AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect

Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review

ABSTRACT. This statement serves to update guidelines for the evaluation of child sexual abuse first published in 1991. The role of the physician is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data and in determining the need to report sexual abuse.

ABBREVIATIONS. AAP, American Academy of Pediatrics; STDs, sexually transmitted diseases; HIV, human immunodeficiency virus.

Few areas of pediatrics have expanded so rapidly in clinical importance in recent years as that of sexual abuse of children. What Kempe called a "hidden pediatric problem"[1] in 1977 is certainly less hidden at present. In 1996, more than 3 million children were reported as having been abused to child protective service agencies in the United States, and almost 1 million children were confirmed by child protective service agencies as victims of child maltreatment.[2] According to a 1996 survey, physical abuse represented 23% of confirmed cases, sexual abuse 9%, neglect 60%, emotional maltreatment 4%, and other forms of maltreatment 5%.[2] Other studies have suggested that approximately 1% of children experience some form of sexual abuse each year, resulting in the sexual victimization of 12% to 25% of girls and 8% to 10% of boys by age 18.[3] Children may be sexually abused by family members or nonfamily members and are more frequently abused by males. Boys may be victimized nearly as often as girls, but may not be as likely to disclose the abuse. Adolescents are perpetrators in at least 20% of reported cases; women may be perpetrators, but only a small minority of sexual abuse allegations involve women. The child care setting, an otherwise uncommon setting for abuse, may be the site for women offenders. Pediatricians may encounter sexually abused children in their practices and may be asked by parents and other professionals for consultation. These guidelines are intended for use by all health professionals caring for children. In addition, specific guidelines published by the American Academy of Pediatrics (AAP) for the evaluation of sexual assault of the adolescent by age group should be used.[5]

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Because pediatricians have trusted relationships with patients and families, they are often able to provide essential support and gain information that may not be readily available to others involved in the investigation, evaluation, or treatment processes. However, some pediatricians may not feel adequately prepared at present to perform a medical evaluation of a sexually abused child without obstructing the collection of essential evidence. Pediatricians need to be knowledgeable about the available resources in the community, including consultants with special expertise in evaluating or treating sexually abused children.

DEFINITION

Sexual abuse occurs when a child is engaged in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child, or nontouching abuses, such as exhibitionism, voyeurism, or using the child in the production of pornography.[1] Sexual abuse includes a spectrum of activities ranging from rape to physically less intrusive sexual abuse.

Sexual abuse can be differentiated from "sexual play" by determining whether there is a developmental asymmetry among the participants and by assessing the coercive nature of the behavior.[6] Thus, when young children at the same developmental stage are looking at or touching each other's genitalia because of mutual interest, without coercion or intrusion of the body, this is considered normal (ie, nonabusive) behavior. However, a 6-year-old who tries to coerce a 3-year-old to engage in anal intercourse is displaying abnormal behavior, and the health and child protective systems should be contacted although the incident may not be legally considered an assault. Children or adolescents who exhibit inappropriate sexual behavior may be reacting to their own victimization.

PRESENTATION

Sexually abused children are seen by pediatricians in a variety of circumstances: 1) They may be seen for a routine physical examination or for care of a medical illness, behavioral condition, or physical finding that would include child sexual abuse as part of the differential diagnosis. 2) They have been or are thought to have been sexually abused and are brought by a parent to the pediatrician for evalua-

tion. 3) They are brought to the pediatrician by social service or law enforcement professionals for a medical evaluation for possible sexual abuse as part of an investigation. 4) They are brought to an emergency department after a suspected episode of sexual abuse for evaluation, evidence collection, and crisis management.

The diagnosis of sexual abuse and the protection of the child from further harm depends in part on the pediatrician's willingness to consider abuse as a possibility. Sexual abuse presents in many ways,[7] and because children who are sexually abused generally are coerced into secrecy, a high level of suspicion may be required to recognize the problem. The presenting symptoms may be so general (eg, sleep disturbances, abdominal pain, enuresis, encopresis, or phobias) that caution must be exercised when the pediatrician considers sexual abuse, because the symptoms may indicate physical or emotional abuse or other nonabuse-related stressors. Among the more specific signs and symptoms of sexual abuse are rectal or genital bleeding, sexually transmitted diseases, and developmentally unusual sexual behavior.[8] Pediatricians evaluating children who have these signs and symptoms should at least consider the possibility of abuse and, therefore, should make a report to child welfare personnel if no other diagnosis is apparent to explain the findings.

