The healing starts here...

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Child sexual abuse: challenges in balancing therapeutic and prosecutorial interests

Issues for discussion:
• Purpose of the medical examination
• What is the “gold standard” for the best interest of the child?
• Creating a therapeutic environment
• Child and adolescent reactions to the CSA examination
• Medical history vs. forensic interview
• Combinations and permutations of clinical presentation of CSA
• Frequency of diagnostic findings and its implications
• What is the most appropriate examination setting
• Collaborative relationships
Purpose of the medical examination in suspected CSA

- **Diagnosis & Treatment of “Abnormality”**
  - Acute and healed genital and anal trauma
  - Extra-genital trauma
  - Sexually transmitted infections

- **Diagnosis & Treatment of “Normality”**
  - Wellness
  - Altered body images
  - Specific and nonspecific worries

- **Prosecutorial**
  - Evidentiary collection
  - Purview of law enforcement
What is the “gold standard” for in the best interest of child victims?

Operative principles:

• Children brave enough to disclose abuse or suspected of being abused deserve access to the most knowledgeable and skilled professionals

• Objective and balanced opinions are the foundation for best interests

• Substantiated abuse is best served by skilled mental health clinicians utilizing evidence based practices
  • “talking doctor”
Creating a therapeutic environment: key components

• Examiner understands the “Disease” of sexual victimization

• Examiner able to gather both historical information but also able to provide important “therapeutic” messages

• Examiner anticipates and addresses age appropriate fears and anxiety

• Examiner demonstrates patience & sensitivity

• Examiner provides patient with choices whenever possible
  • Assessing emotional readiness
  • Accompanying support

• Examiner utilizes technology to demystify the examination and afford the child an opportunity to have a sense of participation and control throughout the examination
Children and adolescent perceptions of the anogenital examination

• Who amongst us looks forward to having an anal and/or genital examination?

• What contributes to the relatively common perception that the examination is traumatic and how can this be counteracted?
  • Personal anxiety
  • Speculum fear
  • Misunderstanding & misrepresentation of the what the examination entails by professionals

• What factors are necessary to make the examination at least neutral and possibly a positive experience?
  • Educate professionals
  • Provide written or videotaped educational materials to child and/or parent for review prior to examination
  • Demystify
Literature on children & adolescent perception of examination

  - 99 children evaluated for how they perceived their examination; fear, pain, kindness of doctor, fear of hypothetical second examination
  - Majority of children did not perceive examination to be strongly negative although greater fear than ordinary doctors visit
  - Previous negative medical experiences play a role in how exam is perceived
Literature on children & adolescent perception of examination


• 7 item scale, Increased score when genital examination completed and increased distress found when positive findings present

Appendix

Genital Examination Distress Scale

Instructions: Immediately at the end of the medical examination for possible sexual abuse rate the 7-indices of behavioral distress for the child during the anogenital phase of the procedure. If the behavior was not observed, assign 1-point. Score 2-points if the behavior was somewhat displayed. A rating of 3-points should be made if the behavior was definitely displayed.

Not displayed — 1; somewhat displayed — 2; definitely displayed — 3

Rating

1. NERVOUS BEHAVIOR (e.g., repeated nail biting, lip chewing, leg fidgeting, rocking or fidgeting in mouth, not attending, not listening)
2. CRY (e.g., crying sounds, tears or the onset of tears)
3. RESTRAINT (e.g., pressure is used to hold onto the child or physical attempts to keep the child from moving)
4. MUSCULAR RIGIDITY (e.g., tension of muscles like clenched fists, facial contortions or general body tightening)
5. VERBAL FEAR (e.g., statement of apprehension or fear like “I’m scared” or “I’m worried”)
6. VERBAL PAIN (e.g., statement of pain in any tense like “That hurt,” “Owwww,” “You’re pinching me” or “This will hurt”)
7. FLAIL (e.g., random movement of arms, legs or body without trying to be aggressive like pounding fists, throwing arms or kicking legs)
Literature on children & adolescent perception of examination

