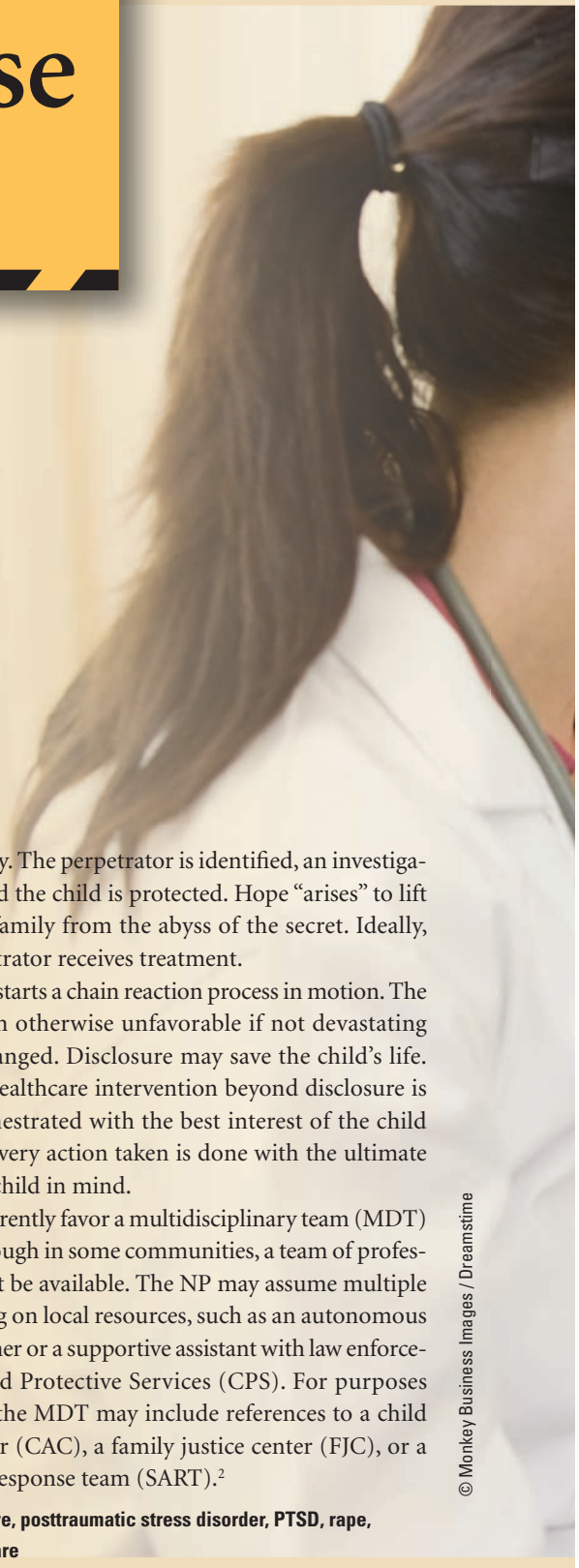
Responding to child sexual abuse disclosure



Abstract: In cases of child sexual abuse (CSA), NPs are faced with a variety of options dictated by community, agency, and individual resources. This article looks at victim-centered care from current guidelines and offers resources for clinical practice decision making when responding to CSA disclosure.

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Child sexual abuse (CSA) is a grim yet relevant topic in NP practice. Because of its correlation with preventing further abuse and decreasing a child's self-blame, early disclosure is always encouraged.[1] This article aims to improve understanding of the role NPs potentially play in responding to victims of CSA and their parents or caregivers after disclosure. Effective care begins with acknowledgment of CSA as a uniquely challenging and specialized area of trauma.

The extent of NP involvement in caring for victims of CSA hinges on the depth of knowledge, experience, and skills they possess. NPs must determine if they are adequately prepared with the education, training, and requisite skills to safely and competently care for victims of CSA.

Perspective

Disclosure is a vital first step toward recovery; without it, there is no hope for change. CSA disclosure is "bad news," but it is also a gateway toward a better outcome. It elicits intervention as CSA begins to lose power over the child and his or her family. The perpetrator is identified, an investigation begins, and the child is protected. Hope "arises" to lift the child and family from the abyss of the secret. Ideally, even the perpetrator receives treatment.

