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The Initial Medical Assessment of Possible Child Sexual Abuse: History, History, History

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Abstract

Primary care professionals (PCPs) can play a valuable role in the initial assessment of possible child sexual abuse (CSA), an all too prevalent problem. PCPs, however, are often reluctant to conduct these assessments. The goal of this paper is to help PCPs be more competent and comfortable playing a limited but key role. This is much needed as there may be no need for further assessment and also because of a relative paucity of medical experts in this area. While some children present with physical problems, the child's history is generally the critical information. This article therefore focuses on practical guidance regarding history taking when CSA is suspected, incorporating evidence from research on forensic interviewing. We have been mindful of the practical constraints of a busy practice and the role of the public agencies in fully investigating possible child sexual abuse. The approach also enables PCPs to support children and their families.

What's New

While primary care professionals may be reluctant to assess child sexual abuse, they are well positioned to play a key and necessary, albeit limited, role. This article offers practical guidance for obtaining a brief history, usually the critical information.

Introduction

Sexual abuse of children is alarmingly prevalent. By age 18, 27% of girls and 5% of boys in the U.S. are estimated to have experienced contact sexual abuse.[1] Only a small fraction become known and are referred to the public agencies mandated to protect children. The potential short- and long-term consequences of child sexual abuse (CSA) have been amply documented.[2–4] Many parents and caregivers, suspecting abuse, bring children to their primary care professional (PCP), anticipating that they can assess whether abuse occurred. However, in most substantiated cases of CSA, medical evidence is lacking.[5] The history is central, and yet PCPs often feel ill-equipped to elicit a report from a child, particularly in young children. Practice guidelines advise pediatricians to conduct "minimal facts" history-taking and ask "open-ended" questions, but clear and consistent guidance is lacking.[6,7] Research has identified the most productive means for questioning children about sexual abuse that can be adapted by PCPs to elicit a minimal facts history and determine whether there is reasonable suspicion of abuse.

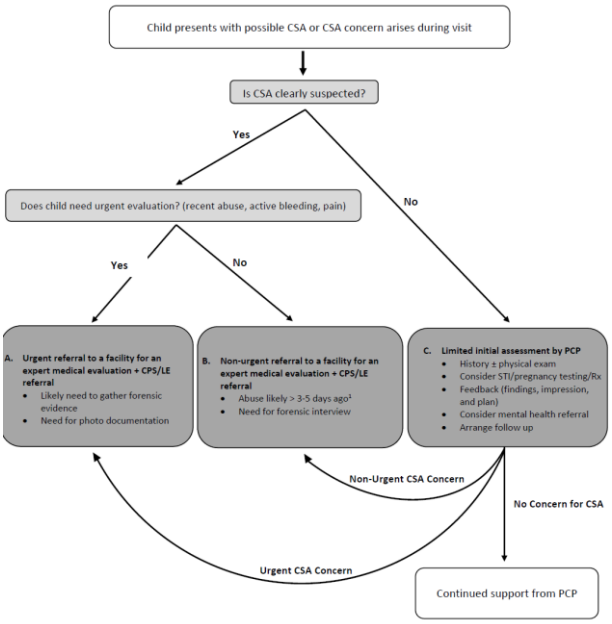
PCP's may be reluctant to assess children when sexual abuse is suspected,[8,9] preferring to refer to an emergency department or medical expert, while reporting the concern to child protective services (CPS) and/or the police. While several factors may contribute to this reluctance, it is often not optimal care, for several reasons. First, in some situations, such as a diaper rash, parental anxiety can be readily allayed. Second, referral to an emergency department often does not lead to an assessment by someone with expertise in this area. Third, data from the American Board of Pediatrics indicate that there were only 336 child abuse pediatricians (CAPs) aged 70 or younger in the U.S. in 2022; the ratio of such professionals varied across states from 0.0 (in four states) to 3.18 per 100,000 children, averaging just 0.5.[10] In parts of all states, there are families living over 40 miles from a facility with a CAP.[11] Fourth, referral to CPS or the police does not guarantee a medical evaluation. Even if taken to a Child Advocacy Center (CAC) for a forensic interview, only a modest proportion are evaluated medically, just 89,058 out of 247,543 interviewed in 2022.[12] Fifth, PCPs usually have long-term trusting relationships with patients and families which are particularly helpful in stressful times.[6] Children may be more inclined to share sensitive information with a professional they know and trust.[8,13] Therefore, PCPS can play an important albeit limited role in initially assessing children when CSA is a concern. This assessment guides their decision on whether there is a reasonable basis for referral to CPS and/or the police, the public agencies responsible for investigating abuse and ensuring children's safety.

