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Medical Response to

Child Sexual Abuse

A Resource for Professionals
Working with Children and Families



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Medical Response to Child Sexual Abuse

A Resource for Professionals
Working with Children and Families

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FOREWORD

Substantiation of reports of sexual abuse of children has been declining since 1990, reduced by 51%, according to Jones (*Childhood Victimization: Violence, Crime, and Abuse in the Lives of Young People*). Researchers in this field expressed doubt that this steep decline could be real, and this prompted further investigation (*Child Abuse Negl.* 2001;25:1139-1158). The findings of this research suggested the decline was real and did not reflect changed standards by agencies or other artifactual explanations (*Explanations for the Decline in Child Sexual Abuse Cases*). They found that this decline paralleled other social improvements: the fall in teen suicides, teenage births, numbers of children living in poverty, youth runaways, juvenile drug use, and improvements in child behavior problems and competence scores on the Child Behavior Checklist.¹ While considering numerous factors to explain these trends, Finkelhor and Jones suggest that agents of social intervention “could well have curbed child victimization through a number of mechanisms” (*Childhood Victimization: Violence, Crime, and Abuse in the Lives of Young People*). These agents include police, victim advocates, legal advocates, teachers who educate about maltreatment and domestic violence as well as the media, who have raised awareness of victimization by reporting on maltreatment and portraying it in film and on television.

I believe another factor involved: more highly developed professional skills at all levels of the diagnostic process. Over the last 25 years, the evidence base in child sexual abuse has grown exponentially. Since 1994, over 300 peer-reviewed articles have been published in medical journals alone, and this figure doesn’t include research published in the social sciences, mental health, legal and law enforcement publications. In addition, the education and training of professionals for this field of practice has improved substantially. This ensures more accurate diagnosis in these cases and avoids confusing normal variants or other mimics of sexual abuse for true cases.

This is where this up-to-date, well-written book is so helpful. The authors of the various chapters in *Medical Response to Child Sexual Abuse* are truly experts in the field, with clinical experience and research to bolster their writing. There are chapters in this volume that are not available in other books on sexual abuse: the background and history of the field, special problems of adolescent patients, qualifications of medical examiners, child sexual abuse as a global issue, child sexual abuse as a symptom, an approach to the disabled child who may have been abused, and sexual abuse prevention strategies, to name just a few. These, in addition to the basics about anatomy and the medical approach to diagnosis, will equip the child abuse professional to be more proficient and precise in the performance and interpretation of a child sexual abuse evaluation.

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FOREWORD

We may never truly know exactly how many children are sexually abused during their childhood years, but we do know that the numbers are enormous. Child sexual abuse is more common than childhood cancer, juvenile diabetes, and congenital heart disease combined. Despite this, public discussion or even acknowledgement of this issue was not commonplace throughout most of history. This is no longer the case today. In fact, public awareness of the problem has never been higher. Internet predators, clergy abuse scandals, and cases involving child pornography regularly make local and national headlines alongside countless other stories of children being sexually abused by family members or other close contacts. Many of the television crime dramas watched by children and parents alike now routinely include stories about the sexual abuse of children. As our collective awareness of the problem of child sexual abuse has grown, so has the recognition that the response of the professional community must involve a collaborative, multidisciplinary approach in order to be successful. Law enforcement, social services, mental health, and medical providers now routinely work closely together to respond to cases of child sexual abuse, each providing their own specific services and expertise to respond to this problem. Of particular importance in this multidisciplinary approach to the care of sexually abused children is the medical component. There have been many changes over the past several decades with regard to what “having a medical evaluation” means for sexually abused children. Much has been learned about anatomy, interpretation of findings, evidence collection, medical management, therapy, and prevention. Consequently, the current standards of care for the medical management of sexually abused children are quite different today than in decades past. It is critical that all professionals who work with sexually abused children are familiar with what the medical response should involve.

