the frequency of abuse between the sexes. In contrast to my findings Dube and Herbert[4] found a higher proportion of males were victims of very serious forms of abuse ($p < 0,001$). When looking at the place where the abuse occurred others[4, 17] have also found that males are more likely to be abused outside their own home. Both De Jong et al[15] and Ellerstein and Canavan[17] found that male victims have more evidence of trauma. Most reports[4, 15, 17] confirm that males tended to be abused by strangers and females by family members, although some[7, 18] report little difference between the sexes.

Comparison according to the age of the victim

34,4% of the victims were 5 years of age or younger. This is similar to the figures reported by Dube and Herbert[4] and

Mian et al[19]. About 13% of victims in each age group were males. Mian et al[19] found a higher proportion of male victims in their study of young victims of sexual abuse.

Unconfirmed or suspected sexual abuse was more common in the younger group, primarily because of the higher population presenting with gonorrhoea ($p < 0,001$). The poorer communication abilities of the younger child may prevent them from disclosing their experience which is only revealed when physical symptoms develop. Older children were more likely to be abused more than once ($p < 0,01$), to be victims of a more serious form of abuse ($p < 0,001$) and to be abused outside their own homes ($p = 0,01$). In Gale's experience[34] with children under 7 years of age over 50% were subject to repeated abuse, which contrasts with this finding. However he did find that the vast majority of these children (78%) were subject to less serious or invasive forms of sexual abuse. The chances of repeated abuse must increase with age and often less serious forms progress to more serious forms of abuse. The place where abuse occurs reflects the greater freedom of movement allowed to older children. There was no difference in the interval between abuse and presentation to hospital.

Older children needed less treatment for their physical state even though they experienced more serious forms of abuse. More of them needed either short or long term

counselling for their mental state and active intervention to ensure the safety of the child was more frequent for older victims ($p = 0,001$). There is no explanation for this difference. It probably reflects an under-estimation of the emotional needs of the younger victims by both the Child Abuse Team and their parents.

A stranger was more likely to abuse the older victim ($p < 0,01$) and older children were abused by older abusers although the age of the abuser was usually not known in the case of a young victim. These features again reflect the greater freedom of movement allowed to older children. Action against the abuser was less likely when the victim was young ($p < 0,01$).

The above findings are similar to those in the literature[4, 14, 15, 34, 48]. In addition Rimsza and Niggemann[48] found that older victims tended to present sooner than younger ones.

Comparison of intrafamilial and extrafamilial abuse

A greater proportion of males were victims of extrafamilial abuse, 16,2% versus 7,5%. The age breakdown was similar in both groups.

More victims of intrafamilial abuse needed to be prompted before disclosing their abuse ($p = 0,02$) and were also more likely to be repeatedly abused ($p < 0,001$). These two factors are interrelated. The victim of intrafamilial abuse is often blackmailed emotionally into secrecy or further participation in the abusive relationship leading to the child sexual abuse accommodation syndrome, delayed presentation and repeated abuse. The nature of the abuse was more serious in extrafamilial abuse ($p = 0,04$) and these children also tended to present to hospital sooner ($p < 0,0001$). Evidence of acute trauma was more common with extrafamilial abuse ($p < 0,0001$), whilst chronic genital signs were more common with intrafamilial abuse ($p = 0,01$). Numerous factors account for these findings. Children subject to extrafamilial abuse experience less coercion and more associated violence. They are more often victims of a single episode of abuse and tend to present sooner after the abuse than victims of intrafamilial abuse. Victims of intrafamilial abuse are more likely to be repeatedly abused and present late. They are less likely to have signs of trauma and more likely to show chronic changes. There was no difference in the management of the physical state of the children. Acute crisis intervention was more likely with extrafamilial abuse ($p = 0,05$) and long term counselling with intrafamilial abuse ($p = 0,02$). Extrafamilial abuse is most likely to be a single event with a resultant acute crisis which is often dealt with by crisis intervention.

Intrafamilial abuse is more often repeated over a prolonged period leading to the accommodation syndrome and complex psychological sequelae which require more prolonged intervention. Action to ensure the safety of the child was more likely with intrafamilial abuse as there was a greater likelihood of abused and abuser living in the same household. More of these children were fostered and more families received family therapy. Action against the abuser was similar in both groups.

