



## CLINICAL REPORT

# The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected

## abstract



This clinical report updates a 2005 report from the American Academy of Pediatrics on the evaluation of sexual abuse in children. The medical assessment of suspected child sexual abuse should include obtaining a history, performing a physical examination, and obtaining appropriate laboratory tests. The role of the physician includes determining the need to report suspected sexual abuse; assessing the physical, emotional, and behavioral consequences of sexual abuse; providing information to parents about how to support their child; and coordinating with other professionals to provide comprehensive treatment and follow-up of children exposed to child sexual abuse. *Pediatrics* 2013;132:e558–e567

## INTRODUCTION

Sexual abuse of children and adolescents is a common problem that is potentially damaging to their long-term physical and psychological health. The Fourth National Incidence Study on Child Abuse and Neglect<sup>1</sup> estimated that in 2006, 1.8 children per 1000 (or a total of 135 300 children) were victims of sexual abuse. Other national studies have found that 5% to 25% of adults reported being sexually abused as children, depending on the population studied and the methods used to define sexual abuse.<sup>2–7</sup> Pediatricians are likely to care for sexually abused children in their practices, even though many victims wait years before telling anyone about their abuse.<sup>8,9</sup> More than half of sexually abused children do not disclose their abuse until they are adults.<sup>10</sup>

A history of childhood sexual abuse can have lifelong deleterious effects on a child's physical and mental health. Sexual abuse increases the risk of developing posttraumatic stress disorder, anxiety disorder, depression,<sup>11,12</sup> low self-esteem,<sup>13</sup> and social phobias.<sup>14</sup> Children exposed to sexual abuse are more likely to need hospitalization for mental illness.<sup>15</sup> Adult survivors of child sexual abuse are more likely to become victims of intimate partner violence and sexual assault.<sup>16,17</sup> They are at higher risk of developing obesity,<sup>18</sup> sexual problems,<sup>19</sup> irritable bowel syndrome,<sup>20</sup> fibromyalgia,<sup>21</sup> and sexually transmitted infections (STIs), including infection with the human immunodeficiency virus (HIV).<sup>22,23</sup> They use more medical services as adults than those without a history of child sexual abuse<sup>21,24</sup> and are more likely to develop addictions to tobacco, drugs, and alcohol.<sup>25–27</sup>

Carole Jenny, MD, MBA, James E. Crawford-Jakubiak, MD,  
and COMMITTEE ON CHILD ABUSE AND NEGLECT

### KEY WORD

sexual abuse

### ABBREVIATIONS

AAP—American Academy of Pediatrics

HIV—human immunodeficiency virus

NAAT—nucleic acid amplification test

STI—sexually transmitted infection

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

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

[www.pediatrics.org/cgi/doi/10.1542/peds.2013-1741](http://www.pediatrics.org/cgi/doi/10.1542/peds.2013-1741)

doi:10.1542/peds.2013-1741

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2013 by the American Academy of Pediatrics

In summary, child sexual abuse occurs commonly and can have lifelong effects on victims' physical and mental health. When the issue of possible sexual abuse is raised in the clinical setting, it is important for pediatricians to know how to respond to and evaluate the child, when to refer the child for evaluation by other professionals, when to report the case to the appropriate investigative agency, and how to counsel parents to decrease the long-term deleterious effects of the abuse. This clinical report updates an American Academy of Pediatrics (AAP) report from 2005 titled "The Evaluation of Sexual Abuse in Children."<sup>28</sup>

### RESPONDING TO A PARENT'S CONCERN ABOUT POSSIBLE SEXUAL ABUSE

When a parent brings up the possibility of sexual abuse of his or her child, the pediatrician should immediately exclude the child from the discussion. Children (particularly young children) might be influenced by hearing their parents' concerns about abuse. Sometimes parents are overconcerned about normal childhood sexual behavior.<sup>29</sup> In those cases, reassuring and educating the parents will probably assuage their fears. Parents' overconcern could be related to their own adverse experiences in childhood, and in such cases, a more in-depth assessment to assist the parent is needed. Occasionally, parents might have concerns about possible sexual abuse because of relationship issues that arise between caregivers. Many of these concerns are raised in good faith but ultimately unfounded. Notwithstanding these caveats, every concern about possible sexual abuse should be approached objectively, thoughtfully, and with an open mind.

The pediatrician faces many challenges in evaluating possible sexual

abuse to determine which cases warrant an immediate intervention in the office and which cases warrant reporting to investigative agencies or referral for evaluation by other professionals. In all these cases, the pediatrician should carefully document the parent's concerns, take a detailed history of the nature of the child's disclosure from the parents' perspective, ask what questions the parent used in eliciting the disclosure, and document a complete medical history, social history, and review of systems for urogenital and behavioral problems. It is important to note in the record the source of the information documented in the medical record. For example, be sure to say, "Mother tells me that the child said . . .," rather than writing, "The child said . . ." Often, a child will present to the pediatrician after direct disclosure to another person regarding sexual abuse. Less commonly, a child presents to the pediatrician with an abnormal genital or anal examination, pregnancy, an STI, or sexual abuse witnessed by a third party or by discovery of sexually graphic images or videos in the possession of a potential perpetrator. The general pediatrician's response depends on what resources are available in the community. Many communities and regions have specialized clinics or child advocacy centers where children can be referred when concerns of sexual abuse arise. In areas without these resources, the general pediatrician is often the most knowledgeable professional in the community regarding the evaluation and interviewing of children. If pediatricians find that their regions do not offer specialized abuse-related services (eg, child advocacy centers or hospital-based child protection programs), it is important for them to educate themselves about childhood genital and anal examinations and

about how to interview children to get enough information to make appropriate decisions about reporting to child protective service agencies, referring to counseling facilities, or referring to pediatric clinics specializing in abuse evaluations. The AAP offers a variety of educational materials on child abuse to physicians, including a comprehensive CD-ROM,<sup>30</sup> textbooks on child abuse,<sup>31,32</sup> and educational offerings at the National Conference and Exhibition.

