OREGON MEDICAL GUIDELINES FOR EVALUATION OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

SECOND EDITION 2004

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FOR EVALUATION OF SEXUAL ABUSE
IN CHILDREN AND ADOLESCENTS
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INTRODUCTION TO THE SECOND EDITION 2004

OREGON MEDICAL GUIDELINES FOR EVALUATION OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

As the editors approached the process of revising these guidelines, the original statement of purpose was reviewed. It was discovered that our purpose remains essentially unchanged. The original statement is included verbatim in this second edition, as a reaffirmation of commitment to the task of compiling guidelines for medical providers who work with children in whom abuse may have occurred.

In the five years since the Oregon Medical Guidelines were first compiled, researchers in the field of child abuse and neglect have continued to direct their efforts toward the honing of diagnostic and intervention skills of professionals providing care for young victims. Efforts to identify findings specific to child sexual abuse have been advanced through several large subject volume studies and some with successful long term follow-up. Diagnostic criteria and classification scales have been repeatedly revised. Insight has been gained to enhance skills at gathering history from children. Increased awareness about the disclosure process and recognition of the compelling features of children's statements have helped clinicians gain confidence in stating their conclusions about whether abuse has occurred. This current revision of the **Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents** reflects many of these advancements in the field.

There remain many challenges for those who, as stated by the Oregon Legislature in 1997, believe that "every child reasonably suspected of having been physically or sexually abused [should] have access to a skilled, complete, and therapeutic child abuse medical assessment."* To accomplish this, medical providers who endeavor to evaluate children in whom sexual abuse is a concern must acquire and maintain the knowledge base and skills needed to afford these patients the high standard of medical assessment that they deserve. The **Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents** is offered to medical evaluators to further that objective. As with the original 1999 Guidelines, the 2004 Oregon Medical Guidelines are NOT PROTOCOLS. It is the intention of the editors that the Guidelines serve as a user-friendly handbook of information, a collection of resources and references, to guide medical evaluators of child sexual abuse through the tasks and challenges of this work.

*For more information about Oregon statutes pertaining to child abuse, refer to ORS 418.746 to 418.796 (2003 Edition) which may currently be accessed at http://www.leg.state.or.us/ under the Bills/Laws tab.

PLEASE NOTE: Throughout this document, when gender of third person pronouns is not relevant to the content, the editors randomly assigned them as either male or female. This style was chosen over including the "he/she" combination forms or consistently selecting a single gender. The editors acknowledge that both sexes are represented in patient and medical provider populations.

ORIGINAL STATEMENT OF PURPOSE

AS PRINTED IN THE FIRST EDITION 1999

The primary purpose of these guidelines is to promote consistency in the quality of care provided to Oregon's children when they are evaluated for possible sexual abuse. This document was also devised as an educational resource for examiners conducting medical examinations for suspected abuse.

These guidelines were developed through literature review and consultation with experienced examiners working in different settings around the state of Oregon. Examiners work in many settings (e.g., rural, urban, differing legal jurisdictions) and have varying relationships with child assessment centers (e.g., employed by the center, in private practice but contracting with the center for suspected abuse exams, emergency department examiners). Consequently, in devising these guidelines, an effort was made to consult examiners across settings and from different regions of Oregon. Some practices should be consistent across settings, while others will vary according to the setting. Because of this variability, the guidelines are not intended to be a standard of medical practice. It is essential that examiners have the freedom to exercise clinical judgement in individual cases. However, examiners should be knowledgeable regarding practice guidelines and the underlying literature and should be prepared to justify their decisions in individual cases. It is hoped that these guidelines will function as a working document to be periodically updated as scientific knowledge and experience in the medical evaluation of suspected child sexual abuse expands.

WITH ACKNOWLEDGMENT FOR THEIR PAST CONTRIBUTION:

OREGON MEDICAL GUIDELINES
For Center-based Child Sexual Abuse Examinations
1999

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MULTIDISCIPLINARY CHILD ABUSE TEAMS (MDTs) IN OREGON

GUIDELINE

Oregon statutes 418.746 to 418.796 include the requirement that the District Attorney in each county is responsible for developing interagency and multidisciplinary child abuse teams, often referred to as MDTs. These teams consist of both mandated and non-mandated members. All team members and those conducting investigations of child abuse and interviews of child abuse victims are to be trained in risk assessment and in the dynamics of child abuse, child sexual abuse and rape of children, including legally sound and age appropriate interview and investigatory techniques. MDT membership, protocols and members' roles vary from county to county. MDTs regularly review child abuse cases in order to obtain multidisciplinary input into decisions involving the assessment, investigation and prosecution of cases, as well as their treatment and disposition.

MEMBERSHIP AND MEETINGS

As specified in ORS 418.746 – 418.796 2003 edition, "the district attorney in each county shall be responsible for developing interagency and multidisciplinary teams to consist of but not be limited to law enforcement personnel, Department of Human Services child protective service workers, school officials, county health department personnel, child abuse intervention center workers, if available, and juvenile department representatives, as well as others specially trained in child abuse, child sexual abuse and rape of children investigation". Among the non-specified members, directors of child abuse evaluation centers, mental health workers and local child abuse medical experts may participate. It can be extremely helpful to have input during MDT discussions from local medical providers who are knowledgeable about child abuse.

County MDTs generally meet on a regular basis and may provide case review, triage and case consultation, as well as referrals for medical evaluation of suspected abuse. MDT meetings are also excellent opportunities for the members to confer about general child abuse issues in the community and state, to discuss available or needed trainings and to brainstorm other matters of concern to the members.

MDT COLLABORATION

1. Working as a Team

In addition to regular meetings at which representatives from the various disciplines come together to discuss child maltreatment cases and issues, there are also day-to-day opportunities for collaboration among professionals working on child abuse matters. Different agencies may come together to coordinate efforts on particular child abuse

cases. For example, individuals from the District Attorney's Office, law enforcement and child protective services may meet at critical points during the investigation, assessment and prosecution phases of a case to determine what each agency will contribute. Another illustration of such collaboration occurs when the law enforcement officer assigned to a particular case and the assigned child welfare caseworker form a "team" on the day of the child's medical evaluation. One or both of them may have interviewed the child and/or family members prior to the evaluation and may share valuable information when they further team up with the clinician who conducts the medical evaluation of the child.

Awareness of the drawbacks of interviewing children numerous times in the course of an abuse investigation provided great impetus for increased multidisciplinary cooperation. Decisions about who will perform the interviews of children in whom abuse is suspected are frequently made according to availability of local expertise. In some communities, the law enforcement officer or DHS caseworker is the child's primary interviewer. In other communities, a designated child interviewing specialist, for example, one associated with a child abuse intervention center, serves as the primary interviewer. The medical provider utilizes the information gained from interviews of the child and tailors the history-taking during the medical evaluation accordingly. Where skilled child interviewing capabilities in the law enforcement or child protection systems are not accessible or timely, and when the medical provider is not teaming with a child interview specialist to conduct evaluations, the examiner may need to interview the children more extensively. See the upcoming section titled, "History from the Patient: the Medical Interview," for recommendations on questioning techniques in child sexual abuse evaluations.

In many jurisdictions, the law enforcement and DHS professionals assigned to a particular case will attend that child's medical evaluation. Although it is an option for them to review a videotape of the interview conducted by a child interviewing specialist at a time separate from the evaluation, the investigator and caseworker may observe the child's interview in process from behind a one-way mirror, or as transmitted to an audio-visual screening room. Some facilities arrange for the LEA and DHS assignees to also be able to hear the audio portion of the medical interview and physical examination conducted by the healthcare professional. However, it must be stressed that, in order to duly respect the privacy of the patient and to maintain an unbiased medical setting, the physical examination of the patient should never be videotaped, nor should the caseworker and investigator view the examination.

When investigators and caseworkers attend medical evaluations as described above, there may be "real-time" opportunities for discussion of the clinician's findings and recommendations. These may expedite the process of investigating the abuse concerns and ensuring the child's safety.

2. The Importance of Good Relationships

The MDT can be a significant resource to the medical professional evaluating a child for suspected abuse. While it is paramount that the medical evaluation be conducted objectively and that the practitioner arrives at an independent conclusion, this does not preclude coordination with other agencies involved in a case of suspected child abuse. As noted above, MDT members may interview the child and/or family, may provide history, and may be involved in follow-up measures. In the course of pursuing information discovered during the medical evaluation, individuals from MDT agencies may provide feedback to and may solicit additional input from the healthcare practitioner who examined the child. MDT partners in law enforcement, child protective services, mental health, the judicial system and schools, etc., who serve in the various roles of protecting the child and identifying additional victims, may also be responsible for ensuring follow-up with medical instructions and helping the child and family cope with the impact of abuse concerns.

Responding to allegations of child abuse is a complex endeavor. It is important for MDT members to be able to work together and communicate effectively so that their complementary skills can be used for the greatest benefit of the children served. Occasionally, confusion may arise regarding the roles of the various agencies involved. The MDT is a good forum to address such questions and improve communication between community partners.

3. The Role of the Medical Professional in the Multidisciplinary Team Context

Medical providers play an important role in the multidisciplinary approach to serving children in whom abuse is suspected. The healthcare professional is relied upon to conduct a competent medical evaluation of a potentially abused child. In the same way that is routine for all other medical presentations, the examining clinician reviews available data pertinent to the case, takes a history and performs a physical examination on each patient. Furthermore, the examiner orders laboratory tests and imaging studies, as needed, and arrives at and documents the medical diagnosis and/or conclusions. Treatment plans and recommendations for the child's ongoing care and disposition are generated as part of the medical evaluation.

Although the focus in child sexual abuse medical evaluations may seem to be directed toward identifying "evidence" gained through examination of the child's anogenital areas, the skilled medical evaluator takes a much broader perspective. The healthcare practitioner is likely to gain a great deal of information from the child's examination that would be useful to other MDT partners involved. Discovery of findings in parts of the child's body other than the genitals or anus may corroborate details in the statements that the child has made about the abuse. The child may share information in the context of the medical evaluation which significantly supplements or clarifies what had been previously known about the case. Other injuries or health concerns that are discovered may be useful in putting together a pattern of abuse or neglect.

Identifying fears or worries that the child may only be triggered to reveal in the context of the medical exam may uncover important data that will be considered in the decisions made by child protective services, mental health workers, schools and other MDT partners. The healthcare provider's unique knowledge of child development can be useful to other professionals who assess the validity of the child's statements and responses. The medical evaluator has privileged access to the child and his/her body in a manner that no other MDT participant does. This access can be capitalized upon to obtain information that will contribute to determining the best interventions for the child.

Information obtained by MDT partners can contribute to the medical provider's accurate and thorough evaluation of a child in many ways. On a basic level, in order to adequately assess the child and formulate a diagnosis, the medical evaluator needs to be informed about what is reported to have happened to the child. With knowledge of the identity of the suspected perpetrator of abuse upon a child, for example, the healthcare provider can assess the risk of sexually transmitted diseases and other infections. As is the standard of care with pediatric patients, it would also be routine for an examiner with such knowledge to make recommendations addressing the safety of the child in the care of those individuals suspected to present a danger to that child. Learning what law enforcement and child protective services have discovered about the timing of alleged incidents of abuse can help the medical evaluator to determine if an injury or finding is related to those occurrences or if forensic evidence should be collected.

In addition to performing the medical evaluations on children, there is also an important place for the healthcare professional at the MDT meeting table. When MDT members come together to analyze the facts of a case in an effort to determine the best course for the child, it can be very helpful to have medical providers knowledgeable about child abuse present to participate in those discussions. They can contribute valuable insights at staffings of the cases of children they have evaluated. Healthcare professionals may also serve as consultants to the MDT on general matters pertaining to health and medicine. They may, for example, provide information about mechanisms of injury and whether the explanations offered to investigators match the findings noted on a child's body. Physicians can recognize symptoms and indicators of illness and interpret physical findings observed by other MDT members. They can address health and safety concerns for children in neglectful environments.

4. Modifying the Medical Evaluation Facility to Enhance MDT Collaboration

Limiting the number of people in the examination room to those who are actually participating in the medical evaluation preserves the child's privacy and may minimize his stress. In communities in which the assigned DHS caseworker and law enforcement officer will attend child sexual abuse medical evaluations, clinicians are encouraged to use or to create facilities which allow cooperation with investigators while prioritizing respect for the patient and the medical evaluation process. Modifications of the medical setting to accomplish this vary from simple to elaborate and depend upon the resources in the community. The basic requirement is for the medical evaluation area to have an audio connection to a different room, so that the child protective services caseworker or

law enforcement officer assigned to the case can listen to the interview and to the child's statements made during the physical examination.

Some child abuse intervention facilities make use of a one-way mirror in the interview room. In other settings, a video camera and microphones record the child's interview and transmit the image or sound from the interview area to an observation/listening room. It is **NOT** appropriate for the physical examination of the patient to be viewed or videotaped. Cameras and one-way mirrors should **NOT** be used during the medical examination part of the child's evaluation. When videocolposcopy is used, special precautions should be taken to maintain the child's privacy.

Another note of caution related to recording the physical examination: Audiotaping of the medical examination has frequently been discussed. However, this practice is discouraged for a variety of reasons. It has been learned from investigators and caseworkers who listen to the audio portion during a child's physical examination at a child abuse center that they often experience frustration because they cannot see what is going on. Patient gestures and expressions, eye contact and other subtle observations which contribute to the clinician's assessment of the patient are not captured on audiotransmission or when the audio portion of the evaluation is recorded. Audiotaping of the medical examination is not a complete representation of what occurs during the patient-clinician encounter. However, even if those who may listen to a tape are advised that, since it does not include important non-verbal factors, the recording is not to be regarded as a complete account of the evaluation, the likelihood that audiotaped information may be taken out of context is considerable. Audiotaping of the medical evaluation is generally not practiced and is not currently recommended.

As part of providing conscientious medical care, healthcare professionals who conduct evaluations for suspected victims of child sexual abuse must commit to preparing a comprehensive medical report that will thoroughly and accurately document what was learned during the medical evaluation of the child. It is an added benefit that well-written, objective medical evaluation reports may also be relied upon by MDT members who make safety and legal decision for children.

REGIONAL CHILD ABUSE TRAINING AND CONSULTATION CENTERS (RTCCs) and OREGON NETWORK OF CHILD ABUSE INTERVENTION CENTERS (CAICs)

GUIDELINE

The effort to develop and support operation of community-based child abuse intervention centers (CAICs) in Oregon was strengthened when, in 1993, the Oregon State Legislature created the Child Abuse Multidisciplinary Intervention Account (CAMI). Since that time, CAICs have been created in most counties in Oregon. The Oregon Network of Child Abuse Intervention Centers works to minimize trauma to child victims of abuse by coordinating medical assessment, investigation, and intervention services in each community.

The Oregon State Legislature allocated funds in 1997 to the Child Abuse Multidisciplinary Intervention (CAMI) Program to establish regional centers and expand community child abuse assessment services throughout the state (ORS 418.746 to 418.796 2003 edition). This legislated expansion of Oregon's child abuse assessment services was intended to ensure that "every child reasonably suspected of having been physically or sexually abused have access to a skilled, complete, and therapeutic child abuse medical assessment."

OREGON NETWORK OF CHILD ABUSE INTERVENTION CENTERS

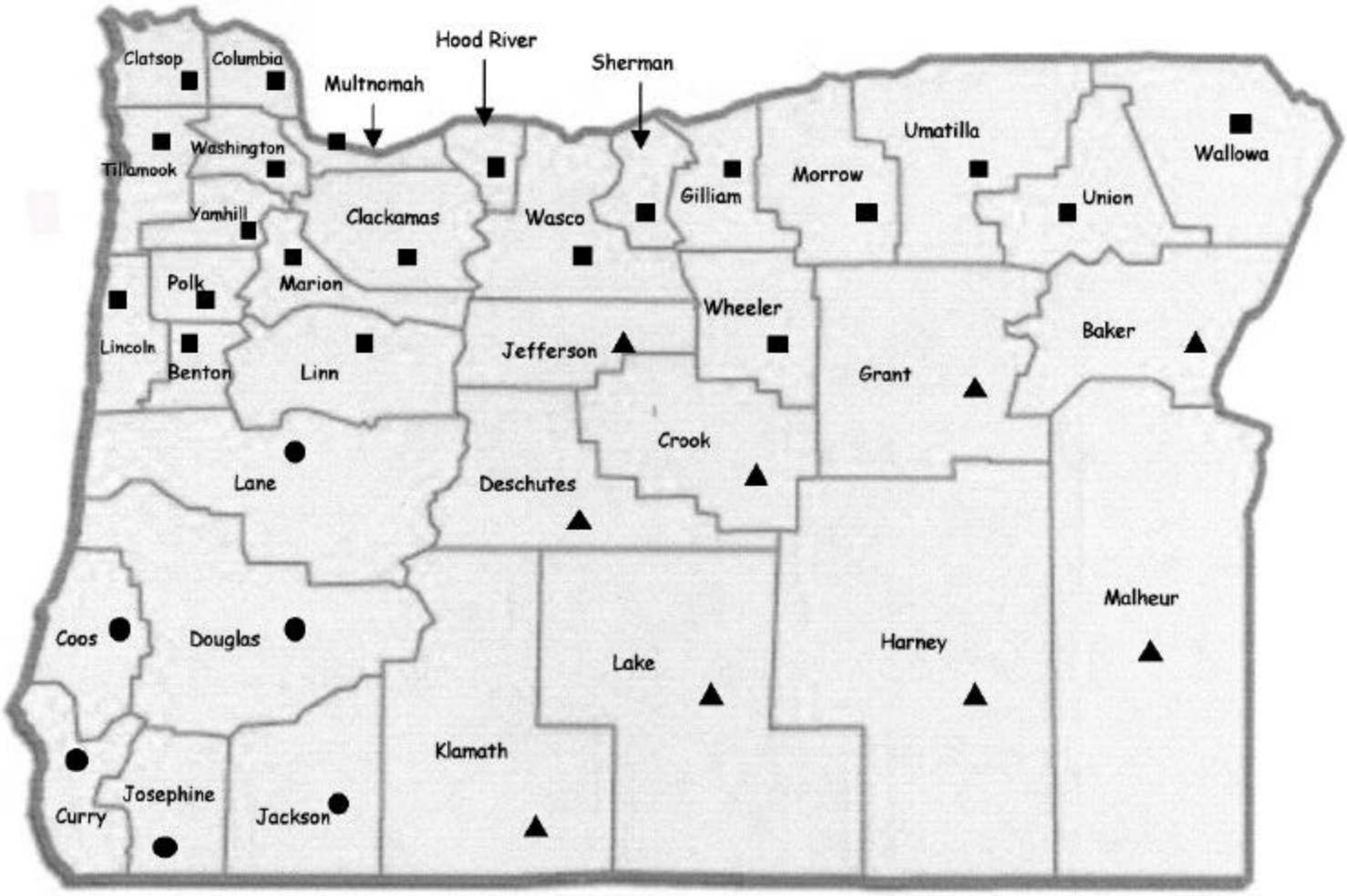
In 1993 the Child Abuse Multidisciplinary Intervention Account (CAMI) was created by the Oregon Legislature to help support the development and operation of community - based child abuse intervention centers. These centers are designed to minimize trauma to child victims of abuse by coordinating the local community's response for the purpose of medical assessment, investigation, and intervention. Comprehensive services are provided in a child-friendly environment and may include medical evaluation, forensic child interviewing, mental health treatment and/or referrals, and other assistance to children.

Child abuse intervention centers are located throughout Oregon (see list at end of this chapter.) Together they form the Oregon Network of Child Abuse Intervention Centers. The Oregon Network works to improve services for children and families in cases of suspected abuse, building the capacity of local communities to provide the best possible care for children and increasing resources for child abuse intervention. Referrals for assessment and intervention may come from a variety of sources, depending upon the guidelines established by the local intervention center and the MDTs in the counties served by the center.

RTCCs IN OREGON

In 1998, CARES Northwest in Portland, KIDS Center in Bend, and Jackson County Child Advocacy Center in Medford were designated Regional Child Abuse Training and Consultation Centers (RTCCs). These Regional Centers are charged with providing professional consultation, education, training, technical assistance, and referral services to the administrators, child interviewers/investigators, and medical staff affiliated with community child abuse intervention centers (CAICs) and county multidisciplinary teams (MDTs).

Medical providers who conduct child sexual abuse evaluations may find the medical, interviewing and program consultants at the three RTCCs to be very valuable sources of information and support. It is recommended that medical evaluators, especially those new to the field, become familiar with their own RTCC consultants and use them liberally. The readily accessible resources provided by RTCCs can enable healthcare professionals to maintain and continually improve the high standard of care intended by the legislature and aspired to for the good of the children who are being evaluated for abuse.



OREGON REGIONAL TRAINING AND CONSULTATION CENTERS (RTCCs)

■ CARES Northwest	2800 N. Vancouver Ave., Suite 201 Portland, OR 97227	Toll free: 1-877-888-9641 Phone: 503-331-2400 Fax: 503-331-2410
▲ KIDS Center	1375 NW Kingston Ave. Bend, OR 97701	Toll free: 1-877-888-3822 Phone: 541-383-5958 Fax: 541-383-3016
● Jackson County Child Advocacy Center	816 W. 10th St. Medford, OR 97501	Toll free: 1-877-888-9810 Phone: 541-734-5437 Fax: 541-734-2425

RTCC at KIDS Center
1375 NW Kingston Avenue
Bend, Oregon 97701
Phone: 541-383-5958
Toll free: 1-877-888-3822

RTCC at KIDS Center serves the following counties:

Baker	Jefferson
Crook	Klamath
Deschutes	Lake
Grant	Malheur
Harney	

RTCC at Jackson County Child Advocacy Center
816 SW 10th Street
Medford, Oregon 97501
Phone: 541-734-5437
Toll free: 1-877-888-9810

RTCC at Jackson County Child Advocacy Center serves the following counties:

Coos	Jackson
Curry	Josephine
Douglas	Lane

RTCC at CARES NW
2800 N. Vancouver St., Suite 201
Portland, Oregon 97227
Phone: 503-331-2400
Toll free: 1-877-888-9641

RTCC at CARES NW serves the following counties:

Benton	Linn	Umatilla
Clackamas	Marion	Union
Clatsop	Morrow	Wallowa
Columbia	Multnomah	Wasco
Gilliam	Polk	Washington
Hood River	Sherman	Wheeler
Lincoln	Tillamook	Yamhill

OREGON NETWORK OF CHILD ABUSE INTERVENTION CENTERS

COUNTY	INTERVENTION CENTER	ADDRESS	PHONE
Benton/Linn	ABC House	PO Box 68 Albany, OR 97321	Phone: (541) 926-2203
Clackamas	Children's Center of Clackamas County	1811 15th St. Oregon City, OR 97045	Phone: (503) 655-7725
Clatsop	The Lighthouse	PO Box 233 Astoria, OR 97103	Phone: (503) 325-4977
Columbia	Columbia County Child Abuse Assessment Center	PO Box 1001 St. Helens, OR 97051	Phone: (503) 366-4005
Coos	Coos County Children's Advocacy Center	125 W. Central, Suite 230 Coos Bay, OR 97420	Phone: (541) 266-8806
Curry	Curry County Child Advocacy Team	PO Box 1037 Gold Beach, OR 97444	Phone: (541) 247-6074
Deschutes	KIDS Center	1375 NW Kingston Ave. Bend, OR 97701	Phone: (877) 888-3822 Phone: (541) 383-5958
Douglas	Douglas CARES	PO Box 190 Roseburg, OR 97470	Phone: (541) 947-5646
Jackson	Jackson County Children's Advocacy Center	816 SW 10th St. Medford, OR 97501	Phone: (877) 888-9810 Phone: (541) 734-5437
Josephine	Josephine County Child Advocacy and Treatment Center	322 NW "F" St. Grants Pass, OR 97526	Phone: (541) 474-5437

COUNTY	INTERVENTION CENTER	ADDRESS	PHONE
Klamath/Lake	Klamath/Lake CARES	2865 Daggett St. Klamath Falls, OR 97601	Phone: (541) 883-6298
Klamath	Klamath Youth Development Center	2210 El Dorado Klamath Falls, OR 97603	Phone: (541) 883-1030
Lane	Child Advocacy Center of Lane County	2560 Frontier Dr. Eugene, OR 97401	Phone: (541) 682-3938
Lincoln	Lincoln County Children's Advocacy Center	PO Box 707 Newport, OR 97365	Phone: (541) 574-0841
Malheur	Project Dove/STAR Center	PO Box 980 Ontario, OR 97914	Phone: (541) 881-0153
Marion	Liberty House	PO Box 2613 Salem, OR 97308	Phone: (503) 540-0288
Multnomah/ Washington	CARES Northwest	2800 N. Vancouver Ave., Suite 201 Portland, OR 97227	Phone: (877) 888-9641 Phone: (503) 331-2400
Umatilla	Guardian Care Center	202 SE Dorian, Suite 102 Pendleton, OR 97801	Phone: (541) 276-6774
Union	Mt. Emily Safe Center	PO Box 1014 Union, OR 97883	Phone: (541) 562-8039
Yamhill	Juliette's House	1075 SW Cedarwood Ave. McMinnville, OR 97128	Phone: (503) 435-1550

TRAINING AND ONGOING EDUCATION FOR MEDICAL EVALUATORS OF NON-ACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

GUIDELINE

Examiners from many disciplines may conduct medical evaluations for suspected non-acute child sexual abuse, provided that they accomplish each of the following:

- **acquire specialized training in child sexual abuse,**
- **acquire specialized training in evaluation of pediatric patients,**
- **practice within the legal scope of their training and license,**
- **obtain appropriate consultation, AND**
- **make child abuse examination a regular part of their continuing medical/nursing education.**

PLEASE NOTE: *Recommendations for prerequisite training for those healthcare professionals intending to perform the medical evaluation in cases of* ***acute*** *sexual assault are included in these* ***Guidelines*** *in the chapter entitled,* **"TRAINING FOR MEDICAL EVALUATORS OFACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS."** *Those practitioners working in an emergency room or who are involved in forensic evidence collection in other settings will require specific training in completion of the standardized "Oregon State Crime Lab" Sexual Assault Forensic Evidence (SAFE) kits, previously referred to as "rape kits" and other essential acute evaluation procedures.*

EDUCATIONAL BACKGROUND AND LICENSURE

Specialized training and clinical experience is essential to ensure that every medical practitioner who evaluates children and teens for non-acute sexual abuse can do so competently and thoroughly. These clinicians must first possess basic knowledge of pediatric and adolescent medicine and/or nursing and be well-versed in normal child growth and development. In addition, it is expected that child sexual abuse medical evaluators can proficiently complete a well-child examination, make medical diagnoses, and recommend medical treatments.

The following types of medical providers may evaluate children and adolescents for non-acute sexual abuse:

1. Physician licensed in Oregon
2. Physician's Assistant working under the direction and supervision of an Oregon licensed physician who is skilled and experienced in evaluating

children who may have been abused. The type of supervision for the PA must be detailed in the "practice description" which is submitted by the PA and supervising physician to the Board of Medical Examiners for approval.

3. Nurse Practitioners licensed in Oregon (*Please note: the particular license of a nurse practitioner dictates the population of patients which that practitioner may medically evaluate.)
   a) For Children and Adolescents (ages 0-18 years)
      - Pediatric Nurse Practitioner (PNP)
      - Family Nurse Practitioner (FNP)
   b) For Adolescents only
      - Adult Nurse Practitioner (ANP) may evaluate pubertal girls and boys
      - Women's Health Care Nurse Practitioner (WHCNP) may evaluate pubertal girls (not boys)

Medical, physician assistant, and nurse practitioner training programs provide a necessary baseline of competence but typically do not include specific training in how to conduct a child abuse evaluation. The medical provider's ultimate level of expertise in child abuse evaluation will be determined by post-graduate training as well as clinical experience rather than simply by the type of degree acquired. Healthcare professionals with any of the degrees mentioned above can obtain the necessary training to conduct screening examinations or to become a community expert.

PREREQUISITE TRAINING FOR MEDICAL EVALUATION OF NON-ACUTE CHILD SEXUAL ABUSE

In addition to competency in the physical examination of children and adolescents, the clinician who evaluates children and adolescents for sexual abuse must possess a **basic knowledge of children's abilities and limitations at different ages**, particularly in the realm of language and communication. The examiner must also have obtained **training and clinical experience in differential diagnosis of pediatric medical conditions**. Finally, the medical evaluator must acquire **advanced knowledge pertaining to the forensic child sexual abuse evaluation.**

Medical evaluators of children and adolescents for sexual abuse should receive training and be competent in the following domains:

- taking a thorough medical and social history
- forensically sound medical questioning of children and teens about abuse
- complete head-to-toe well-child care examination

- appropriate anogenital examination techniques, including proper use of equipment
- discrimination of normal and abnormal anogenital findings
- differential diagnosis of sexual abuse
- treatment recommendations for children who may have experienced sexual abuse
- screening and treatment for sexually transmitted diseases in pediatric and adolescent populations
- documentation of the complete medical evaluation, including photo-documentation
- making the diagnosis of sexual abuse, including facility with assigning levels of certainty regarding the likelihood of abuse
- fundamentals of the medical evaluation of child physical abuse, psychological/emotional abuse, and neglect
- providing testimony as an expert witness

As stated above, additional, specialized training in the completion of standardized rape kits will be essential to those practitioners who intend to do acute forensic evidence gathering exams in the emergency room or other settings. See Chapter 17 in these ***Guidelines***, **"TRAINING FOR MEDICAL EVALUATORS OF ACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS."**

ADDITIONAL TRAINING NEEDS FOR MEDICAL EVALUATORS OF NON-ACUTE CHILD SEXUAL ABUSE

Children and teens in whom sexual abuse is suspected are seen in a variety of healthcare settings and by medical providers who have a wide range of competence in the evaluation of these patients. At the least specialized level, patients may be very basically triaged, i.e., screened solely to rule out obvious abnormalities or acute medical needs. While access to more thorough and skilled medical evaluation may not be available at all times and in all circumstances in our state, it is preferred that, if such limited triage is employed, it be followed by referral to a medical practitioner who has interest, as well as the requisite training and experience in conducting more thorough child sexual abuse evaluations. Below are outlined the recommended training requirements for medical practitioners who provide two categories of "skilled, complete and therapeutic child abuse medical assessment[s]," (ORS 418.746 to 418.796 2003 edition), for children in whom sexual abuse is suspected.

Additional Training for Medical Practitioners Who Intend To Provide Competent "Screening" Evaluations

Medical practitioners who intend to provide competent screening evaluations for non-acute child sexual abuse must learn the fundamental components of the evaluation, listed above under "PREREQUISITE TRAINING…" To begin learning the fundamentals, health care professionals will benefit from attending the medical track of a major child

abuse conference such as the annual Chadwick Center Child and Family Maltreatment Conference in San Diego, California, or the annual conference on child abuse sponsored by the Regional Training and Consultation Center at CARES Northwest in Portland, Oregon. A new medical evaluator should also acquire clinical experience with child abuse evaluations by observing the clinical work of a child abuse medical specialist.

Additional Training for Medical Practitioners Who Intend To Provide Competent "Specialized" Evaluations

For the medical professional who intends to serve as the specialist performing child sexual abuse evaluations in his/her community, thorough training should include all that is recommended for those who provide "screening" evaluations (see above), as well as some type of preceptorship. Ongoing access to case consultation with experienced child abuse medical evaluators is essential, as well. Such training, mentorship and consultation are available through the following medical training programs at Oregon's three Regional Child Abuse Training and Consultation Centers (RTCCs):

RTCC at CARES NW
2800 N. Vancouver St., Suite 201
Portland, Oregon 97227
Toll free: 1-877-888-9641
Phone: 503-331-2400

RTCC at KIDS Center
1375 NW Kingston Avenue
Bend, Oregon 97701
Toll free: 1-877-888-3822
Phone: 541-383-5958

RTCC at Jackson County Child Advocacy Center
816 SW 10th Street
Medford, Oregon 97501
Toll free: 1-877-888-9810
Phone: 541-734-5437

Initial training periods should involve observation of a medical specialist during several child sexual abuse evaluations. New evaluators should engage in discussing the evaluation process, findings and observations, differential diagnoses and considerations, conclusions, documentation and recommendations with the experienced specialist. Review (if possible, with an experienced medical evaluator) of teaching cases, videotapes, and photos of physical findings is important when a healthcare practitioner is first learning to evaluate children and teens for sexual abuse. In this way, exposure to

conditions and circumstances that present diagnostic challenges may be increased, even for those clinicians whose case load of such cases may not be large.

As part of initial specialized education and in addition to obtaining clinical training and experience, medical evaluators of non-acute sexual abuse should:

- Become acquainted with the child abuse literature mentioned in the "**References",** Chapter 20 of these ***Oregon Medical Guidelines.***
- Read the ***Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents.***
- Attend at least one major child abuse conference with a strong medical track.
- Develop a plan for remaining up-to-date on the literature in the field and maintaining and improving skills utilized in conducting child sexual abuse medical evaluations.

ONGOING EDUCATION

Components of ongoing education for healthcare professionals who evaluate children and adolescents for sexual abuse include training opportunities (e.g., conferences, seminars, observation of medical evaluations on-site at Regional Child Abuse Training and Consultation Centers or local child abuse intervention centers), literature review, case/peer review, quality assurance activities, and consultation on challenging cases.

Training Opportunities

For **healthcare practitioners who perform "screening" evaluations** for non-acute child sexual abuse, some portion of continuing medical education credits in each licensure cycle should focus on child abuse medical evaluation.

In small communities, a **local child abuse specialist** may examine only a few children per year for possible abuse, while in urban communities, a single practitioner may evaluate hundreds of children annually. Continuing education for the medical professional functioning as the local expert should be indexed to his/her caseload in the area of child abuse.

- When the clinician's caseload is light in this area, one annual training in the area of child abuse should suffice to maintain an adequate level of expertise.
- Healthcare providers whose practice consists primarily or entirely of child abuse cases should acquire most continuing education credits in the area of child abuse.

Literature Review

Medical practitioners who are **designated local child sexual abuse evaluation specialists** should establish mechanisms for thorough literature review. Those clinicians who conduct "screening" evaluations should also periodically review articles related to

child sexual abuse. Pertinent abstracts and articles may be found, for example, in the following journals:

Pediatrics
Child Abuse and Neglect
Child Maltreatment
Journal of Pediatric and Adolescent Gynecology
The Quarterly Child Abuse Medical Update

The ***Quarterly Child Abuse Medical Update*** is an excellent resource, as it features abstracts and critical reviews of recently published articles in the field of child abuse. (For information about subscription to the ***Quarterly Child Abuse Medical Update***, contact Robert Reece, MD, Editor, at P.O. Box 523, Norwich, VT 05055-0523 or view the website at www.quarterlyupdate.org)

The ***Newsletter of the Section on Child Abuse and Neglect (SCAN)***, published by the American Academy of Pediatrics and distributed to section members, also features a listing of reference articles.

Consultation / Peer Review / Quality Assurance

To enhance skills, develop clinical expertise, stay current and maintain competency in the field, the medical provider should also participate regularly with more experienced child abuse specialists in one or all of the following:

- Case consultation
- Case review (peer review)
- Quality Assurance

These activities may be arranged through the medical consultants at each of the Regional Training and Consultation Centers.

In the medical field, training, case consultation, peer review, and quality assurance are among a continuum of standard methods for achieving and ensuring professional competence. Particularly in the child abuse arena, these mechanisms can be effective means of securing support, especially for examiners practicing in isolation or in remote rural areas and for those who see a low volume of patients. Participation in a regular process of peer review and quality assurance with other child abuse experts is likely to bolster examiner qualifications and expertise.

Distinction between case consultations, peer review and quality assurance activities may be helpful to elucidate. Case consultation occurs at the request of the examining health care provider who seeks input about an active or current case from another provider, usually one that has greater experience in the area of child abuse medical evaluations. The purpose of case consultation is to aid the requesting examiner in the process of completing a medical assessment, making a medical diagnosis and formulating treatment recommendations. Peer review and quality assurance (QA) are often used synonymously. Both processes have in common the review of inactive or past cases for the purpose of improving the quality of the medical evaluations.

1. Case consultation

Healthcare practitioners who evaluate children and adolescents for sexual abuse should use consultation and peer review to continually enhance their skills. Medical providers whose volume of child sexual abuse cases is low and those with minimal initial training or few continuing education credits in the area of child abuse should consult with specialists on most cases. Any children with questionable findings should be referred to a child abuse medical specialist. Local child abuse medical specialists will also benefit from consulting on a regular basis with other experienced medical evaluators of child sexual abuse.

Surveys and clinical practice show that inexperienced examiners may be more likely to call a finding abnormal than experienced examiners. Experienced examiners are a critical consultation resource for screening evaluators because they can offer a wealth of information regarding the diagnostic complexities of individual cases. Establishing a mechanism for consultation is particularly important for isolated rural examiners. When consultation is used liberally and often, the clinician will gain expertise with each additional case evaluated.

In Oregon, the **Regional Child Abuse Training and Consultation Centers** referenced above have designated child abuse medical consultants available for direct consultation via the Oregon Telemedicine Project, telephone, U.S. mail, electronic mail, or in person. (For more information about using telemedicine for child abuse consultations, refer to "**A special note about Telemedicine"** below). Medical providers seeking consultation are advised to contact their RTCC to decide upon the most appropriate manner of sharing information. The RTCC consultants may also be helpful in suggesting local consultation resources for medical evaluators.

In addition, **CARES Northwest in Portland** maintains an **after-hours child abuse consultation service** for medical providers, law enforcement agencies, and child protection workers. This after-hours service **can be accessed through the Legacy Emanuel Hospital Operator at 503-413-2200 or toll-free at 1-866-888-4398.**

2. Peer review

Peer review in child abuse medical circles may also be dubbed slide/videotape/photo review, case conference, or case review. As commonly understood among child abuse professionals in Oregon, peer review involves the voluntary and somewhat informal participation of child abuse providers with other providers, including experts, in mutual review and discussion of physical findings, diagnostic decision-making, and/or medical management. Specific cases intentionally selected by the examining practitioner are presented in part or as a whole to the clinician review group. Such review may occur among providers affiliated with the same agency (internal peer review), among providers from different agencies (inter-examiner, inter-center, external peer review), or with other

providers attending conferences or meetings (external peer review). The peer review process serves as continuing education and is not specifically intended to influence or change the outcomes of reviewed cases.

3. Quality Assurance activities

As with peer review, quality assurance activities (aka quality assurance consultation, records review, QA) are not intended to impact decisions made about active cases. QA may be requested by a medical provider who evaluates children for abuse, either on a specific case or cases, or on a random selection of patient records. QA may be voluntary or may be required as part of a facility's continuous improvement plan. Examiners within the same facility may provide review for each other (internal QA) or QA may be conducted between providers from different facilities (external QA).

QA may involve an in-depth review and critique of the complete medical record, including written and photodocumentation, of a specific child abuse case. Medical records, randomly or voluntarily selected, may also be reviewed by another child abuse professional to assess specific performance parameters, e.g., proper patient identification, appropriate documentation of the history and chief complaint, accuracy of written and photo documentation of complete evaluation, diagnostic accuracy, appropriateness of treatment recommendations, etc. Through QA activities, practice patterns, case judgments, examination technique, and communication and systems processes can be evaluated. Based upon the information gained, child abuse medical providers and facilities may initiate measures to ensure consistency and continuous quality improvement.

4. A special note about Telemedicine

Telemedicine, broadly defined, is the use of electronic communication and information technologies to provide health care. Since 1998, a majority of the child abuse intervention centers (CAICs) in the state have used Second Opinion™ software to facilitate a secure exchange of photos and case information. The purpose of this telemedicine system was to provide CAICs and medical professionals a direct link to the medical consultants at the three Regional Child Abuse Training and Consultation Centers (RTCCs) in the state.

Widespread use of telemedicine in child maltreatment cases in Oregon, however, has been limited due to funding, technological resources, and equipment accessibility issues. Most of these problems will likely be eliminated in the future with the development of a password-protected, secure, web-based system. Rather than requiring special equipment and programs, such a system will only require that providers have Internet access, a computer and a way to download patient photos into their computer. When the examining clinician contacts the consultants at their RTCC, passwords and other information about how to securely upload the data to the Internet can be explained. Patient confidentiality will be preserved through the use of a secure connection.

Healthcare practitioners who evaluate children and adolescents for sexual abuse are reminded that photos should never be faxed or sent as email attachments. Especially in these very sensitive cases, it is critical that photos and case information are shared only via secure means. Medical evaluators are encouraged to make use of telemedicine to enhance consultation with child abuse specialists, e.g., at RTCCs. When initiating a consultation, clinicians are advised to contact the consultant to make arrangements for case and/or photo review and to identify the most secure means by which information will be shared.

PREPARING CARETAKERS FOR THE MEDICAL EVALUATION OF THE CHILD OR ADOLESCENT

GUIDELINE

It is helpful to review what will occur during the medical evaluation with the child's caretakers in advance. The medical provider should obtain necessary consent from the patient's legal guardian and should apprise the caretaker regarding limits to confidentiality pertinent to the medical evaluation of child sexual abuse. It is also helpful for the clinician to outline expectations regarding the caretaker's participation in the evaluation. These explanations generally increase cooperation and minimize potential for misunderstanding.

ABOUT THE EXAM ITSELF

Typically, the child's parent or caretaker (the terms are used interchangeably throughout this document) may have misconceptions or concerns regarding a child abuse evaluation. Law enforcement and child protective workers also may have misconceptions, particularly if expertise in child abuse assessment is new to the community or if the professional is new to the field. Information directed toward educating and seeking cooperation from caretakers may also be useful when communicating about the examination with other professionals.

1. Reassure the parents and child

It is helpful to reassure the child and the parents that, in general, it is anticipated that nothing done during the examination will cause pain to the child. Stating up front that there will be no shots during the evaluation (if this is true, of course) will relieve a fear that children commonly have. Caretakers and older children may be advised that any potentially uncomfortable procedures (e.g., anogenital cultures or exploring the edge of the hymen with a wet cotton swab) will be explained to the child before they are undertaken. Caretakers and patients may be comforted to hear that most children do quite well with the exam and that the examiner will interrupt, modify or curtail the examination process if the child experiences any discomfort. Sometimes it is necessary to schedule a second visit to complete any procedures not accomplished during the initial examination.

2. Explain the examination procedures

Parents generally do not know what to expect from a child sexual abuse medical evaluation. They are frequently worried that their prepubertal daughter will undergo the equivalent of an adult pelvic examination, or that a digital anal examination will be performed on their child. Since speculum exams are rarely performed, except in some adolescents, and digital anal exams are not recommended, the

examiner can reassure parents and caretakers of children that the evaluation will most likely consist of a head-to-toe check-up (much like a standard well-child examination), which also includes careful inspection of the genital and anal areas.

