THE PROBLEM OF SEXUALLY ABUSED CHILDREN
INCLUDING DISABLED CHILDREN – ASPECTS OF MEDICAL
AND NURSING CARE

PROBLEM DZIECI WYKORZYSTYWANYCH SEKSUALNIE Z UWZGLĘDNIENIEM DZIECI NIEPEŁNOSPRAWNYCH – ASPEKTY OPIEKI LEKARSKIEJ I PIELĘGNIARSKIEJ

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ABSTRACT
The problem of sexually abused children, including children with disabilities, is an important issue in both gynecology and sexology of developmental age. Medical assistance to victims of sexual violence, especially children – including children with disabilities, comprises not only the correct medical care of injuries but also all other activities that accompany the performance of treatment to reduce the psychological trauma caused by sexual abuse. This paper presents symptoms of sexual violence against children, its consequences as well as rules of a medical examination of a disabled child – a victim of sexual violence.

KEYWORDS: sexually abused children, disabled children.

STRESZCZENIE
Problem dzieci wykorzystywanych seksualnie, w tym dzieci niepełnosprawnych, jest ważną kwestią zarówno w ginekologii, jak i w seksuologii wieku rozwojowego. Pomoc medyczna ofarom przemocy seksualnej, w szczególności dzieciom – w tym dzieciom niepełnosprawnym, obejmuje nie tylko właściwą opiekę medyczną nad urazami, ale także wszystkie inne czynności towarzyszące wykonywaniu leczenia w celu ograniczenia urazów psychicznych spowodowanych wykorzystywaniem seksualnym. W artykule przedstawiono objawy przemocy seksualnej wobec dzieci, jej konsekwencje oraz zasady badania lekarskiego niepełnosprawnego dziecka – ofiary przemocy seksualnej.

SŁOWA KLUCZOWE: dzieci wykorzystywane seksualnie, dzieci niepełnosprawne.

“Taking care of a child is the first and fundamental test of human to human relation”. Pope, John Paul II

Introduction
Both in gynecology and sexology of the developmental age in terms of the problem of sexual offenses against children, concern is expressed in a particular and specific manner, and the problem is even more difficult if victims of sexual violence are children with disabilities. Care for children, including children with disabilities who are victims of sexual violence, requires a specialized, specific, fully empathic and professional approach.

According to Professor Imieliński, one should leave as much freedom as possible in expressing and satisfying one’s needs, if it does not negatively affect the development of another human being or society [1].

The pedophile actions are harmful in this aspect of expressing and satisfying one’s sexual needs [2–7]. Often the victims of sexual offenders are people with disabilities. For pedophiles, they are particularly easy-defense victims [3, 7–8]. Authors of many reports on sexual violence against children emphasize the fact that the majority of such cases are not due to various complex issues revealed by both children and their caregivers. This applies especially to children with disabilities, both somatically and intellectually. In the opinion of the perpetrators, their deeds will not come to light. It is important in medical practice to know not only somatic
Symptoms, but also changes in the child’s behavior that may indicate sexual harassment [2–6].

The first diagnostic step is a professional interview. In the case of intellectually disabled children, the interview with the child is unfortunately very difficult or even impossible. However, you should always make such an attempt. Most often, the source of information about these acts of sexual abuse are the victims themselves; however, in the case of children with disabilities, it is not easy to read the information properly. Children in general rarely speak directly about the fact that someone uses them sexually.

Symptoms depend on the duration of abuse, relationships with the perpetrator, type of sexual activity, as well as factors related to the development of the child, in the case of children with disabilities – with the type of disability. They can be divided into three groups: symptoms concerning the child’s behavior, his emotions and the sexual sphere. There are many reasons why children hide harassment. They are often intimidated, forced to be silent by bribery or blackmail, they are afraid of rejection on the part of their parents, they also have a sense of their separateness, feel inferior, often are unaware that sexual actions taken by the perpetrator are unacceptable and outlawed – the problem is even more complicated for disabled children.

A separate problem is connected with the symptoms that may indicate the sexual abuse of a child. If they occur in the form of physical injuries, then most likely they will be able to be diagnosed only by medical services. They are often noticed during nursing care of a disabled child. Acute somatic symptoms requiring rapid medical intervention are e.g. external and internal genital injuries – vulvae area, perineum: midline crotch fracture, which may extend from the vaginal mucosa to the rectal mucosa (vulvae vestibule and rectum as one post-traumatic cavity) [4-7].

