

Emergency Department Care for Prepubescent Patients Who Have Been Sexually Abused

Joint Position Statement





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Emergency Department Care for Prepubescent Patients Who Have Been Sexually Abused

Description

Sexual abuse of prepubescent children is a complex pediatric health care problem requiring medical intervention designed to meet the specific needs of this vulnerable population. Over 90% of children who experience sexual abuse are violated by an individual known to them or their caregivers: someone they know, trust, and love (Centers of Disease Control and Prevention [CDC], n.d.-b). While the initial report may be of a single encounter, abused children commonly experience mistreatment over multiple weeks, months, or years because of offenders' ready access to them (Elliott et al., 2022; U.S. Department of Justice, Office of Violence Against Women, 2016). Dependence on caregivers, as well as the child's developmental age and cognitive ability, create an opportunity for offenders to manipulate and silence children, especially if the offenders are family members or other trusted adults (Gewehr et al., 2021; U.S. Department of Justice, Office of Violence Against Women, 2016). Sexual abuse is often hidden by offenders, unwitnessed by others, and many times leaves no obvious physical signs of its occurrence (Elliott et al., 2022; Gewehr et al., 2021; U.S. Department of Justice, Office of Violence Against Women, 2016). Children who experience sexual abuse often suffer from a wide range of health problems throughout their lifespan, with acute concerns that include sexually transmitted infections, physical injuries, and psychological trauma (Hailes et al., 2019; Hornor, 2017; Ports et al., 2016). Pediatric patients who have been sexually abused are at greater risk for many adverse physical and psychological problems that may extend into adulthood (Alley & Diamond, 2021; Hailes et al., 2019; Ports et al., 2016; Pulverman et al., 2018; U.S. Department of Justice, Office of Violence Against Women, 2016).

Pediatric patients who have been sexually abused should not be treated under the same policies or guidelines used in the adult emergency care setting (Hoehn et al., 2018; U.S. Department of Justice, Office of Violence Against Women, 2016). Since 2004, The Joint Commission has required emergency care facilities to have policies and procedures for identifying, assessing, and maintaining legal responsibility for collection, retention, and safekeeping of evidentiary material relating to patients who are victims of childhood sexual assault, sexual molestation, abuse, and neglect (Futures Without Violence, n.d.). Healthcare providers within the emergency care setting have become part of a multidisciplinary team that, along with criminal justice and child protective services, recognizes child sexual abuse as a public health issue with long-term physical and psychosocial effects on children, families, and communities at large (Bentivegna et al., 2019; Mathey et al., 2020; U.S. Department of Justice, Office of Violence Against Women, 2016). Using this trauma-informed approach, pediatric patients who have been sexually abused can benefit from specialized care by qualified pediatric sexual assault nurse examiners (SANE) (Goyal et al., 2013; Hornor et al., 2012; Mathey et al., 2020).

ENA and IAFN Position

It is the position of the Emergency Nurses Association and the International Association of Forensic Nurses that:

1. Children who may be victims of sexual abuse are provided a safe and private environment upon arrival at an emergency care setting.
2. Emergency nurses provide developmentally age-appropriate, empathetic, and non-judgmental support to pediatric patients as well as to the caregivers presenting with them.
3. Non-offending parents and caregivers of children who may have been sexually abused have access to a community-based advocate, where available, at any time during their stay.
4. Emergency nurses engage social workers, where available, to facilitate completion of a psychosocial assessment to determine risk factors and strengths within the family.
5. Emergency nurses use a developmentally appropriate, trauma-informed approach throughout the child's care.
6. Children who have been sexually abused receive consistent, objective, immediate medical care, and forensic evidence is collected by emergency nurses and medical providers who know the appropriate jurisdictional guidelines and protocols.
7. Whenever possible, forensic nurses with specialized education as pediatric SANEs or physicians trained as child abuse pediatricians are consulted or assigned to care for children who disclose sexual abuse or for whom there is concern that sexual abuse may have occurred.
8. Emergency nurses receive continuing education on medical forensic sexual abuse evaluation and maintain access to current legislative guidelines and protocols for proper examination and reporting options.
9. Emergency nurses screen and assess all acute and non-acute concerns or disclosures of sexual abuse, neglect, or suspected abuse, making proper jurisdictionally mandated reports, referrals, and transfers based on the need for time-sensitive exams or follow-up.
10. Patients who have been sexually abused receive medically appropriate evaluation, testing, and treatment according to the most current recommended pediatric standards, protocols, and guidelines.
11. Emergency nurses consult and collaborate with multiple agencies, including child advocacy centers, to develop an individualized, multidisciplinary approach to evaluation, treatment, and continuity of care specific to each patient's circumstances, to minimize short- and longer-term physical and psychological trauma.
12. Emergency nurses trigger community intervention in cases of non-disclosure where there are concerns of child abuse and remain cognizant that other children living in the same household are potential sexual abuse victims.

13. Emergency nurses participate in community education and research to identify and implement best practice standards of care for pediatric patients who have been sexually abused.
14. Healthcare facilities recognize that they have an obligation to provide or facilitate appropriate medical forensic intervention when a child at risk for sexual abuse presents for care, whether or not the facility has a SANE program or a pediatrician specializing in child abuse.
15. Policies regarding patient and staff safety are developed for instances where the person accompanying the child victim is the suspected offender, is suspected to be in collusion with the offender, or is otherwise believed to be contributing to the abuse.
16. Healthcare facilities support pediatric SANEs by developing or maintaining their own programs, or by establishing relationships and appropriate transfer arrangements with other facilities where pediatric SANE programs exist.

Background

Sexual abuse of children is a problem of epidemic proportions. According to the Centers for Disease Control & Prevention (n.d.-b), 1 in 4 girls and 1 in 13 boys in the United States experience sexual abuse in childhood. However, the true prevalence of child sexual abuse is difficult to measure because it is almost certainly underreported. Retrospective studies of adults have shown that approximately 1 in 5 victims of child sexual abuse never disclose their victimization (Tener & Murphy, 2015). Although medical personnel are mandated reporters for all forms of child maltreatment in 2020, only 11.6% of child abuse and neglect cases were reported by medical personnel (U.S. Department of Health & Human Services (2022). Child victims of sexual abuse frequently receive care in emergency departments (Hornor et al., 2022). Medical personnel, including emergency nurses, must be versed in identification, care, and reporting of sexual abuse as well as other forms of child maltreatment (Goyal et al., 2013; Neggia et al., 2021). Children who have experienced sexual abuse can experience a wide range of related acute and chronic health problems. Acute health issues may include anxiety, injury, or sexually transmitted infections (Hornor, 2017). Other health problems such as depression, suicidal ideation, substance abuse, and sexual dysfunction may develop later in life (CDC, n.d.-b; Jenny et al., 2013; Selvi et al., 2018). In 2016, the Department of Justice released a national protocol (US DOJ, 2016) which recognizes that child sexual abuse differs from adult and adolescent abuse and compels a different response—a response that emergency providers and policy makers must seriously consider when implementing the level of care this special population deserves. Pediatric SANEs have been shown to improve the care of these vulnerable children compared to healthcare providers without specialized education in treatment of child sexual abuse (Hornor et al., 2012). Pediatric SANE care improves detection and documentation of ano-genital injury, includes testing for sexually transmitted infections and pregnancy, and requires the keeping of detailed documentation (Hornor et al., 2012; Hornor et al., 2012). While it may not be possible for all emergency care settings to offer pediatric SANE services, all must be prepared to facilitate access within their community to appropriate facilities and examiners capable of providing a high quality, evidence-based response for children who have been sexually abused (US DOJ, 2016).

Resources

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