The clinician should explain that he will be utilizing a special light source/magnifying device (e.g., colposcope or whatever is used in that setting), to better visualize those areas. It should be made clear that the colposcope does not even touch the child's body and that most examinations are conducted without the need to insert anything into the child's vagina or anus.

In most circumstances, the parent can be told that the medical provider will be placing his/her gloved hands only on the outside of the anogenital areas to aid in visualization. For pubertal females, it is possible that the need for slightly more invasive procedures (e.g., insertion of swabs to collect specimens for culture, use of a soft catheter to expose the hymenal edge, and, occasionally, speculum examination) may arise. This possibility should be discussed with caretakers of adolescents, as well as with the patients themselves. Emphasis may again be placed on the gentle approach the examiner will be taking and on the control that the patient may exercise during the evaluation (e.g., informing the medical provider if experiencing any discomfort, requesting a break, etc.).

3. Inform the parent and patient regarding photo- or video-documentation

If the child's examination will be documented via macro lens photography, photo-colposcopy or video-colposcopy, it is necessary to inform the parent and to get his/her consent in advance. Parents should be informed that medical photographs will be taken during the examination to document normal findings or abnormal changes. It may be reassuring to caretakers and to the child to have it explained to them that one of the benefits of taking photographs is to help the clinician get a better, more magnified look at those areas of the body, without the child needing to remain in the examination position for an extended period of time. They may also be encouraged to hear that future questions about the child's physical findings may be addressed by referring to the photos, perhaps avoiding the need for the child to undergo another examination. It is helpful to inform them that the photographs do not reveal the child's identity and the photos and/or videos will be handled and stored in a way that protects the child's privacy as much as possible.

OBTAIN NECESSARY CONSENT

The consent or authorization to medically evaluate a child for possible sexual abuse should be obtained from the child's legal guardian prior to beginning the evaluation. No evaluation should go forward without signed consent from the legal guardian. One copy of the signed consent becomes part of the child's medical record, and another copy should be given to the legal guardian for their records.

Specific areas for which a medical provider might want to obtain consent or authorization include:

- Release of information concerning the interview, physical examination results, diagnostic test results, and the medical and social history of the child and family to the child's primary health care provider and mental health therapist. (Department of Human Services/Child Welfare

and law enforcement agencies investigating child abuse have legal access to these medical records.)

- Consent to medical photographs and videotape of interview (including audio portion) of the child and/or parent or guardian for the purpose of medical treatment or legal purposes.
- Participation of professionals in training in the evaluation process.
- Possible use of medical photographs or written materials related to the evaluation for research or teaching purposes, assuring the removal of patient identification when materials are used for these purposes.

HIPAA Considerations

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) has two key purposes. The first (Title I) protects health insurance coverage for workers and their families when they change or lose their jobs. The second (Title II) requires the U.S. Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses, through new protections, the security and privacy of patient health information.

HIPAA's privacy requirements apply only to information and records maintained by "covered entities." A physical health care or mental health care "provider" that conducts certain transactions in electronic form is a covered entity. Any person, business, or agency that furnishes, bills, or receives payment for such care, in their normal course of business, where they also transmit relevant transactions electronically, are covered entities. Medicaid and Child Health Insurance Programs are also covered entities.

HIPAA requires that covered entities give patients written notice of their privacy rights. Under most circumstances, patients must give specific authorization before covered entities can share their information or records, except for disclosures necessary for the treatment of the patient, for payment or for health care operations. Also, a covered entity may disclose, without an authorization, protected health information to law enforcement officials and DHS if it is required to do so by law. An example would be a covered entity complying with Oregon State Law mandating the reporting of child abuse. Health care providers can release protected patient information to LEA and DHS to assist in investigation of child abuse. Information cannot be released to attorneys, including district attorneys, without an authorization or a subpoena that is compliant with HIPAA and state law (see ORCP 55H) or a valid court order. Additionally, to testify in court and, in so doing, to disclose protected health information, a subpoena compliant with HIPAA and state law or a valid court order is required.

Important Issues Regarding Consent and Minors*

1. A minor in Oregon is an unmarried person under the age of 18 (ORS 109.510).
2. By statute, a person 15 years of age or older may give consent for most medical treatments (ORS 109.640).

3. When a minor up to and until 18 years of age consents to medical treatment, this information may be disclosed to the parents or legal guardians (ORS 109.650).
4. With three exceptions, the consent of the parent/guardian must be obtained BEFORE medical treatment is give if the child is under 15
    a. Treatment for venereal disease and birth control information or services can be give to a child of any age upon their request and consent (ORS 109.610).
    b. HIV testing and treatment can be administered to a child of any age upon their request and consent (ORS 433.045).
    c. Emergency medical treatment can be given to a child of any age when consent is impossible or impractical to obtain (ORS 418.307).
5. A minor of ANY age can give consent to the furnishing of hospital, medical or surgical care relating to the diagnosis or treatment of venereal disease (ORS109.610).
6. A minor of ANY age can give consent for birth control information and services (ORS 109.640).

* ORS cited are from the 2003 version.

LIMITS TO CONFIDENTIALITY

Taking into consideration the potential for confusion regarding consent and exceptions to the need for parental consent, as well as pertinent HIPAA points, the medical evaluator may wish to simplify for the caretaker, the following details:

1. The information obtained during the evaluation may not be strictly confidential

Typically, doctor-patient communication is confidential. The parents may assume that the results of the child's sexual abuse evaluation will be confidential, as well, particularly if the primary care provider is conducting the examination. It is helpful to let the caretaker know, in advance, that, because of laws governing child abuse investigations, conversations with the parent and the child and the results of the child's physical examination may need to be shared with law enforcement or child protection workers.

2. Others have legal access to the results of the evaluation

It is helpful to tell the parent that, if a child abuse investigation is already in progress or if one begins as a result of the evaluation, police officers, child protection workers and attorneys may have legal access to the information obtained. Additionally, the information might need to be disclosed to insurance companies and/or in court, should legal proceedings occur.

ROLE EXPECTATIONS FOR THE CARETAKER

1. It is optimal to evaluate the verbal child without the caretaker present

It is important to try to question the child without the caretaker present. Children can be very sensitive to their parents' agendas and emotions and may modify their statements based upon their parents' reactions. Some adults have a vested interest in their child's statements and may have even coached the child about what to say. Other parents have difficulty controlling emotional reactions, particularly if they are subjected to hearing the details of the abuse.

Most caretakers cooperate with this restriction, once it is explained that the evaluation is considered more neutral and that their child's statements are considered more valid in court if the caretaker is not present during questioning. The examiner may want to explain that if the parent is not present, she is less likely to be accused of trying to control the evaluation process or to influence what the child says during the evaluation. Parents may also agree to having the child interviewed privately when it is explained to them that children may disclose more information when they are not worried about the effect it will have on the parent hearing it.

The caretaker can be reassured that she will be given a summary of the examination findings and statements at the end of the evaluation. It also helps to let the parent know that if the child becomes uncomfortable and needs his/her parent, the evaluator will request that the parent join the child.

2. When a caretaker is present, he/she needs to let the child answer the questions

It is not advisable for the parent to be present during the child's primary interview, nor during the portion of the child sexual abuse medical evaluation when questioning about the suspected abuse occurs. However, when either a parent or a child is unable to separate or if a child really needs support, the parent may be present for the physical examination. Should this occur, some instructions to the caretaker beforehand are in order.

The parent should be informed that the examiner needs to converse directly with the child and that the parent should not answer questions for the child. This is especially important to cover with parents of young children, who are used to answering for the child. The caretaker may also be instructed to be seated in the room in a position that supports the child but is out of the line of eye contact between examiner and child, so as not to distract from their communication. After the exam is completed, if the child is feeling more comfortable and is willing to meet alone with the medical evaluator, the caretaker may be invited to wait for the child in another area. The clinician can then focus questions on the concern of abuse.

3. If a child is unable to separate, abuse questions can occur with the parent present

If a child is unable to separate, even with encouragement from the examiner and parent, abuse questioning can occur with the parent present. The medical provider and the parent should be aware that the child's statements might be challenged in court on this basis. If a parent is present, it is recommended, as above, that he sit out of the child's view and not answer questions for the child. Any

attempts by the caretaker to verbally or non-verbally influence the child should be noted. The healthcare practitioner's report should clearly state that the parent was present and should describe any interaction that occurred between parent and child during the medical interview.

4. A form outlining these issues can expedite communication

Medical professionals who evaluate children and adolescents for sexual abuse may wish to provide for caretakers a form that includes information about what to expect during the examination, limits to confidentiality, and a description of who may have access to results of the evaluation. The form may review the intention to document the child's interview on videotape and to photograph physical examination findings. When the medical provider meets with the parents, any questions they have regarding the matters presented on the form can be discussed.

HISTORY GATHERED FROM CARETAKERS OF THE CHILD OR ADOLESCENT

GUIDELINE

Gathering history and doing a thorough review of systems are key components of all medical evaluations. In a child abuse evaluation, the extent of history gathered may be dictated by whether the exam is acute or routine or may depend upon the physical setting in which the child is evaluated.

TIPS FOR GATHERING HISTORY

Use of a written history form

A written history form, completed by the child's caretaker before the clinician begins the child's evaluation, can be used to gather much of the needed information. (See sample forms included at the end of this chapter.) Additional information is best obtained directly from the caregivers, whenever possible, in order to clarify or expound on answers provided on the form or to broach topics not covered in writing. In some settings, an assistant or another professional participating in the evaluation gathers additional historical information from parents and guardians. When the healthcare practitioner is conducting the evaluation alone, she gathers all of the relevant history. Portions of this information may not be accessible to the medical provider in some situations because the person providing history may not be the child's primary caretaker, such as when the child presents with a foster care provider, or when the examination is conducted in an emergency department or at the coroner's office.

IMPORTANT: Verbal questioning should occur without the child present.

Ideally, all history-taking from the parent or caregiver should occur without the child present. Even very young children are likely to pick up on their parents' emotions and concerns; furthermore, there is a risk that they may confuse or blend what they have personally experienced with what they hear their caregivers discuss. It is beneficial to have the family bring an adult helper or to have an adult at the evaluation facility be available to tend to the child, so that the caregiver and evaluators can discuss the history without regard to influencing the child. If there are separation problems for child or parent, at least the history of the chief complaint and information regarding prior abuse history should be gathered outside the child's hearing. Should it not be possible for the parent and child to separate at all during the evaluation, pertinent history can be gathered via telephone, a written questionnaire or at a separate appointment with the parent.

BASIC INFORMATION TO BE OBTAINED ON ALL CHILD SEXUAL ABUSE EVALUATIONS

1) History pertinent to the chief complaint
2) Prior concerns of abuse
3) History of problems in the anogenital region
4) Current health status, medication list and brief major medical history
5) Names of the child's primary caretakers and contacts
6) Permission to contact the primary healthcare provider

1. History pertinent to the chief complaint

It is important to interview the child's caretaker about how the concern of abuse first arose. A description of the circumstances of the disclosure or concern (e.g., whether it was spontaneous or in response to questioning) and a sense of questions asked and the child's responses are useful to obtain from the parent. When the concern of abuse is based upon behavioral indicators, the examiner should ask what behaviors were observed and when any change was first noticed. The caretaker's presentation of this information may give the medical provider insight into other factors impacting the abuse concerns, such as custody arrangements, unresolved abuse issues in the parent, parental coaching of the child, coincidental medical conditions. The caretaker's observation of any physical symptoms or signs that the child has displayed may cue the examiner regarding whether physical findings are likely and whether cultures may be necessary.

The medical evaluator should establish whether the caretaker actually observed the child's behaviors and/or discussed the matter with the child. If the parent is relating second-hand information, clinicians should also document the primary source from whom the caretaker learned the history and that individual's relationship to the child.

It is valuable to learn from the caretaker significant timeframes and patterns, such as when the child had been in contact with individuals who may have been involved with the abuse or frequency of visits with a potential offender. It is important to establish the last time the child may have had contact with a suspected abuser in order to correlate physical findings with the history.

2. Prior concerns of physical or sexual abuse and neglect

Although brief initial questions on a history form may address past abuse, follow-up verbal questions are frequently necessary. Information about past abuse concerns may reveal whether the child resides in a high-risk environment and can often be a clue to family dysfunction (e.g.,

neglect, poor supervision, poor parental judgment). Prior abuse may be a source of sexual knowledge for the child. The child's ability to discriminate between current and previous incidents of abuse will be important to ascertain. Prior abuse also may explain current exam findings. If the child was medically evaluated regarding prior sexual abuse allegations, it is helpful to consult with the previous examiner or to access documentation regarding past anogenital exams to compare with current observations.

In addition to history of prior abuse to the child, it is valuable to ask about abuse to other children present in the same environment or family in which the current report of abuse took place. Inquiring about abuse in the history of caretakers may also be contributory for several reasons. Knowing that the child is exposed to individuals who have abused in the past would figure in to the clinician's recommendations regarding the child's safety. Also, awareness that others in the family have been abuse victims might shed light on the perspective of those relating the history and would be useful in determining the need to recommend intervention/counseling for various family members.

3. History related to problems in the anogenital areas

The medical evaluator should inquire about urinary tract infections, accidental injuries, bleeding, bruising, discharge, sores, pain, and itching in the anogenital areas. If any of those have occurred in the patient, follow-up questions should be asked about symptom onset, duration, frequency and resolution, appearance and healing of injuries and sores and appearance/odor of any discharge noted. These questions are critical to differential diagnosis and to decision-making regarding the need for cultures and additional testing. The examiner should obtain history regarding enuresis or encopresis because these may be symptoms of possible abuse or of other medical conditions in need of attention. The history should include approximate times of onset, duration, frequency, and resolution of these difficulties.

As mentioned earlier, the medical provider will want to know about any prior anogenital examinations of the child in order to compare findings. It will be important to find out who did the evaluation and why the child was examined. The examiner should get the caretaker's permission to consult with the previous evaluator.

If the child is a post-pubescent girl, a brief menstrual history is needed to screen for medical concerns. Also, knowing the age at menarche, the date of the last menstrual period, any missed periods and regularity of the cycle assists in the diagnosis of pregnancy and may direct needed follow-up.

Excessive masturbation and sexualized behavior with other children may be indicators of sexual abuse. Therefore, it is recommended that the examiner ask questions about whether the child touches his/her own or other people's "private parts." Specific questions regarding frequency of masturbation and whether the child inserts objects into the vagina or anus can help differentiate normal from concerning masturbation practices.

Particularly with young children, it may be beneficial for the medical practitioner to ask the caretaker what names the child uses for private body parts. Many children and families use non-anatomic and frequently very idiosyncratic terms for penis, breasts and vulva or vagina. Learning the particular child's common name for body parts can reduce confusion and greatly facilitate communication during the medical evaluation. It should be noted, however, that the words the parents report that the child uses and what the child actually calls those body parts during the evaluation may not correspond.

For quick reference, history taking related to problems in the anogenital areas may be outlined as follows:

The clinician should question child and/or caregiver regarding patient history of:

- urinary tract infections
- accidental anogenital injury or surgery
- presence of any of the following in the anogenital areas
    - bleeding
    - bruising
    - discharge
    - sores, lesions
    - pain
    - itching
        - if any of those symptoms have occurred, follow-up questions should be asked:
            - onset
            - duration
            - frequency
            - resolution
            - appearance and healing of injuries and sores
            - appearance/odor of any discharge noted
- enuresis or encopresis
    - onset
    - duration
    - frequency
    - resolution
- previously diagnosed anogenital abnormalities in patient or family members
- any prior anogenital examinations of the child
- menstrual history
- masturbation frequency and extent
- child's names for private body parts

4. Current health status, medication list and brief major medical history

The medical provider will need to know about chronic health problems, ongoing medications, medication allergies, immunization status, major illnesses, injuries, accidents, or surgeries and whether the child is currently displaying signs of illness. These questions can help focus the evaluation, provide explanations for marks and scars, index risk status (as with multiple injuries, especially those that are unexplained) and permit appropriate follow-up recommendations. The examiner also can use this information to begin developing a differential diagnosis.

5. Names of child's primary caretakers and contacts

In acute evaluations, the names of the biological parents and disclosure of where and with whom the child resides should suffice. In screening and assessment center evaluations, it is helpful to obtain a list of parents, stepparents, mother's and father's partners, siblings, regular baby sitters and others with whom the child spends significant time. This information provides for a comprehensive, neutral evaluation by broadening the focus from the acts of a single alleged perpetrator to consideration of the child's whole range of contacts. Knowing the names/nicknames of significant people in the child's life can help evaluators to understand a child's statements. This is particularly contributory with young children who may use first names but may not be able to articulate the person's role in their life. Gathering this data also frequently provides an opportunity for the caretakers to reveal family problems, such as drug and alcohol abuse or custody disputes, which may impact the evaluation.

6. Permission to contact the primary medical provider

It is helpful to get the caretaker's verbal and written permission to contact the primary medical provider for consultation. The primary healthcare provider may contribute aspects of the medical and social history not reported by the child's caretakers. Moreover, because this individual may be responsible for medical follow-up with the child, it is recommended that he/she be informed about the results of the evaluation.

INFORMATION USEFUL TO OBTAIN DURING EXTENDED EVALUATIONS

- Medical
  1) Prenatal History
  2) Birth History
  3) More comprehensive past medical history

- Social
  1) Child behavior problems
  2) Discipline and caretaking
  3) Sources of sexual knowledge
  4) Family risk factors

Medical History Useful For Extended Evaluations

1. Prenatal history

A history of the pregnancy is most relevant with young children and special needs children or when there is concern regarding transmission of a sexually transmitted disease. Some medical practitioners obtain a prenatal history on all children, while others gather the information only when it appears pertinent. Standard questions regarding the history of the pregnancy include prenatal care, complications, infections and sexually transmitted diseases, abnormal pap smears, use of prescription and non-prescription medications, and substance abuse. Questions regarding prenatal care, pregnancy complications and drug use are helpful in determining risk status and may explain ongoing developmental difficulties, such as learning disabilities, cognitive impairments and hyperactivity. With many sexually transmitted diseases, such as anogenital warts or chlamydia, perinatal transmission is a possibility. The examiner will need to know about possible prenatal or perinatal transmission in determining possible sources for a current infection.

2. Birth history

The birth history is another important source of information regarding risk status and sources of developmental difficulty. Like the pregnancy history, it is most relevant with young children, special needs children and in children presenting with a sexually transmitted disease. It is helpful to find out where the child was born, in case it will be necessary to request medical records, and because the current evaluator's records may be the most complete medical history recorded for this child. It is very important to learn if the child was born pre-term, at term or late, if the delivery was complicated and whether it was vaginal or Caesarean. The child's birth weight and history of any post-natal complications may also be contributory.

3. More comprehensive past medical history

Some child sexual abuse medical evaluators find it helpful to develop a checklist to inquire about the patient's past medical history. The clinician may wish to become aware of any developmental difficulties (e.g., motor or cognitive delays or disorders; vision, speech, hearing deficits), chronic illnesses (e.g., asthma, diabetes, allergies, seizures, heart problems), serious medical events (e.g., loss of consciousness, anaphylaxis, major accidents or injuries), mental health diagnoses, learning disorders or ADHD, and common medical problems (e.g., ear infections, childhood illnesses, broken bones or stitches, skin problems) that the child has experienced. It is also routine to take history regarding emergency department visits, hospitalizations and surgeries. This information may be helpful in predicting the child's response to the examination and in providing explanations for physical findings (e.g., scars, marks).

If the patient has developmental limitations, the examiner may need to make adaptations in terms of language and physical accommodations. In children with a history of having undergone

painful medical procedures, it may be most reassuring for the examiner to tell the child repeatedly and clearly that this evaluation will not involve such procedures.

Social History Useful For Extended Evaluations

Extended evaluations for sexual abuse in children and teens are commonly conducted by a team consisting of the medical provider and a mental health professional such as a social worker or other child interview specialist. The child interviewer/mental health professional typically takes a comprehensive social history from the parents. Healthcare professionals conducting extended evaluations alone may also gather a thorough social history.

1. Child behavior problems

Identifying a history of child behavior problems can provide clues to the onset of abuse and may help the clinician to determine the need for mental health follow-up for the child and family. A description of problem onset, frequency, effect on the family and child, and how/whether it has been resolved may be useful in exploring possible associations with abuse. Use of a checklist format can be most effective in screening for behavioral concerns. The medical evaluator can create his/her own simple checklist to identify and document problem behaviors or may utilize a standardized checklist. Many behavioral questionnaires and checklists have been developed, usually intended originally for other purposes, but which may be applied to the extensive child sexual abuse evaluation setting. (Examples include Friedrich's Child Sexual Behavior Inventory, the Achenbach Child Behavior Check List and several others.) Medical evaluators are reminded that such instruments may require specific training in interpretation of responses. Mental health professionals may provide useful consultation regarding the application of behavior checklists.

2. Discipline and care-taking in the home

A discussion about who bathes the child, who assists him with toileting, who puts the child to bed, with whom she sleeps, who disciplines and how the child is disciplined may be valuable in determining opportunities and risk for abuse. This information may establish perpetrator access and may provide important insights into how well the child is nurtured in the home. Particularly for young children and developmentally disabled children, the clinician can use this knowledge as a frame of reference for interpretation of statements the child might make.

3. Sources of sexual knowledge

Understanding the exposures that the child has had to sexual materials and matters can provide a foundation for considering various possible explanations for what the child has reported or for sexualized behaviors the child has displayed. The evaluator should ask about the child's exposure to nudity in the home or other living environments, screen nudity (e.g., on television,

movies and computer screens to which the child has access), and pornographic materials. Most skilled clinicians ask the caretakers if the child has ever witnessed sexual activity (e.g., by observing or walking in on adults engaged in sexual activity). This information can assist the medical provider in considering the basis for the child's statements or behaviors, other than or in addition to, the current abuse allegation.

4. Family risk factors

The medical evaluator should inquire about the child's experiences with caretaker's separation and divorce and any exposure to domestic violence, drug and alcohol abuse and criminal activity. Information about the parents' mental health history and any prior involvement of the family or child with child protective agencies is important to consider. Contributory insights may also be gained from questioning the caretakers about major stressors in the family, health challenges, deaths or absences of significant figures, changes in residence or other life events impacting the child and family.

SPECIAL CONSIDERATION FOR OLDER CHILDREN AND ADOLESCENTS

Although it is advisable to obtain medical and social history from the caretakers of children of all ages, including adolescents, the healthcare professional should consider also taking medical and social history directly from the patient. It is not uncommon for there to be differences in information offered by parent and adolescent. The history obtained from an older child or teen may alter the clinician's approach to the patient and may prompt the provider to modify components of the physical examination and laboratory studies to suit the individual patient's needs. Furthermore, social and medical information learned from the child may impact diagnosis, as well as debriefing with the family.

In addition to improving the evaluation by acting upon the pertinent information that the older child or adolescent may reveal, taking history directly from the patient honors her contribution to the evaluation and may significantly enhance the building of rapport. Demonstrating to the patient that his input is desired and respected by the medical evaluator may foster cooperation and may increase patient comfort.

Jackson County Children's Advocacy Center
Medical History Questionnaire

Patient Name _____Date of Birth _____ Age _____

Male _____ Female _____ Allergies _____

Your Name and Relationship to Child _____

Primary Care Physician _____Phone # _____

Dentist _____Phone # _____

Medications/ Dosage _____

_____

Are immunizations current? Yes _____ No _____

Does the Child have any ongoing/ chronic health problems? _____

_____

Is the child sick today or been sick recently? If so explain _____

_____

Has the child had any serious illnesses, injuries or hospitalizations? Yes _____ No _____

Explain: _____

Are there any illnesses or diseases that run in the family? _____

Has the child had any of the following? If so please circle and explain:

1. Problems with vision, speech, hearing _____
2. Problems with movement or walking _____
3. Asthma/ breathing_____
4. Frequent ear infections _____
5. Seizures/ convulsions _____
6. Passing out/ losing consciousness _____
7. Skin problems (warts, eczema, sores, other) _____
8. Accidental poisoning _____
9. Broken bones _____
10. Stitches _____
11. Burns, operations/ surgeries (date and reason) _____

_____

Has your child had any of the following problems with private parts? (vagina, penis, anus, buttocks) If so please circle and explain:

1. Bedwetting or wetting pants_____
2. Soiling or "pooping" in pants, constipation or frequent diarrhea _____
3. Bladder or urinary tract infections _____
4. Accidental injury to front private parts_____
5. Accidental injury to back private parts _____
6. Bleeding from front or back private parts _____
7. Sores, bruises or discharge on the back or front private parts _____
8. Pain or itching of back or front private parts _____
9. Has the child had an examination of their private parts? Yes_____ No _____

<u>Menstrual History (if applicable)</u>

When was the first menstrual period? _____

Date of the last menstrual period? _____

Has she ever missed a period? Yes _____ No _____

Are her periods regular? Yes _____ No _____

Has child been exposed to any of the following? If yes, please explain:

Domestic violence: Yes _____ No _____ (please explain) _____

Drug/alcohol use: Yes _____ No _____ (please explain) _____

Any problems at school? Yes _____ No _____ (please explain) _____

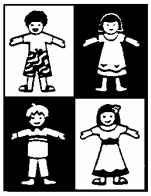
Is your child? Doing well _____ average _____ poorly _____ in school.

Any learning problems? Yes _____ No _____ (please explain) _____

Signature of person providing medical history _____

Relationship to Child _____Date _____

THIS FORM IS SENT BY MAIL OR FAX TO THE GUARDIAN TO FILL OUT PRIOR TO THE EVALUATION



CARES NORTHWEST

Kaiser Permanente
Legacy Emanuel Children's Hospital
OHSU – Doernbecher Children's Hospital

CHILD HISTORY FORM

Medical History

Background information

Child's name _____ Nickname (*if preferred)*_____

Birth date _____ Ethnicity (*optional*)_____

Your name _____ Relationship to child_____

Pregnancy history

Where was the child born? (*hospital, city, state)*_____

When was the child born? ☐ On time ☐ Early ☐ Late

How was the child born? ☐ Vaginal delivery ☐ Caesarean section

How much did the child weigh? _____

Were there any problems with the pregnancy or delivery? ☐ No ☐ Yes

*(explain)*_____

Did the mother have regular prenatal care? ☐ No ☐ Yes

Were any substances used during pregnancy?

☐ Alcohol ☐ Prescription drugs ☐ Street drugs ☐ Cigarettes ☐ Unknown

Medical/dental care

Child's regular doctor_____ Phone_____

When did doctor last see the child? _____

Why was the child seen? _____

Child's dentist _

When did dentist last see the child? _____

Are there any dental problems? _____

Allergies

☐ Unknown ☐ No ☐ Yes To what?_____

Does child take any medicines (including fluoride) daily? ☐ No ☐ Yes

Please list medications:

_____

_____

_____

Are immunizations up-to-date? ☐ No ☐ Yes ☐ Unknown

If not, do you have an immunization record or know what the child needs? _____

Has this child ever had *(please check and explain)*

☐ Emergency room visits/hospitalizations
☐ Surgeries
☐ Major injuries/accidents
☐ Stitches/broken bones
☐ Burns/accidental poisonings
☐ Seizures/passing out
☐ Speech, vision or hearing problems/concerns
☐ Developmental concerns or evaluations
☐ Other medical problems/concerns *(explain)* _____

For younger children

Has the child met all developmental milestones on time? ☐ No ☐ Yes Age toilet trained _____

For older girls

Date of first menstrual period _____ Date of last menstrual period _____

Does she use: ☐ Pads ☐ Tampons ☐ Both Has she ever missed a period? ☐ No ☐ Yes

Are there problems with *(please check and explain)*

☐ Daytime wetting or nighttime wetting
☐ Pooping or soiling accidents
☐ Rashes or sores of front or back private areas
☐ Bleeding or discharge from front or back private areas
☐ Pain or itching of the front or back private areas
☐ Bladder/kidney/urinary tract infections
☐ Past injury to private areas
☐ Toilet training

Family history

Has anyone in the child's father's or mother's family had any medical problems, such as genetic or inherited childhood diseases or conditions, substance abuse, mental illness, or learning problems?

☐ No ☐ Yes *(explain)* _____

What words does child use for private areas?

Male front private area _____ Bottom/buttocks _____
Female front private area _____ Chest/breasts _____

Is the child well today? ☐ Yes ☐ No *(explain)* _____

Social History

Family

Biological father _____ Birth date _____
Biological mother _____ Birth date _____
Brothers/sisters _____ Birth date _____
_____ Birth date _____
_____ Birth date _____
_____ Birth date _____
Stepfather _____ Birth date _____
Stepmother _____ Birth date _____
Stepbrothers/sisters _____ Birth date _____
_____ Birth date _____
_____ Birth date _____
Mother's current partner/husband _____ Birth date _____
Mother's past partner/husband _____ Birth date _____
_____ Birth date _____
Father's current partner/wife _____ Birth date _____
Father's past partner/wife _____ Birth date _____
_____ Birth date _____

Residences of child

Address	Who lived here?	Dates

Has child ever been in foster care? ☐ No ☐ Yes Dates: From _____ to _____
From _____ to _____

Caretakers

Please list others who have cared for child (such as babysitters, daycare, relatives).

Name	Relation	Dates

Parents' employment

Does child's mother work outside the home? ☐ No ☐ Yes Hours/days _____

Does child's father work outside the home? ☐ No ☐ Yes Hours/days _____

Prior concerns of abuse

Have there been prior concerns of physical or sexual abuse to this child or siblings? ☐No ☐Yes
*(explain)*_____

_____

Has DHS (child protective services) been involved with the family? ☐No ☐Yes
*(explain)*_____

Exposure to fighting

ADDITIONAL SCREENING REQUIRED; SEE (1) IN BOX AT THE END OF FORM

Has this child seen adults hit one another? ☐No ☐Yes *(explain)*_____

_____

Exposure to sexual material or nudity

ADDITIONAL SCREENING REQUIRED; SEE (2) IN BOX AT THE END OF FORM

Has this child seen nudity or sexual activity on TV, videotapes, computers, or magazines? ☐No ☐Yes

*(explain)*_____

Is there pornography in the child's home? ☐No ☐Yes

Is there pornography in homes the child visits? ☐No ☐Yes

Has this child ever walked in while adults were having sex? ☐ No ☐Yes

Has this child seen adults nude in other circumstances? ☐No ☐ Yes

Education

Child's school_____Grade_____Teacher_____

How is child doing in school? ☐ Good ☐ Average ☐ Below average

Any learning problems? ☐No ☐Yes *(explain)*_____

Special education placement? ☐No ☐Yes

Does child have difficulties getting along with teachers or adults? ☐ No ☐ Yes

(explain) _____

Does child have difficulties getting along with other children? ☐ No ☐ Yes *(explain):* _____

_____

Counseling history

Has child ever been in counseling? ☐ No ☐ Yes (*explain*)_____

_____

Therapist_____ Agency/Phone_____ Dates_____

Have any other family members been in counseling? ☐ No ☐Yes *(explain)*_____

_____

Concerning behaviors
Have any of these behaviors in the child been a concern?

☐ No ☐ Yes Sleep problems
☐ No ☐ Yes Nightmares
☐ No ☐ Yes Fear of people, places, situations
☐ No ☐ Yes Aggressiveness, hitting others
☐ No ☐ Yes Sexualized behavior or play
☐ No ☐ Yes Withdrawal
☐ No ☐ Yes Anger (tantrums, foul language)
☐ No ☐ Yes Sadness (lasting more than a few hours)
☐ No ☐ Yes Nervous habits (nail biting, picking at skin)
☐ No ☐ Yes Problem eating
☐ No ☐ Yes Changes in mood or routine
☐ No ☐ Yes Cruelty to animals
☐ No ☐ Yes Match or fire play
☐ No ☐ Yes Hyperactivity/difficulty concentrating
☐ No ☐ Yes Injuries to self

Other concerns_____
_____

Methods of discipline
What discipline is used at home?

☐ No ☐ Yes Spanking
☐ No ☐ Yes Time-out
☐ No ☐ Yes Privilege removal
☐ No ☐ Yes Other_____

Daily care
Who bathes child?_____
Who helps toilet child?_____
Who puts child to bed?_____
Where and with whom does child sleep?_____

Family stressors
Have there been any significant stressors affecting the child or family (such as deaths, illnesses, conflict between family members, divorce, job loss, moves) over the past year?
*(explain)*_____

ADDITIONAL SCREENING QUESTIONS (asked in person, not answered in writing on form)

1. Domestic violence—screen for history of pushing, shoving, verbal abuse, controlling behavior, etc., between partners
2. Exposure to sexual material/nudity—if "Yes" obtain additional details
3. Previous DHS history for children in family
4. Parental/guardian history of child physical and/or sexual abuse (or foster care placement)
5. Parental/guardian criminal history

KIDS Center
1375 NW Kingston Ave.
Bend, Oregon 97701 (541) 383-5958

CLIENT INFORMATION

Date:_____/_____/_____

Name of person filling out form:_____
Relationship to child:_____

CHILD INFORMATION

Last Name_____ First Name_____Middle_____

Race: ❑African American ❑Asian ❑Caucasian ❑Hispanic ❑Native American ❑Other

Date of Birth____/____/____ Age_____ ❑ Male ❑ Female Social Security_____/_____/_____

Address:_____ City_____ State_____ Zip_____

Home Phone:(_____)_____-_____

Who to contact in case of emergency:_____
Relationship_____ Phone(____)_____-_____

Child's Primary Medical Provider_____
Child's School_____ Grade_____ Teacher_____

Does child have any disabilities? ❑ Yes ❑ No if yes, type of disability_____

_____

PARENT INFORMATION

BIOLOGICAL MOTHER:_____ Other Names Used:_____

Street Address:_____ City_____ State_____ Zip_____
(if different from child)
Mailing Address (if different):_____ Home Phone:(____)_____-_____

Birth date:____/____/_____ Social Security Number:_____/____/_____

Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Separated ❑ Widowed

Has child's mother been married before? ❑ Yes ❑ No

To Whom:_____When:_____To Whom:_____When:_____

Mother's Employer_____ Work Phone:(____)____-_____

Mother's Education (highest grade completed)_____

BIOLOGICAL FATHER:_____ Other Names Used:_____

Street Address:_____ City_____ State_____ Zip_____
(if different from child)
Mailing Address (if different):_____ Home Phone:(____)_____-_____

Birth date:____/____/_____ Social Security Number:_____/____/_____

Marital Status: ❑ Divorced ❑ Married ❑ Single ❑ Separated ❑ Widowed

Has child's father been married before? ❑ Yes ❑ No

To Whom:_____When:_____To Whom:_____When:_____

Father's Employer_____ Work Phone:(____)____-_____

Father's Education (highest grade completed)_____

Name of Brothers/Sisters	Social Security	Date of Birth	Age
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____

Name of Step-Father

_____	_____/_____/_____	____/____/____	_____

Name of Step-Mother

_____	_____/_____/_____	____/____/____	_____

Name of Step-Brothers/Sisters

_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____
_____	_____/_____/_____	____/____/____	_____

If parents are not living together, who has custody of child?_____
What is visitation schedule?_____
_____

Please list all households in which your child has lived, starting with the **present.**

PLACE (City, State)	**WHO ELSE LIVED THERE**	**APPROX. AGE of CHILD AT THE TIME**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been in foster care? ❑ Yes ❑ No When_____

Please list other people who have taken care of your child (babysitters, relatives, daycare providers, etc.)

NAME	**RELATIONSHIP**	**AGE OF CHILD**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any worries that someone who has taken care of your child has abused him/her?
_____
_____
_____
_____

MEDICAL INFORMATION

Pregnancy History
Was the child born: ❑ On Time ❑ Early ❑ Late
How was the child born: ❑ Vaginal ❑ Caesarean section
Were there any problems with the pregnancy or delivery? ❑ Yes ❑ No *(explain)*_____
_____

Did child go home from hospital with mother? ❑ Yes ❑ No
_____

Were there any substances used during pregnancy? ❑ Alcohol ❑ Prescription drugs ❑ Street drugs ❑ Cigarettes ❑ None
Has this child ever had any of the following: *(if so, please describe and indicate age of child when it occurred)*

			Age of Child
❑ Yes	❑ No	Overnight hospitalization	_____
❑ Yes	❑ No	Surgery *(ear tubes, hernia, tonsils, etc.)*	_____
❑ Yes	❑ No	Major injury/accident	_____
❑ Yes	❑ No	Serious head injury	_____
❑ Yes	❑ No	Stitches/broken bones	_____
❑ Yes	❑ No	Burns/accidental poisonings/overdose	_____
❑ Yes	❑ No	Speech or hearing problems/concerns	_____
❑ Yes	❑ No	Developmental concerns or evaluations	_____
❑ Yes	❑ No	Are there firearms or weapons in your home	

List other medical problems/concerns *(chronic illness, asthma, seizures/heart problems, ADHD, etc.)*
_____
_____

Has the child had the following problems?
❑ Yes ❑ No Nausea/vomiting
❑ Yes ❑ No Constipation/diarrhea
❑ Yes ❑ No Burning or pain with peeing
❑ Yes ❑ No Daytime wetting
❑ Yes ❑ No Nighttime wetting
❑ Yes ❑ No Pooping or soiling accidents
❑ Yes ❑ No Bladder/kidney/urinary tract infections
❑ Yes ❑ No Redness/rashes or sores on genitals, buttocks or anus (front or back private areas)
❑ Yes ❑ No Pain or itching of the genitals, buttocks, or anus (front or back private areas)
❑ Yes ❑ No Discharge or bleedings from genitals or anus (front and back private areas)
❑ Yes ❑ No Any injuries to genitals, buttocks or anus

What words does child use for private areas?

Penis_____ Vagina/female genitals(front private part)_____ Buttocks/anus_____ Breasts_____

Menstrual history *(if applicable)*
Date of first period_____ Date of last period_____
Does she use: ❑ Pads ❑ Tampons ❑ Both
Has she ever missed a period? ❑ Yes ❑ No ❑ Unknown

To assist us in knowing what labs *if any* may be needed, please answer the following:
Does the child's caregiver(s) have/had any sexually transmitted diseases? ❑ Yes ❑ No ❑ Unknown
Does the alleged perpetrator(s) have/had any sexually transmitted diseases? ❑ Yes ❑ No ❑ Unknown

Allergies to any medications ❑ Yes ❑ No ❑ Unknown
If yes, please explain_____
_____

Does the child take any **medicines** daily? ❑ Yes ❑ No ❑ Unknown *(please list)*
_____
_____

Are immunizations up-to-date? ❑ Yes ❑ No ❑ Unknown

BEHAVIORAL/SOCIAL INFORMATION

If in school, how is child doing?
Academically_____
Socially_____
Any learning problems? ❑ Yes ❑ No ❑ Unknown Special Ed Placement? ❑ Yes ❑ No ❑ Unknown

Have any of these behaviors in your child been a **concern**?

❑ Yes ❑ No Sleep Problems
❑ Yes ❑ No Bedwetting
❑ Yes ❑ No Nightmares
❑ Yes ❑ No Fear of people, places, situations
❑ Yes ❑ No Aggressiveness, hitting others
❑ Yes ❑ No Sexualized behavior or play
❑ Yes ❑ No Withdrawal
❑ Yes ❑ No Lying
❑ Yes ❑ No Stealing
❑ Yes ❑ No Anger
❑ Yes ❑ No Sadness
❑ Yes ❑ No Nervous habits
❑ Yes ❑ No Eating problems
❑ Yes ❑ No Changes in appetite
❑ Yes ❑ No Changes in mood or routines
❑ Yes ❑ No Cruelty to animals
❑ Yes ❑ No Match or fire play, burned anything (toys, papers, grass, household items), left burn marks on anything
❑ Yes ❑ No Hyperactivity or difficulty concentrating

Other behavior concerns_____
_____

Who bathes your child?_____
Who helps toilet your child?_____
Which household members has child seen nude?_____
Who puts your child to bed?_____
With whom does your child sleep?_____

What discipline is used for your child?

Time out ❑ Yes ❑ No
Taking away privileges ❑ Yes ❑ No
Spanking ❑ Yes ❑ No
Other (please list) ❑ Yes ❑ No
_____
_____
_____

Have there been any significant stresses in the child's family (such as a death, major illness, conflict between family members, job loss, move, etc.) in the last year? Please explain_____
_____
_____
_____
_____

Have there been any prior concerns of physical and/or sexual abuse to this child or siblings? ❑ Yes ❑ No ❑ Unknown
If so, please describe briefly_____
_____
_____

Have you, the other parent, or anyone else in the family experienced any type of abuse? ❑ Yes ❑ No ❑ Unknown
Please describe_____
_____
_____

Have the following ever occurred in the child's family?

Mental health concerns (depression, anxiety, flashbacks, anger, etc.)	❑ Yes ❑ No ❑ Unknown
Drug or alcohol use	❑ Yes ❑ No ❑ Unknown
Violence (hitting, pushing, shoving, slapping, etc.)	❑ Yes ❑ No ❑ Unknown
Child exposed to sexual activity or walked in on adults having sex	❑ Yes ❑ No ❑ Unknown
Child exposed to pornography on TV, in movies, videos, magazines, computers, internet	❑ Yes ❑ No ❑ Unknown
Previous child protective services involvement	❑ Yes ❑ No ❑ Unknown
Previous law enforcement involvement (anyone in trouble with the law)	❑ Yes ❑ No ❑ Unknown

Has your child been or is he/she currently in counseling? ❑ Yes ❑ No When:_____
Therapist_____
Address_____
Phone#_____

Have other family members been (or are currently) in counseling? ❑ Yes ❑ No ❑ Unknown

What questions/concerns do you have about today's evaluation?_____
_____
_____
_____

I certify that the above information is true and correct to the best of my knowledge. I will notify KIDS Center promptly of any change in the above information.

_____ _____
I hereby swear I am the legal Custodian of child Date

_____ _____
Foster Parent Signature Date

CONSENT FOR FOLLOW-UP CONTACT
I give my consent for follow-up contact through telephone calls or letters by the KIDS Center staff after I have completed services At the KIDS Center. I understand that I can cancel this consent at any time through a written request.

_____ _____
I hereby swear I am the legal Custodian of child Date

FEEDBACK PROCEDURE

KIDS Center wishes to provide high quality service, therefore, suggestions for improvement of, or complaints about services are welcomed. If you have a concern or suggestion regarding services you are encouraged to discuss this concern with the professional providing service, or the Center Coordinator. Positive feedback is also encouraged.

HISTORY FROM THE PATIENT: THE MEDICAL INTERVIEW IN CHILD SEXUAL ABUSE EVALUATIONS

GUIDELINE

Information gained during the medical interview is used by the healthcare provider to determine what happened to the patient, to identify potential sites of injury that may be noted during the physical examination, to assist development of clinical diagnoses and to consider necessary interventions. In cases of suspected child sexual abuse, medical professionals can apply basic, clinically endorsed techniques to conduct a diagnostically useful and forensically sound interview of the patient.

