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Putting It All Together

Martin A. Finkel^a

^a University of Medicine and Dentistry of New Jersey , Stratford, New Jersey, USA

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Putting It All Together

MARTIN A. FINKEL

University of Medicine and Dentistry of New Jersey, Stratford, New Jersey, USA

The most available form of evidence in child sexual abuse cases is what the child has to say about his or her alleged experience. The most difficult skill for clinicians to develop is the “how tos” of talking to children in a developmentally appropriate, nonjudgmental, facilitative, and empathetic manner. This manuscript provides insight into obtaining historical details about a child’s experience and guidance regarding how to incorporate those details when formulating a balanced and defensible opinion. The consultative report should be an instrument to explain the presence or absence of physical findings, the significance of symptoms temporally related to sexual contact, and discrepancies between a child’s perception of an experience and physical findings.

KEYWORDS *evidence, history, defensible, physical, sexual abuse*

Once the clinician has obtained the medical history of the alleged sexual contact, conducted a thorough physical examination, and reviewed all laboratory findings, what remains is the formulation of a comprehensive medical report. The medical report provides the physician’s diagnostic conclusions and the basis on which they are formed. Because the medical report is likely to be read by nonmedical colleagues, it should be written in a manner that is clear and informative, minimizing the use of medical jargon. Where medical jargon is required, an explanation can be helpful. A detailed, clear, understandable, and defensible report may reduce the need to appear in court. Surely a medical record that is incomplete, illegible, or poorly documented has the potential to not only increase the likelihood of a court

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Address correspondence to Martin A. Finkel, CARES Institute, School of Osteopathic Medicine, University of Medicine and Dentistry of New Jersey, 42 E. Laurel Road, Suite 1100, Stratford, NJ 08084. E-mail: finkelma@umdnj.edu

appearance but almost assures that the author can anticipate adversarial questions regarding the report (Dubowitz & Bross, 1992). The time in which to create a defensible record is prior to appearing in court, as rehabilitation of a medical record within the court setting is far more difficult.

MEDICAL REPORT COMPONENTS

A medical report should include the following and may be formatted sequentially as follows (Finkel, 2008, 2009):

1. History obtained from caretaker regarding presenting complaint
2. Information obtained from child protection and law enforcement
3. Complete past medical history, review of systems, family and social history
4. Medical history obtained from child
5. Physical examination findings
6. Laboratory findings
7. Diagnostic assessment including recommendations for medical and mental health follow-up as required

CASE SCENARIOS

When all is said and done, the diagnosis will reflect a combination of medical history, physical examination, and laboratory/evidentiary results. There are numerous permutations and combinations of each of the elements that support a diagnosis. The following are examples of these common scenarios:

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 (DeLago, Deblinger, Schroeder, & Finkel, 2008).
3. Medical history/behaviors are clear and descriptive of inappropriate sexual contact and physical diagnostic residual is present (e.g., acute/healed injuries, STD, other physical forensic evidence).
4. Medical history/behaviors are concerning and raise suspicion that the child either experienced something inappropriate and/or was exposed to something inappropriate but the examination yields no physical diagnostic residual.
5. Medical findings are apparent that mimic sexual abuse but, on evaluation, are found to be associated with medical conditions and are not the result of abuse.

6. The caretaker observed sexually acting out behaviors on the part of the child. The physical examination did not demonstrate any physical findings that could explain the behaviors. This scenario is common when children are exposed to sexually inappropriate materials and/or experience sexual abuse.
7. There are insufficient historical, behavioral or physical examination findings to support referent's concern that the child experienced anything of a sexually inappropriate nature.
8. Physical examination or laboratory studies are diagnostic of sexual contact without supporting history.
9. Concerns arise for a family with custody/visitation arrangements in a young child requiring genital care.

DOCUMENTATION

The clinician must rely on the documentation within the medical record to craft a medical report. The narrative of the medical history obtained from the child should be a verbatim record of the history. If the physician is questioned about the medical history, the medical record should be able to substitute for independent recollection. When there is independent recollection of medical history details that were not incorporated into the report or were not in the medical record, the opportunity arises to create the impression that the clinician picked and chose what to include. Every detail of the history obtained must be a part of the written report, or if no formal report is written, the history must be as noted in the chart, reflecting both the questions asked and the child's responses.

