Sexual abuse in the family
Suggestions for medical curricula

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Summary
Awareness of the recent escalation of sexual abuse in the RSA has exposed inconsistencies in the intervention and treatment process and has implications for routine health care. Fifth-year medical students at the University of the Witwatersrand are involved with children in institutions as part of their community paediatrics course. During 1985, 9 of the 50 students had to deal with children who had previously been sexually abused. The students recognized their limitations in dealing with the sexually abused child and became aware of their own feelings when confronted with this problem. This has implications for the teaching of the dynamics of sexual abuse to medical students. It is suggested that knowledge of sexual abuse and its ramifications be addressed at the medical school curriculum level and be taught in the various clinical departments and incorporated into ward teaching rounds and seminars.

Reports of the sexual abuse of children have recently escalated in the media in the RSA.1,2 Despite increased public awareness of sexual abuse, the true incidence is unknown. In the USA unofficial estimates are that some form of sexual abuse occurs in 10 - 25% of American families.3 However, this explosion of interest creates new hazards for the child victim of sexual abuse, since it increases the likelihood of discovery, but fails to protect the victim against the secondary assaults of an inconsistent intervention system.4 This would seem to apply to those children removed from their families and placed in institutional care. Many have been so emotionally damaged by their experiences that they become distrustful and resistant towards those responsible for their care, which poses an additional impediment in the treatment process and has implications for routine health care.

Medical student involvement
Fifth-year medical students at the University of the Witwatersrand can choose to be involved with children in institutions as part of their community paediatrics requirement. The purpose of this attachment is to sensitize students to the special needs of children in institutions; to teach them how to communicate with children through play and varied activities, including health-related topics; and to orient students to a psychosocial as well as a biomedical approach to clinical problems. They are expected to do medical examinations as a screening device for any physical abnormalities and to monitor growth and development of the children. They thus perform a valuable service to the institution.

During 1985, 9 of the 50 students placed in institutions had to deal with children who had previously been sexually abused by a close family member, e.g. father or stepfather. The father as the most frequent abuser has been well documented.5,6 There were both boys and girls and they were all prepubertal at the time of the sexual abuse, which took place over a number of months or years. The discovery of the abuse was frequently the precipitating factor leading to a Children's Court Inquiry and subsequent placing of the child in an institution.

Students became aware of the sexual abuse through reading the children's files, speaking to the houseparents, and observing children's masturbatory behaviour or play with dolls. Consequently 5 students decided not to do routine physical examinations because they felt it was an intrusion or because they feared the possible reactions and felt they might not be able to cope adequately with the distressed behaviour.

Three female students and 1 male student examined the children. The reactions of both boys and girls examined by the female students were embarrassment, self-consciousness, and resistance to talking about menstruation among the girls. A 13-year-old who was sexually abused over a long period by her father told the medical student that she was afraid of being examined by a male doctor. The reaction that the male medical student encountered when attempting to examine one of the girls was: 'You're just like my father, you want me to take off all my clothes ... and touch me all over.'

Sexual abuse syndrome
Sexual abuse is a symptom of disturbed family relationships and conflicts, and social isolation.6 Fathers who approach their daughters sexually have unsatisfying sexual relationships and turn to their daughters or stepdaughters instead.6 It is apparent that the wives are emotionally distant and collude with their husbands. The sexually abused child has not only had to contend with the relationship with the abusive parent, but also with lack of caring and support from the non-abusive parent, and frequently with the accompanying aggression from the abuser. The removal from home and placement in an institution, dissolution of the family and the legal implications constitute a further crisis for the child. Additional sequelae for the child are low self-esteem, feelings of guilt and responsibility for the abuse and break-up of the family, and perceiving the residential placement as punishment. The latter is reinforced since these children are frequently openly blamed by the parents.6,9

The long-term effects have been documented as the inability to develop trust in intimate relationships,6 chronic depression, unintegrated sense of identity, neuroses, psychosexual developmental disorders, psychosomatic illness, sexual and marital difficulties, prostitution,10 and difficulties in assuming parenting
The medical approach