Disclosure starts a chain reaction process in motion. The trajectory of an otherwise unfavorable if not devastating outcome is changed. Disclosure may save the child's life. Ideally, every healthcare intervention beyond disclosure is mindfully orchestrated with the best interest of the child at the center. Every action taken is done with the ultimate healing of the child in mind.

Experts currently favor a multidisciplinary team (MDT) approach, although in some communities, a team of professionals may not be available. The NP may assume multiple roles depending on local resources, such as an autonomous forensic examiner or a supportive assistant with law enforcement and Child Protective Services (CPS). For purposes of this article, the MDT may include references to a child advocacy center (CAC), a family justice center (FJC), or a sexual assault response team (SART).[2]

Keywords: ARISE, child abuse, child advocacy center, child sexual abuse disclosure, posttraumatic stress disorder, PTSD, rape, sexual assault, SPIKES, victim-centered care

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How is CSA disclosed?

Disclosure of CSA may occur in the following ways:

- The child discloses the abuse.
- The parent(s) or caregiver(s) access healthcare because of a suspicion or actual knowledge that CSA has occurred (discovery of the child with the perpetrator, hearing rumors of day-care/babysitter abuse, or observing an attempted assault, pornographic solicitation, or kidnapping).
- A medical forensic exam is requested by another agency (judiciary, law enforcement, CPS, or the Department of Health and Human Services).
- CSA is discovered by the examiner incidentally while the child is being seen for another reason (for example, an infant presents with vaginal discharge and her urine is positive for chlamydia and gonorrhea).

Children are at risk for multiple forms of violence (much of which goes unreported), and CSA is one of many forms of victimization. Promoting disclosure through education and prevention (of revictimization) leads to more favorable outcomes, namely arrest and prosecution, but also family intervention. Disclosure of CSA should result in:

- assessment
- activation of an MDT response
- victim protection
- a thorough investigation, including identification of the perpetrator
- professional intervention
- follow-up.[2]

Discussing CSA disclosure with the nonoffending parent or caregiver (the nonoffender) is a formidable task. Often, the perpetrator is someone known, loved, and trusted by the family; the news shatters confidence on multiple levels, producing intense pain and potential violence. The nonoffender may feel guilty or irresponsible for not protecting the child. Cultural differences may impact nonoffender response in a way that devalues or blames the child, placing him or her at even greater risk.

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CSA is a complex injury because it is usually committed by a person that the child deeply trusts, fears, loves, respects, or depends upon for nurturing, guidance, and security. It may go unreported for years until the child reaches a place of personal strength (sometimes adulthood) and resilience. CSA may not be disclosed until the perpetrator is deceased. A disclosure of CSA often comes after another victim exposes abuse by the same perpetrator. The triggering of remembrance or revictimization by the second victim may precipitate the first victim to break his or her silence and come forward in support of the first victim and together seek prosecution.

When the nonoffender accesses healthcare in a courageous first step to protect the child, the NP should offer praise and acknowledgment of this difficult act.

The Child Abuse Prevention and Treatment Act defines sexual abuse within the context of child abuse and neglect as "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act, which presents an imminent risk of serious harm.[3]" State law may define it by more specific statutory language such as "sexual activity to provide gratification," "molestation or incest," "statutory rape," "prostitution," "voyeurism," or other sexually exploitative activities, including human trafficking.[4]

The impact of CSA is often lifelong, producing physical, emotional, and social conditions such as posttraumatic stress disorder (PTSD). All children are at risk for low self-esteem, aggressive behaviors, shame, guilt, and fear following CSA, but younger children are at a heightened risk for later attachment and abandonment issues. Studies of adolescents suggest a correlation with CSA and difficulty in developmental progress in terms of social interaction, school attendance and performance, instability in later relationships, and encounters with law enforcement. Higher rates of depression and a host of maladaptive behaviors related to CSA include suicide, self-mutilation, and eating and sleep disorders. Experiencing multiple victimizations of different kinds (polyvictimization), especially in females, places these children at greater risk for unplanned pregnancy and illicit drug use.[3,5,6]

