Identifying and Reporting Child Sexual Abuse in Health Care Settings

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever wondered when physical contact and signs of affection appear to cross the line? Have you been uncertain about how to screen for or ask about something that happened and how a child or adolescent feels about it? Have you been perplexed about the criteria for child sexual abuse and when and to whom your suspicions should be reported? Have you been hesitant to document your observations and impressions in the medical record? If you have, then the following case vignette and discussion should prove useful.

CASE VIGNETTE

A 13-year-old girl with an unremarkable psychiatric and medical history presented to the outpatient clinic for her annual checkup. She was accompanied by her mother. During the interview, the girl's mother reported concern over her daughter's declining school performance over the past 6 months, as she had always been at the top of her class but was now getting lower grades. The patient noted she had trouble keeping up with her classes, as she was often sent home by the nurse for complaints of stomach pain, and she had difficulty concentrating. Her mother noted that this pain had been evaluated by specialists, and the results were inconclusive.

Several months later, the patient returned to the clinic with her mother for vaginal itching and burning with urination that had been going on for about a day. She was noticeably irritable during the interview and was unwilling to answer questions. A pelvic examination was performed, and she was found to have malodorous greenish-yellow discharge. Microscopic evaluation was positive for mobile trichomonads, confirming the diagnosis of trichomoniasis. A urine pregnancy test was also ordered, which was negative. On further interview, without her mother in the room, the patient endorsed a history of sexual activity with an adult family friend who had been living in their house for the past year. The sexual acts often took place when her mother was at work. The patient reported that she had yet to tell her mother, as she feared she would get in trouble.

DISCUSSION

What Is Meant by the Term *Sexual Abuse*?

The Centers for Disease Control (CDC) defines *sexual abuse* as "any completed or attempted (noncompleted) sexual act, sexual contact with, or exploitation (ie, noncontact sexual interaction) of a child by a caregiver."[1] A sexual act includes "contact involving penetration . . . between the mouth, penis, vulva, or anus of the child and another individual" or any amount of penetration of the anal or genital opening. Sexual contact includes the intentional touching of

Clinical Points

- There are numerous barriers to diagnosing child sexual abuse, leaving it underreported and undertreated, making it a problem that is difficult to address from a public health standpoint.
- Health care providers are mandatory reporters of suspected child abuse; as such, they should be familiar with the state laws regarding the reporting of suspected or confirmed abuse as well as the local resources available for victims of abuse.
- Childhood sexual abuse has been associated with long-term negative medical and psychosocial effects.

a child directly on the genitalia, anus, groin, breast, inner thigh, or buttocks. Sexual contact can be direct or over clothing. Sexual exploitation includes exposing a child to sexual activity, filming a child in a sexual manner, sexual harassment of a child, and prostitution of a child. Sexual exploitation includes sexual trafficking, which is the transporting of children for the purpose of forced sexual acts.[1] As a person must be a legal adult to consent to a sexual act, any sexual act between an adult and a child is considered a form of child sexual abuse.[2]

When and to Whom Should Your Suspicion of Sexual Abuse Be Reported?

There are multiple reasons why childhood sexual abuse can be difficult to diagnose; therefore, it often goes underreported. First, children are typically fearful of disclosing sexual abuse until later in life or until they can communicate when sexual abuse is occurring. Additionally, the symptoms of abuse are nonspecific. Children who have been sexually abused may present to a hospital with evidence of a urinary tract infection, genital injury, abdominal pain, or constipation. Behavioral abnormalities can also arise, with behavioral problems, thoughts of suicide, and symptoms of posttraumatic stress disorder (PTSD), such as nightmares, flashbacks, and startle reactions without a clear trauma. Sexually transmitted infections (especially gonorrhea, chlamydia, syphilis, trichomoniasis, or human immunodeficiency virus [HIV] infections) without a known history of sexual partners suggest sexual abuse, as can genital injury that has been detected on the physical examination that is not explained by trauma; however, these are relatively uncommon findings in victims of child sexual abuse.[3,4]

Sexual abuse should be reported as soon as it is suspected, especially if there is ongoing concern for the child's safety. The Federal Child Abuse Prevention and Treatment Act (CAPTA) requires that all states have a system for mandatory reporting of suspected child abuse or neglect.[5] Every state has a toll-free phone number to report suspected child abuse or neglect. States determine who is considered a mandatory reporter; however, health care providers are almost always included.[5] Collateral information from the suspected perpetrator is not required before reporting cases of suspected sexual abuse.[6] The victim's caretakers may be notified of the report being filed, but the emphasis should be placed on ensuring the child's immediate safety.[7]

Who Is Responsible for the Investigation of Cases of Possible Sexual Abuse?