All physical findings that are considered important to the formulation of a diagnosis of sexual abuse must be documented, not just in writing but also through photo documentation by a digital camera, video camera, or a combination (Finkel, 1998; Finkel & Ricci, 1997; Ricci, 1988). The visual record of the examination findings must be an accurate reflection of what was observed at the time of initial examination and any subsequent follow-up examinations. Whatever the examining clinician sees and documents should be available for any challenge regarding the interpretation of findings. With photo documentation, all parties can see the basis on which a diagnosis was made. If there is a challenge to the diagnosis, photo and video colposcopy documentation spare the child the need for a reexamination. The photo documentation also reflects the condition of the child as she or he appeared at the time of the examination, which may be different than if observed at a later date. If there is a request for an expert review of the case, a copy of the examination can be made available to that expert. If the child has an acute injury, there should be follow-up examinations that document the healing of those injuries. In children who are or will continue to be at risk for sexual

abuse, photo or video colposcopy documentation should also be obtained, as it will serve as a baseline reference should there be any concerns in the future. If either the parent or child objects to photo documentation, their wishes should be respected. In children who have been photographed in the context of pornography, special sensitivity is needed when seeking to secure photo documentation. Visual documentation can be of value when allegations arise in the context of a custody dispute, as it delivers the message that there will be a potential to observe any changes due to future inappropriate contact. A protocol for the handling, retrieving, and storage of images on a secure server is essential.

FORMULATION OF DIAGNOSTIC CONCLUSIONS

The manner in which the diagnostic conclusions are formulated requires thoughtful construction. The conclusions must summarize the key elements of the presenting concern and note key historical details that factor into the diagnosis, the presence or absence of physical findings, significant laboratory findings and the interpretation of such, physical evidence collection, medical treatment provided, follow-up examination expectations, urgent mental health issues to be addressed, and an assessment as to whether the accompanying caretaker is supportive and protective (Adams et al., 2007; Finkel, 2009).

Where an opinion can be provided with diagnostic certainty, it should be stated as such. The report should educate the reader and explain elements of the report that are of special import. Examples include an explanation as to why there is a discrepancy between the child's perception of what he or she experienced and the physical findings, how acute injuries can heal without leaving any residual at the time of the examination, information about the hymen, how children contract sexually transmitted diseases without genital-to-genital or genital-to-anal contact, and the significance of an idiosyncratic historical detail provided by the child.

The tone of the report should be factual and objective, and the report should note the limitations regarding what can be concluded. The physician should keep in mind that the medical record is only one component of the whole picture of what a child might have experienced. Child protection and law enforcement also play an important role in understanding what a child experienced, the level of safety and risk, and ultimately, the substantiation of allegations. In many cases, the pieces of the "puzzle" fit nicely together, corroborating details and providing a fuller understanding of what the child experienced, more than any one discipline could surmise independently. In some cases there may be contradictory details that need to be understood and addressed. Further insights into the presenting concerns may only become apparent after a complete psychological assessment and/or in the context of treatment.

CASE EXAMPLES

The following three cases represent examples of the three most common scenarios when children present with concerns of sexual abuse. Each case reflects components of a medical report of a child's medical history, physical examination findings, and diagnostic conclusions. The following excerpts from actual case reports do not include parental history, past medical history, review of systems, or social and family history. These cases serve as examples as to how some components of the report may be documented and conclusions can be formulated. The histories presented represent excerpted components of the complete history and do not include transitional elements that set the stage for eliciting statements regarding the specifics of the inappropriate interactions that follow. The author was the examining physician in each of the following cases.

Illustrative Case Scenario 1: 5-Year, 10-Month-Old Female

In the following case, medical history/behaviors are clear and descriptive of inappropriate sexual contact but no physical diagnostic residual was present.

MEDICAL HISTORY

I asked the child how she felt now that she told, and she said, "Very happy." When asked who did the things that were not okay, she said, "Poppy" (maternal grandfather). 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." When asked if he wanted her to tell about what he was doing, she said, "No." When asked how she knew that he did not want her to tell, she said, "He told me." When asked what he had told her, she responded, "He said don't tell my mommy or mom-mom. He told me it was a secret." Asked why she told, she stated, "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 simply to understand what has 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 me to help?" She responded, "Harder." I then explained, "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."

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 again asked what she was wearing and she responded, "A nightgown and panties." I asked if Poppy touched her on top of her nightgown and she said, "No, under my panties." I asked what he did next and she said, "He just 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 he did 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, "He wiped it off of his pee-pee." I asked if he kissed her and she said, "Yes." I asked if he kissed her anywhere other than her mouth and she said, "Yes, on my pee-pee." I asked what that felt like and she responded, "Yucky." I asked if he did anything else and she said, "No." I asked if this happened more than 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, "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 them." 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 "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 up's private part not on a movie 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 boy’s pee-pee.” I asked if it looked any different than her little brother’s 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 afterward and she said, “No.” I asked if it felt different when she went to the bathroom and she said, “No.” I asked if there was anything she wanted to tell me or ask me and she said, “No.” I asked whose fault it was and she said, “Poppy’s.”