  - 272 children, mean age 7.2 yrs
    - 55% disclosed sexual abuse
    - 17% positive examinations
  - 85% watched and were either cooperative or enthusiastic before & after examination
  - GEDS scores strongly correlated with observed responses after the procedure
  - Children with CSA disclosure were 3X more likely to watch the exam and 5X more likely than those without disclosure to have improved outcomes
Literature on children & adolescent perception of examination

- Adolescents’ Responses to sexual abuse evaluation including the use of video colposcopy

Purpose:
- Explore adolescents’ responses to the medical examination for sexual abuse
- Investigate adolescents reactions to the use of video colposcopy
- Identify demographic variables that may be associated with their responses
- Explore possible relationships that might exist between adolescents’ anxiety level and their coping styles and their responses to the examination
- Examine the impact of an educational intervention provided during the examination
Adolescents’ responses to sexual abuse evaluation including the use of video colposcopy

• **Methods**
  • Girls 11-18 referred for evaluation & treatment of sexual abuse
  • Demographic data & information regarding alleged sexual abuse
  • Subjects were assessed for the following;
    • Anticipations regarding the medical exam; level of anxiety using the State-Trait Anxiety Inventory (STAI)
    • Response to stressful situations along the dimensions of information seeking or information avoiding using the Miller Behavioral Style Scale (MBSS)
    • Medical examination using video colposcopy with monitor for subject viewing
    • Examining physician provided standardized educational intervention regarding genital anatomy and STI’s
    • Exit interview assessed perceptions of the medical exam and video colposcopy and reassessed anxiety using the STAI
    • F/U interviews at 3 months to reassess knowledge of reproduction & genital anatomy
Adolescents’ responses to sexual abuse evaluation including the use of video colposcopy

• Results
  • 78 participants with 51 returning for F/U
  • Mean age 13.5 years
  • 51% Caucasian, 29% AA, 18% Hispanic
  • 79% chose to watch monitor
  • Post examination perceptions were significantly more positive than pre exam
  • Anxiety on STAI significantly decreased from pre to post examination
  • Pre & post examination anxiety were negatively associated with pre-exam anticipation and post exam perceptions respectively
  • Information-avoiding coping styles on the MBSS were associated with positive anticipations of the exam perhaps because the information-avoiding coping style prevents one from focusing on the potentially anxiety provoking procedure
  • Scores assessing knowledge of reproductive functions of their bodies at 3 month F/U revealed no significant change from pre-exam assessment
Adolescents’ Responses to sexual abuse evaluation including the use of video colposcopy

Table 1. Percentage of Subjects Who Agreed vs. Disagreed or Were Uncertain Regarding Items Assessing Anticipation of and Responses to the Medical Examination (N = 77)

<table>
<thead>
<tr>
<th>Pre- and Post-Examination Paired Questions</th>
<th>Agreed (%)</th>
<th>Disagreed/Uncertain (%)</th>
<th>McNemar Test for Correlated Proportions (1, N=76)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-examination: The examination will help me feel better.</td>
<td>42.1</td>
<td>57.9</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The examination helped me feel better.</td>
<td>78.9</td>
<td>21.1</td>
<td>6.13**</td>
</tr>
<tr>
<td>Pre-examination: Coming to see the doctor today is a good idea.</td>
<td>56.6</td>
<td>43.4</td>
<td></td>
</tr>
<tr>
<td>Post-examination: Coming to see the doctor today was a good idea.</td>
<td>90.8</td>
<td>9.2</td>
<td>10.04**</td>
</tr>
<tr>
<td>Pre-examination: The examination will be helpful.</td>
<td>59.2</td>
<td>40.8</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The examination was helpful.</td>
<td>89.5</td>
<td>10.5</td>
<td>8.07**</td>
</tr>
<tr>
<td>Pre-examination: The doctor will make me feel comfortable.</td>
<td>32.9</td>
<td>67.1</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The doctor made me feel comfortable.</td>
<td>90.8</td>
<td>9.2</td>
<td>.34**</td>
</tr>
<tr>
<td>Pre-examination: The examination will be embarrassing.</td>
<td>53.9</td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The examination was embarrassing.</td>
<td>51.3</td>
<td>48.7</td>
<td>1.85</td>
</tr>
<tr>
<td>Pre-examination: The examination will be painful.</td>
<td>13.2</td>
<td>86.8</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The examination was painful.</td>
<td>34.2</td>
<td>65.8</td>
<td>.17*</td>
</tr>
<tr>
<td>Pre-examination: The examination will be scary.</td>
<td>43.4</td>
<td>56.6</td>
<td></td>
</tr>
<tr>
<td>Post-examination: The examination was scary.</td>
<td>44.7</td>
<td>55.3</td>
<td>1.08</td>
</tr>
</tbody>
</table>