It is in this context that Dr. Rich Kaplan has brought together many of the world’s leading authorities regarding child sexual abuse to create *Medical Response to Child Sexual Abuse*. Dr. Kaplan brings his vast experience and his unique perspective to this text, having worked with abused children for over 30 years—first as a social worker and then as a pediatrician. His thoughtful, thorough, objective, meticulous, and hopeful approach to providing care to children is reflected throughout the book. Dr. Kaplan and his co-authors cover a vast amount of material in a clear and easily accessible manner. Although written from a medical perspective, *Medical Response to Child Sexual Abuse* is intended as a comprehensive resource for both medical as well as non-medical professionals. To know what the current, state-of-the-art standard of care approach to the medical evaluation of sexually abused children is, this text will serve as a primary resource.

The chapters that address basic anatomy of the genitalia and anus as well as the medical evaluation when sexual abuse is suspected should be mandatory reading not only for every clinician who provides medical care to children, but also to any other professional who works with sexually abused children. This book clarifies and demystifies the examination process, and most importantly, addresses what exams can and cannot “tell” us. We recognize that when children disclose sexual abuse, they do so in various timeframes, having experienced a wide variety of abuse. How does the care of a child who discloses an event that occurred yesterday differ from that of one who discloses an event from last summer? How does the care of an adolescent differ from that of a young child? What kind of medical management is required? We have learned that there is no “one exam fits all” response to child sexual abuse. This text addresses all these issues at length and allows the clinician to provide the best possible care to their patients. One of the most important issues in the medical evaluation of child sexual abuse is to ensure

that physical findings are identified correctly for what they are. Dr. Kaplan's text addresses these issues at great length as well. *Medical Response to Child Sexual Abuse* also assists providers in working with children and families with the long term consequences of sexual abuse.

Quite simply, this text provides everything that professionals who work with sexually abused children and adolescents need to understand the medical response to child sexual abuse. Medical providers who are familiar with this information will provide even better care to the children they serve and will be more effective members of their community's multidisciplinary team. The non-medical professionals who use this book will better understand exactly what it is that medical providers can do for children and for them. We owe Dr. Kaplan and his co-authors a debt of gratitude for creating such a singularly useful text for all professionals who work with these children and their families.

James E. Crawford-Jakubiak, MD, FAAP

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FOREWORD

Medical Response to Child Sexual Abuse is a carefully crafted compendium of chapters taking the reader from an initial review of history to a glimpse of hope for the future. Along the way, we learn a great deal about what is known about child sexual abuse from basic anatomy to 5 chapters focused on medical evaluation issues, and other chapters presenting information on evidence-based literature review, the description and value of multidisciplinary teams, collaborative practice models, the importance of prevention and expanding perspectives for the way we think about and react to the sexual maltreatment of children.

As the field of child abuse pediatrics has recently evolved into a pediatric subspecialty, we plan to increase the education of all health professionals in the many facets of violence and abuse involving children. The goal is to have informed health care providers at many levels, from those delivering primary care and those with increased knowledge and clinical competencies in child abuse to the pediatricians who are board certified in the subspecialty.

We have learned a great deal over the last several years about the lifelong consequences of maltreatment. If we can properly discover, treat, and remedy the effects of sexual abuse, we cannot only foster healthy lives, but we can also dramatically affect the huge economic costs of morbidity and mortality created by unrecognized abuse followed by health behaviors and physiologic responses to the stress created by the abuse.

An important outcome of having a uniformly informed cadre of clinicians evaluating children who may have been sexually abused will be consistency with the process of initial evaluation and treatment, follow-up care, documentation of important findings, and collaboration between physicians and other professionals. This text, complete with up-to-date information on interpretations of physical findings including conditions that may mimic sexual abuse, sexually transmitted infections, and forensic interpretation, is a template for the consistency we desire. The reader will find well-referenced chapters, allowing easy access to the literature supporting authors' opinions and advice. Case scenarios and clear examples of clinical situations as well as reports of successful approaches to child abuse prevention and intervention will assist readers in evaluating their own programs and/or developing new programs.