CSA is divided into emergent, urgent, and nonurgent categories depending on the immediacy of the victim's physical needs.[7] Triage determines acuity, which determines the order of treatment and events. If CSA disclosure is associated with a recent event, it should be triaged as an urgent encounter requiring prompt treatment, unless there are acute signs of physical trauma necessitating immediate attention. If the CSA disclosure occurs well after the immediate event and there are no acute sign (s) of trauma at presentation, it would reasonably qualify as nonurgent. NPs should always follow the principle of "start by believing."[8]

For safety purposes, once CSA is disclosed, the child and the nonoffender should be separated from the perpetrator, if possible. Once immediate security measures are met, including activating the MDT and/or notifying law enforcement, the child and nonoffender should be assured that they will be kept informed of all aspects of the process. CSA is reportable in every state.

Unless there are immediate physical needs, the mandatory reporting procedures of the state are explained, including what the child may have said (or displayed) to indicate that a forensic exam is necessary. An informed consent for treatment may have been signed by the nonoffender (particularly in an emergency or urgent care setting) but if not, it should be obtained.[9]

Helping the victim ARISE

The education and ability needed to deliver this type of "bad news," initiate legal protection of the child, separate the perpetrator from the child, provide family support, direct the nonoffender to community resources, and collaborate with other members of the healthcare team require an in-depth understanding of multiple intersecting factors of a complex psychosocial situation. Some communities may not have available resources, including a CAC, SART, or FJC, and the NP may have to provide care after disclosure without adequate professional preparation to include family-focused multidisciplinary, collaborative, organized, and specialized care.

To assist NPs in remembering key aspects of victim-centered care, the authors developed an "ARISE" acronym that outlines essential interventions from initial assessment to long-term follow-up incorporating current guidelines. It stands for Assessment and activation, Reporting and referrals, Information and informed consent, Safety and the sexual assault medical forensic exam for pediatrics (SAMFE-P), and Education and empowerment (see *ARISE*).

A: Assessment and activation

Calmly separate the child from the perpetrator and secure the area. Keep the nonoffender and the child together throughout the interview and assessment. Ask the following questions: Why did the child access healthcare? What is the chief concern? How was CSA disclosed? What level of care is indicated? Are there immediate security issues? Is the perpetrator present? What is his or her demeanor?

Follow these principles:

- Remember that children cannot give consent. Never blame the child by doing or saying anything to cause guilt or shame.
- Refer to the child as a victim or survivor and not an "alleged" victim. The term *alleged* implies doubt, damaging rapport and violating the first principle of care, which is to start by believing. Telling children that no one believes them is a perpetrator tactic.
- Use accurate terminology. Be clear and absolute in language. Use the term *rape*, not *sexual conduct*, *intercourse*, or *relations*.
- Assess family dynamics. There may be an overt reaction to "loss" similar to other traumatic events. Be prepared for extreme emotional displays.
- Model support. Emphasize that CSA is never attributable to the victim's behavior.
- Keep the child the core priority.
- Help the family understand its role, as victim support is critical to recovery.[10]

ARISE

- **A** Assessment of the situation, and activation of the MDT (if available)
- **R** Reporting and referral to proper agencies
- **I** Information and informed consent
- **S** Safety and SAMFE-P exam
- **E** Education and empowerment

Sexual trauma history. Collecting a sexual trauma history is different from a medical history and requires specialized knowledge. Obtaining a sexual trauma history will not likely fit neatly into the eight variables for symptom analysis at the first interview. Nurses who are Sexual Assault Nurse Examiner-Pediatric (SANE-P) certified are specialists in the field of obtaining CSA forensic evidence, including a sexual trauma history. This history precedes a sexual assault medical forensic exam unless physical needs are emergent.