Pediatricians who suspect sexual abuse has occurred or is a possibility are urged to inform the parents of their concerns in a calm, nonaccusatory manner. The individual accompanying the child may have no knowledge of, or involvement in, the sexual abuse of the child. A complete history, including behavioral symptoms and associated signs of sexual abuse, should be sought. The primary responsibility of the pediatrician is the protection of the child, sometimes requiring a delay in informing the parent(s) while a report is made and an expedited investigation by law enforcement and/or child protective services can be conducted.

TAKING A HISTORY/INTERVIEWING THE CHILD

In many states, the suspicion of child sexual abuse as a possible diagnosis requires a report both to the appropriate law enforcement and child protective services agencies. All physicians need to know their state law requirements and where and when to file a written report. The diagnosis of sexual abuse has civil (protective) and criminal ramifications. Investigative interviews should be conducted by the designated agency or individual in the community to minimize repetitive questioning of the child. This does not preclude physicians asking relevant questions to obtain a detailed pediatric history and to obtain a review of systems. The courts have allowed physicians to testify regarding specific details of the child's statements obtained in the course of taking a medical history to provide a diagnosis and treatment. Occasionally, children spontaneously describe their abuse and indicate who abused them. When asking young children about abuse, the use of line drawings,[9] dolls,[10] or other aids[11] are generally used only by professionals trained in interviewing young children. The American Academy of Child and Adolescent Psychiatry and American Professional Society on the Abuse of Children have published guidelines for interviewing sexually abused children.[12,13] Children may also describe their abuse during the course of the physical examination. It is desirable for those conducting the interview to use nonleading questions; avoid showing strong emotions such as shock or disbelief; and maintain a "tell me more" or "and then what happened" approach. If possible, the child should be interviewed alone. Written notes in the medical record or audiotape or videotape should be used to document the questions asked and the child's responses. Most expert interviewers do not interview children younger than 3 years.

A behavioral history may reveal events or behaviors relevant to sexual abuse, even in the absence of a clear history of abuse in the child.[7] The parent(s) may be defensive or unwilling to accept the possibility of sexual abuse, which does not necessarily negate the need for investigation.

When children are brought for evaluation by protective personnel, little or no history may be available other than that provided by the child. The pediatrician should try to obtain an appropriate history in all cases before performing a medical examination. The child may spontaneously give additional information during the physical examination, particularly as the mouth, genitalia, and anus are examined. History taking should focus on whether the symptoms are explained by sexual abuse, physical abuse to the genital area, or other medical conditions.[14]

PHYSICAL EXAMINATION

The physical examination of sexually abused children should not result in additional emotional trauma. The examination should be explained to the child before it is performed. It is advisable to have a chaperone present—a supportive adult not suspected of involvement in the abuse.[15] Children may be anxious about giving a history, being examined, or having procedures performed. Time must be allotted to relieve the child's anxiety.

When the alleged sexual abuse has occurred within 72 hours, or there is bleeding or acute injury, the examination should be performed immediately. In this situation, protocols for child sexual assault victims should be followed to secure biological trace evidence such as epithelial cells, semen, and blood, as well as to maintain a "chain of evidence." When more than 72 hours has passed and no acute injuries are present, an emergency examination usually is not necessary. An evaluation therefore should be scheduled at the earliest convenient time for the child, physician, and investigative team.[5]

The child should have a thorough pediatric examination, including brief assessments of developmental, behavioral, mental, and emotional status. Special attention should be paid to the growth parameters and sexual development of the child. In the rare instance when the child is unable to cooperate and the examination must be performed because of the likelihood of trauma, infection, and/or the need to collect forensic samples, consideration should be

given to using sedation with careful monitoring. Instruments that magnify and illuminate the genital and rectal areas should be used.[16,17] Signs of trauma should be carefully documented by detailed diagrams illustrating the findings or photographically. Specific attention should be given to the areas involved in sexual activity—the mouth, breasts, genitals, perineal region, buttocks, and anus. Any abnormalities should be noted.