PHYSICAL EXAMINATION

The child 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 percentile) and her height was 47 $\frac{1}{4}$ inches (90th percentile). She was afebrile. Her head, ears, eyes, nose & throat (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 four, six, and 10 magnification with white and green light. She was Tanner Stage I for her genital development. The labia majora and 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. 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 provided for outpatient serological testing for HIV, a hepatitis screen and rapid plasma reagin (RPR; a test for syphilis) 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.

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” 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 masturbating with potential contact with infected genital secretions, exposure to pornography, and an attempt to have her touch his 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 it be anticipated that residual would be found in light of the history presented. Any genital fondling was limited to penetration within the structures of the vaginal vestibule.

Fortuitously, this young girl was able to tell her mother what had happened to her in spite of the fact that her grandfather attempted to have her maintain secrecy. Her mother responded in an appropriate and protective manner. The primary impact of her experience is psychological, and it was recommended that she be seen by a clinical child psychologist to assess the impact of the abuse and develop a treatment plan.

Illustrative Case Scenario 2: 6-Year, 5-Month-Old Female

In the following case, medical history/behaviors are clear and descriptive of inappropriate sexual contact with symptom-specific complaints reflective of genital and/or anal trauma.

MEDICAL HISTORY

Prior to proceeding with the examination I met with this young girl independent of her mother. I provided some introductory comments. I explained to her that one of the things I do that’s a little different than most kids’ doctors is talk to kids who have a worry or concern that they may have had something happen that can be confusing or difficult to understand by someone they know and trust. I asked if that happened to her and she said, “Yeah.” I asked why she told and she said, “Because I don’t like that stuff.” I asked who did this stuff to her and she said, “Kenny.” I asked who Kenny was and she responded, “My stepbrother.” I obtained the information that her stepbrother was 14 years old. I asked if he said why he was doing this kind of stuff and she said, “He didn’t say anything.” I asked if Kenny wanted her to tell and she said, “No, but I told mommy he did that.” I asked whose fault it was and she said, “Kenny.”

The explanation given to her as to what happens when she goes to the doctor was similar to that provided in Illustrative Case 1. I asked her if it's important to tell the doctor the truth and she said, "Yes." I asked why, and she responded, "So I can get better." I asked where this happened and she said, "At my house. I was in the bed. Kenny was in the bed. Mommy was sleeping and then he said to touch him." I asked what he wanted her to touch and she said, "He made me touch his private part." I asked what his private part looked like and she said, "It was big, he pushed my head down into his private." I asked why he did that and she said, "He made me." I asked what he wanted her to do when he pushed her head down and she responded, "He wanted me to open my mouth." I asked why, and she responded, "He wanted me to kiss his private."

I asked if she did that, and she said, "He made me." I asked what that was like and she responded, "Nasty." I asked what was nasty and she said, "His private and icky stuff." I asked what she did after the icky stuff got in her mouth and she responded, "I went to the bathroom to spit it out and brushed my teeth." I asked if he kissed her and she said, "He didn't kiss me." I asked if he put his mouth on any part of her and she said, "No." I asked what he did next and she said he "touched my private." I asked if Kenny said why he was doing that and she said, "He wanted to." I asked what he touched her private with and she said, "His hand." I asked if her clothing was on and she said, "Part way off." I asked how they came off and she said, "He took them off."

Utilizing an anatomic model, I showed her the different kinds of touching and she demonstrated that he placed his fingers inside in the adult sense of penetration. I asked what he did when he touched her private and she responded, "He rubbed it." I asked what that felt like and she said, "It hurt a little bit." I asked in what way and she said, "When I went to the bathroom it was hurting."

I asked what it hurt to do in the bathroom and she said, "To pee-pee." I asked her why she thought it hurt and she said, "Because he put his private into my private." I asked if she noticed anything that made her know she was hurt and she said, "No." I asked if she ever felt that before and she said, "No." I asked how long it hurt and she said, "Just that day." I asked if she ever felt that again and she said, "Almost every time he did that."