* p < .01; ** p < .001.
Adolescents’ Responses to sexual abuse evaluation including the use of video colposcopy

<table>
<thead>
<tr>
<th>Items</th>
<th>Agreement (%)</th>
<th>Disagreement (%)</th>
<th>Uncertain (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I would rather not have had the video camera present during the medical examination.”</td>
<td>19.2</td>
<td>63.0</td>
<td>17.8</td>
</tr>
<tr>
<td>“I was uncomfortable having pictures taken during the medical examination.”</td>
<td>24.6</td>
<td>60.3</td>
<td>15.1</td>
</tr>
<tr>
<td>“Watching the video screen during the medical examination helped me learn about my body.”</td>
<td>79.2</td>
<td>9.4</td>
<td>11.3</td>
</tr>
<tr>
<td>“Watching the video monitor during the medical examination helped me understand what the doctor was doing.”</td>
<td>96.2</td>
<td>3.8</td>
<td>0</td>
</tr>
</tbody>
</table>
Adolescents’ Responses to sexual abuse evaluation including the use of video colposcopy

- **Conclusions**
  - Teens generally reported the medical exam including video colposcopy beneficial
  - Significant reduction in anxiety from pre to post examination with significantly more positive feelings about the medical examination afterwards
  - 78%-90% reported the medical exam “was helpful”, “a good idea” and helped them “feel better”.
  - 34 to 51% of the adolescents still reported the examination as painful, scary or embarrassing
What is more likely to provide clarity and certainty to what a child might have experienced?

- Medical history
- Physical examination
- Laboratory tests
- Forensic evidence
Who is this man and what is his importance to medicine?
Q: Why do you rob banks?

A: Because that’s where the money is.

Sutton’s Law: The idea of looking for the obvious, before going further a field, when diagnosing.
Frequency of diagnostic findings and its implications

Physical examination findings:

  - 236 children
  - normal in 28%, nonspecific in 49%, suspicious in 9%, and abnormal in 14% of cases, 1% abnormal anal

  - 2384 children
  - 96.3% of all children referred for evaluation had a normal medical examination

  - 2/36 definite findings of penetration
Sexually transmitted infections:

  - < 5% positive for a STI

  - 704 girls, 151 boys
  - the prevalence of STDs in prepubertal girls was 3.2% and 14.6% in pubertal girls
  - No males + for a STI
Frequency of diagnostic findings and its implications

Presence of “forensic evidence”

  - 80 children & adolescents presenting within 72 hours
  - 16 positive for semen (13 adolescents)
  - No seminal products recovered from any pre pubertal child, when retrieved only + on clothing/bedding

  - 273 children <10
  - 24.9% + when examined less than 44 hours, 90% of + < 24 hours, 1 + >24 hrs.
  - No positive swabs after 9 hours
  - 64% of evidence from clothing/bedding, 35% of clothing/bedding collected
What is the most appropriate examination setting

- **Basic principles**
  - Setting should be chosen based on presenting history
    - Disclosure precipitates “need to know”
  - Avoid ER as community default resource
  - When children brought to ER’s triage to appropriate environment and exam conducted in appropriate time frame
  - Avoid repeat examinations
  - Avoid evidentiary examination conducted independent of diagnostic examination
  - CPS & law enforcement conduct forensically defensible joint investigative interview preferably videotaped
Medical history vs. forensic interview

- **Medicines role:**
  - Diagnosis & treatment of effects of suspected sexual abuse
    - Conduct comprehensive medical assessment which is balanced and defensible
  - Physicians should obtain medical histories not conduct interviews
    - Histories should not be artificially truncated at request of law enforcement
  - Admissibility of medical history as exception to hearsay dependent on physicians clarity of role
  - Quantitatively and qualitative differences exist between medical history obtained by medical professional vs investigative interview by CPS and/or law enforcement
Combinations and permutations of clinical presentation of CSA

1. Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

2. Medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.

3. Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (i.e. acute/healed injuries, STD, other physical forensic evidence).

