MEDICAL EVALUATION OF POTENTIAL CHILD SEXUAL ABUSE
(ie, Why It's Normal to Be Normal)
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**The information contained in this handout is intended for educational purposes only, and should not be construed as advice or opinion about any particular case.

False beliefs about child sexual abuse are common in society. This includes in jury pools.
Quas et al (2005) found that it was common for jury-eligible adults to believe that:

-serial disclosure indicates that the disclosure is false
-inconsistencies mean the report is false
-children who recant are lying
-most children tell someone right away
-children will not deny abuse if asked by a trusted adult
-children will make up false claims to get back at an adult

Realities of disclosure:

-Even children whose abuse was captured on video, may not disclose or only partially disclose
-Immediate or short-term disclosure occurs in only a minority of child sexual abuse patients
-Reasons that children do not disclose: fear of perpetrator, fear of being in trouble, fear of not being believed, fear of how it will affect their family; more likely with in-home offender, nonbelieving nonoffending caregiver
-Self-blame is very common among victims of child sexual abuse and decreases likelihood of disclosure
-Most children are emotionally neutral while disclosing; displaying negative emotions is less likely the more often/chronically they have been abused

False beliefs about physical effects of child sexual abuse are also common, ie that something gets 'popped', that a doctor can check for virginity, that an absence of physical findings is suspicious.

These types of false beliefs may serve as barriers to protecting and supporting children.

In reality, most sexually abused children have no physical findings diagnostic of their abuse. Studies have repeatedly found rates of diagnostic findings in pediatric sexual abuse exams of less than 10%. The largest and most recent studies have found overall rates of diagnostic findings of around 5%.

**The caveat to this is that sexual abuse exams should be performed by a provider appropriately trained to do them, such as a PSANE or a child abuse clinic, in order for the child to have the best possible experience and to obtain accurate results.

Why are so many exams normal????:
-Delay in disclosure is the norm
-Injuries heal very quickly and without leaving visible scars – we see this repeatedly in medical practice, in children with genital injuries both from sexual assault and accidents
-Prepubertal girls perceive that the contact was 'inside' or penetration when the labia/vestibule are traversed but the hymenal orifice is not
-The genital and anal tissues are highly elastic and penetration can occur without permanently visible injury – this is observed repeatedly in clinical practice and in literature w/ young children with STDs, pregnant teens
-Even when prepubertal children present acutely for assault exam, recovery of DNA evidence is the exception rather than the rule

What is the evidence in the medical literature that supports the above? A few of the most commonly cited and useful studies, but not a comprehensive list:

Adams: Guidelines for assessment of children who may have been sexually abused
-Development of a standardized language and approach to sexual abuse patients
-First published 1994, multiple updates since, most recently 2015
-Standard of care in US & Canada that all sexual abuse exams be interpreted in a way that is consistent with this framework

Berenson: Case-control study comparing abused vs nonabused children
-4/192 prepubertal children with a history of penetration had diagnostic exams
-'The genital examination of the abused child rarely differs from that of the nonabused child. Thus legal experts should focus on the child's history as the primary evidence of abuse'.

Kellogg: Genital exams in pregnant adolescents
-Subjects were 36 currently or recently pregnant adolescents evaluated for sexual abuse
*incontrovertible evidence of vaginal penetration
-2/36 had definite physical findings of penetrating vaginal trauma

McCann: Observed healing patterns of hymenal injuries
-Subjects: 239 girls, both prepubertal and adolescent, had sustained hymen injuries
-Most healed without clear evidence of the known prior injury

Heger: Description of exam results in large sample of patients referred for sexual abuse evaluation
-2384 subjects
-96.3% of all referred children had normal exams
-Of children who specifically disclosed penetration, exams were abnormal in 6% of girls and 1% of boys

Gallion: Description of evaluation results; evaluation of language children use to describe genital contact
-1500 female subjects
-7% had diagnostic physical findings
-described girls' perceptions of 'inside' vs 'outside' genitals – often perceived labial penetration as 'inside'

Smith: Description of evaluation results in large sample of patients referred for sexual abuse evaluation
-3569 subjects – largest sample ever amassed
-exams interpreted according to Adams guidelines
-diagnostic findings present in 4.8% overall
-diagnostic findings more common in adolescents>younger children, girls>boys, acute>nonacute exams
-latest replication of the infrequency of diagnostic exams – replication adds validity

What to tell children?
It's not your fault
We are here to help and protect you
(After medical exam, for most children) Your body is healthy and normal
You are so brave for disclosing – you may have prevented someone else from being abused
When someone else chose to do something wrong, it doesn't make you a bad person

What to tell parents?
Believe your child
Protect your child
Get trauma-focused mental health care

References:

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Greenbaum et al (2015) Child sex trafficking and commercial sexual exploitation: health care needs of victims. Pediatrics 135(3): 566-576.

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Smith TD et al (2018) Anogenital findings in 3569 pediatric examinations for sexual abuse/assault. Journal of Pediatric & Adolescent Gynecology 31 (2): 79-83