The contributors chosen by the authors are well known in the field and collectively have a great amount of experience, paving the way for the next generations of dedicated professionals that have a desire to work with children to both prevent their abuse and to intervene with an appropriate evaluation and diagnosis of sexual abuse when necessary.

We know now that most physical examinations of children alleging sexual abuse will be normal. Descriptions of these examinations are not only important medically, but legally as well. This is also true for descriptions of injuries when they are found. Appropriate treatment, whether for the emotional stability of the child, or for injuries or infections is an important facet of our work. *Medical Response to Child Sexual Abuse* clearly defines practical, evidence-informed advice for documenting and managing a variety of cases. When we are confronted with substantiating our findings and opinions in court, it is helpful to know that this text will be an accepted authority to support our work. For those future pediatricians who will bravely enter into fellowships in child abuse pediatrics, this book will pave the way to successful passage of certification examinations. For other health care providers, incorporating the information provided in the text will enable them to practice in an equivalent, evidence-based style consistent with the best

practices all our children deserve. After all, it is our children for whom we seek the knowledge and skills necessary for their care.

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PREFACE

The concept of medical care for children who are possible victims of child sexual abuse is relatively new. In the last decade, we have seen the medical care for these children undergo a significant evolution in which we now see these children as patients who require medical attention and care. The focus of this book is to address the medical care for these children from a variety of perspectives.

Our central goal has been to demystify the medical care of these children, and it is emphasized that while there are special competencies involved, this is much more similar to medical care for other conditions than it is different. When caring for a child who is a possible victim of child sexual abuse, the same principles and standards of medical care exist, such as obtaining a complete and well-documented history and physical examination, performing an appropriate and scientifically driven laboratory evaluation, and forming a medical diagnosis to guide the ongoing care needs of the child. This is the definition of good pediatric medical care. It should be clear that the medical component is simply one part of the response to possible maltreatment, but we hope that this text will help crystallize the elements that make this component such an important part of the community response.

While the legal issues certainly are important for the safety and well-being of children, the focus of this text primarily will be on the medical and therapeutic care these children need to heal and, hopefully, to have a happy and productive life.

In *Medical Response to Child Sexual Abuse*, we have brought together national experts and scholars with a variety of expertise in the scientific fields that relate to the care of young victims. This group of contributors has created an impressive and helpful text that covers the entire range of the medical response to child sexual abuse. While the focus of this book is medical care, it is our hope that other members of the multidisciplinary team will find this a useful reference.

We would like to thank all the wonderful contributors for their hard work and their patience in the development of this text. Collaboration with them has been both gratifying and educational, and hopefully it will be the same for those who use this text as a reference.

Rich Kaplan, MSW, MD, FAAP

Joyce A. Adams, MD

Suzanne P. Starling, MD, FAAP

Angelo P. Giardino, MD, PhD, MPH, FAAP

REVIEWS

This text is destined to be an excellent resource for novices as well as experienced providers of medical care to victims of sexual abuse. In addition, investigators and social workers without medical backgrounds will benefit from increased understanding of the nature, importance, and value of these medical assessments. Clinicians faced with the seemingly never-ending stream of victims will find the last chapter on prevention particularly helpful, providing hope that we can effect change.

Deborah Lowen, MD
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This textbook offers a comprehensive and detailed accounting of the medical assessment of the alleged childhood sexual abuse victim. It serves as an excellent resource for the multidisciplinary team responsible for the evaluation of these complex cases. Both Martin Finkel and Allan De Jong have provided the clinician with a well-referenced guide for how to accurately and effectively medically assess, interpret, and document sexual abuse or assault in children and adolescents. Anyone working in the field of child maltreatment should add this publication to their annals.

