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# The Medical Evaluation of Child and Adolescent Sexual Abuse

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Introduction</td>
<td>9</td>
</tr>
<tr>
<td>A. Background</td>
<td></td>
</tr>
<tr>
<td>B. Rapid Advances in Medical Knowledge and the Need for Peer Review</td>
<td></td>
</tr>
<tr>
<td>C. Statement of purpose</td>
<td></td>
</tr>
<tr>
<td>D. References</td>
<td></td>
</tr>
<tr>
<td>2) Epidemiology and Demographics of Child Sexual Abuse</td>
<td>11</td>
</tr>
<tr>
<td>A. Prevalence and incidence</td>
<td></td>
</tr>
<tr>
<td>B. Risk factors</td>
<td></td>
</tr>
<tr>
<td>C. Relationship between child sexual abuse and domestic/spousal violence</td>
<td></td>
</tr>
<tr>
<td>D. Perpetrator behaviors</td>
<td></td>
</tr>
<tr>
<td>E. Victim responses to sexual abuse</td>
<td></td>
</tr>
<tr>
<td>F. References</td>
<td></td>
</tr>
<tr>
<td>3) Behavioral Correlates of Sexual Abuse</td>
<td>14</td>
</tr>
<tr>
<td>A. Sexualized behaviors in children: What’s normal? What’s not?</td>
<td></td>
</tr>
<tr>
<td>i) Behavioral “changes” associated with normal childhood development</td>
<td></td>
</tr>
<tr>
<td>ii) Psychosexual development of children: ages 0-6</td>
<td></td>
</tr>
<tr>
<td>iii) Psychosexual development of children: ages 6-12</td>
<td></td>
</tr>
<tr>
<td>iv) Psychosexual development of children: adolescence</td>
<td></td>
</tr>
<tr>
<td>B. Behavioral changes associated with sexual abuse</td>
<td></td>
</tr>
<tr>
<td>C. References</td>
<td></td>
</tr>
<tr>
<td>4) Interview Approaches and Techniques</td>
<td>22</td>
</tr>
<tr>
<td>A. Forensic interviewers: CAC, videotape, etc.</td>
<td></td>
</tr>
<tr>
<td>B. Rationale for clinician interviews</td>
<td></td>
</tr>
<tr>
<td>C. Legal considerations</td>
<td></td>
</tr>
<tr>
<td>i) Outcry witness</td>
<td></td>
</tr>
<tr>
<td>ii) Hearsay exception: medical diagnosis and treatment</td>
<td></td>
</tr>
<tr>
<td>iii) Hearsay exception: excited utterance</td>
<td></td>
</tr>
<tr>
<td>D. Important principles to remember</td>
<td></td>
</tr>
<tr>
<td>i) Before You Ask</td>
<td></td>
</tr>
<tr>
<td>ii) Asking the Question</td>
<td></td>
</tr>
<tr>
<td>iii) History of Events</td>
<td></td>
</tr>
<tr>
<td>iv) Current symptoms</td>
<td></td>
</tr>
<tr>
<td>v) Gynecologic history</td>
<td></td>
</tr>
<tr>
<td>vi) Family background (domestic violence, siblings, family support of victim)</td>
<td></td>
</tr>
<tr>
<td>vii) Safety issues</td>
<td></td>
</tr>
</tbody>
</table>
E. Approach to the interview
   i) The physical setting
   ii) Beginning the interview
   iii) Mid-interview
   iv) Closure
F. When the child discloses abuse: do’s and don’ts
G. Information that may be requested by CPS or Law Enforcement
H. Summary
I. References

5) Approach to the Medical Evaluation
   A. Approach to the child
   B. Approach to the parent: initial assessment of family and abuse risk factors
   C. Examination positions and techniques
      i) Examination positions
      ii) Examination techniques
   D. Discussion of findings with child and parents
   E. Non-genital injuries encountered in sexual abuse or assault victims
   F. Issues in providing medical treatment to sexual abuse victims
      i) Emergency contraception
      ii) Gynecologic and surgical referrals
   G. References

6) Diagnosis and Treatment of Sexually Transmitted Diseases in Sexual Abuse Victims
   A. Introduction
   B. When to test for sexually transmitted diseases
   C. Implications of STD diagnoses in the evaluation of sexual abuse
   D. Diagnosis, treatment, and prophylaxis of specific STD’s
      i) Neisseria gonorrhoeae
      ii) Chlamydia trachomatis
      iii) Trichomonas vaginalis
      iv) Treponema pallidum (syphilis)
      v) Herpes simplex (HSV)
      vi) Human papillomavirus (HPV)
      vii) Hemophilus ducreyi (chancroid)
      viii) Hepatitis B
      ix) Human immunodeficiency virus (HIV)
   E. Pelvic inflammatory disease
   F. STD prophylaxis
   G. Reporting of STD’s
   H. References

7) Photographic Documentation and Telemedicine
   A. Introduction
   B. Methods of photodocumentation
   C. Telemedicine
D. References

8) Forensic Evidence Collection
   A. When to collect forensic evidence
   B. Methods
   C. Coordination with requesting agency
   D. References

9) Written Documentation of Findings, Assessment, and Conclusions
   A. Use of standardized protocols
   B. Use of standardized terminology for anatomic and clinical findings (APSAC terminology)
   C. Use of standardized terminology for assessment and conclusions (Adams criteria)
   D. Summarizing history/interview findings
   E. Summarizing physical findings—“It’s normal to be normal”
   F. References

10) Billing, Reimbursement, and Other Funding for Child Sexual Abuse Evaluations
    A. ICD-9 and CPT codes
       i) ICD-9 diagnosis codes
       ii) CPT procedure codes
    B. Medicaid reimbursement
    C. Private insurance
    D. Examinations requested by law enforcement
    E. Children’s Protective Services
    F. Crime Victims Compensation
    G. Non-fee-for-service funding
       i) Private foundations
       ii) Criminal Justice Division grants (VOCA and 421 funds)
    H. References

11) Normal Anogenital Anatomy
    A. Embryology of the external genitalia
    B. Development of the external genitalia in girls
    C. Anatomic variations in girls
    D. The hymen
       i) Variations in configuration
       ii) Clinical features of the normal hymen
       iii) Transhymenal diameter
       iv) Effects of estrogen
    E. Development of the external genitalia in boys
    F. Anatomic variations in boys
    G. Sexual maturity ratings and normal pubertal findings
    H. Embryology and anatomy of the anorectum
       i) The normal perineum and anorectum
       ii) Anatomic variations
    I. References
12) Acute and Nonacute Anogenital Findings Associated with Sexual Abuse/Assault

A. Findings in acute sexual assault
B. Healing of acute anogenital injuries
C. Residua of anogenital injuries
D. Controversies: transhymenal diameter, reflex anal dilatation, nontraumatic “lacerations,” hymenal narrowing
E. Assessment of children presenting with nonspecific symptoms or signs, or when there is no clear outcry of sexual abuse
F. References

13) Nonspecific Anogenital Findings and Conditions Confused with Sexual Abuse

A. Conditions that mimic trauma
   i) Lichen sclerosus
   ii) Streptococcal cellulitis
   iii) Urethral prolapse
   iv) Foreign bodies
   v) Hemangiomas
B. Accidental anogenital trauma
   i) Straddle trauma
   ii) Anal fissures
C. Infectious diseases, or conditions that mimic infections, not specific for sexual abuse
   i) Vulvovaginitis
   ii) Bacterial vaginosis
   iii) Behçet’s Disease
   iv) Varicella-zoster
   v) Molluscum contagiosum
   vi) Verruca vulgaris
   vii) Perianal lymphangioma circumscriptum
   viii) Lymphangioma
D. Other conditions seen in both abused and non-abused children
   i) Labial adhesions
E. References

14) Psychological Sequelae and Psychotherapy of Sexual Abuse Victims: an Overview

A. Psychological sequelae of child sexual abuse and sexual assault
B. Physiologic sequelae
C. Overview of psychotherapy for sexual abuse victims
   i) Short-term therapy
   ii) Longer-term psychotherapy
   iii) Treatment of non-offending parents and siblings
   iv) Pharmacotherapy
D. References
15) **Legal Issues in Child Sexual Abuse Investigations**

A. Definitions of sexual abuse
   i) Family code definitions
   ii) Texas Penal Code sections

B. Reporting issues
   i) Reporting
   ii) Failure to report
   iii) Immunities
   iv) Professionals with duty to report
   v) Confidentiality and privileged communications
   vi) Criminal penalties for false reporting

C. Investigation
   i) Joint investigations with law enforcement
   ii) Priorities of investigation of report
   iii) Conduct of the investigation (medical, psychological, Advocacy Center)

D. The CPS case
   i) Legal representation of the Department in CPS cases

E. Child statements
   i) Interviewing
   ii) Suggestibility
   iii) Use of anatomical dolls

F. Proof at trial
   i) Admissibility of child statements
   ii) Admissibility of documentation

G. Testimony
   i) Expert testimony
   ii) Potential subjects of expert testimony

H. References and footnotes

16) **Courtroom Procedures in Sexual Abuse Cases**

A. Introduction
B. Fact and Expert Witnesses
C. Types of judicial proceedings
D. Ethical issues for expert witnesses
E. Testifying in legal proceedings
   i) The subpoena
   ii) Preparing for court
   iii) Testifying on the stand
   iv) Presenting medical evidence in court
F. Conclusion

17) **Children’s Advocacy Centers and the Multidisciplinary Team**

A. Children’s Advocacy Centers Defined
B. Primary Goals of Children’s Advocacy Centers
C. Key Components of Children’s Advocacy Centers
D. Governing Documents for Texas CACs
E. Role of Medical Professionals on CAC Multidisciplinary Teams
F. Overview of Various CAC Medical Components

18) Future Challenges: Prevention, Integration of Services, and Self-Preservation
A. Prevention
   i) Prevention of victimization
   ii) Prevention of perpetration
B. Integration of Services
C. Self-Preservation
D. References

19) Appendix
A. TPS Committee on Child Abuse Resource List
B. AAP and CDC policy statements re: testing for STD’s
C. TPS Child Sexual Abuse Protocol Form
D. Adams Classification System for Assessing Physical, Laboratory, and Historical Information in Suspected Child Sexual Abuse
E. TPS Clinical Practice Guidelines for Evaluation of Suspected Child Abuse (proposed, 2001)
F. AAP Guidelines for Reporting Suspected Sexual Abuse
G. Roster of Texas Children’s Advocacy Centers
H. Texas Dept. of Health Report Form for Notifiable Diseases

20) Supplemental Materials
A. TPS Child Abuse Pocket Guide
B. Texas Evidence Collection Protocol
1) Introduction

A. Background

The medical evaluation of child and adolescent sexual abuse and assault is an emerging and specialized area of pediatrics that presents unique forensic, legal, and emotionally burdensome challenges. Training and experience among health professionals is highly variable; clinical approaches and diagnostic assessments lack consistency and consensus. These problems are further complicated by the diversity of health professionals involved in the assessment of children and adolescents for sexual abuse: physicians, registered nurses, nurse practitioners, and physician assistants. Standard clinical protocols and training for all health professionals are essential to the appropriate diagnosis and treatment in children, appropriate interpretation by investigative agencies and the integrity and credibility of the health professions involved in this field.

Child sexual abuse offers diverse challenges:
- The medical literature continues to contribute significant changes and advances in knowledge.
- Disturbing nature of child abuse contributes to clinician stress, “burn-out”, and high turnover rate of examiners.
- Compensation for these labor-intensive evaluations has been inconsistent, insufficient, or nonexistent.
- Significant time requirement for multidisciplinary interactions, including court testimony, which is often inconvenient and adversarial.
- Opinions among clinicians are highly variable depending on training and expertise.

B. Rapid Advances in Medical Knowledge and the Need for Peer Review

Significant advancements in medical knowledge of child sexual abuse have occurred over the past 10 years. While the earliest research articles appeared in the 1980’s, normative studies on genital and anal anatomy first appeared in the early 1990’s (Berenson, 1991, 1993; Kellogg, 1991, 1993). As this understanding of normal anatomical variations increased, the proportion of examinations with concerning or conclusive findings of abuse decreased from about 50% to less than 20%. In a recent survey of 122 physicians who have performed an average of 1,738 examinations, they reported that 17% of genital exams and 5% of anal exams had findings consistent with abuse (Kellogg & Adams, 2001, in preparation). Another study (Paradise, 1998) reports that disagreement in the interpretation of exam findings is greatest for less experienced clinicians and when interpreting normal anatomical variations. These studies suggest an important role for peer review and frequent consultation with experienced clinicians.

C. Statement of purpose

The purpose of this manual is to provide:
1) The most current medical knowledge in the field of child sexual abuse;
2) Clinical guidelines and approaches based on medical knowledge;
3) Information about goals and procedures of investigative and advocacy agencies as they relate to medical evaluations;
4) Information about agencies and individuals in Texas that may provide information or consultative services; and
5) A complement to the one-day training sponsored by the Texas Pediatric Society Committee on Child Abuse and supported by the Children’s Justice Act Grant to Texas.