In regards to prosecution, the sexual trauma history (not the exam) is the single most important component of evidence. Because victim-centered care avoids repetitious interviews, law enforcement often utilizes the history that the NP has obtained. The NP may not have all the details/answers available for the nonoffender's questions at this phase, and it is important to prepare the family for a potentially lengthy process that should include family counseling.[2,11] The child is encouraged to disclose information at his or her own pace and to continue to disclose additional information at a future time as needed.

Counseling, education, and referral to other services are dictated by the level of care, and while vital to overall healing, may be placed on hold if the child's immediate physical health is in danger. If CSA occurred in the distant past and there is no expectation of physical findings of trauma or

DNA evidence, the sexual assault medical forensic exam may not be done immediately but should be scheduled later through the local CAC or FJC.

The rationale for delaying or omitting the sexual assault medical forensic exam should be explained to the nonoffender. Priorities of care are indicated by the child's individual needs. Continued emotional support, counseling, and education are important and may be directly provided by the NP or shared collaboratively.[12,13]

CPS, collaboratively with other MDT members (FJC, SART, or CAC), assists the NP in making the correct next step, including whether a sexual assault medical forensic exam (utilizing a sexual assault evidence collection kit [also known as a rape kit]) is useful following CSA disclosure. Decisions concerning referrals for further medical and psychiatric care and whether the child should be moved to foster care are based on the best interest of the child. All care decisions should be explained to the child and the nonoffender.[14]

The child is encouraged to disclose information at his or her own pace and to continue to disclose additional information at a future time as needed.

The nature of CSA disclosure (like the trauma it produces) is unlike other injuries. CSA rarely occurs contemporaneously with the first incident but more commonly "leeches out" over years. The account shared initially is often not the full narrative, but only part of it. A complete history often emerges over time.[14,15] With education and support, the NP assists the child and nonoffender in understanding childhood memory concerning traumatic events and coping. The NP also educates the nonoffender about childhood remembering of trauma.

Assessing the impact of trauma. One of the strengths of a trauma assessment is its ability to apply concise methodology for obtaining intensive data and deriving a diagnosis based on an in-depth review of past and present needs, signs, symptoms, and behaviors, including coping skills and strengths. Because children divulge history incrementally, some have debated their credibility (for example, false accusations) regarding recanting of testimony. Providing information to the family increases awareness and acceptance of childhood remembering and reinforces emotional recovery. Explaining that a series of interviews may be needed for the child to "let out" the full story of CSA prepares everyone for long-term counseling and helps set realistic expectations.[14,15]

Studies regarding childhood memories of CSA, recantation of abuse, and embellishment by children dispel notions that children exaggerate, falsely accuse perpetrators, or imagine CSA. Children may, out of fear or concern for their families, themselves, or even the perpetrator, be influenced to alter the account of CSA. Notably, the child's testimony, alone, is considered evidence.[16,17]

When the NP understands the far-reaching effects of CSA beyond physical harm, he or she is better equipped to educate the child and nonoffender. Even when no physical signs of CSA are apparent, there is often deep psychological harm to the child and family. The nonoffender must be informed that emotional, behavioral, and developmental signs are common and more difficult to identify and manage than physical problems.

Damage to the psyche as evidenced by difficulties faced later by the child in establishing trusting friendships, securing emotional attachments, and/or developing rich, fulfilling sexual relationships may be devastating. Successfully identifying the needs and strengths of the child and nonoffender, determining the depth of psychological trauma and risk for PTSD, assessing the family dynamics, and developing a plan of care are best accomplished if there is an operational MDT that focuses on child advocacy.[2,18,19]

Activation. The NP should identify the strongest available resources in the community for CSA response and activate them as early as possible. The multiple aspects of intervention and continued follow-up are explained as simply and succinctly as possible, emphasizing that recovery usually takes a long time and works best when shared as a family journey and not something the child does alone.