Whenever the issue of possible child sexual abuse arises in the office setting, 5 important issues should be addressed.

1. **The child's safety.** Is the child safe to go home? Is the child at imminent risk of additional harm if sent back to an environment where a possible perpetrator has access to the child? Is the child likely to be harmed or punished for disclosing abuse? Is there concern that the child might be coerced or intimidated to recant the disclosure? If any of these questions are answered "yes" or "maybe," this is a child protection emergency, and the appropriate authorities (child protective services or law enforcement) should be contacted immediately.
2. **Reporting to child protection authorities.** If the child is not at imminent risk, the pediatrician should decide whether child protective services should be contacted about the allegation. It is important to remember that in every state, and in all provinces and territories in Canada, it is mandated that professionals report *suspected* child abuse and neglect to the appropriate government agency (child protective services or police agencies, including tribal agencies). Studies have shown that some pediatricians are hesitant to involve outside agencies,

even if they strongly suspect abuse has occurred.<sup>33</sup> Pediatricians worry about the intrusion of agencies into family life, the risk of the child being separated from the parents, or the possibility that the family will leave the practice if reported to a child protection agency. Some pediatricians have experienced negative interactions with child protection agencies, which could make them distrustful of an agency's response and its effect on the family.<sup>34</sup> Some physicians might overestimate their ability to manage the situation within their practice. Physicians should not let these concerns act as barriers to protecting a child. In the United States, physicians are protected against liability for reporting a reasonable suspicion of child abuse and neglect if the report is made in good faith. This is also the case in many other jurisdictions, but because laws can vary, it is important for physicians to be familiar with the laws that pertain to their practice. Still, the safety of the child should take precedence over the physician's fear of lawsuits.

One problem lies in the definition of *suspected*. If a parent is going through a contentious divorce and the child is having symptoms of anxiety and depression, should abuse be suspected? If a child is sexually acting out with peers, should abuse be suspected? Each pediatrician will need to consider the facts of the individual case when making the decision to report suspected child abuse while bearing in mind the statutory requirements for reporting suspected abuse in his or her state. The threshold for reporting is low. The pediatrician should report when there is a reasonable suspicion that the child was abused. The child protective services agency

then has the responsibility to conduct a thorough investigation to determine whether abuse has occurred.

3. **The child's mental health.** In every case, the patient should be assessed for possible mental health problems, and if any are identified, appropriate emergency mental health care should be sought. The initial disclosure of abuse can be extremely stressful for a young person. It is important to consider the possibility that symptoms of depression and posttraumatic stress disorder might already have developed. The family might be angry at the child because the disclosure has introduced stress into the family or because the threatened loss of a family member could result in financial insecurity. A disclosure of sexual abuse is perhaps one of the most explosive events that can occur in a family.

4. **The need for a physical examination.** If sexual abuse is suspected, a thorough examination should be performed to rule out injury, particularly if a child is reporting genital or anal pain or bleeding. If the abuse occurred in the distant past and the asymptomatic child is going to be referred to a specialty center for medical evaluation, examination might be deferred. If the child reports dysuria, a urinalysis is indicated. Rarely, acute sexual assault can cause severe genital or anal injury that can lead to excessive blood loss (a medical emergency).

5. **The need for forensic evidence collection.** Children who have had recent sexual contact involving the exchange of bodily fluids should be immediately referred to a specialized clinic or emergency department capable of collecting evidence using a forensic evidence kit.<sup>35</sup> Many states recommend that

forensic evidence be collected if less than 72 hours have passed since the assault. Some states require evidence kits to be performed as late as 96 hours after assault. Some evidence supports limiting collection of forensic evidence in prepubertal children to those who present within 24 hours after assault.<sup>36,37</sup> As more laboratories use DNA testing to analyze forensic specimens, however, the time for collection of useful forensic evidence might be extended beyond the current 72-hour standard.<sup>38,39</sup> Pediatricians should familiarize themselves with the relevant policies of the jurisdiction in which they practice. The referral center also should be capable of evaluating the child for the appropriateness of antiretroviral HIV prophylaxis,<sup>40</sup> postexposure prophylaxis for STIs,<sup>41</sup> and pregnancy prophylaxis. HIV and pregnancy prophylaxis should be given as soon after the sexual contact as possible and are not recommended more than 72 hours after contact.

## INTERVIEWING CHILDREN ABOUT POSSIBLE SEXUAL ABUSE

Depending on the community services available, the pediatrician should be prepared to conduct a basic interview with a verbal child about an abuse experience. Often, this is necessary to make the appropriate decision about referral to another facility or to report to child protective services. Several fundamental guidelines inform this process.

1. If the child spontaneously discloses abuse, it is important that the person hearing the disclosure respond by telling the child it is okay to talk about it with adults. If the child begins to make a disclosure and the physician says, "I'm

not the person you should tell this to,” the child might be hesitant to disclose at another time.

2. The child should be separated from the parent for the interview if at all possible. Parents can subtly or not-so-subtly influence the child’s statements. Separation from the parent is particularly important if the parent is a suspected perpetrator or is supportive of the suspected perpetrator, to prevent the child from feeling intimidated or threatened. The parent will later be present for the examination if that is the child’s preference.
3. If the pediatrician has not already established a relationship with the patient, some time should be spent talking about nonthreatening issues, such as school, friends, or pets. It is difficult for a child to be asked painful or embarrassing questions without first feeling safe and supported by the adult asking the questions.
4. Pediatricians should tell children that it is their job as doctors to keep children healthy and that it is okay for children to talk about difficult or uncomfortable subjects with their doctors.
5. The pediatrician should not ask leading or suggestive questions. It is important to begin with open-ended, general questions about the child’s likes and dislikes or about the people in the child’s family. Then ask about things the child is worried or confused about, or about things that have happened to the child that have been unpleasant or stressful. A question should never suggest an answer. Examples of open-ended questions include the following:

“Is anything bothering you?”

