

Obtaining a History of Sexual Victimization from Adolescent Females Seeking Routine Health Care

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Abstract

Objective: To evaluate the clinical practice of direct physician inquiry of adolescent females during routine history taking and medical examination, with regard to their experience of childhood sexual abuse and/or assault.

Method: During a one-year period, a female physician directly questioned 146 consecutive female patients, aged 12–22, who were being seen for routine medical histories and physical examinations, as to whether they had ever been sexually victimized. Patients who disclosed histories of sexual victimization were immediately counseled and provided with appropriate on-site mental health referrals. Follow-up of these referrals was conducted to determine if patients complied with referrals to seek mental health services.

Results: For 141 of the 146 patients, the physician was unaware of a history of sexual victimization. Of these 141 patients, thirty-two (23%) cases were identified using this clinical strategy. Almost all (93%) of these young women accepted referrals for on-site psychotherapy, and 81% kept their initial appointments for psychotherapy.

Conclusions: The routine medical history and physical examination may be an appropriate setting for health care providers to accurately and comfortably elicit a history of sexual victimization from adolescent females, and provide appropriate referrals for mental health counseling.

Key Words: Adolescent health, ethics, sexual victimization, sexual abuse.

SEXUAL ABUSE RATES are alarmingly high for both boys and girls (1). Nearly 1 million children in the U.S. were substantiated as victims of child abuse in 1997 (2). The true incidence and prevalence of sexual and physical abuse are probably higher, as these experiences often go undetected and unreported (3).

In order to diagnose and treat adolescents who have experienced sexual abuse or assault, their trauma or abuse must first be disclosed. However, abuse victims often do not report their experiences (3). It is believed that direct questioning about physical and sexual victimization during routine medical examinations can effectively “interrupt the secrecy phase”

that might otherwise keep the abuse hidden (4). But to accomplish this, primary care physicians, psychiatrists, and other health professionals must find ways to routinely elicit sexual victimization histories, or else many cases of abuse will continue to go unidentified and untreated (5, 6). The purpose of this study is to report on the clinical practice of direct physician inquiry of adolescent females who presented for a routine medical examination in a primary care setting.

Method

Direct physician inquiry was conducted with 146 consecutive adolescent female patients who presented for a routine medical examination at a comprehensive adolescent health care center during a one-year period. The patients involved in the clinical practice ranged in age from 12–22 years (mean age 16 years) and were all from inner-city neighborhoods from different sections of New York City. Patients’

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self-reported ethnicity was 58% Latino, 39% African-American and 3% Caucasian, which was consistent with the ethnic population seen by the physician doing the inquiry. At the time of this study, the physician had prior knowledge that 5 of the 146 patients had a history of sexual abuse (they had been referred to her with such a history), but did not have any parallel information on the other 141 adolescents.

Prior to taking each patient's history, the physician discussed confidentiality laws with the patient, making it clear that a physician is mandated to report any sexual abuse if it is disclosed while conducting the history. The physician then began with a series of questions that elicited the patient's health attitudes, behaviors and practices, and ended the session with the following questions: (a) Has anyone ever touched your body when you did not want them to? (b) Did anyone touch your breasts? Your vagina? Your buttocks? Anus? Or any other part of your body when you did not want them to? (c) Did anyone ever make you touch their body when you didn't want to? Where? and (d) If yes, was it your father? Your stepfather? Your brother? Uncle? Mother? Stepmother? Sister? Aunt? Grandparent? Teacher? Neighbor? Babysitter? Friend? Family friend? Stranger? Or any other person?

The physician used simple, straightforward language for all the questions pertaining to sexual abuse, in order to avoid confusion for the patients. These questions were all based on the physician's two decades of experience in working with adolescents. The physician also rehearsed the questions with a colleague prior to asking patients, so as to assure that the tone and demeanor did not fluctuate.

If, during the course of the questioning, the patient revealed a history of sexual victimization, her experiences and feelings were elicited and recorded. The physician then explored a number of issues with the patient, including the age of onset, the nature of the abuse (e.g., Did penetration occur? How long did the abuse continue? When was the last time she was abused?) and the relationship of the abuser to the victim. The physician provided support and clarified any misconceptions concerning the abuse. For example, it was often necessary for the physician to correct the belief held by many victims that they were the only ones with these experiences and that they were somehow to blame.

Again, using simple and direct language, the physician repeated her legal obligations to report the abuse to Child Protective Services

and informed the patients of additional services that were available to help them work through the sexual victimization experience (including psychotherapy). Referrals were then made for individual, family, or group psychotherapy (or a combination thereof), according to the patient's needs. These mental health services were available on site, so that many of the patients could be directly introduced to mental health professionals, thus further facilitating their transition to appropriate counseling.