When the community has an MDT, the victim's advocate is introduced to the child and family early, often in the clinical setting. This trained professional is able to establish rapport, follow the case, and meet regularly with the child and family. The advocate also attends counseling; arranges legal and other follow-up sessions via the CAC, FJC, or other agencies; and provides services such as transportation assistance and sibling childcare while the child and nonoffender seek counseling. Communities may have a CAC, FJC, SART, or CPS available through state health and human services agencies, and data support their value and success over traditional approaches.[2,13]

R: Reporting and referrals

Mandatory reporting. Once the child's safety is ensured depending on the extent of risk (which may include placement

under the state's protection), activation of the MDT occurs. Fulfilling the axiom of care, "first to know, first to respond, first to report," mandatory reporting to law enforcement and/or referring the case to CPS is a priority.

Unexplained injuries, inconsistent history, and other high-risk factors may offer clues of abuse even prior to or without disclosure, requiring reporting. The nonoffender is informed and reassured that CSA falls under mandatory reporting guidelines (an exception to the Health Insurance Portability and Accountability Act). As mandatory reporters, the NP receives immunity as a good faith reporter.[20,21] Referrals are individualized to the child and the circumstances.

I: Information and informed consent

Informed consent is the standard of care for all aspects of treatment and procedures because it allows the patient to be the central decision maker. In CSA, informed consent (which is not mandatory because the child is a minor and protected by statutory mandates) is recommended. Once the mandated report is made, the remainder of the encounter pertains to meeting medical needs, making referrals, answering questions about CSA, offering resources for follow-up, and addressing any other patient concerns.

Communicating with the nonoffender regarding all treatment actions is vital. Even in the midst of intense clinical decision making and professional multitasking, the NP continues to explain all care measures to the victim and nonoffender. Alleviating anxiety through open dialogue reassures the child and family that they are safe and secure.[22]

S: Safety and the SAMFE-P

Following the SPIKES protocol (see *Understanding the components of the SPIKES protocol*), the NP ensures privacy, provides information succinctly, and notices the emotional response of the child and nonoffender. Throughout the encounter, the child and nonoffender are given brief, simple, developmentally appropriate explanations in easily understandable terminology in regards to all procedures. A strategy for follow-up is summarized with the child and family. Parents of school-aged children and adolescents may want to communicate with educators in the follow-up phase to ensure that the child has plenty of adult support at school.

If there is a sexual assault medical forensic exam, the NP allows the child to make choices and have as much control over the environment as possible. Complete honesty and approachability with the child help build rapport.[10,23] For example, the NP may ask simple questions such as "Do you have a dog?" or "Do you like to go to school?" The child is allowed to choose where to sit on the exam table and handle some of the nonthreatening equipment (for example, a tongue blade) while the NP explains how it is used. Each step of the exam is discussed simply.

What occurs at every stage of the exam should be described in age-appropriate language at a slow and steady pace that promotes calmness and trust. Statements such as "This is what is happening now," "This soft swab is going to touch your skin," or "Someone is coming to help your family" should be utilized. When discussing the situation, the NP should speak to the nonoffender and the child together, explaining and repeating instructions if needed. Explanations should be succinct and frequent: "This is going to take a few minutes," "I am going to ask some questions," "Would you like me to call someone to look after the other children?"

CSA disclosure presents in various ways, from horrendous trauma including the death of the child to discovery by an incidental comment from the victim or nonoffender

Understanding the components of the SPIKES protocol

The SPIKES protocol is a tool reflecting an effective methodology for communicating bad news. The protocol was initially developed by Dr. Walter Baile and his colleagues at the University of Texas M.D. Anderson Cancer Center and the Toronto-Sunnybrook Cancer Center with an aim to provide a systematic framework for oncology professionals, including those in training.

In the years following, the protocol was adapted to other health specialties and professionals, studied extensively, and refined only slightly. It continues to offer a cogent, sensitive, patient-first approach in communicating bad news and has utility in situations such as CSA disclosure.

- **S** **Setting (Make it private):** At multiple points along the spectrum of CSA, "bad news" may need to be communicated.
- **P** **Patient's perception (primary): Make the encounter patient centered.** Determine the patient's comprehension of the CSA event(s) and traumatic injuries based on age/developmental stage.
- **I** **Invitation (The patient has control):** The NP allows the patient to guide communication. By "inviting the clinician to the conversation," the patient conveys trust in the NP to receive information.
- **K** **Knowledge:** Use easy-to-understand terminology. Medical vernacular should not be used, as it is likely to be misunderstood. Speak in plain language to both the nonoffender and the child.
- **E** **Emotional response/empathy:** Observe and consider.
- **S** **Strategize the future:** Wrap-up and do not rush it.