The identification and management of children who have been victims of prolonged sexual abuse is a much neglected area in the medical curriculum. The medical practitioner is often the first person with whom the child and family come into contact. It has been noted that general practitioners frequently do not recognize the probable diagnosis of child sexual abuse and dismiss it as ‘fantasy, confusion or displacement of the child’s own wish for power and seductive conquest’. Medical students in both rural and urban areas should be alerted to the problem and implications of sexual abuse in children, even long after it has occurred. Extreme sensitivity is required when doing routine medical examinations. The need for privacy should be respected at all times. Severe embarrassment or self-consciousness may be a pointer to previous or ongoing sexual abuse. A tactful psychosocial history should be obtained with the use of empathetic and supportive statements. Children are reluctant to discuss incestuous relationships with anyone outside the family and therefore may be very reticent. It has been found that adult women who were sexually abused as children had never previously disclosed their childhood experiences, even to their spouses, until they were involved in group therapy. The doctor should not be another colluding party by maintaining the secret, but should encourage the child to confide in him by being non-judgemental and by providing a warm, accepting atmosphere. The new Child Care Act, 1983, which is not yet in force, makes it obligatory for doctors to report all cases of actual and suspected child abuse. The support and expertise of other related health professionals, e.g. social workers, health visitors or psychologists, should be enlisted. Police action and prosecution may be necessary, for without this therapeutic intervention cannot be initiated.

Psychotherapy and family therapy may help to resolve the crisis for all family members and prevent the long-term effects of abuse.

General practitioners should be alerted to include child sexual abuse in the differential diagnosis when unexplained physical symptoms occur, e.g. recurrent urinary tract infections, unexplained bleeding and discharges, genital or rectal itching or soreness, inappropriate sexual play, suicide attempts, social withdrawal, and promiscious behaviour may be indicators. A higher than average rate of positive cultures for gonorrhoea when doing routine medical examinations. The need for privacy should be respected at all times. Severe embarrassment or self-consciousness may be a pointer to previous or ongoing sexual abuse. A tactful psychosocial history should be obtained with the use of empathetic and supportive statements. Children are reluctant to discuss incestuous relationships with anyone outside the family and therefore may be very reticent. It has been found that adult women who were sexually abused as children had never previously disclosed their childhood experiences, even to their spouses, until they were involved in group therapy. The doctor should not be another colluding party by maintaining the secret, but should encourage the child to confide in him by being non-judgemental and by providing a warm, accepting atmosphere. The new Child Care Act, 1983, which is not yet in force, makes it obligatory for doctors to report all cases of actual and suspected child abuse. The support and expertise of other related health professionals, e.g. social workers, health visitors or psychologists, should be enlisted. Police action and prosecution may be necessary, for without this therapeutic intervention cannot be initiated. Psychotherapy and family therapy may help to resolve the crisis for all family members and prevent the long-term effects of abuse.

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Cases of sexual abuse are often seen at surgical outpatient departments and other specialist clinics. The identification and management of sexual abuse should be taught in the various clinical departments and incorporated into ward teaching rounds and seminars. In the obstetrics and gynaecology teaching rotation, the subject of sexual abuse could be brought into teaching on venereal disease, unmarried parenthood, and promiscuity. Similarly in psychiatry and paediatrics the symptoms and cycle of sexual abuse should be taught in the context of the family system. In surgery, sexual abuse could be incorporated into the management of trauma, and in urology it could be brought into discussion of urinary tract infections. An aspect of medical student training which is frequently neglected in medical curricula is the need for students to become aware of their own feelings. Nowhere is this more pertinent than when dealing with sexual abuse, since this arouses very powerful feelings, e.g. revulsion, rage toward the abuser, reluctance to become involved if a court appearance is necessary, impatience when proceedings may be protracted, helplessness, and the inadequacy of not knowing how to deal with the situation. Opportunities for discussion of feelings should also be interwoven in the regular teaching programme.

Conclusion

With the stresses on families of the present economic and political climate, family breakdown and disruption is becoming more prevalent in both black and white communities. It is therefore of paramount importance for doctors in all disciplines to be aware of the ramifications of sexual abuse in the community.