Our recommendations improve upon the 2013 Clinical Report, "The Evaluation of Children in the Primary Care Setting When Sexual Abuse is Suspected," regarding how pediatricians should conduct "minimal facts" history-taking, anticipating that a forensic evaluator will conduct "a more detailed interview."[6] First, although the Report recommends that "time should be spent talking about nonthreatening issues, such as schools, friends, or pets," it fails to discuss the types of questions that increase children's willingness to report abuse. Our paper gives clear guidance on question types. Second, the Report recommends that 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." Our paper avoids words like "difficult" or "uncomfortable" that are often misunderstood by young children. Third, the Report warns that "[t]he pediatrician should not ask leading or suggestive questions," and should begin with "open-ended" questions, but fails to define these terms. Instead the Report provides examples of what it calls open-ended questions, such as "Is

anything bothering you?" We explain the problems with yes-no questions, which elicit brief and often erroneous responses. The use of "anything" is particularly problematic, pulling for a "no." To its credit, the Report recommends "Tell me why you're here today." Our paper improves upon this question, discusses how to avoid phrasing it as a yes-no question, and describes what to do if the question is ineffective. Fourth, our paper discusses topics that pediatricians should avoid when conducting "minimal facts" history-taking, including enumeration, dating, and yes-no questions about pain, penetration and ejaculation. The Report is not alone in recommending problematic questions. We routinely see these in practice guides for pediatricians. For example, "The Pediatrician's Role in Child Abuse Interviewing" recommends "Has something happened to you?" as an open-ended question, not recognizing that it's yes-no structure and vagueness could lead to false "no" responses.[7]

The circumstances concerning CSA vary (See Figure). If it is readily evident that abuse likely occurred and local medical expertise is available, PCPs may prefer to minimize their assessment and refer to CPS and/or the police, without obtaining a detailed history or conducting an exam. In some situations, an alternative medical explanation such as a diaper rash can be readily reassuring. At times, there is a need for an urgent medical assessment including gathering forensic evidence and the PCP can facilitate a referral. In some regions, PCPs can directly refer children to a CAP for an expert evaluation. There are also many ambiguous circumstances and a PCP's limited assessment can clarify how to proceed. This paper focuses on these unclear situations, and offers practical guidance to initially assess possible CSA, without expecting a comprehensive and definitive evaluation. PCPs are clearly not forensic interviewers nor investigators, but they can apply principles of good interviewing techniques in eliciting a limited history, assessing the likelihood of CSA, and determining next steps.[7] Their assessment can clarify concerns for a child and family, guide them towards further evaluation if needed, have investigative value, and help protect a child.

Figure: Decision Tree for Assessing Possible Child Sexual Abuse



CSA — child sexual abuse, CPS — child protective services, LE — law enforcement, STI — sexually transmitted infection, Rx — treatment, PCP — primary care professional

[1] in prepubertal girls, forensic evidence should be collected, if at all, within 3 days of the last incident; this extends to 5 days for pubertal girls

In sum, this paper offers PCPs guidance for an initial assessment when concern for CSA arises. Much of this guidance also pertains to emergency medicine professionals, particularly concerning "acute" situations when recent abuse is alleged. It should also be useful to medical professionals in many areas where there is no or limited access to a CAP or similar expert. We focus on the history, typically the critical information in assessing the likelihood of CSA. Guidance on the physical exam and laboratory testing can be found in AAP and CDC publications.[14,15]