THE MEDICAL PROFESSIONAL'S ROLE IN QUESTIONING CHILDREN ABOUT ABUSE

The extent to which the medical provider conducting an evaluation for child sexual abuse will take a history from the child regarding the concern of abuse is dependent upon the resources available in the community and the agreed-upon multidisciplinary approach to evaluations in that location. When a formal videotaped interview is possible with child interview specialists at an accessible child abuse intervention center or through local agencies (e.g., law enforcement or child protective services), the healthcare practitioner can restrict questioning to those areas more specific to the medical aspects of the evaluation.

When such skilled interviewing is not available in a particular locale or not available in a sufficiently timely manner, more complete inquiry may fall to the medical evaluator. The comprehensiveness of the medical interview of the child may also vary on a case-by-case basis, as dictated by the acuity or severity of a child's physical findings or emotional state or by the potential danger to the child if returned to the environment in which the abuse may have occurred. The practitioner's comfort and skill level with interviewing children about abuse, as well as the individual child's degree of comfort in the medical evaluation setting, will also impact the determination as to how much questioning the examiner will do.

A healthcare provider should not go beyond his/her own limits of skill and comfort level when interviewing children about abuse. A poorly conducted interview may diminish the possibility of obtaining accurate, if any, statements from the child at the time of that medical assessment or even in the future. However, equipped with very basic forensic interview techniques – most of which can be reviewed in this short chapter – conscientious healthcare professionals can appropriately interview a child in whom abuse is suspected.

When considering how extensively to question a patient, the medical professional should always take into account the number and nature of other interviews planned. If the child

or teen has already been interviewed, it is useful for the practitioner to be informed about what the child may have disclosed to other professionals. If the child is scheduled to have a formal interview in the near future, it is advisable for the medical evaluator to limit the questions asked so as to avoid the pitfalls of multiple or repeat interviews. In general, healthcare providers are discouraged from extensively questioning patients about matters that do not affect the formulation of the medical diagnosis. However, each clinician must gather from the patient and family enough information about the abuse to develop a differential diagnosis and medical opinion.

There are occasions, dictated by the patient, when the medical provider ends up taking a more extensive history than may have been planned. Even when it is the usual procedure in the community for interviews to be conducted by a designated specialist, it cannot be predicted when a child may feel ready to tell about what happened. The healthcare practitioner may be in the right place at the right time to receive that information. A child who is disclosing about abuse should not be put off. It cannot be known whether another opportunity for a professional to hear and clarify the child's statements will arise. The medical professional should avoid communicating to the patient any unwillingness or discomfort at receiving the child's disclosure.

If a formal interview is scheduled to be conducted in the immediate future, it is sometimes possible for the healthcare provider to smoothly transition the disclosing child to the interview setting, where the exchange may be better documented, e.g., on videotape. Otherwise, the clinician should not interrupt a child's disclosure, but should follow the child's statements with non-leading and clarifying questions. The medical practitioner should record, as accurately and thoroughly as possible, the information that is discussed.

In some cases, it is during the medical interview that a child reveals the most information about the abuse. The healthcare setting is unique among the situations in which a child may be interviewed. In general, the medical environment may be recognized by children as one where they have received care and in which they may inherently trust the participating adults. They are familiar with the process of discussing issues concerning their bodies with a healthcare professional. The focus on the child's body during the physical examination process sometimes contributes to the recall process or provides the child a concrete reference point for giving more or clearer details about what happened. Multidisciplinary team members serving abused children may utilize information obtained during the medical evaluation to help make safety and legal determinations.

INITIAL APPROACH TO INTERVIEWING CHILDREN IN SEXUAL ABUSE EVALUATIONS

The medical provider conducting the evaluation is urged to:

1. Question the child apart from the parent, in the presence of another staff member

It is optimal to obtain history from the child or adolescent separate from family and friends. The rationale for parental absence and suggestions for handling separation difficulties are explained in the chapter entitled, **"Preparing Caretakers for the Medical Evaluation of the Child or Adolescent"**. Medical providers are encouraged to have an "assistant" present during child sexual abuse evaluations. That individual (e.g., a nurse, medical assistant, mental health professional, or other appropriate staff member) can take notes during the patient encounter, freeing up the examiner to focus on the interaction with the child. The "assistant" may be called upon to offer verification regarding exam procedures and the questioning process. This can be a very important legal safeguard, particularly in volatile situations.

2. Introduce her/himself as a medical professional and describe her/his role

The healthcare practitioner conducting a sexual abuse evaluation should introduce her/himself to the patient, using her/his name and professional title. It is important to communicate to the child that he is undergoing a medical evaluation, in terms the child will understand. For example, many clinicians tell their patients that they will be asking a lot of questions and doing a "check up" on their bodies to help make sure that they are healthy and safe. In addition to beginning to build rapport with the patient, this process also may be later referred to in court as foundation for the medical hearsay exception. (See Chapter 18, **"The Healthcare Professional's Role in Legal Proceedings Related to Child Sexual Abuse Evaluations"**.)

3. Maintain a caring, though neutral, objective stance

The recommended stance for healthcare professionals assessing children and teens for sexual abuse is quite similar to that taken with other medical problems. Medical evaluators should convey interest in what the patient says and should encourage the patient to discuss her experiences by offering verbal and non-verbal attentive cues. Disclosure and non-disclosure should be handled in a similarly empathic, yet objective manner. It is important to resist the temptation to interpret the experience for the child. For example, the clinician should not assume that the child was hurt or upset by the experience, or that the child has a negative opinion of the person who abused him. Instead, asking the child how she feels about the experience or person demonstrates less bias and is less likely to influence the child's response.

4. Offer information and choices

The patient should be given as much control as possible over the evaluation process. The clinician should demonstrate the use of instruments, such as the colposcope, perhaps focusing the light on the child's hand or leg and offering to allow the child to look through it. The examiner should tell the child what will happen next during the exam. It will also increase the child's sense of control to be assured that the medical professional will stop and make changes at any point that the patient requests.

Some other choices that the child may be offered:

(a) To change into an examination gown or keep on his own clothes and remove one item at a time for the exam
(b) Having the examiner leave the room or turn away as the child is disrobing
(c) Alternative forms of describing the abuse (e.g., whispering, writing it down, drawing pictures, demonstrating on drawings)
(d) If the exam appears to be particularly trying for the child, it may be helpful to let the child get dressed and complete the interview in a different space.
(e) If unable to continue alone, the child's parent or another support person may be invited into the room during the physical examination portion of the evaluation. (Questioning would be conducted separate from the examination, with the child alone.)

5. Explain "ground rules" so that the child will know what to expect

The medical evaluator may prepare the patient by suggesting some or all of the following "ground rules":

- During our time together, we need to talk only about things that really happened.
  - Nothing made up.
  - No pretending.
  - No guessing.

- If you know the answers to my questions, please give them

- It's OK if you don't know an answer.
  - When you don't know, say "I don't know".
  - When you don't understand the question, tell me you don't understand.
  - If you don't remember, just tell me.
  - If, for some reason, you don't want to answer a question, tell me that.

- Tell what you saw, heard, felt, remember.

- If you don't know an answer from your own experience, but you heard about it from someone else, tell me what you were told or what you heard and who you heard it from.

- If it's hard to talk about something, you can tell me that.
  - If you prefer, you can whisper, write it down, draw it, or whatever makes it easier for you to let me know what happened.

- There is nothing that would not be OK for you to say during our time together.
  - It's OK to talk about secrets or private matters.
  - Kids don't get into trouble with me for anything they say.

- If there is something I don't ask that you would like to tell me or talk about, you can interrupt me at any time.

- If you have any questions, you may ask them at any time.

- Let me know if you need anything.

The healthcare provider may also inform the patient about what to expect from the provider:

- I'll tell you what I am going to do before I do it.

- I don't expect that anything I do during your examination will hurt.
  - No shots.
  - If anything does hurt or bother you, just tell me right away and I'll change what I am doing.

- I'll give you choices whenever possible.
  - Kids have lots of choices here.

- I will tell you what I learn from your check-up so that you know how your body is doing.

- As much as I am able, I will answer whatever questions you have.

- From what I learn from talking with you and checking your body, I will figure out:
  - if you need any special medicine and or if you need to come see me or another "doctor" (or other helping person) again.

  - I'll be talking with your parents (or other caretakers) about that and any other things that I think will help you.

In the past, it was recommended that the medical evaluator preliminarily ascertain that a child knew the difference between truth and lie. Arbitrary scenarios were created to test the child's ability to distinguish truth. However, despite good intentions, it was realized that those efforts did not achieve the desired end. Rather than asking the child to demonstrate their understanding of a misinterpretable and morally-charged concept, i.e., "truth", it is now advised that the professional simply state the expectation that what is discussed will be factual. Children may simply be told that, during the evaluation, they should only tell about things that have really happened. They should not make anything up nor share something that did not occur or isn't true. Having outlined these conditions, the medical evaluator may confirm with the child that she/he understands those expectations.

Children may also be advised that they can answer questions in a variety of ways. If they know the correct response, they are invited to offer it. They may ask for clarification if they do not understand the question. "I don't know" or "I don't remember" are acceptable responses, if either of those apply. When not presented with options, children may feel that they have to come up with an answer, even if they have to guess or make one up. It is anticipated that children who have been offered these choices may be more relaxed and less likely to provide inaccurate answers or guesses. For situations in which a child appears reluctant to continue or does not seem able to communicate verbally, the medical provider may offer the alternatives of writing answers or drawing pictures in response to the evaluator's questions.

INCORPORATING INTERVIEW TECHNIQUES INTO THE MEDICAL EVALUATION

Child abuse medical specialists have learned a great deal from collaborating with those who have special expertise in the interviewing of children. What follows are suggestions for consciously incorporating some very simple techniques of inquiry into medical history taking with children who may have experienced abuse. Although they are offered to enhance abuse evaluation, it is noted that these same skills can be applied to medical interviewing of all patients.

1. Building rapport and practicing communication

It is important for the healthcare practitioner to build rapport with the child, both to create comfort for the patient and to maximize the amount of information that the patient is willing to share. This ultimately yields more data for the practitioner to use to formulate diagnosis and treatment plans. While conveying friendliness and professionalism and seeing to basic needs of the patient, the clinician may also communicate what will occur during the evaluation and what is expected of the child. Admitting to the child that the patient knows more than anyone about his own body, the evaluator can state her preference to learn directly from the source. Informing the child that the medical

provider will be asking the child a lot of questions in order to decide how to best take care of her signals to the patient that her participation is instrumental to the process.

Healthcare providers are usually taught to begin to develop rapport with several focused, fact-finding questions, such as asking the child's age, grade at school, interests, or activities. It is common for the professional to use these ice-breakers to gauge the child's communication style and cognitive capabilities, but this direct question-and-answer format has many limitations. Generally, it communicates to the child that the adult will decide what information is important to discuss and that the adult is interested only in answers to the questions the adult poses. It has been identified that use of the **"free running narrative" approach** (Sternberg KJ et al, *Child Abuse Negl., 1997* and Orbach Y et al, *Child Abuse Negl.*, 2000) may produce more desirable results.

This common-sense method, supported by research, samples the child's ability to give unrestricted details about a situation the child has experienced. Rather than the more traditional method of asking the child a series of one-line questions about, for example, a routine or a recent event, (e.g., birthday party: "Where did you have your party?" "Who came to your party?" "Did you get any presents?"), the healthcare practitioner simply asks the child to "tell all about what happened at your birthday party" or "tell me all about what you did this morning before you came to see me." When the child pauses, the evaluator encourages more narrative: "And then what happened?" "What else can you tell me about that?" "Tell me more about that."

The free running narrative approach may be effective with any verbally communicative child. Younger children may give briefer responses and may require more encouragement to continue sharing, but can quickly grasp the concept of telling as much as they choose. Inviting narrative responses conveys to children that the clinician is interested in what the child thinks is important. Unlike more directed question and answer formats, the child is not expected to wait for the adult to ask the questions. Practicing free narration with the child during the opening stages of the patient encounter, by inquiring about routine or benign life experiences, the medical evaluator demonstrates that the child need not wait for a specific cue or question to elaborate. Establishing this freedom for the child can later be of great benefit when exploring abuse circumstances. Professionals cannot know which particular details of the concerning events are most important to elicit. Children who have been empowered to share what they feel is interesting or important are likely to give a more complete account of their experiences.

As children share information about various events and experiences, the medical practitioner may need clarification or may wish for the child to expound on particular aspects. Examiners can obtain more details by following up the child's responses with open-ended and clarifying inquiry just like that which is recommended to be used during conversation about abuse-related topics. (See discussion under **Types of Questions** below).

2. Keep it simple

Healthcare practitioners are cautioned to be very conscious of the complexity of language that they use when evaluating children. Technical jargon should be avoided, or, at least, restated in age-appropriate terms. It has been suggested that sentence length should be limited to one word for each year of the child's age. Concrete cues, such a pointing to body parts, can be especially important when communicating with preschool age children. In older children, despite their more advanced cognitive development, anxiety about the abuse, the evaluation or other situations may impair their comprehension. Thus, even older children and teens may also require simpler questions and more concrete references to understand what is being asked. Compound statements and questions hamper communication for all age groups; clinicians should include only one point in each question asked.

3. Establish a starting point

It can be surprising to realize the huge variability in the way that children who present for a sexual abuse evaluation have been prepared for the experience. Some families give the child very little information about where they are going that day. Some explain that the child is simply having a medical check up. Some patients are told that they are coming to talk about the abuse. At the far end of the spectrum, some children appear to be coached about what to say when questioned about the abuse concerns. It's a good idea for the healthcare provider to ask the caregiver how the child has been prepared and what the child is expecting will happen during the medical encounter. It is noted, however, that what the parent reports and what the child understands or tells the clinician may be very different.

Once the ground rules have been explained and as rapport is being established, many medical evaluators pose a question that gets at the patient's expectations about the evaluation. Invitations like, "Tell me about why you have come for a check up today" or, "What did you parents tell you about why you were coming here today?" may begin the process of getting onto the "same page" with the patient. The examiner may learn how the child has been prepared or influenced. He may gain a sense of how willing or comfortable the child feels to talk about the abuse concern. Occasionally, the child offers an immediate disclosure of abuse at this point. More commonly, the child reports a vague notion of the purpose of the visit. The astute evaluator tailors the next questions to the child's response and may affirm, in some version geared to the child's developmental level, that, during this evaluation, he intends to ask questions and check the child's body to ensure that the child is healthy and safe.

4. Head-to-toe approach

Many medical providers who evaluate children for sexual abuse employ a simple and time-conserving **head-to-toe examination and questioning approach**. Using this efficient method, the clinician asks the patient non-leading questions about each individual body part as it is examined. The child is asked if she has experienced any

problems with each individual body part or system, whether she has been hurt in that area of the body or if anyone has touched the child there or done something to that body part that made the child feel uncomfortable or that may have been "private" or secret. Any affirmative responses are followed with an invitation for narrative to expound (e.g., "Tell me all about that") and other clarifying questions, as appropriate.

This style of interviewing serves to normalize the questions asked. It is anticipated that when the same questions are posed with regard to the genital and anal areas as to body parts less commonly involved in abuse, the child will not presume an unusual focus on those areas. This may help the child to integrate the evaluation in a positive way, i.e., the healthcare provider is taking care of her whole body, rather than just checking to see what happened to their "privates". Also, using this process, the examiner may discover additional health issues or may identify previously unrevealed aspects of abuse that the child may have experienced.

5. Additional topics that may be raised during the head-to-toe evaluation

Additionally, when examining **various body orifices** (e.g., ears, nose, mouth, genitals, anus), the child may be asked **if anyone has ever inserted, or put anything into those places.** Examiners may offer a list of possible items that may have been inserted, such as various objects and body parts, including private parts, "or something else" (to offer an unspecified option) for the child to consider. Some evaluators inquire of patients whether anyone has put something into their mouth or other orifices that was "yucky" or that burned them. Another line of inquiry that gets at sexual abuse issues, without precise focus on the topic, offers a few questions about who kisses the patient and where on the body he is kissed. The clinician may also ask if someone has put his or her mouth on the child's body in a way he doesn't like or that seemed unusual to him.

Any affirmation that the patient has experienced injury to or inappropriate contact with a body part should prompt the medical professional to **inquire further about the circumstances in which the trauma or touch occurred**. It is important that the examiner not only pursue topics which may lead to discussion of abuse, but that each concern expressed by the patient is given due attention.

Whether a slap, bite, or blow left a **mark that could be seen** on the child's skin and how long it lasted may be useful to elucidate. Many medical evaluators include questions about spanking or punishment when examining the back and buttocks area. "Tell me about what happens in your family when kids do something that they're not supposed to do," is an illustration of one open-ended way to lead in to a **discussion of discipline** with a child. Similarly, when the clinician asks about pain with urination or defecation or questions about bleeding from the genitals or anal area while examining those areas, the child may divulge circumstances of abuse.

6. Other modes of communication

The medical evaluator may consider offering the child the option of **pointing to a place on a drawing of a body or on his own body** to help specify the location of an injury or contact. Healthcare professionals are discouraged from utilizing anatomical dolls for the same purpose, as their use has become highly controversial. Unless the provider has extensive training and experience with anatomical dolls, it may create more confusion than clarification to attempt to use them in child sexual abuse medical evaluations.

7. Alternative hypotheses

The evaluators of children and teens in whom sexual abuse is suspected must consider **alternative hypotheses** throughout the evaluation process. This is as critical when formulating questions during the medical interview, as it is when developing the differential diagnosis. Healthcare practitioners must **question the patient adequately to grasp the context of a child's statements**. For example, when a child indicates that she has been touched on her bottom, many scenarios are possible. With younger children, the touching may occur in the process of diapering, helping with toileting or other hygiene measures. School-age children may be describing non-sexual, commonly over-the-clothing, perhaps mischievous physical contact, such as playmates smacking each other on the buttocks or poking each other's backsides with pencils or sticks. Adults may apply topical medications to the anogenital area of a child, or may take rectal temperatures, insert suppositories or otherwise stimulate the anus in a constipated baby – all of which may be described by a child experiencing or observing the contact as "touching" the bottom. This is not to say that abuse may not also be occurring during, or in addition to, the above processes. However, the astute clinician must be willing to explore a range of possibilities.

TYPES OF QUESTIONS

Questions to be asked during medical interviews may be grouped into various categories. It may be convenient to think of them as positioned along a continuum according to the extent to which they draw upon two different types of memory. It is more difficult to access a memory when no cues are provided – this relies upon an individual's **recall memory**. **Recognition memory** is tapped when an individual tries to remember something after cues or choices are given.

Interviews in child sexual abuse evaluations will make use of both means of memory retrieval. In general, questions that rely on recall memory are open-ended and require longer explanatory responses, whereas those that utilize recognition memory are more direct and may require very brief, often yes/no answers. Inquiry that requires the use of recall memory is thought to be less suggestive and more likely to result in accurate response.

Types of Questions Used in Interviews of Suspected Child Abuse Victims

TYPE OF QUESTION	CHARACTERISTICS	EXAMPLES
Open-ended	-Draws mainly upon recall memory -Accuracy is thought to be maximized -Optimal starter questions; follow with clarifiers	-"Tell me why you came in to see me today." -"Tell me all about it." -"And then what happened?"
Specific or focused	-Both recall and recognition memory are tapped -Reasonable accuracy -Appropriate when used to clarify responses to open-ended questions	-"Who hit you there?" -"Where did Pat touch you?"
Multiple choice	-Draws mainly upon recognition memory -Accuracy may be improved if an unspecified alternative is included -Appropriate as a clarifying question	-"Did that happen in the bedroom, the bathroom, or somewhere else?" -"Did she hit you one time or more than one time?"
Yes/No	-Forces a choice. Younger children may simply choose first or last option -May be less reliable -Best used for clarification or in head-to-toe review of systems, returning to open-ended query, if child gives affirmative response	-After child has stated that she had been touched on her private parts, "When you were touched on your private parts, did that hurt you?" -"Have you ever been hurt on your back?"
Leading	-Suggests that there is only one acceptable response -Format of question generally includes an act, an actor and a tag -Accuracy questionable -Should never be used	-"Your dad hit you, didn't he?" -"No one has ever done anything to hurt your bottom, have they?"
Coercive	-Evokes emotions, secondary gain, not necessarily memory retrieval -Accuracy severely compromised -Inappropriate, should never be used	-"Tell me who did that to you, and I'll let you go back to see your mommy in the playroom

Reichert S, Chianello T, Rourke M. Sexual abuse: Issues related to interviewing children. In: Giardino AP, Alexander R, eds. *Child Maltreatment: A Clinical Guide*. 3rd ed. St. Louis, Mo: GW Medical Publishing, Inc; in press.

In general, it is best to start medical history taking with open-ended questions which have the highest probability of eliciting a free running narrative (e.g., "Tell me all about why you are here today"). Additional open-ended inquiry may be used to help the child expound (e.g., "Tell me more about that," or "Then what happened?"). Likewise, focused and clarifying questions, such as Yes/No questions and multiple-choice questions, are used to obtain additional details about statements the patient has offered. This application is quite different than when direct questions are used as a starting point in an interview. If used other than as follow-up to statements made, direct questions can limit the amount and quality of information that may be obtained.

Some examples of specific or focused questions that are useful to ask in child sexual abuse evaluations are the **"Four W's": WHAT** happened? **WHO** did it? **WHERE** did it happen? And lastly, **WHEN** (or HOW MANY TIMES) did it happen? WHAT and WHO are the most important information for the healthcare provider to obtain, as they may greatly impact the medical evaluation process, diagnosis and recommendations for safety and care. If it is anticipated that the child will be undergoing a formal interview in the near future, additional data may be best obtained by the interview specialist.

It should be noted that young children may have difficulty naming locations in which incidents of abuse may have occurred, but may be able to give some descriptors, such as the color of a building or room, whose house it was or what it was near. Children, even as old as ten years of age, are usually not developmentally capable of giving accurate information regarding concepts related to time or number of events. The answers they give, when pinned down about time and frequency, may seem inconsistent or improbable. This may confound and frustrate those attempting to assign jurisdiction and number of counts. They may assume that the child is not telling the truth, when, in fact, the child may not yet be able to process that type of information. The child may be interpreting the question asked differently than the adult intended. Aware medical professionals can be helpful to others involved in child abuse cases by explaining to them these aspects of normal child development.

When attempting to clarify a statement made by the patient, the examiner is advised to **frame focused or direct questions in order to ensure that the child knows exactly what the professional is attempting to understand**. The clinician can do this by restating the point of information that the child has related and then posing specific questions about that point. For example, "You said that someone had touched you on your bottom. Who touched you on your bottom?" Subsequent questions to clarify context may also be anchored for the child by repeating the information they share and then asking the next question.

Multiple choice questions can help to stimulate children's memory without leading them to a particular answer. Used to clarify responses to open-ended and focused queries or when desiring to vary the pace of the questioning, the healthcare professional may offer the child a list of several possible responses to a query. For example, if a child has reported that her babysitter touched her front privates with his hand while she was

wearing her pajamas, it is an option for the evaluator to ask if the babysitter touched the child's front privates on top of (or on the outside of) her pajamas, right up against her skin or something else. The **inclusion of an unspecified option (e.g., "something else," or "some other way", etc.) decreases the likelihood that the patient will arbitrarily, and sometimes inaccurately, select among the choices offered**. The list of questions may vary in length, depending on the age of the child. Older children may retain three or four possibilities, while it is best to offer not more than two choices plus the "something else" alternative to younger patients.

Leading and coercive questions should never be used in medical interviews. Leading questions present information to the patient and imply an expected answer. The format of the questions usually includes an actor, an act and a "tag" (e.g., "Your uncle touched your bottom, didn't he?"). It is manipulative and counterproductive to use any type of coercion, e.g., promise of reward, to obtain information in child abuse interviews. Accuracy of responses to such questions is dubious.

In Summary:

It is important for the clinician to remember to return to open-ended inquiry once a specific point has been explored with direct questioning. The **interview may be viewed as a dynamic process** which begins with open-ended queries followed with more open-ended questions or with clarifying questions and then automatically shifts back to more open-ended invitations for narrative. It is a common error for medical evaluators to start with open-ended query but, when pursuing affirmative responses with a series of focused questions, they forget to go back to the open-ended approach. That method is unlikely to capture the breadth of information that the child may have to share.

For healthcare practitioners who are new to this style of interviewing, it may, at first, seem complicated and unwieldy. Having to be so careful about how to pose questions takes effort and focus, but the benefits are considerable. Many medical providers who have learned these techniques choose to incorporate them in regular patient encounters as well in the abuse evaluation setting

SPECIFIC CIRCUMSTANCES

1. Treats, bribes, coercion

Many experienced clinicians include questions aimed at uncovering whether others have influenced children about what they tell or do not reveal during the evaluation. To get at **threats and bribes**, when asking the patient if anyone ever hurt or touched them on various parts during the body survey, (e.g., "Has someone ever hurt you on your neck or touched you there in a way that was uncomfortable…"), the examiner may add the phrase, "…and told you not to tell?" By asking the same question about body parts less likely to be involved in abuse events as well as the anogenital areas, the child's attention

is again not focused on sexual abuse. Should the child reply affirmatively, additional questions to clarify who has coerced the child and what was promised to happen can be posed. Similarly, children may be asked if they have any secrets or if someone has asked them to keep a secret. Some children may be willing to reveal those confidences in the context of the medical evaluation.

2. Non-disclosing child

In some cases, the healthcare provider must decide how to proceed with a child who has not disclosed abuse during the evaluation. Examples include children who have abnormal physical or laboratory findings but have not discussed abuse, patients who have disclosed to someone else but don't disclose to the examiner during open questioning or the body survey, and those in whom concern about abuse remains high, but who seem unfocused or evasive in their responses. If the opportunity exists for a formal interview in the near future with a child interviewing specialist, it may be preferable for the medical practitioner to defer the interview to that professional. Such an interview may occur as a component of the medical assessment or may be conducted as part of the law enforcement investigation. Some examiners who are especially skilled at interviewing children may choose to question further. Additional exploration may be in order if a specialized interview is not available or if the degree of concern for the child's safety is great.

Some cautious ways to proceed when the child does not disclose and concerns of abuse remain:

a) Introduce general concept of being hurt, touched or abused

The healthcare provider may choose to make a broad statement acknowledging that some of the children who are seen in that setting have been hurt by someone or have been touched in a way that was uncomfortable or private. In older children, use of the term "abused" may supply a useful reference point, since many of them have heard the term through the media or abuse prevention programs. The practitioner may ask if the child knows of anyone who has been abused, touched, etc., or if such a thing has ever happened to the patient. The medical provider may alternatively ask if anyone is worried that something like that has happened to the child.

b) Mention one factor involved in the abuse concern

When considerable open-ended inquiry has failed to introduce the topic of abuse and significant concern persists, the evaluator may choose to ask a focused question about one factor related to the current abuse circumstances, such as a person, place, or behavior. For example, if the child has mentioned an individual about whom the clinician is aware that there are abuse concerns, the medical evaluator may re-introduce that person's name and ask the child to tell her all

about that individual. Questions to clarify and gain more details should follow whatever the child shares about the individual.

c) Offer a "laundry list"

A "laundry list" variation on the multiple choice questions may also be an effective way to inquire about abuse without overly directing the patient. The examiner asks the same question about a variety of individuals or situations, embedding in the list those which have been specified in the allegation or concern. A "place" question might be: "Is there anything that has happened at your school that makes you feel (*choose one or two of the following)* scared, bad, uncomfortable, unsafe?" The same question is then posed about ". . . your house?", ". . . Grandpa's house?", ". . . camp?", "…somewhere else?"

This type of questioning must proceed with special caution, avoiding unduly influencing the child and refraining, as always, from asking suggestive or leading questions. Whether or not the child responds by disclosing abuse, the evaluator should follow each response with the same pattern of inviting more narrative and clarifying details. The healthcare practitioner should document all pertinent questions asked and the child's responses.

3. Children for whom the evaluation appears to be traumatic

When a child reacts adversely to the examination or has a strong emotional response to disclosure, it is important to acknowledge how difficult the exam process is for the child and offer reassurance or choices for making it easier. The child should be given as much control as possible over the process. In children who seem distressed during the examination, distraction measures (e.g., talking or reading with the assistant, counting, looking at a glitter wand or other toy) may help them to complete the process more comfortably. If the exam was particularly trying, it may be helpful to let the child get dressed and question the child in a different space. In the event that a child appears to dissociate during the examination, unless there is a health reason that precludes postponing the medical exam, consideration should be given to curtailing the examination and addressing mental health needs before proceeding.

CLOSURE

When the evaluation process nears completion, the medical provider may offer to answer any questions that the patient may have. The healthcare professional may ask the child if there is anything that she would like to add or anything important that they have not covered. Children should not be praised for disclosing or for what they shared. Rather, the clinician may thank or commend the child for helping the examiner to learn about and take care of the child's body.

The medical evaluator should offer children a brief explanation of findings and give reassurance about the normalcy and/or healing potential of the child's body. The child or

adolescent's particular concerns should be elicited and addressed. Recommendations for return visits, tests, interviews or counseling may be introduced to the child, as appropriate. Especially with teens, it is advisable to explain that the examiner will be discussing findings and conclusions with parents, investigators, caseworkers, and so on. It is important to address issues of confidentiality and to decide if the patient wants to participate in the debriefing with the parents.

SPECIAL POPULATIONS

1. Preschool children

Children ages 2-4 years may be able to express what happened to them but may not be able to cooperate in question and answer formats of some length. They are most likely to disclose to a trusted caretaker. Children of this age group may only share what has happened to them when particular cues trigger memory of an event. It is a challenge and may be impossible for an interviewing professional to identify those unique cues. The medical exam is very important in young children because the focus on body parts and visual and tactile cues may be more likely than verbal cues to elicit recall. In general, videotaping of interviews of children this young is not recommended.

Parents, caseworkers, law enforcement and evaluators alike may experience frustration when the child does not repeat her/his disclosure during the medical evaluation. However, when a preschooler is non-disclosing, the medical evaluator should be prepared to consider the child's statements to others and the context of past statements when making a diagnosis and recommendations for the child's safety, including contact with potentially abusive individuals.

2. Children with developmental disabilities

Information about the child's specific disability and how it affects him should direct the evaluation process. The physical examination may be the best setting for clarification and possible disclosure in children with developmental disabilities. Memory and communication differences may affect a child's ability to give a running narrative account of her experiences. The medical provider's use of simple sentences (three to five words) as well as visual and tactile cues (e.g., in the process of the head-to-toe questioning and examination), may be particularly effective strategies with this population.

3. Adolescents

Sometimes adolescent behavior in the exam room will be indistinguishable from that of school-age children. Other adolescents, or the same adolescent at other moments, will have an adult-like need for detailed explanations of procedures and findings. It is generally expected that adolescents will be able to provide detailed narratives with little prompting. Teens may appear to be more traumatized than children from other age

groups because they are in a developmental period where emotions are experienced with particular intensity. Adolescents may be acutely focused on issues of body image and virginity. It can be very helpful for the examiner to inform the child that her/his body is normal or, if there are injuries, to reassure the child that healing usually takes place quickly and without lasting visible changes. Exploring the adolescent's perception of how the abuse has affected her may offer the clinician opportunities to dispel myths and to identify acute need for mental health intervention.

4. Custody and visitation disputes

It may be particularly difficult, in cases which involve disputes over custody or visitation, to determine the source of the child's statements. Varying motives of parents and caregivers may add to the confusion. It may be tempting to dismiss allegations of abuse in these situations as attempts of parents in conflict to get at each other. However, the objective medical evaluator realizes that abuse must be evaluated independently from the obvious adult conflict. Due to the complexities presented by allegations of sexual abuse in the context of a custody or visitation dispute, the examiner should be prepared to:

- Make tentative treatment recommendations (e.g., "until this matter is fully investigated" or "until a more thorough evaluation is completed").
- Consider obtaining information from both parents, individually and/or documenting when information was not obtained from one of the parents, e.g., so as not to interfere with investigation or because of safety concerns for the child or family members.
- Refer the family for more extensive evaluation by psychologists or social workers, as in a full "custody study".
- Remain open to consulting with the custody study team.

DOCUMENTATION OF THE MEDICAL INTERVIEW

The unique information gained during the child's medical interview should be preserved as comprehensively as possible. Documentation of the medical interview should include relevant questions posed by the medical evaluator, the child's statements and responses and any significant emotional or behavioral reactions displayed by the child during the examination or questioning. When the clinician is certain of the child's or the professional's own exact language, questions and answers may be directly quoted in the medical report. As stated above, it is very helpful to have a skilled "assistant" take notes during the evaluation. The clinician can then give full attention to connecting with the child and conscientious questioning. The notes can later be relied upon for exact quotations and to prompt the examiner's recall as the case report is prepared.

It is also important for the medical record to note the specific source of the information obtained. Information learned directly from the child should be distinguished from what is obtained from caregivers, previous interviewers, investigators, prepared reports, referring parties, and others involved. It should be recorded that the child was

interviewed alone or not; those present during the interview or examination should be identified.

Although it has become standard practice to videotape forensic interviews of suspected child abuse victims, for privacy reasons and to comply with usual medical practice, videotaping of the physical examination is inadvisable. Audiotaping, as a less invasive option, may seem to be a reasonable way to more precisely document the information exchanged during the medical encounter. However, the "audio" portion is only one aspect of the clinician–patient interaction and the very significant non-verbal contributors to the assessment will not be captured on audiotape. Even if the medical provider includes those factors in the report, the tape may be viewed as a complete record and consideration may not be given to those more subtle, but significant forms of communication. Some providers audiotape the evaluation strictly to serve as "notes" to be used in the preparation of the official medical report. Once transcribed, the tape is then erased. Clinicians are advised to develop a routine and utilize whatever method suits them in best documenting the important information gained from the medical interview.

THE PHYSICAL EXAMINATION IN CHILD AND ADOLESCENT SEXUAL ABUSE EVALUATIONS

GUIDELINE

The evaluation of sexual abuse in children and adolescents should include a complete physical examination.

GENERAL CONSIDERATIONS

Although it may seem that the main goal of sexual abuse medical evaluations is to accomplish the anogenital examination, there are many sound arguments for why the physical examination of these child and adolescent patients should not focus solely on the anogenital areas. **Many parts of the body may be involved** in an abusive experience. If the healthcare professional limits examination to the genitals and anal areas, opportunities to discover **additional injuries or signs of abuse** are lost. Furthermore, such a restricted examination eliminates, for the patient, the **trigger of having memory stimulated by questions and examination of various body parts**. Examination of the whole body is likely to **increase comfort for young patients** because it puts the medical evaluation into a **familiar context** – that of having a medical provider ask questions and do a "check up" on their bodies. A comprehensive examination may **reduce embarrassment and anxiety** for children and teens by not drawing particular attention to the "private" areas of their body which may have been involved in the abuse.

The patient has **time to become accustomed to the examiner and to examination process** before undergoing an anogenital examination when the healthcare practitioner first checks out other perhaps less emotionally sensitive areas of the body. Having the examiner remove pieces of clothing to listen to the heart/lungs and to inspect the skin on the upper body, for instance, sets the stage for a similar process with the lower body. Establishing the routine of asking questions about being hurt or touched inappropriately on each part of the body during the head-to-toe evaluation **normalizes those questions for children when they are asked about genital or anal contact.** Additionally, it is hoped that the child will gain a sense that the medical provider is **concerned for the child's total well being**, rather than focused exclusively on the finding out about the abuse.

OTHER REASONS TO CONDUCT A COMPLETE PHYSICAL EXAMINATION IN SEXUAL ABUSE EVALUATIONS

Addressing neglected health needs

Some children who present to emergency departments and child assessment centers have not received regular medical care. A whole body check is an opportunity to address neglected health issues for those patients.

Examination for other types of abuse

Children who have experienced one form of abuse frequently have been subjected to other forms of maltreatment as well. Symptoms of neglect and physical abuse might not be identified if the examiner focuses exclusively on the child's anogenital area. Identification of other types of abuse can result in needed services for the child and his/her family and in a more comprehensive plan for protecting the child (and siblings).

Facilitating differential diagnosis

Sexual abuse is a medical diagnosis. Accurate diagnosis requires the examiner to rule out other diseases that might masquerade as abuse. Many conditions mistaken for sexual abuse are general conditions (e.g., lichen sclerosus, streptococcal infection) that may produce lesions on many parts of the body, including genitalia. In many cases, a whole body exam and history from parent and child regarding when and where lesions first appeared are essential to accurate differential diagnosis.

More neutral from a forensic perspective

During a whole body exam, questions will be posed regarding injuries and concerns for each body part. This context minimizes concerns regarding child suggestibility and avoids misperceptions that the examiner is focused on finding evidence to support allegations of abuse.

Addressing the emotional needs of the child or adolescent

Children and teens who have been sexually abused may be very concerned about the health and normalcy their bodies. They may believe that their "private parts" have been permanently, even recognizably, damaged as a result of the abuse. They may fear that they have become pregnant as a result of the abuse, or may worry that they won't be able to get pregnant when they are older because of damage caused. When medical providers offer reassurance that their patients' bodies are normal or, if injuries are present, that they will likely heal completely can significantly reduce anxiety and emotional stress for many victims of child sexual abuse. A complete physical examination offers patients the opportunity to access a healthcare practitioner who may provide

supportive and informative answers to questions that children or adolescents may have about the effects of abuse on their bodies.

EXCEPTIONS TO PERFORMING A COMPLETE PHYSICAL EXAMINATION

In some settings (e.g., emergency departments), time constraints may not permit a complete examination. In these cases it is recommended that the medical provider at least do a cursory review of systems and inspect the child's skin for injuries before initiating the anogenital examination. These processes give the child a few minutes to acclimate to the examiner and the situation, which may increase the child's comfort and compliance. If the child's medical or emotional needs preclude even a brief interactive head-to-toe evaluation, the treating clinician should consider scanning the patient's body for signs of injury and for other indicators of abuse, neglect and other conditions.

LOOKING FOR SIGNS OF ABUSE IN A GENERAL PHYSICAL EXAMINATION

Any part of the human body may be abused; there are certain places where abuse indicators may be more commonly discovered. The medical practitioner conducting abuse evaluations should be sure to screen these areas. Exposing a little of the body at a time as the examination proceeds, the healthcare provider should inspect all of the child's skin to identify any bruising, burns, lesions, scars, lacerations, abrasions, pigmentation or marks of any kind, dermatological or other medical conditions. Special attention should be paid to the following areas, in order to identify signs of trauma, infection, medical conditions or other abnormalities.

Skin	Inspect all areas.
Scalp	Assess for hair loss. Be sure to inspect back of head.
Eyes	In potential head trauma, perform fundoscopic exam to check for retinal or other hemorrhages. Also be alert for subconjunctival hemorrhages and other external injury.
Ears	Examine in, on and behind ears. Note that these are unusual places to sustain accidental injury.
Mouth	Examine palate. Check under the tongue, as well as lingual and upper/lower labial frenula.
Neck	Identify any petechiae, bruises, ligature marks.
Breasts	Determine if there are any bruises, bites, fingernails marks, suction injuries.
Back	Be sure to examine unclothed back and buttocks.
Abdomen	Inspect for bruises and other injuries and palpate. Have high index of suspicion for intra-abdominal trauma. Intra-abdominal injuries can present very insidiously and have very high mortality rate.
Genitals & Anus	Examine as part of complete physical examination in all patients, especially those who have other signs of abuse. See subsequent chapters for specific anogenital examination instructions.
Extremities	Check for injuries and impairment of function or range of motion.

EQUIPMENT TO MAXIMIZE VISUALIZATION AND DOCUMENTATION OF EXAMINATION FINDINGS

State of the art medical evaluations for child and adolescent sexual abuse require that the healthcare provider utilize a good light source and magnification in order to get a detailed view of the anogenital area. Furthermore, it is strongly recommended that examination findings be photodocumented. Use of the colposcope or the Medscope ™ System, both of which have photo or video documenting capabilities, has become standard procedure in child sexual abuse evaluations.

Colposcopes are typically large moveable instruments containing a good light source, binocular magnification at different levels and photographic or video capabilities. A wide variety of features are now available on different models of colposcopes. They may come equipped to capture still and/or video photographs and many are now using digital technology. Some models essentially consist of a video camera mounted on a base. The clinician observes the magnified examination field through eyepieces or may view it on a video monitor.

Medscope ™ System is a digital, rather than optical, videocolposcope. The MedScope ™ System features two interchangeable lenses to document abuse on all parts of the body thereby giving the clinician the opportunity to document both physical and sexual abuse. Magnification lenses are designed to allow viewing without constant refocusing. The clinician views the magnified examination field through the color monitor. Storage options include videotapes, prints from live video or video tape playback, and computer linkups.

Healthcare professionals who will be conducting child sexual abuse evaluations should educate themselves about the various types of imaging and documentation systems available and choose one that will best suit the setting in which they practice. Information may be obtained from the various equipment representatives, but consulting with several experienced examiners may be the best way to identify equipment that will best meet an individual facility's needs. It is also strongly recommended that providers try out various models before making their selection. Representatives frequently demonstrate their scopes at child abuse medical conferences. Some companies will provide "demo" equipment for examiners to try out in their offices. Practitioners should take into consideration the size of the colposcope or Medscope ™ and ease of use, requirement for versus space for accessory equipment in the exam room, as well as the quality of visualization and documentation. Ready access to the equipment representative for ongoing assistance and service is another desirable feature. Clinicians should also consider present and future storage capacity when deciding whether to document on hard copy photos or slides, on videotape or digitally, on discs.

It is acknowledged that not all examination facilities are equipped with a colposcope or Medscope™. In those circumstances, the examiner must endeavor to use the best source of

light and magnification available and to photograph, or otherwise record, the patient findings as well as possible. Portable binocular microscopes and optical glass binocular magnifiers may provide reasonable light and magnification for visualization, but they lack the capacity for photodocumentation of findings. Otoscopes or ophthalmoscopes offer little advantage over a simple light source. The examiner's hands are better put to use performing techniques that enhance visualization of the anogenital area (e.g., labial traction or labial separation in the prone knee-chest position) while a strong lamp illuminates the examination field, rather than to try to conduct an anogenital examination through the small view allowed by otoscopes or ophthalmoscopes. A camera capable of good magnification may be mounted on a tripod or hand held to document physical findings. Use of standard anatomic drawings on which to document findings may be an option when photography is not available.

Medical consultants and other staff at each of the Regional Child Abuse Training and Consultation Centers may offer helpful input into decisions about equipment options and documentation of examination findings.

