Child Abuse & Neglect 34 (2010) 289–295

Contents lists available at ScienceDirect

Child Abuse & Neglect

Practical Strategies

# Evaluations of child sexual abuse: Recognition of overt and latent family concerns

John M. Leventhal*, Janet L. Murphy, Andrea G. Asnes

*Department of Pediatrics, Yale University School of Medicine, New Haven, CT, USA*

ARTICLE INFO

*Article history:*
Received 17 August 2009
Received in revised form
16 December 2009
Accepted 4 January 2010
Available online 26 March 2010

*Keywords:*
Child sexual abuse
Family concerns
Clinical evaluation

ABSTRACT

**Objective:** To describe a clinical approach to the recognition of overt and latent concerns of parents and children when children are evaluated for suspected sexual abuse by medical examiners.
**Method:** Description of a clinical approach.
**Results:** We describe 10 concerns—six of parents: (1) should we believe our child?; (2) worries about the child's body; (3) expressing emotions; (4) why the child delayed in telling; (5) how to talk to my child; (6) when will the perpetrator be arrested?; and four of children: 7) who will know about this?; (8) protecting one's parents; (9) worry about one's own body; and (10) what about my sexuality?
**Conclusions:** We believe that by addressing these concerns in the medical evaluation of suspected sexual abuse, clinicians can help families focus on important issues, including ensuring the child's safety, acknowledging family members' feelings, and arranging counseling for the child and parents.



## Introduction

As medical examiners in a busy child sexual abuse clinic, we strive to provide a high standard of care to children who are suspected of having been sexually abused. To this end, we employ evidence-based standards and rely on peer review. In addition, with over 50 years of cumulative experience in this role among us, we recognize that we have developed an approach to our usual medical tasks of taking histories and performing physical examinations that reflects an understanding of the particular concerns common to our patient population. As part of our ongoing peer review process, we endeavor to identify what each of us has come to understand about our patients and their families and to share what we have learned with one another. We believe that this process has improved and continues to improve our collective and individual practice. For this reason, we offer the following article as part of the *Practical Strategies* section. Our goal in doing so is to complement what we know about examining children with the wisdom, derived from clinical experience, about what we feel most concerns the children and families we see and how best to address these concerns.

Much has been written about the purpose of an evaluation of a child for suspected sexual abuse and the approach to such an evaluation (e.g., Finkel & Giardino, 2009; Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007; Leventhal & Asnes, 2009). Much less has been written about the concerns of child victims and their parents and how to respond to these concerns. In this article, we focus on the overt and latent clinical issues that frequently arise during such an evaluation, but often

* Corresponding author address: Department of Pediatrics, Yale University School of Medicine, Post Office Box 208064, 333 Cedar Street, New Haven, CT 06520-8064, USA.

0145-2134/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.chiabu.2010.01.005

**Table 1**
Critical questions and worries for parents and children.

| |
|---|
| For parents |
| (1) Should we believe our child? |
| (2) Worries about the child's body. |
| (3) Expressing emotions. |
| (4) Why the child delayed in telling. |
| (5) How to talk to my child. |
| (6) When will the perpetrator be arrested? |
| For children |
| (1) Who will know about this? |
| (2) Protecting one's parents. |
| (3) Worry about one's own body. |
| (4) What about my sexuality? |

are not addressed because the major focus of the evaluation is on the forensic issues: what the child is able to report in the forensic interview about the sexual abuse and what the physical examination shows about possible forensic medical evidence. While the interview and exam provide essential information to the investigation of a case of suspected sexual abuse, both the allegations of sexual abuse and the evaluation raise important issues for the nonoffending parent(s) and child, and these need to be addressed.

In this article, we describe 10 major concerns that are listed in Table 1 (6 of parents and 4 of children). In addition, we offer suggestions regarding a clinical approach to helping parents and children in the context of five critical variables that can affect how families respond: (1) the age of the child, (2) intra- vs. extra-familial sexual abuse, (3) a parent's own experience of sexual abuse, (4) how supportive the nonoffending parents are to the child, and (5) the family's strengths and weaknesses and previous involvement with Child Protective Services.

## Concerns of the parents

In the US, because of the rapid response to allegations of child sexual abuse, once a case is reported to Child Protective Services (CPS), a CPS social worker and police usually begin the investigation within 24 hours of the report, and the forensic interview and exam may occur within days of the report. Thus, parents are quickly faced with two obvious and immediate concerns: (1) should we believe our child and (2) has our child been hurt or damaged physically?

### *Should we believe our child?*

Believing the child's statements can seem straightforward to clinicians; clinicians understand that children who disclose their experience of sexual abuse often do so because of their upset at what has been happening to them, and clinicians recognize that children may not tell their family all the details. For parents, of course, deciding whether to believe their child can be more complicated. Parents' beliefs can be on the spectrum from definitely believing to definitely not believing, and their location on the spectrum can depend on a variety of factors, such as what the child said in the initial disclosure and to whom the child told first, whether the accusation is about someone inside the immediate or extended family or outside, whether the child has delayed in telling someone about the abuse, whether the child is perceived as a "child who tells stories," what the parents' relationships are with the child, and whether the parents' have their own histories concerning sexual abuse. Each parent may also differ in the extent to which they believe the child. We have found that many parents are facing conflicting loyalties to a child and to another family or household member who has been accused of abusing the child. When parents express feeling conflicted, or express concern for the suspected perpetrator, the degree of this conflict should be explored and addressed and, if parents are thought to be unable to support and believe a child, this information should be fed back to CPS.

Parental beliefs about the child's truthfulness also may change over time, as new information is provided. For example, a parent might directly approach the alleged perpetrator who might be the child's uncle (and mother's brother) and ask that person if anything has happened. If the brother denies that anything has happened, the mother is then faced with the dilemma of believing her daughter versus believing her brother. Since both persons cannot be telling the truth, the mother faces a difficult decision.

When there is a delay in the child's disclosure and/or the child's first disclosure is not to a parent, parents may have doubts about the child's truthfulness. "She talks to me every night before she goes to bed and never said a word about it." Sometimes, we remind parents that a delay in disclosure does not mean the child lied and explain the potential reasons for the delay.

Another particularly challenging situation for parents can occur when the child has made a clear statement to a parent, but provides little information at the forensic interview such that the police and/or CPS indicate that they cannot do much about the situation. Thus, parents may be left with two conflicting pieces of data: information from their child indicating that something has occurred and information from investigators indicating that not much can be done about the situation. The absence of a clear statement by a child at a forensic interview may not be completely surprising to clinicians, but it can