

Child Sexual Abuse: Are Health Care Providers Looking the Other Way? Shelia Savell, MSN, RN

Child sexual abuse (CSA) is defined as any sexual activity with a child when consent is not or cannot be given; it includes sexual penetration, sexual touching, exposure, and voyeurism (Berliner, 2000; Finkelhor, 1979). Child sexual abuse is a crime and all states have laws related to CSA that specify the age at which an individual can consent to sexual contact, usually between 14 and 18 years (Myers, 1998). In addition, every state mandates that professionals, including physicians and nurses, report suspected child abuse to child protection agencies. The mandate does not require the ability to prove the suspicion, only that reporting must occur any time there is suspicion of CSA. However, multiple studies have demonstrated that professionals do not always report suspected child abuse (Delaronde, King, Bendel, & Reece, 2000; Horner & McCleery, 2000; Ladson, Johnson, & Doty, 1987; Lentsch & Johnson, 2000).

Barriers to reporting CSA include inadequate knowledge and training related to CSA, lack of confidence in the evidence collected, fear of harming the child and/or family, lack of confidence in the ability of the social service agency to deal with the investigation, concerns about interacting with the legal system, loyalty to the family, and the belief that an accusation might lead to undesirable consequences (Delaronde et al., 2000; Leder, Emans, Hafler, & Rappaport, 1999; Vulliamy & Sullivan, 2000; Willis & Horner, 1987). In addition, Willis and Horner (1987) in their survey of 101 Family Medicine physician faculty and residents found that many physicians did not believe CSA actually occurred at the rates indicated by the literature.

In 2002, 56% of reports of alleged child abuse and neglect were made by professionals. The remaining 44% were made by parents, relatives, friends, alleged victims, alleged perpetrators, and anonymous callers. The largest percentage (16.1%) of professional reports were made by educational personnel, followed by legal and law enforcement personnel (15.7%), and social services personnel (12.6%). Medical personnel reports accounted for only 7.8% of professional reports (United States Department of Health and Human Services [US DHHS], 2004).

Physicians, nurses, and other health care professionals have an important role to play in identifying and treating CSA (American Academy of Pediatrics [AAP], 1999). They can afford the child a safe and private environment in which to disclose and they have the skills to assess, document, and treat or refer for treatment of CSA (Diaz & Manigat, 1999). Clearly, health care providers must expand their role in identifying and reporting CSA. The American Academy of Pediatrics (1999) and the American Professional Society on Abuse of Children (1998) both recommend that providers observe for signs and symptoms of child sexual abuse during routine encounters. They agree screening for abuse (physical or sexual) should be incorporated in every well-child visit.

Criteria for Initiating Preventive Health Services

Both the U.S. Preventive Services Task Force (USPSTF) and the *Journal of the American Medical Association* (JAMA) evidence-based medicine working groups have developed criteria for evaluating the initiation of preventative services. They propose that before screening for any health problem is implemented the following criteria must be considered:

- (a) Is the health problem serious?
- (b) Is a clear diagnosis available?
- (c) Is there evidence that earlier intervention works?
- (d) Does a suitable screening test exist?
- (e) What are the potential harms?
- (f) Is screening cost-effective? (Barratt et al., 1999; Goodyear-Smith, 2002; USPSTF, 2004)

These criteria provide a framework to discuss the value of screening for CSA. The main objective is to determine whether the benefits of screening are greater than the potential harm of screening.

Seriousness of the Problem

In the United States, the number of substantiated cases of CSA decreased by 40% between 1992 and 2000; however, the numbers have remained stable since then. During 2000, 2001, and 2002, substantiated cases of CSA occurred at a rate of 1.2 per 1,000 children (Jones, Finkelhor, & Kopiec, 2001; US DHHS, 2004). These numbers only include cases reported to child protective services and do not include cases in which the abuser was not a caretaker. Cases involving noncaretakers are typically handled by the

criminal justice system, and there is currently no national database with information related to those cases. According to Finkelhor (1994), 20% to 25% of women and 5% to 15% of men experienced contact sexual abuse during childhood. A recent review of English-language articles published after 1989 that contained data on CSA (n=117), reported prevalence rates of 16.8% and 7.9% for adult women and men, respectively (Putnam, 2003). This means that approximately 160 to 250 per 1,000 women and 50 to 150 per 1,000 men report experiencing child sexual abuse, though only 1.2 cases per 1,000 children are reported and substantiated by child protective services. The difference in the number of cases of CSA identified during childhood and the prevalence numbers obtained from adult retrospective reports [are] disturbing. It is difficult to know the actual prevalence of CSA; however, it is clear that the issue deserves attention and action on the part of health care providers.