THE FEMALE GENITAL EXAMINATION

GUIDELINE

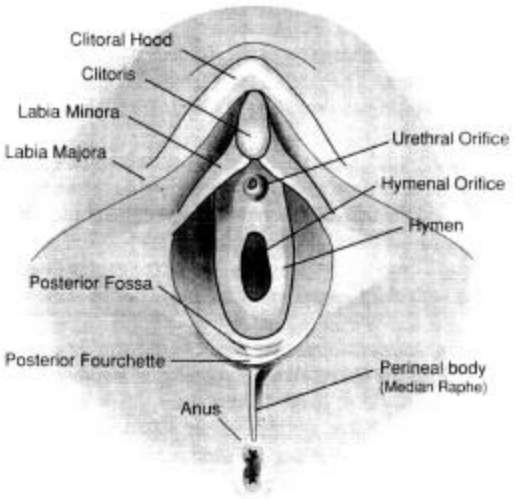
Examination of the female genital area should include the child's inner thighs, mons pubis, clitoral hood, urethral opening and periurethral tissue, labia majora, labia minora, hymen, exposed intravaginal contents, fossa navicularis or posterior fossa and posterior fourchette. Sufficient light and magnification should be used. It is most common for examination findings to be normal. The medical evaluator must be competent in identifying signs of acute injury, chronic traumatic changes and sexually transmitted disease and should be skilled in assessing the appearance of the hymen.

IMPORTANT NOTE: *The genital and anal examination chapters in these* ***Guidelines*** *should be regarded as providing only basic overviews of the very complex processes involved in examining these areas and interpreting findings observed. Healthcare providers who endeavor to examine the anogenital area and to interpret examination findings related to abuse should meet the prerequisites and training recommendations outlined in* **"Training and Ongoing Education for Medical Evaluators of Non-acute Sexual Abuse in Children and Adolescents".** *It is further advised that pertinent textbooks and other references be relied upon for more comprehensive information and guidance (see* **"References,"** *Chapter 20, for many suggestions).*

BASIC ANATOMY

The examiner should use supplemental light and magnification paired with appropriate positioning of the child to permit visualization of each of the parts diagrammed below:

PREPUBERTAL FEMALE GENITALIA



APPROACH TO THE PATIENT

When initiating the genital examination in a young female, it is important to put the patient at ease. Helping the child to get as comfortable as possible on the exam table and explaining that the medical provider is going to look at her genital area with the special light (that has already been introduced to the patient by that time) are important initial steps. While donning examination gloves, the medical professional may inform the child that the examiner will use her/his hands to move the skin on the outside of the child's "privates" in order to make sure that part of her body is healthy. She may be told that the looking is not expected to be physically uncomfortable for her, and reminded that, if she feels any pain or needs a break, she need only tell the clinician and the process will be modified to accommodate her.

The supine frog-leg position is the most common starting point for the genital examination of young females. Girls are assisted with flexing their knees, putting the soles of their feet together and letting their knees flop outward. Older adolescents and some obese or tall patients may require the use of stirrups (lithotomy position) in order to accomplish adequate visualization of the genital area.

Before manipulating any of the tissues, it is important for the medical evaluator to simply inspect the external genital area of the patient. The child's Tanner Stage, or indication of sexual maturity, may be estimated during initial observation of the genitals. (See Tanner table attached at end of this chapter). This assignment may assist the examiner in determining age-appropriateness of secondary sexual characteristics and in anticipating estrogen effect on hymenal appearance.

After inspecting the inner thighs and the external genital structures, the examiner may ease the patient into the next phase of the examination by first placing his/her hands on the patient's thighs or on the lateral aspects of the labia majora. This allows the patient a chance to get used to the examiner's contact and gives the clinician immediate feedback about the patient's degree of anxiety and discomfort.

The medical evaluator is advised to speak calmly to the patient, to remind her to breathe and to relax as much as she is able. Many medical practitioners who conduct sexual abuse evaluations talk children through the genital examination, just as they have done with the rest of the body, asking questions about symptoms and experiences while accomplishing the inspection. In some cases, however, it may be helpful to distract the child by asking about unrelated matters or by having an assistant help the child to focus on something else.

EXAMINATION TECHNIQUES

Examination Positions Employed in Child Sexual Abuse Examinations

Examining the patient in the **supine frog-leg** or **lithotomy** position, as well as in **prone knee-chest** position is recommended to accomplish a thorough assessment of the anogenital area in females. Most children, particularly young children are able to assume both supine frog-leg and prone knee-chest positions with little discomfort or embarrassment. The prone knee chest position may be more embarrassing for teens. Very young children who are unable to separate from their caretakers can assume the frog-leg or supine knee-chest positions in a parent's lap.

1. Supine frog-leg

To assume the supine frog-leg position, the child lies on the back, with the soles of the feet together and knees resting on the exam table to the sides. Labial separation or traction can be used in this position. This position is particularly good for young children. Telling the child that his/her legs will be "like a frog" or "like the wings of a butterfly" makes the process feel less threatening. Some preschool children and most school-aged children will respond to instructions to do "criss-cross applesauce." Once in this position, children's feet can be adjusted so that the soles of their feet are together.

2. Lithotomy

In this position the child is supine with feet in stirrups at about a 45 degree angle from the exam table. The child should be encouraged to allow the knees to "flop out" to either side. This position is ideal for older or obese children, children with long legs or particularly squirmy young children. Labial separation and traction can be used in this position.

3. Prone knee-chest

To assume the prone knee-chest position, the child rests on the knees, lower legs, and elbows and forearms, with the back relaxed in a lordotic curve ("sway back") and buttocks elevated. The child's chest and head should also rest against the exam table. Pillows may be placed beneath a child's abdomen to provide stability in this position. Prone knee-chest position may facilitate improved visualization of the hymen and may provide a view of the vagina and cervix. The anus also can be easily inspected in this position.

It can be somewhat difficult, initially, for the child to get into this position, but, once established, it is reasonably comfortable. The main disadvantage of the position is that many older children may initially find it awkward. To view the genital area, the examiner's thumbs are placed on either side of the labia majora with the other fingers on the buttocks and labial separation is applied in a posterior (toward the ceiling in this position) and lateral direction. Traction is not necessary to improve the view. In older or very large children, it may be difficult to obtain

enough separation to fully view the hymen in this position; other techniques may be necessary. Gentle lateral separation of the buttocks is used to view the anal area.

4. Supine knee-chest

In this position the child remains on his/her back and hugs the knees to the chest. The supine knee-chest position permits an anal exam with the child still lying on his/her back, without having to re-position the child into prone. It is mostly used in boys and with girls who may not be willing or are unable to assume prone knee-chest.

5. Lateral decubitus

To assume the lateral decubitus position, the child rolls to the side, either hugging the knees or resting the knees on the exam table, approximately perpendicular to the torso. This position allows the buttocks to be viewed for signs of injury and permits a complete anal exam. The lateral decubitus position offers generally less optimal visualization for female genital examination.

Rationale for Various Examination Positions

It should be noted that the size of the hymenal orifice and the exposure of the vestibule changes significantly in the different positions. Measurement of the hymenal opening diameter is generally not necessary. Rather, the goal of utilizing supine and prone positioning is to obtain as complete a view of the genital structures as possible. Abnormal anogenital findings seen in the supine positions should be verified in the prone knee-chest position whenever possible. Knee-chest positioning utilizes gravity to allow the hymenal edge to smooth out, thus more clearly displaying any irregularities or defects. In prone knee-chest position, the hymenal edge may appear sharper, rolled edges may smooth out and mounds may elongate, perhaps identifying themselves as septal remnants (normal variant). What looks like a notch or other abnormal finding in a supine position may even out and appear normal in prone knee-chest. Actual notches may appear as more distinct in the knee-chest position.

When the genital exam is clearly normal in supine, it may be tempting for the clinician to complete the anal examination in supine knee-chest and omit transitioning the child into prone knee-chest. Although the prone knee-chest examination may seem less necessary in those circumstances, it should be taken into consideration that there are cases in which genital abnormalities were not noticed during supine examination and were visible only with the patient in the prone knee-chest position. As a rule, prone knee-chest positioning should be part of the examination routine on each patient.

Techniques to Provide Optimal Exposure of Genital Structures

The goal of both the labial separation and labial traction techniques is to expose the vestibule and allow visualization of the hymen and perihymenal tissues. Labial separation is useful to scan the genitalia but visualization of the genital structures is significantly enhanced when the labial traction technique is employed.

•Labial separation	Simple spreading or separating of each side of the labia majora laterally
•Labial traction	With thumb and forefinger held in a "pinch" position on each of the labia majora, gentle traction is applied laterally and toward the examiner

1. Labial separation

To separate the labia majora, the examiner can use the thumb and index finger on one hand, the index and middle fingers of each hand or both thumbs. With the patient supine, the clinician's fingers are placed on each of the labia majora between 5 and 7 o'clock. Gentle lateral, in some patients, posterior pressure is exerted. In the supine position, the examiner spreads the labia to the sides and slightly down. When the patient is in the prone knee-chest position, the medical practitioner uses both thumbs to gently "lift" the labia upward and laterally.

It should be noted that the exact positioning of the fingers will vary depending on placement of the hymenal orifice, size of the child and whether there are labial adhesions. The medical provider should experiment with various placements of the examining fingers and directions of separation to achieve an optimal view of the target tissue. However, in most cases, labial separation alone will not permit adequate visualization and the examiner may use labial traction to more thoroughly inspect the area.

2. Labial traction

To perform the labial traction examining technique, the practitioner grasps the labia majora between the thumb and forefinger on either side of the labia majora. The labia are then gently retracted in three dimensions: out toward the examiner, laterally and, to varying degrees, anteriorly or posteriorly, depending on the target structure to be visualized. Traction should be maintained for several moments, allowing the tissues to relax and any temporary adherence of mucosal surfaces to separate. At that point, the hymenal edge may be clearly viewed, even in children with redundant hymens (e.g., those experiencing estrogen effects in the hymen as when very young or with puberty). If traction does not provide a clear view of the hymenal orifice, the examiner can request that the child cough or perform a Valsalva maneuver. In some girls, the hymen may be more clearly visualized in the prone knee-chest position.

3. Application of warm water or saline

The edge of some hymens may not be adequately exposed even with the use of labial traction and increased intra-abdominal pressure. Droplets of warm water or saline (e.g., from a small mist bottle, single-use vial or syringe) may be administered to moisten the hymenal tissue and release any adherence of the mucosal tissue created by surface tension. Hymenal edge projections and fimbria are often well-visualized when "floated" with liquid in this way.

Alternatively, in patients with estrogenized hymens, by inserting a saturated cotton swab just behind the proximal free border of the hymen and then using that swab to follow the tissue edge around the perimeter of the hymenal orifice ("running the edge" of the hymen), the examining clinician may segmentally separate and view the entire hymenal edge. This technique is most successfully used with pubertal females, as the estrogenized hymen is apparently less sensitive to contact. It is NOT recommended to touch minimally estrogenized, prepubertal hymens with anything, as most patients will experience discomfort or pain and may reflexively and/or purposefully withdraw from further examination.

4. Foley catheter technique for use in viewing the estrogenized adolescent hymen

If the foregoing techniques do not permit adequate visualization of an estrogenized hymen, use of a Foley catheter may be beneficial in displaying the redundant tissue. The deflated catheter is inserted through the hymenal opening, then inflated with air and gently drawn outward (distally), thus splaying out the hymen against the bulb of the catheter and permitting full view of the hymenal edge. Varying sources recommend using 14 – 18 gauge catheters with greater than 30 cc balloon capacity. The amount of air (or water, as some clinicians prefer) with which the balloon is inflated also varies – may be 10 cc to as much as 40 or 50 cc in some cases – and should be based upon the volume needed to keep the balloon behind (proximal to) the hymen while gently spreading out the tissue edge, as well as the capacity of the balloon. Exceeding the capacity of the balloon may cause the balloon to rupture. Inflating with too little air will let the catheter slip out without achieving its purpose; too much air may excessively stretch the hymenal edge and give it a falsely narrow appearance.

Patients with well-estrogenized hymens generally do not experience discomfort with this procedure. However, while quite instructive, the Foley catheter technique may require more hands than one examiner possesses, particularly when photodocumentation of the findings is also desired. It is recommended that the clinician make use of an assistant when attempting this technique. Also, practitioners should be aware that **this technique is not likely to be effective and may produce discomfort in prepubertal females.** Before attempting this technique, it is recommended that medical evaluators review supporting literature for instructions and/or consult with an experienced child abuse medical examiner.

A word regarding preparation of parents and patients is in order. In general, before the examination occurs, pubertal patients and their parents should have been informed that, while

most evaluations for child sexual abuse do not require that anything be inserted into the child's genital area, in some situations, additional procedures may be necessary. It will be important to explain that, with the Foley catheter technique, a very soft and flexible rubber tube is passed only slightly beyond the hymen (not far up into the vagina, as with a speculum), and that it is not expected to be at all painful for the patient.

PHYSICAL FINDINGS ON FEMALE GENITAL EXAMINATION

1. General inspection

The genital area should be inspected for signs of sexually transmitted disease, including discharge and lesions. See the guideline on "Sexually Transmitted Diseases" for more details regarding diagnosis and treatment of these conditions.

2. General diagnostic considerations regarding genital findings

Pain, bleeding, discharge, lesions, bruises or injuries noted in the genital area may be signs of sexual abuse. However, when a child presents with such findings, the astute medical provider considers a differential diagnosis which includes infections, a variety of medical conditions, accidental trauma, as well as abuse.

Bleeding from the anogenital area is a common symptom prompting referral for evaluation of possible sexual abuse. While acts involved in sexual abuse can certainly cause genital bleeding, there are many other explanations to consider. Seborrheic, atopic and diaper dermatitis may bleed, as might a ruptured or denuded hemangioma. Lichen sclerosus, urethral prolapse and labial adhesions that are torn or friable are other causes of genital bleeding. Infections such as streptococcus may cause anogenital lesions, bleeding and pain. The onset of menstruation may take some parents and children by surprise. It should also be considered that a child may have more than one explanation for genital findings, e.g., children with a friable skin condition may also be sexually abused. Identifying a condition does not eliminate abuse.

Straddle injuries generally result from blunt trauma in which soft tissues are crushed by an object forcefully contacting the area between the legs. Swelling, bruises, abrasions, bleeding and lacerations may result. The anterior labia, clitoris and peri-urethral tissue are common sites of tissue damage in straddle injuries. The injuries produced are typically unilateral and anterior and do not involve the hymen or other internal structures (i.e., usually do not extend proximal to the labia). The pubic bones, labia and buttocks protect internal structures.

Accidental penetrating injuries to the genitals are quite rare. The histories associated with those injuries are generally quite dramatic and medical care is usually promptly sought. Penetrating trauma may produce bleeding, abrasions, lacerations and bruising of external and internal genital structures, depending upon the direction, force and depth of the penetration. Damage to the urethra, vagina, rectum and internal organs may result.

Both external and internal genital injuries may result from sexual abuse. Isolated hymenal damage is very rare in accidental injury and is far more commonly caused by sexual abuse.

Rashes, pain, and itching in the genital area may result from a variety of dermatologic conditions such as seborrheic or atopic dermatitis, contact dermatitis (from soaps, bubble baths, fabric softeners, toilet paper, dyes, topical medications), psoriasis, lichen simplex, lichen sclerosus or rubber allergies provoked by underwear elastic. Children with pinworms or poor hygiene may experience genital irritation and itching. Rashes, pain and itching can also result from irritation produced during abuse or from sexually transmitted diseases.

Pigmented areas in the genital region may prove to be bruises, skin manifestations of various medical conditions, birthmarks, dyes or tattoos. Patient history may be most useful in helping to distinguish the origin of such markings. Bruises may be sustained accidentally or may be inflicted. There is a long list of medical conditions which may present with ecchymotic discolorations, sometimes located in the genital area. Rather than mention each possibility, it is advised that the clinician evaluating children for sexual abuse should carefully examine all discolorations and screen for any history of systemic illnesses. The discovery of a bleeding disorder or of similarly colored areas on multiple parts of the body may lead the diagnostician to consider explanations other than sexual abuse. Examining the child on a later occasion may assist with discriminating between transient findings (e.g., dyes, bruises) and those which are more persistent (e.g., Mongolian spots (alternatively known as slate gray nevi or blue spots of the newborn), chronic disorders).

Genital lesions and/or vaginal discharge should prompt the provider to consider sexually transmitted diseases and other infections. Specific information about diagnosing, interpreting and treating these conditions is contained in the Guideline chapter on **"Sexually Transmitted Diseases in Children and Adolescents"**.

Occasionally, patients present with genital abnormalities which may not be readily recognizable to the examiner. The healthcare professional evaluating a patient for abuse may rarely encounter cases of imperforate hymen, ambiguous genitalia, etc. Unless observed during the acute timeframe following the procedures, the genitals of girls who have undergone female circumcision/genital mutilation may have a distorted, unfamiliar appearance. Clinicians encountering any unusual findings should carefully and thoroughly document observations, especially with colposcopic photos, and should obtain expert consultation.

3. Inner thighs

The child's inner thighs should be inspected for any abnormalities, such as chafing, abrasions or bruising. The groin should be palpated to identify inguinal adenopathy. Concerning findings on the inner thighs may be the result of intracrural intercourse or may otherwise result from impact sustained during abuse. Clinicians should attempt to distinguish between such findings and those

noted in straddle injuries or from irritation not related to abuse (e.g., repetitive friction due to obesity or tight clothing).

4. Mons pubis, clitoris, clitoral hood

The list of observations noted in other areas of the genitals may also be found on the mons pubis and clitoral area, e.g., injuries, infections, medical conditions and anatomic variants. Frictional trauma produced during sexual abuse may manifest in these areas, as may the lesions of sexually transmitted diseases. During genital examination, the clitoral hood should be raised to inspect for lesions. Human papilloma virus (warts) has frequently been noted in that location.

5. Labia majora, labia minora

As with the inner thighs, the labia should be inspected for signs of chafing, abrasion or bruising. If these symptoms are noted, the history from both the parent and child will be important in ruling out straddle injury, tight clothing and self-stimulation as potential causes. As noted above, alternate explanations for bruising can be ruled out through visual inspection (over time if necessary), history and a whole body exam.

Erythema of the labia is a common finding, particularly on the inner aspect of the labia majora. While erythema can result from the irritation or impact of abuse, it also may be caused by a variety of irritants, including bubble bath, heat, lack of air circulation (as with non-cotton underwear or tight clothing), scratching, intertrigo or infection.

Although the natural history of labial adhesions remains uncertain, it is thought that labial adhesion, or fusion, may result from chronic irritation. Such adhesions are common in young children wearing diapers. Labial adhesions may occur anteriorly, but are more commonly noted near the posterior commissure. They are most readily identified in supine positions. Sexual abuse may provide a source of recurrent irritation to genital tissues and may result in labial adhesions in some victims. However, labial adhesions are a common finding in children with no history of abuse. They are considered to be a nonspecific finding and are not diagnostic of abuse.

Hypertrophy of the labia minora occurs in some adolescents and may be symmetric or unilateral. This is a normal developmental variant.

6. Urethral meatus and peri-urethral tissues

The urethral meatus and peri-urthral tissues should be examined for bleeding, injuries, lesions, discharge, erythema, dilation and other abnormalities, as well as anatomic variants. Some degree of urethral dilation is relatively common among both abused and non-abused females and may be particularly noticeable when labial traction is applied. Urethral damage may result from insertion of foreign objects into the urethra. Urethral catheterization is not known to

produce injury to the urethra. Periurethral bands are a commonly found variant of normal anatomy.

A number of relatively rare urethral conditions (e.g., ureterocele, sarcoma botryoides, ectopic ureter, prolapsed bladder and caruncle) can produce masses protruding into the periurethral area. Polyps, papilloma, condyloma and cysts can appear on the urethra. Urethral prolapse presents as a red or purple rosette surrounding the urethral meatus. The prolapsed tissue is friable and may bleed or become ulcerated or infected. Urethral prolapse may cause genital pain and dysuria. These symptoms and the appearance of the prolapsed tissue may be confused with symptoms of sexual abuse. Prolapse occurs most commonly in prepubescent African American girls. It is unclear why prolapse occurs; in some patients, increased intra-abdominal pressure and straining with crying, coughing or defecation have been noted as precipitants. Cases of urethral prolapse associated with sexual abuse also have been documented.

7. The hymen and perihymenal tissue

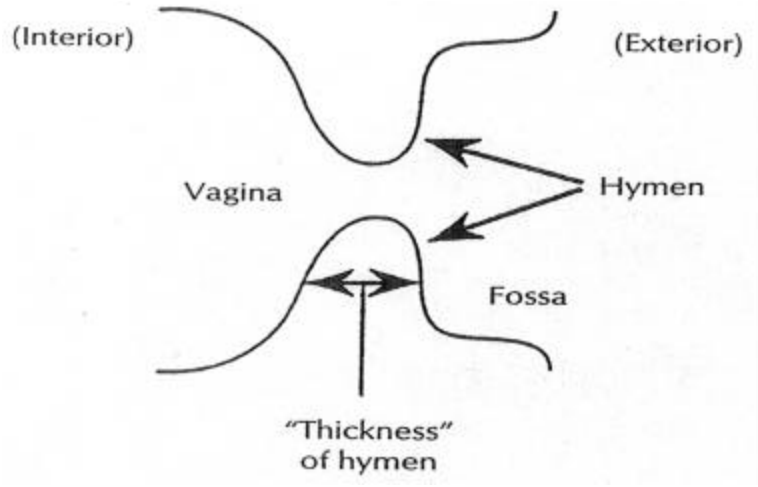
The approximate location of hymenal and perihymenal findings can be described using a clock-face referent. It should be noted that when the child changes exam positions, as in moving from supine to prone knee-chest, **the clock does NOT rotate along with the child**. For example, a finding noted at 6 o'clock in the supine position would be found at 12 o'clock in the knee-chest position.

The medical professional examining a child or adolescent for concerns of sexual abuse should observe the following about the hymen and perihymenal tissue, utilizing both supine and prone knee-chest patient positions:

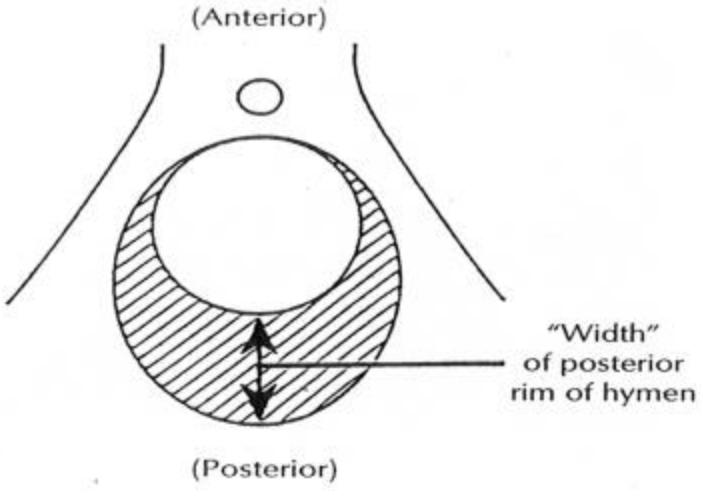
- hymenal configuration or morphology
- presence of anatomic variants, e.g., septa, perihymenal bands, tags
- thickness or translucency of the hymen, noting areas of rolled or thickened hymenal edge
- presence of edema
- vascularity
- irregularities of the hymenal edge
    - notches or concavities
    - mounds, projections
    - complete hymenal transections
- relative size of the hymenal opening and degree of exposure of intravaginal contents (measurement of orifice diameter is not necessary)
- width of the posterior hymen, noting any areas where hymenal tissue is absent
- lesions or inflammation
- signs of acute trauma, e.g., petechiae, abrasions, lacerations, ecchymoses
- signs of healing injuries

Healthcare practitioners are referred to the **Classification Guide for the Medical Diagnosis of Child Sexual Abuse** in the ***Guideline*s** section **"Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Adolescents"** for information about the significance of various hymenal findings.

CROSS-SECTIONAL VIEW OF HYMEN



FRONTAL VIEW OF HYMEN



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VARIATIONS IN HYMENAL MORPHOLOGY

Hymenal Morphology	Description
Annular or Circumferential	Hymenal membrane tissue extends completely around the circumference of the vaginal orifice.
Crescentic	Hymen attaches somewhere between the 9-11 and the 1-3 o'clock positions, with no tissue visible between the two attachments anteriorly.
Redundant	Abundant hymenal tissue that tends to fold back on itself or to protrude. Membrane may appear frilly, thick and floppy, or may appear sleeve- or cuff-like. Redundancy is thought to be due to estrogen effect.
Septate	The hymenal orifice is traversed by one or more bands of hymenal tissue, creating two or more openings. Lysed septa or septal remnants may appear as mounds or tags.
Fimbriated	Hymenal edge has multiple fine projections (giving it a "ruffled" appearance) which may be especially well displayed when water or saline is applied to the tissue.
Fenestrated or Cribriform	The hymen has multiple small openings.
Imperforate	The hymen has no opening. This is a rare condition which requires gynecologic consultation and corrective surgery. Pelvic ultrasound is warranted to verify that vagina and uterus are present. When no hymenal opening is apparent during genital examinations for sexual abuse, labial traction in both supine and knee-chest position, as well as application of water or saline to the tissue should be used to confirm the diagnosis.

Adapted from *Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Exams*, American Professional Society on the Abuse of Children, 1998.

Non-estrogenized hymens may appear crescentic, annular/circumferential, septate, cribriform or imperforate. The non-estrogenized hymenal edge is typically crisp. Hymenal edges may appear thickened and rolled in supine positions, but it is unusual for a thickened, rolled edge to persist in

the prone knee-chest position. With estrogen effect, the above listed configurations are possible, as well as redundant variations. The thick, redundant appearance of the estrogenized hymen is most commonly found in very young girls (maternal estrogen effect on hymenal tissue may persist to age 4 years) and in postpubertal females. Asymmetric estrogenization of the hymen may normally occur during puberty.

Acute injury to the hymen and perihymenal tissue, as with other genital area injuries, may present with bleeding, ecchymoses or petechiae, abrasions or lacerations, including partial hymenal tears or complete transections. Irregularities of the hymenal edge may have been produced as a result of past abuse or may be normal variants. Child sexual abuse research has focused the examiner's attention on findings located on the posterior half of the hymen. Hymenal tags, mounds, and projections are common findings in both abused and non-abused girls. In many cases these findings are associated with intravaginal ridges, or they may be remnants of hymenal septa.

The presence of notches or clefts (indentations; areas where hymenal tissue is narrower than the rest of the hymen) along the posterior hymenal edge may be related to past penetrating trauma. However, according to most recent research, unless the hymen is completely transected to its base, or there is an area where posterior hymenal tissue is absent, these findings may be considered worrisome, but not diagnostic, for past sexual abuse. It is important to note that, in studies of girls with both straddle injuries and accidental sharp, penetrating injuries, disruptions of the hymenal edge were not noted. Masturbation has not been shown to produce hymenal damage.
Tampon use in adolescents was previously felt to produce no hymenal damage. More recently, there has been controversy as to the possibility of "painful" tampon insertion causing hymenal changes. Case reports of tampon or plastic tampon applicators causing small vaginal lacerations have been documented.

8. The fossa navicularis or posterior fossa and the posterior fourchette

Inflammation, lesions and various signs of trauma may also be observed in the posterior fossa and on the posterior fourchette. Midline avascular areas or linea vestibularis (also known as the linea alba) in the fossa navicularis and on the posterior fourchette are normal anatomic variants which may be confused with scars. The linea alba, or linea vestibularis, as the names would imply, has a linear appearance. The term, "midline avascular area", usually refers to a broader area of pallor. Both the linea alba and midline avascular areas are generally pale, smooth and regular, and their surface is continuous with surrounding skin. Scar tissue is more dense and irregular and does not blend as completely with surrounding skin. Scar tissue will often deviate from the midline and may have irregular borders. However, it may be difficult to clinically distinguish scars from midline avascular areas.

Asymmetry of the fossa navicularis is considered to be a normal anatomic variant. Adolescents may present with a "developmental groove," a midline depression in the fossa navicularis, which

may appear concerning, but has not been correlated with abuse. Pubertal females may also present with papillary proliferation in the fossa navicularis, which may also extend to the inner labial walls. This finding sometimes raises concerns about infection or trauma, but is quite common and has not been associated with sexual abuse. Follicles and inclusion cysts may also be noted in the fossa navicularis and do not indicate abuse.

In some cases, the posterior fourchette is friable, probably as the result of irritation from various causes. Healthcare providers conducting sexual abuse evaluations should be aware that the tissue may superficially split in the midline during genital examination, particularly when labial traction is used. Should this occur, it is advisable to inform the parents and/or patient and, perhaps, to use the analogy of a split in the corner of one's lips. They should be cautioned that a small amount of blood noted on the underwear or toilet tissue would not be unexpected, or worrisome. Sitz baths or application of topical mild over-the-counter antimicrobial ointment for a day or two is likely to relieve any discomfort experienced.

9. Expect normal findings on female genital examinations

Medical providers who examine children and adolescents for sexual abuse should anticipate discovering normal physical findings. Research has suggested that as little as 15% of female genital examinations conducted outside the acute timeframe following sexual abuse will reveal any visible signs of injury. Partly due to wide variability in normal anatomy, physical features which are diagnostic indicators of abuse are rarely observed. The absence of physical findings in some cases may also be explained by a lack of initial injury related to the type of abuse (e.g., cunnilingus, fondling). In the face of disclosures or even perpetrator confessions of vaginal penetration, it is important to realize that attempted penetration may result in intracrural (between the thighs) intercourse or may be incomplete, i.e., because the hymen is recessed from the labia majora, "penetration" may not extend so deep as to pass through the hymenal orifice. Furthermore, rates of erectile or ejaculatory dysfunction among sex offenders are reported to be high.

Because of delays in disclosure and reporting, evaluations for child sexual abuse are commonly conducted a significant length of time after the abuse occurred. Elasticity of the hymen, coupled with the rapid healing of genital and hymenal tissue, further decreases the likelihood that physical findings related to sexual abuse will be detected on delayed examination. Irritation and inflammation may disappear within a few hours to a week. Acute genital injuries, including hymenal tears, may heal completely within weeks to a month. The onset of puberty with attendant changes in hymenal morphology may obscure tissue changes caused by sexual abuse.

The healthcare professional should acknowledge the limitations of physical examination as a source of "evidence" for sexual abuse, but realize that the ability to make the diagnosis and to make recommendations for patient treatment and safety is not so limited. Clinicians are referred to the chapter on **"Making the Diagnosis in Cases of Suspected Sexual Abuse in**

Children and Adolescents" in these ***Guidelines*** for suggestions on effectively stating the diagnosis of abuse in patients whose genital examination is normal.

TANNER STAGING OF SEXUAL MATURATION IN FEMALES

Tanner Stage	Pubic Hair	Breasts
Stage 1	None	Prepubertal
Stage 2	Sparse; covers medial border of labia	Breast bud
Stage 3	Darker, curly, increased amount	More breast tissue; continuous contour
Stage 4	More abundant, course	Areola and papilla form secondary mound
Stage 5	Adult; spread to medial thighs	Adult distribution of tissue with continuous outline

Adapted from Tanner, JM, *Growth at Adolescence* (2nd ed.), Oxford, England: Blackwell Scientific Publications, 1962.

THE MALE GENITAL EXAMINATION

GUIDELINE

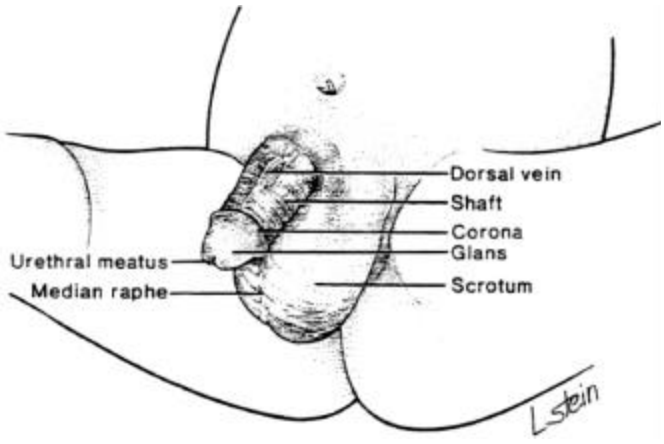
The medical provider conducting a child sexual abuse assessment on a male should evaluate the child's inner thighs, penis, scrotum, and perineum using adequate light and magnification. The genital examination on most young males is expected to be normal. As each part is examined, the clinician must be alert for signs of acute or chronic injury, for symptoms of sexually transmitted disease and for other medical conditions.

IMPORTANT NOTE: *The genital and anal examination chapters in these* ***Guidelines*** *should be regarded as providing only basic overviews of the very complex processes involved in examining these areas and interpreting findings observed. Healthcare providers who endeavor to examine the anogenital area and to interpret examination findings related to abuse should meet the prerequisites and training recommendations outlined in* **"Training and Ongoing Education for Medical Evaluators of Non-acute Sexual Abuse in Children and Adolescents".** *It is further advised that pertinent textbooks and other references be relied upon for more comprehensive information and guidance (see Chapter 20,* **"References,"** *for many suggestions).*

BASIC ANATOMY

The examiner should use sufficient light and magnification, paired with appropriate positioning of the child, to permit visualization of each of the parts diagrammed below:

PREPUBERTAL MALE GENITALIA (CIRCUMCISED)



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GENITAL EXAMINATION COMPONENTS

1. General genital inspection

It is useful for the healthcare practitioner to identify any genital abnormalities, including precocious or delayed sexual development. Assignment of Tanner stage (See Table at end of chapter) documents the child's current level of pubertal maturation and may be useful when considering reported events which include description of a child's genital appearance or function.

The examiner should inspect the genital area for lesions, bruises or other skin discolorations, abrasions, lacerations, burns and scars. The source of any bleeding or discharge must be identified. Any piercing or markings should be noted. The examiner should palpate the genital area to check for hernias and inguinal adenopathy.

2. Diagnostic considerations during general inspection

Bleeding, bruising, abrasions and rashes may be related to sexual abuse or physical abuse but also have many other causes. See the section on the female genital exam for diagnostic considerations in evaluating these findings. Traumatic injuries such as straddle injuries, kicks or blows to the groin, zipper injuries, and animal bites may produce ecchymotic findings in the genital area. The genitals may also be injured in accidental falls and auto accidents. The anogenital area should be inspected for signs of sexually transmitted disease, including discharge, papules and lesions. See the Guideline on **"Sexually Transmitted Diseases"** for more details regarding diagnosis and treatment of these conditions.

3. The penis

The shaft, foreskin, glans and urethral meatus should be examined. The examiner should note whether the penis is circumcised or uncircumcised and whether the foreskin is retractable. The clinician must be alert for presence of discharge, rashes, abrasions, scar tissue, edema and petechiae. While catheterization does not produce injury, children can be injured by inserting foreign objects into the urethral opening. Rare, but potentially serious injury to the penis can be caused by strangulation. Both accidental (e.g., hair tourniquet or clothing entrapment) and purposeful (e.g., applying a ligature for punishment of a toileting accident) strangulation may occur. Burns to the genital area may also be accidental or inflicted. Careful history taking may help make the distinction.

4. The scrotum

The examiner should palpate the testes to check for swelling, masses or tenderness. The testes should also be evaluated for asymmetry and for descent into the scrotal sac. The examiner must be alert for the presence of rashes, abrasions, scar tissue, edema, and petechiae in this area.

Pain, swelling, and hematoma of the penis and/or scrotum can occur among patients with Henoch-Schonlein Purpura. In some cases scrotal symptoms may precede the characteristic rash by up to 36 hours. Lichen sclerosus may cause phimosis at the urethral opening in boys. In some cases skin biopsy may be helpful in confirming the diagnosis of lichen sclerosus.

5. Most male genital examinations identify normal findings

Genital findings in males are rarely abnormal – even less so than in females. This may logically be related to the methods by which males are abused, as well as by inherent gender differences in the anatomy involved in sexual acts. As with females, delays in examination reduce the likelihood of detecting sign of acute abuse, e.g., abrasions, edema, petechiae, sperm and other transient findings. Medical evaluators are again reminded that the absence of physical findings should not be interpreted as a sign that abuse did not occur. In cases in which a child has a normal physical examination, but a history concerning for abuse, the healthcare professional must often actively represent this fact to those who make decisions regarding protective and legal matters.

TANNER STAGING OF SEXUAL MATURATION IN MALES

Tanner Stage	Pubic Hair	Genitalia
Stage 1	None	Prepubertal
Stage 2	Scanty; growth at outer edges of pubis; slight pigmentation	Slight penile enlargement; enlarged testes (5cc)
Stage 3	Darker; covers pubis; curly	Penis longer; Testes larger (8-10cc)
Stage 4	Adult type. No extension to thighs	Larger penis; glans breadth increased; Testes larger (12cc)
Stage 5	Adult distribution; spread to medial thighs	Adult. Testes 15 cc or larger
Stage 6	Triangular escutcheon	Adult

Adapted from Tanner, JM, **Growth at Adolescence** (2nd ed.), Oxford, England: Blackwell Scientific Publications, 1962.

THE ANAL EXAMINATION

GUIDELINE

Using sufficient light, magnification and appropriate positioning and applying gluteal separation, the medical professional conducting the evaluation for child sexual abuse should inspect the buttocks, perianal skin and anal verge. Normal exam findings are common. Nonetheless, the examiner must remain alert for signs of acute or chronic injury, infections and other medical conditions.

IMPORTANT NOTE: *The genital and anal examination chapters in these **Guidelines** should be regarded as providing only basic overviews of the very complex processes involved in examining these areas and interpreting findings observed. Healthcare providers who endeavor to examine the anogenital area and to interpret examination findings related to abuse should meet the prerequisites and training recommendations outlined in* **"Training and Ongoing Education for Medical Evaluators of Non-acute Sexual Abuse in Children and Adolescents".** *It is further advised that pertinent textbooks and other references be relied upon for more comprehensive information and guidance (see* **"References,"** *Chapter 20, for many suggestions).*

BASIC ANATOMY

The external part of the anus, the anal verge, consists of the tissue overlying the external anal sphincter and extending to the margin of the perianal skin. The anal verge is marked by rugae, which are symmetric, circumferentially radiating folds. The anus may dilate, permitting inspection of the ampulla and the internal and external sphincters.

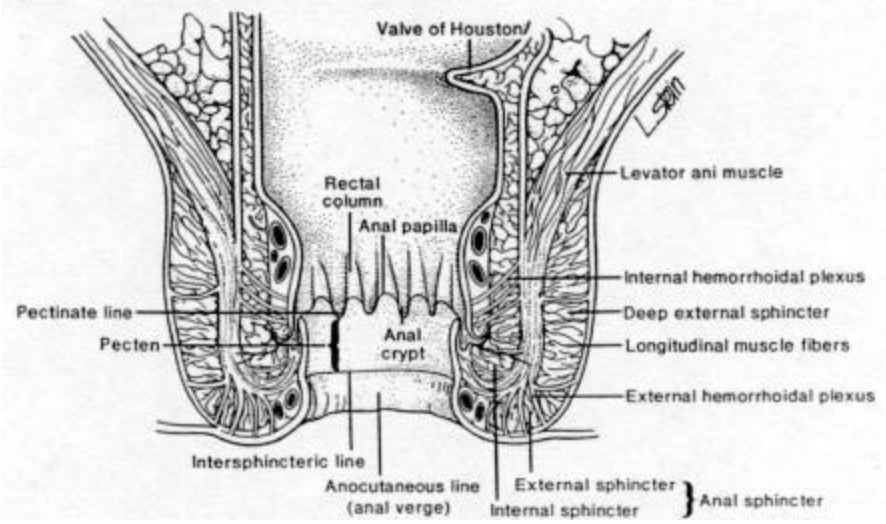
GENERAL ANAL INSPECTION

The examiner should inspect the buttocks, perianal skin and anal verge. The location of anal findings, like female genital findings, can be described using a clock face for orientation. Documentation should reference the position in which the child is being examined at the time the finding is noted and consider the top of the examination field (closest to the ceiling) to be at 12 o'clock.

The anus can be visualized well when the patient is in supine or prone knee-chest positions. If more convenient for the patient or examiner, the lateral decubitus position may also offer adequate visualization of anal and perianal tissues.

Healthcare practitioners may refer to the **"**Classification Guide for the Medical Diagnosis of Child Sexual Abuse**"** in the Guideline section **"Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Teens"** for assistance with interpreting various anal findings.

CROSS-SECTIONAL VIEW OF THE ANUS



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GENERAL ANAL INSPECTION

The examiner should inspect the buttocks, perianal skin and anal verge. The location of anal findings, like female genital findings, can be described using a clock face for orientation. Documentation should reference the position in which the child is being examined at the time the finding is noted and consider the top of the examination field (closest to the ceiling) to be at 12 o'clock.

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Healthcare practitioners may refer to the **"**Classification Guide for the Medical Diagnosis of Child Sexual Abuse**"** in the Guideline section **"Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Teens"** for assistance with interpreting various anal findings.

NORMAL ANAL ANATOMY AND NORMAL VARIANTS

Studies conducted on both abused and non-abused children have demonstrated wide variability in the appearance of normal anuses. Very few anal findings may be considered diagnostic for penetrating trauma. Healthcare practitioners who evaluate children and adolescents for sexual abuse must be familiar with normal variants of anal anatomy and remain alert for signs of recent and past injury, as well as for signs of infection and other medical conditions.

Commonly observed in the anal area are ***diastases ani***, sometimes referred to as **"clear areas,"** located in the anterior and/or posterior midline of the anus. These smooth, flat and somewhat fan-shaped areas are the result of a congenital difference in the superficial division of the external sphincter muscle fibers. These interruptions in the purse-string musculature surrounding the anal opening are normal anatomic variants, but are sometimes confused with scars. The presence of **anterior midline tags** and **flattening of the anal verge and rugae during transient anal dilation** have also been established as normal findings. A **prominent anal verge** is postulated to be related to the patient's muscle tension during the examination and is also not considered to be the result of sexual abuse. **Increased pigmentation**, particularly in non-Caucasian children, **venous congestion**, particularly after two minutes of hip flexion in supine or knee-chest positions, anal dilation to less than 15 mm are common among non-abused children

SPECIAL CONSIDERATION: ANAL DILATATION

Many medical providers have been trained to become suspicious for sexual abuse when they note anal dilatation. It is true that persistent excessive anal dilatation may be the result of injury sustained from penetrating trauma to the anus. However, **anal dilatation may be a normal finding and is common under certain conditions**. Transient anal dilatation is frequently noted and may be related to passage of flatus or to variations in muscle relaxation. If stool is present in the rectal ampulla or vault, one or both of the anal sphincters may dilate. The examiner who notes anal dilatation when stool is also visible in the rectum is advised to repeat the anal inspection after the patient has had a bowel movement or on another day (hopefully, when defecation is not again imminent). Children who have had problems with constipation, encopresis or diarrhea may also present with anal dilation. When the patient has neurological deficits, either chronic or acute, e.g., with neuromuscular disorders, when sedated or experiencing loss of consciousness or post mortem, the anus may normally dilate.