In female children, the genital examination should include inspection of the medial aspects of the thighs, labia majora and minora, clitoris, urethra, periurethral tissue, hymen, hymenal opening, fossa navicularis, and posterior fourchette.

Various methods for visualizing the hymenal opening in prepubertal children have been described. Many factors will influence the size of the orifice and the exposure of the hymen and its internal structures. These include the degree of relaxation of the child, the amount of traction (gentle, moderate) on the labia majora, and the position of the child (supine, lateral, or knee to chest).[17,18] The technique used is less important than maximizing the view and recording the method and results (see below for discussion of significance of findings). Speculum or digital examinations should not be performed on the prepubertal child.

In male children, the thighs, penis, and scrotum should be examined for bruises, scars, chafing, bite marks, and discharge.

In both sexes, the anus can be examined in the supine, lateral, or knee to chest position. As with the vaginal examination, the child's position may influence the appearance of anatomy. The presence of bruises around the anus, scars, anal tears (especially those that extend into the surrounding perianal skin), and anal dilation are important to note. Laxity of the sphincter, if present, should be noted, but digital examination is not usually necessary (see below for discussion of significance of findings). Note the child's behavior during the examination, and ask the child to demonstrate any events that may have occurred to the areas of the body being examined. Care should be taken not to suggest answers to the questions.

LABORATORY DATA

Forensic studies should be performed when the examination occurs within 72 hours of acute sexual assault or sexual abuse. The yield of positive cultures is very low in asymptomatic prepubertal children, especially those whose history indicates fondling only.[19] The examiner should consider the following factors when deciding whether to obtain cultures and perform serologic tests for sexually transmitted diseases (STDs): the possibility of oral, genital, or rectal contact; the local incidence of STDs; and whether the child is symptomatic. The Centers for Disease Control and Prevention and the AAP also provide recommendations on laboratory evaluation.[20,21] The implications of the diagnosis of an STD for the reporting of child sexual abuse are listed in Table 1. Pregnancy prevention guidelines have been published by the AAP.[5]

TABLE 1. Implications of Commonly Encountered Sexually Transmitted Diseases (STDs) for the Diagnosis and Reporting of Sexual Abuse of Infants and Prepubertal Children

STD Confirmed	Sexual Abuse	Suggested Action
Gonorrhea*	Diagnostic†	Report‡
Syphilis*	Diagnostic	Report
HIV§	Diagnostic	Report
*Chlamydia**	Diagnostic†	Report
Trichomonas vaginalis	Highly suspicious	Report
Condylomata acuminata* (anogenital warts)	Suspicious	Report
Herpes (genital location)	Suspicious	Report‖
Bacterial vaginosis	Inconclusive	Medical follow-up

* If not perinatally acquired.
† Use definitive diagnostic methods such as culture or DNA probes.
‡ To agency mandated in community to receive reports of suspected sexual abuse.
§ If not perinatally or transfusion acquired.
‖ Unless there is a clear history of autoinoculation. Herpes 1 and 2 are difficult to differentiate by current techniques.