4. Medical history/behaviors are suspicious and/or concerning that child either experienced something inappropriate and/or exposed to something inappropriate and the examination is without physical diagnostic residual.
Combinations and permutations of clinical presentation of CSA

5. Observed inappropriate sexual interactions without physical diagnostic residual. (Common scenario with young children with sexually reactive behaviors)

6. Medical findings that mimic sexual abuse but upon evaluation are associated with medical conditions and not the result of abuse.

7. Physical examination and/or laboratory studies diagnostic of sexual contact without supporting history.

8. Concerns arising in family with custody/visitation arrangements in young child requiring genital care.

9. Insufficient historical, behavioral or physical examination findings to support referents concern that child experienced anything of a sexually inappropriate nature.
Collaborative relationships are essential

- Child abuse is a puzzle
  - Medicine is an important component of a comprehensive assessment but not always the ordinal piece
  - Collective insights of CPS, law enforcement, schools and collateral information essential
  - MDT’s for review and case management throughout the life of a case
- Hospital & out patient based diagnostic & treatment providers
- CAC’s
  - Co-location advantages & disadvantages
- SANE/SART programs
  - Relationship with hospital based programs
Medical Diagnosis of Child Sexual Abuse: Essential Knowledge & Skill Set

- Skilled at obtaining a medical history grounded with an understanding of the dynamics of child sexual victimization
- Ability to conduct a comprehensive medical examination that is “therapeutic” for child
- Diagnose acute and healed trauma, identify STD’s & collect “evidence”
- Differentiate examination findings that could be misinterpreted as diagnostic
- Obtain visual documentation, colposcopy with digital still documentation and/or video colposcopy
- Medical history documentation
- Formulating a Diagnosis
Medical Diagnosis of Child Sexual Abuse: Essential Knowledge & Skill Set

The Medical Model of Diagnosis:
Tried & True

• Understanding pathophysiology of a disease entity
• Understanding the clinical expression of a disease
• Developing clinical skills in eliciting medical history
• Formulation of a preliminary diagnostic impression
• Physical examination to confirm diagnostic impression
• Use of diagnostic tests to augment physical examination
Basic principles when obtaining a medical history:

• Primary objective is to obtain a medical history which captures both the core & peripheral components of the child’s experience.
• The history is obtained in a manner which is empathetic, non judgmental and facilitating.
• Open ended and non leading approach to obtain idiosyncratic details.
  • Continuum of Suggestibility: Open-ended, focused, specific, leading.
• Document all questions and child’s responses in a “verbatim” manner.
Beginning the dialogue:
The purpose of the examination is both to gather information but equally important to impart information and thus the value of “therapeutic” messages to the child that both educate and enhances the child’s comfort in disclosing. Craft introductory comments to meet this objective.

- Ask if the child knows why being seen
- Explain the purpose of being seen
- Reduce child’s anxiety by anticipating and addressing age appropriate concerns and fears
- Share information that gives the child comfort that you have an understanding of what they may have experienced and can help
- Explain why Doctors ask questions and the importance of telling the doctor the truth
- Inquire about any worries or concerns that they may have and want answered
Medical Diagnosis of Child Sexual Abuse: Essential Knowledge & Skill Set

• Understanding the “Disease’ of sexual victimization
  • Engagement
  • Sexual interaction
  • Secrecy
  • Disclosure
  • Suppression
  • Recantation

• Hallmarks
  • the abuse of power
  • the manipulation of trust
  • the misrepresentation of moral standards
Medical Diagnosis of Child Sexual Abuse: Essential Knowledge & Skill Set

Elements of Medical History:

- History of chief complaint obtained from CPS/law enforcement and/or parent
- Past medical history with detailed review of systems
- Family and social history
- Medical history obtained from child