The anal opening is typically round or oval with maximum dilation. Irregularity suggests that scar tissue may be distorting the appearance of the opening, since this tissue is less able to stretch with dilation. In considering the significance of anal dilation, the examiner must be mindful of the size of the opening, the shape of the opening, rapidity and frequency of dilation and whether stool is present at the time of dilation. Although there is still no definitive conclusion as to exactly at what point anal dilatation may be considered diagnostic for abuse, the medical evaluator should **be concerned for abuse when noting a markedly irregular anal orifice or anal dilation which is 20 mm or greater in diameter** (given that there is no stool in rectal vault, no bowel movement within the past 30 minutes, no history of chronic constipation or encopresis and no sedation or neurological deficits at the time). (Clinicians are referred to Chapter 15 of these ***Guidelines***, **"Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Adolescents"** in which the **Classification Guide for the Medical Diagnosis of Child Sexual Abuse** addresses these considerations.)

ABNORMAL ANAL FINDINGS

Infections, a variety of medical conditions and trauma may produce abnormalities discovered on anal examination. Many abnormal findings may occur as a result of sexual abuse, but may also be produced

by other causes. Clinicians evaluating children for sexual abuse should document abnormal findings and develop a differential diagnosis to consider the range of possible explanations for the abnormality observed.

Acute findings may include erythema, edema, petechiae, abrasions, hematomas, contusions, fissures and lacerations. Erythema, edema, petechiae, abrasions and fissures in the anal area may resolve within hours. Hematomas, contusions and lacerations are more persistent, but these too become less detectable over time as healing proceeds. Erythema, edema and fissures may be related to acute injury but are also found in non-abused children, for example, young children with severe, sometimes excoriating, diaper rash. Skin irritants such as bubble bath and non-cotton underpants, poor hygiene and a variety of disorders may produce these findings. Anal fissures may be the result of constipation or diarrhea or may be produced with the passage of a particularly large stool.

Lichen sclerosus, Crohn's disease and hemolytic uremic syndrome can produce perianal skin changes that may be mistaken for abuse-related erythema, ecchymosis, abrasions and anal scarring. Prolonged diarrhea can provoke spasmodic contraction and dilation of the anal sphincter and venous dilation. Fistula in ano may produce perianal scars and fissures. This disorder frequently presents as a draining pustule during the first year of life. In most cases surgical intervention is necessary. Eversion of the anal canal can result from sexual abuse as well as from a number of other conditions, including chronic constipation, acute diarrhea, suction injuries, cystic fibrosis, rectal polyps, surgical repair of imperforate anus and various neurological problems. Children with myotonic dystrophy present with an array of anal symptoms, including lax anal tone, perianal inflammation, fecal soiling and reflex anal dilation. When a child presents with abnormal muscle tone or a neuromuscular disorder, an understanding of the underlying condition may facilitate interpretation of genital findings.

Sexually abusive insertion of objects into the anus can produce tearing, rectal perforation, bruising and eversion, yet these same findings may be caused via accidental injury, as with impalement injuries or as have occurred in rare cases of sitting on a swimming pool drain.

The literature discusses findings which may be suggestive of chronic abuse to include tags outside the midline, lax sphincter tone and thickened rugae with complete dilation of the external anal sphincter. Dilation greater than 20 mm with no stool in the ampulla or an irregularly shaped anal opening may also signal the examiner to consider past penetrating trauma.

The anal area should be inspected for signs of sexually transmitted disease, including discharge and lesions. Clinicians are referred to the Guideline on **"Sexually Transmitted Diseases"** for more details regarding diagnosis and treatment of these conditions. Discovery of anal warts presents its own diagnostic challenges and should precipitate consideration of consultation with a child abuse medical specialist who has extensive experience and up-to-date knowledge regarding sexually transmitted diseases as they relate to child sexual abuse.

With all of the abnormal findings listed above, careful history gathering is critical in making a definitive diagnosis. Accidental injury, congenital conditions and acquired disorders can produce findings mimicking those caused by sexual abuse.

SEXUALLY TRANSMITTED DISEASES

GUIDELINE

Sexually transmitted diseases (STDs) are uncommonly found in children who have been sexually abused. Children can acquire STDs through vertical transmission, auto-inoculation or sexual contact. STDs are more common among children presenting with symptoms of genital pain, pruritis, vaginal discharge, lesions or urinary symptoms. They are also more common when risk factors such as multiple offenders, intravenous drug use for the offender and vaginal or anal penetration are present. When an STD is suspected in a sexually abused child, the child should be tested.

The diagnosis of an STD in a child has serious legal and social implications. Thus, the STD diagnosis should be made using tests with high sensitivity and specificity to avoid false negative or positive results. When tests other than the "gold standard" are used and results are positive, antimicrobial therapy may need to be withheld until the gold standard test is obtained. However, once the sample for the gold standard test is obtained, clinical treatment can be initiated based on signs and symptoms of an STD and a positive "non-gold standard" test.

IMPORTANT NOTE: *The STD information contained in this Guideline is a brief summary. The examiner is encouraged to refer to current references on STDs and/or to consult with experts when considering whether a child should be tested, how to test, or how to interpret the test result. A list of basic references on the topic of STDs is provided in* **"References,"** chapter 20.

GENERAL INFORMATION

1. The overall incidence of STDs among children is low

- Approximately 5% of children acquire an STD as a result of sexual abuse (***Red Book*** 2003)
- Higher incidence when:
  - ✓ Local incidence among adults is high
  - ✓ Post-pubertal children are included in the sample
- Lower incidence among pre-pubertal females because:
  - ✓ Prepubertal females have an alkaline vaginal pH
  - ✓ Prepubertal females have columnar epithelial cells in the vagina rather than stratified epithelium like adults

2. Consultation regarding the diagnostic significance of STDs is helpful

Information regarding the diagnostic significance of sexually transmitted diseases continues to be the subject of ongoing research and discussion. Consultation with statewide or national experts may be helpful when considering how best to evaluate a child for an STD or the implication of the test results. This document presents brief summaries of current information regarding individual STDs. More detailed information is available through review of CDC Guidelines (2002), Sexually Transmitted Diseases by Holmes, Mardh, Sparling and Wiesner (1999), and the American Academy of Pediatric's ***Red Book*** (2003). Consultation is also available from the Centers for Disease Control and Prevention at www.cdc.gov/std or (770)488-4115.

3. Guideline for determining which children should be tested for STDs

When evaluating children suspected of having been sexually abused who have one or more of the following features, consideration should be given to testing for STDs:

- Children presenting with:
  - ✓ Genital pain, pruritis or bleeding
  - ✓ Vaginal discharge
  - ✓ Urinary symptoms
  - ✓ Genital lesions or irritation
  - ✓ Confirmed pregnancy
  - ✓ Child is sexually active or has used intravenous drugs
  - ✓ Pubertal child
  - ✓ Child has an abnormal anogenital exam
  - ✓ History of anogenital penetration

- Offender considerations:
  - ✓ Multiple offenders have abused the child
  - ✓ The identity of the offender is unknown
  - ✓ The offender is at high risk for STDs

- Other considerations:
  - ✓ When the child or offender resides in an area of high prevalence for one or more STDs
  - ✓ When a family member has an STD

Incidence data on STDs in prepubertal children suggest that even if all prepubertal children were tested, only a very small percentage would test positive. The potential benefits of diagnosing and treating this small percentage of children must be weighed against the disadvantages of testing. The process of obtaining culture specimens for testing can be uncomfortable, invasive and potentially traumatic to a child victim.

The decision whether or not to test should take into consideration that the quality of the sample is dependent on the skill of the examiner, the child's ability to tolerate the procedure, the availability of appropriate media and lab technique. Post-pubertal children are more likely to contract an STD and to

suffer long-term health problems if the disease is not identified and treated. The overall prevalence of STDs in the local community must be considered in decisions to formulate testing criteria. Criteria should be more inclusive in communities with relatively high prevalence of STDs and more restrictive in communities with relatively low prevalence rates.

4. Standard test selection in STD evaluation

Testing for STDs in children should minimize pain and trauma to the child while providing a reliable diagnosis regarding the STD. Additionally, if a child has signs or symptoms of an infection that might be sexually transmitted, the child should be tested for other STDs, as well.

Because of the legal, medical and psychological implications of both false positive and false negative diagnoses, only tests with high sensitivity and specificity should be used. With some tests, such as nucleic acid amplification tests (NAAT), the low prevalence of STD in the child population makes the positive predictive value low. The reader is referred to current CDC recommendations and ***Red Book*** (2003) for up to date gold standard tests and alternative test considerations.

Neisseria gonorrhoeae (GC):

- CDC (2002) recommends standard culture with confirmation by at least two tests that involve different principles

Chlamydia trachomatis (Chlamydia):

- CDC (2002) recommends the isolation of chlamydia by culture, confirmed by microscopic identification of inclusions by staining with fluorescein-conjugated monoclonal antibody specific for *Chlamydia trachomatis*
- Alternatively, NAAT on urine samples and vaginal swabs can be performed only if the culture is not available and if the positive test can be confirmed by a second NAAT that uses another genetic target or by culture. NAATs in adult women have high sensitivity and specificity but the low prevalence of STDs in children gives the NAAT a low positive predictive value

Treponema pallidum (Syphilis):

- Nontreponemal serology test (e.g., RPR or VDRL)

Human Immunodeficiency Virus (HIV):

- Serum HIV antibody test using enzyme immunoassays

Human Papilloma Virus (HPV):

- Cytology evaluation
- DNA-based testing

Herpes Simplex (HSV) Type 1 and 2:

- Cell culture with confirmation by fluorescent antibody staining or enzyme immunoassay
- Typing of HSV strains should be considered

Trichomonas vaginalis:

- Culture and/or wet mount

Bacterial Vaginosis:

- Clinical diagnosis from signs and symptoms and/or gram stain

Hepatitis B and C Virus (HBV, HCV):

- Serology testing

5. CDC (2002) recommendations for specimen collection sites for cultures:

Recommended Site	Organisms to be Cultured
Oropharynx	Gonorrhea
Anus	Gonorrhea, Chlamydia
Vagina	Gonorrhea, Chlamydia (prepubertal girls only), Trichomonas vaginalis, bacterial culture
Cervix	Chlamydia (post-pubertal girls only)
Male Urethral meatus	Chlamydia, Gonorrhea (if discharge is present)
Male Intra-urethra	Gonorrhea (if no discharge is present)

It is not necessary to test the pharynx for chlamydia because of the long persistence of perinatal infections and because of the potential for confusion with *C. pneumoniae*. Medical providers must confirm with their laboratory that the tests used by the lab are consistent with CDC (2002) recommendations.

When STD testing is performed, it should focus on likely anatomical sites of infection based on the history of the abuse and epidemiologic considerations (***Red Book*** 2003).

6. When a decision is made to test for one STD, testing for other STDs is recommended.

This recommendation is made because:

(1) symptoms may be nonspecific
(2) individuals with one STD are at heightened risk for other diseases
(3) many infections are asymptomatic

7. Additional history is necessary when an STD is identified

When a child presents with a sexually transmitted disease, it is critical to gather information regarding the biological mother's history of STDs. In some cases, it also may be helpful to know the STD history for all members of the child's household and for non-familial caretakers.

The STD history and risk assessment of the alleged perpetrator is useful but is frequently not available. In some cases, this may be available through the criminal justice or court system.

8. Reporting obligations when an STD is identified

As specified in OAR 333-018, healthcare professionals who identify gonorrhea, chlamydia, chancroid, lymphogranuloma venereum, syphilis, hepatitis B, acute hepatitis C or PID are obligated to make a report. It is recommended to report within one working day to the local health department so that epidemiologic effort to prevent transmission of the disease may be initiated.

NEISSERIA GONORRHOEAE (GC)

1. Incidence

Siegal (1995) found an incidence of 2.9% among all children, both prepubertal and pubertal, evaluated for sexual abuse.

2. Typical presentation

- Children are often symptomatic with genital discharge
- In adolescents, females are often asymptomatic
- Common clinical symptoms are urethritis, endocervicitis and salpingitis
- Males are often symptomatic; primary site is often the urethra
- Rectal and pharyngeal infections are often asymptomatic
- Even asymptomatic infections can produce PID in adolescents

3. Diagnostic considerations

- Cultures for GC are rarely positive in prepubertal children without signs or symptoms of vaginitis or exposure to a perpetrator with a documented infection
- Transmitted via direct contact with exudate and secretions from infected mucosal surface
- Incubation period is 2-7 days
- Can be misidentified using gram stain
- Diagnostic of sexual abuse in children outside the neonatal period
- Rectal infections do not necessarily imply anal sodomy in females because vaginal secretions can infect the rectal area and vice versa

4. Testing considerations

- Gold standard is culture on chocolate agar or modified Thayer-Martin agar
- *Neisseria gonorrhoeae* can be confused with other *Neisseria* species that colonize the genitourinary tract or pharynx. If the culture is positive, use at least 2 confirmatory bacteriologic tests involving different principles (e.g., biochemical, enzyme substrate or serologic)
- Gram stains are inadequate and should not be used for screening or diagnosis

- Nucleic Acid Amplification Tests (NAAT) using urine samples or vaginal swabs can be an alternative only if the culture is not available and if the positive test can be confirmed by a second NAAT that uses another genetic target or by culture (CDC 2002). NAATs in adult women have high sensitivity and specificity but the low prevalence of STDs in children gives the NAAT a low positive predictive value
- Some child abuse intervention centers use sequential testing, i.e., NAAT used for screening, followed by culture confirmation. Forensic diagnosis is based on the culture result

5. Treatment

Because of the prevalence of penicillin and tetracycline resistance, cephalosporin is recommended (***Red Book*** 2003) for treatment of gonorrhea. Oral antimicrobial option is cefixime. Children treated with ceftriaxone do not require a test of cure (TOC), but if treated with other regiments, TOC is indicated (***Red Book*** 2003).

CHLAMYDIA TRACHOMATIS

1. Incidence

Siegal (1995) found an incidence of 2.7 % among all children both prepubertal and pubertal evaluated for sexual abuse.

2. Typical presentation

- Typically asymptomatic in children
- In prepubertal females, it may cause vaginitis
- In pubertal females, it can cause urethritis, cervicitis, endometritis, salpingitis and perihepatitis
- In males, it may cause epididymitis
- Reiter syndrome (arthritis, urethritis and conjunctivitis) and lymphogranuloma venereum (invasive lymphatic infection with initial genital lesion) can occur

3. Diagnostic considerations

- Chlamydia is an obligate intracellular bacterial agent with at least 18 serological variants
- Incubation period is 7 to 21 days
- Transmitted only via direct contact with infected secretions
- Perinatal transmission has been documented with asymptomatic anal infection for up to 12.5 months and 12.2 months in the vagina (Bell, et al., 1992)
- The rate of perinatal transmissions to the conjunctiva is high (30-50%) and at least 50% of these affected infants have nasopharyngeal infection. The rate of vaginal and rectal transmission is lower (10-20%)
- Diagnostic of sexual abuse if not perinatally acquired and standard culture was used for diagnosis (AAP 2004)
- Rectal infections do not necessarily imply anal sodomy in females because vaginal secretions can infect the rectal area and vice versa

4. Testing considerations

- Chlamydia culture method requires:
  - ✓ Dacron swabs on a non-wooden shaft
  - ✓ Vigorous swabbing is required to remove epithelial cells to capture the intracellular organism. In prepubertal females, epithelial cells from the vaginal wall are collected; the cervix must be swabbed in postpubertal females
  - ✓ Swab immersed in a specific chlamydia transport medium
  - ✓ Medium kept cool before and after inoculation
  - ✓ Inoculated medium should be frozen at –70 degrees Centigrade if immediate lab processing is not possible
- CDC (2002) recommends culture for the isolation of chlamydia, confirmed by microscopic identification of inclusions by staining with fluorescein-conjugated monoclonal antibody specific for *Chlamydia trachomatis*
- Culture is highly specific, but has low sensitivity. Sensitivity of CT culture of endocervical specimen, using NAAT as the standard, range from 55-85% (Hammerschlag, 2003). Sensitivity can be improved by proper handling
- Some child abuse intervention centers use sequential testing with NAAT, e.g., screening with NAAT, followed by culture confirmation if the NAAT is positive. Forensic diagnosis is based on the culture result

5. Treatment

In children, erythromycin or azithromycin is recommended. For adolescents and adults, azithromycin or tetracycline is recommended. See Table 1 at the end of this chapter, CDC (2002) or ***Red Book*** (2003) for further detail. No test of cure (TOC) is indicated if treatment was completed with azithromycin and child is asymptomatic. If erythromycin or tetracycline is used, consider TOC. If NAAT is used for TOC, wait at least one month after treatment was completed before retesting.

TREPONEMA PALLIDUM (SYPHILIS)

1. Incidence

In Siegals (1995) study of children evaluated for sexual abuse, none of the 275 children who were tested for syphilis were positive.

2. Typical presentation of acquired syphilis

Primary stage

- Presents 10 to 40 days post-infection
- Classic symptom is a single painless indurated ulcer (chancre) at site of inoculation
- Frequently at genital site

Secondary stage

- Begins 1 to 2 months later
- Rash, mucocutaneous lesions and lymphadenopathy
- Rash is generalized maculopapular which involves palms and soles
- In moist areas such as vulva and anus, hypertrophic papular lesions (condyloma lata) can occur

Latent stage

- A period after infection when patients are seroreactive but demonstrate no clinical manifestations of the disease
- Gumma changes of skin, bone or viscera

Neurosyphilis

- Can occur at any stage of infection

3. Diagnostic considerations

- Incubation period for syphilis is typically 10 to 90 days
- Congenital syphilis may be contracted from an infected mother at any time during the pregnancy
- Acquired syphilis is contracted through direct contact with an infected lesion
- Lesions of primary or secondary stage are highly infectious
- If nonsexual transmission unlikely or excluded, syphilis is diagnostic of sexual abuse (AAP 2004)

4. Testing considerations

- Serologic tests:
  - ✓ Nontreponemal tests are useful (VDRL-Venereal Disease Research Laboratory, Quantitative; RPR-Rapid Plasma Reagin Circle Card). False positive tests may result. False negative tests can occur in early primary syphilis
  - ✓ Positive nontreponemal tests should be confirmed using treponemal tests such as FTA-ABS (Fluorescent Treponemal Antibody Absorption) or MHA-TP (Microhemagglutination Test for *T. pallidum*)
  - ✓ Serological testing is best done at 3 months post-exposure to evaluate for acquired disease
- Darkfield examination and direct fluorescent antibody tests of lesion exudates or tissue

5. Treatment

Parenteral penicillin G is the preferred drug at all stages. See CDC (2002) or ***Red Book*** 2003 for treatment specifics.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

1. Incidence

- Cases of AIDS in children account for approximately 1% of all reported cases in the U.S. (***Red Book*** 2003)
- In the U.S., more than 90% of HIV-infected children younger than 13 years of age acquired the infection from their mother perinatally. Almost all the other cases were in children who had received transfusion of blood or blood components. A few HIV infections in children have been the result of sexual abuse by an HIV infected perpetrator (***Red Book*** 2003)
- Almost all new infections in preadolescents are perinatally acquired (***Red Book*** 2003)

2. Diagnostic considerations

- Adults and children develop serum antibody to HIV by 6 to 12 weeks after infection
- Transmitted via blood or bodily fluids
- Because of blood safety, transfusion has been a rare source of HIV transmission in the U.S.
- Four current modes of transmission have been identified in the U.S.:
  - ✓ Sexual contact (vaginal, anal, oral)
  - ✓ Percutaneous (via needles or sharp objects) or mucous membrane exposure to contaminated blood or body fluids
  - ✓ Mother to infant before or around the time of birth
  - ✓ Breastfeeding

  (United States' Blood Safety measures have made HIV transmission by transfusion rare.)
- Highest rates of HIV acquisition during sexual abuse occur:
  - ✓ With repeated abuse
  - ✓ When the abuse involves vaginal or rectal penetration
  - ✓ When the perpetrator is homosexual, bisexual, uses intravenous drugs, or has multiple sexual partners
  - ✓ When there are multiple perpetrators
- If not perinatally or transfusion-acquired, HIV infection in children is diagnostic of sexual abuse (AAP 2004)

3. Testing considerations

- Specific tests are available to test infants born to HIV infected mothers
- HIV serology may take several months after infection to become positive. Repeat serology may be needed
- Enzyme immunoassay is the standard initial test for serum HIV antibody. If positive, it should be confirmed, by a Western blot test and evaluated more extensively with NAAT
- Serologic tests should be performed at 3 and 6 months after exposure, with consideration of obtaining a baseline at the time of initial evaluation
- When a test is done within 2 weeks of exposure, a negative test provides information of prior HIV status
- Written informed consent for HIV serologic testing is required so that the patient has an opportunity to review the risk and benefits of testing and the consequences of HIV infection

4. Treatment

- Postexposure prophylaxis (PEP) can be considered within 72 hours of sexual assault if the child is at risk for HIV transmission based on:
  - ✓ specifics of the case,
  - ✓ risk of HIV in the perpetrator,
  - ✓ likelihood of compliance by the patient
  - ✓ the overall risk-benefit analysis

  Consultation with a pediatric HIV expert is suggested.
- Data are insufficient concerning the efficacy and safety of PEP for children
- HIV positive children should be referred to an infectious disease specialist

HUMAN PAPILLOMA VIRUS (HPV)

1. Incidence

Ingram and colleagues' (1992) study of 1538 children referred for evaluation for possible sexual abuse placed the incidence of condyloma acuminata (genital HPV lesions) at 1.8%.

2. Typical presentation

- Over 100 viral subtypes of HPV exist; 30 types infect the genital tract
- Visible genital condyloma are usually caused by types 6 and 11
- Types 6 and 11 are rarely carcinogenic. They have been associated with conjunctiva, nasal, oral and laryngeal warts
- Types 16, 18, 31, 33 and 35 rarely produce visible lesions but are significantly more carcinogenic
- There is tremendous variability in appearance of the lesions

3. Diagnostic considerations

- Perinatal HPV infection is extremely rare in infants of infected mothers (Watt et al. 1998) and the risk of the children developing clinical warts is even more rare (Puranen et al. 1996; APSAC 2002)
- Most cases of genital and anal warts in children are caused by HPV types which are sexually transmitted rather than by non-genital skin warts (APSAC 2002)
- 2 studies have compared genital specimens from abused and non-abused females and found the HPV virus only in the abused girls (APSAC 2002). While others (Myhre 2003) report similar rates of HPV between abused and nonabused 5-6 year old children
- In every case occurring outside the neonatal period, sexual abuse should be considered as a possible etiology
- Questions remain regarding the epidemiology of HPV in children

4. Testing considerations

- Incubation periods may be long (typically 2-3 months but may be 3 years or longer in some cases)
- Cytology evaluation by Papanicolaou smears can be used. Due to the high false negative rate, alternative methods of collection and preparation that use liquid-based technology can be considered. Two such tests, Thin Prep and Sure Path, are approved only for cervical samples in adolescents and adults
- Biopsy can confirm diagnosis but may be too traumatic for the child
- HPV infection is measured most sensitively by DNA-based testing, which can also provide type-specific information useful for follow-up. These tests are approved for cervical samples

5. Treatment

- If left untreated, visible genital warts may resolve, remain unchanged, and/or increase in size and number
- Treatment goal of visible *symptomatic* genital warts is the removal of the symptomatic warts
- Existing data indicate that currently available therapy for genital warts may reduce, but probably not eradicate, infectivity (CDC 2002)
- No evidence indicates that either the presence of visible genital warts or their treatment is associated with increased likelihood of the development of cervical cancer (CDC 2002). Therefore, one option is to forego treatment and await spontaneous resolution
- No definitive evidence suggests that any of the available treatment options are superior to the others (CDC 2002)
- Treatment options include application of podofilox, imiquimod cream, podophyllum, trichloroacetic acid, or bichloroacetic acid. Cryotherapy, surgical removal, laser surgery or intralesion interferon are also treatment options
- Consider referral for long-term follow-up to a pediatric gynecologist to facilitate detection of oncogenic change

HERPES SIMPLEX (HSV), TYPE 1 AND 2

1. Incidence

Genital herpes are seen primarily among sexually active adolescents and adults. In Ingram and colleagues' (1992) study of children 12 and under referred for evaluation for sexual abuse, the incidence rate was 0.1%.

2. Typical presentation

- Painful vesicular or ulcerative lesions
- Type 1 is more common orally, but may infect the genital area. Less likely to cause recurrent genital lesions
- Type 2 is more common genitally, but may infect the oral cavity. Most likely to cause recurrent genital herpes

3. Diagnostic considerations

- Incubation period outside the neonatal period is 2 days to 2 weeks (***Red Book*** 2003)
- After primary infection, HSV persists for life in a latent form
- Inoculation of skin occurs from direct contact with HSV-containing oral or genital secretions
- Type I can be transmitted sexually, perinatally, via fomites and via auto-inoculation
- Type II can be transmitted perinatally and sexually; fomite transmission is theoretically possible
- Asymptomatic and symptomatic individuals with primary or recurrent infection can transmit the disease
- Genital HSV 2 is considered suspicious for sexual abuse (***Red Book*** 2003), AAP (2004) classifies any HSV infection in the genital location as suspicious for sexual abuse. Similar consideration should be given to herpes infection in the anal area
- Genital HSV infection caused by HSV 1 can result from auto-inoculation from the mouth or sexual abuse. Consideration should be given to typing anogenital HSV isolates from children in order to differentiate between HSV 1 and HSV 2

4. Testing considerations

- Special transport media is available if specimen cannot immediately be inoculated directly into culture
- Sensitivity of the culture declines rapidly as lesions heal, usually within a few days of onset
- Best culture results are from freshly opened vesicles
- Subtyping is possible
- Positive cultures should be confirmed by fluorescent antibody staining or enzyme immunoassay
- Serology
    - ✓ Type-specific serology is currently not commonly used or available

5. Treatment

Acyclovir is the treatment of choice for children and adolescents with primary herpes. See Table 1 and the CDC treatment guidelines (2002) for more specific information regarding treatment and dosage.

TRICHOMONAS VAGINALIS (TV)

1. Incidence

There is very little information on the incidence of TV among prepubertal girls. The disorder is believed to be uncommon in prepubertal girls because the high pH and lack of glycogen in the vaginal environment of this population is not conducive to TV colonization. In Siegal (1995) study of 208 sexually abused children, 1.9% had TV and all were pubertal females.

2. Typical presentation

- Commonly asymptomatic
- In symptomatic pubertal females, symptoms include frothy vaginal discharge, mild vulvovaginal itching, dysuria and, rarely, lower abdominal pain
- Discharge is pale yellow to gray-green and musty smelling
- Vaginal mucosa is erythematous
- Cervix may be friable, inflamed and covered with petechiae

3. Diagnostic considerations

- TV is a flagellated protozoan
- Incubation period averages 1 week but ranges from 4 to 28 days
- May be transmitted perinatally or sexually
- Fomite transmission has not been documented
- Perinatal infections may persist up to 9 months if untreated and is seen in 5% of infants born to infected mothers (Thomas 2002)
- Is considered "highly suspicious" for sexual abuse (AAP 2004)

4. Testing considerations

- Commonly coexists with *Neisseria gonorrhoeae* and bacterial vaginosis
- Testing is recommended only with symptomatic children
- Cultures are more sensitive but are problematic because:
  - ✓ They are costly
  - ✓ The medium is difficult to maintain
- Cultures are positive in more than 80% of confirmed cases (***Red Book*** 2003)
- Vaginal wet mounts are commonly used but are problematic because:
  - ✓ High false negative rate (30-50%)
  - ✓ *T. vaginalis* must be distinguished from *T. hominis* by motility and size
- If wet mounts are used, the specimen should be transported to the lab in a small amount of physiologic saline
- Enzyme immunoassay and immunofluorescence techniques are available at some labs

5. Treatment

Metronidazole is the treatment of choice for children and adolescents. See Table 1, ***Red Book*** (2003) and the CDC treatment guidelines (2002) for more information regarding dosage and administration methods.

BACTERIAL VAGINOSIS (BV)

1. Incidence

BV is a syndrome primarily occurring in sexually active adolescents and adult females. In children, it can be acquired through sexual and nonsexual means (Finkel 2001). It is characterized by changes in vaginal flora. The incidence of BV is increased after sexual contact, but is also a common cause of nonsexually transmitted vaginitis in children and adolescents (Finkel 2002)

2. Typical presentation

- White homogenous, adherent vaginal discharge with a fishy odor
- Asymptomatic

3. Diagnostic considerations

- Because of the controversy over differential incidence rates, the significance of a positive diagnosis is unclear
- **Red Book** (2003) notes that BV in prepubertal girls should raise suspicion of sexual abuse
- Others report it should not be considered a significant marker for sexual abuse because asymptomatic colonization is common among nonabused children (Finkel 2001)
- The relationship of BV to sexual abuse is "inconclusive" (AAP 2004)

4. Testing considerations

- Incubation period is not known but estimated at 7-14 days
- Clinical diagnostic testing includes the presence of 3 of the following signs or symptoms*:
  - ✓ Homogenous, white, non-inflammatory vaginal discharge that smoothly coats the vaginal walls
  - ✓ "Clue cells" (squamous vaginal epithelial cells covered with bacteria which give a stippled appearance and ragged borders) noted on microscopic examination of discharge. Clue cells in BV usually constitute 20% of vaginal epithelial cells
  - ✓ Vaginal pH greater than 4.5
  - ✓ A fishy odor of vaginal discharge before or after adding 10% potassium hydroxide (i.e. "whiff" test)

  *The accuracy of these diagnostic criteria used for adults have not been clinically tested in children (Hammerschlag 1998)
- Gram stain of vaginal secretions is an alternative method of testing. Typically seen are numerous mixed gram-negative bacteria, including small curved bacilli and cocci, with few large gram-positive bacilli
- Culture for *Gardenerella vaginalis* is not recommended because the organism can be found in females without BV

5. Treatment

Treatment may not be necessary if the child is asymptomatic. However, the examiner should be mindful of the potential for Pelvic Inflammatory Disease in pubertal children with ascending infections. Symptomatic children could be treated with metronidazole or clindamycin cream. See Table 1 and the CDC treatment guidelines (2002) for more information regarding dosage and administration methods.

HEPATITIS B VIRUS (HBV)

1. Incidence

Studies have not determined the frequency with which HBV infection occurs following sexual abuse or rape (CDC 2002).

2. Typical presentation

- Children with HBV may present with a variety of signs and symptoms
- Asymptomatic seroconversion is common

3. Diagnostic considerations

- HBV is transmitted through blood or body fluids including wound exudates, semen, cervical secretions and saliva
- Blood and serum contain the highest concentration of virus; saliva contains the lowest
- Common modes of transmission include percutaneous and permucosal exposure to infected body fluid, sharing of needles/syringes, sexual contact and perinatal exposure to an infected mother
- Transmission by transfusion of contaminated blood is now rare in the U.S.

4. Testing considerations

- Incubation period averages 90 days and ranges from 45 to 160 days (***Red Book*** 2003)
- Serologic antigen and antibody tests are available to determine infection status
- Antibody tests can discriminate between those who have been infected, acute versus chronic status and those who have been immunized. See CDC (2002) for specific serologic markers in different stages of HBV infection
- Seroconversion tests are best done 3 months post-exposure to identify new infection

5. Treatment

- No specific treatment is available for persons with acute HBV infection outside of study settings; treatment is supportive
- Fully vaccinated victims sexual assault are protected from HBV
- For a victim who is not fully vaccinated, the vaccine series should be completed on schedule

- Unvaccinated victims and those whose vaccination series are not complete should be administered Hepatitis B vaccine
    - ✓ If the offender is known to have acute HBV, HBIG should also be administered

HEPATITIS C VIRUS (HCV)

1. Incidence

The role of sexual abuse in the transmission of HCV has not been well studied. Sexual transmission of HCV is assumed to occur. CDC (2002) reports that sexual transmission of HCV may account for up to 20% of HCV infections in adults, while others report that sexual transmission from HCV positive partners to heterosexual, monogamous, non-drug abusing HCV negative partners is very low. Seroprevalence for HCV is 0.2% in children under 12 and 0.4% in adolescents (***Red Book*** 2003). For most infected children and adolescents, no specific source of infection can be identified (***Red Book*** 2003).

2. Typical presentation

- Signs and symptoms of HCV infection are indistinguishable from those of HBV
- Acute disease tends to be mild and insidious in onset
- Most infections are asymptomatic
- Persistent infection with HCV occurs in 50% to 60% of infected children
- Most children with chronic infections are asymptomatic

3. Diagnostic considerations

- Modes of transmission include perinatal transmission and exposure to blood and body fluids contaminated with infected blood
- HCV is spread primarily by parenteral exposure to blood of HCV infected people
- Transmission by contaminated blood products is now rare in the United States

4. Testing considerations

- Incubation period averages 6-7 weeks with a range of 2 weeks to 6 months
- Serologic evaluation for anti-HCV and HCV RNA are available
- False negative test results can occur early in the infection
- Positive anti-HCV tests should be verified with either a recombinant immunoblot assay (RIBA) and/or a qualitative assay for HCV nucleic acid (qualitative HCV RNA PCR) to confirm HCV infection

5. Treatment

Children with HCV infection should be referred to a pediatric specialist

OTHER STDs

Many other sexually transmitted diseases exist but are rarely seen among children in the United States. These disorders will not be reviewed here, but the reader may consult the CDC guidelines (2002) or ***Red Book*** (2003) for more information.

Table 1. RECOMMENDED STD PROPHYLAXIS

	<45 kg (100#)	**>45 kg (100#)**
GC	Ceftriaxone 125mg IM **OR** Cefixime 8mg/kg po x 1	Ceftriaxone 125mg IM **OR** Cefixime 400mg po x 1
Chlamydia	Azithromycin (Zithromax®) 20mg/kg (max 1g) po x 1 dose **OR** Erythromycin 50mg/kg/d po ÷ QID x 10-14d	Azithromycin (Zithromax®) 1g po x 1 **OR** Doxycycline 100mg po BID x 7d
Trich/BV	Metronidazole (Flagyl®) 15mg/kg/d po ÷ TID x 7d	Metronidazole (Flagyl®) 2g po x 1

Table 2. IMPLICATIONS OF COMMONLY ENCOUNTERED SEXUALLY TRANSMITTED DISEASES (STDS) FOR THE DIAGNOSIS AND REPORTING OF SEXUAL ABUSE OF INFANTS AND PREPUBERTAL CHILDREN

Excerpted from American Academy of Pediatrics (2004; review in progress). Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review. American Academy of Pediatrics Committee on Child Abuse and Neglect.

STD Confirmed	Sexual Abuse	Suggested Action
Gonorrhea*	Diagnostic[1]	Report[2]
Syphilis*	Diagnostic	Report
HIV[3]	Diagnostic	Report
Chlamydia*	Diagnostic[1]	Report
Trichomonas vaginalis	Highly suspicious	Report
Condyloma acuminata* (anogenital warts)	Suspicious	Report
Herpes (genital location)**	Suspicious	Report[4]
Bacterial vaginosis	Inconclusive	Medical follow-up

* If not perinatally acquired.
[1] Use definitive diagnostic methods such as culture.
[2] To agency mandated in community to receive reports of suspected sexual abuse.
[3] If not perinatally or transfusion acquired.
[4] Unless there is a clear history of autoinoculation.

**Although not mentioned in this AAP table, similar consideration may be given for anal herpes.

DEBRIEFING AND FOLLOW-UP FOR THE PATIENT AND FAMILY

GUIDELINE

The medical professional will need to consider how to sensitively communicate examination findings and evaluation results to the patient and to her/his caretakers. The clinician should also discuss recommendations for the child, including those pertaining to physical and mental health treatment, as well social and family considerations. It is necessary for the healthcare practitioner to meet legal requirements for child abuse reporting.

DEBRIEFING WITH THE FAMILY

1. Debriefing with the child

At the end of the evaluation, many child abuse medical examiners choose to thank the child for cooperating with the process and reassure her that she did a good job of helping the professional find out about keeping the child healthy and safe. Children should not be praised based upon the content of information shared.

Clinicians are reminded to use simple, non-technical, age-tailored language when sharing evaluation results with the patient. With some school-age children and many adolescents, giving a brief summary of exam findings is advised. If the examination findings are normal, the child may be reassured to hear something like, "Your body looks completely normal, including your private parts. No one will be able to tell by looking at you that this has happened". When the physical findings are abnormal, the language used should be general but honest. For example, "When I look with my magnifying scope, I can see a small area where your body was hurt. It should heal quickly and in a little while, no one, maybe not even a doctor, is likely to be able to tell by looking that you were hurt."

The healthcare provider is encouraged to solicit and respond to any questions the child may have. It is encouraged that the examiner discuss treatment recommendations with the child or adolescent, as is appropriate for their age and understanding. Adolescents and older children may be offered the choice of being present when the medical professional discusses findings and recommendations with their caretakers.

2. Provide a summary of the child's exam findings and statements

In most cases, it is advisable to provide the caretaker with a verbal summary of the child's examination findings and statements the child made during the exam regarding possible abuse. Exception to this may be considered in situations in which the safety of a child or someone else would be compromised by the sharing of this information at the time of the evaluation. Also, when the caretaker present is not the child's legal guardian (e.g., foster parent, grandparent, family friend accompanying the child to the evaluation), permission should be obtained from the legal guardian before any information regarding the child's evaluation is divulged.

The level of detail provided should be gauged to the interest level and coping resources of the caretaker. For example, the parent who was upset about not being present during the examination might require more details than the parent who begins to shed tears as soon as she hears that the examination findings were abnormal or that the child disclosed abuse. Generally, a brief summary is optimal. The clinician should answer any questions about the medical evaluation that the family may pose, to the extent that she is able.

3. Reassurance can be very helpful to the family

Many laypersons make assumptions that make it difficult for them to cope with the news that their child was sexually abused. For example, some people assume that penetrating sexual abuse always leaves physical damage and that children are universally psychologically scarred by sexual abuse. It can be very helpful for the medical practitioner to provide one or more of the following types of reassurance to the family.

> Present an easily-understandable, realistic picture of the physical findings: e.g., the child's injury is microscopic, is likely to heal completely, would only be noticeable to a trained professional, if at all, or is likely to appear completely normal once the child has entered puberty.
>
> Tell them how they may reduce the child's emotional trauma: e.g., when children are supported, believed, receive treatment and are not re-abused, psychological outcomes for the child are generally good.
>
> Share your positive assessments: e.g., the child appears emotionally healthy and seems to be handling the situation well, the family's support of the child seems to be helping her to recover quickly, it is extremely unusual for children to experience permanent physical damage from child sexual abuse.

4. Coping with a non-believing or unsupportive caretaker

At times, the caretaker may be reluctant to believe the child or is very concerned that the child is lying. In this situation, the child and family will likely need a referral for mental health treatment. If the child makes clear disclosures and/or there is physical evidence, the examiner can assert that the exam and/or statements are diagnostic of abuse and encourage the caretaker to seek counseling to address the issues that are preventing acceptance of this information. In some situations, the evaluator will be called upon to refute the caretaker's assumption regarding what happened to the child. For example, a caretaker may need to be told that the child's injury is not likely to have been caused by falling on his/her bicycle or to be apprised of the significance of the child's clear, detailed statements regarding a particular individual.

When the parent is unbelieving or non-supportive, the examiner should request child protective services involvement, perhaps delaying dismissal of the patient from the medical facility until safety can be assured. The clinician is advised to document that the child is residing with a non-supportive, non-believing caretaker.

5. Coping with unclear evaluation results

Deciding how to respond when the evaluation is inconclusive can be difficult for parents and professionals alike. When the examiner and/or evaluation team are unable to determine if abuse has occurred, parents may feel confused and upset. The continued involvement of law enforcement or child protective services may provide some hope that additional clarity, and perhaps, protection for the child, may be gained. However, it is important for the clinician to recognize that, even if the system is unable to take action on the case, the caretaker will continue dealing with the issue and will likely pursue a resolution to the concern. The medical provider can play a critical role at this time, acknowledging the caretakers' frustration and encouraging them to support and protect the child, to avoid further questioning of the child and to remain neutral regarding whether or not the child was abused. It is often helpful to make a treatment referral for the child, explaining to the family that, over time, some unclear allegations are clarified in therapy. The healthcare professional may need to encourage parents to seek treatment for themselves as well, either in consultation with the child's therapist or through an independent provider.

FACILITATING PHYSICAL HEALTH FOLLOW-UP

1. Return for follow-up with the evaluating medical practitioner

A patient may require a repeat examination for conditions identified during the sexual abuse evaluation (e.g., to complete a portion of the evaluation that was not accomplished, to re-evaluate a finding, monitor healing or test for cure of an infection, etc.). The clinician who conducted the initial evaluation is the recommended choice for performing the follow-up exam. However, if such an arrangement is not possible, or if the family has a strong preference to consult another provider, it is strongly advised that the initial examiner communicate with the individual who will be offering follow-up care.

2. Consult with the primary care provider, if possible

Ideally, whenever the child has a designated primary care provider, a release is obtained at the time of the sexual abuse evaluation so that the primary care provider may be made aware of the suspected abuse. Such communication is particularly important when the examination is abnormal or when sexually transmitted diseases are diagnosed. The child abuse medical examiner can discuss with the primary care provider any need for medications or other treatment, follow-up testing or examinations.

3. Helping the family monitor the child's physical health needs

Particularly in cases of alleged penetration or when the child has an abnormal exam, the medical professional may want to provide the family with a list of signs or symptoms that should prompt them to schedule a follow-up visit: for example, if the child begins to have odd-colored or malodorous discharge or pain, itching or bleeding from the anogenital area. Caretakers who have been hyper-vigilant

regarding the child's anogenital area may need to be told not to try to examine the child themselves and only to bring the child in if he is displaying symptoms or making new abuse disclosures.

4. Clarifying expectations for follow up

The healthcare practitioner should be clear about his/her recommendations and expectations for follow-up. It may be helpful to put these into writing for the child's caretakers. (See sample form included at the end of this chapter.)

Some examples of instructions given to families might include:

(a) the family will give the child nightly sitz baths until the pain subsides;
(b) the mother will ensure that the child takes the prescribed medication;
(c) the primary care provider will be responsible for medical follow-up;
(d) the medical professional who evaluated the child for abuse will conduct follow-up tests for sexually transmitted diseases in two weeks.

FACILITATING MENTAL HEALTH FOLLOW UP

1. Awareness of community mental health resources is helpful

It is helpful for the medical professional or a staff member to be knowledgeable regarding mental health resources in the community. Collaborating with child interview specialists to determine appropriate referrals is recommended, as they are frequently familiar with providers who are skilled at working with children who may have experienced abuse. Some practitioners provide a list of resources to families to assist them in accessing needed services. The types of resources that may be needed following an evaluation for suspected abuse include counseling, psychological evaluation, developmental evaluation, speech and language evaluation, and management of divorce and custody issues.