Dube and Herbert[4] also found repeated abuse more likely with intrafamilial abuse. Russell[49] reports that extrafamilial abuse tends to be associated with a more serious form of sexual abuse. Rimsza and Niggemann[48] found general physical trauma more likely with extrafamilial abuse. Finkelhor[10], Dube and Herbert[4] and Russell[49] all found a greater tendency for the abuser to be prosecuted in cases of extrafamilial abuse.

Comparison of victims of repeated abuse and victims of a single episode of abuse

Fewer male children and fewer children 5 years of age or younger were repeatedly abused. The mean age range for the victims of repeated abuse was 8,3 years compared to 6,9 years for victims of a single episode only. If the age of the repeatedly abused child at the onset of the abuse was

compared to that of the victim of a single episode this difference may well disappear. Unfortunately this information was not available in the hospital records.

Evidence of acute trauma was more likely in children abused once only ($p < 0,001$) whilst chronic signs were more common in repeatedly abused children ($p < 0,001$). Single episodes of abuse usually occurred in cases of extrafamilial abuse. As mentioned previously these children present sooner following the abuse whilst physical evidence is still obvious. They are also at greater risk of associated violence during the abuse. Acute crisis intervention was commoner with children abused once only ($p = 0,01$) and more victims of repeated abuse needed short term counselling ($p = 0,01$). Active intervention was needed to ensure the safety of repeatedly abused children ($p < 0,001$).

Repeatedly abused children were most likely to be abused by members of their own family ($p < 0,001$) and strangers were more often abusers of children abused once only ($p < 0,01$). Victims of single episodes of abuse were more likely to prosecute their abusers ($p = 0,02$).

Most of the differences between these two groups reflect the differences between cases of extrafamilial and intrafamilial abuse. Although common in both groups a single episode of sexual abuse is more representative of extrafamilial abuse.

Repeated abuse is more representative of intrafamilial abuse.

CHAPTER 6 - CONCLUSION

In Cape Town, as in the literature, there has been a steady increase in the number of cases of sexually abused children presenting for help. As shown in Figure 1 there was a steady increase in the number of sexually abused children presenting to the Child Abuse Team at RCWMCH from 1985 to 1988. The male:female ratio was similar to that described in the literature, but the mean age was lower. This younger age is most likely due to the policy at RCWMCH of only seeing children up to 13 years of age.

Serious forms of sexual abuse - rape, attempted rape and sodomy - formed a greater proportion of the cases than would be expected from the literature. Less invasive forms of sexual abuse are possibly being missed altogether; presenting to alternative services with psychological problems, not physical ones; not causing sequelae warranting attention or occur less often in Cape Town than elsewhere.

The majority of children presented directly to RCWMCH which is understandable in light of the fact that 60% of children attending the outpatient departments at the hospital use the hospital as their primary health care centre[50]. However the delay between abuse and presentation to the hospital remains unexplained.

In contrast to the literature the majority of children were accompanied by an adult, usually a parent, when presenting to hospital. This may reflect the younger age of this sample or be related to the greater proportion of children subject to a more serious form of abuse.

Sexually transmitted disease was a common mode of presentation. The true prevalence following sexual abuse is probably even higher as many of the children who presented to hospital soon after being abused may have subsequently developed evidence of a sexually transmitted disease. Poor follow up of these children means this may well have been missed. Physical evidence of trauma was also more common than in some reports in the literature and may also be higher than actually recorded as the delay prior to presentation to hospital allows for the resolution of many of the clinical signs.

Follow-up of these children was poor when compared to what is reported. Physical sequelae were not sought and when undertaken follow-up concentrated on emotional sequelae. Numerous reasons were responsible for the poor follow up, paramount of which was the financial status of the families. As a result an open door policy has been adopted allowing children and their families to return to the social worker dealing with their case should they feel the need for further help.

Comparing the victims on the basis of their sex showed a similar age spectrum and severity of abuse. Female victims tended to be abused at home by members of their own family. Male victims were abused outside their homes by strangers, presented to hospital sooner than female victims and had more evidence of associated trauma. The management of the two groups was similar.

