

Families coping with the forensic anogenital colposcopic examination

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ABSTRACT

Background: The anogenital colposcopic examination is not a routine procedure in the ordinary examination of children, and knowledge is sparse regarding child and parental anticipation and coping.

Methodology: The study included 60 children aged 4 – 15 years of age, examined on grounds of alleged sexual abuse, during a two year period. The physician rated the child using the Procedure Behavioral Rating Scale (PBRs). In addition, the child and parent completed a questionnaire concerning their experience.

Principal findings: Mean PBRs score was 1.3. Significant positive correlations were found between the parental expectations to the child's anxiety regarding the examination, and the children's anxiety, the experience of the examination being bad/ugly and the experience of pain during the examination. Significantly higher PBRs scores were found in the group with no perpetrator conviction.

Conclusions: High levels of parental and child distress emphasizes the need for better preparatory and stress reducing procedures, to avoid possible re-victimization and negative influence of parental anticipatory anxiety on the child. The finding of significantly higher PBRs scores in the group with no conviction could indicate, that lack of behavioral distress might be related to the possibility of sexual abuse.

Keywords:

Child sexual abuse, Forensic medical examination, Anogenital colposcopic examination, Coping, Anxiety.

INTRODUCTION

The anogenital colposcopic examination is not a routine procedure in medical examinations of children. Knowledge is therefore sparse regarding children and their parents' anticipation and coping with such examinations.

In one study, the majority of children were found not to perceive the suspected sexual abuse (SSA) examination as strongly negative. The study reported, however, greater fear associated with a hypothetical re-examination, compared to medical examinations by the general practitioner. Using multiple regression analysis, general fear of doctor visits, as well as fear and pain associated with the SSA examination contributed to the prediction of greater fear for a hypothetical re-examination [1].

Other studies have found that most children reported mild to moderate levels of distress in connection with the examination [2], some children were significantly less distressed after the anogenital colposcopic examination than before [3], and adolescents generally reported the examination to be beneficial, and their anxiety to be reduced significantly after the examination, nevertheless, 34 – 51 % reported that the examination was painful, scary or embarrassing [4].

Waibel-Duncan et al (1999) furthermore found that children's distress regarding the examination was relatively consistent with their parents' report, but uncorrelated to the reports of the medical staff. One third of parents reported a high level of concern for their children's distress and the potential painfulness of the examination. Misconceptions and a general lack of exam information were suggested to exacerbate this parental distress.

This theory is supported by results from another study, which indicated that understanding of the examination, as well as caregiver response to disclosure were significantly associated with caregiver and child anxiety [5].

In a prospective study, parents found the medical examination significantly less stressful than they had anticipated. Increased parental and child distress were also shown to be significantly associated with the child being 12 years or older [6].

One study investigated associations between emotional distress during the anogenital examination and alleged sexual abuse. It was found that emotional distress, measured with the Genital Examination Distress Scale, observed during the anogenital examination, significantly correlated with a greater frequency of sexual abuse, more perpetrators, physical injury and more severe sexual events reportedly described by the children prior to the medical examination [7].

A study, surveying children and adult guardians' attempt to cope with the anogenital exam provided indirect evidence of the inherent strengths and self-righting tendencies of children dealing with these exceptional circumstances. This pointed to the value of identifying individually coping resources to facilitate successful completion of the medical evaluation [8].

Psychological problems are well-known consequences to child sexual abuse. One study found that abused children were more likely to subsequently be diagnosed with a behavioral or emotional disorder [9]. Another study showed the predictive utility of avoidant coping as

indicator for future depressive, posttraumatic stress, anxiety and dissociative symptoms, as well as aggression and attention problems [10].

The value of prompt disclosure to an adult was realized in a study regarding re-victimization, where they found that participants with prompt disclosure were less likely to report additional unwanted sexual experiences [11].

The aim of this study was to investigate children and their parents' reactions to the forensic medical examination, in particular the anogenital colposcopic examination, immediately after the procedure and again three months later, and to evaluate possible differences in the children's reactions in cases with and without perpetrator conviction.