Barbara L. Knox, MD, FAAP
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This is a valuable, exhaustive resource combining anatomic, epidemiologic, therapeutic, and preventative strategies for children and young adults. Beginning with historical context and moving through basic anatomy, physiology, and pathology, the reader quickly learns best practices in health services for sexual abuse, assault, and exploitation. Team approaches, collaboration, telemedicine, training, treatment, and mental health services are reviewed in great detail, and there is a superlative discussion of research methods and the state of knowledge in the field topped off with legal and international issues and prevention. This book should be read by any professional who wants to responsibly provide services for children and families facing these difficult problems.

Vincent J. Palusci, MD, MS, FAAP
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This comprehensive text will be an invaluable resource to any medical provider who has contact with children. With topics ranging from basic genital anatomy to court testimony and future directions for prevention, it is an excellent resource not only for those whose careers are primarily focused on child sexual abuse but also to those who simply desire a basic understanding. In recent decades, there have been tremendous advances in medicine related to child sexual abuse, and this book synthesizes all of this information.

Mark Hudson, MD
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St. Paul, Minnesota

This comprehensive text ought to be available to each multidisciplinary team member tasked with treating and/or investigating child and adolescent sexual abuse and assault.

Diverse topics are carefully addressed including interviewing children with impairments, commercial sexual exploitation, and efficacious mental health therapies. Dr. Allan De Jong's chapter on acute sexual abuse should be required reading for physicians and sexual assault nurse examiners tasked with forensic evidence collection and acute medical treatment. Dr. Martin Finkel details the highest standards to which clinicians should adhere as they elicit histories, conduct physical exams, and complete medicolegal documentation. This text is an excellent resource for both novice and established clinicians who serve child sexual abuse survivors and their families.

Tanya Hinds, MD, FAAP
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Dr. Kaplan's new text is much more than a "how to do a sexual abuse exam" or a "how to interpret the exam" handbook. The book includes chapters on how to talk with families after the examination, the history and future of child sexual abuse prevention, and child and youth prostitution and pornography. This is both a reference book and a thoughtful stimulus to broaden our thinking about the causes and effects of child sexual abuse and the role of the medical professional in caring for our patients and for the community.

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Medical Response to

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THE MEDICAL RESPONSE TO CHILD SEXUAL ABUSE: AN HISTORICAL OVERVIEW

Rich Kaplan, MSW, MD, FAAP

It is fitting for a textbook on medical care for victims of child sexual abuse to begin with a view toward the past. The social, scientific, and clinical factors that have evolved are briefly reviewed in this chapter in order to provide an historical context in which to view current practice and perhaps a vantage point from which to view the future.

FROM THE DAWN OF CIVILIZATION

The sexual maltreatment of children appears to be as old as civilization. Claude Levi-Strauss¹ described the incest taboo as being present from the “dawn of culture.” There are many descriptions of child sexual abuse from a variety of ancient cultures. The description of Lot being seduced by his daughters in Genesis suggests that both sexual contact with children and incest were social issues in ancient times. In a fascinating depiction of the sexual mistreatment of young children in the Byzantine Empire from 324-1453 CE, the abuse of children from both peasant and royal classes is described.² The authors conclude that “child sexual abuse is an ancient social phenomenon” and despite political and religious prohibitions, “the problem seems to have remained endemic in all social classes.” Likewise, references to child sexual abuse among ancient Greeks, Romans, Egyptians, Hebrews, and others have been reported.³

Through the Renaissance, Enlightenment, and Modern Era, maltreatment—including sexual abuse—showed no evidence of abating. Accounts of sexual abuse from early 20th-century Scotland⁴ and Canada⁵ give disturbing insights into the response to child sexual abuse in the relatively recent past. Even as society articulates its abomination of child sexual abuse, there is no doubt that it persists and, with the advent of modern technology, has added new forms.

