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VAGINAL INSPECTION AS IT RELATES TO CHILD SEXUAL ABUSE IN GIRLS UNDER THIRTEEN

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Abstract—Inclusion of vaginal inspection in all physical examinations resulted in doubling identification of cases of child sexual abuse. Forty-five of 247 girls under 13 years of age were admitted because sexual abuse had been reported. Of the 202 girls not suspected, 45 additional cases of sexual abuse were discovered by suspicious findings on vaginal inspection. The horizontal diameter of the vaginal opening exceeding 4 mm correlated in three of four instances with a confirming history for past sexual abuse. It is recommended that physical examination of young girls routinely include inspection of the vaginal opening. Pediatric caregivers need to teach themselves the parameters of the normal to protect those children who are suffering sexual abuse in their environment.

Résumé—Le nombre de cas de sévices sexuels (violences sexuelles) double lorsqu'on inclut dans l'examen physique celui du vagin chez les filles. Le matériel clinique de la présente étude provient d'un centre de crise situé à Denver, au Colorado et ce centre a été inauguré en 1978. En deux ans, environ 1000 filles mineures y ont été examinées pour mauvais traitements. 247 fillettes de moins de 13 ans ont été examinées sur une période de 6 mois pour violence sexuelle soupçonnée ou prouvée. Chez 45 de ces 247 fillettes, la violence sexuelle avait été mentionnée dès l'admission. Chez 202 filles chez lesquelles il n'était pas fait mention d'emblée de sévices sexuels, on a trouvé 45 cas supplémentaires à cause de l'aspect du vagin suggestif de sévices sexuels. Un diamètre horizontal plus large que 4 mm est 3 fois sur 4 une preuve d'abus sexuels, que l'interrogatoire confirme par la suite. Pour cette raison, l'auteur recommande que, chez des fillettes examinées pour sévices physiques, on comprenne dans l'examen physique celui de l'ouverture vaginale. Les responsables de soins pédiatriques ont besoin d'apprendre l'aspect du vagin normal, afin de savoir détecter une atteinte sexuelle chez les mineures et de protéger celles-ci de leur entourage. L'auteur insiste sur la validité de la mensuration du vagin dans le plan horizontal sans introduire un instrument ou le doigt. Elle donne également des détails quant aux questions posées pour infirmer ou confirmer la molestation sexuelle.

THE ONGOING PROBLEM of sexual abuse in young children is a grave one. In 1979 reported cases of sexual abuse to children under 18 years of age had an incidence of 1:1000 total population [1]. Young children are particularly vulnerable since they are trained in our society to obey their parents and elders, the same parents and elders who may be abusing them. Reported cases are shifting toward younger children: 47% are under 12 years of age and 16% are under six. The percentage of perpetrators who are family members is higher than reported in 1967 [2]: 54% are fathers, stepfathers or live-in boyfriends and, only when the assailant is a stranger, does the average age of the victim rise to 12 years or older (see Tables 1 and 2).

Sexual play with an adult may not be perceived as inappropriate by victims under age 7 or so years. Others may fall silent if enough threatening occurs. A mother may be unable or unwilling to protect her child from the sexual activity she knows about. Many children end up being sexually abused in their homes for years (Table 2). Literature abounds with reports indicating the serious consequences an abused child may face in adolescence and adulthood [3,4,5,6,7,8,9].

Table 1. Reported Cases of Sexual Abuse to Children

	De Francis New York City Study (2) 250 Cases in 1967 (Percentage)	Cantwell Denver Study 226 Cases in 1979 (Percentage)
Perpetrators		
Father	27	54
Natural	13	26.5
Surrogate	14	27.5
Mother	3	0
Mother helped	0	1.3
Relative	11	10.5
Natural	4	
In-law	7	
Friend	37*	19**
Stranger	25	16.5
Victims		
Male	10	15
Female	90	85

*In the DeFrancis study the "Friend" category included Friend of family, of Victim or Family of victim's friend.

**In the Cantwell study the "Friend" category included Family friend, Babysitter, or Babysitter's family.

The literature does not contain any specific information which might aid the pediatrician in diagnosing cases of sexual abuse. For example, no data exists on the vaginal opening of prepubescent girls. How then can a potential abuse victim be isolated in examination?

The case history has long been an effective weapon in guiding the physician to problems otherwise undetectable. The pediatrician has a uniquely fragile situation in attempting to draw information from an "in-house" sexually abused child. The taboo in our society is not the "doing," but the "talking about," where incest is concerned. This secrecy perpetuates the abuse. The child care professional must upgrade the overall examination process to responsibly include both a familiarity with normal prepubescent vaginal openings, and the inclusion of abuse-related inquiry in history taking. A child's normal development can be adversely affected if sexual abuse goes undiscovered.

The inclusion of vaginal inspection in all routine examinations resulted in a doubling of identified cases of sexual abuse. These cases would have remained undetected had vaginal inspection not been included. The victims would have risked continued exploitation by someone in their environment, very likely a close relative.