Our hypothesis being that sexually abused children, documented by conviction of the perpetrator in court, would present a higher degree of emotional distress during the examination.

EXPERIMENTAL PROCEDURES

Methods

The study included all children aged 4 – 15 years of age, referred by the police for a forensic medical examination at the Department of Forensic Medicine, Aarhus, Denmark, during a 31-month period (February 1st 2000 to September 1st 2002). In this prospective study, data was consecutively collected among the children who were accompanied by a parent or guardian, and where informed consent was given.

The Department of Forensic Medicine, Aarhus, Denmark, serves an area of Jutland with about 2.5 million inhabitants, which is almost half of the total Danish population, of whom half a million are children aged 0 – 16 years.

The forensic medical examination is a lengthy procedure, including the child's medical history, but with no questioning about the assault. Prior to the examination, the child and the parents or guardian are informed both in writing and in person, about the purpose of the examination and how it will proceed. All parents or guardians sign an informed consent. The details of the sexual assault, the police investigation with interrogation of the child and perpetrator and eventually the court decision come from police- and court reports. During the examination the child gets fully undressed, with a normal medical examination including a Tanner stage, and hereafter a forensic medical examination with description of lesions, including an anogenital examination with a video-colposcope, performed with the child in both back position and knee-elbow position. The monitor for the video-colposcope is placed behind the child.

Since 1994, the Department of Forensic Medicine, Aarhus, Denmark, has used a Zeiss video-colposcope (Olympus, Ballerup, Denmark) in examining the anogenital area. A camera with a 5 – 16 x image magnification is mounted on the colposcope. The camera has different filters, enabling capillaries and vessels to be viewed with great accuracy. Two medical doctors, the examining doctor and a senior doctor, review the videotape of the anogenital examination, before writing the forensic medical report.

Collection of biologic trace evidence, such as semen, is time dependent, only relevant for a period of less than 72 hours from the assault. Testing for sexually transmitted diseases is only performed, when the examination or the medical history gives rise to concern, e.g. in cases with a history of vaginal penetration.

This study was approved by the local scientific ethics committee.

Measures

Physician questionnaire

The Procedure Behavioral Rating Scale (PBRs) consists of 13 items with operational definitions of behaviors believed to be indicative of anxiety in the child; crying, clinging, verbal anxiety, verbal pain, screaming, stalling, carrying, flailing, refusal position, restrain, muscular rigidity, emotional support and termination request. The occurrence (1) or non-occurrence (0) of the behavior is rated, summed to a total score of 0 – 13 points. The PBRs has been found reliable to measure anxiety responses to painful procedures in children, and to differentiate between high and low anxious children [12].

Immediately after the forensic medical examination, the physician and the assistant individually rated the child using the PBRs. In addition, they rated whether they believed the child to be anxious during the examination, on a scale from 0 (not at all) to 4 (very anxious).

Child questionnaire

Following the forensic medical examination the child immediately, with the assistance of the participating parent, completed a questionnaire concerning anxiety and pain, whether the examination was bad or ugly, anxiety regarding ordinary visits to the doctor or a hypothetical re-examination, expected anxiety before the examination, and perception of the examining physician (Table 1).

The items in both child and parent questionnaire were constructed by the authors. Item 1-6 in the child questionnaire had facial as well as verbal descriptions.

Parent questionnaire

Following the forensic medical examination the participating parent immediately completed a questionnaire concerning anticipation and distress in their child and within themselves (Table 1).

Follow-up questionnaire

Three months after the forensic medical examination, a questionnaire concerning possible reactions to the examination and the child's recollection of the examination, was posted to the participating families. A reminder was posted after one week.

Data analysis

Frequency distributions were analyzed and Pearson Product-Moment Correlations were calculated. The relationship between the responses was examined through *t* tests. A hierarchical multiple regression analysis was used to predict the intensity of children's anxiety of a hypothetical re-examination.

RESULTS

During the study period, a total of 156 children aged 4 – 15 years of age were referred by the police for a forensic medical examination. Of these,

Table 1. List of questions and response items given to the children and their parents.