The Texas Pediatric Society Committee on Child Abuse selected the components of this manual and the training based on responses to the question, “What does a clinician need to know to be considered competent in evaluating children and adolescents for possible sexual abuse or assault?” In addition to this didactic material, the Committee recommends:

- On-site clinical training at a child abuse specialty clinic (see “Resources” in the Appendix)
- Participation in peer review activities, including regional meetings and remote consultations through telemedicine (see “Resources” in the Appendix).

The goal of the Committee is to provide training, knowledge and resources to clinicians of all health professions to improve consensus of opinions, maintain clinician involvement to facilitate greater expertise, and identify valuable resources that provide support and professional consultation.

Thank you for your commitment and dedication to children!

D. References


Kellogg ND and Adams J. The role of clinical expertise and training in the interpretation of examination findings in suspected victims of child sexual abuse. Submitted, *Child Abuse and Neglect*.

2) Epidemiology and Demographics of Child Sexual Abuse

Nancy D. Kellogg, MD

A. Prevalence and Incidence

Sexual abuse is a common childhood problem. National U.S. statistics (Wang and Dara, 1996) indicate that more than 200,000 children are reported to Child Protective Services each year for suspected sexual abuse. Estimated numbers are much higher: the most conservative figures indicate that at least 20% of females and about 10% of males will experience sexual abuse prior to their 18th birthday (Finkelhor 1994). The discrepancy in reported and estimated numbers suggests that child sexual abuse remains a significantly underreported and underdetected problem.

Most recently, since the mid 1990’s there has been a one-third decrease in reported cases of child sexual abuse. Jones and Finkelhor have postulated that this decrease is related to several possible factors: 1) an actual decrease in incidence; 2) more judicious reporting of cases, especially in younger children with sexualized behaviors; and/or 3) smaller reservoir of non-disclosing victims relative to earlier years. Parallel trends include decreases in female victimization by inmate partners, rapes and violent crime, and births to teen mothers.

B. Risk Factors

Sexual abuse is not considered a random event. Well-documented risk factors include:

1) presence of a step-father or other father figure;
2) living without the mother at some interval;
3) lack of maternal education (did not finish high school);
4) lack of emotional closeness to the mother;
5) sexually repressive mother;
6) lack of physical affection from the father;
7) family income less than $10,000 and
8) fewer than 3 friends in childhood (Finkelhor 1979).

These risk factors are cumulative such that each additional factor increases the child’s vulnerability by 10-20%.

Sexual abuse, in turn, places the child at 2-3 fold increased risk for the following: revictimization (40% are revictimized before turning 18), delinquency, runaway behavior, excessive/frequent alcohol use, illicit drug use, and teen pregnancy. Sexually abused children are more likely to become abusive parents and battered partners, and to have difficulty with forming stable intimate relationships. Therapy initiated shortly after the abuse is discovered and the presence of supportive, protective, and affectionate caretakers moderate the risks of these health risky and dysfunctional behaviors in abused children.

C. Relationship between child sexual abuse and domestic/spousal violence

While spousal violence and child physical abuse are unquestionably linked, few studies have addressed the relationship between child sexual abuse and domestic/spousal violence. In one study (Kellogg, et al, 2001) of 164 subjects from 7 to 19 years old who were interviewed in a sexual abuse clinic, 52% reported spousal violence in their home. When the sexual offender of the child was a father or father...
figure, 58% of them also physically assaulted their adult female partners. Only one-third of the adult partner violence was reported, but the majority of the adult victims sustained visible injuries from the assault. Seventy-four percent of the sexually abused children had been hit in the face, punched, hit with objects, kicked or cut by adults living in their home.

In many cases, discovery of the sexual abuse to the child by an in-home adult who is also a batterer prompts the adult victim (usually the mother) to separate from the abuser. Since most battered victims are killed when they leave their partner, this separation is a time of significant danger to the children and the adult victim. Sexually abused children and their family members should be questioned about physical abuse and the presence of violence among adults in their home so the appropriate safety plans can be initiated.

D. Perpetrator behaviors

In addition to these risk factors for abuse, sexual offenders are often selective in their victims. They will look for trusting/naive, quiet children with little confidence and a greater tendency to follow and obey others. Summitt (1983) describes the processes of deception and entrapment in incestuous relationships: 1) secrecy (a prerequisite for maintaining a sexual relationship with a child); 2) Helplessness (abuser establishes authority, reinforces guilt/shame in child, further reduces risk of child disclosure); 3) entrapment and accommodation; 4) delayed, unconvincing disclosure (child “leaks out” part of abuse and gauges reactions before deciding to disclose further or recant); and 5) retraction (child learns it is too stressful or hopeless to disclose abuse). Some or all of these components may be present in chronic child sexual abuse.

Most sexual offenders of children are males well-known to the child and most (80%) are molesters rather than rapists. Molesters desire an ongoing relationship with the child and tend to progress slowly from “accidentally-on-purpose” touching to more penetrative sexual acts.

Dietz et al (1990) categorized sexual offenders into situational and preferential types. The situational type of sexual offender does not have a true preference for children. There are four subtypes of situational sex offenders: regressed, morally indiscriminate, sexually indiscriminate, and inadequate. Motivation for abusing children includes boredom, opportunity, substitution for another relationship, curiosity, and insecurity in other relationships. The preferential sex offender has a specific preference for children over adults and often collects child pornography. The three subtypes of the preferential sexual offender are seductive, introverted and sadistic. Motivation includes identification with children, fear of adult relationships and communication, and need to inflict pain. The motivation(s) and types of sexual offender are sometimes apparent in their threats to the child: “If you tell I'll beat you” (situational-morally indiscriminate); “If you tell I'll have to go to jail” (situational-inadequate); “If you tell I won’t be able to give you gifts anymore” (preferential-seductive).

E. Victim responses to sexual abuse

Child sexual abuse encompasses all socioeconomic and ethnic groups. The psychological effects are far more devastating and long-lasting than physical injuries. Another kind of turmoil often begins with the child’s disclosure of abuse as a myriad of agencies and individuals intrude on the family and the child. The effects of the investigation should be understood and monitored after the child’s disclosure.
When a child discloses sexual abuse their anxiety and suffering does not always improve or end. The many agencies and individuals that become involved are sometimes confusing and threatening from the child’s perspective. The figure on the next page captures the investigative and personal process from disclosure of abuse to trial. The mountains represent proportional degrees of stress that accompany the various events following the first disclosure.

One study (Kellogg 1995) found that sexual abuse victims told 3.5 other children before they told an adult. The first 3 mountains in the figure represent the other children victims disclose to first. When a child first discloses to an adult, fear—of not being believed, of getting in trouble or causing trouble, of the distress it will cause—make this perhaps the biggest mountain of all. The “reactive family stress” may persist for years. Soon after disclosure to an adult begins the litany of various investigative procedures, each frightening and strange in its own way. In larger cities, a case may be reset as many as 7 times (hence 7 small mountains) before it actually goes to trial. Certainly the depth and breadth of the mountain range will vary from community to community, and child to child. With respect to “The Mountain Range” the role of Children’s Advocacy Centers is to provide ski lifts whenever possible.

F. References


A. Sexualized behaviors in children: What’s normal? What’s not?
Clinicians should become familiar with the subtle warning signs of abuse which signal the need for
further medical and psychosocial evaluation. It is important to realize that such warning signs are rarely
specific for abuse and that they merely signal the need for further questioning. Some “warning signs” as
reported by caretakers, may be normal developmental behavior. Of all the behavioral indicators, sexual
behaviors in children are most frequently attributed to sexual abuse.

To appropriately evaluate these behaviors, the clinician must first be familiar with normal
developmental processes.

i.) Behavioral “Changes” Associated with Normal Psychosexual Development
Many children will be referred for sexual abuse evaluations based on behavioral changes such as
masturbation, inspecting other children’s genitalia, or pregnancy mimicking behaviors. This section
provides a brief review of normal psychosexual behavior at various stages of development. These stages
have been divided into 3 general age groups: 0-6 years, 6-12 years, and Adolescence.

ii.) Psychosexual Development of Children: Ages 0-6
Please refer to Table 1. At the top of the table “Developmental Tasks” are the Ericksonian stages
of development; “Psychological Processes” are how the developmental tasks are processed
psychologically; “Behavior Responses” are the resultant behaviors we observe; “Preferred Relationships”
are the people the child prefers to associate with or attach to, assuming an intact, nuclear family; “Physical
Modifiers” are the physiologic capabilities and functions for each stage.

A newborn’s behavior is largely a function of innate or instinctual processes. The infant is
concerned with obtaining the very basic needs of nurturance and food both of which are acquired through
sucking. This is the Trust vs. Mistrust stage. As with primates, infants bond quickly with their mothers, the
primary provider of his needs. To reinforce acquisition of these needs, the infant soon begins to coo in
response to receiving nurturance. Within a few days of life infants are capable of sexual arousal and
erectio ns.

When the infant becomes a toddler he capitalizes on his new-found independence – he is now able
to feed himself, move around, and acquire things on his own. He constantly attempts to establish
autonomy or independence. This is the stage of Autonomy vs. Shame and Doubt.

While toddlers become curious, keen explorers, they also become little Napoleons, always testing
the limits with a resounding, sometimes physically dramatic “No!” These toddlers at times seem to lead two
lives – one the independent, very finicky, devil and the other, a clinging cuddly, dependent angel.

This stage of holding on to things known and secure vs. letting go is exemplified in potty training.
Children become absorbed with their newly acquired ability to hold onto and release feces and urine,
sometimes crying fearfully as their prized deposit is flushed away for eternity. In the course of their
exploration children also begin a closer inspection of their genitalia and begin to connect more concretely the self-manipulation of the genitals with the sensation of pleasure. This self-manipulation often begins with an itch or sensation of bladder fullness, which causes them to manipulate their genitals. The sensation of emptying the bladder or rectum is a satisfactory, somewhat sensual feeling for the toddler, not much dissimilar to those feelings arising from masturbation. It is therefore no surprise that there is great overlap in the child’s mind concerning the 2 functions of the genitalia – excretory and sensual.

One must be careful what messages are relayed when changing diapers (excretory function) in view of the additional sensual feelings associated with the genitalia. An exclamation of “What a dirty, yucky diaper” along with a look of disgust may lead some children to associate “yuckiness” with the sensual aspect, leading to guilt and confusion during masturbation.

Self-manipulation and inspection lead naturally to an interest in the difference between boys and girls. Once they notice a difference the next question is “why”? It is important that children understand that boys have a penis and girls have a vulva; it should not be a proposition of boys have it and girls don’t have it or lost it or had it cut off. Some inspection of the opposite sex’s genitalia may take place. Genital self-manipulation may become a little more refined in 4 and 5 year olds, and tends to occur when the child has to urinate, or is stressed or tired (MUST acronym: Masturbate when have to Urinate, are Stressed or feel Tired). A typical time to observe this behavior in normal children is the beginning and end of naptime.

As long as the masturbation is not excessive, persistent, or explicit, it is probably normal and should not be actively discouraged or punished. The parent should simply say: “Good feelings can come from our private parts. But we must touch our privates only in private places.”

In the Initiative vs. Guilt Stage, the child seeks to further assert independence, and increase his self-esteem, the fuel which sustains his drive to take initiatives. Some of these initiatives involve the Freudian concepts of the Oedipal and Electra complex. This is where the girls tend to attach to their fathers or other close male relatives and the boys want to marry their mothers and kill their fathers. These thoughts may produce guilty feelings for the children.

While many parents treat these crushes lightly as “cute”, certain events may be quite alarming and amplified for the children. For example, the mother who “flirts” with her husband openly to playfully tease her daughter may provoke jealousy and frustration. It is a time when limits should be set – Johnny should not be permitted to shower with Mom or sleep with her. Normal children may play “Mommy and Daddy”, leading to sexual play between opposite sex and same sex children. About this time children are physiologically capable of orgasms but generally do not have the psychological capability to carry out this capacity out successfully.

iii.) Psychosexual Development of Children: Ages 6-12 (See Table 2).

The school age years, sometimes referred to as the “latent stage” by Freud, is hardly an idle time. The Eriksonian stage of Industry vs. Inferiority drives the child to seek accomplishments and enter into competition with peers. Consequently, the child begins to participate more in group activities and the preferred relationships switch back to the same sex parent and, in addition, same sex peers. The children still derive pleasure from their genitals and may still masturbate occasionally, depending to some extent on the messages they received from their parents and society when they initiated this behavior a few years back. Similarly, sexual play and exploration with other children may continue in this stage. Flirtatious
behaviors between opposite sex peers generally begin in this stage. This is imitative, practice behavior for the real thing later.

Children begin to rationalize or put things together. They discover that animals “do it” too and develop a curiosity about the particulars of genital anatomy, including size differences (“Is my penis big enough?” The response: “your penis is just the right size for your body”). These anatomy questions naturally lead to questions about how it works, especially reproduction. They may learn about menstrual periods, making babies, homosexuals, and slang or dirty words for sex.

While this is a stage of *Industry vs. Inferiority* for children, it should probably be called *Ignorance vs. Embarrassment* for parents as many either ignore these questions or mumble confusing answers due to their own embarrassment.

Also about this time many children desire a nonsexual, yet sensual or affectional closeness to parents, perhaps in resolution to earlier Oedipal/Electra complexes.