“Tell me why you’re here today.”

“Do you think he would want you to tell me what happened?”

Examples of incorrect questions are as follows:

“Who touched your privates?”

“I know that Uncle Joe hurt you; tell me about it.”

6. Developmentally appropriate language should be used with the child. The terms and concepts understood by a 12-year-old are very different from those understood by a 4-year-old. Be aware of the terms the child uses for the genitalia and anus. The parents should be asked in advance which terms the family uses for private parts and bathroom activities.
7. Any descriptions of abuse given by the child should be recorded word for word (using quotation marks) in the medical record, using the child’s own language, and should be attributed to the child. When practical, the response should be recorded together with the question. For example, “When asked why she was not wearing underwear, the patient answered that . . .” or “Without my asking, the child stated that. . .” Careful notes should be taken during the interview. Video or audio recording of the interview is not needed unless this is part of the pediatrician’s regular practice.
8. The child should not be urged or coerced to talk about abuse. The child should be allowed to talk about it if he or she wants to, but there should never be an expectation that the child must disclose to the professional. The child should not be rewarded after a disclosure. (For example, “Tell me what happened with Uncle Joe, and then you can go back to your mom” is not an appropriate statement.) Forcing a child who has been abused to give a disclosure can be experienced by the

child as revictimization and loss of control and can make an already painful experience worse.

9. The pediatrician should remember that this is a *medical* interview and that he or she is obtaining information needed to make the appropriate diagnostic and treatment decisions. If the child makes an initial disclosure to the pediatrician, it is likely that the child will be interviewed again by another adult professional. Parents and children can be told this before the interview begins. Professionals with advanced training in forensic interviewing conduct a very different type of interview than the medical interview conducted in the clinical setting. Although it is important to avoid multiple interviews of the child, in many situations the interview will be a 2-stage process in which the initial evaluator obtains minimal facts to evaluate the need to report to the authorities, and a forensic evaluator conducts a more detailed interview.
10. The pediatrician should be supportive and empathic. Treat the patient with the same respect and caring given to all your patients. If the child tells you about abuse, show appropriate concern; do not act shocked, outraged, or dismissive.
11. Appropriate language should be used to interview children. Translators should be used if necessary, and the child’s use of words to describe body parts should be understood.
12. If the pediatrician records his or her impression of the child’s emotions during the examination or interview, these subjective impressions should be identified as such (eg, “It was my impression



that the child seemed agitated.”). Similarly, if an observation is made that may bear on the truthfulness of the history, it should be clearly identified as separate from fact (eg, “I noted that the child and her mother used identical words when answering this same question. I therefore considered the possibility that the answers may have been rehearsed.”).

## **THE PHYSICAL EXAMINATION WHEN SEXUAL ABUSE IS SUSPECTED**

Studies have shown that pediatricians often have not been properly trained to examine the genitals and anuses of children when abuse is suspected.<sup>42</sup> Some of the most basic knowledge, such as the appropriate identification of anatomic structures, has not always been part of pediatric residencies or physicians’ continuing education.<sup>43,44</sup> Appropriate techniques for evaluating children’s anogenital regions are an important part of pediatric education.

When the question of sexual abuse arises in the medical setting, the pediatrician might want to consider whether the child should be triaged to another facility for evaluation, such as a child advocacy center or a specialized abuse assessment clinic at a children’s hospital (after considering the safety questions discussed previously). If the pediatrician does not think that the situation constitutes an emergency, he or she should consider referring the child for evaluation if he or she is not confident that he or she has the necessary examination skills. Unnecessary multiple anogenital examinations should be avoided because they can be upsetting to a sexually abused child. On the other hand, routine examination of the genitals and anus (appropriately chaperoned)<sup>45</sup> during well child

examinations can help patients and parents understand that anogenital health is as important as the health of other parts of the body and will familiarize pediatricians with normal anatomic structures.

The anogenital examination should be preceded by a thorough general physical examination. Children who have experienced one type of abuse also are at risk for other types of abuse or neglect. In addition, the general physical examination establishes the physician’s role and is likely to be an event the child has previously experienced at a physician’s office.

The nature and process of the examination should be explained to the child in age-appropriate language before the examination takes place. An appropriate chaperone must be present. Most children will want a same-gender parent in the room during the examination. If a parent is not available, a second medical professional should be in the room to reassure the child, to assist the examining physician, and to act as a chaperone. A parent or caring professional at the head of the examination table can provide support for the child as well as reasonable assurance and distraction during the examination. Use of appropriate gowns and drapes can protect the child’s modesty and make the child feel less vulnerable.

The examination of the genitalia and anus does not require the use of instruments in most cases. For girls, separation of the labia and gentle labial traction while the child is supine with the knees bent and hips abducted (frog-leg position) will adequately expose the genital structures. Speculum examinations are contraindicated in prepubertal children in the office setting. If intravaginal trauma is suspected, vaginoscopy should be performed under anesthesia.

In an adolescent, an examination for sexual abuse should follow the recommendations of the AAP regarding intravaginal examination using a speculum.<sup>46</sup> In many cases, a speculum examination is not needed in the absence of signs or symptoms of genital disease but is usually indicated after acute vaginal sexual assault to document injuries and to collect forensic specimens.<sup>47</sup> Girls should receive their first cervical cytologic examination (Papanicolaou test) at 21 years of age unless there are special circumstances, such as immune suppression or infection with HIV.<sup>46,48</sup>

For boys, the examination of the genitals consists of inspection of the penis and scrotum, documenting any noted trauma or scarring and any other abnormalities.