Multiple negative sequelae have been associated with a history of CSA. Sexually abused children are more likely to be diagnosed with depression, attempt suicide, have lower self-esteem, and have more anxiety than their nonabused peers. They may also develop post-traumatic stress disorder (Berliner & Elliott, 2002). Adolescents with a history of CSA exhibit more risk-taking behaviors and are at higher

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risk of becoming pregnant (Putnam, 2003). The National Comorbidity Survey found that adult respondents who reported a history of CSA had a higher prevalence of psychiatric disorders than those not reporting CSA. They were almost twice as likely to have lifetime depression, mood, anxiety, or substance abuse disorders (Molnar, Buka, & Kessler, 2001). Putnam (2003), who did a 10-year review of the literature on CSA, concluded that a history of CSA was associated with major depression, borderline personality disorder, somatization disorder, post-traumatic stress disorder, dissociative identity disorder, bulimia nervosa, and an increase in alcohol and drug abuse. CSA has both acute and long-term detrimental effects, and it is a serious health problem in childhood that frequently carries over to adulthood.

Is a Clear Diagnosis Available?

The American Academy of Pediatrics (AAP) Committee on Child Abuse and Neglect (1999) and the American Professional Society on Abuse of Children (1998) maintain current recommendations for classifying findings on CSA. Specific guidelines for deciding to report or not to report CSA are provided by AAP. History, physical, and laboratory data are analyzed to establish the level of concern, which then dictates the reporting decision (AAP, 1999).

Adams (2001) has proposed a classification system based on the AAP recommendations and on current research. Part 1 of the system offers health care providers a means to categorize physical and laboratory findings and children's statements and behaviors possibly related to CSA. The findings are categorized as normal, normal variants of other causes, not specific (may or may not be related to CSA), concerning (have been associated with CSA), or clear evidence of CSA. In Part 2 the likelihood of abuse is assessed by determining which class the evidence places the child in: no indication of abuse, possible abuse, probable abuse, or definite evidence of abuse (Adams, 2001). It is important to note that only 4% of children evaluated for sexual abuse have abnormal examinations at the time of the assessment and the child's history is the single most important diagnostic criterion (Heger, Ticson, Velasquez, & Bernier, 2002). The diagnosis of CSA is not always clear; however, a health care provider who is up-to-date on evidence-based practice guidelines and who uses expert resources should be able to recognize CSA and make the decision whether or not to report with confidence.

Early Intervention

It is difficult to compare CSA victims who receive early intervention with those who do not. The National Comorbidity Survey found that the prevalence of lifetime psychiatric disorders was significantly higher among those who did report experiencing CSA than among those who did not report CSA (Molnar et al., 2001). Also, studies examining the effect of specific interventions on victims of CSA have demonstrated an improvement in psychopathology (Berliner & Elliott, 2002). Abuse-specific cognitive behavioral treatment (CBT) has been very effective in reducing post-traumatic stress reactions. Children whose parents also receive treatment have less depression and fewer behavior problems (Berliner & Elliott, 2002; Cohen, Deblinger, Mannarino, & Steer, 2004). Early identification and treatment of child sexual abuse has the potential to minimize the acute and long-term effects of the abuse (Jenny, 2002). Early recognition and reporting of child maltreatment may also lead to preventing repeated abuse of the victim and abuse of other children (Johnson, 2002).

Screening

Currently there is no evidence-based CSA screening tool. In fact, only one study has addressed the development of a specific screening procedure (McGlinchey, Keenan, & Dillenburg, 2000). In that study, stimulus equivalence training, a behavioral-analytic procedure, was used in an attempt to differentiate children who had been sexually abused from those who had not. The differences were not significant, however, and the procedure is too complex to administer in a health care setting.

Several tools to screen for domestic/family violence have been studied and some of these tools include questions related to CSA. However, according to the USPSTF (2004), no studies addressed the effectiveness of screening in reducing harm and therefore the balance of benefits and harms cannot be decided. Nevertheless, they do note that asking questions about physical abuse is justified by the high prevalence of undetected domestic violence (USPSTF, 2004). Further study is needed to develop and validate specific screening techniques for CSA.

Potential Harms

Lack of knowledge may cause harm if signs of CSA are not recognized and addressed or if normal variations are mistaken for signs of CSA. Hibbard and Zollinger (1990) examined knowledge of CSA among social, legal, and medical professionals (n = 902) who interacted with CSA cases regularly by administering a survey at a conference on CSA. Social workers had the highest knowledge scores (85.9), followed by physicians (84.7) and then nurses (82.6). Legal professionals had the lowest knowledge scores (80.6). Less than half of the respondents reported prior training related to CSA. A survey tool developed by Ladson, Johnson, and Doty was used in two physician studies (Ladson et al. 1987; Lentsch & Johnson, 2000) and one nurse practitioner study (Horner & McCleery, 2000). The findings of all three studies were essentially the same and demonstrated a deficiency in knowledge related to basic anatomy and findings that are indicative of CSA. Forty percent of the physicians (n = 295) and nurse practitioners (n = 83) surveyed were unable to correctly identify the hymen and vaginal opening of a 6-year-old female's genitalia. Thirty to forty percent of survey respondents said they would not order a culture in the presence of vaginal discharge (Horner & McCleery, 2000; Ladson et al., 1987; Lentsch & Johnson, 2000).