Goals of the Initial Medical Assessment

The goals of the initial medical assessment are similar regardless of setting. These are:

1. To clarify whether a child may have been sexually abused - by obtaining a history from a parent(s) and child.
2. To decide on the need for/extent of a physical examination.
3. To decide whether to test for STIs and pregnancy.
4. To provide preliminary feedback and reassurance to parent(s) and child.
5. To consider the need for other services, especially further medical evaluation and mental health care.
6. To decide whether to refer to CPS and/or the police.

Preparing Accompanying Parent(s) or Caregivers and Child

The possibility of CSA may precipitate a crisis for a family and evoke disbelief, a sense of betrayal, anger and fear of financial insecurity. Generally, the alleged offender is not present for the initial medical assessment. There is often anxiety concerning the medical examination. Mothers and older girls may worry that it will resemble an adult gynecologic exam. A speculum exam is seldom needed and clarifying what to expect is comforting. This includes first talking with the parent alone, then the child alone, followed by the exam for which the child chooses who will accompany them. If it is impossible to separate the parent and younger child for the history, the child should be seated next to the parent or on the parent's lap facing outward, reducing their influence. Explaining that no "shots" will be given and that "this should not hurt" is useful. Finally, feedback will be provided and questions answered. If concern for CSA first arises during an unrelated visit, the approach is essentially the same.

History from a Parent(s) or Caregiver

Table 1. History from a Parent(s) or Caregiver: Suggested Questions

Issue	Suggested Question
How the concern for CSA arose	"What made you think s/he'd been abused?"
The chronology of events	"Please tell me how you think this started, then …" "When was the last time ____ was with the person who may have abused her/him?"
Responses	"How did you respond? And your child?"
Possible questions and responses	"What did you ask? What did s/he say?"
Physical complaints	"Were there problems urinating (peeing) or with defecation (pooping)?"
Behavioral or emotional changes	"What changes if any have there been in her/his behavior or emotions?"
Past Medical History	"Did s/he have trauma or injury to their genitals before this?" "Did s/he have a sexually transmitted infection before?" "Has s/he had behavioral or emotional problems in the past?"
Social History	"Who lives at home?" "Who takes care of ___?" "Regarding the person who may have done this, what's their age, sex, relationship to ___?" "Do you know if they use drugs, whether they have HIV?"
Possible exposures	"Has your child ever seen others having sex?" "Has s/he seen porn?"

When CSA is the presenting complaint, one needs to first hear a parent's account, without the child or alleged offender present. This includes clarifying the chronology of events, how the concern for CSA arose, how the parent and others responded, as well as the child's or adolescent's responses. Documentation of what the parent recalls about key questions posed to the child and the child's responses is useful. Any physical symptoms (e.g., dysuria) or signs (e.g., genital discharge) or changes in behavior and emotional state (e.g., appetite, sleep, mood) need probing.[16]

The past medical history should cover possible prior genital trauma, CSA, STIs and mental health concerns. The social history includes the caregiving and living arrangement, information regarding the alleged perpetrator – age, sex, relationship to the child, substance misuse, HIV status and last contact alone with the child, and, possible exposure to sexual behavior or pornography.

History From a Child

Background

The child's history is extremely important, both for determining whether there is reasonable suspicion necessitating a referral and for other professionals to assess the truth of the abuse allegation in an investigation and legal proceedings.[17] If a child describes sexual abuse during the visit, this may be for the first time, or the first time to an impartial adult. Early statements have special legal significance because subsequent contact with those involved raises concern about distorting children's reports. In both state and federal courts children's reports of abuse made to medical professionals are potentially admissible under a medical diagnosis and treatment hearsay exception, and/or under special hearsay exceptions for children's abuse reports.[18] The medical diagnosis exception is founded on the principle that patients are motivated to tell the truth, knowing that appropriate medical care requires their honesty.[19] Although some courts assume the reliability of statements made to medical professionals, many expect evidence that the child understood the medical significance of their report. It is good practice to explain the purpose of the assessment to the child, such as "to make sure you're healthy and safe." The special hearsay exceptions assess the credibility of the child's report, including the questions asked and the nature and spontaneity of the child's responses. Thus, it is best to document both one's key questions and the child's answers.