THE EARLY MEDICAL RESPONSE

As pervasive as the sexual maltreatment of children has been throughout recorded time and as widespread the religious, political, and cultural sanctions against such abuse have been, people may conclude that the medical community has, with equivalent consistency and vigor, responded to this abuse as it has to other major health concerns. However, the medical response to child sexual abuse has been, for the better part of modern history, absent or—at best—sputtering and sporadic.

There was an attempt at a response early in the second half of the 19th century when a visionary French pathologist named Ambroise Tardieu wrote the remarkably accurate and essentially first modern medical descriptions of both child physical and sexual abuse.^{6,7} Tardieu described and analyzed over 900 cases of sexual abuse of both boys and

girls. His drawings of genital findings (**Figures 1-1 through 1-5**) are extremely accurate and hold up well even in the colposcopic age. Like so many scientific visionaries, Tardieu's work was remarkably underappreciated by his contemporaries. Rather than becoming the observational cornerstone for a burgeoning line of scientific inquiry and clinical practice, it faded into obscurity for well over a century.

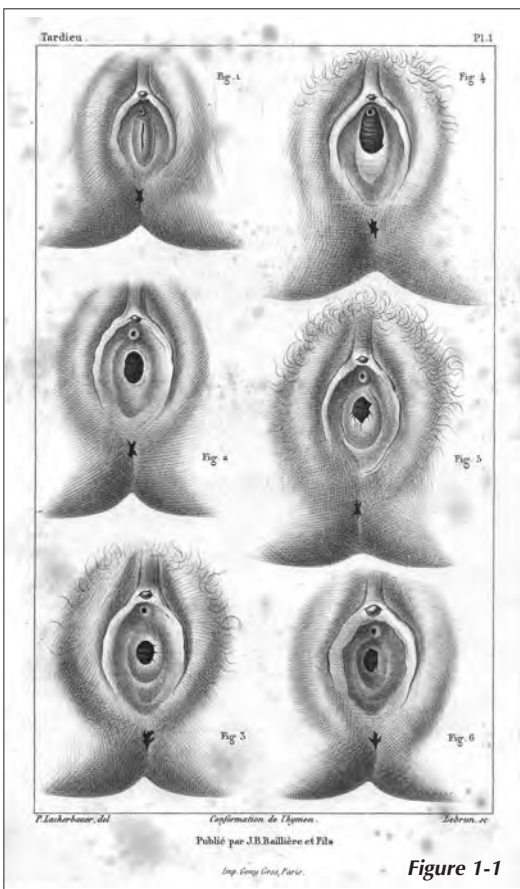
It is not entirely fair to say that Tardieu was completely alone. Several other French physicians addressed the issue of child sexual abuse during this brief enlightenment. Masson⁸ describes works by Lacassagne, Garraud, and Bernard that support Tardieu's work and elaborate on the incidence and nature of the sexual abuse of children.⁹ In fact, in *Des Attentats a la puduer sur les petites filles (The Sexual Assault on Young Girls)*, Bernard noted 36 176 reported cases of "rape and assault on the morality of young children" between 1827 and 1870. These works notwithstanding, considering the prevalent social and medical response to child sexual abuse, Tardieu was essentially a voice in the wilderness that was quickly forgotten.

Figure 1-1.
Tardieu's drawings
of genital findings.
Reproduced from
Tardieu A. *E'tude
me'dico-le'gale
sur les attentats
aux moeurs.* 7th
ed. Paris: Librairie
JB Baillie're et
Fils;1878.

What stands as perhaps the best example of the 19th century's social and medical ambivalence toward the sexual abuse of children comes from a man who was certainly no stranger to ambivalence—Sigmund Freud. Long a source of great speculation and debate, it is clear that in less than 3 years, Freud—at least publicly—abandoned his revolutionary seduction theory, which essentially identified sexual abuse as a cause of hysteria, in favor of the now-famous Oedipal complex. Whether Freud's reversal was the result of social and professional pressure^{8,10} or because of a natural evolution of psycho-

analytic theory¹¹ is well beyond the scope of this chapter. Suffice it to say that at least on one level, the child victim became a seductress.¹² Postulating that children have sexual feelings toward a parent essentially made them coconspirators in any incestuous abuse.