Lack of knowledge may lead to either under- or over-diagnosis of CSA. False-negative screening results may minimize the identification of children who are truly at risk, and false-positive results may cause incorrect labeling and undeserved punishment. Possible negative outcomes related to suspicion and reporting of domestic violence in general include psychological distress, escalation of the abuse, family tension, loss of family resources, erosion of family structure, and the child's loss of established support systems (USPSTF, 2004). However, if health care providers rely on standard guidelines and the clinical expertise of specialists, the chance of false positives can be minimized. The lives of young innocent children are at stake.

Cost-Effectiveness

The cost of screening for CSA is unknown. Any assessment added to the health care visit will increase the practitioner's time and the skill level required to complete the exam. If CSA is suspected and a report is made, then the provider will have to commit even more time to the process. One Canadian study (Vulliamy & Sullivan, 2000) examined pediatricians' (n=26) experiences with reporting

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child abuse (physical and sexual) to Child Protective Services (CPS). The survey asked about their personal experiences and reactions to reporting and why they thought other physicians might not report child abuse. Concerns about interacting with CPS and the court system were listed as barriers to reporting suspected child abuse.

Conclusion

Screening for CSA has a long way to go to meet the requirements for evidence-based criteria established by the USPSTF and the JAMA evidence-based medicine working group. However, the seriousness of the problem warrants work toward achieving that goal. Identifying and reporting child sexual abuse can be difficult and intimidating to the general health care provider; however, there are evidence-based diagnostic criteria and experts available for consultation (Adams, 2001).

There is also evidence that identifying and treating CSA early may be beneficial. The potential benefits of stopping the sexual abuse of a child and perhaps preventing abuse of more children far outweigh any potential harm or cost.

The Joint Commission on Accreditation of Healthcare Organizations mandates that hospitals screen for domestic violence, and as a result, reporting and referrals for domestic violence have increased

ognizing that health care providers come into contact with CSA victims regularly and must be prepared to assess for it.

In the absence of an evidence-based screening tool, providers must at least have a heightened level of suspicion and stay current on psychological, behavioral, and physical signs of abuse. Vigilance is required to recognize the signs of CSA, which are frequently subtle. Being aware of and utilizing expert resources are also key. Continuing education to increase knowledge related to CSA is recommended.

Communication and anticipatory guidance on the risks of CSA and prevention of abuse should be incorporated into well-child visits. The Massachusetts Medical Society (2004) has developed a parent education card, "Protecting Your Child from Sexual Abuse," which emphasizes that most sexual abusers are not strangers to their victims and children should never keep secrets from their parents. Resources such as the card can increase patient knowledge and awareness of the problem. Also, during the physical exam the provider can inform children that adults should not touch their body parts and they should not keep secrets from their parents.

General inquiry directly to children about how they are doing and whether they have any concerns may be enough to elicit disclosures of sexual abuse (Petronio, Reeder, Hecht, & Mont' Ros-Mendoza,

Table 1.
Recommendations for Assessing and Preventing CSA by Developmental Level

Developmental Level	History/Assessment	Anticipatory Guidance
Infant/Toddler	Child care arrangement. General physical exam, including genitalia.	Teach children correct terminology for body parts.
Pre-school	Child care arrangement. General physical exam, including genitalia. Behavior changes.	Give children permission to say "no" to advances. Explain good touch and bad touch and how to deal with strangers.
School age	General physical exam, including genitalia. Behavior changes.	Provide sex education and education on personal safety. Encourage open communication with parents.
Adolescent	STD screening. Vaginal exam. Sexual history.	Emphasize personal safety, risk taking, sexuality. Explain risk of sexual assault.

(American Academy of Pediatrics, 1999; Jenny, Sutherland, & Sandahl, 1986)

(Punukollu, 2003). CSA is also highly prevalent and under-reported, but CSA may or may not be addressed by domestic violence screening tools. Experts in the CSA field must focus their efforts on developing an evidence-based screening tool that could be used easily during encounters with children for various types of health care visits.

Recommendations

Health care providers cannot ignore the problem of CSA. Children need advocates to intervene on their behalf. Health care providers are in a unique position to reach out to children who may be suffering in silence. The first step in eliminating the sexual abuse and exploitation of children is acknowledging that it happens and rec-

ognizing that health care providers come into contact with CSA victims regularly and must be prepared to assess for it.

Child sexual abuse is a disturbing and difficult issue. Looking the other way will not solve the problem and will cause undue suffering to children who are dependent on the professionals who serve them. Health care providers must equip themselves with the knowledge and resources to meet the needs of the children they serve. Early recognition and reporting are necessary to eliminate the problem of CSA. No child should be a victim of this crime.

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