Comparison of the victims according to their age revealed that confirmation of sexual abuse was a problem in the younger group. Children in the older age group were more likely to be repeatedly abused, were victims of more serious forms of abuse and tended to be abused outside their homes. Older children received more psychological intervention, whilst younger children needed more physical attention. When identified, the abuser was invariably known to the younger victim, and more likely to be a stranger when the victim was older.

Comparing the children according to whether they were victims of incest or extrafamilial abuse showed victims of incest were more likely to need prompting before disclosing the abuse. A greater proportion of them received long term counselling and more were placed in foster care. Victims of extrafamilial abuse tended to be subject to more serious forms of abuse, presented sooner after the abuse, had more

evidence of physical trauma and received acute crisis intervention only.

Comparing those children who were repeatedly abused with victims of a single episode showed females and older children were more likely to be repeatedly abused. In addition, victims of repeated abuse were most likely victims of incest, had evidence of chronic genital changes, received short term counselling and were more likely to be placed in foster care. Action was more likely to be taken against the abuser in cases of a single episode of sexual abuse.

Finally the profile of the abuser. The abuser's sex, relationship to the victim and action against him was similar to that described in the literature. The only discrepancy was that the age of the abuser in this series tended to be older than that in the literature.

CHAPTER 7 - RECOMMENDATIONS

The following recommendations arise from this study:

1. There is a need for regular education of medical staff at RCWMCH, particularly new members of staff and those in MOPD and specialist outpatient clinics, about the recognition and management of sexually abused children.

2. There is a need for the establishment of a special unit at RCWMCH of specially trained doctors to whom cases of sexual abuse can be referred for examination.

3. A uniform policy needs to be implemented throughout the hospital for the management of the physical state of sexually abused children. A suggested policy is attached as Appendix III.

4. Greater attention needs to be paid to the emotional needs of both the children and their families, and especially to those of the younger victims of sexual abuse.

5. Follow-up facilities are needed in the community. The physical problems arising from sexual abuse may be monitored at local child health clinics or Day Hospitals. The emotional needs may be managed either

by the same services or by community based social welfare agencies. At present the latter are used primarily to assist in confirmation of sexual abuse and are under-utilised in the management of these children.

6. Finally further studies are needed to:

   a. Identify all resources in the community which may be utilised in the follow-up of these children.

   b. Review the family structure, dynamics and socio-economic status of sexually abused children in order to identify risk factors for sexual abuse.

   c. Document rates of sexually transmitted disease and pregnancy following childhood sexual abuse so that more informed judgement can be used in making management decisions.

   d. Describe the psychological profile of the abuser and his environment or circumstances.

   e. Prospectively evaluate the management provided to sexually abused children.

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APPENDIX I

SEXUAL ABUSE AT RXH

NAME

FOLDER NO

A. RACE/SEX

B. DATE OF BIRTH

C. ADDRESS

D. DATE OF PRESENTATION

E. ACCOMPANIED BY:

1. Mother
2. Father
3. Parents
4. Grandparents
5. Sibling
6. Neighbour
7. Child Minder
8. Unaccompanied
9. Unknown
10. Other .....

F. REFERRED BY:

1. Family
2. School Nurse
3. Clinic
4. G.P.
5. Police
6. M.O.P.D.
7. S.O.P.D.
8. Wards
9. District Surgeon
10. Social Work Agency .....
11. Trauma Unit
12. Special Clinic .....
13. Other Hospital .....
14. Other .....
15. Unknown .....

