Childhood Sexual Abuse: A Call to Action in Pediatric Primary Care

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"Every one of my doctors failed me." The impact of her words rippled through the auditorium on a rainy morning during my first year of medical school, where my fellow medical students and I were engaged in a panel discussion featuring survivors of childhood sexual abuse (CSA). Palpable unease permeated the room as the guest speaker spoke about her repetitive abuse at the hands of a family member throughout her childhood. As a young girl, she had visited doctors repeatedly for recurrent urinary tract infections, but, with each visit, she was lectured on proper hygiene and sent home without further investigation. This woman now stood fearlessly before 200 earnest medical students, and we listened in devastated silence as she shared her story. Would we fail our future patients in the same way?

The US Department of Health and Human Services defines CSA as "involvement of [a] child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities."[1] The scope of CSA is notoriously difficult to assess because of the multitude of unreported cases. Although the Centers for Disease Control and Prevention states that 1 in 4 girls and 1 in 13 boys experience CSA at some point in childhood,[2] it is suggested in some estimates that >1 in 5 people in the United States experience CSA.[3] Although CSA may occur in children of any race, ethnicity, or socioeconomic status, children with disabilities or histories of other forms of maltreatment are at increased risk for abuse.[4] It has been established that people exposed to adverse childhood experiences (ACEs), including CSA, are more likely to have health risk factors such as smoking, obesity, physical inactivity, and illicit drug use.[3] In addition, ACEs have been shown to increase the risk for a variety of psychiatric and behavioral health consequences, including depression, anxiety, sexual revictimization,[5] and dysfunctional intimate relationships.[6] The striking prevalence and lifelong sequelae of CSA constitute a substantial public health problem that cannot be dismissed.

The American Academy of Pediatrics emphasizes prevention of CSA through anticipatory guidance, including encouraging parents to use proper names for body parts and functions, know the whereabouts and caretakers of their children at all times, and give their children permission to share uncomfortable or threatening experiences.[4] Although these guidelines help raise awareness of CSA among pediatricians and parents, there is no well-accepted method for early detection of CSA.

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Despite a much higher estimated prevalence,[2] reports of CSA to Child Protective Services in 2018 comprised <1 in 1000 children, with just 10.5% of reports filed by medical personnel.[1] This demonstrates a massive deficit of timely detection and response. So why is it so challenging to detect cases of sexual abuse in pediatric primary care?

CSA often goes unaddressed in pediatric primary care settings because of significant obstacles complicating detection. First, victims of CSA most commonly present without obvious physical signs or symptoms.[7] Second, many pediatricians feel uncomfortable or inadequately trained to evaluate for sexual abuse during standard well-child checks. In a qualitative study that was focused on pediatricians, researchers found that inadequate training may actually be the most significant barrier to inquiring about sexual abuse.[8] Third, primary care physicians are notoriously limited by time and resources. Uncovering suspected child abuse in the clinic initiates a cascade of consequences that devastates families and disrupts clinic flow, so it is vital to have trained staff available to minimize further trauma and provide emotional support.[9] Finally, even if a physician has unlimited time and resources, some practical obstacles complicate the detection of child abuse. There is rarely an opportunity to be alone in the room with a young child, and it is possible that the alleged perpetrator may accompany the child to the appointment. Eliciting disclosure in the context of a standard office visit requires patience, proper training, and expert responsiveness to emotional cues from the patient and family.

Despite these challenges, detection of CSA is essential to promoting children's long-term health. As mandated reporters, pediatricians are responsible for maintaining the safety and health of their patients in cases of suspected abuse. Primary care pediatricians are ideally situated to detect abuse in children because most children have frequent contact with primary care services and many have trusting longitudinal relationships with their doctors.[10] Furthermore, for some families, pediatricians may be the most accessible liaison to the resources necessary to manage cases of sexual abuse. With earlier detection of CSA in the primary care setting and prompt referral to support services, interventions like trauma-focused cognitive behavioral therapy could be employed to reduce the symptoms of trauma for child and adolescent victims of CSA.[11]

In an initiative that reflects growing recognition of the impact of childhood trauma on long-term health, the state of California is now exploring universal ACEs screening in pediatric well-child checks.[12] Specifically, pediatricians are incentivized to assess their patients using the 17-item Pediatric ACEs and Related Life-events Screener tool.[12] Although the tool has not yet been validated, a randomized controlled trial is currently in progress. Universal implementation of a comprehensive screening method like the Pediatric ACEs and Related Life-events Screener may be an effective way to identify CSA along with other forms of childhood trauma, once it has been validated and the availability of appropriate follow-up resources has been ensured.[13]

Physicians may also detect CSA by asking appropriate open-ended questions during well-child checks, an approach that also helps cultivate and strengthen the doctor-patient relationship. Using evidence, researchers suggest that children are far more likely to disclose their abuse if they are asked directly, although in a nonleading manner.[14] For example, pediatricians may ask about CSA and other traumatic events at primary care visits using the single question, "Since the last time I saw you, has anything really scary or upsetting happened to you or your family?"[10] In addition to direct inquiry about trauma, questions regarding a child's daily life and relationships may raise suspicion for CSA. Regular use of illicit drugs, fear of violence in the school environment, feelings of not being accepted by one's peers and altered body-image, self-mutilation, and suicide attempts have been correlated with CSA.[15] These questions can be used as part of a trauma-informed approach to care that identifies patients in need of further evaluation and referral to social work or mental health services.

Given the growing awareness surrounding the significance of ACEs, I am optimistic that there will be greater emphasis on early detection of CSA and other forms of maltreatment by the time I am a practicing physician. For my medical school class, the moving words of one CSA survivor provided a potent reminder that many children face unconscionable obstacles to health and happiness, and that we have an important role in helping them thwart a lifelong cascade of physical and mental health consequences. Many of us will remember this message for the rest of our careers and strive to deliver trauma-informed care to each of our patients as well as advocate for further improvements to the care of these patients within the health care system. As cornerstones of community health, it is essential that primary care physicians be equipped with effective training and resources to identify victims of abuse in a timely manner, thus providing opportunities for treatment and hope to affected children and their families.

ABBREVIATIONS

ACE: adverse childhood experience
CSA: childhood sexual abuse

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