If Tardieu's unappreciated pioneering and Freud's about-face serve as metaphors for 19th century medicine's inability to respond scientifically to child sexual abuse, then we need to look no further than the issue of childhood gonorrhea for a metaphor for the same inability for the early part of the 20th century. By the early 20th century, the science of medicine had clearly established a causal link between sexual contact and venereal diseases, including gonorrhea. However, it was not until the 1970s that there was general acceptance of the role of sexual abuse in the etiology of childhood gonococcal infections. Evans pointed out that, with respect to children, for the better part of the century, "physicians consistently downplayed and often denied the possibility of sexual transmission, providing other, less plausible explanations."¹³ Arguments about differences in prepubertal anatomy and physiology that supported nonsexual transmission were proposed from multiple credible sources. Even when sexual transmission was acknowledged, it was not thought to occur in good families. As late as



BASIC ANATOMY OF THE GENITALIA AND ANUS

Joyce A. Adams, MD

In order to recognize signs of child sexual abuse, it is necessary to first be familiar with normal genital anatomy, its variations, and its development. While this may seem obvious, the lack of understanding of the many variations in normal appearance of the genital and anal tissues in children has led to misunderstandings among medical and non-medical professionals alike. Even after the publication of the first detailed descriptions of anal and genital anatomy in non-abused prepubertal children,¹⁻³ some physicians and nurses who perform child sexual abuse medical evaluations are not familiar with the findings from those and subsequent studies.⁴⁻⁹

When a child's examination is thought to show signs of injury or abuse but actually represents normal findings or evidence of another medical condition, the medical provider may contact child protection and/or law enforcement officials to report the suspicions. The child and family would then be unnecessarily traumatized by a referral and investigation of those suspicions.

It is also important for medical and nursing professionals, as well as non-medical professionals, to be able to speak the same language when describing features of genital and anal anatomy in children and adolescents. Anatomy courses in medical and nursing school rarely provide the necessary detail about the features of genital anatomy in children, usually focusing on adults and on pathology common to adult patients rather than children.

In the early 1990s, a group of physicians met at conferences to agree on proper terminology for describing features of genital and anal anatomy, and the results of a 4-year consensus development process was published by the American Professional Society on the Abuse of Children in 1995. Some of the definitions were taken from standard medical dictionaries and anatomy textbooks, but, out of necessity, other definitions were created by specialists working in the field of sexual abuse medical evaluation.

Table 2-1 is a list of terms and definitions from that publication.¹⁰

Table 2-1. Basic Genital Anatomy, Related Terminology, and Definition of Terms.¹⁰

ANATOMICAL STRUCTURES IN THE FEMALE:

- **Mons pubis:** The rounded, fleshy prominence, created by the underlying fat pad that lies over the symphysis pubis (pubic bone).
- **Vulva:** The external genitalia or pudendum of the female. Includes the anterior commissure, clitoris, labia majora, labia minora, vaginal vestibule, urethral orifice, vaginal orifice, hymen, and posterior commissure.

(continued)