Source: Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-a six-step protocol for delivering bad news: application to the patient with cancer. *Oncologist.* 2000;5(4):302-311.
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during an otherwise routine encounter. The reason for seeking healthcare may involve a different chief concern (for example, bedwetting or vaginal itching). Once CSA is disclosed, current treatment guidelines recommend that any victim of CSA be offered a sexual assault medical forensic exam by a special trained SANE-P, physician, or other provider who is qualified to perform pediatric forensic exams.[14,15] When the NP is providing medical care, the determination about whether or not to perform a forensic interview and/or sexual assault medical forensic exam may fall on his or her judgment. If a forensic exam provider is not available, the child should be referred to the closest center where the exam can occur.

A sexual assault medical forensic exam may include the collection of specimens of body fluids and smears, as well as photo documentation of signs of injuries, or the lack thereof. It may involve the use of colposcopy. All documentation, including lab test results, is preserved as evidence for trial. Strict adherence to the chain of evidence applies to the handling of all documents and specimens. Generally, a sexual assault medical forensic exam occurs within 24 hours after CSA, particularly in younger children, but in adolescents if the CSA occurred within the past 72 hours the exam may be done (longer in some regions or if it is thought that DNA evidence may still be available).[14] The child is also assessed for emergency contraception, postexposure prophylaxis for sexually transmitted infections (STIs) including HIV, and treatment for other injuries.

Physical findings may not always support a diagnosis of CSA and are not essential. The physical forensic exam may appear normal and forensic testing may or may not reveal signs of sexual contact. DNA collection may be difficult to obtain, especially after a few days. If CSA occurred recently (less than 72 hours to 1 week), DNA may be obtainable by forensic collection.[14] If DNA is secured, there is a better outlook for the prosecution. This is another reason to encourage children to speak up and get help as quickly as possible.

A complete medical exam should be offered to all victims of CSA to ensure that there are no other undiagnosed conditions.

The NP reviews the steps that have occurred, clarifying as needed. Commonly, there are questions regarding reporting requirements, informed consent, and CPS. If the NP has little or no training in CSA victim care, his or her role may be supportive after activation of the MDT. The SANE-P, NP, or physician may be called in to conduct the forensic interview and sexual assault medical forensic exam, or the child may be referred to another facility or CAC, FJC, or center where a SANE or trained sexual assault physician examiner can continue care.

The NP should explain CSA as a unique form of trauma exacting a unique toll on the physiologic processes of the mind and body. Normally when the body perceives a life-threatening event, homeostasis is interrupted, and a series of events occur as the body redirects metabolic energy to conserve and preserve the system. CSA disrupts stress regulation, causing the body to remain in a state of hypervigilance experiencing panic for prolonged times, often precipitated by benign events (a car backfiring, an image on the TV, a barking dog, a smell, a sound, or a room). Victims of CSA who experience disordered remembering may also suffer a disordered stress response activation and chronic imbalanced homeostasis, all factors that play a role in the development of PTSD.[18,19] A complete medical exam should be offered to all victims of CSA to ensure that there are no other undiagnosed conditions.[14,15]

The physical exam. If the child presents to the primary care provider with significant injuries, the medical exam is done to diagnose and triage traumatic injuries. The exam provides objective data as to whether the child has sustained a life-threatening injury and needs emergency care (if not an emergency facility). The exam is also used to evaluate the child's general state of health and to inspect for gross injuries (old or new) and other medical conditions that need prompt attention, treatment, or referral. It enables the NP to assess for developmental, psychological, emotional, or behavioral signs or symptoms not correlated with the age and stage of the child that may need further evaluation, consultation, or referral for intervention. It provides an opportunity for the NP to determine whether a sexual assault medical forensic exam will be necessary.