Results

Of the 141 female adolescents for whom no history of sexual victimization was known at the time of the routine medical history and physical examination, 32 (23%) disclosed a history of sexual abuse (Table 1). Vaginal penetration occurred in 63% of the overall cases, none within the prior 72 hours. Reported perpetrators included fathers, stepfathers, brothers, uncles, cousins, family friends, neighbors, friends, sexual partners and strangers. Through direct questioning, the physician found that of the patients who disclosed abuse and were given referrals, five were already undergoing psychotherapy (for reasons other than abuse-linked trauma) but none of these five victims had revealed their history of sexual abuse to their therapists. Of the remaining 27 patients, 25 accepted referrals and two refused, saying that they were "fine" and did not need or want to talk about the abuse (Table 2). Follow-up by the physician revealed that 20 of the 25 patients who accepted referral for mental health treatment kept their initial appointments for psychotherapy at the Adolescent Health Center Mental Health Program.

Discussion

Given the premise that it is advisable to question an adolescent patient on sexual victimization, three conclusions are suggested from the findings of this clinical practice: (a) Adolescent girls are willing to reveal a history of sex-

TABLE 1
Female Adolescent Patients Disclosing History of Childhood Sexual Victimization During Patient Interview

	N	%
None	109	77
Sexual victimization	32	23
Total	141	100

TABLE 2
Acceptance Rate for Psychotherapy Referrals of Adolescents with a History of Sexual Victimization Not Already in Psychotherapy*

	N	%
Refused	2	7
Accepted	25	93
Total	27	100

* Five of the 32 adolescents with a history of sexual victimization were already in psychotherapy but had not disclosed their history of abuse to their therapists.

ual victimization if asked directly by their health care provider in a confidential primary care setting; (b) The health care setting in which the questioning takes place contributes to the atmosphere of trust and safety that appears to be a prerequisite of disclosure; and (c) A majority of adolescent girls who disclose episodes of sexual victimization in the health care setting will probably be compliant with referrals for on-site mental health programs.

These data also point to the importance of using direct inquiry regarding the occurrence of sexual victimization when taking a history from adolescents. The observation that five of the patients in this study were already in psychotherapy but had not revealed their sexual abuse to their psychotherapists further emphasizes the need for direct questioning by providers.

The patients' reactions upon initial exposure to direct questioning varied considerably. For example, a 16-year-old teenage mother giggled upon hearing the first question, but when the physician explored the subject further, the patient disclosed a history of sexual victimization. She went on to describe how her own mother believed the perpetrator's allegation that the blood around her vagina was the result of her getting hurt during play. She laughed out of nervousness, because she had never even been given an opportunity to discuss the abuse in the many years since it had first occurred. This supports the view that how a patient reacts to the question has no bearing on the validity of her disclosure (or lack thereof) (7).

The use of a series of concrete questions, rather than a single question (e.g., "Have you ever been sexually abused?") is critical. In our experience, an adolescent may say no when asked if she has experienced sexual abuse, yet when asked what sexual abuse means, she will shrug her shoulders and admit she is not sure. When the concept of sexual abuse is clarified

with additional concrete questions (e.g., "Has anyone ever touched private parts of your body without your permission?"), the patient may indeed reveal sexual abuse. In this type of interaction, a young woman may learn for the first time that what she experienced is considered inappropriate and abusive, and she may be empowered to seek services.

If a positive history is obtained, the provider could then inquire about symptoms of depression, suicidality, self-mutilation, or post-traumatic stress disorder. Such symptoms are common in survivors of abuse. The provider could also screen for symptoms of depression and post-traumatic stress disorder to ensure the patient's safety from self-injurious behavior. If the provider does elicit symptoms, the patient should be assured that these symptoms are common in teenagers who have experienced abuse, and that they might improve after she avails herself of mental health services.

There are several reasons why a routine medical history and physical examination may be an effective setting for inquiring about sexual victimization. The health care provider may be one of the few available confidants for a young person. The medical setting may also provide an environment where the subject of sexual victimization can be broached with younger patients in a less threatening manner. If this is the case, then health care providers must be better trained to elicit abuse history, react to disclosure in a professional yet compassionate manner, and ensure that their patients seek the appropriate follow-up. The health care provider also must be prepared to answer questions the patient may have, dispel some of the commonly held myths about sexual victimization, and replace them with realistic appraisals of the situation.

To what extent disclosure in this comprehensive primary care setting increases the likelihood of young victims accepting and following through on mental health referrals deserves further study. One factor that may have contributed to high follow-up rates in this study is the presence of an extensive in-house mental health services at the health center where the study took place. Medical providers who do not have these on-site resources should have a referral network that includes adolescent mental health service providers. In this situation, when other relevant adults are not available to accompany the adolescent, an outreach worker or other staff member could be assigned to accompany her to her first referral, to ensure compliance and address any fear or embarrassment.

Summary

While the primary care setting does not present the only opportunity for disclosure of sexual abuse, it has certain advantages. Health care providers, including nurses, physician assistants, physicians, social workers, psychologists, health educators and others, can provide an atmosphere of trust and confidentiality, take accurate histories, provide an environment where patients can feel comfortable sharing sensitive personal information, and make appropriate referrals. In doing these things, they can identify problems and facilitate treatment for many adolescent female victims of sexual abuse who might otherwise enter adulthood with unresolved issues related to that abuse.

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