Identity issues begin to develop about the time the biological clock kicks into high gear for girls. Sexual identity in Eriksonian terms means mastering the capacity for trust, intimacy among peers, and autonomy from parents. This is viewed as preparation for heterosexual selection of a mate, signifying successful completion of this *Identity vs. Role Confusion* stage—according to Erikson.

In this society, the media plays a large role in the identity-forming process. Pre-adolescents begin to bond closely with their peers and become similar in their music tastes, clothing, language, and appearances. In boys this begins as same-sex cliques, later in adolescence expanding to include some opposite sex peers. Girls begin to develop more serious crushes and preferences for boys when they begin puberty, about 2 years ahead of same-age boys. This is why we see many 10 and 11 year old girls seeking out the more physically, psychologically mature 13- and 14-year-old boys.

Girls begin their growth spurt 2 or 3 years before boys do. In fact, by the time boys finally start growing at ages 12-16, girls have almost attained adult height, and have breasts and pubic hair. Pubic hair in boys follows the growth spurt.

iv.) **Psychosexual Development of Children: Adolescence** (See Table 3)

By the time boys and girls become teenagers, they become almost obsessed with perfecting their appearance as determined by peer approval.

They experience a turmoil not unlike the terrible two’s stage of Autonomy vs. Shame and Doubt where independence, parental opposition, a pervasive mistrust of the “establishment” and lofty plans for the future are jeopardized by self-doubt and desire for attention and approval from peers and parents. They become focused on needs of the “here and now.” Typically we see an extremely self-conscious teenager whose most critical concern is who she will stand next to at the school dance. Hours of preening and telephone conversations are common place, laying the foundation for more intimate, complete relationships later.

The rapidly progressive physical changes are cruel to these painfully self-conscious teenagers. First, the growth spurt begins with the hands, feet, and legs leading to gangly, awkward-appearing
adolescents. Teenagers tend to develop myopia or nearsightedness with their growth spurt. As a result, they need glasses which is exciting for about one week before it becomes “nerdy”. Then they get acne. Then, around ages 13-14, about 50% of boys develop some breast tissue, sometimes causing great alarm and concern about their masculinity. The more visible and desirable signs of masculinity such as facial hair and voice changes occur late, around ages 15-17 in boys.

Because the teenage years are largely moderated by stereotypes and socialization, boys and girls differ noticeably in their concept of sexuality.

While girls envision a romantic relationship, preferring an emotional attachment as much (or more) than a physical attachment, boys are focused on sexual prowess and “proving it” rather than the less satisfactory and sometimes burdensome emotional attachment. Both sexes seek out partners approaching their ideals.

Masturbation increases dramatically in boys around age 12-13. Wet dreams are first experienced around this age. One study found that 13-year-old boys masturbated about 3 times a week whereas girls masturbated approximately once every 3 weeks. The reasons for the differences are not clearly defined but may be related to societal views that females are supposed to be subdued sexually (at least until marriage) whereas males need to “prove their worth” as soon as they are capable of doing so.

B. Behavioral changes associated with sexual abuse

Having established a basic understanding of the normal psychosexual behavior of children and adolescents, the following will address recognition of abnormal sexual behaviors that may signal child abuse. It is important to remember that most sexual behaviors, understood within the proper context, will be normal or nonspecific for abuse.

In his normative study of children’s sexual behavior, Friedrich reports that in children ages 2-12 screened for non-abuse, sexual behaviors that were aggressive and more imitative of adult sexual behavior were rare. Friedrich also reports that family nudity was associated with greater sexual behavior among children in all age groups. The following behaviors were considered unusual in normal children:

- Puts mouth on sex parts (.1%);
- Asks to engage in sex acts (.4%);
- Masturbates with object (.8%),
- Inserts objects in vagina/anus (.9%);
- Imitates intercourse (1.1%); and
- Touches animal sex parts (1.3%).

In comparing the sexual behaviors of sexually abused children to a normative and to a psychiatric sample, Friedrich (2001) found that sexually abused children from 2-12 years in age displayed a greater number of sexual behaviors and a greater intensity or frequency of these behaviors. However, sexual behaviors were also found in the non-abused group of children that received psychiatric care and were related to family variables such as life stress, boundary problems, and family sexuality. More sexual behavior was seen in sexually abused children with:

1) medical evidence;
2) history of oral, vaginal or anal penetration;
3) family member perpetrators;
4) longer-term, more frequent abuse, and  
5) multiple sexual offenders.  
Sexually abused children were more likely to be poor, have less-educated parents, live with a single parent,  
and live in distressed and sexualized homes.

Other behaviors of concern would include: 1) Coercive sexual play, where one child directs or forces participation by another child; 2) Obsessive nature to sexual behavior such that the child cannot be easily diverted from the behavior; 3) Persistent-repetitive sexual acts over several days; or Explicit sexual acts such as insertion of objects or organs into genital orifices (*COPE* acronym).

The clinician faces additional challenges when evaluating the sexual behavior of young, often preverbal, children presenting within a custody dispute. One parent may be adamant that certain behaviors are occurring when the observations of other caretakers do not confirm this. The clinician should gather a careful and complete history of the child’s behavior, understanding that within the context of a custody dispute there is considerable stress which may manifest as increased masturbation in the child.

### PSYCHOSEXUAL DEVELOPMENT OF CHILDREN: AGES 0-6

<table>
<thead>
<tr>
<th>Developmental Tasks</th>
<th>Psychological Processes</th>
<th>Behavioral Responses</th>
<th>Preferred Relationships</th>
<th>Physical Modifiers</th>
<th>Specific Examples</th>
</tr>
</thead>
</table>
| **Trust vs. Mistrust** | - Nourishment  
- Nurturance  
- Self-absorbed  
*Own needs like eating, sleeping are focus. Need for physical and emotional affection.* | - Sucking  
- Cooing | Mother | - Arousal  
- Erection | Grabs penis/crotch |
| **0-1½ yrs.** | | | | | |
| **Autonomy vs Shame & Doubt** | - Independence  
- Curiosity  
- Retention/letting go  
*Base security w/parent is needed to help child explore the world. Symbolic letting go of bowel.*  
- Gender identity | - Exploration  
- Manipulation  
- Bowel/Bladder Training | Mother | - Identify sexual organs with excretory functions (there is an overlap of sensual feelings and defecation) | - Undresses/exposes self  
- Scratches crotch  
- Touches breasts  
- Disinhibited |
| **1½-3 yrs.** | | | | | |
| **Initiative vs Guilt** | - Beginning of  
- Socialization  
- Seeks to increase self-esteem  
*Exploring doing on own.*  
- Develops conscience | - Curiosity about sex differences  
- Sexual play/exploration  
- Guilt about parental desires | Opposite sex parent | - Orgastic capacity child develops the ability to experience emotional release (physical without the mental understanding) | - “Dirty” language |
<table>
<thead>
<tr>
<th>Developmental Tasks</th>
<th>Psychological Processes</th>
<th>Behavioral Responses</th>
<th>Preferred Relationships</th>
<th>Physical Modifiers</th>
<th>Specific Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry vs Incompetency</td>
<td></td>
<td>- Competition</td>
<td>- Same sex peers and parents</td>
<td>- Continues to derive pleasure from genitals</td>
<td>- More inhibited</td>
</tr>
<tr>
<td>6-12 yrs.</td>
<td>- LOTS of Learning</td>
<td>- Group Activities</td>
<td></td>
<td>- Desires affection to parents</td>
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<td></td>
<td></td>
<td>- Sexual play/exploration continues</td>
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<tr>
<td></td>
<td></td>
<td>- Flirtatious behaviors</td>
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<tr>
<td></td>
<td></td>
<td>- Curious about sexual anatomy</td>
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<td></td>
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<td>- Curious about reproduction</td>
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<tr>
<td></td>
<td></td>
<td>- Increase in peer (same sex activities)</td>
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<tr>
<td>Identity vs Role Confusion</td>
<td></td>
<td>- Identify with peers</td>
<td>- Opposite sex peer (girls)</td>
<td>- Breast budding (girls 9-13)</td>
<td>- Exhibitionistic</td>
</tr>
<tr>
<td>13-19 yrs.</td>
<td></td>
<td>- Increase in peer (same sex activities)</td>
<td>- Same sex peer (boys)</td>
<td>- Growth spurt (girls 10-14)</td>
<td>- Moaning</td>
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<td></td>
<td></td>
<td></td>
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<td>- Pubic hair (girls 11-14)</td>
<td>- Kissing/dating</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>- “Falling in love”</td>
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<td>Developmental Tasks</td>
<td>Psychological Processes</td>
<td>Behavioral Responses</td>
<td>Preferred Relationships</td>
<td>Physical Modifiers</td>
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<tr>
<td>Identity vs. Role Confusion</td>
<td>Peer approval is critical</td>
<td>Parental opposition</td>
<td>Opposite Sex Peer</td>
<td>Growth spurt</td>
<td>Courtship behavior ranging from telephone to petting from clumsy to sophisticated</td>
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<tr>
<td>13-19 yrs.</td>
<td></td>
<td></td>
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<td>(boys 12-16)</td>
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<tr>
<td>Appearance Future goals</td>
<td>Self-conscious</td>
<td>Cliques</td>
<td></td>
<td>Myopia (sight)</td>
<td></td>
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<tr>
<td>Sexual Prowess (males)</td>
<td>Physical attraction&gt;emotional attachment</td>
<td>Telephone</td>
<td></td>
<td>Increased masturbation</td>
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<tr>
<td>Romantic Relationship (females)</td>
<td>Emotional attraction or = physical attraction</td>
<td>Preening</td>
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<td>Period starts</td>
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<td>(avg. 12.8 yrs.)</td>
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<td>Pubic hair</td>
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<td>(boys 12-14)</td>
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<td>Acne</td>
<td></td>
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<td></td>
<td>Breast tissue development in boys (13-14)</td>
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<td></td>
<td></td>
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<td></td>
<td>Facial hair (boys)</td>
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<td></td>
<td></td>
<td>Voice change (boys)</td>
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</table>
C. References


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4) Interview Approaches and Techniques  
Cathy Crabtree and Nancy D. Kellogg, MD

A. The Critical Importance of the Forensic interview

Child abuse investigations, particularly those involving allegations of sexual abuse, rely heavily on the disclosure a child makes regarding specifically what has happened to them. It is for this reason that the focus of the criminal and civil justice systems on the forensic interview process has increased so dramatically in recent years. In Texas, Child Protective Services, when investigating alleged child abuse, is required by law to audiotape or videotape the interview conducted with that child. Whenever possible, videotape is overwhelmingly preferred over audiotape as it allows for capturing the child’s facial expressions, body language and demeanor as well as their words. Ideally, the forensic interview is conducted in a neutral, child-friendly environment where the child will not feel threatened or intimidated and where all professionals who need to be privy to the information can gather to watch and listen to the interview from a nearby observation room at the same time. This process prevents unnecessarily subjecting a child to multiple interviews regarding the abuse while ensuring that the informational needs of all the agencies involved are met through this teamed process.

A professional with specialized training in the field of forensic interviewing of children should be the one to conduct the actual interview with the child. This professional may be an investigator with Child Protective Services or law enforcement or an independent interviewer on staff at a Children’s Advocacy Center working as part of the CAC’s multidisciplinary team. Regardless of who conducts the interview, the other investigative and sometimes the prosecutorial professionals involved in the case are present in the observation room during the interview.

Videotaped forensic interviews with children are frequently used in the presentation of cases to grand juries and, in some instances, as a tool for investigators in the interrogation of the alleged perpetrator in the case. In certain specific instances, the videotapes may be introduced in court during civil and/or criminal court proceedings, although the existence of a videotaped interview does not preclude a child from having to be available to testify during the trial process.

In many communities, multidisciplinary teams also videotape interviews conducted with children over the age of 12, as deemed appropriate. Regardless of whether an audio or video tape is needed, and regardless of the age of the child, it is vital that the interview be conducted by a professional with appropriate training in this specialized field and that a team approach to the interview process be implemented. This approach is designed to minimize re-victimization of the child victim and reduce the need for multiple interviews, as well as to protect the integrity of the investigative process -- eliminating inappropriate, leading questions while gathering the critical detailed information needed for effective fact finding.

The videotaped forensic interview conducted by investigative agencies may occur prior to or following the medical examination, depending on the dynamics of the specific case in question, whether or not the child has already made any type of disclosure and where the child first presents with statements or symptoms regarding abuse. The history taken by a medical professional conducting an assessment sometimes provides additional information the child may not have disclosed to the forensic interviewer and, when the child repeats the disclosure details to a medical professional, those statements represent
important collaborative evidence regarding the validity of the child’s statements. From one jurisdiction to another procedures will vary in terms of which professionals interview the child, whether the forensic interview is a part of the medical examination, or whether a videotaped forensic interview precedes or follows the medical examination. However, regardless of the agreed-upon local protocols and procedures in this regard, it is vitally important for each and every professional involved in investigation, prosecution and intervention involving child abuse cases to maintain open lines of communication and coordinate all related activities, especially all interviews with the child, in order to protect both the child and the case throughout the process.