	<i>Children</i>	<i>Response items</i>
1	Were you anxious before the examination	5 point scale (0-4) with facial and verbal descriptions
2	Were you anxious during the examination	
3	Did the examination hurt	
4	Was it bad or ugly to have the examination	
5	Are you normally anxious of visiting a doctor	
6	Would you be anxious of having a new examination	1) Less unpleasant, 2) As I had expected, 3) More unpleasant
7	How unpleasant was the examination compared to what you had expected	
8	How nice was the doctor	
	<i>Parents</i>	<i>Response items</i>
1	How did you expect your child to react to the examination	11 point scale: 0 (not anxious) – 10 (very anxious)
2	How did your child react compared to what you had expected	1) Less anxious, 2) As I had expected, 3) More anxious
3	How was your expectations to the examination before your child was examined	11 point scale: 0 (not anxious) – 10 (very anxious)
4	How did you feel after the examination compared to what you had expected	1) Less anxious, 2) As I had expected, 3) More anxious
5	Have your child previously had the genitals examined	Yes - No
6	How do you think the examination went	11 point scale: 0 (good) – 10 (bad)
7	How did your child cooperate compared to previous medical examinations	1) Better, 2) The same, 3) Worse
8	How do you think your child would react to a new genital examination	11 point scale: 0 (not anxious) – 10 (very anxious)
9	How did you react to the examination	11 point scale: 0 (not anxious) – 10 (very anxious)
10	Do you think that your child felt offended by the examination	11 point scale: 0 (not offended) – 10 (very offended)

60 children (54 girls and 6 boys) subsequently returned a complete questionnaire package. Fifty-six of these 60 children (93 %) were Caucasian. The mean age of the children was 9.3 years of age (SD = 3.6).

The children in the study group were compared to the remaining children regarding age, sex and legal outcome, no differences were found between the two groups.

Physician's rating

The interrater reliability was investigated using independent ratings by two observers, obtained for 52 children. For the remaining 8 children, ratings were only investigated by one observer. The PBRS total score correlation was 0.64 ($p < 0.0005$). Two items (carrying and flailing) never occurred, and were omitted in further analyses. The sample was divided into groups by age (Table 2). Four items (screaming, refusal position, restrain and termination request) did not occur in all three age groups, found in only 2 – 8 % of the children, and they were therefore omitted in further analyses. The final PBRS thus consisting of 7 items; crying, clinging, verbal anxiety, verbal pain, stalling, muscular rigidity and emotional support. The Cronbach Alpha for the 7-item scale was 0.70.

The mean PBRS score was 1.3 (SD = 1.6), with an average in the youngest age-group of 1.8 and of 1.0 within the adolescent age-group. Of all the children, 70 % displayed at least one behavior during the

examination, the most frequent being clinging, verbal pain and muscular rigidity.

On a scale from 0 (not anxious) to 4 (very anxious), the physician rated 30 % as 0, 35 % as 1, 25 % as 2, 10 % as 3 and 0 % as 4 (Table 3), giving a mean anxiety of 2.2 (SD = 0.9). The PBRS ratings correlated significantly with the physicians ratings of anxiety ($R = 0.62$, $p < 0.0005$), the child's rating of anxiety ($R = 0.38$, $p < 0.005$), pain ($R = 0.41$, $p < 0.001$), and the experience of the examination being bad/ugly ($R = 0.32$, $p < 0.05$).

Children's rating

No significant difference was found between the children's anxiety before (mean = 1.4, SD = 1.2, range = 4) and during (mean = 1.2, SD = 1.2, range = 4) the colposcopic examination. When combining the two highest item scores (3 and 4), 16 % of the children were anxious during the examination, 14 % reported pain associated with the examination and 22 % experienced the examination as being bad/ugly. A total of 21 % were anxious of a hypothetical re-examination whereas only 6 % reported to be anxious of ordinary visits to the doctor (Table 3).