DIAGNOSTIC CONSIDERATIONS

The diagnosis of child sexual abuse often can be made based on a child's history. Physical examination alone is infrequently diagnostic in the absence of a history and/or specific laboratory findings. Physical findings are often absent even when the perpetrator admits to penetration of the child's genitalia.[22–24] Many types of abuse leave no physical evidence, and mucosal injuries often heal rapidly.[25–27] Occasionally, a child presents with clear evidence of anogenital trauma without an adequate history. Abused children may deny abuse. Findings that are concerning, but in isolation are not diagnostic of sexual abuse include: 1) abrasions or bruising of the inner thighs and genitalia; 2) scarring or tears of the labia minora; and 3) enlargement of the hymenal opening. Findings that are more concerning include: 1) scarring, tears, or distortion of the hymen; 2) a decreased amount of or absent hymenal tissue; 3) scarring of the fossa navicularis; 4) injury to or scarring of the posterior fourchette; and 5) anal lacerations.[18,26–28] The physician, the multidisciplinary team evaluating the child, and the courts must establish a level of certainty about whether a child has been sexually abused. Table 2 provides suggested guidelines for making the decision to report sexual abuse of children based on currently available information. The presence of semen, sperm, or acid phosphatase; a positive culture for gonorrhea; or a positive serologic test for syphilis or human immunodeficiency virus (HIV) infection makes the diagnosis of sexual abuse a medical certainty, even in the absence of a positive history, when congenital forms of gonorrhea, syphilis, and congenital or transfusion-acquired HIV (as well as needle sharing) are excluded.

Other physical signs or laboratory findings that are suspicious for sexual abuse require a complete history from the child and caregivers. If the child does not disclose abuse, the physician may wish to observe the child closely to monitor changes in behavior or physical findings. If the history is positive, a report should be made to the agency authorized to receive reports of sexual abuse.

TABLE 2. Guidelines for Making the Decision to Report Sexual Abuse of Children

Data Available			Response	
History	Physical Examination	Laboratory Findings	Level of Concern About Sexual Abuse	Report Decision
None	Normal	None	None	No report
Behavioral changes†	Normal	None	Variable depending upon behavior	Possible report*; follow closely (possible mental health referral)
None	Nonspecific findings	None	Low (worry)	Possible report*; follow closely
Nonspecific history by child or history by parent only	Nonspecific findings	None	Intermediate	Possible report*; follow closely
None	Specific findings‡	None	High	Report
Clear statement	Normal	None	High	Report
Clear statement	Specific findings	None	High	Report
None	Normal, nonspecific or specific findings	Positive culture for gonorrhea; positive serologic test for HIV; syphilis; presence of semen, sperm acid phosphatase	Very high	Report
Behavior changes	Nonspecific findings	Other sexually transmitted diseases	High	Report

* A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective services agencies.
† Some behavioral changes are nonspecific, and others are more worrisome.[7]
‡ Other reasons for findings ruled out.[13]

The differential diagnosis of genital trauma also includes accidental injury and physical abuse. This differentiation may be difficult and may require a careful history and multidisciplinary approach. Because many congenital malformations and infections or other causes of anal-genital abnormalities may be confused with abuse, familiarity with these other causes is important.[14,18]

Physicians should be aware that child sexual abuse often occurs in the context of other family problems including physical abuse, emotional maltreatment, substance abuse, and family violence. If these problems are suspected, referral for a more comprehensive evaluation is imperative. In difficult cases, pediatricians may find consultation with a regional child abuse specialist or assessment center helpful.

After the examination, the physician should provide appropriate feedback and reassurance to the child and family.

RECORDS

Because the likelihood of civil or criminal court action is high, detailed records, drawings, and/or photographs should be kept. The submission of written reports to county agencies and law enforcement departments is encouraged. Physicians required to testify in court are better prepared and may feel more comfortable if their records are complete and accurate. The more detailed the reports and the more explicit the physician's opinion, the less likely the physician may need to testify in civil court proceedings. Testimony will be likely, however, in criminal court, where records alone are not a substitute for a personal appearance. In general, the ability to protect a child may often depend on the quality of the physician's records.[28]

TREATMENT

All children who have been sexually abused should be evaluated by the pediatrician or mental health provider to assess the need for treatment and to measure the level of parental support. Unfortunately, treatment services for sexually abused children are not universally available. The need for treatment varies depending on the type of sexual molestation (whether the perpetrator is a family member or nonfamily member), the duration of the molestation, and the age and symptoms of the child. Poor prognostic signs include more intrusive forms of abuse, more violent assaults, longer periods of sexual molestation, and closer relationship of the perpetrator to the victim. The parents of the victim may also need treatment and support to cope with the emotional trauma of their child's abuse.