Seek to obtain historical details that speak to the reality of a child’s experience

- Body image concerns
- Age inappropriate descriptions of sexual activities
- Post fondling dysuria
- Post sodomy burning
- Excited utterance
Medical Diagnosis of Child Sexual Abuse:
Essential Knowledge & Skill Set
Medical Diagnosis of Child Sexual Abuse: Essential Knowledge & Skill Set

Physician Familiarity with Genital Anatomy

- Correct % identification of genital anatomy
  - Clitoris 89.4%
  - posterior commisure 80.9%
  - urethral opening 78.4%
  - Labia minora 76.4%
  - labia majora 61.5%
  - hymen 59.1%

- Frequency of genital examinations in clinical practice
  - 77% routinely check
  - 50% of the time
  - 17.2% examined
    - <10% of the time

Ladson, Johnson, 1987
Medical Diagnosis of Child Sexual Abuse: Variables that mitigate presence or absence of trauma

General principles:

- Most perpetrators have little intent to hurt their victims physically
- Most injuries when they occur are superficial
- Most examination findings are nonspecific and must be correlated temporally with the event
- Physical findings which can be stated with medical certainty to represent the residual to trauma are limited and infrequent
- Retrospective interpretation of changes in anogenital anatomy can be difficult
- Predictive value for residual increased if:
  - child states that they were hurt as a result of the contact
  - historical details have been obtained suggesting that the child had been in contact with potentially infected genital secretions
Medical Diagnosis of Child Sexual Abuse: Variables that mitigate presence or absence of trauma

- Age differential between perpetrator and victim
- Presence or absence of force
- Position
- Degree of relaxation
- Use of lubricants
- Number of episodes
- Size and nature of object introduced
Medical Diagnosis of Child Sexual Abuse: Correlation of symptoms and physical findings

- Post fondling/vulvar coital dysuria
- Post anal penetration anodynia
Medical Diagnosis of Child Sexual Abuse: Differentiating “in from on”

• Factoid:
  • Women have bleeding with first intercourse
  • A physician can tell with certainty if a women is a virgin

• Fact:
  Bleeding with first intercourse
  • None 44%
  • Slight 35%
  • Moderate 9%
  • Heavy 12%

  Pain with first intercourse
  • None 32%
  • Slight 22%
  • Moderate 15%
  • Severe 31%

Medical Diagnosis of Child Sexual Abuse: Differentiating “in from on”

- Determining the child's perception of their experience
  - use of Ortho anatomic model
- Addressing any discrepancy between child's perception and their examination findings
  - educating the judge and jury
Medical Diagnosis of Child Sexual Abuse: Differentiating “in from on”
Medical Diagnosis of Child Sexual Abuse: Differentiating “in from on”
Medical Diagnosis of Child Sexual Abuse: Healing principles

- Retrospective interpretation of changes in anogenital anatomy
- Understanding healing chronology of acute trauma
- Regeneration of labile cells without residual
- Repair results in formation of granulation tissue -repair
- Appreciate limitations of retrospective interpretation

Formulating a Diagnosis:
Information incorporated into a consultative report

- History obtained from caretaker regarding presenting complaint
- Information obtained from child protection and/or law enforcement
- Complete past medical history, ROS, Family and social history
- Medical history obtained from child independent from caretaker whenever possible
- Physical examination findings
- Laboratory findings
- Recommendations for medical and mental health follow-up as required
Formulating a Diagnosis:
General principles when formulating a conclusion

- Objectively state the facts
- Do not exaggerate the meaning of a particular finding
- Know the limitations of what can be said
- Do not co-mingle hearsay and clinician obtained history when formulating a diagnosis
- State limitations
- Presume that diagnosis will be challenged
- Make sure that every statement is defensible and rests on sound scientific footings
Formulating a Diagnosis:
General principles when formulating a conclusion

• Utilize the diagnosis section to explain and educate those who will have access to need the report to address treatment & protection issues
• Issues for which an explanation can be helpful
  • Why evidence does not exist when history of injury
  • Why evidence does not exist when child states that an object was placed inside them
  • How a child can acquire a sexually transmitted disease without genital to genital contact
Illustrative Case scenario #1: Medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual is present.