Examination of the anus is performed in most cases by external inspection with gentle traction of the buttocks to expose the anal sphincter while the child is supine with the knees pulled up to the chest (cannon-ball position). Anoscopy or a digital rectal examination is not routinely indicated.

Documenting the findings of the anogenital examination is important. In specialty centers, the examination is usually documented with photographs or videos. In the pediatric office, a detailed description of the structures will suffice. If photographs are taken, however, they should be treated as a confidential part of the medical record, and care should be taken to label them for proper identification.

An expert committee that has written practice standards for medical examinations in child advocacy centers recommends that all examinations be reviewed by an expert clinician.<sup>49</sup> This usually entails a secondary review of photographs or videos to verify the physical findings. If the examination findings are deemed to be abnormal

or consistent with trauma, pediatricians also should have a secondary review of physical findings, either by having a clinician experienced in forensic anogenital examinations review the photographs or by referring the child to a center specializing in child abuse. Studies have shown there to be better agreement on interpretation of examination findings when clinicians have had extensive experience and education in the evaluation of child sexual abuse.<sup>50</sup>

All pediatricians should gain experience in the anogenital examination of children and adolescents. Many conditions can mimic trauma. It is important to recognize these findings and to distinguish them from lesions caused by child abuse.<sup>51</sup> The Supplemental Appendix reviews genital and anal conditions that can be confused with sexual abuse.

Most sexually abused children have normal anogenital examinations.<sup>52,53</sup> Many types of molestation (eg, oral genital contact or fondling) leave no permanent scars or marks. Even children who have been sexually penetrated often have normal examinations.<sup>53,54</sup> Anogenital tissues heal quickly and completely after many types of anal or genital trauma.<sup>55,56</sup> A normal examination of the genitals and anus neither confirms nor rules out sexual abuse. This fact should be mentioned in the assessment portion of the record. After the examination, it is important to reassure the child that he or she is healthy.

### TESTING FOR STIs

STIs occur infrequently in prepubertal sexually abused children. A recent multisite prospective study of 536 children evaluated for suspected sexual abuse revealed that 8.2% of the female children younger than 14 years had an STI.<sup>57</sup> *Chlamydia trachomatis*

infections were found in 3.1% of the girls, and *Neisseria gonorrhoeae* infections were found in 3.3%. Only 1 girl tested positive for syphilis (0.3%), and none tested positive for HIV. Five of 12 girls with genital lesions tested positive for herpes simplex virus. Five of 85 symptomatic girls (5.9%) had *Trichomonas vaginalis* identified on a wet mount. Girls with vaginal discharge were more likely to have an STI.

Because STIs are not common in prepubertal children evaluated for abuse, culturing all sites for all organisms is not recommended if the child is asymptomatic. Each case should be evaluated individually for STI risk. Factors that should lead the physician to consider screening for STI include the following<sup>41</sup>:

1. Child has experienced penetration of the genitalia or anus.
2. Child has been abused by a stranger.
3. Child has been abused by a perpetrator known to be infected with an STI or at high risk of STIs (intravenous drug abusers, men who have sex with men, or people with multiple sexual partners).
4. Child has a sibling or other relative in the household with an STI.
5. Child lives in an area with a high rate of STI in the community.
6. Child has signs or symptoms of STIs.
7. Child has already been diagnosed with 1 STI.

Sexually abused adolescents are at higher risk of STIs and should be screened for all STIs, as would any sexually active adolescent presenting for routine care.

Genital and anal infections with *N gonorrhoeae* are rarely acquired perinatally, and outside the newborn period they are considered likely to be caused by sexual abuse.<sup>58</sup> *C trachomatis* infections in children older than

3 years also are likely to be sexually transmitted.<sup>59</sup> *T vaginalis* infection also should raise a concern of possible abuse.<sup>60</sup> Herpes simplex virus and genital warts (human papillomavirus) can be sexually transmitted in children, but these infections are not diagnostic of abuse by themselves.<sup>61</sup> HIV infections in children who have not been exposed to the virus perinatally, through blood products, or by needle sticks are also highly likely to be caused by abuse.<sup>62</sup> In any case of an STI in a child, a careful investigation into risk factors and contacts should be conducted, a thorough medical and social history should be obtained, and the child should be evaluated for possible sexual abuse.

The recommendations for laboratory methods best used to detect infection with *C trachomatis* and *N gonorrhoeae* in abused children are evolving. Current standards require these organisms to be confirmed by culture in cases of suspected sexual abuse that involve the legal system.<sup>41</sup> However, a recent multicenter study found that commercially available nucleic acid amplification tests (NAATs) are highly sensitive and specific for these organisms and that these tests provide "a better alternative than culture as a forensic standard."<sup>63</sup> The study also found that NAATs performed on urine specimens worked as well as vaginal swabs to detect infection in both prepubertal and postpubertal girls, obviating more invasive tests. All positive NAAT results in this study were confirmed by genotypic and sequence analysis tests, leading to a high positive predictive value for *C trachomatis* and *N gonorrhoeae*.

In medicolegal cases, culture-based tests have been preferred because of their high specificity (nearing 100%). This would make the possibility of a false-positive result highly unlikely. Unfortunately, culture-based tests for *C trachomatis* and *N gonorrhoeae* are

very insensitive. In addition, many laboratories no longer offer culture-based tests, making it impossible to screen victims for infection using culture methods. If laboratories do maintain limited culture facilities, they would be more likely to provide false results, given limited experience with cultures. Because NAATs provide highly sensitive detection of organisms and their specificity approaches that of culture, the AAP recommends the use of NAATs when evaluating children and adolescents for genital infections with *C trachomatis* and *N gonorrhoeae*.