G. OUTSIDE PATIENTS REFERRED TO:

1. M.O.P.D.
2. S.O.P.D.
3. Trauma Unit
4. Social Worker
5. Psychologist
6. Other .....

H. METHOD OF REVELATION:

1. Spontaneous Disclosure
2. Prompted Disclosure
3. Unintentional Disclosure
4. Suspicion Without Confirmation
5. Unknown

I. ACT OF ABUSE:

1. Non-contact
2. Orogenital
3. Anal Contact
4. Genital Contact
5. Sodomy
6. Rape
7. Unknown

J. FREQUENCY:
1. Date Known
2. Month Known
3. Repeated
4. Unknown

K. DATE OF ABUSE:

L. TIME OF ABUSE:
1. Morning
2. Afternoon
3. Evening
4. Night
5. Unknown

M. PLACE OF ABUSE:
1. School
2. Built-up Area
3. Veld
4. Neighbourhood
5. Home of Victim
6. Home of Abuser
7. Other .....
8. Unknown

N. PHYSICAL FINDINGS:
1. Nil
2. Fractures
3. Stab Wounds
4. Genital Trauma
5. Anal
6. General Bruising/ Abrasions
7. S.T.D.
8. Genital Discharge
9. Other

O. AGE OF PERPETRATOR:
1. < 10 Years
2. 10-14 Years
3. 15-19 Years
4. 20-29 Years
5. > 30 Years
6. Unknown
7. 'Adult'

P. SEX OF PERPETRATOR:
1. Male
2. Female
3. Both
4. Unknown

Q. NO OF PERPETRATORS:
1. Unknown
2. One
3. Two or More

R. RELATIONSHIP TO VICTIM:
1. Parent
2. Sibling
3. Grandparent
4. Uncle/Aunt
5. Neighbour
6. Lodger
7. Parent's Consort
8. Child Minder
9. Family Friend
10. Peer
11. Stranger
12. Unknown

S. TREATMENT OF PHYICAL STATE:
1. EUA
2. Surgery
3. STD Prophylaxis
4. Pregnancy Prophylaxis
5. Nil

T. TREATMENT OF EMOTIONAL STATE:
1. Acute Crisis Intervention
2. Short Term Follow Up
3. Long Term Follow Up
4. Nil

U. FOLLOW UP BY:

0. No follow up
1. RXH Social Worker
2. Psychologist
3. S.A.P.
4. S.H.A.W.C.O.
5. Diakonale Dienste
6. Child Welfare Society
7. A.C.V.V.
8. Dept. of Health Services & Welfare
9. Child Health Clinics
10. C.P.A. Community Services
11. Child & Family Unit
12. Other .....

V. ACTION RE CHILD:

1. Nil
2. Family Therapy
3. Child Relocated
4. Family Relocated
5. Unknown
6. Child Removed

W. ACTION RE PERPETRATOR:

1. Nil
2. Charged - Open
3. Court - Convicted
4. Court - Dismissed
5. Unknown
6. Other
7. Charged - Closed
8. Court - Outstanding
9. Family - Intended to lay charge but no record at S.A.P.

APPENDIX II

ABBREVIATIONS

A'tance	Aquaintance
Behav	Behavioural problem
Chrg	Charged
C reloc	Child relocated
C rem	Child removed
d	Day
D/C	Discharge
EUA	Examination under anaesthesia
E'where	Elsewhere
F reloc	Family relocated
F Rx	Family therapy
G P	General practitioner
Int	Intended to
MOPD	Medical Outpatient Department
N'hood	Neighbourhood
OPD	Outpatient Department
Preg Rx	Pregnancy prophylaxis
RCWMCH	Red Cross War Memorial Children's Hospital
SOPD	Surgical Outpatient Department
Spont	Spontaneous
Sp clinic	Specialist clinic
STD	Sexually transmitted disease
STD Rx	Sexually transmitted disease prophylaxis

S W agency	Social welfare agency
Tr A	Anal trauma
Tr G	Genital trauma
Tr gen	General trauma
?	Unknown
Unint	Unintentional

APPENDIX III

MANAGEMENT POLICY FOR PHYSICAL STATE OF SEXUALLY ABUSED CHILDREN

1. Treat general physical condition.

2. History of penetration - oral, vaginal or anal.

   a. Good following compliance anticipated:

      Swab oropharynx, vagina and anus for bacteriology
      VDRL at 6 weeks
      Treat according to results

   b. Poor follow up compliance anticipated:

      Treat prophylactically: Amoxycillin 50 mg/kg stat
      Probenecid 25 mg/kg stat

3. Post-menarchal female victim: offer abortifacient (Diethylstilboestrol)