Table 2. Types of Questions.

Question Type	Definition
Invitation	Broad open-ended request for information
Wh-	What, Where, Who, When, Why, How
Yes/No	Question that can be answered "yes" or "no"
Forced/multiple choice	Question that provides options using the word "or"
Suggestive/Leading	Question that clearly conveys a desired response

Applying Research Findings from Forensic Interviewing

Research into children's ability and willingness to report sexual abuse highlights the value of eliciting narrative reports maximizing the use of broad open-ended recall questions ("invitations").[20] Definitions and examples of question types are in Tables 2 and 3.

Invitations include "Tell me what happened," "What happened next," and "Tell me more about [a detail mentioned by the child]".[21] By age 5, children provide the most information in response to invitations, and children of all ages provide more (and more accurate) information in response to *wh- questions* than Yes-No or forced-choice questions.[21–23] *Wh- questions* include what, where, who, when, why and how; "what" questions about actions appear particularly useful.[24]

Even though they are not inherently suggestive, Yes-No questions are problematic for several reasons. First, reluctant children simply say "no".[25] False denials of sexual abuse are common, particularly if the child has never reported the abuse.[26,27] Children routinely fail to report abuse because of embarrassment, shame, fear, and a desire to protect the perpetrator.[20] Second, children tend to answer "no" to Yes-No questions they do not understand, rather than

signal their confusion.[28] Third, children may not answer "I don't know" to Yes-No questions but guess when they do not know the answer.[29] Fourth, children choose "yes" or "no" rather than indicate when the best answer is neither "yes" nor "no" (e.g., "were your clothes on?").[30] Fifth, children fail to elaborate on their responses, saying just "yes" or "no" and nothing more.[31]

Forced-choice questions are similarly problematic. Children simply choose rather than signal incomprehension, guess rather than answer "I don't know," fail to provide intermediate responses, and fail to elaborate on their choices.[32] Including a "something else" option may reduce but not eliminate the problem.[30] Thus, PCPs should use invitations and *wh- questions* whenever possible. Of course, PCPs should avoid suggestive questions, which may lead to false allegations, particularly among young children.[23]

Table 3. Examples of Recommended and Suboptimal Questions.

Recommended Questions	Suboptimal Questions
Rapport Building - Invitations	
Tell me what you like to do.	Do you like sports?
Tell me what happened the last time you [activity].	Are you good at soccer?
Assessing Abuse - with prior report	
Tell me what you came to talk to me about today.	Do you know why you came to see me?
I heard you talked to a [disclosure recipient] Tell me what you talked about.	I heard you told your teacher that [name] touched your privates.
You said [child's words]. Please help me understand what happened.	
What happened next?	
Tell me more about [child's words].	
Assessing Abuse - without prior disclosure	
What do you call it where pee/poop comes out?	Has anyone ever touched your private parts in a way you didn't like?
Tell me everyone who has touched your [child's term].	Did [name] touch your private parts?
You said [name of toucher]. Tell me what happened.	
Eliciting Details	
How did you feel when/after s/he touched you?	Did it hurt? Did s/he touch you inside or outside your privates?
What did you see when you went to the bathroom?	Did anything come out of his privates? Did blood come out of your privates?
Where were your clothes when you were touched?	Were your clothes on or off?
Closure	
What questions do you have for me?	Do you have any questions for me?