Utilizing the anatomic model I again showed her the different kinds of "inside" that kids might refer to, and she demonstrated that she thought he put his private between her labia. I asked what he did when he put it there and she said "I forgot" and seemed embarrassed. She continued spontaneously, "He had a nasty book." I asked what she saw in that and she said "Boys and girls playing nasty." I asked if their clothing was on and she said, "Off." I asked if she had any worries or concerns because of what she experienced, and she asked, "Am I going to get into trouble?"

PHYSICAL EXAMINATION

As in Illustrative Case 1, this child's examination was negative for any acute or chronic signs of injury. She was Tanner Stage I for her genital development and the hymenal orifice diameter was insufficient to allow intromission of a foreign body through the hymenal orifice and into the vagina. All laboratory testing was negative, and the review of systems was negative for alternative explanations for the dysuria other than trauma.

DIAGNOSTIC ASSESSMENT

The medical history provided by this child details a variety of age-inappropriate sexual activities that she was forced to engage in, initiated by her adolescent stepbrother. The activities involve oral-genital contact with ejaculation into her oral pharynx. Her oral examination did not demonstrate any residual from that contact, nor would it be anticipated to in light of the history provided. She provided a history of genital fondling and genital-to-genital contact. She perceived the genital fondling as penetrating into her vagina and the genital-to-genital contact as being limited to penetration between the labia. Her physical examination suggests that any fondling or genital-to-genital contact was limited to penetration within the structures of the vaginal vestibule. She complained of discomfort both while she was being touched inappropriately and afterward. Although she did not observe any bleeding associated with her physical discomfort, she complained of it hurting to urinate following the genital contact. She experienced the symptom of dysuria only within the context of inappropriate touching and under no other circumstances. Her physical examination did not demonstrate any signs of trauma, nor would signs be anticipated, as the injuries that she incurred were superficial and had since healed as anticipated. Her history of postfondling/vulvar-coital dysuria confirms with medical certainty her inappropriate sexual contact. This 6-year-old girl would have had no alternative way of knowing about her symptom-specific complaints temporally related to the genital contact unless she had experienced such. Although her physical examination did not demonstrate any stigmata of sexually transmitted diseases, I evaluated her for the full spectrum of sexually transmitted diseases. The diagnostic assessment concluded with medical, mental health, and child protection follow-up recommendations.

Illustrative Case Scenario 3: 9-Year, 4-Month-Old Female

In the following case, medical history/behaviors were clear and descriptive of inappropriate sexual contact, and physical diagnostic residual was present (acute/chronic residual, STD, and other physical forensic evidence).

MEDICAL HISTORY

The examination began with introductory comments as noted in the previous case examples. I asked if something that was confusing and difficult to understand happened to her and she said, "Yes." I asked whose fault that was and she said, "My cousin Man-man." I asked if he ever said why he was doing this stuff and she said, "No." I asked if he wanted her to tell and she said, "No." I asked her how she knew that and she said, "Because he told me if I tell, he was going to hit me."

I asked the child if it is important to tell the doctor the truth and she said, "Yes." I asked why, and she responded, "Then the doctor can help me." I asked her what was the first thing that "Man-man" did that wasn't okay and she said, "When my dad left, he came upstairs at my grandmom's." I asked what happened next and she replied, "He turned the TV off and he turned the light on and he pulled down my pants." I asked about his pants and she said, "He pulled both of our pants down."

I asked what happened next and she said, "He got on top of me." I asked what he did next and she said, "He kissed me in my mouth." I asked if he touched her anyplace else and she pointed to her genital area. I asked what he touched her privates with and she said, "His hand." Utilizing an anatomic model, I showed her different kinds of touching and she demonstrated that he placed his fingers between the labia. I asked what he did when he placed his hand there and she said, "He scratched me." I asked what that felt like and she said, "It cut." I asked if he touched her with anything else and she said, "His private."

Utilizing an anatomic model, she demonstrated that she thought that he had put his private just between her labia. I asked what happened when he did that and she said, "He scratched me and got off." I asked if she saw anything after that and she responded, "When I went to the bathroom to clean myself I saw blood." I asked where she saw the blood and she said, "It was falling down my legs."

I asked if he did anything else and she said, "No." I asked if she had to do anything else and she said, "No." I asked if it bothered her to do anything after he had done this and she said, "No." I asked if anything felt different when she went to the bathroom afterward and she said, "No." I asked if he did anything like this before to her and she said, "No," but continued spontaneously, "He did it to me and my cousin. He did it to my cousin and he started doing it to me." I asked if anyone else ever touched her in a way that wasn't okay and she denied.

