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Psychosocial symptoms in very young children assessed for sexual abuse: A qualitative analysis from the ASAC study

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ABSTRACT

Child sexual abuse (CSA) is a worldwide problem with serious consequences. No recognizable symptom pattern for suspected CSA has yet been identified in very young children. We aim to investigate psychosocial symptoms in a sample of children with confirmed or strongly suspected CSA and the interpretations given to such symptoms by independent clinical experts. Secondly we examined whether experts were able to identify confirmed victims of severe CSA. A qualitative study including inductive content analysis of medical files and focus group discussions with independent experts on the interpretation of psychosocial symptoms was conducted. We included 125 children (76 boys, 60.8%, and 49 girls, 39.2%; median age 3.3 years; age range 0–11) who were involved in the Amsterdam sexual abuse case (ASAC) and had been examined for strongly suspected CSA. We identified four themes among the psychosocial symptoms: problems concerning emotions, behavior, toilet training, and development, whether or not associated with the daycare center or the perpetrator. Clinical experts identified signs of posttraumatic stress disorder (PTSD), regression in continence skills (not otherwise explained), and problems triggered by exposure to the perpetrator or the abuse location as concerning symptoms for CSA. Less concerning symptoms were designated as worrisome if they were numerous and there was no clear explanation for these symptoms. A clear symptom pattern was lacking and about half of the confirmed severe victims of CSA did not display any psychosocial problems. Therefore, it is difficult for experts to identify confirmed CSA victims. Thus, the assessment of suspected CSA should be over time and multidisciplinary.

1. Introduction

The worldwide prevalence of childhood sexual abuse (CSA) ranges from 3% to 31% (Barth, Bermetz, Heim, Trelle, & Tonia, 2013;

Abbreviations: AMC, Academic Medical Center Amsterdam; ASAC, Amsterdam sexual abuse case; CSA, child sexual abuse; OPD, Emma children's hospital outpatient department; PTSD, posttraumatic stress disorder; FGDs, focus group discussions

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Euser, van, Prinzie, & Bakermans-Kranenburg, 2010; Finkelhor, Shattuck, Turner, & Hamby, 2014). Overall, girls appear to have higher probabilities of becoming CSA victims (Stoltenborgh, van, Euser, & Bakermans-Kranenburg, 2011). Prevalence studies of CSA in young children, below the age of six years, are limited in number (Barth et al., 2013).

Short-term consequences of CSA in childhood and adolescence include fears of reabuse, serious posttraumatic stress symptoms (PTSS) (Kelley, 1989), attachment problems (van Hoof, van Lang, Speekenbrink, van, & Vermeiren, 2015), anxiety, depression, withdrawn behavior, physical health symptoms, aggression, and school problems (Kendall-Tackett, Williams, & Finkelhor, 1993). Reviews on the long-term consequences of CSA in adulthood report a high prevalence of psychological symptoms and psychiatric disorders (Maniglio, 2009). Research shows associations between CSA and lifetime diagnoses of anxiety, eating, sleep, conduct, and post-traumatic stress disorders (PTSD), depression, suicide attempts and other self-destructive behavior, sexually inappropriate behaviors, and functional somatic syndromes (Afari et al., 2014; Bonvanie et al., 2015; Bremner, 2003; Browne & Finkelhor, 1986; Chen et al., 2010; Dube et al., 2005; Ehrensaft, 1992; Maniglio, 2009; Maniglio, 2010; Maniglio, 2013; Zucker, 1991).

Unfortunately, CSA often remains unrecognized, as reflected in the discrepancy between the prevalence rates of self-report and informant studies (Alink et al., 2010; Stoltenborgh et al., 2011). Most children do not disclose until adult life, let alone during preschool years (McElvaney, Greene, & Hogan, 2014; Munzer et al., 2014). Given the unlikelihood of early disclosures in children, clinicians look for other cues to diagnose CSA, such as physical and behavioral symptoms. However, physical indications specific to CSA are found at examination in just 4% to 5% of cases (Adams, Harper, Knudson, & Revilla, 1994; Adams et al., 2015; Berenson et al., 2000; Heger, Ticson, Guerra, et al., 2002; Heger, Ticson, Velasquez, & Bernier, 2002; RCPCH, 2015). It is important to emphasize that the absence of physical (including anogenital) findings at examination never excludes CSA (Adams et al., 1994; Anderson et al., 2014; RCPCH, 2015). Sexual behavior problems are found in about one third of children after CSA (Kendall-Tackett et al., 1993), but there is no one specific sexual behavior that is indicative of sexual abuse; other origins of the problems, such as physical abuse, family violence, and other types of maltreatment, are also possible (Kellogg, 2009).