If a sexual assault medical forensic exam is needed and cannot be performed on site, the child is referred to a center where it can occur. In addition to important forensics, the medical exam may reveal hidden medical conditions that are unaddressed and may or may not be urgent (developmental delay, dental follow-up, need for surveillance). Untreated medical conditions may support a finding of medical neglect or may be incidental. Other forms of abuse may be identified as well. Explanation of planned testing, results, and ongoing support are imperative. Providing care to victims of CSA has become increasingly more specialized and includes standardized training, certification, and a

competency-based clinical preceptorship with experienced providers and peer review. The medical provider, regardless of degree, should have formal education in CSA evaluation as well as clinical experience in the treatment of STIs.[14,15] Therefore, an examiner who lacks proper qualifications as a CSA forensic examiner should refer a victim for specialized care as the appropriate course. Explaining the rationale for referral to the nonoffender ensures that a forensic exam can be provided safely and without further delay.

E: Education and empowerment

Victim and family education. After the interview/exam, carefully review the findings with the nonoffender, being aware that a good deal of education may be needed. Often there is confusion as to what a forensic exam can and cannot determine that should be clarified. The child will likely receive follow-up through the community CSA or similar agency where in-depth crisis intervention, family, and mental health counseling will be ongoing. These expectations should be explained, explored, and encouraged.

When CSA is approached by the MDT with each member having a select role, the NP's chief function is often that of forensic examiner. Because the advocate, family counselor, life coach, case manager, or social worker may develop a stronger rapport with the child, one of these members may assume a dominant role in providing emotional support and service resources. Some professionals, including NPs, are able to work with the child and family over time and throughout the process of recovery, reintegration of the family, and litigation (which may take years). NPs should be adequately prepared for a role in long-term care of the child and his or her family. Their competencies and/or subspecialties as well as limitations in caring for the CSA patient should be disclosed early in the patient-provider relationship. NPs must determine if their individual educational preparation, position, and skillset are proficient for ongoing supportive care prior to assuming a counseling or long-term advocacy role.

It is important that NPs work collaboratively with existing resources in their individual communities to avoid duplication of services. Caregiver satisfaction and support for CACs is overall positive, and these agencies are generally preferred. By openly discussing and explaining the role of the NP and providing information and support, the child is empowered toward a successful recovery.

Conclusion

Without proper education and training, an NP may prevent a victim of CSA from receiving the help he or she needs. Disclosing CSA prompts access to care and is linked to revictimization prevention. Child and parental education initiatives that empower children to prevent victimization/revictimization through early disclosure should be widespread. Communities are challenged to be proactive and prepared by having teams of professionals trained in evidence-based programs in prevention awareness, personal boundary training, conflict resolution, effective parenting, and sexual assault to assist children and families at all stages, from acute injury to recovery. It is crucial for every member to collaborate with all agencies, particularly school systems, that interact with children regularly and to support communities to develop MDTs.[23]

When CSA is disclosed, much has changed in the child's and family's lives. Many losses have occurred and potential harm follows the child into adulthood. A chain reaction of medical and legal events involving an MDT is activated. The team assists the family in a complex process that lasts for years. The child, depending on the extent of risk, may have been removed to foster care. The family will experience a number of inquiries, assessments, counseling sessions, and interventions. Utilizing principles of privacy, information sharing, and encouragement promoted by models such as the SPIKES protocol and following practice guideline reminders prompted by the ARISE acronym, NPs can confidently individualize a plan of care for the victim following CSA disclosure.

Children are known to be resilient survivors. Hope for healing and recovery cannot begin without disclosure. Treating CSA including responding after disclosure requires NPs of specific educational preparation with necessary skillsets to support victims/families, provide adequate education and counseling, competently obtain sexual trauma histories, and perform sexual assault medical forensic exams, including prophylaxis and treatment of infections. In addition, NPs must be able to collaborate with MDTs and be available to follow CSA cases through the legal system.

While the news of CSA is bad, its disclosure is also the first step toward a better future for its victim. No parent wants to be informed of CSA or have suspicions confirmed. However, if CSA remains hidden, it continues. When it is disclosed, treatment begins and hope *arises*.