Child Protective Services (CPS) and law enforcement are responsible for investigating cases of suspected sexual abuse. Typically, CPS is involved if the perpetrator is a caretaker of the victim, and law enforcement is involved if the perpetrator is not a caretaker of the victim. CPS also becomes involved if there are signs of neglect that led to the sexual abuse.[2]

Most areas of the country have an infrastructure to investigate and manage cases of suspected sexual abuse; these resources include child advocacy centers and specialized clinics. If there is a concern for sexual abuse, a referral to these centers is recommended so that further evaluation can proceed. If there is any suspicion that bodily fluids were exchanged, the child should be referred immediately to an emergency department or to a specialized clinic for collection of forensic evidence. A forensic evaluation is most reliable when completed within 72 hours of an incident, but it can provide additional information during the 7 days following the abuse. The emergency department or specialized clinic will be able to determine if HIV prophylaxis, sexually transmitted infection prophylaxis, or pregnancy prophylaxis is warranted.[3,8] If there is no immediate access to these facilities or if there is a safety concern regarding the child returning home, the child should be admitted to the hospital inpatient unit for further evaluation and as a protective measure.[9]

How Much Detail Should You Provide in the Medical Record Involving Possible Sexual Abuse?

Providing details of the history, examination, and laboratory results for the medical record can protect the child, as it assists the agencies involved in future investigations and prevents unnecessary repetition of the interview and the exam, both of which can be distressing to children. When documenting the interview, quotations should be used, and the record should be clear about which details were provided by the child and which were provided by the caregiver.[8] If a physical examination was performed, details of the examination (eg, signs suggestive of sexual abuse, such as lacerations or bruising of the genital area) should be documented, as they may be found only within 7 hours of the abuse.[3] Photographs of any anogenital findings are also recommended; however, victims may find this method of documentation threatening, and both the child and child's caretaker should provide consent for taking such images.[3,7] If photographs cannot be taken, a detailed description of any findings should be documented to prevent repetition of the exam, as this can be stressful for the child.[7,8]

Who Is at Risk for Being Abused and Who Are Most Likely to Be the Perpetrators?

Impulsive children and those who are considered emotionally needy are at higher risk for sexual abuse.

Children with a history of psychiatric problems, learning disabilities, physical disabilities, or substance use are also more vulnerable to abuse. Children who have been separated from their families, including those who are in out-of-home placements, who are in detention, and who are living in war zones or post-war settings are at especially elevated risk. Victims of sexual abuse are also at risk for being revictimized later in life (ie, during their childhood and adult years).[2] Perpetrators typically report that their targets were often children who were both available and easily manipulated.[10]

Family risk factors include poor parent-child relationships, poor relationships between parents, and the presence of a nonbiologically-related male in the home. Socioeconomic status and race have not been associated with sexual abuse.[10] Perpetrators are often adults (between the ages of 20 and 29 years of age) in a position of trust (such as parents, aid workers, hospital workers, priests, and teachers); this further complicates detection.[10]

Where and When (location and age) Does Sexual Abuse Tend to Occur?

Children are more likely to be abused when they are preadolescents (aged 8-12 years old).[11] Sexual abuse typically occurs in the home (particularly if the child lives in a single-parent home), at family events, or in the perpetrator's home.[10]

How Can Children and Adolescents Who Are Being Abused Act and Feel?

Mental health professionals and other health care providers need to remain vigilant so that they can screen for potential signs and symptoms of sexual abuse in children and adolescents. Collateral information from caregivers is often crucial to the recognition and reporting of abuse. Parents may describe their concerns about abrupt behavioral changes in their child, including having difficulty sleeping alone, persistent nightmares, paranoia during darkness, and new-onset enuresis. Observations of behavioral change (such as social withdrawal, frequent irritability and anger, and unexplained sadness) may also be reported.[12,13]

Although adolescents can typically express subjective feelings and mood changes, younger children may be unable to reliably report these symptoms due to their neurodevelopmental stage. Instead, presence of somatic features (such as headaches, fatigue, malaise, and gastrointestinal upset) can be monitored. In addition, health care providers look for visible signs of distress, especially during questioning. Common examples of distress include separation anxiety from caregivers, an unwillingness to be examined, and a refusal to undress.[14]

How Can Potential Victims of Sexual Abuse Be Interviewed and Treated?

Routine screening for sexual trauma has been proposed as a practice that should occur across mental health and primary care settings. Identification of salient items would then prompt providers to conduct a more thorough examination. A 2012 prospective cohort study[15] in the Netherlands demonstrated that systematic screening in emergency departments led to significantly improved detection rates of child abuse. Similar studies[16] that used screening tools suggested that it is potentially helpful even in pediatric populations not suspected of being abused. Examples of childhood sexual abuse screening tools include Salvagni and Wagner's questionnaire,[16] "Spotting the Signs,"[17] and the PedHITSS[18] (Pediatric Hurt-Insult-Threaten-Scream-Sex).

The clinical interview should focus on collecting nonbiased information surrounding the abuse. Its primary purpose will differ from a forensic evaluation, as this interview is not meant to judge the veracity of the abuse but to gather information to report to the authorities. As suggested by the American Academy of Child and Adolescent Psychiatry,[7] the assessment should take place in a relaxing and nonstressful environment. An appropriate developmental, medical, psychiatric, and social history should be obtained, without suggestive questioning. Children who cannot verbalize may require an interview with the use of anatomically correct dolls and drawings. Collateral information should be obtained from all caregivers. It is essential to realize that false allegations and questionable credibility may arise and may be difficult to distinguish. Suggested strategies to gather unbiased information include noting specific details and words used to describe the abuse, emotional responses during the interview, the child's behavior during the abuse, and how the child utilizes any dolls or drawings.