The children were significantly more anxious of a hypothetical re-examination (mean = 1.3, SD = 1.4, range = 4) compared to ordinary visits to the doctor ((mean = 0.5, SD = 0.9, range = 4) $t = 5.0$, $p < 0.0005$), with a medium effect size (Cohen's $d = 0.68$).

Table 2. Percentage and number of sample responding with behaviors from the PBRS.

	Full sample (N = 60) % (N)	Age 4-7 (N = 23) % (N)	Age 8-11 (N = 17) % (N)	Age 12-15 (N = 20) % (N)
Crying	10 (6)	9 (2)	6 (1)	15 (3)
Clinging	25 (15)	26 (6)	35 (6)	15 (3)
Verbal anxiety	8 (5)	9 (2)	12 (2)	5 (1)
Verbal pain	37 (22)	57 (13)	24 (4)	25 (5)
(Screaming)	7 (4)	13 (3)	6 (1)	0
Stalling	8 (5)	9 (2)	12 (2)	5 (1)
(Carrying)	0	0	0	0
(Flailing)	0	0	0	0
(Refusal position)	8 (5)	17 (4)	6 (1)	0
(Restrain)	2 (1)	4 (1)	0	0
Muscular rigidity	23 (14)	17 (4)	41 (7)	15 (3)
Emotional support	15 (9)	17 (4)	12 (2)	15 (3)
(Termination request)	3 (2)	4 (1)	0	5 (1)

Table 3. Frequency distribution of item responses in percentages.

Variable	0 (not at all)	1	2	3	4 (a lot)
<i>Physician</i>					
Children's anxiety during the examination	30	35	25	10	0
<i>Children - Immediately after the examination (N = 60)</i>					
Anxiety before the examination	27	42	13	7	11
Anxiety during the examination	35	32	17	10	6
Anxiety of a hypothetical re-examination	43	17	19	9	12
Anxiety of ordinary visits to the doctor	72	17	5	2	4
Pain associated with the examination	35	33	18	7	7
Bad/ugly to have the examination	28	29	21	10	12
<i>Children - Three months after the examination (N = 36)</i>					
Anxiety during the examination	22	33	25	6	14
Anxiety of a hypothetical re-examination	33	22	17	14	14
Pain associated with the examination	42	25	28	0	5
Bad/ugly to have the examination	31	28	22	14	5

In total, 43 % of the children experienced the examination as less unpleasant than they had expected, 28 % as they had expected and 29 % as more unpleasant than they had expected (Figure 1). The children who rated the examination as more unpleasant, were also more anxious during the examination ($t = 2.0$, $p < 0.05$), experienced the examination to be more bad/ugly ($t = 2.3$, $p < 0.05$), reported more pain during the examination ($t = 4.3$, $p < 0.0005$) and were more anxious of a hypothetical re-examination ($t = 3.6$, $p < 0.001$).

Overall, 88 % of the children described the physician as being very nice, 10 % as rather nice and 2 % as not nice.

The follow-up questionnaire was returned by 36 children, giving a

response rate of 60 %. The responders were compared to the non-responders according to age, sex and legal outcome, no differences were found between the two groups.

Paired t-test revealed no significant differences concerning the children's distress rating, immediately after the examination and three months later.

Parent's rating

Parental expectations regarding the child's reaction to the examination

On a scale from 0 (not anxious) to 10 (very anxious), 7 % of the parents expected their child not to be anxious during the examination, 9 % expected