If a child does not disclose sexual abuse, and no physical evidence or sexual behavioral problems are apparent, then psychosocial symptoms are the only possible indications that remain (Kendall-Tackett et al., 1993). Studies on the effects of sexual abuse in daycare settings often include children abused by different perpetrators, children who were ritually abused (Burgess & Hartman, 2005; Kelley, 1989; Kelley et al., 1993), or female victims (Schumacher & Carlson, 1999) which is logical considering the fact that girls are more likely of becoming CSA victims (Stoltenborgh et al., 2011). These studies show that preschool children abused in daycare settings display more fears, anxiety, problems in social functioning (e.g. social withdrawal), internalizing and externalizing behavioral problems and inappropriate sexual behavior (Burgess & Hartman, 2005; Gale et al., 1988; Kelley, 1989; Kelley et al., 1993). Studies on CSA case series by one perpetrator often include small samples (Lindblad & Kaldal, 2000).

Almost nothing is known about the impact of sexual trauma, symptoms and symptom patterns in infants and preschool children (often in a preverbal phase), male victims, and children abused in daycare settings by one perpetrator. In general, the level of evidence for CSA is low as forensic evidence or perpetrators testimonies are often lacking. Whether the symptoms and symptom patterns of CSA can also be found in infants and preschool children is much less clear (Finkelhor & Berliner, 1995; Kendall-Tackett et al., 1993), especially with regard to psychosocial symptoms other than sexual behavior and knowledge.

To improve our understanding of CSA, clinicians need to know more about psychosocial symptoms and patterns in children who are examined for confirmed known or strongly suspected CSA, and how such symptoms should be clinically interpreted.

The purpose of this study is to investigate (1) the variety of psychosocial symptoms, other than sexual behavior and knowledge, in children assessed for confirmed or strongly suspected CSA;(2) how experts in the field of CSA would interpret such presenting psychosocial symptoms to identify subtle distinctions between symptoms more or less concerning for CSA; and (3) whether experts are able to identify confirmed victims of severe CSA.

2. Methods

2.1. Setting and population

In 2010, a daycare center employee in Amsterdam was suspected of having sexually abused dozens of young children. The case came to light through a child pornography investigation in the United States. Many very young children, most of them boys, were considered possible victims in what became known as the Amsterdam sexual abuse case (ASAC)—the largest confirmed CSA case series by one perpetrator in history. The ASAC is a unique case, owing to its large scale, the predominance of young boys, the confessed and convicted perpetrator, the high level of evidence, and the detailed documentation available about the abuse. Child pornographic images were decrypted in police investigations, and the employee eventually admitted sexual abuse of 87 children. Parents of 20 children decided against pressing charges, and the daycare worker was convicted for abusing 67 children.

Immediately after discovery of the ASAC, the Emma Children's Hospital of the Academic Medical Center (AMC) in Amsterdam set up an emergency outpatient department (henceforth OPD) to examine the possible victims of CSA. Children involved were referred if CSA was strongly suspected or confirmed on at least one of the following grounds:

a. The child currently or previously attended a daycare center where the perpetrator worked (strong suspicion of CSA).
b. The perpetrator had worked as a babysitter at the child's home (strong suspicion of CSA).
c. The child was identified in pornographic images decrypted by police (confirmed CSA).
d. The perpetrator had confessed to CSA with the child (confirmed CSA).

In neither of the groups of children CSA could be excluded, for every child CSA was very likely. It is also possible that a child witnessed CSA in other children or in their siblings as most abuse took place at the daycare or at the children's homes. It was therefore