Table 2. Reported Cases of Sexual Abuse to Children—Denver 1979

	Perpetrator						
	Family			Friend			
Victim	Father	Stepfather	Relative	Mother's Boy friend	Family friends	Stranger	Total
Total no. of children	60(26.5%)	47(21%)	24(10.5%)	15(6.5%)	43(19%)	37(16.5%)	226
Average age (Yrs.)	7.6	11.4	7.8	9	10	12.4	
No. under 12 yrs. (47%)	24	18	17	12	23	13	107
No. under 6 yrs. (16%)	7	7	7	3	8	4	36
Male children (15%)	9	5	5	2	10	3	34
Male under 12 yrs. (10.5%)	7	2	5	2	6	2	24
Male under 6 yrs. (3.5%)	2	1	1	1	3	0	8
Abused by multiple perpetrators (10.5%)	5	2	5	5	1	6	24
Told someone—no response (18.5%)	19	14	0	6	3	0	42

METHOD

The cases involved in this study were treated at the Crisis Care Unit (CCU) of Denver, Colorado, which opened in October of 1978. Children placed in the unit include those who have been physically or sexually abused or neglected. In cases of abuse where a police hold has been put on a child under 13, the child is referred to the CCU. Children who are brought under the general category of neglect are those who may have been left alone at home or who are placed in police protection because their caretaker may be hospitalized or jailed. Some may have been involved in delinquent behavior and are being held for disposition.

On arrival at the CCU each child is given a complete physical examination, which includes inspection of the vaginal area of females. With the increased awareness that sexual abuse of young children is common, it has become imperative to inspect the vaginal opening of young females.

In a period of two years about 1,000 female children were inspected for sexual abuse. In this study, a population of 247 female children under 13 years of age were seen in a six month period. Forty-five of these children were examined because their possible sexual victimization was reported by authorities. Among the 202 girls not suspected of sexual victimization, an additional 45 had vaginal findings indicating that sexual abuse had possibly occurred. Thirty-three of them confirmed this through histories. (Those who denied may have been victims but unable to relate this to the interviewer, or some of the older ones may have been sexually active and unwilling to divulge such information). Eight of these had no enlargement of the vaginal opening but gave a history of oral sex or molestation without finger or penile penetration. The remaining 37 children had a vaginal opening exceeding 4 mm.

There were 65 (26%) children admitted because they were abused, demonstrating physical injury. Two of them gave a history of sexual molestation but had small vaginal openings. Six had an enlarged vaginal opening but gave no history of sexual abuse. Sixteen gave a positive history and had enlargement of the vaginal opening.

Of the 59 (24%) girls who were unattended at home (under 12 years of age), three reported sexual molestation without vaginal injury, four denied any incident which might explain the enlarged vaginal opening and eight had been sexually abused. The remaining 78 (32%) girls were labeled as "in need of protection." This included children whose parents were mentally ill, drug impaired, or violent. Parents might have been hospitalized, taken to jail, or merely evicted from their abode. Interestingly, in this group the fewest children were suspected of or gave a history of sexual abuse. Nine children described and had physical evidence of sexual abuse; additionally, two denied by history but had suspicious findings on inspection.

Nine children in the total sample gave clear histories of accidental injuries, explaining the old trauma to the vaginal orifice. Such findings have not been investigated specifically as they might relate to horseback riding, gymnastics and other vigorous participation in sports. The children described, for example, falling awkwardly when learning to ride a bicycle or when climbing a crib rail, a fence, or a tree and landing in a straddle position. They remembered that after falling there were some spots of blood, some pain or burning on urination.

An enlarged vaginal opening as a single finding appears to correlate to occurrence of sexual abuse in about three of four children (70 of 95 or 74%). Without the physical finding, an additional thirteen children (5%) related in history taking that they had been victims of sexual abuse (Table 3).

EXAMINATION

A logical point of intervention is the pediatric physical examination. The genital area of young males is always a matter of record; yet a vaginal inspection of young females is not

Table 3. Six-Month Review of History Concerning Sexual Abuse and Size in Vaginal Opening in Prepubertal Female Children

Admitted for	Physical Finding and History			Totals	Predictability
	VO (+) H (+)	VO (+) H (−)	VO (−) H (+)	VO (+) or H (+)	VO (+) only
Sexual Abuse					
45 (18%)	37	0	8	45	82%
Physical abuse					
65 (26%)	16	6	2	24	67%
Left alone					
59 (24%)	8	4	3	15	53%
Shelter					
78 (32%)	9	2	0	11	82%
Total					
347 (100%)	70	12	13	95	(70 of 95)
	28%	5%	5%	38%	74%

VO (+)= Vaginal opening larger than 4 mm
VO (−)= Vaginal opening smaller than 4 mm
H (+)= History given of sexual abuse
H (−)= History denied for sexual abuse

done on a routine basis. In general, pediatric caregivers are either unfamiliar with the frequency of sexual abuse of children, do not believe it, or do not want to know. Reassessment of this oversight could help in curbing chronicity of sexual abuse.