B. Rationale for clinician interviews

Of all the types of evidence and information that may be collected during the medical assessment, the history is the most important evidence. In most cases of child sexual abuse or assault, other types of evidence – semen/sperm, anogenital or bodily injuries, and sexually transmitted diseases – will not be present. Not all clinicians have the training or the luxury of time to conduct extensive interviews of children, but that should never preclude the clinician obtaining a medical history from the patient or family, sufficient for the performance of the medical evaluation.

Advantages to clinicians performing complete (i.e., forensic) interviews include:

- Helps establish rapport with the child, facilitating child relaxation and cooperation during the examination.
- Children generally see the doctor as someone who helps them. This perception may facilitate disclosure of additional information not obtained by Child Protective Services or Law Enforcement officers, whose role may be unknown or threatening to the child.
- The assessment can be more comprehensive, e.g.: “History is consistent and detailed for fondling and attempted vaginal-penile penetration. Physical exam is normal and can be consistent with the history given.”

A normal examination, taken in isolation from historical facts, can sometimes be misconstrued by the legal and lay community as meaning “nothing happened;” thus, the inclusion of the clinician’s interview findings may improve the overall effectiveness of the medical assessment in addressing the allegations.

Disadvantages of extensive clinician interviews include time and inconvenience. Difficult interviews may take up to one hour. Most clinicians in private practice or in an emergency room setting are rarely able to set aside such time on a short notice. In addition, child sexual abuse may provoke anger and even denial in some professionals. Medicolegal implications of child abuse and the possibility of testimony in court are added disadvantages.

The decision to perform a forensic interview is clearly dependent upon each physician’s personal preferences, availability of time, and access to other resources of assistance.

C. Legal considerations: outcry witness and exceptions to hearsay rule

There are specific circumstances under which a medical professional may testify about the medical history gathered from the child in sexual abuse evaluations (refer to Chapter 15 for more details):

i) **Outcry witness.**

If the professional is the first person over the age of 18 years that the child has disclosed sexual
ii) **Hearsay exception: medical diagnosis and treatment.**  
If the medical professional is asking the child for information important for medical diagnosis and treatment, then the medical professional may testify as to what the child told him or her and the medical records may be admitted into evidence and read by the judge or jury.

iii) **Hearsay exception: excited utterance.**  
If the child suddenly discloses new information to a person because of the unique nature of the circumstances (i.e., during a genital exam or while testing for genital infections).

### D. Important Principles to Remember in Interviewing Children about Sexual Abuse

i.) **Before You Ask** (excerpted from the TPS Child Abuse Pocketguide)

Professionals should begin to communicate directly with all school-aged children (i.e., not just their parents). Conversations about incidental occurrences in the child’s life (like birthdays, pets, holidays, family events) show the child you respect and listen to what they say, especially when you encourage eye contact and conversation from the child. Once children understand you will respect and listen to them, they are more likely to be receptive to any information you may impart (i.e., safety issues like seat belts and bicycle helmets). Routinely ask children if they have any health or safety concerns and explain that it is part of your job to take care of the child’s health, education, and safety needs. This establishes a foundation of trust for any subsequent discussions of “uncomfortable, confusing, or threatening” events that occur in a child’s life. These principles of respect, honesty, concern, and trust should be reinforced frequently with each child. Professionals may wish to talk with the child out of the presence of other family members. Each professional should give frequent and explicit permission to the child to talk about any uncomfortable or threatening experiences. In one study, one out of five sexual abuse victims disclosed simply because “someone asked”.

Many children do not disclose because they are fearful of their abuser, not being believed, getting in trouble, or the effects on other family members. When a child discloses abuse, acknowledgment of these fears is one way to show understanding and support for the child: “Does anything worry you? Some children worry about what people will think or do after they tell. You’re not in trouble here. Thank you for talking to me about this.”

ii.) **Asking the Question: Listen and Look, Don’t Lead**  
It is critically important that professionals not prompt or provide details for children when asking screening questions for abuse. The goal of screening questions is to obtain sufficient information to make a report and define the terms of the report. Rely on the foundation of respect, honesty, concern, and trust that you’ve already established with the child. Reiterate that it is your job to help with any safety and health issues the child may have, and that is important for the child to share any information regarding these issues with you. If the child has a physical finding or injury suspicious for abuse, ask the child to simply tell you “how this happened,” or “everything about how these bruises happened”. If the explanation is inconsistent with the pattern, age, or severity of the injury, be honest with the child. “It’s confusing to me how you would get two black eyes from falling down only one time. Sometimes children get bruises in other ways and they might feel scared to talk about it. I’m here to help. Is there anything else you can tell me about these bruises?” If the child does not disclose abuse but the physical examination findings are
highly suspicious for abuse, a report to Child Protective Services (CPS) or the local law enforcement agency should be made.

“Keep the information confidential” means that the information the child shares with you will be made available only to the necessary individuals (CPS, police, supervisors) and that the information will be shared with respect and sensitivity to the child. This means no talk among professionals in the presence of children as if they weren’t there.

iii.) History of Events

The frequency of sexual contact and timing of the most recent sexual contact will assist in the interpretation of examination findings and will determine whether emergent forensic evidence collection is indicated. Children and adolescents presenting within 48-72 hours of sexual abuse involving genital contact will usually require forensic evidence collection is indicated. Children and adolescents presenting within 48-72 hours of sexual abuse involving genital contact will usually require forensic evidence collection. Other forensic materials include assailant debris and hairs (pubic and head) that may be found on the child's body or clothing/linens.

The type of sexual contact will determine which examination procedures and tests are most appropriate. If there is a history of (perpetrator's) genital contact with the child's body, then testing for sexually transmitted diseases may be appropriate. With repeated genital contact, risk of STD’s, including AIDS, increases. Condom use by the assailant reduces, but does not eliminate the risks of pregnancy and diseases. The use of lubrication reduces the likelihood of anal or genital trauma. Characteristics of the perpetrator that increase the risk of AIDS in the child or adolescent include: known positive serology for HIV, stranger, gang member, intravenous drug user, and multiple sexual partners. When any of these characteristics are identified, the clinician should discuss HIV testing with the child and family enabling them to make an informed decision about whether to undergo testing.

Children and adolescents that present for medical evaluations after an acute sexual assault should be questioned and examined carefully for other non-genital injuries. Injuries may result from assault by the assailant, restraint by the assailant and attempts to defend oneself from the assailant. Assault injuries most frequently involve the face and neck and are inflicted to silence the victim. Slap marks, grab marks, and contusions from blows by a fist or object may be seen on the face, neck, head, and extremities. Bite marks on the neck and breasts may bee seen and can be examined and analyzed by forensic odontologists for identifying teeth marks. Both recent and healed bite marks may yield important forensic information. Restraint injuries include traumatic (hair pulling) alopecia, grab marks on the face, neck, arms, and legs, gag marks around the mouth and ligature marks around the neck, wrists, and ankles. The victim's attempt to shield herself from an assault typically results in bruises on the extensor surfaces of the arms and on the legs. Victims may bite their assailants and assailants may be examined for this evidence.

iv.) Current physical/psychological/emotional symptoms

Victims may report various areas of tenderness over body surfaces after an acute assault. Victims of chronic abuse tend to have concerns or complaints regarding their genitals that often have no identifiable pathologic etiology. Nonetheless, children should be asked if they are having pain/bleeding/discharge and if so, these concerns should be specifically addressed during the examination to relieve any anxiety about diseases and distorted body image the child or adolescent may have. Genital symptoms that may indicate trauma or medical conditions include genital bleeding/pain (evidence more likely if there is a history of
bleeding), dysuria (UTI’s), vaginal discharge (STD’s, bacterial vaginosis, etc.) and abdominal pain (pelvic inflammatory disease). Recent drug/alcohol use, or mental status changes may implicate the need for drug testing or alcohol blood levels. Such testing may assist law enforcement in assessing the extent to which the victim could consent to sexual acts and may assist the medical team in the short- and long-term treatment of drug toxicity and substance abuse.

Victims may present with acute shock, depression and suicidal ideation. The clinician should ask directly about suicidal thoughts: “Have you ever felt so bad that you thought about killing yourself?” If the answer is yes, the clinician should establish the most recent suicidal thoughts/action and consider an immediate referral to psychiatry. The clinician should be cautious in prescribing anxiolytic and anti-depressant drugs, and should utilize psychiatric expertise whenever possible.

Some children will present with sexualized behaviors and the clinician will be challenged to interpret these behaviors and address the risk of sexual abuse. Chapter 3 provides a detailed discussion regarding the differentiation of normal sexualized behavior and sexual behavior that may indicate abuse. Other behavioral responses to sexual abuse include aggressive behaviors, sleep disturbances, school dysfunction, weight changes, and delinquent behaviors. The table below summarizes some of the more common physical and behavioral symptoms associated with sexual abuse. Identification of problems in this area will assist the clinician in assessing the extent of the abuse effect and in providing the appropriate referrals for therapy.

<table>
<thead>
<tr>
<th>Physical signs and symptoms</th>
<th>Behavioral Changes</th>
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<tbody>
<tr>
<td>Genital Discharge</td>
<td>Sexualized Play</td>
</tr>
<tr>
<td>Genital Bleeding</td>
<td>Excessive Masturbation</td>
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<tr>
<td>Genital Pruritis</td>
<td>School Problems</td>
</tr>
<tr>
<td>Genital Irritation</td>
<td>Aggressive Behavior</td>
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<tr>
<td>Recurrent Urinary Tract Infections</td>
<td>Suicidal Ideation</td>
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<td></td>
<td>Substance Abuse</td>
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<td></td>
<td>Abdominal Pain</td>
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<td>Enuresis</td>
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<td>Encopresis</td>
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<td>Sleep Disturbance</td>
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<td>Runaway Behavior</td>
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<td></td>
<td>Depression</td>
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<td></td>
<td>Social Withdrawal</td>
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</tbody>
</table>

v.) Gynecologic history

Information regarding prior gynecologic evaluations will assist the clinician in interpreting examination findings of healed injury or infection, and will assist support staff in the preparation of the adolescent for the examination. Prior infections, pregnancies and gynecologic conditions should be noted. A sexual history regarding gender and number of partners, type(s) of sexual contact (including anal contact) and frequency of barrier contraceptive use will determine which STD’s should be tested and the
optimal intervals for testing. For example, venereal warts have a latency phase of 2 weeks to 2 years with an average of 2 months, so an examination may be indicated two months after the most recent sexual assault or contact. The information about the last menstrual period will determine risk and best timing for pregnancy testing.

vi.) Family background (domestic violence, siblings, family support of victim)
Sometimes the child may reveal that the nonabusive caretaker does not believe or is ambivalent about whether abuse has occurred. When there is compelling evidence, either in the child’s history or in medical findings, that abuse has occurred, the clinician should report any perceived lack of support or belief in the child to Child Protective Services. Prior abuse by family members or prior reports of abuse to the child should be noted. History of spousal violence in the home of the child is particularly important as the risk of further violent outbursts and homicides increase when a battered adult leaves the batterer. More than half of sexually abused children have lived in homes with spousal violence. When the sexual abuse of the child by a batterer is revealed, this is often the first time the battered partner attempts to leave the batterer. This presents considerable risk to the adults and children in the home.

The child’s coping depends on how well the nonabusive adult copes with the disclosure of abuse. The child may perceive the adult’s distress as threatening and this may in turn effect the child’s willingness to talk about the abuse. Such concerns should be identified and addressed. The clinician should also ask the child what concerns they have for diseases, pregnancy, virginity, and alterations in body appearance or function. By providing answers and reassurance regarding these matters, the clinician may directly enhance the healing process.

vii.) Safety issues
In addition to issues of domestic violence, children may also fear punishment or repercussions from the disclosure of their abuse. For example, victims of “date rape” may fear physical punishment by parents for “letting that happen”. Clinicians should ask teens if they feel safe going home and if they’ve considered running away instead of returning home. As discussed in a previous section, actively suicidal patients should be referred emergently to psychiatry to address the risk of self-injurious behavior.

E. Approach to the interview
The clinician’s initial approach will depend on whether child has disclosed that the abuse has occurred. If abuse is suspected because of physical, behavioral, or emotional symptoms but no abuse has been disclosed, the clinician may question the child in a careful, non-leading, non-suggestive manner. If the child has already disclosed abuse, questions must still be carefully phrased, but the interview is based on information already presented.

i.) Physical Setting (For Interview)
Time: 5 minutes (when they “don’t want to talk about it”) to 2 hours. Average about 30 minutes.
Persons present: Interviewer, child, “neutral” witness (social worker or nurse) when possible.
Equipment (optional): pad/pencil (some children may prefer to write what happened). Anatomically detailed dolls should only be used by trained individuals.

ii.) Beginning the Interview
Children are especially worried about the examination, and providing that information at the onset can alleviate anxiety and facilitate information-gathering during the interview. A nurse or social worker may help prepare the child for the examination.