REFERENCES

1. Finkelhor D. The prevention of childhood sexual abuse. *Future Child*. 2009;19(2):169-194.
2. Cross TP, Jones LM, Walsh WA, et al. Evaluating children's advocacy centers' response to child sexual abuse. Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin. 2008. www.ncjrs.gov/pdffiles1/ojjdp/218530.pdf.
3. The Child Abuse Prevention and Treatment Act (CAPTA) 2010. Definitions. 2011. www.acf.hhs.gov/programs/cb/resource/capta2010.
4. Alabama Criminal Code §13 A-6. http://alisondb.legislature.state.al.us/ALISON/CODEOFALABAMA/1975/COATOC.HTM.
5. Bush K. Joint position statement: Care of prepubescent pediatric sexual abuse patients in the emergency care setting. *J Forensic Nurs*. 2017;13(3):150-153.

6. Finkelhor D, Ormrod R, Turner H, Hamby S. School, police, and medical authority involvement with children who have experienced victimization. *Arch Pediatr Adolesc Med*. 2011;165(1):9-15.
7. U.S. Department of Justice Office on Violence Against Women. A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric. 2016. https://www.justice.gov/ovw/file/846856/download.
8. Zahn MA, Agnew R, Fishbein D, et al. Causes and correlates of girls' delinquency. Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin. 2010. www.ncjrs.gov/pdffiles1/ojjdp/226358.pdf.
9. Ross LF. Health care decisionmaking by children. Is it in their best interest? *Hastings Cent Rep*. 1997;27(6):41-45.
10. The Center for Family Justice. What is child abuse? http://centerforfamilyjustice.org/faq/child-abuse. http://centerforfamilyjustice.org/faq/sexual-violence.
11. Isaac L. The origins and practice of trauma-focused cognitive behavioral therapy (TF-CBT). Social Justice Solutions. 2015. www.socialjusticesolutions.org/2015/07/29/origins-practice-trauma-focused-cognitive-behavioral-therapy-tf-cbt.
12. Campbell R, Greeson MR, Fehler-Cabral G. With care and compassion: adolescent sexual assault victims' experiences in sexual assault nurse examiner programs. *J Forensic Nurs*. 2013;9(2):68-75.
13. Carlson FM, Grassley J, Reis J, Davis K. Characteristics of child sexual assault within a child advocacy center client population. *J Forensic Nurs*. 2015;11(1):15-21.
14. Adams JA, Kellogg ND, Farst KJ, et al. Updated guidelines for the medical assessment and care of children who may have been sexually abused. *J Pediatr Adolesc Gynecol*. 2016;29(2):81-87.
15. Poarch CJ, Wieczorek K, Pierce-Weeks J, et al. IAFN Guidelines for SANE Education. 2015. www.forensicnurses.org/?page=educationguidelines.
16. Jones v. State, 719 So.2d 249, 255 (Ala. Crim. App. 1997). https://casetext.com/case/jones-v-state-3629.
17. United States v. Howard, 218 F. 3d 556, 565 (6th Cir. 2000). https://casetext.com/case/us-v-howard-107.
18. NCTSN Core Curriculum on Childhood Trauma Task Force. The 12 core concepts: concepts for understanding traumatic stress responses in children and families. 2012. www.nctsnet.org.
19. De Bellis MD, Zisk A. The biological effects of childhood trauma. *Child Adolesc Psychiatr Clin N Am*. 2014;23(2):185-222.
20. Child Welfare Information Gateway. Mandatory reporting. 2015. www.childwelfare.gov/pubPDFs/manda.pdf.
21. Jordan KS, Steelman SH. Child maltreatment: interventions to improve recognition and reporting. *J Forensic Nurs*. 2015;11(2):107-113.
22. Morris K, Ditton M. Veracity for children in pediatric forensics. *J Forensic Nurs*. 2009;5(1):49-50.
23. Finkelhor D, Ormrod R, Turner H, Hamby S. Child and youth victimization known to police, school and medical authorities. Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin. 2012. www.ojjdp.gov/pubs/235394.pdf.

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