All positive test results should be considered presumptive evidence of infection and, if used, should be interpreted with caution. Positive results should be confirmed using additional tests in populations with a low prevalence of the infection or when a false-positive test could have an adverse outcome. When establishing a protocol to evaluate positive NAAT results for *N gonorrhoeae* or *C trachomatis*, experts in laboratory medicine and pediatric infectious diseases should be consulted to determine appropriate secondary tests. All positive specimens in suspected abuse cases should be retained by the laboratory for additional testing.

Recently, various rapid antigen tests, DNA hybridization tests, and NAATs have been developed for *Candida* species, *Gardnerella vaginalis*, and *T vaginalis*.<sup>64</sup> These tests have not been extensively studied in children and should not be used at this time. Bacterial vaginosis (the vaginosis associated with *G vaginalis*) and genital candidiasis are not specific indicators of sexual abuse.

By recommending the use of NAATs for *N gonorrhoeae* and *C trachomatis* in cases of suspected sexual abuse of children, the AAP recognizes that pediatricians' first priority should be protecting the health of children. The pediatrician should be considered

primarily a provider of health care for children and should prioritize ensuring the health and well-being of their patients rather than focusing on the legal outcome of criminal cases. In practice, rarely have cases of suspected sexual abuse been adjudicated on the basis of a positive test result for an STI alone in the absence of a history, physical finding, or other confirmatory evidence of abuse. Although properly collected, tested, and confirmed laboratory specimens can aid in the prosecution of sex offenders, the pediatrician's main responsibility lies in protecting the child's health.

The Food and Drug Administration has not approved NAATs for the diagnosis of *C trachomatis* or *N gonorrhoeae* infections of the throat or anus. The Food and Drug Administration does allow laboratories to use NAATs for testing nongenital specimens if the individual laboratory undergoes internal validation of the method used in a method verification study. In verification studies, positive and negative specimens are compared with reference standards or with results from a second laboratory.<sup>65</sup> No studies have been published evaluating the use of nongenital-site NAATs in prepubertal children. However, studies in adults have had promising results when using some NAATs to test for rectal or pharyngeal *N gonorrhoeae* and *Chlamydia* infections in high-risk populations.<sup>66–68</sup> At this point, the use of NAATs in children for rectal or pharyngeal specimens is not warranted until more research is available. If used, they should be interpreted with caution.

If diagnosed with an STI, the child should be treated promptly. When there is a possibility that the child has been exposed to HIV, proper follow-up or prophylaxis is needed. When appropriate, consideration should be given

to treating the patient with emergency contraception.

## WORKING WITH FAMILIES TO MITIGATE THE ADVERSE EFFECTS OF SEXUAL ABUSE

When children disclose sexual abuse, people close to them are usually deeply affected. Parents often have feelings of guilt for not protecting their children<sup>68,69</sup> and might experience intense anger at the abusers. A child's disclosure can exacerbate a parent's own feelings about his or her adverse childhood experiences. Previous family conflict (eg, marital conflict, substance abuse issues) can be aggravated. Some parents want to sweep the disclosure under the rug to avoid dealing with the painful reality. Family members can feel protective of the accused abuser, especially if that person is another family member. Families should be given the following guidance about how to respond to children who disclose abuse.

1. Parents should understand that medical professionals are required to report suspected abuse to the proper authorities for investigation. It is not an option for the pediatrician to keep the disclosure secret.
2. It is important for families to cooperate with agencies investigating the alleged abuse.
3. Studies have shown that the long-term outcomes of children who have experienced sexual abuse are better if they are believed and supported after a disclosure.<sup>11,70</sup> The parents' initial response to the disclosure is important. If the parents show extreme distress and become nonfunctional, the child will feel less secure and less protected. If the parents are openly emotional and weeping, the child might feel that he or she has to recant or minimize the abuse to decrease the parents' distress.

Parents should respond in a calm and protective manner, assuring the child that the abuse was not his or her fault and that they will do all they can to protect the child and keep him or her safe.

4. Parents should not independently try to question the child or accuse the child of lying. If the child wants to talk about the abuse experience, the parent should listen and be supportive, but it is not helpful to repeatedly question the child or force the child to describe the abuse in detail. This type of questioning can be damaging to the legal adjudication of the case.
5. Pediatricians can provide guidance to families by recognizing the importance of mental health assessment after childhood trauma and by familiarizing themselves with mental health treatments that have been shown to be effective in ameliorating the effects of abuse.<sup>71</sup> Children should be treated by therapists with proper training and experience in dealing with child trauma. Options are available to facilitate the delivery of psychological services to abused children through child advocacy centers, community mental health centers, and victims' compensation programs.

## GUIDANCE FOR PEDIATRICIANS

1. Pediatricians should understand the mandatory child abuse reporting laws in their states and should know how to make a report to the responsible agency in their jurisdiction that investigates cases of alleged child sexual abuse.

2. Pediatricians should recognize that sexual abuse of children occurs commonly, and they should be prepared to respond appropriately in their clinical practices.
3. Pediatricians should be aware of normal, developmentally appropriate variations in children's sexual behaviors.<sup>29</sup>
4. Pediatricians should be aware of community resources available to assist in the evaluation of alleged child abuse.
5. Pediatricians should be educated about normal and abnormal genital and anal anatomy in children.
6. Pediatricians should seek a second expert opinion in cases of child sexual abuse when the child's anal or genital examination is thought to be abnormal.
7. Pediatricians should know when and where to refer cases of acute alleged sexual abuse or assault that require forensic testing, prophylaxis for STIs and HIV, and emergency contraception.
8. Pediatricians should know the importance of using nonleading, open-ended questions if they are asking questions about possible abuse.
9. Pediatricians should understand how to support children and families when child sexual abuse is suspected.
10. Pediatricians should be aware of the effects of sexual abuse on children's mental health and be able to refer abused children to mental health professionals who have expertise in treating child trauma.