Allow the child to describe in his or her own words the first (or most recent) episode of abuse spontaneously with little interruption, except to clarify terms. Be very concrete: when the child says "he touched me" you say "with what?" Child: "His hand." Interviewer: "Where?" Child: "on the privates." Interviewer: "Kids have lots of different kinds of privates. Which private do you mean?" Remember that the meaning of "rape" may be highly variable: for one teenager "rape" was having her shirt ripped off and breasts fondled. ("Rape means I was forced" she said.) Tell the child why you are asking questions: "Since I'm a doctor, it is my job to check your body. For me to do the best job of checking your body, I need to know about anything that may have happened to you or your body. That way I know what to check for."

iii.) Mid-Interview: Sustaining the flow of information and filling in the gaps.
Give positive reinforcement cautiously and not just after statements of abuse. The best reinforcement is the silent acknowledgment with eye contact and body language that you are listening and hearing what the child says. After the child has described "the first time", ask "whether it happened once or more than once" and "whether other kinds of things happened the other times". Try to establish a time frame and frequency of abusive episodes. While you may want to ask if anything "went inside" (when referring to vaginal-digital or vaginal-penile contact) remember that even teens may not be able to distinguish attempted (or vulvar) versus completed (or vaginal) penetration. Document experiential and corroborative details that the child volunteers: visual/olfactory/taste characteristics of ejaculate; urge to defecate during or after sodomy; unusual body markings; pornographic pictures or movies taken of child.

Some information will not be volunteered spontaneously unless you ask including:

- “Has anyone ever done anything like this to you before?”
- “Do you know if he (perpetrator) did this to anyone else?” (Some children have witnessed other children being victimized.)
- “Did he make you do anything to him?”
- “Did he take (or show) any pictures or movies of you (or other people) without your clothes on?”
- “What did he say about telling?”
- “What did he say would happen if you told?”
- “Did he drink or use drugs?” (AIDS testing)
- “Did he make you drink or use drugs?”

iv.) Closure: Appreciation, support, and “what’s next?”
Many of these children and families have experienced a lot before arriving at your office. One little girl said that when the police came to her house, “I thought they came to arrest me.” Similarly, they think a doctor gives shots, or they may even think the doctor has the power to take them away from their families (children think of everything). Give very clear instructions on what you will do next (“I will write up a report which goes to the police, Child Protective Services and the District Attorney’s office”) and what more they can expect from you (“You don’t need to see me again; I will call you if any of the tests for infections come back positive”).

In your closure after the interview and examination, be sure to do the following:
1) Explain findings and provide an interpretation. Let children know that they are “normal” or “almost better”; a drawing sometimes helps the child and family understand and since hymens never disappear into nothingness, reassure them that their hymen is “still there”. Although children and especially teenagers rarely voice this concern most are worried their bodies may be “different”.

2) Answer any questions – spoken or unspoken – you think the child or parent may have.

3) Give the family your name and work number.

4) Leave the door of possibilities open especially if you’re dealing with long-term abuse and the child alleges only fondling, or the physical exam suggests more severe abuse than what the child alleges.

F. When the Child Discloses Abuse: Do’s and Don’ts

The following are general guidelines for “What to Do” when abuse is suspected and are excerpted from the Child Abuse Pocketguide published by the Texas Pediatric Society Committee on Child Abuse (1998). The Pocketguide is included in the Supplemental Materials.

When a child first discloses abuse, the professional should maintain a demeanor of respect and concern and allow the child to carry most of the conversation, interceding only as needed for clarification purposes. Keep notes as to what the child says, explaining that you want to remember their own words. Do ask for clarification when a child says “he hurt me” (Who is “he”? Where did he hurt you? With what?), or “we did the nasties” (What is meant by “nasties”? If there was body contact, what part or parts of the other person touched which parts or parts of the child?).

The initial screening questions for abuse should be open-ended. Questions should not be leading, where the answer is suggested in the question (‘Somebody broke your arm, didn’t they?’), or suggestive where components of the answer are projected by the questioner (‘Did Mommy hurt your arm?’). In general, it is recommended that questions begin with “what”, “who”, “where”, “when” or “how”, NOT “did” or “why”.

If a child stops while describing an incident of abuse, provide general reinforcement (I know this is hard for you but you are doing a good job” not “I know when your daddy touched your private you must have felt upset. I don’t blame you!”), then repeat what was last said by the child so they are encouraged to continue. Offer them the option of writing “what happened”; other props such as dolls, puppets, or telephones are useful in the hands of skilled interviewers but can also be distracting and leading to younger children.

Once children begin to disclose abuse they may wish to share more details than you need to make a report. Allow children to share as much as they wish but do not probe beyond the basic information required for a report unless you are conducting (or plan to conduct) a complete medical evaluation. By showing your support and concern during this anxious and painful process of disclosure, you begin the child’s healing process.

Children will sometimes say they still love their abuser, or their non-believing mother. Do not try to convince the child to feel otherwise. Acknowledge those feelings (“I know you love your Mom–she’s still your mom…”) but allay the child’s guilt with the appropriate placement of responsibility (“…but your mom needs help learning how to keep you and your sister safe”). Be sure the child knows that the abuse is not their fault.
Inform the child of any actions you plan to take (*I'm going to call someone you can talk to that can help.*). Inform the adult accompanying the child of your actions if that adult supports and believes the child. If there is a concern that the parent may not believe or support the child, you may want to ask CPS if it is advisable to inform the parent about the child’s disclosure of abuse or your report.

Abused children depend on your honesty to maintain their trust. Out of eagerness to assist such children, professionals sometimes predict or promise things that cannot be guaranteed. This may jeopardize the child’s trust in you.

**DO NOT promise:**
- that the child will never be abused again
- that their mother or caretaker will believe them or protect them
- that the abuser will be put in jail or arrested

**DO promise:**
- to keep the child informed as to what you do, including examination procedures and the information that you share with others
- to answer any questions the child may have
- to be available for the child

**Information that may be requested by Child Protective Services or Law Enforcement**

The clinician should make certain that information required to rapidly identify and, if possible, reach the location of all involved adults and children is obtained and recorded:
- Child’s name and address;
- Child’s date of birth;
- Both parents’ names and address(es);
- Parent’s work and home numbers;
- Siblings’ names and present locations;
- The name of the school the child attends;
- Suspected abuser’s name and address (when possible);
- What the abuse involved (physical injuries, sexual abuse contact, etc.)
- Where the abuse occurred (county or city)
- When the abuse occurred; and
- Whether the abuser has continuing access to the child.

The use of formal protocols for recording history and physical findings greatly reduces the chance that key information will not be recorded, and should be used by all clinicians involved in child abuse evaluations. Formal child abuse protocols will be discussed in Chapter 9.

**G. Summary**

The medical interview should also incorporate information regarding physical, emotional, and psychological symptoms, gynecologic history, family background, and safety issues. Some of this background information can be obtained by a nurse, social worker, counselor, or investigator. The following table provides a summary of this information.
### TABLE: Medical Interview for Sexual Victimization

**History of event(s)**
- frequency and most recent incident
- type(s) of sexual contact
- condom use, lubrication
- perpetrator identity/risk factors for STD’s, HIV (stranger, gang member, substance abuser)
- bodily injuries; attack/defense injuries

**Current physical/emotional/psychological symptoms**
- pain/tenderness over body surfaces
- bite marks (recent/healed)
- genital symptoms (pain/bleeding, dysuria, discharge, abdominal pain)
- recent drug/alcohol use; memory lapses, mental status changes
- symptoms of shock, depression, suicide
- sexualized, aggressive behaviors
- sleep disturbances, school dysfunction, weight/appetite changes

**Gynecologic history (adolescents)**
- prior gynecologic evaluations/conditions/infections/pregnancy
- sexual history (timing and type(s) of previous sexual contact, contraceptive use, gender of partners)
- last menstrual period

**Family background**
- degree of support/belief in the child
- prior abuse in family members
- family violence
- parental and child coping
- changes in family structure/function since disclosure of abuse
- concerns for child: virginity/"damaged goods", AIDS, STD’s, pregnancy, delinquency/runaway, depression

**Safety issues**
- Does the child fear repercussions at home because they’ve disclosed abuse?
- Is the child actively suicidal?
- Does the child have a history of runaway behavior?

### H. References


5) **Approach to the Medical Evaluation**  
*Nancy D. Kellogg, MD and Joy L. Blackmon, PA-C*

The keys to a successful genital exam of a child or teenager are:

- Adequate preparation of the child (and often the parent) for the examination;
- Familiarity with various examination positions; and
- A confident yet sensitive approach to the child.

**A. Approach to the child**

The goal of preparation is to reduce anxiety and give the child some control. The child or teenager should be shown the examination room and equipment prior to the medical evaluation. This preparation is ideally done by a nurse or other support personnel. It may be helpful to show them a sample cotton-tipped applicator used for cultures and to let them touch the cotton tip to appreciate how soft it feels. Preparation can be done in the presence of a parent to reduce their anxiety as well. With adequate preparation, most examinations can be done without sedation.

When an examiner is nervous and anxious, the child or teenager is more likely to be nervous and anxious. Respect the child’s privacy and need for control. Tell the child you will “explain everything before it happens”. Raise the head of the exam table up so the child can see you and you can gauge the child’s reaction and anxiety during the exam. Allow them to change into the examining gown in private and keep all other areas of their body draped. Let the child choose a support person to be with them during the examination (Many teenagers prefer no one!). Avoid “shop talk” during the examination, moving quickly and gently through the examination. When using any of the examination techniques, apply constant, even, gentle pressure with your fingers to avoid “groping” movements. It is sometimes a more effective distraction to have the child talk during the examination rather than an adult talking to them (John McCann, personal communication).

**B. Approach to the parent: initial assessment of family and abuse risk factors**

Parents and caretakers can provide important information regarding the child’s behaviors, reactions to abuse, reactions of family members to the abuse, and other abuse-related stressors. The parent may fill out a questionnaire prior to the child’s assessment. Alternatively, the clinician, a social worker, a counselor, or a case manager may interview the parent regarding their observations and concern for the child.

The goals of this initial assessment conducted with the parent are to identify:

1) Behaviors/symptoms suggestive of psychological disorders or functional (school, eating, sleeping) difficulties in the child that may require treatment or referral.
2) Physical symptoms or concerns that should be addressed or treated during the assessment.
3) Past assessments for abuse, including circumstances/details to assure accurate interpretation of any current findings.
4) Family reactions to abuse, including lack of support and degree of distress among family members; do reactions correspond to concomitant changes or recantation of the child’s history? Many children recant if the reactions of family members are too distressing or punitive; the clinician may elect to proceed with a full medical evaluation in such cases to ensure appropriate detection and treatment of injuries or conditions that may be abuse-related.
5) Escalation or exacerbation of family stressors, particularly physical violence against children and adults. In a recent survey in San Antonio (Kellogg, Ernst et al, in preparation) of mothers whose children had disclosed sexual abuse, 71% reported physical and/or sexual violence by their adult partners, many of whom were also the sexual offender of the child. Such families may require immediate shelter/safety plans.

6) Past medical problems and history, mental health problems, and mental or developmental disabilities in the child that may alter the clinician’s approach or interpretation of findings or history.

7) Any additional changes in family functioning or needs that may require assistance or referrals.

C. Examination positions and techniques
The practitioner should become familiar with the appropriate uses of the various examination positions to ensure adequate and complete visualization of anogenital anatomy, and the techniques required to perform a comfortable and thorough examination. These skills can be achieved through numerous examinations on normal children and adolescents.

i.) Examination positions
There are 5 positions that may be helpful during the medical examination. These are listed below.

Most examinations require only two of these positions: either the supine frog-leg position or the supine lithotomy position (depending on the child’s age and size); and the prone knee-chest position.

Supine frog-leg position: This position is used for smaller prepubertal children. The child places the soles of the feet together with knees flexed laterally. This position provides an adequate view of the vulva, hymen, and vestibule. If abnormalities of the hymen are seen in this position, examination in the prone knee-chest position is essential to confirm these findings. In the supine position, the normal hymen may sometimes fold on itself, creating an artificial abnormality (thickening or irregularity) that unfolds or normalizes in the prone knee-chest position. Some clinicians allow the child to adopt a modified version of this position while sitting in the mother’s lap.
Supine lithotomy position: This position is used for larger female prepubertal children and all female adolescents. The feet are placed in the examination table stirrups, the patient moves the hips and buttocks to the end of the table, and flexes the knees outward “to the side”. This position provides an adequate view of the vulva, hymen, and vestibule.

Prone knee-chest position: This position provides the best view of the perianal area. The child’s shoulders, elbows, and forearms are placed on the table, the lower back is lordotic, extending the hips upward and knees are placed about 18 inches apart. As discussed above, this position is also important for confirming irregularities seen in the supine position. In this position, it is possible to visualize the vagina and cervix without inserting a speculum.
Supine knee-chest position: This position is generally used to examine the anus of infants and small toddlers. (Lateral position may be used instead). The knees are drawn up onto the chest to visualize perianal structures.

Lateral decubitus position: This position can be used for all age groups to examine the anus. The knees should be together and drawn up on the chest such that the anus can be visualized with minimal gluteal separation or distortion of the tissue.
ii.) **Examination techniques**

Begin with labial separation (the labia majora are moved laterally and inferiorly).

Then proceed to labial traction. The labia majora are grasped close to the posterior commissure and pulled gently in the anterior direction, towards the examiner.
Proceed to the lateral or prone knee-chest position, as appropriate and indicated.