The classification of the symptoms of sexual violence against children

I. Acute (immediate medical intervention required):

1. Injuries of external and internal genital organs:
   - vulvae area, perineum: midline crotch fracture, which may extend from the vaginal mucosa to the rectal mucosa (vulvae vestibule and rectum as one post-traumatic cavity);
   - hematoma within the hymen (made with the finger are smaller);
   - damage to the anal area: bruising, anal fissures reaching the surrounding skin.
   - Damage to other parts of the body: the lips and oral cavity (bruises and bloody petechiae on the palate), lower and upper limbs.
   - Bite wounds.
   - Genital ulcers and wounds caused by sexually transmitted diseases (STDs).

Acute somatic symptoms are usually infected wounds with uneven edges, massed and bruised. The important thing is that if the child is afraid to say in what circumstances the injuries have occurred and the person reporting with the child wants to conceal the truth (e.g. the mother knows the perpetrator and wants to protect him), the circumstances of the injuries given by the mother or child are incoherent or unlikely: “...fell on a frame from a bicycle, a clotheshorse, a table edge, a tree branch, etc....”

II. Chronic:

1. Leading are psycho-emotional disorders.
2. Calm and confident behavior of the child during the gynecological examination (this attitude should arouse suspicions of the gynecologist, because the non-abused child is usually afraid of the examination).
3. Loss of hymen (location of changes can be described in terms of reference to clock hands on the dial): lack of hymen below the hypothetical horizontal line between 3 o’clock and 6 o’clock, loss or healed crack, most often at 6.00.
4. Permanent dilation of the anus to diameter > 1.5 cm. In the general and gynecological examination in 50–90% of patients we do not find any changes, which results from a different way of sexual abuse of a child, e.g. sexual intercourse, oral relations. Even after 3 months after vaginal intercourse there may not remain visible traces.

III. Certain, direct:

1. Pregnancy.
2. Sexually transmitted disease (STD).
3. Semen in the vagina.
4. Someone else’s hair, blood, saliva, epidermal cells (in the vagina, in the oral cavity, underneath the nails of the victim) confirmed by molecular DNA analysis.

IV. Unjustified, doubtful, confusing inexperienced doctor

A register of possible behaviors of the child associated with sexual violence has been constructed (also in the case of disabled victims of sexual violence in childhood changes in their behavior are observed). They are:

1. Sleep disorders, nightmares and fears.
2. Incomprehensible appearance of somatic complaints, such as abdominal pain, headache, vomiting, nausea.
3. Anxiety, fear, phobias.
4. Isolation, closing in on oneself.
5. Regressive behavior, such as crying, persistent adherence to parents.
6. Hyperactivity, masturbation.
7. Learning problems, conflicts at school, unwillingness to do homework.
8. Depression, melancholy, sadness, suicide attempts.
9. Fears suddenly revealed to the parent of a given sex.
10. Sudden and unexpected interest in sex, own and others’ body, sexual life of parents and other people.

Medical examination of a child with disability
In the medical examination of a child with disability – a victim of sexual violence, a nurse specifically trained for such cases should participate.

Foundations and principles of a physical examination:
1. Examination of the general condition of the child in terms of other currently occurring diseases, taking into account the type of disability: whole body skin screening, palpation of the head, lung and heart auscultation, etc.
2. During the examination, an attempt should be made to establish contact as much as the child’s incompetence allows one should try to minimize the fear associated with the examination.
3. Symptoms related to sexual violence should first be sought in other parts of the body than the genitals.
4. Genital examination is performed at the end. Regardless of the type and degree of disability, an attempt should be made to explain the purpose of the examination to the child, put on the gynecological chair or on the couch depending on the type of disability (a trained nurse assisting in the examination helps in proper placement of the child) [2, 4–7].

Among girls with spastic paralysis, the big problem is placing the lower limbs on the footrests or loosening the perineal muscles enabling the examination. The solution to these limitations is to carry out a test on a chair or a trolley in positions known in obstetrics and gynecology. The recommended position is the ‘diamond shaped’ position, which does not require opening the feet, or the ‘M-shape’ position. In extreme situations with increased spasticity, a ‘knee-chest’ position should be used. Unfortunately, this position prevents full evaluation of the vaginal portion of the cervix in the sight glass.

An examination of a disabled girl may require much more time, especially a disabled girl who is a victim of sexual violence. Both in patients with cerebral palsy and in some patients with nerve root injury, the relaxation time are considerably extended. In the absence of a two-handed test, the only method remains the ultrasound examination of the abdominal wall. Some authors also consider the possibility of examining these patients under anesthesia. Others suggest using relaxation techniques in the examination of girls with increased spastic tension, but there is no evidence for the effectiveness of this technique.