11. Advice on protection of children from sexual abuse should be part of the anticipatory guidance given to parents in the medical home. The AAP Web site provides guidance for pediatricians (<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Sexual-Abuse.aspx>) and for parents (<http://www.aap.org/en-us/about-the-aap/aap-press-room/news-features-and-safety-tips/Pages/Parent-Tips-for-Preventing-and-Identifying-Child-Sexual-Abuse.aspx>) about preventing child sexual abuse. In addition, the AAP developed an educational toolkit for "Preventing Sexual Violence" (<https://www2.aap.org/pubserv/PSVpreview/pages/main.html>).

## LEAD AUTHORS

Carole Jenny, MD, MBA, FAAP Former Committee Member

James E. Crawford-Jakubiak, MD, FAAP

## COMMITTEE ON CHILD ABUSE AND NEGLECT, 2011–2012

Cindy W. Christian, MD, Chairperson, FAAP

James E. Crawford-Jakubiak, MD, FAAP

Emalee G. Flaherty, MD, FAAP

John M. Leventhal, MD, FAAP

James L. Lukefahr, MD, FAAP

Robert D. Sege MD, PhD, FAAP

## LIAISONS

Harriet MacMillan, MD, American Academy of Child and Adolescent Psychiatry

Catherine M. Nolan, MSW, ACSW, Administration for Children, Youth, and Families

Janet Saul, PhD, Centers for Disease Control and Prevention

## STAFF

Tammy Piazza Hurley

## REFERENCES

1. Kellogg N; American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of sexual abuse in children. *Pediatrics*. 2005;116(2):506–512

2. Sedlak AJ, Mettenburg J, Basena M, et al. Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): 2004–2009. Washington, DC: US Department of Health and

Human Services, Administration for Children and Families; 2010. Available at: [www.acf.hhs.gov/programs/opre/abuse\\_neglect/natl\\_incid/index.html](http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/index.html). Accessed November 4, 2012