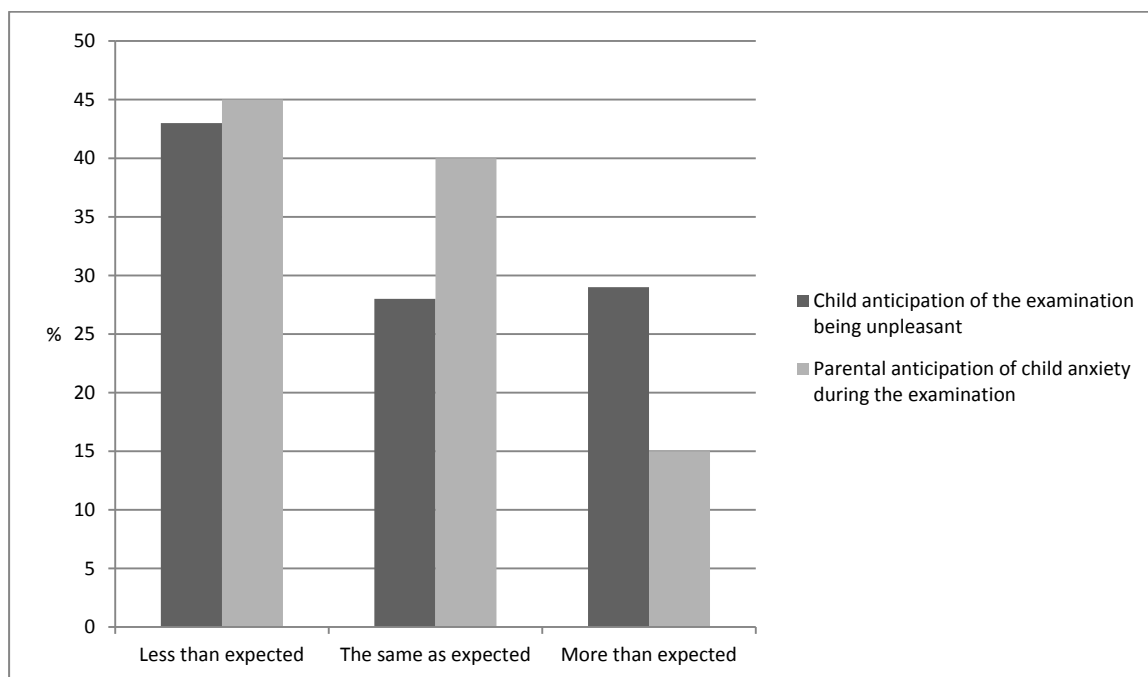


Figure 1. Child and parental anticipation of the child's experience regarding the examination.

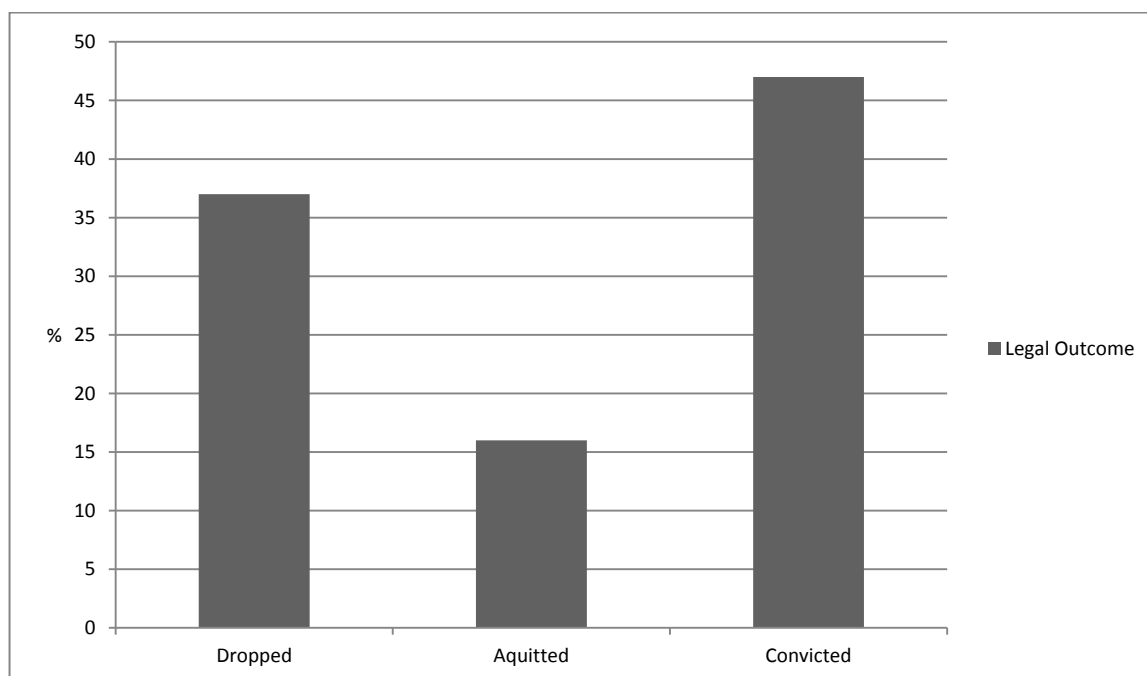


Figure 2. Legal outcome in the 56 known cases.