Recommended positions of the gynecological examination of girls with physical disabilities are:
- ‘knee-chest’ position – the patient lies on the side of the table;
  - legs flexed toward the abdomen/chest, the top leg is raised by the midwife;
  - the inner leg is pushed to the back.
This position allows a limited palpation examination; in particular the posterior wall and posterior vaginal vault are available. Unfortunately, this position prevents full and thorough expertise of the vaginal portion of the cervix in the sight glass. It is highly recommended in extreme situations with increased spasticity.
- ‘diamond-shaped’ position – the patient lies on her back with her knees bent so that both legs are spread flat and her heels meet at the foot of the table;
  - legs bent form the shape of a rhombus.
It is the recommended position for patients with limited mobility in the hip joint.
- ‘M-shaped’ position – the patient lies on her back, knees bent and apart, feet resting on the exam table close to her buttocks. After the legs are positioned letter ‘M’ is shaped which resembles the classic position of the gynecological examination. Recommended for patients with moderate leg paresis.
- ‘V-shaped’ position – the patient lies on her back with her straightened legs spread out wide to either side of the table.
It is the recommended position when examining on the wheelchair.

The mother of the disabled child should participate in the examination; she is asked to stand close to child’s head and hold her hand. Often, however, children with disabilities remain without their parents or legal guardians [2, 3, 8].

An important stage of a gynecological examination in which a trained nurse is necessary is to watch the skin: abdomen, medial compartment of thighs, buttocks, anus, crotch, labia majora, and mucous mem-
Their reactions are often inadequate to the strength of the stimulus. There may be aggression, crying, fits of rage, hyperactivity, and concentration and memory disorders. Sometimes these children wet, and not only at night, they self-mutilate and make suicide attempts. They also have nightmares or difficulties in falling asleep, they complain about various types of pain and general fatigue [2, 4–7].

Depending on the degree and type of disability of a child who is a victim of sexual violence, one can observe inadequate to child’s age sexualization of character play, the use of vocabulary of the sexual context, touching genitals and other people or unwillingness to undress or hypersensitivity to touch.

The most frequently recognized sexual violence – with physical contact – includes, i.e.: touching, kissing or caressing the child’s intimate places, rubbing against a child, masturbating in his presence, penetration of the child’s genital organs (also with the help of a finger or objects), forcing a child to do it in the presence of the perpetrator and rapes. Things are less often diagnosed when a parent is constantly sleeping with a child (who is no longer an infant) in one bed (often naked) or bathing a child in order to get his own sexual pleasure. There are mothers who ‘for fun’ or ‘nursing’ touch the intimate places of their sons and fathers, uncles, grandparents or grandmothers, who, laughing, touch the breasts or buttocks of adolescent girls.

A child sexually abused not necessarily has to be touched.

Sexual violence without physical contact refers, among others, to exposing yourself in the presence of a child, walking naked at home, peeping a child in a room while changing clothes or in a bathroom while bathing, forcing him to watch sexual intercourses, showing newspapers and pornographic films or allowing them to watch them.

On the other hand, emotional sexual violence includes for example: vulgar calling of the child, excessive attention to the sexual aspects of his body, telling him about own sexual contacts with other adults, arranging meetings where people talk about sex in the presence of children. All these behaviors are unlawful, unsuitable for the child and must be banished immediately.

Sexual violence cannot be observed directly unless someone (i.e. a nurse or doctor) notices that there has been mechanical damage to the reproductive organs; unnatural redness of the vagina or anus; there are bleedings and the discharge from the vagina or damage to the anal sphincter muscles, causing involuntary fecal contamination, the child may have frequent and long constipation without a clear medical reason. Disconcerting may be very frequent urination caused by mental tension and irritation of the urethra and constantly re-
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Repeated urinary tract infections. In addition, a child may have a genital infection or a sexually transmitted disease, and a girl under 15 may be pregnant [2, 4–7, 9].

Children affected by sexual violence can be cruel to animals, steal and tell lies, take drugs, abuse alcohol, more often than other children flee from school. For girls, eating disorders are typical. Young people are suddenly disturbingly overweight or overly tying, becoming addicted to sweets. This serves to reduce your physical attractiveness, although for the perpetrator the appearance of the child is usually irrelevant. The most common eating disorders include anorexia nervosa and bulimia nervosa (usually called simply ‘anorexia’ and ‘bulimia’). This is a very important problem in the aspect of gynecology of the developmental age, which should also be taken into account in the case of children used sexually [10].

Summary
To summarize, sexual violence imposes a mark on the child, even if it does not seem to be so, because no obvious external symptoms are observed (in children with disabilities this is difficult).

It should be emphasized that among children who are victims of sexual abuse are (and this is a group of special risk) children with disabilities. Sexual violence is the most serious form of child abuse. Medical assistance to victims of sexual violence, especially children – including children with disabilities, comprises not only the correct medical care of injuries but also all other activities that accompany the performance of treatments to reduce the mental trauma caused by sexual abuse [2, 5–9].

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