The most common errors in examination techniques include:
- Insufficient labial traction and to adequately visualize the hymenal margins and vestibule;
- Inadequate lower back lordosis of the patient while in prone knee-chest position; and
- Inadequate lifting of the gluteus muscles with the examiner’s thumbs during examination of the child in prone knee-chest position.

Additional techniques that enhance visualization of genital structures include:
- Moistening the hymen with water so that redundant folds that adhere to the vestibule or vaginal structures are straightened and freed.
- Manipulation of the hymenal edges with a Foley catheter filled with water (Persaud and Squires, 1997), a balloon-covered large cervical swab (Adams and Kellogg, 2000) or a moistened cotton-tipped applicator. The Foley catheter is inserted into the vaginal canal, inflated with a small amount of water, then pulled gently in an external direction such that the edges of the hymen are splayed over the inflated catheter tip. The balloon covered swab is placed just inside the vaginal opening then stretch out the hymen.

D. Discussion of findings with child and parents
After the examination, have them sit up and adequately draped or changed into clothing before discussing the results of the exam. In a brief, age-appropriate way, talk to the child or teenager first about the examination findings. The patient should be reassured that they are normal and healthy, and that even if minor injuries are found, they will heal quickly and completely.

E. Non-genital Injuries Encountered in Sexual abuse or assault victims
The types of nongenital injuries are outlined in chapter 4, “Interviewing the Child for Possible Abuse”. Suspected victims of abuse should be examined/screened for all types of abuse. The “Clinical Practice Guidelines” (see Appendix) details emergency room assessment and treatment of suspected victims of physical abuse.

A complete physical examination should be performed. Body surfaces should be examined and palpated for bruises, scars, and areas of tenderness. Dr. Joyce Adams (2001, submitted for publication) reviewed 217 charts of girls between 14 and 19 years of age seen for acute rape. Non-genital injuries occurred in 21%; 10% had suction marks, and 17% had multiple types of injuries. There was a significant correlation between the severity of genital injuries and the number of non-genital injuries. The number of non-genital injuries also correlated significantly with the number of symptoms (nausea, vomiting, pain, etc.).

Injuries of moderate severity occur in approximately 5% of adult sexual trauma victims (lacerations, hematomas, fractures) and approximately 1% require hospitalization for their injuries; the prevalence of such injuries is unknown in children. The most common non-genital injury sites are the head and neck, followed by the extremities and trunk. In addition to the types of injuries outlined in Chapter 4 (assault, restraint, defense types) the child should be examined carefully for intraabdominal injuries including organ rupture and intestinal hematomas, abrasion/friction in juries to the back, and intraoral injuries from forced penile-oral penetration. (Kellogg & Sugarek, 1998).
F. Issues in providing medical treatment to sexual abuse victims

i. Emergency Contraception

The American Academy of Pediatrics (1994 and 1997) recommends that clinicians who care for sexual abuse/assault victims should offer their pubertal and postpubertal female patients emergency postcoital contraception (EC). The most commonly prescribed form of EC is the so-called Yuzpe regimen (Yuzpe and Lancee, 1997):

Two doses of a combination of 100mcg of ethinyl estradiol and 0.5mg of levonorgestrel each, the first dose taken within 72 hours after intercourse and the second 12 hours later.

Alternatives to the Yuzpe regimen include mifepristone (RU 486), danazol, the use of 1mg norgestrel in place of 0.5mg levonorgestrel, and single-agent estrogen or progestins. Combinations of oral-contraceptive tablets given in sufficient quantity to achieve the above dosages remain the most widely-used form of EC. Currently, the Food and Drug Association has approved the use of three combination monophasic oral contraceptive brands for use as EC: Ovral®, Lo-Ovral®, and Nordette®. Preven® is a combination product specifically for EC that has recently been marketed in the U.S.

When the Yuzpe regimen is followed correctly, its efficacy in preventing conception is estimated to be at least 74% (Glasier, 1997 and Delbanco et al, 1998). Patients who use EC do not need to be counseled to terminate the pregnancy if they conceive after taking EC’s, since there is no evidence that combination oral contraceptives are teratogenic or predispose to ectopic pregnancy (Brown, 1996). However, close followup of these patients is indicated and, in the event of conception, they should be counseled regarding the option of terminating the pregnancy.

The most common side effects are nausea (in up to 50% of women) and vomiting (up to 20%) (Glasier, 1997). Prescription or over-the-counter antinausea medications can reduce the incidence of these if taken before the EC is administered. Withdrawal bleeding is variable, ranging from none (if EC is administered early in the menstrual cycle) to spotting to full menses if taken late in the cycle.

The following website has current, frequently-updated information regarding the use of emergency contraception, including the number of pills needed for each oral contraceptive brand; frequently asked questions; patient information; etc.:

http://ec.princeton.edu/info/ecp.html

ii. Gynecologic and surgical referrals

Studies of adult sexual assault victims report that approximately 1 percent of survivors have genital injuries severe enough to require surgical intervention (Hampton, 1995). Lacerations of the upper vagina can present with profuse bleeding and pain, and occasionally can extend into the peritoneum. About 1/3 of patients with active anal bleeding have deep lacerations requiring admission for transanal repair and intravenous antibiotics. Orr et al (1995) reported a series of four deaths (3 adults and 1 infant) after anorectal assault.
Muram et al (1995) found that adolescent sexual assault victims were less likely to sustain serious injury than were adult victims, but the clinician should be alert to the possibility of serious anogenital trauma, particularly in the setting of persistent genital bleeding, or where the source of bleeding cannot be readily identified.

Victims of non-acute child sexual abuse rarely require gynecologic or surgical consultation. There are a few instances where referral to a gynecologist may be beneficial, such as sexually transmitted diseases that do not respond to standard therapy, or sexually transmitted diseases that might require surgical intervention (e.g., large condylomata).

G. References


6) Diagnosis and Treatment of Sexually Transmitted Diseases in Sexual Abuse Victims
Juan M. Parra, MD

A. Introduction
The overall prevalence of sexually transmitted diseases (STD’s) in sexual abuse evaluations is low. The prevalence of STD’s in sexual abuse has been summarized to range from 2% to 7% in females and 0% to 5% in males (Atabaki & Paradise, 1999). Prevalence rates vary between age, region, and types of sexual contact that occurred (Hammerschlag, 1998). The highest rates of STD’s are found in pubertal females. The most commonly diagnosed STD’s in sexual abuse evaluations are gonorrhea, chlamydia, trichomonas, and human papilloma virus (HPV). Bacterial vaginosis is common in sexually active adolescents.

B. When to test for sexually transmitted diseases
The American Academy of Pediatrics (AAP) has published guidelines for testing for STD’s in children and adolescents (AAP Committee on Child Abuse & Neglect, 1999; AAP Committee on Adolescence, 1994a). Cultures, microscopy, and serologic testing for STD’s should be considered in prepubertal children when either oral, genital, and rectal contact has been described in the history and if the child is symptomatic. Cultures are for gonorrhea and chlamydia. Saline wet mount viewed with a microscope is done to identify Trichomonas vaginalis. The symptom most likely to signal the presence of gonorrhea and chlamydia is a vaginal discharge. In adolescents, cultures and microscopy for gonorrhea, chlamydia and trichomonas should be strongly considered from sites of contact with or without symptoms. Serologic studies should include testing for syphilis, HIV, and Hepatitis B. Studies by Siegel and Ingram have supported selective testing using the AAP criteria for STD screening (Siegel et al, 1995; Ingram et al, 1997). Selective screening of STD’s have been summarized by the Centers for Disease Control (CDC) and the AAP as follows (CDC, 1998; AAP Red Book, 2000):

<table>
<thead>
<tr>
<th>Recommendations for Testing for Sexually Transmitted Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History of multiple perpetrators</td>
</tr>
<tr>
<td>• Perpetrator or patient with known STD or history of STD</td>
</tr>
<tr>
<td>• Sibling of a patient with an STD</td>
</tr>
<tr>
<td>• History of consensual sexual contact</td>
</tr>
<tr>
<td>• Signs and symptoms of an STD</td>
</tr>
<tr>
<td>• Ano-genital injury</td>
</tr>
</tbody>
</table>

The article by Siegel et al (1995) recommends all pubertal girls to be tested for STD’s due to high rates of asymptomatic infections in this population. The CDC (1998) recommends a follow-up examination in two weeks after the initial evaluation to assess for STD’s if clinically indicated if no antibiotic prophylaxis has been given. Serologic tests for syphilis, HIV and Hepatitis B are recommended at the initial visit and repeated 6, 12, and 24 weeks after the reported sexual contact. A Pap smear in sexually active adolescents is also recommended for dysplastic changes due to HPV.
C. **Implications of STD diagnoses in the evaluation of sexual abuse**

The diagnosis of an STD in adolescents implies sexual contact. It has been shown that nonsexual transmission of certain STD's occurs infrequently and is isolated mostly to prepubertal children (Neinstein et al, 1984). Consideration should be given to vertical transmission of HIV through drug use in adolescence and Hepatitis B through household contacts. Herpes type I can also be transmitted to the ano-genital area by autoinoculation from oral mucosa. In sexually active adolescents, the presence of an STD does not imply that the disease was acquired by assault but could have been acquired from previous sexual contact. It is important to note that if one STD is identified and confirmed, screening for other STD's should be performed if not done previously.

The AAP has given guidelines for implications of confirmed STD's in prepubertal children. The following is a table adapted from those guidelines (AAP Committee on Child Abuse & Neglect, 1999):

<table>
<thead>
<tr>
<th>STD Confirmed</th>
<th>Sexual Abuse</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea*</td>
<td>Diagnostic***</td>
<td>Report</td>
</tr>
<tr>
<td>Chlamydia*</td>
<td>Diagnostic***</td>
<td>Report</td>
</tr>
<tr>
<td>Syphilis*</td>
<td>Diagnostic</td>
<td>Report</td>
</tr>
<tr>
<td>HIV**</td>
<td>Diagnostic</td>
<td>Report</td>
</tr>
<tr>
<td>Trichomonas vaginalis*</td>
<td>Highly Suspicious</td>
<td>Report</td>
</tr>
<tr>
<td>Condylomata acuminata*</td>
<td>Suspicious</td>
<td>Report</td>
</tr>
<tr>
<td>Herpes (genital)†</td>
<td>Suspicious</td>
<td>Report</td>
</tr>
<tr>
<td>Bacterial Vaginosis</td>
<td>Inconclusive</td>
<td>Medical Follow-Up</td>
</tr>
</tbody>
</table>

* If not perinatally acquired
† Report unless there is clear history for autoinoculation
** If not perinatally or transfusion acquired
*** By culture technique

Reports are to be made to agencies responsible for investigation and protection of children. In Texas the agency identified is the Texas Department of Protective and Regulatory Services. Controversy exists when condyloma acuminata (HPV) is diagnosed in a young child especially when the child is preverbal. In such cases, the disease could have been acquired perinatally, by nonsexual means, or by sexual abuse (Gutman, Herman-Giddens, & Phelps, 1993). The incubation period for congenital HPV is reported as varied and can range from several months to 3 years after birth (AAP Red Book, 2000; Boyd,
Regardless of the possible modes of transmission, a young child with anogenital or oral HPV without a clear source of transmission should be evaluated for suspected abuse, including an interview of the child if appropriate and a thorough physical examination. Consideration should be given to screening for other STD’s if sexual abuse is suspected (Atabaki & Paradise, 1999).

D. Diagnosis, treatment and prophylaxis of specific STD’s

Both the AAP and the CDC have given recommendations for the diagnosis, treatment and prophylaxis for STD’s (CDC, 1998; AAP Red Book, 2000). Consensus of recommendations will be presented here. There are many sexually transmitted diseases that are recognized. The following list has been adapted from the AAP for STD’s in adolescents (AAP Committee on Adolescence, 1994b):

<table>
<thead>
<tr>
<th>Bacterial</th>
<th>Protozoal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neisseria gonorrhoeae</td>
<td>Trichomonas vaginalis</td>
</tr>
<tr>
<td>Chlamydia trachomatis</td>
<td>Entamoeba histolytica</td>
</tr>
<tr>
<td>Treponema pallidum</td>
<td>Giardia lamblia</td>
</tr>
<tr>
<td>Ureaplasma urealyticum</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma hominis</td>
<td></td>
</tr>
<tr>
<td>Haemophilus ducreyi</td>
<td></td>
</tr>
<tr>
<td>Gardnerella vaginalis</td>
<td></td>
</tr>
<tr>
<td>Calymmatobacterium granulomatis</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Viral</th>
<th>Parasitic</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Sarcoptes scabies</td>
</tr>
<tr>
<td>Herpes simplex virus</td>
<td>Phthirus pubis</td>
</tr>
<tr>
<td>Human papilloma virus (HPV)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C (non-A, non-B)</td>
<td></td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td></td>
</tr>
</tbody>
</table>

Only the most commonly encountered STD’s will be discussed for diagnosis and treatment. The treatments discussed in this section are for uncomplicated disease and presentation. Treatments for complicated disease such as bacteremia, arthritis and meningitis can be found in the 1998 STD Treatment Guideline from the CDC and the 2000 Red Book (CDC, 1998; AAP Red Book, 2000). Pelvic inflammatory disease will be discussed separately. If either gonorrhea or chlamydia are confirmed, then treat for both diseases. Treatment of sexual partners is important to reduce risk of re-infection.

i.) Neisseria gonorrhoeae

**Incubation:** 2-7 days

**Clinical presentation:** Prepubertal: Vaginitis is the most common presentation. Anorectal and pharyngeal infections can occur. Urethritis in males. Adolescents: Urethritis, endocervicitis and salpingitis are common as well as asymptomatic disease. Rectal and pharyngeal infections are commonly asymptomatic.
Diagnosis: Cultures for the organism from pharynx, vagina, and rectum as indicated. Cervical cultures in the adolescent if tolerated. Urethral cultures in males. Confirmation of organism as Neisseria gonorrhoea by at least two confirmatory tests of different principles. Nonculture testing in sexual abuse evaluations should not be used unless cultures are not available.