their child to be very anxious. The mean rating of the parental expectations regarding their child's anxiety was 5.0 (SD = 2.8, range = 10).

Overall, 45 % of the parents rated that their child had been anxious to a lesser extent than they had expected, 15 % rated it to be more (Figure 1).

There was a significant decrease in parental expectations regarding the child's anxiety of a hypothetical re-examination (mean = 3.1, SD = 3.0), compared to the actual examination ((mean = 5.0, SD = 2.8) $t = 4.9$, $p < 0.0005$).

Significant positive correlations were found between the parental expectations to the child's anxiety regarding the examination, and the children's anxiety during the examination ($r = 28, p < 0.05$), the experience of the examination being bad/ugly ($r = 26, p < 0.05$) and the experience of pain during the examination ($r = 34, p < 0.01$).

Parental reactions to the examination

In total, 6 % of the parents were not anxious before the examination, whereas 15 % were very anxious. The mean parental anxiety being 4.8 (SD = 3.2, range = 10).

After the examination, 52 % of the parents were anxious to a lesser extent than they had expected, 10 % were more anxious.

Overall, 55 % of the parents thought that the examination went well, no one thought it went bad (mean = 1, SD = 1.7, range = 7).

Regarding the children's cooperation during the examination, 27 % of the parents rated their child to cooperate better compared to prior medical examinations, 67 % the same and 13 % rated their child to cooperate worse.

No children had had an anogenital colposcopic examination before.

Of the 36 parents who returned the follow-up questionnaire regarding their child's reaction to the examination, only 1 thought that their child subsequently had reacted negatively.

Legal outcome

Information about legal outcome was subsequently obtained for 56 children. Hereof, 21 (37 %) were dropped by the police and therefore not proceeded in court, 9 (16 %) were brought to court with acquittal and 26 (47 %) were brought to court with conviction (Figure 2).

When dividing the children into groups; one in which the offender was convicted (group 1, $N = 26$), and one with no conviction (group 2, $N = 30$), a significantly higher PBRS score was found in group 2 (mean = 1.9, SD = 1.9, range = 5), compared to group 1 (mean = 0.7, SD = 0.9, range = 2) $t = 2.9, p < 0.005$, with a large effect size (Cohen's $d = 0.8$). No differences between the two groups were found for the other variables including the age of the child.

DISCUSSION

The result of our investigation suggests that the PBRS is a suitable method for measuring observational distress in children undergoing a forensic medical examination. The interrater reliability was considered acceptable, and significant correlations were obtained, between both the PBRS ratings and the physician's ratings of anxiety, and between the PBRS ratings and the child's rating of anxiety and pain during the examination along with the experience of the examination being bad/ugly, supporting the validity of the scale.

The PBRS has primarily been used on children exposed to painful medical procedures, and has not previously been used on children undergoing a forensic medical examination after alleged child sexual abuse.

A study has been published concerning reliability and validity of the Genital Examination Distress Scale (GEDS), especially designed to measure distress during the anogenital phase of a forensic medical examination [13]. This scale, however, was not available at the time of the design of this present study, but the 7-item version of the PBRS used, is very similar to the GEDS.

In our study, the most frequently expressed behavioral distresses by children of all age groups were clinging, verbal pain and muscular rigidity, with 70 % of all the children responding with at least one behavior during the examination, the youngest age-group having an average score of 1.8.

Of the four items omitted from further analyses (screaming, refusal position, restrain and termination request), it is noteworthy that although small scores, they are the strongest negatives in the PBRS, and they are mostly seen in the youngest age-groups.