LEGAL ISSUES

The legal issues confronting pediatricians in evaluating sexually abused children include mandatory reporting with penalties for failure to report; involvement in the civil, juvenile, or family court systems; involvement in divorce or custody proceedings in divorce courts; and involvement in criminal prosecution of defendants in criminal court. In addition, there are medical liability risks for pediatricians who fail to diagnose abuse or who misdiagnose other conditions as abuse.

All pediatricians in the United States are required under the laws of each state to report suspected as well as known cases of child sexual abuse. These guidelines do not suggest that a pediatrician who evaluates a child with an isolated behavioral finding (nightmares, enuresis, phobias, etc) or an isolated physical finding (erythema or an abrasion of the

labia or traumatic separation of labial adhesions) is obligated to report these cases as suspicious. If additional historical, physical, or laboratory findings suggestive of sexual abuse are present, the physician may have an increased level of suspicion and should report the case. Pediatricians are encouraged to discuss cases with their local or regional child abuse consultants and their local child protective services agency. In this way, agencies may be protected from being overburdened with high numbers of vague reports, and physicians may be protected from potential prosecution for failure to report.

Increasing numbers of cases of alleged sexual abuse involve parents who are in the process of separation or divorce and who allege that their child is being sexually abused by the other parent during custodial visits. Although these cases are generally more difficult and time-consuming for the pediatrician, the child protective services system, and law enforcement agencies, they should not be dismissed because a custody dispute exists. Allegations of abuse that occur in the context of divorce proceedings should either be reported to the child protective services agency or followed closely. A juvenile court proceeding may ensue to determine if the child needs protection. The pediatrician should act as an advocate for the child in these situations and encourage the appointment of a guardian ad litem by the court to represent the child's best interests. The American Bar Association indicates that the majority of divorces do not involve custody disputes, and relatively few custody disputes involve allegations of sexual abuse.[28]

In both criminal and civil proceedings, physicians must testify to their findings "to a reasonable degree of medical certainty."[27] For many physicians, this level of certainty may be a focus of concern because in criminal trials the pediatrician's testimony is part of the information used to ascertain the guilt or innocence of an alleged abuser.

Pediatricians may find themselves involved in civil malpractice litigation. The failure of a physician to recognize and diagnose sexual abuse in a timely manner may lead to a liability suit if a child has been brought repeatedly to the physician and/or a flagrant case has been misdiagnosed. The possibility of a suit being filed against a physician for an alleged "false report" exists; however, to our knowledge there has been no successful "false report" suit against a physician as of this writing. Statutes generally provide immunity as long as the report is done in good faith.

Civil litigation suits may be filed by parents against individuals or against institutions in which their child may have been sexually abused. The physician may be asked to testify in these cases. In civil litigation cases, the legal standard of proof in almost all states is "a preponderance of the evidence."

CONCLUSION

The evaluation of sexually abused children is increasingly a part of general pediatric practice. Pediatricians are part of a multidisciplinary approach to prevent, investigate, and treat the problem and need to be competent in the basic skills of history taking, physical examination, selection of laboratory tests, and differential diagnosis. An expanding clinical consultation network is available to assist the primary care physician with the assessment of difficult cases.[29]