Treatment:

**Prepubertal children < 45 kg:**
- Ceftriaxone 125mg IM X 1 dose OR *Spectinomycin 40mg/kg (max 2gm) IM x 1 dose
  *Not recommended for pharyngeal infections.

**Children and adolescents > 45 kg and are 8 years or older:**
- Ceftriaxone 125mg IM x 1 dose OR Cefixime 400mg po x 1 dose OR *Ciprofloxacin 500mg po x 1 dose OR *Ofloxacin 400mg po x 1 dose
  *Contraindicated during pregnancy, lactation and less than 18 years of age. Strains of N. gonorrhea resistant to quinolones have been reported.

  ii.) **Chlamydia trachomatis**

**Incubation:** Variable, at least one week.

**Clinical presentation:**
- **Prepubertal:** Urethritis and vaginitis.
- **Adolescents:** Cervicitis, endometritis, salpingitis and perihepatitis. Urethritis and epididymitis in males.

**Diagnosis:** Culture for organisms from urethra, vagina, and rectum as indicated. Nucleic amplification tests such as PCR and LCR are more sensitive than culture but culture remains the gold standard in sexual abuse evaluations. Do not use organic materials such as cotton or wood swabs to collect specimens.

**Treatment:**
- **Infants less than 6 months:** Erythromycin 50mg/kg/day po QID x 7 days.
- **Infants and children, greater than 6 months-12 years:** Erythromycin 50mg/kg/day po x 7 days OR Azithromycin 20mg/kg (max 1g) po x 1 dose.
- **Adolescents:** Azithromycin 1g po x 1 dose OR *Doxycycline 100mg po BID x 7 days.
  *Contraindicated during pregnancy and lactation and less than 8 years of age.

  iii.) **Trichomonas vaginalis**

**Incubation:** Average is one week. May vary from 4-28 days.

**Clinical presentation:** Frequently asymptomatic. Frothy dull yellow to green vaginal discharge with itching to vulva and vagina. Dysuria and lower abdominal pain can occur. Urethritis, prostatitis, and rarely epididymitis in males.

**Diagnosis:** Saline wet mount preparation of discharge and microscopy. View motile flagellated protozoan. Mobile flagella with jerky movements of organism. Cultures and antibody tests may be available in some laboratories but are not required for diagnosis.

**Treatment:**
Infants and children: Metronidazole 15mg/kg/day (max 2g per day) po TID x 7 days, or 40 mg/kg/day (max 2 g) x 1 dose.

Adolescents: Metronidazole 2g po x 1 dose OR Metronidazole 500mg po BID x 7 days.

iv.) Treponema pallidum (Syphilis)

Incubation: Acquired primary syphilis typically in 3 weeks. Range is 10-90 days after exposure.

Clinical presentation: Three stages of disease in acquired (not congenital) syphilis:
Primary stage: Painless indurated ulcer (chancre). Can appear on skin and mucus membranes at site of contact. Most commonly appears in the genitalia.
Secondary stage: Maculopapular rash that is typically generalized and classically includes the palms and soles. Hypertrophic papular lesions (condyloma latum) can occur in moist areas of vulva and anus. Rash can be accompanied by lymphadenopathy, fever, malaise, splenomegaly, sore throat, headache and arthralgia.
Tertiary stage: Aortitis and gummatous changes of skin, bone or viscera. This occurs years to decades after primary infection.

Important variants include:
Latent syphilis: Seroactive but no manifestation of disease.
Neurosyphilis: CSF testing is mandatory when signs of neurologic disease are present, or in acquired untreated syphilis of more than one year’s duration.

Diagnosis: Definitive diagnosis can be made by identifying spirochete organisms by darkfield microscopy or direct fluorescein antibody tests of lesion exudate or aspiration of regional lymph node. False negative microscopic tests are common. Mouth lesions require direct fluorescein antibody testing to distinguish from other treponeme organisms.

Presumptive diagnosis can be achieved using two serologic tests, nontreponemal and treponemal tests. The use of only one type of test is not adequate due to false-positive results. Nontreponemal tests are the Venereal Disease Research Laboratory (VDRL), rapid plasma reagin (RPR), and the automated reagin test (ART). Positive nontreponemal tests should be confirmed with treponemal tests such as the fluorescein treponemal antibody absorption (FTA-ABS) and the microhemagglutination test for T. pallidum (MHA-TP). It is important to note that the FTA-ABS and the MHA-TP tests usually remain reactive for life. Sustained four fold decreases in titer of nontreponemal tests can be used to judge adequate treatment.

Treatment:
Children (primary, secondary, and early latent): *Benzathine penicillin G 50,000 µ/kg IM (max 2.4 million units) x 1 dose.
Late latent syphilis (more than one year in duration): Benzathine penicillin G 50,000 µ/kg IM (max 2.4 million units) administered as three doses at 1 week intervals. (Total max of 7.2 million units).
Neurosyphilis: Aqueous crystalline penicillin G 200,000 to 300,000 µ/kg/day IV divided 4-6 hours for 10-14 days. (Do not exceed adult dose of 18-24 million units per day).
*Penicillin allergic patients should be desensitized.

Adolescents: Primary, secondary, and early latent syphilis: Benzathine penicillin G 2.4 million units IM x 1 dose OR **Doxycycline 100mg po BID x 14 days OR **Tetracycline 500mg po QID x 14 days.
**Late latent syphilis:** Benzathine penicillin G 2.4 million units IM x 3 doses one week apart OR
**Doxycycline 100mg po BID x 4 weeks OR Tetracycline 500mg po QID x 4 weeks.**

**Tertiary syphilis:** Benzathine penicillin G 2.4 million units IM x 3 doses one week apart.

**Neurosyphilis:** Aqueous crystalline penicillin G 18-24 million units per day. Administer as 3-4 million units IV every 4 hours for 10-14 days OR Procaine penicillin 2.4 million units IM daily plus Probenecid 500mg po QID x 10-14 days for both.

**Contraindicated in pregnancy, lactation and less than 8 years of age.

v.) **Herpes simplex (HSV)**

**Incubation:** 2 days to 2 weeks.

**Clinical presentation:** Primary infections can be asymptomatic. Gingivostomatitis is mostly caused by HSV type I. Vesicular and ulcerative lesions of the genitalia, perineum and perianal regions are usually caused by HSV type 2. Herpes Simplex Virus is present for life and after primary infection is in a latent form. The virus is latent in regional nerve ganglia. Lesions can appear at distal ends of fingers (herpetic whitlow).

**Diagnosis:** Cell culture technique should be used for both HSV type 1 and 2. Viral transport media should be used to collect specimens. Rapid diagnostic tests are available but are less sensitive than cultures. Serologic testing is also available but not useful in sexual abuse evaluations due to cross reaction between antibodies of HSV type 1 and 2. Culture swabs are taken from site of lesions. Ulcers are swabbed and vesicles can be scrapped and swabbed for specimen collection.

**Treatment:**

*Children:* Acyclovir 80mg/kg/day po TID or QID (max 1g/day) for 7-10 days.

*Adolescents:* Acyclovir 1-1.2g/day po TID or 5 divided doses for 7-10 days.

Treatment should be initiated early in the disease to receive maximum benefit. Topical acyclovir has minimal effects on duration of illness and shedding of virus. Oral regimens are recommended. Safety of oral acyclovir use in pregnant women is not well established but it can be used for the first episode of genital herpes during pregnancy. Repeated use of acyclovir during pregnancy is not recommended.

vi.) **Human papillomavirus (HPV)**

**Incubation:** The exact incubation period is not known. Can vary from several months to several years.

**Clinical presentation:** Warts on skin and mucus membranes. Anogenital HPV infections can be asymptomatic. Warts (condyloma acuminata) when visible appear as flesh-colored with a cauliflower surface. They can vary in size. In males, the warts can be found on the penile shaft, meatus, scrotum and perineum. In females, the warts are found commonly on the vulva and perineum. Genital warts are usually caused by HPV types 6 or 11. Other types in the anogenital region, types 16, 18, 31, 33, and 35, have been associated with cervical dysplasia. The oral mucosa is another site of infection with HPV but it is uncommon (Gutman, Herman-Giddens, & Phelps, 1993).

**Diagnosis:** Warts are usually diagnosed by physical examination and visual inspection. Colposcopy and application of 3-5% acetic acid (aceto-whitening: warts turn white) can aide in the diagnosis. Aceto-whitening is not specific for HPV infections. Biopsy with histologic examination of lesions is diagnostic. Typing of wart tissue can be done but may not aide in the diagnosis of abuse.
Treatment: No treatment is optimal for HPV. Spontaneous regression can occur. Treatments are for external warts:

- **Podofilox, 0.5%**. Applied by patients or parent with cotton swab for solution and with finger for gel, BID x 3 days with a 4 day period of no treatment. Four cycles may be repeated. Area treated not to exceed 10cm$^2$ and amount of volume of Podofilox not to exceed 0.5cc per day. Health care provider, should apply first treatment to instruct on use. Safety in children and during pregnancy has not been established.

- **Imiquimod, 5% cream**: Patient or parent applied. Applied with finger three times a week for as long as 16 weeks. Treatment sites should be washed with soap and water 6-10 hours after treatment. Safety in pregnancy has not been established.

- **Podophyllum Resin 10-25% with tincture of benzoin**: Applied to each wart and air dried. Small areas are to be treated at a time (<10cm$^2$ and <0.5 cc). It has been recommended that treatment area can be washed 1-4 hours after treatment. Podophyllum resin is applied by health care provider. Safety in pregnancy and children has not been established.

- **Other treatment options** are trichloracetic acid, cryotherapy, laser surgery and surgical excision. Treatments do not remove asymptomatic HPV infection from surrounding tissue.

vii.) **Hemophilus ducreyi (Chancroid)**

**Incubation:** 3-10 days.

**Clinical presentation:** Tender papule that ulcerates over several days. Lesion is sharply demarcated. Males usually have a single ulcer and females multiple. Ulcer is painful and tender. One-third of cases have associated painful unilateral inguinal adenitis (bubo). Ulcers are mainly on genitalia.

**Diagnosis:** Clinical findings and excluding other diseases such as syphilis, herpes and lymphoma granuloma venereum (chlamydia). Confirmation with isolation of H. ducreyi from ulcer or aspiration of lymph node.

**Treatment:**

- **Children:** Ceftriaxone 50mg/kg IM x 1 dose OR Azithromycin 20mg/kg (max 1g) po x 1 dose.
- **Adolescents:** Ceftriaxone 250mg IM x 1 dose OR Azithromycin 1g po x 1 dose OR Erythromycin 500mg po QID x 7 days.

viii.) **Hepatitis B**

**Incubation:** Average is 120 days. Range 45-160 days.

**Clinical presentation:** Can have asymptomatic disease. Subacute illness can present with general malaise, with hepatitis and jaundice, or with fulminant hepatitis causing death. Asymptomatic disease is common in children.

**Diagnosis:**

- HBs Antigen: Acute chronic infection.
- HBe Antigen: Infected and increased risk of transmission.
- IgM anti-HBc: Acute or recent HBV infections.
Treatment: No specific treatment is available. Alpha-interferon in chronic liver disease. Consult with pediatric infectious disease specialist. Stress importance of up to date Hepatitis B immunization for adolescents. Post exposure prophylaxis can be given with Hep B vaccine alone or with Hepatitis B Immune Globulin (HBIG).

ix.) Human Immunodeficiency Virus (HIV)

Incubation: Serum antibody to HIV usually develops by 6-12 weeks after infection.

Clinical presentation: HIV infection can cause a wide spectrum of clinical and disease presentations. For conditions and disease spectrums please refer to the AAP 2000 Red Book pp. 326-327, Tables 3.23 and 3.24. HIV infections in children can manifest with lymphadenopathy, hepatosplenomegaly, failure-to-thrive, oral candidiasis, recurrent diarrhea, or recurrent serious infections. Pneumocystis carinii infection is a commonly-encountered opportunistic pathogen in HIV-infected children.

Diagnosis: Many tests are available for diagnosis. Screening can be done during evaluations with ELISA followed by Western Blot for positive screens. Testing can be done initially for history of genital, oral and anal penetration or if a high risk of HIV transmission exists such as known HIV infection of perpetrator or acute trauma is noted on exam. Screens are repeated at 6, 12, and 24 weeks after exposure. The screen can be repeated at 6 months and one year after exposure if HIV risk is high.