3. Saunders BE, Kilpatrick DG, Hanson RF, Resnick HS, Walker ME. Prevalence, case characteristics, and long-term psychological correlates of child rape among women: a national survey. *Child Maltreat*. 1999;4(3):187–200
4. Tjaden P, Thoennes N. Full Report of the Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey. Washington, DC: US Department of Justice, National Institute of Justice; 2000. Available at: <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>. Accessed November 4, 2012
5. Finkelhor D. Current information on the scope and nature of child sexual abuse. *Future Child*. 1994;4(2):31–53
6. Finkelhor D, Turner H, Ormrod R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics*. 2009;124(5):1411–1423
7. Finkelhor D, Ormrod RK, Turner HA. Lifetime assessment of poly-victimization in a national sample of children and youth. *Child Abuse Negl*. 2009;33(7):403–411
8. Hanson RF, Self-Brown S, Fricker-Elhai AE, Kilpatrick DG, Saunders BE, Resnick HS. The relations between family environment and violence exposure among youth: findings from the national survey of adolescents. *Child Maltreat*. 2006;11(1):3–15
9. Kogan SM. Disclosing unwanted sexual experiences: results from a national sample of adolescent women. *Child Abuse Negl*. 2004;28(2):147–165
10. Smith DW, Letourneau EJ, Saunders BE, Kilpatrick DG, Resnick HS, Best CL. Delay in disclosure of childhood rape: results from a national survey. *Child Abuse Negl*. 2000;24(2):273–287
11. Roesler TA. Reactions to disclosure of childhood sexual abuse. The effect on adult symptoms. *J Nerv Ment Dis*. 1994;182(11):618–624
12. Jonas S, Bebbington P, McManus S, et al. Sexual abuse and psychiatric disorder in England: results from the 2007 Adult Psychiatric Morbidity Survey. *Psychol Med*. 2011;41(4):709–719
13. Deblinger E, Mannarino AP, Cohen JA, Steer RA. A follow-up study of a multisite, randomized, controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1474–1484
14. Swanston HY, Plunkett AM, O'Toole BI, Shrimpton S, Parkinson PN, Oates RK. Nine years after child sexual abuse. *Child Abuse Negl*. 2003;27(8):967–984
15. Simon NM, Herlands NN, Marks EH, et al. Childhood maltreatment linked to greater symptom severity and poorer quality of life and function in social anxiety disorder. *Depress Anxiety*. 2009;26(11):1027–1032
16. Boxer P, Terranova AM. Effects of multiple maltreatment experiences among psychiatrically hospitalized youth. *Child Abuse Negl*. 2008;32(6):637–647
17. DiLillo D, Guiffre D, Tremblay GC, Peterson L. A closer look at the nature of intimate partner violence reported by women with a history of child sexual abuse. *J Interpers Violence*. 2001;16(2):116–132
18. Messman-Moore TL, Walsh KL, DiLillo D. Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse Negl*. 2010;34(12):967–976
19. Midei AJ, Matthews KA. Interpersonal violence in childhood as a risk factor for obesity: a systematic review of the literature and proposed pathways. *Obes Rev*. 2011;12(5):e159–e172
20. Feiring C, Simon VA, Cleland CM. Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual difficulties and dating aggression. *J Consult Clin Psychol*. 2009;77(1):127–137
21. Walker EA, Gelfand AN, Gelfand MD, Katon WJ. Psychiatric diagnoses, sexual and physical victimization, and disability in patients with irritable bowel syndrome or inflammatory bowel disease. *Psychol Med*. 1995;25(6):1259–1267
22. Finestone HM, Stenn P, Davies F, Stalker C, Fry R, Koumanis J. Chronic pain and health care utilization in women with a history of childhood sexual abuse. *Child Abuse Negl*. 2000;24(4):547–556
23. Jones DJ, Runyan DK, Lewis T, et al. Trajectories of childhood sexual abuse and early adolescent HIV/AIDS risk behaviors: the role of other maltreatment, witnessed violence, and child gender. *J Clin Child Adolesc Psychol*. 2010;39(5):667–680
24. Mosack KE, Randolph ME, Dickson-Gomez J, Abbott M, Smith E, Weeks MR. Sexual risk-taking among high-risk urban women with and without histories of childhood sexual abuse: mediating effects of contextual factors. *J Child Sex Abuse*. 2010;19(1):43–61
25. Arnow BA, Hart S, Scott C, Dea R, O'Connell L, Taylor CB. Childhood sexual abuse, psychological distress, and medical use among women. *Psychosom Med*. 1999;61(6):762–770
26. Topitzes J, Mersky JP, Reynolds AJ. Child maltreatment and adult cigarette smoking: a long-term developmental model. *J Pediatr Psychol*. 2010;35(5):484–498
27. Khoury L, Tang YL, Bradley B, Cubells JF, Ressler KJ. Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. *Depress Anxiety*. 2010;27(12):1077–1086
28. Najdowski CJ, Ullman SE. Prospective effects of sexual victimization on PTSD and problem drinking. *Addict Behav*. 2009;34(11):965–968
29. Kellogg ND; Committee on Child Abuse and Neglect, American Academy of Pediatrics. Clinical report: the evaluation of sexual behaviors in children. *Pediatrics*. 2009;124(3):992–998
30. Lowen D, Reece RM. *Visual Diagnosis of Child Abuse on CD-ROM*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
31. Finkel MA, Giardino AP, eds. *Medical Evaluation of Child Sexual Abuse: A Practical Guide*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2009
32. Reece RM, Christian C, eds. *Child Abuse: Medical Diagnosis and Management*, 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
33. Flaherty EG, Sege RD, Griffith J, et al; PROS network; NMAPedsNet. From suspicion of physical child abuse to reporting: primary care clinician decision-making. *Pediatrics*. 2008;122(3):611–619
34. Flaherty EG, Jones R, Sege R; Child Abuse Recognition Experience Study Research Group. Telling their stories: primary care practitioners' experience evaluating and reporting injuries caused by child abuse. *Child Abuse Negl*. 2004;28(9):939–945
35. American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. *Pediatrics*. 1999;103(1):186–191
36. Young KL, Jones JG, Worthington T, Simpson P, Casey PH. Forensic laboratory evidence in sexually abused children and adolescents. *Arch Pediatr Adolesc Med*. 2006;160(6):585–588
37. Christian CW, Lavelle JM, De Jong AR, Loiselle J, Brenner L, Joffe M. Forensic evidence findings in prepubertal victims of sexual assault. *Pediatrics*. 2000;106(1 pt 1):100–104
38. Thackeray JD, Hornor G, Benzinger EA, Scribano PV. Forensic evidence collection and DNA identification in acute child sexual assault. *Pediatrics*. 2011;128(2):227–232
39. Girardet R, Bolton K, Lahoti S, et al. Collection of forensic evidence from pediatric