Medical History: 5 10/12-year-old white female

...I asked her how she felt now that she told and she said, “Very happy.” I asked who did that stuff and she said, “Poppy.” I asked if he had a name for what he had done and she said, “He called it baby stuff. That’s how you get babies.” I asked if he wanted her to tell about what he was doing and she said, “No.” I asked her how she knew that and she said, “He told me.” I asked what he told her and she responded, “He said don’t tell my mommy or mom-mom. He told me it was a secret.” I asked her why she told and she said, “Because I wanted to.”

I explained to her that when she’s gone to the doctor in the past and not felt well the doctor asks all kinds of questions such as; Does your tummy hurt? Does your head hurt? Do you have a temperature? I explained that the reason the doctor asks those questions is to simply understand what’s been bothering her so the doctor can decide what to take a look at and whether there is a need for any special tests or medicine to get her better.

I explained to her that I would be asking some questions about what had happened, not to embarrass her, but to simply be able to do the same. I asked her if it is important to tell the doctor the truth and she said, “Yes.” I asked her why and she said, “Because you have to tell the truth, so they know what to look at and stuff.” I explained that it is always important to tell the truth but it is particularly important to tell the doctor the truth because patients and doctors work together to solve problems. I asked her if you told me that your finger hurt and it was actually your toe that hurt would that make it easier or harder for the doctor to help. She responded harder. I then explained yes and that you can tell doctors anything because they know how to listen and the more you tell the doctor to help them to understand the more they can help you.
Formulating a Diagnosis: Examples

I asked what was the first thing that poppy did that just didn’t seem okay and she said, “He played with my pee-pee.” I asked what she was wearing and she said, “My nightgown.” I asked her if she could show me what he did and she said, “He touched me right there (pointing to her genital area). I asked if she was wearing anything underneath her nightgown and she said, “A shirt and panties.” I asked if poppy touched her on top or under her panties and she said, “Underneath.” I asked what he did next and she said, “Then he put his hand on my pee-pee and tickled it more.” I asked what that felt like and she said, “It tickled, it didn’t hurt.” I asked if she had to do anything and she said, “He tried to take my hand and put it on his pee-pee.” I asked if he did and she said, “No.” I asked what happened next and she responded, “He touched his pee-pee and then he found this sticky stuff.” I asked where that sticky stuff came from and she said, “I think his package” and then she continued spontaneously, “He wiped it off of his pee-pee.” I asked if he kissed her and she said, “Yes.” I asked where he kissed her and she pointed to her lips. I asked if he kissed her anyplace other than her mouth and she said, “Yes, on my pee-pee.” I asked what that felt like and she said “yucky”. I asked if he did anything else and she said “no”. I asked if this happened just once and she responded, “a lot”.

I then showed her an anatomical model of the female private parts. I explained to her that when kids say that someone has touched their pee-pees there are different kinds of touching and I wanted her to help me understand what kind of touching she thinks she experienced. I demonstrated on the model where she pees, where she poops and how she has been taught to wipe herself when she goes to the bathroom. I explained that when kids say they have been touched in the pee pee touching can be between like wiping, inside like this (illustrating penetration into the vaginal canal on the model) or sometimes kids aren’t sure what kind of touching they experienced. I asked her to show me what kind of touching she thought poppy did to her and she demonstrated a wiping motion between the labia. I asked what he did when he put his hand there and she said, “He tickled it.” I asked what that felt like and she said, “Like wiping.” I asked what happened next and she said, “He turned on a movie about that stuff.” I asked what she saw and she said, “Boys and girls doing stuff after they were married to get babies.” I asked what were they wearing and she said, “Nothing, only their skin.”
Then she continued, “I saw a girl sucking a boy’s pee-pee.” I asked if there was anything else on there and she said, “Horses.” I asked what was poppy doing and she said, “He was sitting next to me.” I asked what he was wearing and she did not respond. I asked if she ever saw a grown ups private part and she responded, “poppy” and continued spontaneously “He pulled his pants and panties half down, because he wanted me to see his private, but I didn’t. I closed my eyes. I saw it a little bit.” I asked what his pee-pee looked like and she said, “Like a boys pee-pee.” I asked if it looked any different than her little brothers and she said, “It was big. My poppy has a big package.” I asked what else he did and she said, “Then he put his hand on my pee-pee and tickled it more.” I asked her what it felt like after he touched her and she said, “Like poppy touching me.” I asked her if it bothered her to do anything afterwards and she said, “no”. I asked if it felt different when she went to the bathroom and she said, “no”. I asked if she had to touch him and she said, “He tried to take my hand and put it on his pee-pee.” I asked if he made her do that and she said, “No.” I asked if there was anything she wanted to ask me and she said, “no”. I asked whose fault it was and she said, “Poppy’s.”
Formulating a Diagnosis: Examples