PHYSICAL EXAMINATION

The child was cooperative for the examination and accompanied by her parents throughout. Her weight was 55 pounds (25th percentile) and her

height was 53 inches (50th percentile). HEENT exam was negative for any signs of trauma to the oral cavity. Her lungs were clear to auscultation and her heart was without murmurs. The abdomen was soft, slightly tender, but without organomegaly or extravisceral masses to palpation or percussion. Examination of the genitalia was completed in the lithotomy and knee–chest position with the use of gross macroscopic and colposcopic visualization at four, six, and 10 magnification with white and green light and recorded through videocolposcopy and 35 mm photographs. She was early Tanner Stage II for her genital development. Labia majora and minora and clitoral hood were well-formed and without acute or chronic signs of injury in the anterior quadrants. However, posteriorly there was significant and extensive trauma to the posterior fourchette, the fossa navicularis, the hymenal membrane, and the most external portion of the vagina. The injuries that were noted were fresh with hemorrhage into the tissues and oozing of blood. There was some blood that was oozing from the vagina as well. Furthermore, in the fossa navicularis there was a hair. With magnification, the hair was collected and the posterior portion of the vagina was swabbed for seminal products and then air dried before being placed into the rape kit. Although there were no stigmata of sexually transmitted diseases on examination, I obtained pharyngeal, vaginal, and rectal cultures and serology for STDs. Urinalysis and urine culture were obtained. Examination of the external anal verge tissues revealed a symmetric rugal pattern, normal response to traction, normal sphincter tone, and no acute or chronic signs of injury. Examination of the skin was remarkable for extragenital signs of trauma in the form of distinct echymosis in the configuration of grasp marks on both upper extremities.

Because of the extensiveness of the external genital injuries and proximal vaginal injuries, I thought it was important to make sure that there were no unrecognized internal injuries that could result in her potentially developing peritonitis. I requested a pediatric gynecologist to arrange for an examination under anesthesia at our regional children's hospital. Upon examination, the pediatric gynecologist observed a one centimeter fresh laceration with active bleeding to the posterior fornix on the left. This laceration, as well as the laceration to the fourchette and fossa, was sutured for hemostasis.

DIAGNOSTIC ASSESSMENT

The historical information that has been provided clearly indicates that this young girl experienced a one-time episode of inappropriate sexual contact by her cousin. The contact involved genital fondling and genital-to-genital contact with penetration into the vagina. The penetration into the vagina resulted in blunt force trauma to all of the posterior structures of the vaginal vestibule from the fourchette to the fornix. This child is left with a distinct transection of her hymenal membrane extending to the base of

its attachment. Examination under anesthesia identified an internal vaginal injury that the surgeon sutured, in addition to approximating the lacerations to the fossa and fourchette. Follow-up examinations will be required to make sure the injuries are healing well and to document the healed residual. The extragenital trauma will heal without residual. Specimens obtained and placed in the rape kit were turned over to law enforcement, maintaining a chain of custody.

Clearly the most significant impact of this experience is psychological. Fortunately, this young girl had disclosed relatively soon after the inappropriate contact and her parents responded in an appropriately protective manner. It will be important to arrange for her to be seen by a child psychologist to assess the impact of her experience and develop a treatment plan.

CONCLUSION

This article on “putting it together” serves to illustrate how medical findings in child sexual abuse cases can be articulated in the medical record and incorporated in the formulation of a diagnostic assessment. The most common scenarios cited illustrate some of the many permutations and combinations of history and findings seen in sexual abuse cases. Although the actual cases used in this text reflect only excerpted components of a full case report, they serve to demonstrate one way of integrating history and physical findings. A full report would include all of the items noted in the medical report components. The diagnostic assessment serves not only to articulate the findings but also to educate the reader, whether it be the case worker, a law enforcement professional, or a medical colleague. The opinion formulated should always be objective, respectful of the limits of what can be concluded, and be defensible.

Allegations of sexual abuse present a puzzle, and as with all puzzles, there are many pieces to fit together. Medicine should always be a piece of that puzzle, but only with the collaboration of professionals from mental health, child protection, and law enforcement will we ever be able to fully understand what a child may have experienced. Understanding a child's experience is the first step to substantiation, which is the conduit to protection and presents the opportunity to provide therapeutic intervention.

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AUTHOR NOTE

Martin A. Finkel, DO, FAAP, is a Professor of Pediatrics and the Medical Director and CoFounder of the Child Abuse Research Education and Service Institute at the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine in Stratford, New Jersey.