2. Document whom is responsible for ensuring follow-up

The healthcare practitioner should communicate clearly with the family and note in the medical record who will be responsible for arranging treatment for the child. Documentation should clarify that the family has been given a referral list, or if a caseworker or a member of the center's or medical provider's staff will be will be assisting the family in locating appropriate treatment.

LEGAL FOLLOW UP

1. Healthcare providers are mandated reporters of child abuse

Physicians, including interns and residents, and other medical providers, including nurses, are mandated by Oregon statute (2003 version, ORS 419B.005 to 419B.050) to report suspected child abuse. The language of the statute indicates a duty to report when there is "reasonable cause" to suspect abuse.

Therefore, the medical practitioner conducting a child sexual abuse evaluation should report whenever there is suspicion of abuse. It is not required that the provider be certain that abuse has occurred, nor is there a requirement to produce evidence of abuse. The clinician is immune from civil and criminal liability when the report is made "acting in good faith and upon reasonable grounds". However, healthcare practitioners may be criminally prosecuted and fined, as well as sanctioned by their licensing boards, for failing to comply with reporting requirements. (When the child has been referred for a medical evaluation for sexual abuse by law enforcement or child protective services, it is usually not necessary for the clinician to report the abuse concern for which the child has been referred. However, if information is gained during the evaluation regarding possible new or different abuse circumstances, the medical provider should make a separate report, as outlined below.)

2. Reporting new suspicions of abuse

When a new concern of abuse (not previously reported) arises in the course of an examination (e.g., a new perpetrator's name is disclosed, prior unreported abuse is divulged), the medical evaluator must make a report of child abuse. The provider or staff should notify either the county DHS child abuse hotline and/or law enforcement. Every county in Oregon has a child abuse hotline in operation from 8 AM to 5 PM, Monday through Friday; some also have after-hours coverage. Medical evaluators of child sexual abuse should maintain a list of LEA and child protective services phone numbers for easy reference when the need to report arises.

It is important to note that even when the law enforcement investigator or child protective services worker on a case is in attendance at the time that the child discloses during her/his medical evaluation, the requirement for the examiner to make a formal report of abuse still applies. After discussing with LEA or DHS individuals present, the clinician should understand whether it is still necessary for him to phone in the report, or if those agency representatives will handle the report. Because of the potential legal and professional implications of failing to report, when in doubt, the medical provider is advised to make the report.

3. Content of the report

If available, the following pieces of information are useful to include when reporting suspicions of abuse:

- The child's name, date of birth, and address
- The name and address(es) of the child's parents or legal guardians
- The nature and extent of the abuse (e.g. a brief description of the incident or concern or symptoms suspicious for abuse)
- The alleged perpetrator's name or any information which may be helpful in establishing the identity of the alleged perpetrator
- Information regarding the alleged perpetrator's access to other children
- The county and/or city in which the alleged abuse occurred
- Information regarding previous abuse to the child

4. When the child's parent or legal guardian is the suspected abuser

The child may be examined without the parent/legal guardian's permission, if there is reasonable cause to believe that the child has been abused. This is done by court order, generally with law enforcement's cooperation. Some children will refuse the exam and, unless there is concern regarding medical danger, the child should not be compelled to cooperate. However, with encouragement and support, most children are able to complete the evaluation. If the child persists in refusing, the examiner should document the refusal and the reasons given.

The medical evaluator is discouraged from advising the caretaker or legal guardian of the child that they are suspected to be responsible for the abuse unless the clinician has the support of child protective services or law enforcement to do so. It is especially important for child protective services or law enforcement to be involved so that steps can be taken to avoid permitting a child to return home with or to a suspected abuser. Child protective services and/or law enforcement will be responsible for deciding on a placement option that will ensure the child's safety.

KIDS CENTER
1375 NW Kingston Ave.
Bend, Oregon 97701
Phone: (541) 383-5958
Fax: (541) 383-3016

KIDS CENTER
INSTRUCTION SHEET
PHONE: 383-5958

Date:_____

Your child,_____has been evaluated at the KIDS Center.
(Name of Client)

Your child was seen by:_____and/or_____.
(Examiner) (Interviewer)

We recommend the following:

- ❑ Therapy with a therapist experienced in treating children who may have been abused
  - ❑ Check with your insurance company for benefits and any preferred providers
  - ❑ Therapy resource list given (on back of this form)
  - ❑ Referral made to KIDS Center Therapy component
- ❑ Therapy for other family members
- ❑ An appointment for dental care: Please make an appointment with a dentist in the next_____weeks/months
- ❑ A medical appointment for:
  - ❑ Immunizations with a private medical provider or clinic
  - ❑ Medical condition(s)_____
  - ❑ Follow-up of_____
  - ❑ Other_____
- ❑ Hearing evaluation ❑ Vision evaluation ❑ Speech evaluation
- ❑ Educational evaluation ❑ Developmental evaluation ❑ Psychological evaluation
- ❑ Medications:_____
- ❑ Laboratory test: done:_____
  (Results will be called to you with in 2 weeks)
- ❑ Have blood drawn for other sexually transmitted diseases(These labs should be repeated at 3 months and 6 months)
- ❑ Re-examination at the KIDS Center on: Date:_____Day:_____ Time:_____a.m./p.m.
- ❑ Contact Law Enforcement Agency and/or Department of Human Services, Child Welfare regarding further recommendations for your child.
- ❑ Other recommendations:_____

  _____
- ❑ We suggest _____ have no contact with_____ until investigation is completed or until the child's counselor deems it's appropriate.
- ❑ We suggest _____ have _____ contact with other children (this includes overnights and babysitting) until investigation is completed or until the child's counselor deems it's appropriate.

KIDSCenter/3-31-04/mspub/jmn

MAKING THE DIAGNOSIS IN CASES OF SUSPECTED SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

GUIDELINE

Perhaps the most critical and challenging step in the medical evaluation process is making the diagnosis of abuse. The practitioner interprets the history, the child's statements, physical and laboratory findings to formulate medical conclusions. Tools to assist the medical provider in making those interpretations are available. Benefiting from the experience of experts in the forensic interviewing of children, clinicians evaluating abuse cases may apply criteria which help determine whether a child's statements are compelling for abuse. Diagnostic classification systems have been created to assist the examiner in ascertaining the significance of various anogenital findings. By considering alternative hypotheses to explain the child's behaviors or statements and by ruling out conditions which mimic findings related to sexual abuse trauma, medical evaluators may confidently arrive at their diagnoses.

Diagnostic classification systems such as those that exist for a number of medical conditions have also been created to address the diagnosis of sexual abuse. These systems can be used to assist the examiner in determining the significance of various anogenital findings. The Classification Guide for the Medical Diagnosis of Child Sexual Abuse included at the end of this chapter provides a working model of how the clinician may analyze physical findings alone and in combination with case history and statements made by the child in order to arrive at a diagnosis

GENERAL CONSIDERATIONS

The practitioner relies upon evaluation findings to formulate medical diagnoses or conclusions. The healthcare professional is likely to come to several conclusions as she/he processes the information gained during the medical encounter. Each identified health and safety need of the child or adolescent should be addressed. Making the diagnosis of sexual abuse requires special attention.

As with other medical conditions, clinicians considering a diagnosis of sexual abuse must also consider alternative hypotheses, i.e., the differential diagnosis. Medical conditions which may mimic physical findings associated with sexual abuse trauma must be ruled out. Likewise, consideration of other explanations for the child's behaviors or statements (e.g., non-sexual contact, incidental exposure to sexual materials, confusion with different or past perpetrator, third party "coaching", etc.) is essential.

ANALYZING THE CONTRIBUTION OF STATEMENTS, BEHAVIORS AND CASE DETAILS

When physical findings and lab tests are non-contributory, as is often the case in child sexual abuse cases, medical diagnosticians draw conclusions based upon their analysis of reported history, patient statements and the observations they make during the evaluation. Medical diagnoses, in general, are based on the premise that the patient information provided is correct. However, in child abuse cases, perhaps more so than in most other clinical situations, the veracity of patient history and statements regularly comes into question. Although medical practitioners can never be certain that a patient is sharing accurate information, the consideration of several factors can prove very useful when ascertaining whether a child's history or statements are compelling for abuse.

Summary of Criteria to Consider When Analyzing Disclosures of Sexual Abuse by Children and Adolescents

- Circumstances of the disclosure
  - Was disclosure spontaneous or in response to questioning by an adult?
  - What was going on at the time of disclosure?
- Reaction of significant others to child's disclosure
  - Was child believed? Supported? Criticized? Blamed? Suppressed?
- Emotional state of child at time of disclosure and when discussing the abuse
- "Child's-eye view"
- Consistency of core details
- Idiosyncratic or rich details
- Use of nonverbal means (gestures, drawings, figures) to describe abusive incidents
- Description of sexual matters advanced for developmental age
- Reported abuser's use of threats, bribes, or coercion
  - Grooming behavior?

Adapted from Kuehnle K. *Assessing Allegations of Child Sexual Abuse*. Sarasota, Fla: Professional Resource Press; 1996.

The circumstances under which a child discloses abuse to others can shed important light on the validity of the statements made. Disclosures made spontaneously, rather than in response to questioning by an adult, are considered more likely to be concerning for abuse. Understanding what was going on at the time the child revealed information about the abuse can also be contributory. Children may wait until an abusive individual moves away from the family before they feel safe to divulge. Some children decide to tell about their own abuse after they view a television program or attend an abuse prevention presentation at school. Teens may disclose when a friend reveals that she/he is also being abused.

The reaction of significant individuals in a child's life to her/his disclosure of abuse can influence whether the child reports the full extent of the abuse, minimizes the events or even recants or denies the disclosure. Children whose primary caretaker, usually their mother, responds to their disclosures of abuse by believing them and taking steps to protect them from further abuse are likely to tell more of what occurred. (Incidentally, these children are also those who tend to recover more quickly and fully from those abuse experiences.) When disclosing children are met with disbelief, anger, blame, punishment or with a collapse in the family system for which they may feel or be made to feel responsible, they are prone to retract their statements and refrain from discussing the abuse.

Children who have been threatened, bribed, or coerced may be reluctant to volunteer information, may deny, when questioned, or may recant their statements about abuse. It is helpful for the clinician to consider that threats or promises which seem improbable (e.g., "Your mother will send you to jail") or those which would be deemed trivial to adults (e.g.,"I'll take away all your Barbie dolls") may strongly impact whether or not children tell about abuse.

It has been observed that children who can provide rich or idiosyncratic details about their abuse experiences are more likely to be recounting actual events. In contrast, the statements of children who are coached to make false claims of abuse often lack depth and detail. Core details, i.e., main themes, of an abuse event tend to remain consistent over time when told by individuals who have experienced the abuse. Although children may not share precisely the same information each time they discuss what happened to them, it is generally the peripheral, more minor details that vary in accounts of actual abuse. Elements of the incident that come to mind during a particular conversation about the abuse may not be repeated at a different telling, but this does not imply that the child is lying. Providing more or less information is very different from making contradicting statements.

Medical evaluators in child sexual abuse cases should ascertain whether the child's choice of terminology, when describing abuse, matches the language style and perspective she/he employs when discussing unrelated events. Disclosures given from the "child's eye view" may contribute to the clinician's determination that abuse did occur. Another developmentally based consideration comes into play when a child's knowledge of sexual matters appears to be advanced for his age. Although it is

sometimes difficult, in our current age of media immersion, to isolate the various influences from which children gain information, graphic descriptions or displays of adult sexual behavior are red flags for sexual abuse, or, at least, inappropriate exposure to sexual materials.

Statements regarding abuse are thought to be supported when a child uses more than one way to convey information about what happened to him/her. Noting that a patient makes use of nonverbal gestures and body language to describe the abuse, points to places on a drawing or on her/his own body to identify areas involved in an abuse incident, creates a drawing or uses figures to demonstrate what occurred, the evaluating clinician's concern about abuse may be appropriately amplified. Although open for wide variances in interpretation, a child's demeanor and emotional responses may also enhance the medical provider's determination of the likelihood of abuse. Changes in affect observed in relation to different topics addressed or to distinct aspects of the physical examination process should be noted. Acknowledging that children may not respond in traditionally anticipated ways to any given experience, the healthcare professional is advised to observe whether the child's affect or display of emotion falls within a range which may be considered congruent with the matter being discussed.

Clinicians may find it useful to refer to the "Forensic Evaluation Critical Analysis Guide" (included at end of this chapter). This tool is adapted from a guide which was developed by the National Children's Advocacy Center for use in Forensic Evaluation™ Training of mental health professionals who conduct extended forensic evaluations of suspected child sexual abuse victims. The modified Guide lists many factors which may contribute to a medical provider's determination as to whether the history in a given case supports the diagnosis of abuse. In addition to salient aspects of the child's disclosure which were mentioned in the paragraphs above, the Critical Analysis Guide also addresses evaluator factors (i.e., ways to decrease any potential coercive elements in the child's evaluation) and motivational factors which may affect what a child shares. The Critical Analysis Guide reminds clinicians to consider alternative hypotheses for the abuse and to include, to the degree appropriate when making a medical diagnosis, contributory factors gained from other professionals who have information about the case.

CLASSIFICATION GUIDE FOR THE MEDICAL DIAGNOSIS OF CHILD SEXUAL ABUSE

The classification of physical and laboratory findings indicative of child sexual abuse began in 1985 when participants at the National Child Sexual Abuse Summit Meeting arrived at a consensus about "physical findings strongly indicative of sexual abuse beyond a reasonable doubt." Considerable medical research has examined both physical and laboratory findings in an effort to determine their relevance in making the diagnosis of sexual abuse. Over the past twenty years, a number of classification systems have been developed, revised, and refined.

When supported by current medical literature and accepted medical practices, classification systems serve as a useful and reliable tool to help clinicians organize a variety of physical and laboratory findings into diagnostic categories. As with classification systems and practice guidelines applied in other areas of medicine (e.g., diagnosis and treatment of otitis media, sinusitis, hypertension, etc.), the development of classification systems in the field of sexual abuse may be viewed as a way of consolidating current data and research in the area into a user-friendly reference for practitioners.

It is extremely important to stress that a classification system is intended to be utilized as a guideline, and **not** as a protocol. There may be considerable case-to-case variation in findings observed on examination; it is anticipated that not all will "fit" perfectly into the given categories. The **Classification Guide for the Medical Diagnosis of Child Sexual Abuse**, included in this section, is offered as just that—a guide, and not a "gold standard." The **Guide** presents a continuum of concern for abuse, reflecting the degree to which information and findings support the diagnosis. It is also not meant to over-simplify the complexity of the evaluation for child sexual abuse. It was created to provide an easily-accessible, practical reference guide for healthcare professionals who are making diagnostic decisions about children in whom sexual abuse is suspected.

A similar guide was presented in the 1999 ***Oregon Medical Guidelines***. Using that as a foundation, certain elements of the classification scale developed by Dr. Joyce Adams' (Child Maltreatment, 2001) and the Guide to the Medical Diagnosis of Child Sexual Abuse, as used at CARES NW, were incorporated.

The first page of the **Classification Guide** outlines laboratory and anogenital physical findings. The second page helps the provider to critically assess the medical and laboratory findings, in combination with the case history and statements made by the child, in order to reach a medical diagnosis.

It should be noted that information contained in this **Classification Guide** is subject to change over time, as knowledge in the field continually evolves and is updated. Clinicians who conduct medical evaluations for sexual abuse in children and adolescents are encouraged to watch the medical literature for new developments that may affect diagnostic considerations.

DOCUMENTATION OF FEATURES WHICH CONTRIBUTED TO THE DIAGNOSIS

Medical professionals involved in child and adolescent sexual abuse cases are referred to the chapter on "**Documentation of the Medical Evaluation"** in these ***Guidelines*** for a more comprehensive approach to the task of recording the evaluation process and outcome. However, it seems appropriate, here, to encourage providers to include in their documentation, those factors that contributed to their medical opinion. Mentioning the features of the child's disclosure or statements that were compelling for abuse fortifies

the diagnosis and serves to educate or to remind involved agencies about the idiosyncrasies of children's disclosures.

The **Classification Guide for the Medical Diagnosis of Child Sexual Abuse** may be referenced to help pin down the degree of certainty with which it may be determined that the physical findings are related to abuse. Ultimately, the clinician can view Part II of the **Classification Guide** as a way to help put the whole puzzle together. By taking into account history, medical interview results, physical and laboratory findings in each case of suspected abuse, the medical provider can confidently proceed to render the diagnosis. Ways to effectively state the medical conclusion are described in section 8 of the "**Documentation of the Medical Evaluation"** chapter.

Forensic Evaluation Critical Analysis Guide

This guide is based on the "Forensic Evaluation Critical Analysis Guide" developed by the National Children's Advocacy Center for use in Forensic Evaluation™ Training of mental health professionals who conduct **extended forensic evaluations** of children in cases of suspected sexual abuse. This guide has been modified from the NCAC's version for consideration by healthcare professionals who conduct medical evaluations of children and adolescents who are suspected to have been sexually abused.

Precautionary Note (from the NCAC Forensic Evaluation Critical Analysis Guide): *This guide is not an empirically normed scale. It is a desk guide, designed to assist the evaluator in analyzing the results of a forensic evaluation. It is intended to be used as a tool in the process of decision making regarding the obtained information. The presence or absence of any given element does not validate or invalidate allegations, rather, the elements are provided as a framework for the analysis of the evaluation outcome.*

Disclosure Factors:

- Child made a verbal disclosure of abuse
- Child provided a demonstration of abuse
- Child provided a description of abuse to someone else
- Child provided the majority of details in first person perspective
- Disclosure was somewhat unstructured without a rote quality
- Child's affect was within a range considered congruent with the disclosure

Attempts were made to decrease potential coercive elements:

- Evaluator clearly communicated to the child that the evaluator lacks knowledge about the child's experience
- Evaluator communicated ground rule to tell the truth, talk about things that really happened and child indicated comprehension
- Child demonstrated freedom to correct interviewer
- Child demonstrated freedom to say, "I don't remember"
- Child demonstrated ability to refrain from guessing
- Child demonstrated ability to disagree with the evaluator

Disclosure is consistent with developmental level:

- Details of time are developmentally appropriate
- Details of location are developmentally appropriate
- Details of acts described are developmentally appropriate
- Identification of alleged offender is developmentally appropriate
- Sexual knowledge and/or terminology is beyond the typical developmental level for age
- General terminology describing alleged offense is consistent with child's typical language

Specific details recounted (taking into consideration child's developmental capabilities):

Alleged offender clearly identified
Identified general timeframe / date / time of day abuse occurred
Identified where offense(s) took place
Provided sensory details
Provided unique or idiosyncratic details
Provided contextual details (decorations, pieces of furniture)
Described props (e.g., lotions, porn, photography, or gadgets)
Identified grooming behavior
Described maintenance of secret or offender's use of force, threats, coercion
Described specifics of own clothing
Described specifics of alleged offender's clothing
Pattern of abuse is plausible
Core factors are identified consistently
Child provided quotes of statements made by self or alleged offender
Child described own or alleged offender's emotional state during alleged offense
Child attempted to justify alleged offender's actions

Corroborative Information/Confirmatory Factors:

Physical findings indicate possibility abuse occurred
Law enforcement has crime scene evidence
Alleged offender confessed
Witness corroboration has been obtained
Other victims of alleged perpetrator have disclosed
Alleged offender has previously been investigated by law enforcement/CPS
Alleged offender has previously been convicted of child abuse

Motivational Factors:

Likelihood of possible secondary gain low
Likelihood of coaching by caregiver low
Child's explanation of present disclosure has been explored

Alternative Explanations:

Evaluator ruled out possibility of specific psychiatric disorder which impairs perceptions of reality
Evaluator ruled out possibility that benign activity (e.g., bathing) was misinterpreted
Evaluator ruled out likelihood of third party influence
Evaluator ruled out likelihood of other explanatory dysfunction in child's life
Evaluator found adequate explanations for any unusual or improbable elements

CLASSIFICATION GUIDE FOR THE MEDICAL DIAGNOSIS OF CHILD SEXUAL ABUSE

Regional Training and Consultation Center
at CARES NW
(6/21/04)

PART I: Physical and Laboratory Findings

	NORMAL/NORMAL VARIANTS/ NON-SPECIFIC FINDINGS	PHYSICAL/LAB FINDINGS WHICH ARE CONCERNING FOR ABUSE	CLEAR EVIDENCE OF ABUSE OR PENETRATING TRAUMA*
Genital (general)	• genital bleeding or discharge (source unclear) • labial adhesion • genital erythema/↑ vascularity • periurethral bands • dilated urethral opening • circumcision scar/pigmentation • median raphe	• acute abrasions/lacerations/bruising of labia, perihymenal tissues, posterior fourchette, perineum, penis or scrotum • scar—post-fourchette or posterior fossa • bite mark, bruise, "hickey" on inner thighs near genitalia	
Hymen/ vagina	• anterior hymenal cleft/notch • hymenal tag/mound • narrowed posterior hymen (1-2mm) • "wide" hymenal opening • shallow hymenal notch/irregular posterior hymenal edge • thickened hymenal edge • hymenal septum/septal remnants • intravaginal ridge/column • ↑ vascularity	• notch in posterior hymen extending <u>nearly</u> to vaginal floor -- <1-2mm notch, but not completely to the base -- confirmed in prone knee chest position	• acute hymenal injury (abrasion/ laceration/bruising) • vaginal laceration • healed posterior [3→9 o'clock] transection (complete cleft) or absence of posterior hymenal tissue -- extending to base of hymen -- confirmed in prone knee chest position
Anal	• midline perianal tag • anal erythema • ↑ perianal skin pigmentation • anal dilation <20mm +/- stool present • anal fissures • flattened anal folds • anal venous congestion/venous pooling • anal bleeding (source unclear) • diastasis ani	• perianal scar • perianal skin tag <u>not</u> at 12 or 6 o'clock • acute abrasions/lacerations/bruising of perianal skin • dilation <u>≥</u> 20mm OR markedly irregular anal orifice [with **no** stool in rectal vault, **no** bowel movement past 30 minutes, **no** history of chronic constipation/encopresis, **no** sedation or neuro deficits]	• perianal laceration deep to the external anal sphincter
Sexually Transmitted Diseases/ Labs**	• molluscum contagiosum • bacterial vaginosis	• HSV I and HSV II anogenital lesions • anogenital HPV (Condyloma acuminata) • trichomoniasis (*Trichomonas vaginalis*)	• gonorrhea (*Neisseria gonorrhoeae*) • chlamydia (*Chlamydia trachomatis*) • syphilis (*Treponema pallidum*) • HIV • positive pregnancy test • positive sperm or seminal fluid in/on child's body

**Given no clear, timely, plausible history of accidental injury or of perinatal or other non-sexual transmission of infection.*

***For STD's—please refer to the STD chapter for guidelines on "ruling out" other modes of transmission and testing recommendations.*

CLASSIFICATION GUIDE FOR THE MEDICAL DIAGNOSIS OF CHILD SEXUAL ABUSE

Regional Training and Consultation Center
at CARES NW
(6/21/04)

PART II: Diagnostic Classification—Medical Diagnosis

No indication of sexual abuse

- normal or nonspecific physical and laboratory findings AND
  - --child without disclosure of abuse
  - --child with no or nonspecific behavioral changes
  - --another known or likely explanation for nonspecific physical findings

- anogenital findings which are accounted for by accidental injury, the history of which is clear and consistent

Sexual abuse possible → highly likely

- normal or nonspecific physical and laboratory findings AND
  - --child without disclosure of abuse
  - --BUT child with sexualized behaviors or at high risk for sexual abuse

- normal or nonspecific physical and laboratory findings AND
  - --child makes disclosures of abuse
  - --BUT disclosure is not detailed, not consistent or is obtained using leading questions

- concerning physical or laboratory findings AND
  - --child without disclosure of abuse

- normal, nonspecific or concerning physical and laboratory findings AND
  - --child without disclosure of abuse
  - --BUT adult witnesses abuse OR individual confesses to sexually abusing child

Diagnostic of or conclusive for sexual abuse

- child has normal, nonspecific or concerning physical and laboratory findings AND
  - --child gives spontaneous, clear, consistent, detailed description of abuse
  - --alternative hypotheses evaluated and ruled out

- physical findings which are clear evidence of abuse or penetrating trauma AND
  - --child is without a history of accidental penetrating trauma

- laboratory findings which are diagnostic for abuse, other modes of transmission ruled out

- photographs/video showing child being sexually abused AND
  - --after law enforcement investigation, photos deemed unaltered

DOCUMENTATION OF THE MEDICAL EVALUATION

GUIDELINE:

Composing a clear and detailed medical report is an essential part of completing an evaluation for child sexual abuse. Medical documentation may follow the SOAP (Subjective, Objective, Assessment, Plan) format and should include history (medical and social history, as well as the history of the current concerns), statements the child makes during the evaluation, identification of the sources of statements and observations, list of those present during the child's evaluation, physical examination findings and laboratory results, diagnostic considerations, medical conclusions and recommendations.

The medical evaluation report should be as lengthy as needed to "stand alone" as a complete and accurate representation of what was learned and what was determined during the evaluation.

GENERAL CONSIDERATIONS

When considering **how much to include in the report**, the practitioner should record all that is necessary for appropriate medical care, as well as whatever may help her/him remember the case well enough to give competent testimony in court, perhaps months to several years in the future.

ELEMENTS TO INCLUDE IN MEDICAL DOCUMENTATION

1. History

Documentation of the history is important and should include the following components:

Chief complaint or reason for referral

This may be a few short sentences stating why the child was scheduled for the medical evaluation.

Medical and social history

The extent of the medical and social history documented will depend on the comprehensiveness of the particular medical evaluation. (See "**History**

Gathered from Caretakers of the Child or Adolescent" in these Guidelines.)

History of the current concerns

The medical report should document statements the child has made to others prior to the assessment, as well as the family's and investigative agencies' concerns of abuse. As stated above, it is critical to identify in the medical documentation the source of these various statements and concerns.

2. Statements the child makes during the evaluation

It is important to accurately document the patient's responses as well as the questions asked during the medical evaluation. This provides the context for the information that the child shares, as well as demonstrating that the examiner did not lead or unduly influence the child to make statements about the abuse. Direct quotations should be included in the medical report whenever possible.

3. Identification of the Sources of Statements and Observations

To avoid confusion which may ultimately compromise case outcome, it is crucial to clearly distinguish the sources from which information is obtained. Common sources include:

- Information directly shared by the patient during the evaluation
- Statements heard or observations made by the child's parent or caregiver, subsequently reported to the medical evaluator
- Information observed by another individual, reported to the caregiver (or to child protective services or law enforcement), subsequently shared with the clinician

4. List of Those Present during the Evaluation

Documentation should reflect who was present during different aspects of the medical evaluation. If the patient is evaluated, or, at least, interviewed without a parent or caretaker in the room (the recommended method), it should be documented as such, simply naming the professionals and any assistants present. However, should there be an exception to this preferred arrangement, the medical report should state who was present for which portions of the evaluation and delineate the reason(s) for the exception. When a caretaker accompanies a child during the evaluation, it may be beneficial for the examiner to document any instructions given to that individual (e.g. not to answer for the child; to sit out of the line of eye contact between child and examiner; etc.) and how much the caretaker interacted with the child during the evaluation process

5. Physical Examination Findings

It is the goal in Oregon that every child evaluated for suspected sexual abuse will undergo a complete physical examination. It is important for the medical practitioner to record observations of all areas that were examined, normal findings as well as abnormal. Failure to document a part of the exam essentially conveys that it was not done! Pertinent negatives should be mentioned. Documentation of a whole body exam contributes to establishing the examiner's neutrality and concern for the patient's overall well being.

When describing the physical examination, it may be helpful to develop an outline or template for documentation, so that critical information is consistently included. An example of a dictation outline is included at the end of this chapter.

With specific regard to the anogenital exam, the following should be documented:

- **Methods used**
  - Examination position (for both anal and genital exams)
  - Examination techniques (e.g. labial separation/traction, cotton swab exploration of hymenal edge, etc.)
  - Instruments used to increase visualization (light, magnification, colposcope)
  - Photos taken
  - Laboratory studies sent or ordered
  - Any examination procedures not routine
    - Changes in general evaluation process to accommodate individual patient
    - Techniques used for specific circumstances (e.g. Foley catheter to expose hymenal edge, toluidine blue dye, Wood's lamp, etc.)
- **Examination findings**
  - Adequacy of visualization accomplished
  - Identification/listing of all anogenital structures examined
  - Special emphasis on description of the hymen
  - Location and description of any unusual or abnormal physical findings
- **Observations of the patient**
  - Apparent comfort/discomfort with the exam
  - Willingness to communicate with the examiner
  - Demeanor and perceived emotional state, observed body language and behavior, particularly if these change at different times during the evaluation
    - Useful to document when such observations were noted, such as:
      - During a particular part of the examination
      - When a specific topic or individual was being discussed

6. Diagnostic Considerations: Summarizing the Assessment

The assessment and conclusion portion of the medical report is probably its most important component. In this section, the healthcare professional assimilates all the information gathered during the evaluation and applies her/his knowledge and experience to generate medical diagnoses. Recommendations for treatment and safety will stem from this diagnostic process. This is the section that readers who make safety and legal decisions in the case often turn to first.

Summarizing pertinent history, statements and disclosures, observations, physical findings and contributory laboratory results in this section will highlight those points and demonstrate the clinician's diagnostic considerations in arriving at medical conclusions.
In much the same way as the complete head-to-toe approach to questioning and examination addresses the health and medical needs of the whole child, considerations reflected in the assessment and conclusions will draw attention to the gamut of identified needs as well.

The medical provider may **summarize the following in the assessment and conclusion section of the report**:

- **Pertinent history**, which may encompass:
  - The presenting concern, including behaviors and disclosures of child prior to this evaluation
  - Previous history of abuse in this child
  - Other medical issues/disabilities
  - Access to / utilization of regular medical care
  - School issues, behavioral concerns
  - Physical discipline used in the home
  - History of DHS involvement with the family
  - History of domestic violence, chaotic lifestyle, residential instability
  - Parental history of abuse
  - Child's exposure to those with drug and alcohol use, criminal history
  - Exposure to weapons

- **Statements made by patient during this evaluation**

- **Relevant physical findings** noted during this evaluation

- **Results of significant laboratory studies**

In addition to outlining the contributory findings discovered during the evaluation, it is essential that the clinician's interpretation of those findings be stated. It is not adequate to list salient features of the case and expect that readers of the report will draw the appropriate conclusions.

Since, the evaluation report for patients in whom abuse is suspected is very likely to be read by parties who do not have medical knowledge, it is especially important for the examiner to explain the significance of evaluation findings.

7. Diagnostic considerations: Arriving at the medical diagnosis of sexual abuse

Of all the steps that must be taken in the process of evaluating children and adolescents for sexual abuse, arriving at the medical diagnosis is perhaps the most challenging. An entire chapter of these **Guidelines** has been dedicated to that task. Clinicians are invited to enhance their diagnostic acumen by reviewing the information and utilizing the tools presented in Chapter 15, "**Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Adolescents".**

8. Stating the medical conclusion

The medical conclusion should be stated as clearly and definitively as possible. It is helpful neither to overstate a conclusion beyond the level of medical certainty which can be supported by the facts of the case, nor to underplay the value of the diagnosis by using pat, canned, or otherwise ineffective or meaningless jargon. It may be helpful for the medical provider to categorize, in her/his conclusion, the likelihood that abuse occurred. Consider the following categories.

When…	**Some terms that may be useful**
• **Concern re: abuse is none or low**	• *"unlikely for sexual abuse "* • *"no indication of sexual abuse"* • *"does not establish sexual abuse"*
• **Moderate to high level of concern**	• *"possible for sexual abuse "* • *"probable sexual abuse"* • *"very concerning for sexual abuse"*
• **Abuse is certain**	• *"diagnostic of sexual abuse"* • **"***diagnostic of penetrating trauma"*

The medical conclusion should reflect the contributory components of the patient's history and statements, physical and laboratory findings. The provider's mention of those factors that contributed to the medical opinion communicates the broad perspective and objectivity of the healthcare provider and serves to educate the reader of the report. The clinician is encouraged to emphasize the features of the child's history and statements which contributed to the diagnosis (see helpful suggestions in Chapter 15, "**Making the Diagnosis in Cases of Suspected Sexual Abuse in Children and Adolescents"**). Consulting the **Classification Guide for the Medical Diagnosis of Child Sexual Abuse**, also in Chapter 15, the medical

practitioner can assign significance to the physical findings observed and arrive at an overall conclusion that incorporates all that was learned from the medical evaluation.

It can be challenging for medical providers to state their conclusion when there is no physical or laboratory evidence, but the history and/or medical interview yield significant concerns for abuse. It would minimize the value of the medical evaluation for the practitioner to merely state that there is "no evidence of abuse" or that the child's examination is "normal." It has been well documented that, in most cases of confirmed sexual abuse, including those with history of penetration, if performed outside the acute timeframe following the abuse, anogenital physical examination will not reveal any visible abnormalities.

It has become a pat conclusion for many examiners to state, "The child's normal physical findings neither confirm nor deny the possibility of abuse." However, it is stronger and far more informative for the medical evaluator to state that a patient's normal physical examination findings are consistent with and, in fact, are the expected findings for the history given. Opining that the abusive acts disclosed by the patient would not have caused any physical injury can be another compelling statement in cases with no physical evidence. The healthcare professional can also educate about the healing process, explaining that it is anticipated that any physical trauma incurred as the result of the reported abuse would have resolved by the time of the physical examination.

Some examples of more complete and informative medical conclusions:

- "The child made clear, detailed and consistent disclosures of sexual abuse by her father. The patient's normal physical examination is consistent with the given history of oral-genital contact."

- "Due to the time lapsed since the abuse occurred and the expected healing of the tissues, it is anticipated that no abnormalities of the genital area would be identified on physical examination. The patient's normal physical findings are consistent with her history of sexual abuse."

These may be followed with a summarizing conclusion, such as:

- "Based upon the history and physical examination findings in this case, the diagnosis is child sexual abuse."

- "The history and physical findings in this case are highly concerning for sexual abuse."

- Rarely: "This child's physical (or laboratory findings) are diagnostic for abuse."

If certain pertinent information is not available at the time of the evaluation, or if there are other reasons which cause the medical provider to be uncertain about the diagnosis, these points should be documented. It can be recommended that additional diagnostic consideration may be given if the missing information is made available to the clinician. If the medical evaluator has concerns due to risk factors identified during the medical evaluation, these should be elucidated in the report and recommendations made to address those concerns. On the other hand, if, after taking into account the history, interview, observations, physical examination, and laboratory findings, it is the medical evaluator's opinion that a diagnosis of abuse is not supported, his/her conclusion should reflect that determination.

9. Recommendations

When a comprehensive medical evaluation of suspected child sexual abuse is conducted, the healthcare professional may have many recommendations. For a shorter evaluation, the recommendation list may consist only of referrals. Treatment recommendations should be linked to information gathered during the course of the evaluation, as well as to the medical diagnoses made.

Recommendations based upon needs and issues identified during the medical evaluation may include:

- Medical and dental follow up
- Laboratory and radiology studies
- Mental health evaluation and therapy
  - For the child
  - For family / caretaker
- Safety and behavioral concerns, including:
  - Contact with the alleged offender
  - Safety of siblings and other children
- Divorce and custody issues
- Educational needs
- Other agency actions

  Obtaining additional information, e.g. further LEA investigation

  Continued involvement or support for child or family, e.g. by DHS
- Caretaker actions

  Examples include:

  Advising parents against further questioning of the child

  Recommending closer supervision or change of childcare arrangements

  Counseling about age-appropriate exposure to media, sexual matters

DICTATION OUTLINE

Demographic Information:

- Patient name, birth date, medical record number
- Date of Service
- Name/names of evaluator/evaluators

Type of Evaluation:

- Emergency examination, interview, exam/interview, examination with interviewer consult.
- Identify who has accompanied child to the assessment.
- Clarify who has provided history.
- Clarify what reports (LEA, DHS) have been reviewed and are part of the history (if not included in interviewer report)
- Identify any interpreters utilized

History of the Chief Complaint:

- State main reason for referral and assessment (comprehensiveness of this section varies, depending on whether co-assessor interviewer documents the details of the allegation. If only a summary of the chief complaint is given, refer reader to accompanying interviewer report for details of the allegation.)
- Clarify name of alleged offender if known

Medical History:

- Clarify how and from whom (parent interview, DHS information, review of records) medical history was gathered
- Pregnancy/birth history; include drug/ETOH exposure in utero
- Document primary care MD, dentist and approximate date of last visits
- Acute or recent medical concerns
- Allergies, medications and immunization status
- Significant medical history
- Family medical history
- Menstrual history (if applicable)
- Specific anogenital concerns
- Adolescent risk factors
- Document words used for private parts

Physical Examination:

- Describe introduction of assessment team to child/family…clarify how roles were explained to the child
- Clarify who was in the room during the examination and who was listening through audioconnection (if applicable)
- Document height, weight (and head circumference in infants) percentiles
- Vision and hearing screens (if available)
- General description of the child. Include brief description of clothing, hygiene, hair color, eye color
- Describe child's presentation (somber, disinterested, anxious)
- Describe child's development (language skills, motor skills, inter-personal affect, cognitive skills)
- HEENT; include dentition
- Cardio thoracic, lungs
- Breasts; document Tanner Stage in females

- ✓ Normal variant or non-specific findings
- ✓ Concerning for abuse/trauma
- ✓ Clear evidence of blunt force or penetrating trauma

- ♦ Statements made by child during examination and/or interview
- ♦ Diagnosis: Based upon the HISTORY, the PHYSICAL EXAMINATION and the STATEMENTS MADE BY THE CHILD…..
  - ✓ No indication of abuse/neglect
  - ✓ Unable to determine
  - ✓ Concerning for abuse/neglect
  - ✓ Highly concerning for abuse/neglect
  - ✓ Diagnostic or clear evidence of abuse/neglect
- ♦ Additional Diagnoses:
  - ✓ Drug and alcohol exposure
  - ✓ Domestic violence exposure
  - ✓ Exposure to persons with criminal involvement or activities
  - ✓ Mental health/mental illness
  - ✓ Developmental disabilities
  - ✓ School issues
  - ✓ Other medical/dental neglect
  - ✓ Sexualized behaviors

Treatment Recommendations:

- ♦ Contact and Visitation
  - ✓ No contact
  - ✓ Supervised or unsupervised contact
  - ✓ Contact determination pending further assessment
  - ✓ Deferral of recommendation due to lack of information
  - ✓ Unable to make recommendation
- ♦ Therapy and Evaluation
  - ✓ Child therapy; include suggestions for issues to be addressed in therapy
  - ✓ Family/caregiver therapy or supports
  - ✓ Psychological or mental health assessment
  - ✓ Discipline education
  - ✓ Parenting classes
  - ✓ Domestic violence counseling/support
  - ✓ Drug and alcohol evaluation/treatment
- ♦ Laboratory and Radiology
  - ✓ Tests done; plan for notification of results
  - ✓ Tests recommended to other health care provider
- ♦ Medical, Dental, Developmental and Educational Follow-up
  - ✓ Medications prescribed
  - ✓ Return to or establish primary health care provider
  - ✓ List acute or chronic medical/dental issues needing attention
  - ✓ List immunizations needed
  - ✓ Developmental assessment
  - ✓ Referral to Early Education or Head Start
  - ✓ Specific school issues
- ♦ Parental Conflict and Divorce/Custody Issues
  - ✓ Recommend custody evaluation
  - ✓ Clarify detrimental effect ongoing parental conflicts
- ♦ Personal Safety/Behavioral Concerns
  - ✓ Bathing, sleeping, toileting
  - ✓ Supervision around other children

- Abdomen
- Neuromuscular
- Extremities
- Skin; skin map or 35 mm camera to document lesions/bruises/birthmarks.
- Female Genitalia
    - ✓ Note positions used during examination (knee chest, supine frog leg)
    - ✓ Describe Tanner Stage
    - ✓ Describe external anatomy; clarify if normal. If not, describe abnormality, even if it is non-specific and unrelated to abuse
    - ✓ Describe posterior fossa and posterior fourchette
    - ✓ Describe the hymen (annular, crescentic, estrogenized)
    - ✓ Describe notches, mounds, intravaginal ridges, discharge, inflammation
    - ✓ Describe intravaginal findings, especially if speculum examination is done
    - ✓ Describe use of examination tools, including colposcope, speculum, OB swabs, Q-tips
- Male Genitalia
    - ✓ Circumcision status
    - ✓ Lesions of urethra, glans or shaft of penis
    - ✓ Presence of discharge
    - ✓ Testicular volume estimate (pre-pubertal vs pubertal)
    - ✓ Scrotum
- Anal
    - ✓ Note erythema, irritation, anal rugae, tags, fissures, dilation, discharge
- Lab/SAFE Kit
    - ✓ Document all tests or specimens obtained

Additional History from the Child:

- Describe in general terms the conversation and questions/answers during the examination.
- Include comments regarding the child's behavior during the examination
- Include important statements by the child. If using quotes, make sure the report reflects exactly what the child said.
- Clarify whether the child transitions to, or has already had, a videotaped interview

Debriefing:

- Clarify with whom and when debriefing after the assessment occurred

Diagnostic Findings:

- Recap the reasons for the referral and pertinent history available prior to the evaluation. Include behavioral symptoms, exposure to drug culture, domestic violence
- Comment on general physical findings and emotional/behavioral state; include pertinent negatives and positives
- For physical injuries or findings, including bruises, abrasions, scars, dental caries, etc.:
    - ✓ Non-specific or accidental
    - ✓ Clearly due to inflicted injury or neglect
    - ✓ Unable to determine
- Describe ano-genital findings in context of indications for abuse:
    - ✓ Normal

- ✓ Gun safety
- ✓ Babysitter/child care issues
- ✓ Exposure to violent or sexualized information/media

♦ DHS/LEA

- ✓ Specific recommendations to LEA
- ✓ Specific recommendations to DHS
- ✓ Other children possibly at risk for abuse

♦ Other

- ✓ Consider other issues

TRAINING FOR MEDICAL EVALUATORS OF ACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

GUIDELINE

Children and adolescents who are suspected to have been sexually abused deserve high quality medical evaluations – whether in the acute timeframe and settings, or under non-acute circumstances. It is acknowledged that many acute sexual abuse evaluations are conducted in an emergency department type of setting and that the healthcare practitioners who perform such examinations may not have extensive training or experience in the comprehensive evaluation of child sexual abuse.