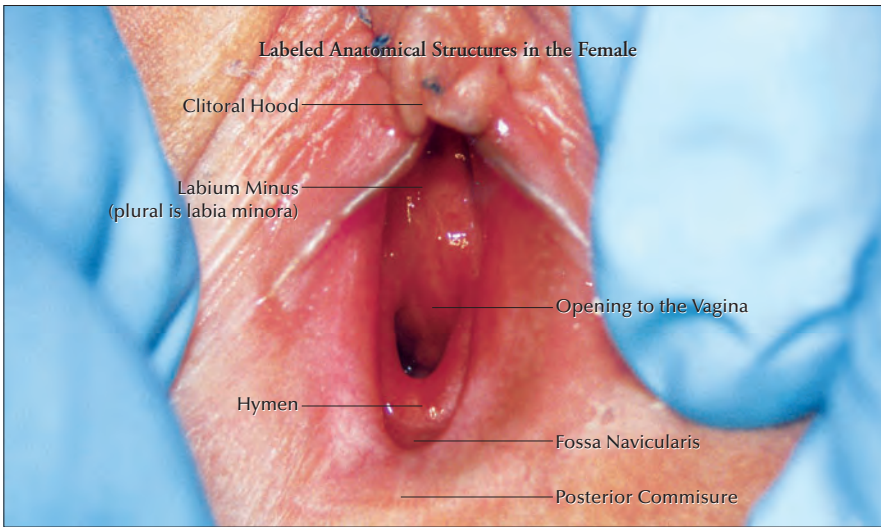


Figure 2-5. Labeled anatomical structures in the female. Photograph of a 5-year-old girl, examined in the supine position using labial separation. See Table 2-1 for definitions.

Table 2-2. Descriptive Terms and Definitions Related to the Hymen.¹⁰

ANATOMICAL STRUCTURES IN THE FEMALE:

- **Annular:** Variation in morphology where the hymenal membrane tissue extends completely around the circumference of the vaginal orifice.
- **Crescentic:** Hymen with attachments at approximately the 11 and 1 o'clock positions with no tissue present between the two attachments.
- **Cribiform:** Hymen with multiple small openings.
- **Imperforate:** Hymenal membrane with no opening.
- **Septate:** Hymen with two or more openings, caused by bands of tissue that bisect the opening.
- **Fimbriated:** Hymen with multiple projections and indentations along the edge, creating a ruffled appearance.
- **Redundant:** Abundant hymenal tissue that tends to fold back upon itself or protrude.
- **Hymenal mound or bump:** A solid elevation of hymenal tissue that is wider or as wide as it is long, located on the edge of the hymenal membrane. This structure may be seen at the site where an intravaginal column attaches to the hymen.
- **Hymenal tag:** An elongated projection of tissue arising from any location on the hymenal rim.
- **Hymenal cyst:** A fluid-filled elevation of tissue, confined within the hymenal tissue.
- **Hymenal cleft:** An angular or v-shaped indentation on the edge of the hymenal membrane.
- **External hymenal ridge:** A midline longitudinal ridge of tissue on the external surface of the hymen. May be either anterior or posterior and usually extends to the edge of the hymen.

Definitions taken from "Practice Guidelines: Descriptive Terminology in Child Sexual Abuse Medical Evaluations" published by the American Professional Society on the Abuse of Children, 1995. Adapted and reprinted with permission from the American Professional Society on the Abuse of Children.

THE MEDICAL EVALUATION OF AN ALLEGED CHILDHOOD SEXUAL ABUSE VICTIM

Martin A. Finkel, DO, FACOP, FAAP

Sexual abuse is a common childhood experience with the potential for serious long-term consequences. Those who participate in the assessment of a child suspected of experiencing sexual abuse must do so with knowledge, skill, and sensitivity that comes from understanding the “disease of sexual victimization.”¹⁻⁴ The medical evaluation of a child suspected to have experienced inappropriate sexual contact is not all that dissimilar from the evaluation of a child with an illness. The process of coming to a diagnostic assessment incorporates all of the traditional components of the evaluation of any complex medical condition. The subject matter, however, requires an understanding of the clinical expression of sexual victimization, just as the diagnosis of any disease is not possible without understanding its clinical presentation. Many of the dynamics of sexual abuse are not intuitive, and they may be counterintuitive to those who are misinformed.⁵⁻⁸ The tools to create a medical evaluation begin with building on the knowledge of the dynamics of sexual victimization and developing the necessary skills to obtain a history in a manner that is nonjudgmental, facilitating, and empathizing. The medical record must precisely reflect the details of the questions asked and the child’s verbatim response.⁹⁻¹⁰