Phases of History-Taking Instructions. In this phase, the PCP conveys the purpose of the assessment, such as "it's important to tell me the truth about what happened. That helps me keep you healthy and safe." This establishes the foundation for the medical diagnosis hearsay exception.[18] It is not necessary to test the child's understanding of "truth"; this is not legally required and assessment tools underestimate understanding.[18]

Rapport-building. Despite time pressures, it is well worth spending a few minutes putting the child at ease. Briefly asking about favorite activities is a common means of building rapport.[33] Narrative practice is an effective tool for increasing children's information when questioned about abuse and the accuracy of their reports.[34,35] In narrative practice, one asks the child to talk about a recent activity using invitations. For example, if the child mentions liking soccer, follow up with "Tell me everything that happened the last time you played soccer." The questioner then asks, "what happened next" and "tell me more about [detail]."[33]

Assessing Abuse, With or Without Prior Disclosure. The assessment phase differs depending on whether the child has previously reported abuse. If the abuse was witnessed, or if the child has already clearly described their abuse to an impartial person (e.g., a teacher), rather than a potentially biased party (e.g., a parent), , it is often unnecessary to elicit a report to conclude that there is reasonable suspicion.[36] When evaluating a child because of an ambiguous statement that might signal abuse, an effective first question is "Tell me what you came to talk to me about."

The precise wording is surprisingly important. Fewer children report their abuse if asked "Do you know why you came to talk to me?"[37] If the child does not know the reason for the medical assessment, it helps to ask about the prior report without specifically mentioning the suspect (e.g., "I heard you talked to your mom. Tell me what you talked about.")[21] If a child describes sexual abuse or mentions the alleged offender, it helps to invite a narrative: "you said [repeat child's words]. Tell me what happened." If the child expresses reluctance, one can reassure them that one talks to "children like you every day," without specifying abuse.

If the child has never reported abuse but abuse is suspected, it helps to first elicit the child's terms for their genitals and anus (e.g., "What do you call it where pee comes out?").[38] Children have many different names for these body parts.[39] Common screening questions tend to be yes-no questions, with all the problems they entail, plus they are often asked using the words "any" and "ever" (e.g., "Has anyone ever touched your vagina?"); these encourage "no" responses.[33,40] It is better to ask: "Tell me everyone who has touched your [child's term]." Of course, a positive response does not prove abuse. Rather, the question takes a neutral approach to genital touch, and allows the child to identify both innocent and abusive touch. One can follow up with "you said [name].Tell me what happened." Younger children may have been touched during bathing or toileting or other appropriate interactions; clarifying the context helps discern possible abuse.

Eliciting details. Often, a child's initial response to "tell me what happened" provides sufficient detail to constitute reasonable suspicion of sexual abuse, enough to justify a report to CPS and/or the police. Therefore, it is best to rely on the child's spontaneous report, with additional questioning only as needed to clarify whether reasonable suspicion exists.

Questions about clothing help distinguish sexually motivated from accidental touch during play or other innocent interactions. "Where were your clothes when he touched you?" is more likely to elicit accurate responses than Yes-No and forced-choice questions about clothing (e.g., "Were your clothes on or off?"), because clothing is often neither totally on nor off.[30]

Clarifying feelings and physical symptoms help characterize potentially abusive interactions and are consistent with the medical purpose of the assessment. "How did you feel when/after he touched you?" elicits reactions and effects (e.g., discomfort, dysuria) that may support the child's report.[41] "What did you see when you went to the bathroom?" can help determine if bleeding or ejaculation occurred.

On the other hand, direct questions about pain and ejaculation are unnecessary and ill-advised. Yes-No questions about pain are not recommended because abuse is often not physically painful, whereas a denial may surprise legal decision-makers unfamiliar with abuse.[41] If a child spontaneously mentions pain, however, this supports penetrative trauma.[18] With respect to ejaculation, one might be tempted to ask if "anything came out" of the suspect's penis.[42] However, children might respond negatively because they did not see the penis and are unfamiliar with the mechanics of sex.