However, it is reasonable to require that medical evaluators of acute sexual assault in children and adolescents have acquired each of the following:

- **basic training and clinical experience in pediatric and adolescent medicine**
- **basic training in child abuse examination and diagnostic considerations**
- **specialized training for acute sexual assault evaluation in children and adolescents**

As with medical providers who evaluate non-acute cases of child and adolescent sexual abuse, those who perform evaluations of acute cases should:

- **practice within the legal scope of their training and license,**
- **obtain appropriate consultation, AND**
- **make child abuse examination part of their continuing medical/nursing education.**

PLEASE NOTE*: Recommendations for prerequisite training and for ongoing education for those healthcare professionals intending to perform the medical evaluation in cases of non-acute sexual assault are included in these* ***Guidelines*** *in the chapter entitled,* **"TRAINING AND ONGOING EDUCATION FOR MEDICAL EVALUATORS OF NON-ACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS".** *Medical evaluators of acute child sexual abuse are encouraged to refer to that chapter for additional information about training, consultation and ongoing education relevant to evaluating sexual abuse in children and adolescents.*

DEFINITION OF ACUTE SEXUAL ASSAULT OF CHILDREN

Acute sexual assault of children may be defined as "acute anogenital injury or bleeding thought or believed to be secondary to sexual abuse, or sexual abuse that has occurred generally within the 72 hours preceding an examination, but may be up to 96 hours and

which necessitates documentation and may necessitate collection of forensic evidence" (Definition taken, in part, from American Academy of Pediatrics, Guidelines for the Evaluation of Sexual Abuse of Children, 1999.)

EDUCATIONAL BACKGROUND AND LICENSURE

The following types of medical providers may evaluate children and adolescents for acute sexual abuse:

1. Physician licensed in Oregon
2. Physician's Assistant working under the direction and supervision of an Oregon licensed physician who is an expert in evaluating children who may have been abused. The type of supervision for the PA must be detailed in the "practice description" which is submitted by the PA and supervising physician to the Board of Medical Examiners for approval.

3. Nurse Practitioners licensed in Oregon
   (*Please note: the particular license of a nurse practitioner dictates the population of patients which that practitioner may medically evaluate.)

   a) For Children and Adolescents (ages 0-18 years)
      - Pediatric Nurse Practitioner (PNP)
      - Family Nurse Practitioner (FNP)

   b) For Adolescents only
      - Adult Nurse Practitioner (ANP) may evaluate pubertal girls and boys
      - Women's Health Care Nurse Practitioner (WHCNP) may evaluate pubertal girls (not boys)

4. Sexual Assault Nurse Examiners licensed in Oregon
   Registered Nurses who expand their clinical competencies to include the forensic nursing evaluation of acutely sexually assaulted children and adolescents require specialized training, clinical preceptorship, and onsite supervision by a physician or nurse practitioner who has had training and experience and/or who has access to consultation with a physician or nurse practitioner who has had the training and experience in the examination of children and can make a diagnosis of sexual abuse.

   The Oregon State Board of Nursing recommends that the setting in which the Registered Nurse functions as a Sexual Assault Nurse Examiner have:
   - clear written policies and procedures regarding the practice of the Sexual Assault Nurse Examiner,
   - a process for ensuring continued competence and
   - a plan for periodic review of performance according to institutional policy and within expected standards of nursing practice.

The Oregon State Board of Nursing (April 10, 2003) adopted a position statement on the scope of practice of the Sexual Assault Nurse Examiner who provides nursing care to two distinct populations of acutely sexually assaulted patients:

a) adults and adolescents age 15 years and older
b) children and adolescents age 14 years and younger

The position statement does not address the scope of nursing practice in the examination of patients presenting for medical assessment of non-acute child sexual abuse. (Contact the Oregon State Board of Nursing to review the position statement in full.)

SPECIALIZED TRAINING REQUIREMENTS FOR MEDICAL EVALUATION OF ACUTE SEXUAL ASSAULT IN CHILDREN AND ADOLESCENTS

Physicians, nurse practitioners, physician assistants and RNs trained as SANEs who provide forensic medical evaluation to acutely sexually assaulted children and adolescents require **specialized training**. On an ongoing basis, these clinicians should participate in **case consultation** and **periodic case review with child abuse specialists**. RNs trained as SANEs should have access to **on-site** consultation with a physician or nurse practitioner who has had training in the evaluation of acute sexual assault of children and adolescents or who can readily consult with a medical provider with such training in order to make a diagnosis of child sexual abuse.

Basic training and clinical experience in pediatric and adolescent medicine as well as basic training in child abuse examination and diagnosis is outlined in the **"Training and Ongoing Education for Medical Evaluators of NON-ACUTE Sexual Abuse in Children and Adolescents"** chapter.

Specialized training for acute sexual assault evaluation of children and adolescents should include the following didactic and clinical components:

- Triage of acute sexual abuse/assault cases
- Medically appropriate and forensically sound clinical management
- Forensic history gathering in acute assault evaluations
    - developmentally appropriate communication skills and techniques
    - obtaining a history from child or adolescent
    - obtaining a history from parent or others as appropriate

- Physical examination
    - injury identification:
        - anal injury
        - genital injury,
        - soft tissue injury
        - recognition of physical abuse
    - differential diagnosis of acute sexual and physical abuse
    - interpretation of physical findings
    - diagnosis of acute assault/abuse

- Physical evidence
    - application of forensic standards and principles
        - evidence identification
        - evidence collection
        - evidence preservation
        - chain of custody
    - use of standardized Oregon Crime Lab SAFE (sexual assault forensic evidence) kit
    - special considerations and techniques in evidence collection in children

- Documentation
    - history from child and from parent or other guardian
    - physical exam findings including injuries
    - physical evidence collected and disposition
    - photos taken or video recordings made
    - maintenance of records
    - mandatory reporting

- Medical treatment of the acutely assaulted patient
    - Informed consents and rights of minors to medical treatment
    - Immunizations
    - STD testing and prophylaxis
    - Pregnancy testing and emergency contraception
    - Injury interventions
    - Toxicology: specimen collection

- Medical follow-up
    - Referrals
        - child abuse intervention center
        - primary care provider
        - mental health provider
        - victim advocate

- Community response and local practices related to:
    - accessing consultation with child abuse specialists
    - Multidisciplinary Team concept, including role of:
        - law enforcement agencies
        - DHS Child Welfare
        - community child abuse intervention center
        - advocacy and other social services

CASE CONSULTATION AND PERIODIC CASE REVIEW

Clinicians who conduct medical evaluations for acute child and adolescent sexual assault should develop a system by which they may regularly consult with child abuse medical specialists. Consultation should occur liberally, and particularly when there are questionable findings in any given patient. However, consultation is recommended even more frequently if the examiner is new to the field, has limited experience with child sexual abuse cases or if considerable time has passed since the medical provider has evaluated this type of patient.

To maintain skills and improve competence in evaluating children and adolescents who have been acutely sexually assaulted, conscientious practitioners should also engage in case review with a child sexual abuse medical specialist. Regular review of documentation and photographs and additional discussion with an experienced specialist can greatly enhance the capabilities of an acute child sexual abuse medical evaluator.

ADDITIONAL ONGOING EDUCATION

Healthcare providers who evaluate children and adolescents for acute sexual abuse may also benefit from attending child abuse conferences, reviewing relevant literature and participating in training opportunities offered through the Regional Child Abuse Training and Consultation Centers in Oregon. These providers are referred to the chapter on **"TRAINING AND ONGOING EDUCATION FOR MEDICAL EVALUATORS OF NON-ACUTE SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS"** for more information about these ongoing education activities. Chapter 4 of these ***Guidelines*** contains contact information and an explanation of services available at RTCCs in Oregon.

MEDICAL EVALUATION OFACUTE SEXUAL ASSAULT IN CHILDREN AND ADOLESCENTS

GUIDELINE

The triage of child sexual abuse cases in Oregon is described in each county's MDT protocol. It is advisable for medical providers knowledgeable about sexual abuse in children and adolescents to have input into the triage of such cases. The medical evaluation of acute cases of child sexual abuse should include a thorough physical examination and may also include collection of forensic evidence, as dictated by the specifics of each situation.

The medical evaluation of acute child sexual abuse can be very complicated. The healthcare professionals conducting these medical evaluations must be adequately trained in the specifics of these assessments (as described in the *Guidelines* chapter, "Training Requirements for Medical Evaluators of Acute Sexual Abuse in Children and Adolescents"). The use of protocols can greatly simplify evaluation procedures, collection of evidence and other decision-making related to child sexual abuse patients. The CARES Northwest Recommended Medical Guideline for Acute Sexual Assault Emergency Medical Evaluation is offered as an example of a useful protocol for medical practitioners who conduct acute child and adolescent sexual abuse evaluations.

GENERAL INFORMATION

Each county Multidisciplinary Child Abuse Team (MDT) has a written protocol outlining how the community triages child abuse cases. The MDT's written triage protocols will affect how children who are suspected to have experienced abuse enter this triage system and what community resources are available. With all types of child abuse, including acute sexual assault, it is important that a health care provider have input into this triage process.

The triage process may involve input from community partners such as LEA, DHS, therapists, the child's primary care provider and the local or regional child abuse intervention center or individual child abuse medical examiner. Child sexual abuse is a medical disease, and, like other medical diseases, it requires triage by a health care provider.

Triage issues

Three key issues to consider in all triage of alleged sexual abuse are:

- When did the abuse occur?
- Does the child have physical symptoms related to the abuse?
- How substantial is the report/concern?

Of the three key triage issues, how substantial the report or concern is may often be the most difficult to assess because of the complexity of factors that can influence the information that is reported.

Generally, the report available during the triage process is based on concerns involving some or all of the following constellation of factors:

- Disclosure by the child that may range from minimal to extensive
- Display of sexualized behavior or knowledge, which may be difficult to assess without knowledge of the child's past exposure to pornography, adult sexualized behavior and domestic violence. Sexualized comments and behavior exhibited by children may be part of normal sexual development seen in non-abused children or may indicate possible abuse.
- Presence of risk factors, which may include substance abuse and/or occurrence of other types of child abuse in the home, domestic violence exposure, criminal involvement by caregivers and contact with a sex offender.
- Behavioral changes are often a nonspecific indicator of child sexual abuse and, in general, indicate some form of stress. With abrupt or vague change in behavior, abuse is one possibility but consideration should be given to other stressors in the child's environment.
- Disclosures of possible abuse may be made by the child, sibling or others in the child's environment. Disclosures may range from vague to specific. Any disclosure indicating possible abuse of a child requires further follow-up.

Gathering as much information from as many sources as possible regarding these factors will assist in determining the urgency of evaluation as well as the appropriate type of follow-up needed.

The issue of when the sexual assault occurred is critical in decisions regarding the urgency of the evaluation and type of examination that is required. In adolescents and adults, forensic evidence (SAFE kit or rape kit) is collected in Oregon up to 84 hours after sexual assault. These same guidelines are used for children in our state. However, there are few studies available on the subject of forensic evidence collection in children.

Supporting information

Christian (2000) reported that 25% of children evaluated for acute assault had forensic evidence found on their body. Of this 25%, all were examined within 44 hours and 90% were examined within 24 hours. Additionally, the majority of forensic evidence (64%) was found on clothing and linen, despite the fact that only 35% of children had clothing collected. This study strongly suggests the importance of:

- Getting children to medical facilities within the first 24 hours after assault

- Routinely collecting children's clothing, and possibly linens, after sexual assault

Christian (2000) also found that 23% of children had genital injuries and that these injuries were a predictor for presence of forensic evidence.

Identification of injuries is important in acutely assaulted children as it corroborates the child's disclosure and increases the likelihood that the child protective system can intervene in evaluating the safety of the child.

CARES Northwest Recommended Medical Guideline for Acute Sexual Assault Emergency Medical Evaluation

The **CARES Northwest Recommended Medical Guideline for Acute Sexual Assault Emergency Medical Evaluation** attached at the end of this chapter stresses the importance of these key research findings. The medical evaluation should prioritize a physical examination to look for injury, as well as the forensic evidence collection process which includes collection of clothing/linens and history gathering regarding the allegation from the child and adult guardian.

CARES NORTHWEST RECOMMENDED MEDICAL GUIDELINE FOR ACUTE SEXUAL ASSAULT EMERGENCY MEDICAL EVALUATION CHILD/YOUNG ADOLESCENT (≤ 14 years)

(Revised June 22, 2004)

Adapted with permission from *Washington State Recommended Guidelines for Medical Evaluation of Sexual Assault*, Harborview Medical Center, 2000.

This guideline is recommended for the care of children age 14 years and younger when there is a history or concern of sexual abuse or assault. The guideline is not intended to include all the triage issues, medical evaluations, tests and follow-up that may be necessary for appropriate care for an individual patient. For children, the timing of the exam, as well as the extent of the exam, depends on the detail and clarity of the history, as well as physical signs and symptoms. Not all the steps outlined in this guideline will be appropriate for every patient.

For care of adults and adolescents age 15 years and older, see the *Recommended Medical Guideline: Acute Sexual Assault Emergency Medical Evaluation - Adolescent (≥15 years)/Adult* available through the Attorney General's Sexual Assault Task Force (email: taskforce@oregonsatf.org). It should be noted, however, that acute triage assessment of an adolescent should include assessment of the specific aspects of physical and cognitive development of the individual adolescent patient to determine whether the Child or Adult Guideline should be used.

The purpose of this guideline is to provide direction for medical professionals in the care of the child or young adolescent patient who is suspected to have been acutely sexually abused. The goal is to ensure that compassionate and sensitive services and care are provided in a developmentally appropriate and non-judgmental manner. The physical and psychological well being of the child is given precedence over forensic needs.

The guideline is based on current Oregon law and Oregon Crime Lab practices, as well as Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and American College of Emergency Physicians (ACEP) recommendations for the prophylaxis of sexually transmitted diseases and pregnancy in the care of the sexual assault patient.

I. GENERAL INFORMATION

PURPOSE OF EXAM

Medical/Forensic	1. Identify and treat injuries 2. Evaluate and treat medical conditions 3. Assess risk of sexually transmitted diseases and provide prophylaxis as needed 4. Assess risk of pregnancy and provide emergency contraception as needed 5. Document history as given by adult 6. Document child's statements 7. Document medical findings 8. Collect forensic evidence
Social/Psychological	1. Respond to patient's and family's immediate emotional needs and concerns 2. Assess safety and immediate mental health needs 3. Explain to the family the reporting process, Crime Victims Compensation, and resources for advocacy and counseling
Report/Refer	1. Refer for follow-up medical care 2. Refer for follow-up counseling if appropriate 3. Report to Oregon Department of Human Services (DHS) and/or law enforcement agency (LEA) immediately 4. Report to LEA in the county where the crime occurred 5. Refer to child abuse intervention center per community protocol

II. TRIAGE DECISIONS

ACUTE

If Assault within Prior 84 Hours	**If there is a <u>clear report</u> (by child or witness) that abuse occurred <u>within prior 84 hours</u>** 1. Medical/forensic exam is appropriate on an urgent basis in the emergency department or designated child abuse intervention center. The preferred examiner is one who is trained in pediatric sexual assault and forensic evidence collection 2. Advise patient or guardian to do the following, if possible: • Patient should not bathe before exam • Bring in clothes worn by child at the time of and immediately after abuse, especially undergarments • Bring change of clothing for child
	If there is a <u>vague report or concern</u> that abuse occurred <u>within prior 84 hours:</u> 1. Medical evaluation is indicated for all patients who have been subjected to sexual abuse or assault and may occur at ED, child

	abuse intervention center or Primary Care Provider (PCP) clinic. The preferred examiner is one who is trained in pediatric sexual assault and forensic evidence collection. Decision for an emergency exam vs. scheduled evaluation is made on a case by case basis

NON-ACUTE

If Assault >84 Hours Prior and No Physical Symptoms are Present	**Forensic evidence collection from child's body is generally not indicated if assault occurred > 84 hours prior.** **If there is a clear report that abuse occurred but the last contact was more than 84 hours prior, and there are no physical signs or symptoms:** 1. Medical/forensic exam generally not indicated on emergency basis 2. Refer to designated child abuse intervention center or trained child abuse medical examiner per community protocol 3. Medical evaluation can be scheduled within 2 weeks or urgently if needed for other medical or safety reasons 4. Individual case circumstances may warrant urgent medical forensic exam up to 96 hours after assault, e.g., multiple offenders, patient unconscious for period of time, patient has not bathed or showered, or when requested by LEA 5. Report to DHS and/or LEA immediately 6. Clothing worn at the time and immediately after abuse, especially undergarments, should be collected by LEA
	If there is a vague report or concern that abuse occurred, but the last contact was more than 84 hours prior and there are no physical signs or symptoms: 1. ED evaluation is not indicated 2. Refer to Primary Care Provider (PCP) or local child abuse intervention center or trained child abuse examiner
If Assault >84 Hours Prior and Physical Symptoms are Present	**Anogenital pain, discharge, redness and bleeding have a number of causes necessitating appropriate medical triage** 1. Telephone evaluation by emergency department triage, child's Primary Care Provider or designated child abuse intervention center should include: • What is the concern of abuse • Whether the parent has noted evidence of trauma • What symptoms are present 2. If there are no serious concerns of abuse, triage should be to child's Primary Care Provider for evaluation of physical symptoms ASAP 3. If serious concerns of abuse, triage to local child abuse intervention center or trained child abuse examiner ASAP

EMERGENCY DEPARTMENT MEDICAL STABILIZATION

	Medical stabilization always precedes forensic examination 1. The following history or conditions should be evaluated medically prior to or during the sexual assault exam:

	• History of loss of consciousness • Head injury • Altered consciousness or mental status • Significant facial injury • Possible fractures • Blunt injury to abdomen or back • Active bleeding • Signs of physical abuse or neglect 2. Psychiatric illness • If apparent psychiatric illness complicates assessment of alleged sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

MANDATED REPORTING

	1. Nursing and medical providers are mandated to report to LEA or DHS when they have a reasonable suspicion of child abuse 2. Report immediately (before patient leaves the health care setting)

CONSENT

	Informed consent for all procedures, evidence collection and treatments is obtained in all cases 1. Patients age 15 years and older may sign the consent 2. For patients age 14 years and younger, a parent or guardian must sign consent; however, a patient seeking treatment for medical conditions related to reproductive health care may consent to such medical care or treatment at any age and without consent of parent or guardian

III. HISTORY AND INITIAL EVALUATION

PATIENT INFORMATION

	Document the following information if it is available and pertinent 1. Routine data: patient name, mother's name, guardian's name, gender, age, birth date, hospital number; home address and phone number for patient and guardian if different, 2. Date and time of arrival 3. Who accompanied patient, and their relationship to child 4. Interpreter name, if used, and language 5. Name of LEA assigned detective 6. Name of DHS caseworker 7. LEA case number if available

HISTORY FROM PARENT OR GUARDIAN

	Interview parent or guardian, outside of presence of child, and document the following: **Facts about assault (obtained first from the adult and independently from the child)** 1. Sources of information (patient, police, or other person) 2. Nature of concern 3. Time, place of assault, and jurisdiction/location, if known 4. Hours since abuse 5. Identity and relationship of alleged offender(s), if known 6. Record reported narrative history of abuse **Nature of influences/force used** 1. Patient had impaired consciousness 2. Known or suspected drug or alcohol ingestion 3. Verbal threats 4. Use of physical force 5. Use of weapon 6. Use of coercion 7. Developmental level of patient **Physical facts of sexual assault** 1. Which orifices or body parts were assaulted 2. By what (finger, penis, mouth, foreign object) 3. Whether condom was used 4. Whether ejaculation was noted and where 5. Physical injuries 6. Whether and where bleeding or pain was reported **Post assault activity of patient** 1. Showered or bathed 2. Douched, rinsed mouth, urinated, or defecated 3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic **Risk factors of offender regarding hepatitis B/C, syphilis, and HIV, if known** 1. Known or suspected IV drug use 2. Gay or bisexual male 3. From an endemic country 4. History positive for STDs, including HIV/AIDS 5. History of prostitution 6. Blood or mucous membrane exposure 7. Multiple offenders

PAST MEDICAL HISTORY

	1. Significant medical problems, surgery, major injuries, chronic disease, developmental delays, congenital conditions 2. Current medications 3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and alcohol 4. Allergies 5. Patient's history of hepatitis B vaccine 6. Past anal or urogenital problems or surgeries 7. Past history of sexual abuse 8. Date of last menstrual period, if post menarchal patient 9. Date of last consensual sexual intercourse, if applicable 10. Birth control method, if applicable

HISTORY FROM CHILD

	Interview child alone, when possible 1. Ask open-ended questions regarding why child has presented for an evaluation 2. Record pertinent questions asked, and child's answers 3. Questioning should include: • What happened? (specifics of the allegation as reported by child) • When did it happen? • Who did it? • Where did it happen? • Any physical complaints? • Any emotional concerns? 4. With adolescents and older children, obtain additional facts about the assault as described in "Facts About Assault Under History from Patient or Guardian"

DISCUSSION WITH CHILD AND GUARDIAN

	1. Discuss medical and forensic procedures 2. Discuss mandatory reporting to DHS and/or LEA 3. Obtain history from parent/guardian and child separately 4. Do not discuss specifics of the allegations of abuse with the parent/guardian in the presence of the child

IV. EVIDENCE COLLECTION

FORENSIC EVIDENCE COLLECTION

	1. Standard Sexual Assault Forensic Evidence (SAFE) Kit, provided by Oregon State Police Sexual Assault Crime Lab, is used for evidence collection 2. Standard documentation forms, provided with kit, are used in the evidence collection process 3. Forensic evidence collection is done by a registered nurse, nurse practitioner, physician assistant or physician – all who must be currently licensed in Oregon and practicing within the professional scope established by the licensing Boards. The preferred examiner is one who is trained in pediatric sexual assault forensic evidence collection.

RELEASE OF INFORMATION

	Per HIPAA regulations, the patient and/or guardian must first be informed of the reasons for the release and written consent obtained before the release of information/documentation is completed.

COST OF EVIDENCE COLLECTION

	The Sexual Assault Victims' Emergency Medical Response Fund can be billed for the evaluation if the child does not have insurance or the guardian does not wish to bill insurance.

CHAIN OF CUSTODY OF FORENSIC SPECIMENS

	One staff member must be responsible for maintaining chain of evidence at all times. That staff member: 1. Observes specimens **or** 2. Designates another staff member to watch specimens by delegating and transferring chain of custody **or** 3. Secures specimens in freezer, refrigerator, cabinet or specific area

MEDICAL PHOTOGRAPHY

	Obtain photographs if visible injuries from assault/abuse are present or request law enforcement to obtain photos. It is recommended that video/ photo colposcopy or Medscopeä be used to document anogenital exam whether injuries are or are not present. Alternative documentation includes use of drawings, 35 mm camera with macro lens, or digital camera 1. Prior to exam, obtain photo of face and of child clothed 2. Include patient's ID in one photo 3. Include a ruler or coin in photos of injuries to document size of lesions 4. For 35 mm: use new film role for each patient, place patient label on metal film canister 5. For Polaroids: place patient label on back of each photo and secure in patient chart 6. For digital photos: place patient label on back of each photo and place in patient chart. 7. Images should be stored securely for future reference 8. Document type of photos, parts of body in photos, and name of photographer in medical chart 9. Place labeled 35 mm film canister in labeled film envelope, and send for processing to hospital/clinic associated photography lab 10. All photos should have patient label on back and examiner's initials 11. Store photos according to hospital protocol (e.g., in patient chart, secure file, other arrangement) 12. Document findings carefully with drawings even when photos are taken 13. Order additional prints or provide double copies of photos if LEA did not obtain their own photos

EVIDENCE COLLECTION

General	**Wear powder-free gloves and change gloves frequently during all phases of evidence collection and processing** **"Bindling":** Paper used to collect debris, scrapings or hair should be bindled to keep collected items from falling out. To bindle: fold paper in thirds lengthwise and fold paper in thirds again widthwise **Temperature** 1. Dry or dried evidence may be kept at room temperature 2. To avoid molding, damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer

Fingernail Debris/Scrapings	**Collect if patient reports scratching offender or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault, and/or history suggests patient scratched offender** 1. Place small paper sheet labeled "Left hand" or "Right hand" on flat surface 2. Using sterile plastic scraper, toothpick or end of wooden swab, scrape under all five fingernails of left or right hand, allowing any debris to fall onto paper; or clip nails with sterile nail clippers/scissors allowing nails to fall onto paper 3. Bindle paper to retain debris, include scraper 4. Place each bindled paper in a separate envelope and label with site 5. Seal envelope with tape or patient label. **Do not LICK** envelope to seal. Sign over seal, and store securely with Evidence Kit
Skin and Hair Debris	**Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes debris is related to assault. Collect dirt, grass, fibers, paint flecks, etc., which may adhere to patient's skin. Omit this step if patient bathed or if no debris visible** 1. Place small paper sheet on flat surface 2. Collect any foreign debris (dirt, leaves, fiber, hair, etc.), place in center of paper 3. Bindle paper to retain debris 4. Place each bindled paper into a separate envelope and label with site 5. Seal envelope with tape or patient label. **Do not LICK** envelope to seal. Sign over seal, and store securely with Evidence Kit
Trace Evidence Collection	**Collect foreign material which may fall when patient undresses. Omit if patient has bathed or changed clothes since assault** 1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper 2. Unfold and place evidence collection paper sheet over the bottom sheet 3. Instruct patient to stand in the center of paper and remove clothing 4. Bindle paper where patient stood, retaining any foreign material, and place in paper envelope and process as forensic evidence 5. Seal envelope with tape or patient label. **Do not LICK** envelope to seal. Sign over seal, and store securely with Evidence Kit
Clothing Collection	**If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important. Omit if patient is not wearing clothes worn at time of or immediately after assault. Wet clothing should be dried in a secure room or area, or transferred to law enforcement ASAP. Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost** 1. Place each item of clothing in a separate paper bag 2. Dry clothing should be placed in paper bags, sealed with tape, signed over seal, and labeled with patient ID label 3. Clothing should be stored in a secure area until transfer to law enforcement 4. Wet clothing must be sealed and labeled as in #2 and either be dried in a secure area, refrigerated or frozen and transferred ASAP to law enforcement

Underpants	**Collect patient's underwear routinely, even if changed after assault (Collect pants, shorts, tights, etc., if no underwear is worn)** 1. Pooled secretions may leak onto underwear 2. Package patient's underpants in a small paper bag. Seal, label, sign over label, and store securely in a clean paper bag
Other Items	**Collect items which may contain forensic evidence, such as diaper, tampon, sanitary pad, and condom, on a case-by-case basis** 1. Place in bag and freeze or refrigerate until pick-up. If no freezer/refrigerator is available, air dry and have LEA transport ASAP 2. Place patient label over seal, sign over seal, and store securely with Evidence Kit or in a separate paper bag 3. Advise LEA that the item being transported is wet and should be processed as soon as possible
Processing Forensic Swabs (For recovery of DNA)	**Obtain forensic swabs for recovery of DNA (saliva, seminal fluid, skin, perspiration)** 1. Use sterile cotton swabs 2. To obtain swabs from dry areas (e.g., skin, fingertips, fingernails, anus) lightly moisten swabs with tap water (soaking in water will prolong drying time and increase likelihood of specimen molding) 3. To obtain swabs from wet areas (e.g., mouth, vagina) use dry sterile cotton swabs **As each swab is obtained** 1. Affix label on the wooden shaft 2. Write on each label the collection site of specimen (e.g., "left hand skin," or "oral," "vaginal," "anal"). Number swabs to identify order in which they were obtained (i.e., 1-4) 3. At conclusion of patient exam, place swabs in drying rack or drying box in secure area 4. Allow swabs to dry **When swabs are dry** 1. Place all swabs from same site in one envelope (i.e., only one site per envelope) 2. Label envelope with specimen site (e.g., "oral," "vaginal," "left lateral abdomen skin") 3. Seal envelope with tape or patient label. **Do not LICK** envelope to seal. Sign over seal, and store securely with Evidence Kit

Processing Forensic Slides (For recovery of sperm cells)	**Prepare forensic slides from swabs collected from areas that fluoresce with an alternative light source or from areas where contact with seminal fluid is suspected** 1. Before drying swabs, use first obtained swab, rub cotton tip in small area on center of slide. Do **NOT** throw away swab. Process this swab with other swabs from same site 2. In pencil, label end of slide with location from which swab was obtained 3. Place slide in open cardboard sleeve and air dry for 5 minutes 4. Close cardboard sleeve, seal with patient label, sign over seal and store securely in Evidence Kit
Processing Evidence Collection Kit	1. Once all evidence has been placed inside the kit • Complete the Forensic Laboratory Information Form found inside the kit • Complete the information requested on the front of the kit • Place a patient label over the envelope, seal and initial • Give the kit to the LEA representative and have him/her sign the Forensic Laboratory Information Form. A copy of this form should be filed in the patient's chart 2. If no LEA representative is available, store the kit in a secure area, then contact LEA immediately and give them the location of the completed kit so LEA can pick it up ASAP. A sign out log should be completed by LEA officer picking up kit.
Drying Box	1. Clean drying box with 20% bleach between each use

EVIDENCE STORAGE

	Temperature 1. Dry or dried evidence may be kept at room temperature 2. Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer in order to avoid molding **Clothing** 1. Dry each clothing item, place in paper bags, seal bags with tape, sign over seal, and label with patient ID label and content 2. Clothing should be stored in a secure area until transfer to LEA 3. Wet clothing must either be dried in a secure area, refrigerated or frozen and transferred ASAP to LEA

	To Process a Forensic Evidence/Evidence Kit 1. Place all evidence in paper bag, kit or envelope 2. Seal envelope with tape or patient label. **Do not LICK** envelope to seal. Sign over seal, and store securely with Evidence Kit 3. All evidence in the Evidence Kit should be dry 4. Any wet evidence should be refrigerated or frozen and kept with the kit 5. Store entire sealed Evidence Kit in room temperature secure area, refrigerator, or freezer until transfer to law enforcement 6. Entire Evidence Kit can be refrigerated or frozen to keep all items together 7. Biological specimens (swabs, slides) should be labeled with site from which specimen was obtained • Swabs from each specific site should be numbered in order obtained (i.e., 1-4) • Swabs should be dried in a secure drying box or area before transfer or freezing • Biologic specimens should be placed in a secure area until transfer to law enforcement

V. MEDICAL EXAMINATION

GENERAL INFORMATION

	1. All patients should undergo a complete, head-to-toe physical examination. 2. It is the patient's right to consent to or refuse any aspect of the exam and evidence collection 3. The patient may have a support person (relative, friend, guardian, or advocate) present during the exam 4. If suspected or known oral sodomy, it is preferable that the patient not eat or drink before the exam, but the patient's comfort should not be compromised to achieve this • Oral swabs, for example, should be obtained immediately if patient is thirsty or wishes to rinse mouth 5. Use powder free gloves and change gloves frequently 6. Document emotional status, mental status, general appearance 7. Document objective observations: "patient avoids eye contact and is teary eyed" is preferable to "patient is sad" 8. Record vital signs, height and weight as indicated

EXAM PROCEDURES

	1. Because a patient may not initially report all aspects of the assault, consider collecting evidence routinely from oral and anogenital areas 2. If the patient has bathed or showered, specific steps of evidence collection may be omitted. These steps are indicated in the sections that follow 3. The following sections outline the steps for the medical exam and evidence collection. The order of these steps may vary by examiner preference or patient need

SKIN EXAM

Document	**Bruises, petechiae, abrasions, lacerations, suction ecchymoses, pattern injuries and other marks, tenderness and any other abnormalities** 1. Describe traumatic lesions or marks on traumagram 2. Ask patient how each injury occurred and document patient's statements 3. Confirm that photos have been taken and a drawing and description have been completed of acute traumatic skin lesions
Forensic Swabs	**Collect when assault occurred within last 84 hours, patient has not bathed, and** 1. Patient reports alleged offender's blood, semen, or saliva may be deposited on skin **or** 2. Offender's blood or dried secretions are visible **or** 3. Offender's bite marks or suction ecchymoses are visible **or** 4. Wood's lamp or Mini Bluemaxx™ scan is positive (swab areas that fluoresce under alternative light source)
Swab and Slide Technique	**Slides are made only when the presence of seminal fluid is suspected** 1. Use 4 cotton swabs 2. Use 2 swabs at a time if possible to save time 3. If secretions are dry, lightly moisten swabs with tap water 4. Gently swab areas of possible secretions 5. Label swabs with site where collected, number 1-4 in order obtained 6. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with the other 3 swabs from this site. 7. Process slide as forensic evidence 8. Process swabs as forensic evidence

ORAL EXAM

Document	**Bleeding, tenderness, inflammation, lacerations, abrasions, petechiae, bruises, dental pain or injury, and check mucosa, palate, tonsils, upper and lower frenula, tongue frenula and lips and gums for injury**
Forensic Swabs	**Collect when** 1. Because a patient may not initially report all aspects of the assault, consider collecting evidence routinely from oral area 2. Abuse/assault occurred within prior 12 hours **or** 3. Visible oral injury **or** 4. History of oral-genital contact in prior 12 hours

Swab Technique	1. Use 4 cotton swabs 2. Use 1-2 swabs at a time 3. Swab around buccal mucosa, under tongue and along gum line of teeth with special attention to inferior (dependent) areas of the mouth 4. Repeat with remaining 2 swabs 5. Process as forensic swab
Reference Swabs	**Collect reference oral swabs to establish patient DNA** 1. Use 4 swabs 2. Vigorously swab inside of cheek of the mouth 3. Process as forensic evidence

PUBIC HAIR COLLECTION FOR ADOLESCENTS

Pubic Hair Combing for Male and Female	**Collect foreign hairs and debris. Omit this step if patient bathed or showered after assault. Omit if pubic hair is not present or has been shaved** 1. Either patient or examiner may do actual combing (if patient, examiner must observe) 2. Patient should be sitting or lying in dorsal lithotomy position 3. Place paper sheet under patient's buttocks 4. Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper 5. Bindle paper to retain both comb and any evidence present 6. Place in envelope, place label on envelope with contents identified 7. Process as forensic evidence (hairs obtained from the pubic combing will not be processed unless a reference sample is collected from the patient)
Pubic Hair Plucking for Male and Female	**Do NOT pluck pubic hair to obtain reference samples to distinguish foreign hair from patient** unless specifically requested by the LEA or Prosecutor's Office

GENITAL EXAM-FEMALE

Exam Technique	1. Use a good light source 2. Use magnification if possible: visor, colposcope, or Medscope™ 3. Use powder free gloves and change gloves frequently 4. Child should be examined in supine frog leg or dorsal lithotomy position and also in prone knee-chest position, if possible 5. Gently apply both labial separation and labial traction techniques for optimal visualization of the genital area 6. Examine thighs, mons pubis, labia majora and minora, inner labial wall, hymen, posterior fossa, posterior fourchette, and perineal body
Document	**Genital tenderness, lacerations, abrasions, bruises, petechiae, lesions, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage**

	NOTE: ***For prepubertal girls a speculum exam is not necessary and is <u>generally</u> <u>contraindicated</u>. To identify source of active vaginal bleeding and depending on the age, size and emotional state of the child, speculum examination under sedation should be considered.***
Forensic Swabs	**Collect when** 1. Abuse/assault occurred within prior 84 hours **<u>and</u>** 2. History of genital-genital or oral-genital contact **<u>or</u>** 3. Reported contact to genitalia, perineum, or anus by any part of offender's body 4. Ejaculation occurred near anogenital area **<u>or</u>** 5. Visible acute genital or anal injury **<u>or</u>** 6. Any surface fluoresces under alternative light source (Wood's lamp or Mini Bluemaxx™) **Generally, omit when patient bathed or showered after assault unless area fluoresces**
External Genital Area Swabs	**Collect routinely in preverbal child and when history provided suggests contact to genitalia, perineum, or anus by <u>any</u> part of offender's body. Omit if patient bathed or showered after assault** **Sites to consider swabbing:** • Inner thighs • Mons pubis • Inguinal folds • External labia majora • Posterior fourchette • Perineal body 1. Use 4 cotton swabs 2. Use 1-2 swabs at a time 3. Lightly moisten swabs with tap water 4. Swab specific area of the external genitalia 5. Repeat with remaining 2 - 3 swabs **Slides are made only when the presence of seminal fluid is suspected** 6. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from the same external genital area 7. Process as forensic slide evidence 8. Process as forensic swab evidence

Inter-Labial and Posterior Fossa Area Swabs	**Sites to consider swabbing:** • Clitoral skin folds • Labial skin folds • Posterior fossa 1. Use 4 cotton swabs 2. Use 1 swab at a time 3. Lightly moisten swabs with tap water 4. Swab interlabial, clitoral hood and posterior fossa areas 5. Repeat with remaining 2 swabs **Slides are made only when the presence of seminal fluid is suspected** 6. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from this site 7. Process as forensic slide evidence 8. Process as forensic swab evidence

Intravaginal/Cervical Swabs	**<u>Prepubertal Patient:</u>** **Intravaginal and cervical specimen collection is rarely indicated for prepubertal girls. This decision should be made on a case-by-case basis** 1. Use 4 <u>small</u> wire-handled cotton swabs for intravaginal collection 2. Use one swab at a time **<u>or</u>** use 2 swabs with wire shaft twisted together 3. Lightly moisten swabs with tap water 4. Use care to avoid touching hymen 5. Insert swab slowly through the center of the hymenal opening using gentle traction technique on the labia 6. Swab pooled secretion 7. Repeat for a total of 4 swabs if possible **Slides are made only when the presence of seminal fluid is suspected** 8. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from this site 9. Process as forensic slide evidence 10. Process as forensic swab evidence **<u>Adolescent Patient:</u>** **For adolescents who have not had a prior pelvic/speculum exam, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs deep into vagina; otherwise:** 1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising 2. <u>Do not use</u> lubricant (i.e., surgilube) for speculum. Rinse speculum in warm water for patient's comfort 3. Sites to consider swabbing • Inner labial folds • Posterior fossa • Vagina (particularly posterior vaginal pool) • Endocervix 4. Use 4 swabs total for each site 5. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist **Slides are made only when the presence of seminal fluid is suspected** 6. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from the same genital area 7. Process as forensic slide evidence 8. Process as forensic swab evidence

GENITAL EXAM-MALE

Document	**Penile, scrotal or perineal abrasions, bruises, lacerations, petechiae, marks, bleeding, edema, discharge, erythema, tenderness, inflammation and any other abnormalities; Tanner Stage**

Forensic Swabs	**Collect if report includes possibility of offender saliva or secretions on patient's genital/perineal area or if any area fluoresces under alternative light source (Wood's lamp or Mini Bluemaxx ä). Generally omit this step if patient has bathed or showered unless area fluoresces** 1. Retract foreskin to examine glans penis 2. Areas to consider swabbing • Mons pubis • Inner thighs • Inguinal folds • External surface of glans/penis • Under foreskin (collect swabs even if patient has bathed or showered) • Scrotum • Perineal body 3. Swab surface of specific area with 2 swabs lightly moistened with tap water 4. Repeat with two more moistened swabs for each specific area 5. For each specific site, dry swabs, label site and label order of swabs obtained (i.e., 1-4) **Slides are made only when the presence of seminal fluid is suspected** 6. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from the same genital area 7. Process as forensic slide evidence 8. Process as forensic swab evidence

PERIANAL AND ANAL EXAM-FEMALE AND MALE

Document	**Perianal bruises, petechiae, edema, discharge, bleeding, abrasions, lacerations, lesions, erythema, tenderness, inflammation, visible anal laxity and any other abnormalities noted**
Exam Technique	1. Use good light source 2. Use magnification with visor, colposcope, or Medscope™ 3. Separate anal folds to visualize any injuries 4. Anoscopy indicated only if active rectal bleeding and or rectal pain with no identifiable source 5. Lubricant should be used for anoscopy. To avoid contamination by the lubricant, perform anoscopy only AFTER FORENSIC SWAB COLLECTION 6. Toluidine blue can be used on skin only AFTER ALL SPECIMENS ARE COLLECTED

Forensic Swabs	**Collect when** 1. Because a patient may not initially report all aspects of the assault, consider collecting evidence routinely from perianal and anal areas 2. Assault occurred within prior 48 hours **and** 3. History of penile-genital or penile-anal contact **or** 4. Report of contact to genitalia, perineum, or anus with any part of offender's body **or** 5. Visible acute anal trauma **or** 6. Any anal or perianal surface fluoresces under alternative light source (Wood's lamp or Mini Bluemaxx™)
External Anal/Perinanal Swab Technique	**Areas to consider swabbing** • Perianal area (external to anal sphincter) • Anus • Rectum • Gluteal cleft 1. Use 4 cotton swabs for each specific site 2. Lightly moisten swab with tap water before using 3. First 2 swabs: using 2 swabs at a time, swab external anal rugal folds. Repeat with second 2 swabs **Slides are made only when the presence of seminal fluid is suspected** 4. Using swab #1, rub swab tip on small area in center of the slide. Retain this swab for labeling and processing with other 3 swabs from the same area 5. Process as forensic slide evidence 6. Process as forensic swab evidence
Internal Anal Swabs	**Collect rectal swabs routinely if there is anal injury or when patient reports contact to genitalia, perineum, or anus by any part of offender's body** 1. Clean the perianal tissue with water after collecting perianal swabs 2. Use 4 cotton swabs 3. Lightly moisten swabs with tap water before using 4. Slowly insert 1 swab past anal sphincter (approximately 2 cm). Slowly withdraw swab. Repeat with 3 remaining swabs, one at a time **Slides are made only when the presence of seminal fluid is suspected** 5. Using swab #1, rub swab tip on small area in center of slide. Retain this swab for labeling and processing as other 3 swabs from the same area 6. Process as forensic slide evidence 7. Process as forensic swab evidence

VI. DIAGNOSTIC TESTS FOR MEDICAL TREATMENT

	The following tests and procedures may be clinically indicated

PREGNANCY TEST

	Obtain urine or serum pregnancy test on all patients at risk of getting pregnant (post menarchal patients, and all premenarchal girls Tanner Stage 3 and above or age 12 years or older) prior to administration of emergency contraception

TOXICOLOGY TESTS

	Obtain toxicology and/or alcohol level when: 1. Patient appears impaired, intoxicated, or has altered mental status 2. Patient reports blackout, memory lapse, or partial or total amnesia 3. Patient or other person is concerned that the patient may have been drugged 4. Separate consents for toxicology specimens need not be obtained, but patient, parent or guardian should be informed that specimens are obtained **Hospital toxicology and alcohol level for medical purposes** 1. If toxicology and/or alcohol results are needed for patient care, stat hospital tests must be done but separate toxicology testing is required for legal purposes **Toxicology for medical-legal purposes** 1. Drug and alcohol testing may be done for legal purposes; specimens follow a chain of custody and generally are processed through hospital lab 2. Examiner may order tests to be run at "any detectible level" rather than the standard cut off and "with appropriate test of confirmation" done. Talk with the lab toxicologist to determine how to order 3. GHB and Rohypnol must be specifically requested 4. When it is deemed necessary to collect samples for toxicology purposes, collect *blood* for alcohol testing and *urine* for drug testing

VAGINAL WET MOUNT

	1. **Not recommended** to examine sperm, due to lack of reproducibility and standardization 2. May be used to assess vaginitis if signs or symptoms are present

STD TESTS FOR GONORRHEA AND CHLAMYDIA

	1. STD testing, if done at time of acute assault, should be repeated at medical follow-up visit 2. Specimens for STD testing go to hospital/clinic lab **NOT** to crime lab 3. Recommended in prepubertal children based on history or physical findings; recommended in all sexually active adolescents 4. Positive tests may indicate pre-existing infection. Highly sensitive tests such as Nucleic Acid Amplification Tests (NAAT) may also indicate infection in offender 5. For vaginitis (visible discharge) • Culture for respiratory and enteric pathogens • Vaginal culture for gonorrhea and chlamydia • NAAT test if culture not available • Positive NAAT test must be confirmed by culture 6. For penile infection (visible discharge) • Culture discharge, if present, for gonorrhea and chlamydia • NAAT test for gonorrhea and chlamydia if culture not available • Postive NAAT test must be confirmed by culture 7. For anal infection • Culture for gonorrhea and chlamydia • NAAT test cannot be done 8. For pharyngeal infection: • Culture for gonorrhea • Do not culture for chlamydia 9. Inform patient and/or guardian that STD tests are related to health issues and are not exclusively for forensic purposes

HIV TESTING

	1. Baseline HIV testing is generally **NOT** recommended in the emergency department 2. Baseline HIV testing may be performed up to 2 weeks after assault, and may be performed in follow-up visit or preferably by the Primary Care Provider • If patient or parent/guardian wishes HIV serology testing in the emergency department or clinic, pre-test counseling must be done and post-test counseling arranged • Patient or parent/guardian must exhibit understanding that test does not reflect acquisition of HIV from the assault but is related to prior exposure 3. If testing is done, arrangements must be made for follow-up visit to discuss results in person with the patient and/or parent or guardian 4. Children in DHS custody require consent of DHS supervisor before HIV testing is done

HEPATITIS B/C SEROLOGY

	1. Can be done to determine immune status if patient and family are uncertain about patient's past history of hepatitis B and immune status 2. Hepatitis B/C serology is best done 3 months after last contact if evaluating for seroconversion

SYPHILIS SEROLOGY

	1. Syphilis baseline test may be offered depending on community epidemiology 2. Testing is best done 3 months after last contact

VII. TREATMENT

PREGNANCY PREVENTION

	Every patient who is post menarchal will be offered prophylactic treatment for pregnancy prevention. If a patient declines pregnancy prophylaxis, a refusal of consent must be obtained from the patient. **Offer emergency contraception when:** 1. Patient is at risk for pregnancy and • assault took place < 120 hours ago **and** • patient is **NOT** using highly reliable method of contraception such as oral contraceptives (no pills missed in cycle), contraceptive patch, Depo provera or IUD and • patient feels any pregnancy conceived in the last five days would be undesirable to continue and • pregnancy test is negative 2. Patient must sign consent for emergency contraception 3. Since the effectiveness of emergency contraception is time dependent, if possible the patient should obtain medications prior to discharge or as soon as possible

	Evidence suggest that emergency contraception MAY be effective as far as 120 hours after unprotected sex (Rodrigues, *et al.*, Am J Obstet Gynecol 2001; 184:531) **Medications for patients who have a negative pregnancy test and are at risk for conception may be given as follows:** **Recommended Regimen:** "Plan B" (progestin only medication) SIG: 100 mg tab (0.75 mg levonorgestrel) Take 1 tab immediately and 1 tab 12 hours later by mouth OR 2 tablets now by moutn Quantity: 2 "Plan B" is more effective and with fewer side effects than combined estrogen/progestin oral contraceptive; anti-emetics are not generally needed

STD PROPHYLAXIS

	1. STD prophylaxis is not routinely offered to prepubertal children after abuse/assault. Advise waiting for culture or MAD test results per CDC guidelines before treating. 2. Every post menarchal patient will be offered prophylactic treatment for sexually transmitted diseases (with the exception of HIV) in cases involving genital-genital contact.