A thorough physical examination should be conducted before the end of the interview. Health care providers should remember that a normal examination does not exclude the possibility of sexual abuse. Research has shown that more than 95% of childhood sexual abuse victims have normal genital findings.[10] Some factors that may be associated with diagnostic findings include age > 13 years, a history of genital penetration, and the timing of the abusive injury.[19]

Initial evaluation for sexually transmitted diseases typically includes NAATs (nucleic acid amplification tests) for *C. trachomatis*, *N. gonorrhoeae*, and trichomoniasis. If there is concern for bacterial vaginosis or candidiasis, wet mount with measurement of pH and whiff test should also be done. Serum samples can be taken to rule out hepatitis B, HIV, and syphilis.[20] The decision to give prophylaxis for HIV, sexually transmitted infections, and pregnancy typically takes place at the emergency department or specialized clinic during the forensic evaluation to prevent additional stress from repeat testing. However, if the child reports dysuria in the office, a urinalysis should be ordered at that time for further evaluation.[8]

Treatment after childhood sexual abuse has occurred is warranted, as untreated victims experience significant mental health problems. The disorders most often detected include PTSD, depressive disorders, and anxiety disorders.[21] For those who are suffering from serious affective symptoms, evidence-based trauma-focused interventions are the most robust treatments. The components of such interventions include psychoeducation (about the impact of trauma), learning about affective modulation skills, developing

exposure-response elements, and cognitive reprocessing.[22] Some evidence suggests that gradual exposure to traumatic memories may be the most important aspect, as it can reduce symptoms of PTSD.[23,24] The most effective and widely used modality is trauma-focused cognitive-behavioral therapy, which incorporates all the above components into a brief, time-limited psychotherapy. Several clinical trials have reported success in terms of short- and long-term response rates.[25] Although trauma-focused therapies are the primary intervention, psychopharmacologic approaches can be considered for more severe or persistent symptoms. At present, there are no "gold standard" guidelines for the use of psychotropics for victims of childhood sexual abuse. Instead, many practitioners base their treatments on practice parameters for the treatment of PTSD. Selective serotonin reuptake inhibitors are often recommended, despite the paucity of evidence for their use in children and adolescents. Other agents to consider include α-2 agonists (eg, guanfacine, clonidine), prazosin, mood stabilizers (carbamazepine and valproic acid), and second-generation antipsychotics (risperidone and quetiapine). However, the study of these agents has been limited to a small number of open-label trials of short duration, with low patient numbers and in children or adolescents with several psychiatric comorbidities.[26] As such, their routine use is not typically recommended.

What Are the Downstream Consequences (medical and psychiatric) of Having Been Sexually Abused?

The consequences of childhood sexual abuse involve both physical and psychological problems. A host of studies have linked persistent negative medical sequelae after such abuse. These conditions include chronic urinary retention, neuroendocrine dysfunction, premenstrual distress, and an increased risk of recurrent sexually transmitted diseases.[10] Sexual abuse has been associated with acute and long-term mental health consequences, including PTSD, depression, and substance use disorders. As victims of sexual abuse age, they are often involved in sexual revictimization acts in adolescence and adulthood.[27] In addition, other behavioral disturbances occur in relation to psychological distress, which can lead to an increased risk of HIV infection, adolescent pregnancy, homelessness, marital conflict, divorce, and pedophilia.[10]

Regarding these sequelae, the literature confirms specific risk factors (including the use of force, physical injury, type of penetration, elevated frequency, prolonged duration, lack of caregiver support, and closeness of the relationship between the victim and the perpetrator) that may increase the severity and persistence of these problems.[12] Protective factors include baseline resilience of the child or adolescent, learned coping strategies, positive caregivers, and access to professional resources.[12]

CASE VIGNETTE FOLLOW-UP

The patient was started on metronidazole with resolution of symptoms. Child protective services and the police were alerted for further investigation. Her mother was alerted to the sexual abuse, and she removed the perpetrator from the home. The perpetrator was subsequently charged with rape. The patient began seeing a psychologist with expertise in child sexual abuse cases, and her mood and school performance improved with outpatient psychotherapy.

CONCLUSION

Child sexual abuse is a public health problem that is grossly underreported due to the difficulty with its detection. Barriers to diagnosing sexual abuse include the child's fear of the repercussions of reporting, the nonspecific findings of most cases of sexual abuse, and the influential role the perpetrator often plays in the child's life. Detailed documentation of the story and a comprehensive physical examination by a health care provider is critical to prevent repeated evaluations and further distress in the victim. Physicians and other health care providers who work with children should be familiar with the mandatory reporting laws for suspected child sexual abuse (as they vary state to state), as well as the location of child advocacy centers where further evaluation should take place. Detection of child sexual abuse is critical, as the consequences of childhood sexual abuse are both physical and psychological and can last into adulthood.

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