Physical examination:

She was cooperative for the examination and accompanied by her mother throughout. She was well nourished, well developed and in no distress. Her weight was 48-pounds (75th%), her height was 47 ¼-inches (90th%). She was afebrile. Her HEENT exam was positive for dental caps. Lungs were clear to auscultation. Heart was without murmurs and regular. The abdomen was soft without organomegaly or extra visceral masses to palpation or percussion. Examination of the genitalia was completed in the supine, frog-leg position with the use of gross and colposcopic visualization at 4, 6 and 10 magnification with white and green light. She was Tanner Stage I, for her genital development. The labia majora, minora and clitoral hood were well formed without findings of injury. With labial separation and traction, it is possible to visualize the structures of the vaginal vestibule. There was no abnormal degree of redness, vaginal discharge or malodor. The hymenal membrane was readily visualized and the hymenal orifice was crescentic in configuration with a transverse diameter of 4 millimeters with traction. There was slight redundancy to the edge of the hymenal membrane. There were no interruptions in the integrity of the membrane edge circumferentially. There were no acute or chronic signs of injury to the external surface of the hymen, fossa or fourchette. The knee chest position confirmed the uninterrupted appearance of the hymenal edge. Although there were no stigmata of sexually transmitted diseases on examination, cultures were obtained for Gonorrhea and Chlamydia and a script was provide for outpatient serological testing for HIV, Hepatitis screen and RPR in light of her history of contact with potentially infected genital secretions. Examination of the external anal verge tissues revealed a symmetric rugal pattern, normal response to traction, normal sphincter tone and no unusual venous or pigmentary changes. Examination of her skin was negative for acute or healed cutaneous injuries.
Formulating a Diagnosis: Examples

Diagnostic assessment:

The historical information that has been provided clearly details this young girl being engaged in a variety of sexually inappropriate interactions. She has stated that the individual who engaged her in these activities and represented them as “baby stuff” to her was her poppy. The activities that she described involved genital fondling with penetration into the structures of the vaginal vestibule, placement of her poppy’s mouth on her genitalia, exposure to her poppy masturbated with potential contact with infected genital secretions, exposure to pornography and an attempt to have her touch her poppy’s genitalia. She did not complain of any physical discomfort associated with the genital fondling or oral genital contact. Her physical examination does not reveal any residual to the contact nor would there be anticipated to be such in light of the history presented. Any genital fondling was limited to penetration within the structures of the vaginal vestibule. I will inform you of the results of the workup for sexually transmitted diseases should anything be positive.

Fortuitously, this young girl was able to tell her mom in spite of the fact that her grandfather attempted to have her maintain secrecy. Mom responded in an appropriate and protective manner. The primary impact of her experience is psychological. She should be seen by a clinical child psychologist to assess the impact of her experience and develop a treatment plan.
Formulating a Diagnosis: Collaborative relationships

- Child abuse is a puzzle
  - Medicine is an important component of a comprehensive assessment but not always the ordinal piece
  - Collective insights of CPS, law enforcement, schools and collateral information essential
  - MDT’s for review and case management throughout the life of a case
- Hospital & out patient based diagnostic & treatment providers
- CAC’s
  - Co-location advantages & disadvantages
- SANE/SART programs
  - Relationship with hospital based programs
Art of Healing Children