Regarding penetration, asking if the suspect put something "inside" is ill-advised, because of young girls' uncertain understanding of "inside" and older girls' often limited experience regarding penetration.[39,43] Legally, penetration includes touching within the labia, yet adolescents may deny contact "inside" if there was no vaginal penetration.[18,39] For these reasons, PCPs should not probe possible penetration; instead, simply document what the child described.

Children are unlikely to be able to enumerate abusive incidents, particularly when abuse occurred repeatedly over a long time. Similarly, asking children to date abuse is not recommended; dating requires understanding conventional temporal information, such as

months, and the ability to infer when events must have occurred based on that understanding.[44] Unless a child spontaneously offers the information, it is best to assess the possible recency of abuse based on the child's last contact alone with the suspect.

Closure. Asking the child "What questions do you have for me?" is a compassionate way to encourage the child to express concerns. "Do you have any questions?" in contrast is likely to elicit a "no."[40] It is hazardous to reassure children who have not clearly expressed concerns (e.g. "it is not your fault") because this may suggest thoughts that had not occurred to them.

Table 4. History-taking Phases.

Phase	Definition
Instructions	Explain the purpose of the evaluation and the child's role.
Rapport-building	Put the child at ease and encourage them to provide narrative responses.
Assessment	Assess whether the child describes abuse.
Eliciting Details	If a child reports abuse, elicit limited details.
Closure	Remind the child of concern for safety, answer questions, provide reassurance.

It helps to thank the child for talking about what happened and to acknowledge that this was not easy. PCPs may feel great empathy, but it is important to remain neutral and avoid unwitting reinforcement of the child's account. However, stating that "I understand how that made you feel. Your parent(s) and I are going to try to keep you healthy and safe" can help healing.

Preliminary Feedback, Reassurance and Need for Additional Services

Following the history, exam and possible lab tests, PCPs should convey their initial impression and recommendations. If the concerns have been allayed, the PCP may feel comfortable discharging the family to home with appropriate follow up. If there is reasonable concern for CSA, this should be referred to CPS and/or the police, and the family apprised of the need for this. In addition, PCPs should consider the need for additional urgent or non-urgent medical evaluation. In some regions, PCPs have access to a medical expert who can evaluate equivocal situations and determine the need for public agency involvement.

All concerns and questions should be addressed. Feedback should first be given to just the parent(s); they may be uncomfortable expressing concerns in front of their child. It helps to talk alone with older children and adolescents; they may be uncomfortable expressing concerns in their parents' company. It is also valuable to talk with family members together. If appropriate, one can explicitly convey that the parent(s) believes and supports the child, and that they will do their best to protect them. It is an opportunity for encouraging open communication, commending a child for reporting their experience, and reassuring them that they can confide in their parent(s) if they face a tricky situation. Parents should be encouraged to listen, believe, support, and protect children who want to discuss their experience, but advised not to probe further about details, at least until the evaluation is completed.

The feedback may cover what they can expect such as another medical evaluation if planned and, if referred, that CPS and/or the police will talk with them. Probing interest in other services such as mental health care and facilitating referrals using Motivational Interviewing helps families at a challenging time.[45]

At the end of the visit, the PCP can often be reassuring. Even a tentative impression helps a child, family and others involved. With good parental support and perhaps professional help, children who have been sexually abused can do well. Physical injuries usually heal well and STIs respond to treatment. PCPs can reassure the family that they will follow the child's progress and provide support.

Conclusion

There is often a need for PCPs to initially assess possible CSA; it is a valuable albeit limited role. The history a PCP obtains may be critical in determining the likelihood of CSA.[7] This paper offers practical guidance for conducting a brief history in an initial medical assessment. It points to circumstances where PCPs determine an alternative medical condition and can reassure parents, as well as situations where the need for a referral is soon evident and their role very limited. In sum, there is a need for PCPs to overcome their reluctance to assess possible CSA; so doing can help children and families address a challenging concern.

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