Almost half of the children (43 %) experienced the examination as less unpleasant than they had expected. Not surprisingly, the children who experienced the examination as more unpleasant than they had expected (29 %) also experienced more distress during the examination.

Our results concerning the rating of anxiety and pain during the examination, and the anxiety of a hypothetical re-examination, are almost identical to the results found by Lazebnik et al (1994). The children were significantly more anxious of a hypothetical re-examination, than of ordinary visits to the doctor.

The experience of the examination being bad/ugly was the distress variable with the highest score, however, to the best of our knowledge, there has been no studies investigating this factor. One could speculate that the adolescents experience of the examination being scary or embarrassing, as found by Mears et al (2003), could be a synonym term for the bad/ugly experience.

Since only sparse data exists regarding the emotional impact anogenital examinations have on non-abused or only physically abused children [14], it is not possible to know whether experience of the examination being bad/ugly might reflect re-victimization of the child, or if it is a normal reaction to an abnormal situation. A Norwegian study, which included 306 non-abused preschool children having an anogenital examination, concluded that the examination was not experienced as a traumatic event [15]. Further research is therefore needed, to identify preparatory techniques to reduce this stress factor during forensic medical examinations.

Almost half of the parents evaluated both themselves and their children to be less anxious during the examination than they had expected. Most of the parents thought the examination went well, and there was a significant decrease in parental expectations regarding the child's anxiety of a hypothetical re-examination, compared to the actual examination. However, 10 – 15 % of the parents rated both themselves and their children to be more anxious, and that their children had cooperated worse than they had expected. Also we found that the parental expectations regarding the child's reaction to the examination were significantly associated with the intensity of the child's distress during the examination. These results indicate that a careful preparation of the parents prior to the procedure to relieve their anxiety might contribute to reduce the children's distress, since parental anticipatory anxiety surely influences the child negatively [16].

Both the physician and the parent's perception of the child's distress were significantly related to the child's own distress rating, which indicates that both physician and parent were responsive to the child's emotional state.

At the three month follow-up the children had similar distress ratings as immediately after the examination, indicating stability of the ratings. Only one parent thought that their child subsequently had reacted negatively to the examination.

Contrary to our expectations, we found significantly higher PBRS scores

in the group with no conviction, which indicate that lack of behavioral distress, as rated by the physician, might be related to the possibility of sexual abuse.

One study found that approximately one third of the sexually abused children reported or exhibited no visible symptoms [17]. This needs, however, to be further investigated.

Possible explanations to the lack of behavioral distress could be, that traumatized children have a tendency to dissociate during the examination, perhaps due to the feeling of re-victimization, or that the child has been habituated to situations with anogenital focus. Maybe the children were relieved of the disclosure of sexual abuse, and that they therefore saw the examination as supportive of their situation.

In the interpretation of the result it is, however, important to realize, that there might be sexually abused children also in the group with no conviction in court, and that lack of conviction might be related to children not being able to disclose abuse or effectively participate in the legal process due to distress, as described with "the child sexual abuse accommodation syndrome" [18].

The conclusions of this study being; that the relatively high level of both parental and child distress regarding the forensic medical examination, emphasizes the need for developing better preparatory and stress reducing procedures, to avoid both the possible re-victimization and the negative influence of parental anticipatory anxiety on the child.

Also the finding of significantly higher PBRs scores in the group with no conviction, could indicate that lack of behavioral distress, as

rated by the physician, might be related to the possibility of sexual abuse.

LIMITATIONS

Less than half of the children (38 %; 60 out of 156 children) referred by the police for a forensic medical examination during the running period of this study were included, which may have resulted in selection biases. The children in the study group were, however, compared to the remaining children regarding age, sex and legal outcome, and no differences were found between the two groups.

Also we had no information regarding previous or current psychopathology, as well as socioeconomic status, for the participating children and parents, which made it impossible to control for the possible influence of these factors.

The behavioral rating scale used in this study (PBRs) has not previously been used with this sample type, and thus lack comparative data. In future studies, the behavioral rating scale (GEDS) developed by Gully et al (1999) should be used.