- victims of sexual assault. *Pediatrics*. 2011;128(2):233–238
40. Fajman N, Wright R. Use of antiretroviral HIV post-exposure prophylaxis in sexually abused children and adolescents treated in an inner-city pediatric emergency department. *Child Abuse Negl*. 2006;30(8):919–927
  41. Workowski KA, Berman S; Centers for Disease Control and Prevention (CDC). Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR-12):1–110
  42. Lentsch KA, Johnson CF. Do physicians have adequate knowledge of child sexual abuse? The results of two surveys of practicing physicians, 1986 and 1996. *Child Maltreat*. 2000;5(1):72–78
  43. Narayan AP, Socolar RR, St Claire K. Pediatric residency training in child abuse and neglect in the United States. *Pediatrics*. 2006;117(6):2215–2221
  44. Starling SP, Heisler KW, Paulson JF, Youmans E. Child abuse training and knowledge: a national survey of emergency medicine, family medicine, and pediatric residents and program directors. *Pediatrics*. 2009;123(4). Available at: [www.pediatrics.org/cgi/content/full/123/4/e595](http://www.pediatrics.org/cgi/content/full/123/4/e595)
  45. Committee on Practice and Ambulatory Medicine. Policy statement: Use of chaperones during the physical examination of the pediatric patient. *Pediatrics*. 2011;127(5):991–993
  46. Braverman PK, Breech L; Committee on Adolescence. American Academy of Pediatrics. Clinical report: gynecologic examination for adolescents in the pediatric office setting. *Pediatrics*. 2010;126(3):583–590
  47. Kaufman M; American Academy of Pediatrics Committee on Adolescence. Care of the adolescent sexual assault victim. *Pediatrics*. 2008;122(2):462–470
  48. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 463: Cervical cancer in adolescents: screening, evaluation, and management. *Obstet Gynecol*. 2010;116(2 pt 1):469–472
  49. Adams JA, Kaplan RA, Starling SP, et al. Guidelines for medical care of children who may have been sexually abused. *J Pediatr Adolesc Gynecol*. 2007;20(3):163–172
  50. Makoroff KL, Brauley JL, Brandner AM, Myers PA, Shapiro RA. Genital examinations for alleged sexual abuse of prepubertal girls: findings by pediatric emergency medicine physicians compared with child abuse trained physicians. *Child Abuse Negl*. 2002;26(12):1235–1242
  51. Adams JA. Guidelines for medical care of children evaluated for suspected sexual abuse: an update for 2008. *Curr Opin Obstet Gynecol*. 2008;20(5):435–441
  52. 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(3):310–317
  53. Muram D. Child sexual abuse: relationship between sexual acts and genital findings. *Child Abuse Negl*. 1989;13(2):211–216
  54. Kellogg ND, Menard SW, Santos A. Genital anatomy in pregnant adolescents: "normal" does not mean "nothing happened." *Pediatrics*. 2004;113(1 pt 1). Available at: [www.pediatrics.org/cgi/content/full/113/1/e67](http://www.pediatrics.org/cgi/content/full/113/1/e67)
  55. McCann J, Miyamoto S, Boyle C, Rogers K. Healing of nonhymenal genital injuries in prepubertal and adolescent girls: a descriptive study. *Pediatrics*. 2007;120(5):1000–1011
  56. McCann J, Miyamoto S, Boyle C, Rogers K. Healing of hymenal injuries in prepubertal and adolescent girls: a descriptive study. *Pediatrics*. 2007;119(5). Available at: [www.pediatrics.org/cgi/content/full/119/5/e1094](http://www.pediatrics.org/cgi/content/full/119/5/e1094)
  57. Girardet RG, Lahoti S, Howard LA, et al. Epidemiology of sexually transmitted infections in suspected child victims of sexual assault. *Pediatrics*. 2009;124(1):79–86
  58. Whaitiri S, Kelly P. Genital gonorrhoea in children: determining the source and mode of infection. *Arch Dis Child*. 2011;96(3):247–251
  59. Bell TA, Stamm WE, Wang SP, Kuo CC, Holmes KK, Grayston JT. Chronic *Chlamydia trachomatis* infections in infants. *JAMA*. 1992;267(3):400–402
  60. Hammerschlag MR, Alpert S, Rosner I, et al. Microbiology of the vagina in children: normal and potentially pathogenic organisms. *Pediatrics*. 1978;62(1):57–62
  61. Hammerschlag MR, Guillén CD. Medical and legal implications of testing for sexually transmitted infections in children. *Clin Microbiol Rev*. 2010;23(3):493–506
  62. Lindegren ML, Hanson IC, Hammett TA, Beil J, Fleming PL, Ward JW. Sexual abuse of children: intersection with the HIV epidemic. *Pediatrics*. 1998;102(4). Available at: [www.pediatrics.org/cgi/content/full/102/4/E46](http://www.pediatrics.org/cgi/content/full/102/4/E46)
  63. Black CM, Driebe EM, Howard LA, et al. Multicenter study of nucleic acid amplification tests for detection of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* in children being evaluated for sexual abuse. *Pediatr Infect Dis J*. 2009;28(7):608–613
  64. Brown HL, Fuller DD, Jasper LT, Davis TE, Wright JD. Clinical evaluation of affirm VP111 in the detection and identification of *Trichomonas vaginalis*, *Gardnerella vaginalis*, and *Candida* species in vaginitis/vaginosis. *Infect Dis Obstet Gynecol*. 2004;12(1):17–21
  65. US Food and Drug Administration. *ORA Laboratory Procedure*, vol. II: *Methods. Method Verification and Validation. Version No 1.5*. Silver Spring, MD: US Food and Drug Administration; 2003
  66. Bachmann LH, Johnson RE, Cheng H, et al. Nucleic acid amplification tests for diagnosis of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* rectal infections. *J Clin Microbiol*. 2010;48(5):1827–1832
  67. Schachter J, Moncada J, Liska S, Shayevich C, Klausner JD. Nucleic acid amplification tests in the diagnosis of chlamydial and gonococcal infections of the oropharynx and rectum in men who have sex with men. *Sex Transm Dis*. 2008;35(7):637–642
  68. Giannini CM, Kim HK, Mortensen J, Mortensen J, Marsolo K, Huppert J. Culture of non-genital sites increases the detection of gonorrhea in women. *J Pediatr Adolesc Gynecol*. 2010;23(4):246–252
  69. Leventhal JM, Murphy JL, Asnes AG. Evaluations of child sexual abuse: recognition of overt and latent family concerns. *Child Abuse Negl*. 2010;34(5):289–295
  70. Everson MD, Hunter WM, Runyon DK, Edelson GA, Coulter ML. Maternal support following disclosure of incest. *Am J Orthopsychiatry*. 1989;59(2):197–207
  71. Cohen JA, Mannarino AP, Deblinger EM. *Treating Trauma and Traumatic Grief in Children and Adolescents*. New York, NY: Guilford Press; 2006

## The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected

Carole Jenny, James E. Crawford-Jakubiak and COMMITTEE ON CHILD ABUSE AND NEGLECT

*Pediatrics* originally published online July 29, 2013;

### Updated Information & Services

including high resolution figures, can be found at:  
<http://pediatrics.aappublications.org/content/early/2013/07/23/peds.2013-1741>

### Permissions & Licensing

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:  
<http://www.aappublications.org/site/misc/Permissions.xhtml>

### Reprints

Information about ordering reprints can be found online:  
<http://www.aappublications.org/site/misc/reprints.xhtml>

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## **The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected**

Carole Jenny, James E. Crawford-Jakubiak and COMMITTEE ON CHILD ABUSE AND NEGLECT

*Pediatrics* originally published online July 29, 2013;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/early/2013/07/23/peds.2013-1741>

Data Supplement at:

<http://pediatrics.aappublications.org/content/suppl/2013/07/23/peds.2013-1741.DCSupplemental>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 345 Park Avenue, Itasca, Illinois, 60143. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