Measurements of vaginal opening have been referred to as admitting a finger. Putting a finger in the vaginal opening of a child has implications which are undesirable. The procedure may be frightening to the child and confuse her perception of appropriate adult behavior towards her. Search of the literature indicates that there is no available data on the vaginal opening of prepubescent girls. Accurate measurement presents problems since the vagina is an elastic organ and the A*P diameter is difficult to measure. Therefore, the measurements reported here were taken in the horizontal plane.

The children were reassured that no instruments are used and that we would only look as we do at their eyes or teeth. Most children were comfortable with this simple inspection. The child can be examined in a prone knee-chest position, a frog-leg position, or on her back with the knees drawn up toward the chest. Slight spreading of the labia will make the vaginal opening easily visible. It can be measured with a tape or ruler held against the vulva. Normally the vaginal opening in prepubescent girls is pinpoint to about 3 millimeters (mm). We regarded as possible sexual abuse victims those who had an opening larger than 4 mm. In addition to inspection of the vaginal opening of all female children, all children (male and female) were asked if anyone had had or attempted to have sexual contact with them. The specific question might be, "Has anyone hurt you there?" (pointing to the perineum). The "yes" answer might simply be related to an application of A and D Ointment. More sophisticated questions could be asked of older children: "Has anyone messed with you?" "Has anyone tried to have sex with you?" "You have a place down there which looks as though it might have been hurt?" The responses correlated in three out of four children with the measurements taken during vaginal inspection. Positive sexual abuse history correlated with a vaginal opening of more than 4 mm in 74% of the children.

Examples

Three children came to CCU because their parents had left them alone. The two-year-old was frightened in the examining room so her four-year-old sister was brought in with her. Having calmed the children, looked at ears, mouths, and listened to their chests, we laid the

two-year-old down to check abdomen, hips, femoral pulses. Her vaginal inspection revealed a large vaginal opening (7 mm). Her four-year-old sister was asked, "How come your sister has a big hole there? Does somebody put something in there?"

"Uh-huh, Unca Pete does that." She was difficult to understand and unable to give comprehensible details.

The seven-year-old brother, when interviewed, supplied further details. An Uncle Peter often babysat and when drunk played with the girls' genitals putting his finger in them. "He put his finger in there and his penis between their legs. He tried it with me, too, but I wouldn't let him." He was very comfortable telling in detail what had happened to him and his sisters.

During history-taking, some children became noticeably evasive. They squirmed and averted their eyes. If this behavior became striking, we might say, "Did he tell you not to tell?" "Did he say he would hurt you if you tell?"

"He said he'd hit me, but I told Mommy anyway."

"What did Mommy say?"

"She told him to quit doing that."

Another conversation involved eleven and nine-year-old boys and a seven-year-old sister. During the interview the older boy became evasive about the sexual incidents which were allegedly witnessed by the boys. He was asked, "Why aren't you looking at me? It makes me think you are hiding something."

Suddenly he said, "You'd better get Charley in here."

Charley, the nine-year-old was invited into the room. He was equally evasive until the older boy said, "How come you aren't looking at us when you talk, you gotta be lying." In a short exchange between them they decided to tell us about the sexual abuse of their sister by their stepfather which both had witnessed.

CONCLUSION

It is urgent that health professionals dealing with prepubescent girls include inspection of the vaginal opening as part of the physical examination. Routine inspection will give professionals an awareness of the normal vaginal appearance, as well as a heightened sensitivity to children who may be in need of their protection.

Normal development can never be expected from a child who is lover to her father, sexual rival of her mother, and mistress to the household in the kitchen and in bed [5,6,7,8,9,10,11]. The findings presented indicate that in the absence of known perineal injury the discovery of an enlarged vaginal opening correlates in three out of four instances to a positive sexual abuse history given by the child. If enlarged openings are found, children need to be asked in private what may have caused the findings since they are often fearful of their parents. Adults seem to forget that children can explain clearly what happened to them. Children talk about this more easily with a woman. It may be prudent to involve a female staff person for interviewing. Such staffers may acquire expertise at interviewing young children. (A report to social services is mandatory if sexual abuse is suspected, as it is when physical abuse is thought to have occurred.)

The consequences for children growing up with in-house sexual abuse are serious. They often become runaways, teen-age prostitutes, suicidal, pregnant in their teens or involved with drug abuse. As adults they have a higher incidence for physical child abuse [6]. The child is in a "no-choice" situation since there is no where else to go for "bed and board." Runaways risk even greater exploitation.

In this no-win situation the problem demands help from outside a sick family. When the parental role as protector and guide of their child's psychosexual development malfunctions,

the physical evidence of sexual abuse can best be recognized by the pediaric health care community, who are then able to initiate intervention.

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