REFERENCES

1. Kempe CH. Sexual abuse, another hidden pediatric problem: the 1977 C. Anderson Aldrich lecture. *Pediatrics.* 1978;62:382–389
2. Wang CT, Daro D. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1996 Annual Fifty State Survey.* Chicago, IL: National Committee to Prevent Child Abuse; 1997
3. Finkelhor D. *Sourcebook on Child Sexual Abuse.* Beverly Hills, CA: Sage Publications; 1986
4. Finkelhor D, Williams LM. *Nursery Crimes: Sexual Abuse in Day Care.* Newbury Park, CA: Sage Publications; 1988
5. American Academy of Pediatrics, Committee on Adolescence. Sexual assault and the adolescent. *Pediatrics.* 1994;94:761–765
6. Yates A. Differentiating hypererotic states in the evaluation of sexual abuse. *J Am Acad Child Adolesc Psychiatry.* 1991;30:792
7. Krugman RD. Recognition of sexual abuse in children. *Pediatr Rev.* 1986;8:25–30
8. Friedrich WN, Grambsch P. Child sexual behavior inventory: normative and clinical comparisons. *Psychol Assess.* 1992;4:303–311
9. Hibbard RA, Roghmann K, Hoekelman RA. Genitalia in children's drawings: an association with sexual abuse. *Pediatrics.* 1987;79:129–137
10. American Professional Society on the Abuse of Children. *Use of Anatomical Dolls in Child Sexual Abuse Assessments.* Chicago, IL: American Professional Society on the Abuse of Children; 1995
11. Jones DPH, McQuiston M. *Interviewing the Sexually Abused Child.* 2nd ed. Denver, CO: C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect; 1986
12. American Academy of Child and Adolescent Psychiatry. Practice parameters for the forensic evaluation of children and adolescents who may have been physically or sexually abused. *J Am Acad Child Adolesc Psychiatry.* 1997;36:423–442
13. American Professional Society on the Abuse of Children. *Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse in Young Children.* Chicago, IL: American Professional Society on the Abuse of Children; 1990
14. Bays J, Jenny C. Genital and anal conditions confused with child sexual abuse trauma. *Am J Dis Child.* 1990;144:1319–1322
15. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. The use of chaperones during the physical examination of the pediatric patient. *Pediatrics.* 1996;98:1202
16. Jones JG, Lawson L, Rickert CP. Use of optical glass binocular magnifiers in the examination of sexually abused children. *Adolesc Pediatr Gynecol.* 1990;3:146–148
17. Bays J, Chadwick D. Medical diagnosis of the sexually abused child. *Child Abuse Negl.* 1993;17:91–110
18. Heger A, Emans SJ, et al. *Evaluation of the Sexually Abused Child: A*

Medical Textbook and Photographic Atlas. New York, NY: Oxford University Press; 1992
19. Siegel RM, Schubert CJ, Meyers PA, Shapiro RA. The prevalence of sexually transmitted diseases in children and adolescents evaluated for sexual abuse in Cincinnati: rationale for limited STD testing in prepubertal girls. *Pediatrics.* 1995;96:1090–1094
20. Centers for Disease Control and Prevention. 1998 sexually transmitted diseases treatment guidelines. *Morbid Mortal Wkly Rep.* 1998;47(No. RR-1):1–116
21. American Academy of Pediatrics. Sexually transmitted diseases. In: Peter G, ed. *1997 Red Book: Report of the Committee on Infectious Diseases.* 24th ed. Elk Grove Village, IL: American Academy of Pediatrics; 1997: 108–116
22. Muram D. Child sexual abuse: relationship between sexual acts and genital findings. *Child Abuse Negl.* 1989;13:211–216
23. Kerns DL, Ritter ML. Medical findings in child sexual abuse cases with perpetrator confessions. *Am J Dis Child.* 1992;146:494
24. Adams JA, Harper K, Knudson S, Revilla J. Examination findings in legally confirmed child sexual abuse: it's normal to be normal. *Pediatrics.* 1994;94:310–317
25. Finkel MA. Anogenital trauma in sexually abused children. *Pediatrics.* 1989;84:317–322
26. McCann J, Voris J, Simon M. Genital injuries resulting from sexual abuse: a longitudinal study. *Pediatrics.* 1992;89:307–317
27. McCann J, Voris J. Perianal injuries resulting from sexual abuse: a longitudinal study. *Pediatrics.* 1993;91:390–397
28. Nicholson EB, Bulkley J, eds. *Sexual Abuse Allegations in Custody and Visitation Cases: A Resource Book for Judges and Court Personnel.* Washington, DC: American Bar Association, National Legal Resource Center for Child Advocacy and Protection; 1988
29. American Academy of Pediatrics, Section on Child Abuse and Neglect. *A Guide to References and Resources in Child Abuse and Neglect.* 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics; 1997

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