ACKNOWLEDGMENTS

This study was supported with a grant by the Research Foundation, University of Aarhus, Denmark.

The authors thank Birthe Bjørn for assistance with manuscript preparation.

REFERENCES

- [1] Lazebnik R., Zimet G.D., Ebert J., Anglin T.M., Williams P., Bunch D.L. et al. How children perceive the medical evaluation for suspected sexual abuse. *Child Abuse & Neglect*, 1994, 18, 739-745.
- [2] Waibel-Duncan M.K., Sanger M. Understanding and reacting to the anogenital exam: Implications for patient preparation. *Child Abuse & Neglect*, 1999, 23, 281-286.
- [3] Steward M.S., Schmitz M., Steward D.S., Joye N.R., Reinhart M. Children's anticipation of and response to colposcopic examination. *Child Abuse & Neglect*, 1995, 19, 997-1005.
- [4] Mears C.J., Heflin A.H., Finkel M.A., Deblinger E., Steer R.A. Adolescents' responses to sexual abuse evaluation including the use of video colposcopy. *The Journal of Adolescents Health*, 2003, 33, 18-24.
- [5] Rheingold A.A., Davidson T.M., Resnick H., Self-Brown S., Danielson C.K. The relationship between knowledge and child and caregiver distress during the medical examination for child sexual abuse. *Journal of Child Sexual Abuse*, 2013, 22, 552-571.
- [6] Marks S., Lamb R., Tzioumi D. Do no harm: The psychological stress of the medical examination for alleged child sexual abuse. *Journal of Paediatrics and Child Health*, 2009, 45, 125-132.
- [7] Gully K.J., Hansen K., Britton H., Langley M., McBride K.K. The child sexual abuse experience and the child sexual abuse medical examination: Knowing what correlations exists. *Journal of Child Sexual Abuse*, 2000, 9, 15-27.
- [8] Duncan M.K.W., Sanger M. Coping with the pediatric anogenital exam. *Journal of Child and Adolescent Psychiatric Nursing*, 2004, 17, 126-135.
- [9] Perna R.B., Kiefner M. Long-term cognitive sequelae: Abused children without PTSD. *Neuropsychology Child*, 2013, 2, 1-5.
- [10] Shapori D.N., Kaplow J.B., Amaya-Jackson L., Dodge K.A. Behavioral markers of coping and psychiatric symptoms among sexually abused children. *Journal of Traumatic Stress*, 2012, 25, 157-163.
- [11] Kogan S.M. The role of disclosing child sexual abuse on adolescent adjustment and revictimization. *Journal of Child Sexual Abuse*, 2005, 14, 25-47.
- [12] Katz E.R., Kellerman J., Siegel S.E. Behavioral distress in children with cancer undergoing medical procedures: Developmental considerations. *Journal of Consulting and Clinical Psychology*, 1980, 48, 356-365.
- [13] Gully K.J., Britton H., Hansen K., Goodwill K., Nope J.L. A new measure for distress during child sexual abuse examinations: The genital examination distress scale. *Child Abuse & Neglect*, 1999, 23, 61-70.
- [14] Britton H. Emotional impact of the medical examination for child sexual abuse. *Child Abuse & Neglect*, 1998, 22, 573-579.
- [15] Gulla K. Hode, skulder, kne og tå – og midt på? Hvordan ikke-misbrukte førskolebarn opplever en undersøkelse av underlivet. NTNU, Trondheim, 2004.
- [16] Shemesh E., Newcorn J.H., Rockmore L., Shneider B.L., Emre S., Gelb B.D. et al. Comparison of parent and child reports of emotional trauma symptoms in pediatric outpatient settings. *Pediatrics*, 2005, 115, 582-589.
- [17] Kendall-Tackett K.A., Williams L.M., Finkelhor D. Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 1993, 113, 164-180.
- [18] Summit R.C. The child sexual abuse accommodation syndrome. *Child Abuse & Neglect*, 1983, 7, 177-193.