The following recommended antimicrobial regimen for prophylaxis of chlamydia, gonorrhea, trichomonas, and BV may be administered to adolescent patients following acute sexual assault (MMWR, May 10, 2002):

	<45 kg (100#)	**>45 kg (100#)**
GC	Ceftriaxone 125mg IM **OR** Cefixime (Suprax®) 8mg/kg po x 1	Ceftriaxone 125mg IM **OR** Cefixime (Suprax®) 400mg po x 1
Chlamydia	Azithromycin (Zithromax®) 20mg/kg (max 1g) po x 1 dose **OR** Erythromycin 50mg/kg/d po ÷ QID x 10-14d	Azithromycin (Zithromax®) 1g po x 1 **OR** Doxycycline 100mg po BID x 7d
Trich/BV	Metronidazole (Flagyl®) 15mg/kg/d po ÷ TID x 7d	Metronidazole (Flagyl®) 2g po x 1

HEPATITIS B VACCINE

	Offer when 1. Patient has not been previously fully immunized for hepatitis B **and** 2. Patient has negative history for hepatitis B **and** 3. Secretion-to-mucosal contact occurred during assault **and** 4. Parent or guardian signs consent for immunization 5. Inform that repeat vaccine doses are necessary at one month and six months after initial vaccine 6. If the patient is unsure of their immunization status or has been partially immunized, a Hepatitis B titer may be drawn. At the time of discharge, provide the patient with instructions for appropriate follow up of titer results and completion of vaccine series

TETANUS PROPHYLAXIS

	Offer when 1. Skin wounds occurred during assault **and** 2. Patient not up-to-date for tetanus immunization (no immunization in past 5 years) 3. Parent/guardian signs consent for immunization

HIV PROPHYLAXIS

	Every patient will be offered prophylactic treatment for sexually transmitted diseases, with the exception of HIV. In the case of HIV, the patient will be offered information regarding HIV and appropriate medical follow up for HIV. Prophylactic treatment for HIV may be started in the emergency department if the supervising physician deems it appropriate and the emergency department has HIV prophylaxis protocols in place or an infectious disease specialist available for consultation **Generally, prophylaxis is not recommended. Consideration can be given in cases of high risk assault:** • Offender gay or bisexual male, IV drug user, prostitution history or from endemic area • Offender known to have HIV or other STD • Multiple offenders • Blood/mucous membrane contact • Patient/guardian will comply with medication regimen

VIII. DISCHARGE AND FOLLOW-UP MEDICAL VISIT

DISCHARGE

	Review with patient and/or parent/guardian 1. Appropriate medical follow up will be identified for the patient with respect to the evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries sustained during the assault 2. Explain to patient and/or parent/guardian what tests were done and procedure for follow-up of test results 3. Offer patient education materials 4. Confirm plans for medical and counseling follow up 5. Give phone number for advocacy and other support services appropriate to child's age and family needs 6. Give written discharge instructions for all treatment and follow up 7. Give information on area resources concerning: • Medical follow up by PCP or child abuse specialist • Crisis intervention phone numbers • Patient/family support and counseling services • Crime Victims Compensation Program • DHS Child Welfare and LEA

MEDICAL FOLLOW UP VISIT

	Recommend within 2 weeks of initial exam. The two-week follow up visit may be done by the child's PCP or by a child abuse specialist depending on community protocol and the child's medical needs
Medical Visit	**Review with patient and/or parent/guardian** 1. Emergency Department/clinic record 2. Lab results 3. Current physical symptoms 4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, behavioral issues, other) 5. Concerns for safety 6. Concerns regarding STDs and HIV 7. Assess social support and any new concerns or family issues 8. Additional history or information regarding the assault; report any new allegations to LEA and DHS Child Welfare agency
Physical Exam	**Depending on history and symptoms** 1. Evaluate for resolution and healing of injury 2. Evaluate current symptoms

Laboratory Tests	**Depending on risk and concerns of patient or family/guardian consider:** 1. Obtain urine pregnancy test from postmenarchal patient. Let patient know that this is only a screening test and should be repeated if patient does not have a regular menstrual period 2. Urine NAAT test or culture for gonorrhea and chlamydia if patient is symptomatic for STD or if postmenarchal patient was not given STD prophylaxis in emergency department 3. HIV: pre-test and post-test counseling required after exposure • Baseline • Three months • Six months 4. Hepatitis B/C serology--three months after exposure 5. Syphilis serology--three months after exposure
Treatment	1. Prophylaxis with Hepatitis B vaccine may be initiated up to 14 days post assault; indicated if there has been secretion-to-mucosal contact and if patient has not been fully immunized; counsel regarding completion of series 2. Assess and treat anogenital complaints and any other medical conditions as needed 3. Refer for further medical follow up, mental health and social services

IX. EMERGENCY DEPARTMENT REFERRAL TO CHILD ABUSE INTERVENTION CENTERS (CAICS)

Every child reasonably suspected of having been sexually or physically abused should receive a skilled, complete, therapeutic child abuse medical assessment (ORS 418.780-796)

COUNTIES WITH CAICs

	In Oregon there is a network of child abuse intervention centers (CAICS) that provides medical follow-up and evaluation for abused children and adolescents. Emergency Departments and CAICs should establish interagency protocols regarding timely notification, referral, and release of medical information related to patients presenting in the Emergency Department with concerns of sexual abuse. In this way, children and young adolescents will have timely access to appropriate medical follow-up and thorough child abuse assessments by child abuse medical specialists

COUNTIES WITHOUT CAICs

	Each county in Oregon has a Child Abuse Multidisciplinary Team (MDT). MDTs are obligated to provide a coordinated response to reports of child abuse In counties where there is no CAIC, timely mandatory reporting by Emergency Department staff and expedited release of medical information related to patients presenting in the Emergency Department with concerns of sexual abuse will facilitate prompt patient referral to a medical provider trained in the area of child abuse

X. CONSULTATION WITH CHILD ABUSE EXPERTS

STATEWIDE CHILD ABUSE CONSULTATION NETWORK

	Consultation with child abuse medical experts is available through the network of child abuse intervention centers and through the Regional Child Abuse Training and Consultation Centers at CARES Northwest in Portland, KIDS Center in Bend, and Jackson County Child Advocacy Center in Medford. CARES Northwest provides 24-hour phone consultation. During business hours call (503) 331-2400. After hours and weekends call (503) 413-2200 and ask for the CARES Northwest on call examiner.

RECOMMENDED STD PROPHYLAXIS

	<45 kg (100#)	**>45 kg (100#)**
GC	Ceftriaxone 125mg IM **OR** Cefixime (Suprax®) 8mg/kg po x 1	Ceftriaxone 125mg IM **OR** Cefixime (Suprax®) 400mg po x 1
Chlamydia	Azithromycin (Zithromax®) 20mg/kg (max 1g) po x 1 dose **OR** Erythromycin 50mg/kg/d po ÷ QID x 10-14d	Azithromycin (Zithromax®) 1g po x 1 **OR** Doxycycline 100mg po BID x 7d
Trich/BV	Metronidazole (Flagyl®) 15mg/kg/d po ÷ TID x 7d	Metronidazole (Flagyl®) 2g po x 1

PREGNANCY PREVENTION MEASURES
IN ACUTE SEXUAL ASSAULT PATIENTS

- Plan B® (levonorgestrel) tablets, 0.75mg to be considered if:
  - ✓ Negative pregnancy test
  - ✓ At risk for conception
  - ✓ Best used within 72 hours of assault, but recommended up to 120 hours after assault

Prescribed As:

Plan B® 100mg tabs disp 2
1 tab po now and 1 tab po in 12 hours
OR
2 tabs po now

- Obtain consent for treatment for Plan B®
  OR
  Document consent or refusal in the medical record

THE HEALTHCARE PROFESSIONAL'S ROLE IN LEGAL PROCEEDINGS RELATED TO CHILD SEXUAL ABUSE EVALUATIONS

GUIDELINE

Medical providers who evaluate children for possible sexual abuse are quite likely to be called to court to discuss their findings. The clinician must be prepared to present findings in a neutral, objective manner. Adequate preparation, good communication skills and an awareness of commonly used questioning techniques are essential to competent courtroom presentation of examination findings.

GENERAL CONSIDERATIONS:

1. Fact witness vs Expert witness vs Consulting expert

Fact witnesses (also known as lay witnesses) are called to court to relate information regarding their own experiences. Fact witnesses may comment on what they have seen, heard, smelled, tasted or felt during a relevant event. They are not permitted to give opinions regarding the meaning of events or the causes of findings. Medical providers may expect to be asked to offer their opinions in court, so would generally not be considered fact witnesses.

Expert witnesses may be called to relate their own experiences but are also qualified to interpret findings and provide opinions. Experts may present information they have personally gathered (e.g., statements of children and family members, exam findings); they may comment on information gathered by others; and they may summarize and comment on the status of knowledge in their field of expertise.

Consulting experts are generally hired to assist an attorney in presenting his arguments. In many cases, consulting experts do not testify, rather they are hired to educate the attorney, to critique opposing experts, and to help attorneys frame questions which will bring out information supportive to the attorney's position

Witness fees: Fact witnesses are usually compensated only for mileage/gas expenses for travel to court, or may be issued a small stipend for their time. Since it is rare that a medical provider will NOT be asked on the witness stand to offer her opinion about the case at issue, it is reasonable and expected that a medical provider will charge an expert witness fee for time spent on the legal case.

2. Qualifying as an expert witness

Experts are qualified to provide opinions on the basis of special knowledge, training, and/or experience. The courtroom definition of an expert is different from how healthcare providers may define an expert. Professionals generally consider experts to be the "best" or best known in their fields -- those individuals who have written books, lectured, made important discoveries or otherwise advanced the field. The courtroom definition of an expert is broader and requires only that the individual know more about a relevant topic than the jury does. This would include as experts individuals who have obtained education in a particular discipline as well as persons with experience in a given area, regardless of their education. In court, experts are not limited to those who have made major contributions or gained notoriety in their field. The court relies upon experts to explain to the judge and jury matters with which they may not have knowledge or experience or might not otherwise understand.

All witnesses offered as experts must be "qualified" by the court before they are permitted to offer testimony. "Qualified" is another term which means something different in the courtroom than it does to professionals or to the lay public. "Qualifying" in the legal setting is a step that must be taken for the court to allow the expert to testify. The clinician's credentials and experience are presented so that the court can determine that the witness has the appropriate knowledge, skill, experience, training or education to offer information and opinion to the jury about the topic in question. Nurse practitioners and physician assistants should be prepared to explain their unique scope of practice and how it differs from that of physicians. In many cases, one or both attorneys will question the medical professional to help establish whether he should be qualified as an expert. On occasion, both attorneys will stipulate to the witness's expertise and there will be no questioning regarding the witness's qualifications.

In order to be qualified as an expert, the medical practitioner may be asked to describe his experience and training related to the topic on which he will testify. Typically, the clinician will be asked about formal education (degrees, areas of study), practical experience (internship, residency, professional positions), certification, and licensure, membership in professional organizations, publications, and prior courtroom experience. It is recommended that the witness be accurate and complete, neither too modest nor grandiose when relating professional history. It is important for the fact finders (judge and/or jury) to gain a sense of the depth of the expert's experience, as they begin to develop their opinion of the expert's credibility and value. Speaking slowly and in a conversational, friendly manner is recommended to engage the jurors and also to convey the human qualities of the healthcare professional. The medical provider should be prepared to estimate the number of child abuse cases she has evaluated, the quantity and nature of training relevant to the field that she has obtained, and the number of times she has been called as an expert or has testified in legal proceedings.

Serving as an expert witness is an important responsibility for medical providers. The issue of "irresponsible expert witness testimony" has arisen, most often pertaining to consulting experts brought in to refute a diagnosis of abuse. It has been suggested that all medical experts testifying in court about child abuse cases should be required to demonstrate general training and experience in evaluating child abuse and neglect, as well as specific training or experience pertinent to the particular type of case about which they offer testimony. Child abuse medical experts must be adept at the differential diagnosis of abuse vs illness vs accidental injury. It is also important that experts explain the measures they use to keep current in this specialized area of study.

3. A word about the Medical Hearsay Exception

It is not within the scope of these ***Guidelines*** to discuss the complexities of hearsay rules and exceptions. However, since the Medical Hearsay Exception is frequently mentioned within earshot of healthcare providers who conduct child sexual abuse evaluations, a brief consideration is in order. Very roughly, statements made for the purposes of medical diagnosis or treatment may be admitted into court through the testimony of a medical evaluator, rather than requiring that the patient testify to those statements in court. A key component to the exception is the requirement that the patient must understand that he is undergoing a medical examination at the time that the statements are made. Healthcare professionals can contribute to this understanding by making it a habit to always introduce themselves and their role to each patient, using language appropriate for the child's age and development.

Strictly for name recognition purposes, the Child Hearsay Exception (pertaining to information shared by minors) is mentioned here as another venue through which a child's statements may be admitted into court without necessarily requiring the child's testimony. Clinicians interested in additional discussion about hearsay rules and exceptions are encouraged to contact the District Attorney's Office or other legal counsel.

SOME TYPES OF LEGAL PROCEEDINGS FOR WHICH A MEDICAL EXPERT MAY BE SUBPOENAED

1. Grand Jury

- Cases are reviewed by the grand jury to determine if there is enough evidence to charge the accused with a crime.
- In Oregon, the Grand Jury is made up of seven citizens.
- The following participants are usually present for expert testimony at the hearing:
  - 7 citizens
  - 1 District Attorney
  - 1 witness (you)

- NOT present at Grand Jury hearings:
  - Judge
  - Opposing attorney
  - Defendant
- Medical providers testifying in Grand Jury hearings will likely be asked to outline their training and experience in the area relevant to the case.
- The style of testimony is much less formal than in a court trial. Witnesses
- generally have the opportunity to share their information with the jury in narrative style.
- There is no opposing attorney present, thus, no cross-examination.
- Expert witnesses are nonetheless advised to dress and conduct themselves most professionally while participating in Grand Jury proceedings.
- An "indictment" is issued if the Grand Jury decides that there is adequate
- evidence for the suspect to be charged with a felony.
- The health care professional may or may not be called to testify when the case
- goes to trial.

2. Pretrial Hearings

In some cases, particular issues that either side intends to present during the trial must first be screened during a pretrial hearing. Experts may be called to give testimony.

- Present during expert's appearance at a pretrial hearing:
  - Judge
  - Attorney who subpoenaed expert
  - Opposing attorney
  - Defendant
  - NO JURY
  - While these hearings are generally open to the public, there may be times
  - when the judge excludes witnesses or may even clear the courtroom, e.g.,
  - when a child testifies
- Examples of issues that may be considered:
  - Relevance of expert's information
  - Reliability of the concepts about which the expert will testify
  - In hearsay exception hearings, experts may be used to present statements made by the child and/or supporting information as to why the statements should be admitted during the trial
- Following a pretrial hearing, the expert may be advised by the subpoenaing attorney regarding any evidence which has been determined to be inadmissible in that case.

3. Criminal Trials and Dependency Hearings

Medical witnesses working with patients who may have experienced child abuse are commonly called in both criminal and civil legal proceedings. In simplest concept, cases are tried criminally

when a person has been accused of a particular crime. The "State," i.e., District Attorney's or Attorney General's Office, will present the case against the accused/defendant; a private and/or court-appointed defense attorney will argue for the accused. The burden of proof in criminal cases is "beyond a reasonable doubt". Dependency cases are brought to court to decide about taking custody of a minor away from the parent or current guardian. These are civil, not criminal, matters; no one is being tried for committing a crime. The level of proof required is "a preponderance of evidence," somewhat less exacting than in criminal proceedings.

See **"Anatomy of a Trial"** below for an overview of proceedings in criminal and dependency court cases.

4. Other Trials

There are any number of other reasons for which a healthcare provider may be required to participate in criminal or civil legal proceedings. She or he may be called to testify on behalf of patients or their family members (e.g., divorce or custody proceedings) or in response to charges filed against other professionals. Malpractice suits are their own particular challenge. The basic anatomy of trials outlined in this chapter is likely to apply to most of these circumstances. However, whenever a medical provider receives a subpoena or other legal notice to appear in court, he is urged to promptly contact the attorney issuing the subpoena and/or personal legal counsel and to become educated about what to expect in each specific circumstance. Consulting with fellow clinicians who have more experience in legal settings is also recommended.

5. Depositions

On occasion, medical professionals will receive a subpoena to be deposed on a certain case. Depositions are usually conducted by one party's attorneys to gain an understanding of what a witness will testify to in court. It is advised that the healthcare provider contact the subpoenaing attorney for details. Furthermore, it may be wise to contact personal/agency legal counsel for advice and to determine if such counsel will also participate in the deposition process.

Although there is no judge or jury present during a deposition, the medical witness may be questioned by several attorneys participating in the case. Deposition witnesses testify under oath and a transcript of the testimony becomes part of the case record. It is critical that the witness be prepared to discuss pertinent aspects of the matter and that any responses given be accurate. Statements made during depositions and, in some circumstances, taped depositions, may be admitted into later court proceedings and the witness may be called upon to justify any discrepancies between former and current testimony. Just as for other legal proceedings, it is reasonable and customary for medical practitioners to charge a fee for time spent participating in depositions.

ANATOMY OF A TRIAL

- Jury selection (if there is a jury on the particular case – e.g., there is no jury in dependency proceedings)
- Opening statements
- State's or plaintiff's case in chief
- Defense case
- Rebuttal
- Closing statements
- Deliberation (judge or jury)
- Decision

OUTLINE OF TESTIMONY FLOW

Qualification of the expert: The expert's credentials will be explored and decisions made about granting expert status (see Qualifying as an Expert Witness above). The examiner should give a complete and accurate account of professional training and experience.

Direct examination: The attorney who subpoenaed the expert will ask questions. Leading questions are not permitted. Generally the attorney will give the witness much latitude in responding to questions and will guide questioning so that the relevant facts and opinions are presented. The attorney is likely to want the witness to describe evaluation procedures and why certain procedures were followed, as well as the information obtained during the evaluation, and the examiner's opinions and conclusions.

Cross examination: The opposing attorney will ask the questions. This portion of the testimony is the most difficult for many witnesses. Some attorneys simply try to elicit information supportive to their case. Other attorneys may attempt to discredit the witness either subtly or in a hostile fashion. Leading questions are permitted.

Redirect examination: During redirect examination, the attorney who subpoenaed the expert may ask additional questions within the scope of topics covered in cross examination. These questions can be used to correct any misconceptions that may have arisen during cross examination or to re-emphasize critical information. Ideally, the attorney who called the expert will have picked up on any points discussed during cross examination that the medical provider could clarify or expound upon to enhance the fact finders' understanding of the case.

Re-cross examination: The opposing attorney is given another chance to refute or clarify statements made during the previous re-direct phase of testimony.

Rebuttal: A clinician may be called as an expert witness during the case in chief and, once his own testimony is complete, may also be asked to provide rebuttal testimony. When serving as a rebuttal witness, a healthcare practitioner may have an opportunity to listen to the testimony of an opposing expert and may be called upon to rebut information presented by an opposing expert or any other witness.

3. The expert witness as an educator

It is the expert's role to educate the judge and jury. The expert witness educates by helping the fact finder understand and interpret the evidence in a particular case. The education may be even more influential, however, because judges may utilize information gained during one trial to enhance their understanding of similar issues in other trials. To be an effective educator, the expert must be clear and credible.

The expert can enhance clarity by:

- Avoiding jargon (e.g., say "bruise" rather than "ecchymosis"; "redness" rather than "erythema")
- Or, when jargon is used, explaining the terms in common language (e.g., "ecchymosis, which means a bruise")
- Providing the information in such a manner that lay persons from the community, without advanced education, can understand the concepts
- Using visual aids and other media whenever possible
- Repeating major points several times
- Monitoring non-verbal cues of jury members to determine if a point has been made or if additional explanation is warranted

The expert can do the following to enhance credibility:

- Dress professionally
- Look at the judge or jury when speaking
- Present his credentials in a detailed, organized manner, stressing education and training in child abuse
- Answer each question truthfully and completely
- Remain calm and courteous irrespective of the demeanor of others in the courtroom
- Admit to what he does and does not know
- Acknowledge the existence of alternative explanations for findings
- Be prepared to present why alternative explanations were ruled out or viewed as less plausible
- Remember her role is as an expert witness, NOT as an advocate for one side or the other

Medical professionals should remain neutral in stating their opinions, by presenting information about alternative explanations for the exam findings and statements and by including information that led to acceptance or rejection of these possibilities. The clinician should help the fact finder understand how she made sense of the available information using objective data, research findings and experience. It is not necessary for the medical provider to apologize for any perceived limitations to his expertise and opinion. The practitioner is certainly more knowledgeable regarding medical matters than the attorneys, judge, and members of the jury. Additionally, there are always limits to current knowledge regarding a particular issue and the onus does not fall upon any single professional to justify those limitations.

It is important to keep in mind the limited role played by the expert witness in a trial. The expert is there to relate facts to the judge or jury and to help the judge or jury to understand the meaning of those facts. It is <u>not</u> the examiner's job to determine or suggest that a particular individual is guilty or innocent.

PREPARING TO TESTIFY

1. General background/ emotional preparation

Medical providers can take several steps to increase effectiveness and confidence and to reduce anxiety during court proceedings. This may be especially helpful when new to court testifying or if called to testify infrequently.

- Attend seminars, read articles, review video or audio tapes for tips on testifying
- Observe other trials:
  - view the testimony of other experts
  - become familiar with courtroom physical setting and procedures, e.g., most direct route to the witness stand, where/how the oath to tell the truth is administered, what to take to the stand, etc.
- Review court transcripts of trials to learn from testimony of other experts
- Discuss intended testimony and any concerns with the attorney who subpoenaed the expert
- Review and practice testimony with experienced testifiers who are not involved in the case
- Develop techniques which promote relaxation and confidence
  - Some examples:
    - Focus on breathing or other relaxation measures, repeat confidence-building affirmations, envision court scene as not intimidating, create a court preparatory ritual that you follow each time
    - Draw upon feelings of ease experienced in other life or professional instances in which you have been relaxed, confident, comfortable and/or competent

- Don't take what occurs when you testify as an expert witness personally

2. Basic case preparation

- Review and be very familiar with the contents of reports and charts
- Outline critical information
- Arrange material for easy access, especially that which you plan to take with you to the stand
- Check and update curriculum vitae--it must be 100% accurate
- Know the leading articles in the area and review any articles that are likely to be cited or are pertinent to your opinion or role
- Consult with other experts, if necessary

It is acceptable for medical providers to discuss a case with other clinicians and to obtain consultation as part of preparation to testify about findings or conclusions. However, it is important to note that witnesses are not supposed to discuss testimony given with other witnesses on the case.

3. The pretrial conference

A pretrial conference is an essential component of effective expert witness testimony. When a subpoena arrives, the healthcare professional should contact the attorney who issued it and set up a time to discuss the case. Ideally, the conference would occur before the day of the trial, unless the expert and attorney have a great deal of experience in working together. Both the witness and the attorney may need to do some "homework" after the pretrial conference, to enhance the presentation of the facts.

Attorney needs to know from expert…

- Expert's qualifications/ experience – review CV
- Findings and opinions and basis for those
- Possible use of media during expert's testimony
- Evaluation practices and procedures performed, in general and in this case
- Perceived strengths and weaknesses of the findings and opinions
- Any deviation from routine noted in case
- Pertinent general concepts
- Relevant literature
- Info about other experts involved
- Expert's fees
- Expert's availability and time restrictions
- Idiosyncrasies of the medical case that attorney may not know to ask about

Expert needs to know from attorney…

- What information is expected to be presented through the expert's testimony
- Other elements of the case which may impact the expert's opinion
- Likely cross-examination challenges
- Other experts involved
- When to show up, where to go
- Court idiosyncrasies
- Anything that has been deemed inadmissible, i.e., which expert is restricted from saying in court

It should be noted that, at times, an attorney might try to discourage the expert from presenting facts which are not favorable to his case. The expert should be prepared to firmly state her ethical obligation to respond honestly to the other attorney's questions. The expert should also review with the attorney any information she feels ethically obligated to present on direct examination. Just as it is critical in formulating a medical opinion that the healthcare provider remain unbiased and not be swayed by the conclusions and perceptions of others involved in the case, when testifying, the medical expert's credibility and value to the system rests upon her objectivity. This does not preclude advocacy. However, the medical expert must objectively arrive at her conclusion and then advocate, not for the patient, or against child abuse, but for that objective conclusion. This is perhaps best accomplished when the clinician expresses her medical opinion in the clearest and strongest manner possible.

4. Other subpoenas

There will be occasions on which a medical provider may be subpoenaed by the defendant's attorney on a case in which the clinician evaluated a child for abuse. If the professional has already been subpoenaed by the State or by the child's attorney, it is reasonable to discuss the matter with the attorney who subpoenaed first. Many times, the lawyers will come to an agreement about when the witness will be called and by whom and no further action is required on the part of the medical practitioner.

If the original subpoena comes from the defense, it is recommended that the healthcare professional contact the subpoenaing attorney to discuss the information about which the practitioner is expected to testify. The medical provider can decide whether or not to meet with that attorney. If such a meeting is arranged, it may be advisable for the clinician to record the interaction, as it is not uncommon for comments made during such meetings to be revisited in court, sometimes not in the same context as when they were originally discussed. Some providers bring a witness along to further substantiate what is discussed.

Subpoenas may also be issued for records or for materials upon which a medical expert's opinion is based. In general, it is important that the healthcare provider release records only to the court, rather than to an individual attorney's office. Some child abuse evaluation centers request that a court order be issued before they release any patient records. This serves to alert the court and both attorneys that the information has been provided. Frequently, records may be released without the appearance of the professional, or may be presented by a member of the professional's staff or team. Again, responding to the subpoena with a phone call to the issuing attorney is recommended.

When a subpoena requires that a medical provider make available all the information and resources used to formulate her opinion, it is advisable that the provider seek legal advice before proceeding. Commonly, such a subpoena arises from the attorney who has NOT called the clinician as a witness. It is not reasonable for any medical professional to identify all the texts and trainings and materials from which they have learned the skills of their field. Perhaps there are a few key references which may be highlighted, or a list provided of some of the materials that the expert has referenced. Before responding, the medical witness should discuss the subpoena with the attorney for whom the medical provider has been subpoenaed to testify, who may serve as an excellent advisor in these situations. The matter may be resolved when the attorneys discuss the intention of the subpoena or even take the matter before the judge to help refine the request.

YOUR DAY IN COURT

1. Experts should be calm, polite, professional and private

Medical witnesses would do well to consider that their testimony essentially begins when they leave home. It is important to dress most professionally. It is joked that all it takes to be a respected expert is an expensive suit, but it seems true that the first impression that a witness makes on judges and jurors goes a long way in establishing a baseline impression of professionalism. Witnesses should also behave especially professionally on court days – all day long. Who a witness may interact with outside the courtroom cannot be predicted. The judge or jurors may be among drivers encountered on a busy road. The opposing counsel may stand behind the witness in line at a neighborhood coffee shop. On the way to court or when waiting to testify in or around the courthouse, it is important to be aware that other individuals in the area may hear whatever the witness says. Whether speaking on a phone or in direct conversation with the attorney that called the witness or anyone else, medical providers should watch what they say and avoid discussing the case unless privacy is certain.

2. In the courtroom

The prepared witness:

- ♦ knows where to go and is familiar with courtroom procedure.

- has in hand those materials that he may want to refer to on the stand (usually just the medical report, or perhaps a particularly relevant article intended to be referenced).
- waits where previously arranged with attorney, if witnesses have been excluded from the courtroom.
- when called to the stand, approaches the bench and, depending upon the particular court's practice, takes the oath or arrives at the stand and then takes the oath to tell the truth.
- once seated on the witness stand,
  - gets comfortable,
  - positions the chair to face the fact finders (helps remind the witness to look at and direct answers to the jury, if present, or judge),
  - adjusts the microphone height for ease of speaking,
  - pours a glass of water, etc., whatever necessary to get settled and ready to testify.

See "**Anatomy of a Trial"** section above to review the format for questioning of witnesses.

To testify effectively, experts should:

- Speak slowly and clearly.
- Use narrative whenever possible
- Be descriptive – let the jurors see the case through your eyes.
- Be prepared to use simple analogies and examples to illustrate important points.
- Consider the use of media to enhance the fact finders' understanding.
- If any attorney makes an objection, stop speaking at once and wait for the judge's instructions.

One of the major challenges for a medical professional, in court, is that it is not permissible to simply "present the case" the way that healthcare providers are trained to formally communicate information about a patient. Information must be given in response to questions from the attorneys. Facts and opinions are generally offered to the fact finders in an order designed by the attorney to provide pieces of the puzzle that they want the jury to put together to come up with a conclusion in favor of their side. The attorneys can be viewed as facilitators or translators, mediating a conversation between the witness and the judge or jury. The judge or jury will be more engaged in the dialogue if the witness makes eye contact with them and directs responses to them.

Medical witnesses are encouraged to use narrative, rather than short, overly brief answers, whenever possible, when describing the evaluation process used, statements heard or findings observed. The expert may use this opportunity to outline "best practice" in the area of child sexual abuse evaluation and demonstrate how that was complied with in this particular case. It is important for the expert to provide rich details and vivid descriptions of observations and findings in order to allow the fact finders to "see" through the eyes of the expert. Use of the

patient's name and referring to specifics of her case demonstrates the clinician's attention to the individual child and reminds the jury and judge that they are there because something happened, not in general or in the abstract, but to a particular young person.

In answering each question truthfully and completely, the healthcare professional should provide information that will help the jury understand how she made sense of the available information using objective data, research findings and experience. When consultation with other professionals was part of the foundation for an expert's opinion, the consultation can be referenced as means by which the expert developed and/or supported her opinion.

When offering an opinion, the expert is advised to state it clearly, concisely and compellingly. Medical providers sometimes are uneasy about offering a definitive opinion, because they reason that, due to limitations in current medical knowledge, it is never possible to be absolutely certain. It is critical to realize that healthcare professionals are testifying to what they know to a "reasonable degree of medical certainty", not a universal absolute. As with all medical diagnoses, the clinician evaluating children for abuse considers the differential diagnosis, rules out other possibilities and eventually makes a determination as to whether the child has the condition in question. During the narrative portions of testimony, it may be helpful to outline the expert's thinking and diagnostic process, but it is critical to also be able to convey a bottom line. The medical diagnostician should be prepared to state his ultimate conclusion simply and objectively.

Examples:

- "It is my opinion that abuse occurred."
- "My diagnosis in this case is abuse."
- "Based upon the history and physical examination findings in this case, my conclusion is that the child was sexually abused."

3. Cross-examination challenges

It is acknowledged that appearing in court as an expert can be a daunting experience. The expert is a vehicle for information transfer, and participating attorneys will be seeking information favorable to their client. Court is, by definition, an adversarial process. It is essentially each attorney's job to cast doubt on the other side's case, which may include discrediting the opposing experts. Witnesses are advised not to take challenges personally, despite how personal they may appear. Medical experts are encouraged to remain unruffled and non-defensive, even when seemingly under attack. It may be heartening to consider that if the attorney is attacking and unpleasant while the healthcare professional remains calm and composed, the contrast may increase the credibility of the expert in the eyes of the jury.

Some tips for handling cross-examination professionally:

- Pay careful attention to each question asked.
- Never answer a question that isn't fully understood.
  - Ask that a question be repeated or clarified.
- With complex or multi-part questions:
  - Address each part separately, or
  - Ask that they be simplified.
- Take whatever time is needed to thoughtfully respond.
  - Slow is better.
- Be suspicious of anything that sounds like flattery
- Expert witnesses should not speak beyond their level of expertise or offer opinions on matter outside their field.
- Avoid engaging in philosophical discussions.
- Always remain calm and courteous – no matter what.

The cross-examining attorney may **ask misleading questions, make misleading statements regarding appropriate practice in the examiner's field or may misstate what the medical expert has said**. The witness is advised to listen very carefully to the questions and to comment separately on points made with which she may agree and to highlight those, in the expert's opinion, have not been represented accurately. A similar response is recommended when the witness is faced with **hypothetical questions**. The expert should clarify assumptions the attorney is making, should note which assumptions are problematic, and should delineate which of the assumed facts were or were not present in the case being tried.

Another approach that is used to unnerve witnesses is **rapid fire questioning.** The attorney fires one question after another at the witness, attempting to confuse, or fluster the expert, or to get the expert to answer inaccurately or in conflict with what he has previously stated. Although it is natural to respond to quick questions with quick replies, the medical expert is cautioned not to be caught in the whirlwind, but to interrupt the pattern and slow the pace by pausing to breathe and consider each question individually. This defeats the attorney's intention and allows for more complete and accurate expert testimony.

The attorney may try to **restrict the witness's answer** by requesting a yes or no response or by cutting off the witness in mid-sentence. Apparently, there is no case law or ruling that forces a witness to give a yes or no answer. In response to either of these tactics, the expert witness should emphasize her obligation to tell the whole truth. The medical provider can do this in many ways, for example, by stating, "If I answer 'yes' or 'no' to that question, it may mislead the jury." Alternatively, "I took an oath to tell the whole truth. Answering only 'yes' or 'no' (or Not permitting me to finish my answers…) does not allow me to do so." Even if the judge

supports the attorney's style of questioning, the witness has alerted the jury to be suspicious and has drawn the other attorney's attention to issues address on redirect examination.

It is important for medical experts to be familiar with leading articles in the areas about which they will testify. The cross-examining attorney may bring into evidence articles, **"learned treatises,"** which dispute the expert's opinions. The attorney may try to get the expert to accept the authority of the article and its relevance to the case prior to quoting it or excerpting passages that appear to contradict the expert's testimony. If the expert is aware of the article and has concerns regarding the article's credibility or is concerned that the attorney may be misquoting or taking a point out of context, the expert should immediately express these concerns. If unaware of the article, the responsible expert should simply state that fact and request a court recess to secure ample time to critically review the article and to ensure that the attorney is using the article responsibly. After reading the article, the expert will be in a better position to decide whether to accept or dispute the article. At times, it may be necessary to consult with other experts regarding a particular article, (for example, if the author's point is unclear or if data presented in the article cannot be clearly interpreted). If the witness accepts the authority of the article but did not rely upon it in this case, he should articulate why other research was more pertinent or why this article has been criticized and was not thought relevant to this particular case.

Several topics in the field of child sexual abuse evaluation are frequently raised in court. Although it may seem that these issues mainly apply to child interviewers, medical providers who assess children and teens for abuse may also be expected to testify about these subjects. Medical experts are wise to also be familiar with recent thinking and references about:

- Disclosure process
- Suggestibility
- Recantation
- Veracity criteria

More information about these topics is contained in the ***Guidelines*** chapter 8, "**History from the Patient: the Medical Interview,"** and in the ***Oregon Interview Guidelines***.

Sometimes, when an attorney asks a difficult question of an expert, it is least damaging to simply concede. Examples:

- The expert doesn't know an answer.
- The expert didn't do something (e.g., order a certain test, interview a specific individual, publish an article, review the world's literature on the topic).
- The expert does not have training or title in a certain area (not a brain surgeon, never studied aerodynamics, etc.).
- The expert is unfamiliar with a particular concept, reference or supposed authority.
- The number of times the expert has:
  - evaluated a child for sexual abuse

- testified in court
- testified for "the other side"

The medical professional can determine, based upon the individual circumstances, if it may be useful to offer an explanation, e.g., "It is my role to evaluate the child, not to conduct investigative interviews of the suspects," or, "I have been subpoenaed by the defense several times, but after discussing the case, they have never actually called me to testify." Or, it may be preferable to answer directly and briefly, e.g., "I have been evaluating children for sexual abuse for six months now," or, "No, I am not a physicist."

A common concession that an expert may be asked to make is in response to the question, "But anything is possible, isn't that correct?" The medical diagnostician can make that global concession, yet bring the fact finders' attention back to the case in point by adding a caveat. For example, "It is a cliché to say that anything is possible, BUT…

- "that is not my conclusion in this case."
- "in my professional opinion, it didn't happen that way."
- "it is very unlikely."
- "that explanation is not reasonable."

Yet another cross examination strategy is to try to get the expert witness to repeatedly answer, **"I don't know."** This may be accomplished by asking about obscure or new research, by asking questions with no precise answer, or by questioning the expert about matters outside his field. The attorney's tactic of trying to demonstrate that the medical professional lacks an expected information base is unlikely to be effective when the expert has already displayed knowledge and expertise during direct examination and if the witness remains composed despite the badgering. The medical expert can, as mentioned above, offer an explanation for why that information is not known or cannot be known or can state that it is not within the expert's particular area of expertise. On redirect examination, the subpoenaing attorney can further dispel any perceived lack of competence that the cross examining counsel had attempted to imply.

Finally, the attorney may attempt to **imply that the witness is biased**. The best defense against this claim is for medical providers to take steps to ensure objectivity in their evaluations and to be able to present these in court. As stated previously, the healthcare professional should be prepared to explain the careful differential diagnosis considered and should be able to articulate why alternative explanations for the child's findings were ruled out. If challenged about any of the following, medical experts can acknowledge that they are paid for their *time* testifying, rather than being paid for their *opinion*. Experts can explain that, in the courtroom, they are advocates for what they believe to be the truth, rather than for the child or defendant and that they consider their obligation to be to the court and the community rather than to a particular attorney or side.

Willingness to testify to the facts, regardless of which "side" is issuing the subpoena, also may increase impression that an expert is impartial. For practitioners who are closely affiliated or who may be employed by community agencies that are involved in prosecution or investigation of child abuse cases, the perception of bias may be exploited by cross-examining counsel. While not denying the fact of such relationship, the effect of such claims may be diminished by the expert who asserts in court that it is his primary commitment is as a medical professional whose job it is to analyze the history, physical and laboratory findings on each patient in order to arrive at an objective medical diagnosis. The expert can convey that this commitment is taken seriously and is adhered to above any employment, political or organizational considerations.

Serving as a witness in court is not a favorite pastime for most medical professionals. However, effective testifying is a skill that can be learned and practiced. It is worth doing well, for the sake of the patients with whose care clinicians are entrusted and also to represent healthcare providers as objective seekers of truth. Effective expert witnesses realize that courtroom attacks are not personal and, as much as possible, they leave their feelings out of legal proceedings. They are aware that medical experts are not responsible for the outcome of the case. They contribute just a piece to a much greater puzzle that the attorneys guide the fact finders to assemble. Ultimately, expert witnesses have no control over how the judge and jury will weigh the expert's contribution to the case. There are no legal consequences for the expert if the judge or jury disagrees with his opinion or if they find another witness' opinion to be more compelling. Medical evaluators of children who may have experienced abuse may be reminded that the task in court is simply to "tell the truth". Having maintained neutrality while deriving a medical conclusion, the expert then promotes his point of view in court. Effective court testimony can be strong advocacy for abused children.

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