The medical record articulates the clinical encounter of the health care providers, child or adolescent patient, and caregiver. The medical record of children who may have experienced abusive sexual contact shares most of the core elements of the standard medical record/consultation format found in either an office-based or a hospital-based practice. Acceptable medical practice dictates that clinicians assessing a child in this circumstance follow a standard set of assessment parameters, similar to what would be anticipated in the evaluation of any medical condition. When a patient sees a doctor, a current medical history is obtained, including a detailed review of systems (ROS) and appropriate developmental and social history. Verifying the medical history affords an opportunity to understand the chronology of events from the possibly abusive contact to the circumstances that resulted in disclosure.

In suspected sexual abuse examinations, the examiner should presume that there is a significant probability that state child protective services (CPS), law enforcement, prosecutors, and defense counsel will review the record. In contrast, most office records are reviewed only in a peer review situation or a malpractice action. In anticipation of external scrutiny, one must construct the medical record with exacting attention to detail. The medical record must be legible, well constructed, and educational, with defensible conclusions.¹⁰ The medical record should carefully chronicle the medical history, anatomic findings (even when normal), and laboratory test results. The medical

record is the instrument the clinician will use to make the diagnosis and treatment recommendations.¹¹ The credibility of the diagnostic assessment will be questioned if the record is incomplete or poorly formulated.¹²⁻¹³

This chapter will describe core elements of conducting a comprehensive evaluation as well as the types of information that need to be obtained, the how-to's of obtaining information, and the documentation of the medical history and physical examination. Intertwined throughout the chapter will be a few inescapable legal concepts that have general applicability to a patient's medical record and that take on special significance in children suspected of having been sexually abused. The end of this chapter will provide some suggestions on how to tie all of the pieces together to formulate a clear and balanced diagnosis.

DOCUMENTING THE CLINICAL EVALUATION

Clinicians document their interactions with their patients in a variety of ways. Documentation can take the form of precise language reflecting details of the medical history or of a synthesis of the information gathered. For example, in most busy practices, the clinician may ask a series of questions, listen to the patient's responses, and, either after the history or the examination, summarize the interaction and record salient points. Although a style that synthesizes and organizes information and deletes irrelevant information may be acceptable for general medical practice, this method is not the standard procedure for documentation of the medical history in cases of suspected child sexual abuse.

When a medical history is obtained, a clinician must take care to record verbatim the questions asked and the responses provided by the child or caregiver (or both). It is precisely the idiosyncratic statements of children that provide the greatest insight into what they may have experienced. Their responses to questions highlight an age-inappropriate understanding of sexual activities or knowledge of symptom-specific complaints temporally related to events; therefore, it is critically important that the medical record reflect the exact details of the history obtained. This can be accomplished by contemporaneously recording in writing the questions asked and the responses provided. It is helpful for children to understand that everything they have to say is important and therefore everything will be written down. Clinicians should indicate that the child may be asked to wait until everything said is written down before telling more of what happened.

Children respond best to and are most likely to provide the richest contextual details when asked questions that are developmentally appropriate and that follow a style that is not leading or suggestive. Clinicians should attempt to avoid questions that allow the child to respond with a short answer in preference to questions that encourage the child to provide a narrative response. A simple self-test is to review the history obtained by reading only the responses to the questions. If the narrative that emerges is understandable and cohesive, then a limited number of leading and suggestive questions were used. There is a clear continuum regarding leading, suggestive, and coercive questioning.¹⁰ Open-ended questions that lack suggestibility tend to provide the clearest understanding of what a child may have experienced.

CHILDREN'S ADVOCACY CENTERS AND THE MULTIDISCIPLINARY APPROACH

Child advocacy centers throughout the United States were developed to coalesce limited resources into the co-location of investigative, child protection, medical, and mental health services, as well as to reduce the number of times a child may have to repeat the

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