Treatment: Consultation with pediatric infectious disease specialist is encouraged. Treatments are varied and complex. Refer to section on HIV in the AAP 2000 Red Book pp. 325-350. Consider prophylaxis for high risk of HIV transmission but there is no data to support such prophylaxis. Merchant and Keshavarz (2001) discuss various prophylaxis regimens and their rationales.

E. Pelvic Inflammatory Disease (PID)

PID encompasses many clinical disorders such as endometritis, salpingitis and tubo-ovarian abscess (CDC, 1998; AAP Red Book 2000; CDC, 1990). Many organisms can cause PID, including N. gonorrhea, C. trachomatis, mycoplasma and other anaerobic and aerobic bacteria (CDC, 1990).

Diagnosis of PID is mostly on the basis of clinical findings. Criteria for the diagnosis of PID made by the CDC 1998 Treatment Guidelines for STD’s are as follows:
1. Minimum criteria when no other disease can be identified such as pregnancy, appendicitis, urinary tract infection and non-infectious adnexal pathology.
   a. Lower abdominal tenderness
   b. Adnexal tenderness
   c. Cervical motion tenderness
2. Additional criteria are:
   a. Temperature > 101°F.
   b. Abdominal, vaginal, or cervical discharge
   c. Elevation in erythrocyte sedimentation rate and C-Reactive Protein
   d. Documented cervical infection with gonorrhea and or chlamydia
3. Definitive diagnosis can be made by:
a. Endometritis on endometrial biopsy
b. Pelvic sonography showing thickening or fluid in tubes
c. Laparoscopic evidence of PID

It is important to obtain all appropriate cultures and serologic tests for STD’s before treatment is initiated. Treatment of PID is with antimicrobials and as with all STD’s strict compliance with treatment inclusive of all sexual partners. Abstinence from sexual activity is recommended. If compliance is an issue for completing oral medications then hospitalization is recommended until acute symptoms resolve (CDC, 1998; AAP Red Book 2000; CDC, 1990). Hospitalization is also recommended during pregnancy, for severe illness when oral medication will not be tolerated as well as presence of tubo-ovarian abscess and immunodeficient state. Hospitalization is also recommended for adolescents.

Antimicrobial treatment is as follows (CDC, 1998; AAP Red Book, 2000):

**Inpatient Treatment:**
- **Regimen A** - Cefotetan 2g IV q 12 hours OR Cefoxitin 2g IV q 6 hours plus Doxycycline 100mg IV or PO q 12 hours.
- **Regimen B** - Clindamycin 900mg IV q 8 hours plus Gentamicin loading dose IV or IM of 2mg/kg followed by maintenance dose of 1.5mg/kg IV q 8 hours. Single daily doses may be used.

Inpatient therapy is continued for 24-48 hours or until patient is improved. Patient can be sent home on doxycycline as in outpatient management for a total of 14 days. Clindamycin can provide better coverage in presence of tubo-ovarian abscess (Clindamycin 450mg po QID to complete a total of 14 days of treatment).

**Outpatient Treatment:**
- **Regimen A** - *Ofloxacin 400mg po BID x 14 days plus Metronidazole 500mg po BID x 14 days* *Contraindicated in pregnancy, lactation and <18 yo.*
- **Regimen B** - Ceftriaxone 250mg IM x 1 dose OR Cefoxitin 2g IM with Probenecid 1g po x 1 dose plus Doxycycline 100mg po BID x 14 days. Other cephalosporins can be used such as cefotaxime and ceftizoxime.

**F. STD Prophylaxis**
STD prophylaxis is mostly recommended for adolescents after acute sexual assault (AAP Committee on Adolescence, 1994a; Siegel et al, 1995). Prepubertal children should be given STD prophylaxis when the risk of transmission of an STD is high (Ingram et al, 1997; CDC, 1998; AAP Red Book, 2000). Recommended prophylaxis has varied on which organisms to treat. Recent guidelines for STD prophylaxis from the 2000 Red Book are as follows:

**Weight < 100 lbs:**
- **Gonorrhea:** Cefixime 8mg/kg (max 400mg) po x 1 dose OR Ceftriaxone 125mg IM x 1 dose
- **Chlamydia:** Azithromycin 20mg/kg (max 1g) po 1 dose OR Erythromycin 50mg/kg/day po QID x 10-14 Days
- **Trichomonas and bacterial vaginosis:** Metronidazole 15mg/kg/day TID x 7 days
**Weight > 100 lbs:**

*Gonorrhea:* Cefixime 400mg po x 1 dose OR Ceftriaxone 125mg IM x 1 dose

*Chlamydia:* Azithromycin 1g po x 1 dose OR *Doxycycline 100mg po BID x 7 days

*Contraindicated during pregnancy, lactation, and less than 8 years of age.

*Trichomonas and bacterial vaginosis:* Metronidazole 2g po x 1 dose

See previous section or the Appendix for discussion of prophylaxis for *Hepatitis B* and *HIV*.

**G. Reporting of STD’s**

The Texas Department of Health (TDH) requires reporting of communicable diseases (Communicable Disease Prevention and Control Act, Texas Health and Safety Code, Chapter 81). STD’s required to be reported are HIV, syphilis, gonorrhea, chlamydia, and chancroid. Voluntary reports can be made for genital herpes, genital warts, non-specific urethritis and other STD’s not required to be reported. A sample reporting form is included in the Appendix. Reporting form can be downloaded from the TDH website. Reports of STD’s are encouraged to be made to the local health department. It is important to report STD’s along with all information on the form especially the exact treatment with dose and duration given.

**H. References**


7) Photographic Documentation and Telemedicine

Nancy D. Kellogg, MD

A. Introduction
Photographic documentation of child sexual abuse examinations is an accepted standard of care. Earlier studies (1980's) have suggested that examinations conducted with magnification devices (colposcope, 35mm camera with macro lens) increased detection of genital injuries. More recently, photodocumentation has become integral to peer review and quality assurance as the range of knowledge and expertise has broadened (Adams, 1997). Photodocumentation has also provided a valuable adjunct for many studies of abnormal and normal anogenital findings. Additional advantages to photodocumentation include: 1) photographs and slides are valuable teaching aids; 2) changes in examination over time may be documented in some cases of repeated victimization; 3) photographs of trauma may be effectively presented in legal proceedings; and 4) photographs may obviate the need for repeated examinations.

B. Methods of photodocumentation
There are numerous methods of photodocumentation. Examination findings can be documented with a 35mm camera and a ring flash, a digital camera, and a photocolposcope with a 35mm camera attachment, digital video camera attachment or an analog video camera attachment. Colposcope equipment options include a hands-free shutter release (foot pedal) enabling the examiner to both view the anatomy and capture images simultaneously; 35mm cameras require an examiner and a second person for photodocumentation. Photocolposcopes are far more costly than cameras. In a recent study of 122 experienced (average 1,700 examinations) clinicians, 85% used photocolposcopes and photocolposcope use was significantly associated with a greater number of correct interpretations of anal/genital findings.

Images taken during a sexual abuse evaluation can be scanned into the computer or captured directly during the examination. Software programs are available to archive such data and create patient files. Images can then be sent or received through modem-to-modem transfer or encrypted and transmitted as electronic mail.

C. Telemedicine
Telemedicine is an efficient, cost-effective, timely method of consultation and peer review. Telemedicine has emerged from a need for less experienced, remotely located clinicians to consult with more experienced clinicians. Approximately 10 states have telemedicine networks for child abuse cases, including Texas (see Appendix: Resources). Challenges include: 1) becoming experienced with the technology, 2) availability of ongoing technical support, 3) maintaining patient confidentiality by securing records within the facility computer and when transmitted electronically, 4) ensuring patient consent/knowledge when sharing case data, 5) need for medical license reciprocity when consulting across state lines, 6) liability of the consultant in the care rendered to the patient at the remote location, and 7) little or no reimbursement for telemedicine consultations (Kellogg, 2001). Pammer et al (2001) recently reviewed the Florida experience with a child abuse telemedicine network. Problems with staff training, facilities, and wide variability in utilization were encountered. Despite these challenges, the benefits of telemedicine are considerable and include more accurate examination assessments. In a recent survey of
the Texas Telemedicine Network, exoneration of individuals accused of abuse was a significant impact and occurred in cases where children had no abuse outcry but exam findings were initially concerning for abuse.

D. References


As with other aspects of the sexual abuse assessment, knowledge regarding forensic evidence collection has continued to expand and alter clinical approaches. For example, the Wood's Lamp, an ultraviolet light source, was once deemed a useful tool in identifying semen of body surfaces. A recent study (Santucci et al, 1999) demonstrated that semen does not reliably fluoresce and that several other substances, including iatrogenically introduced lubricants may impair the identification of semen.

Another recent study (Christian et al, 2000) of prepubertal children tested for forensic evidence revealed that in most (75%) cases, no forensic evidence is recovered. This study also reported the time-sensitive nature of such evidence, and the source of most “positive” results. No swabs taken from the child’s body were positive for blood after 13 hours and no swabs were positive for sperm/semen after 9 hours. Most (64%) of the forensic evidence was recovered on clothing and linens. However, clothing and linens were collected in only 35% of cases. The study’s conclusions were that current general guidelines for forensic evidence collection were “not well-suited for prepubertal victims”, swabbing the child’s body is unnecessary after 24 hours, and clothing and linens “should be pursued vigorously for analysis.”

Due to the more tedious and intrusive nature of forensic evidence collection, many children will experience difficulty with this component of the medical assessment. Respect, privacy and a child-appropriate explanation of procedures are essential in the clinical approach. The potential benefits of recovering “legal proof” must be weighed against the risks of furthering the patient’s discomfort and distress. When the purpose and procedures of evidence collection are explained appropriately and clearly, most children and adolescents well cooperate. However, the patient does have the right to refuse any component of the medical assessment. Small children, mentally disabled children or adults and intoxicated or combative patients may require sedation or anesthesia.

### A. When to collect forensic evidence

In general, forensic evidence collection should be done as soon as possible when the child or adolescent reports sexual contact within 72 hours. Beyond 72 hours, collection of clothing and linens, and a crime scene investigation may still yield important evidence. The 72 hour proposed guideline is based on both clinical data and studies reporting the presence of sperm in the adult vagina for up to 17 days (Sharpe 1963). Activities such as bathing, running/walking, spitting, brushing teeth, voiding, and defecating further reduce the likelihood of evidence recovery. The clinician’s decision to collect forensic evidence should be based on the time lapse from the most recent sexual contact, type of sexual contact (genital-genital contact is more likely to yield evidence than fondling or oral-genital contact), and clarity of the child’s history. If the child or adolescent presents with genital complaints but no history of sexual abuse or assault, they are unlikely to have exam findings consistent with abuse (Kellogg et al, 1998) and should probably not undergo forensic evidence collection.

### B. Methods

Protocols for evidence collection are established to reduce contamination, degradation and tampering of potential evidence. To meet these requirements, a chain of custody is maintained and each person handling specimens must be identified, usually by signing specific evidence collection forms.
Specimen envelopes should be sealed using moistened swabs rather than saliva to avoid contamination. Special drying devices prevent degradation of evidence collected on swabs; freezers must be maintained at temperatures less than −10°C for optimal preservation of biological material. Secured storage in locked refrigerators, cabinets and freezers is required. Due to these stringent requirements, forensic evidence collection is usually conducted in hospital emergency rooms rather than outpatient clinics or other facilities.

Protocols may be mandated by the state (i.e., the Texas Evidence Collection Protocol, 1998) or may be hospital-based. Protocols should be updated to reflect new developments in forensic medicine. Hospital-based protocols are more readily updated than state-mandated protocols (Jenny, 2000).

Procedures specifically outlined in evidence collection protocols include:
1. Collection of clothing/linens
2. Submission of paper over which victim unclothes.
3. Nail scrapings/clippings if victim scratched assailant
4. Pubic hair combings/plucked
5. Head hair combings/plucked
6. Documentation/photographs and swabbing of bite marks
7. Collection of debris found on unclothed body
8. Swabbing of dried debris found on body with pre-moistened swabs
9. Oral pharynx swabs including behind tonsillar pillars, between lips/gums, and under tongue (Jenny, 2000) depending on type of sexual contact reported
10. Vaginal and cervical swabs OR vaginal swabs OR vaginal wash depending on age and tolerance of child and type of sexual contact reported
11. Anal swabs depending on type of sexual contact reported

Types of forensic analysis include (Jenny, 2000):
1. Microscopic examination for spermatozoa. Motile sperm are present for a few hours (adult vagina and mouth) up to 6 days (adult endocervix).
2. Acid phophatase assay: an enzyme found in copious amounts of prostatic secretions and small amounts in adult female vaginas. Acid phosphatase disintegrates within hours and can be found in the semen of vasectomized men.
3. P30 protein assay: a semen-specific glycoprotein detected by enzyme-linked immunosorbent assay (ELISA) generally found within 24 hours of intercourse. Also found in semen of vasectomized men.
5. Hair analysis: analyzable characteristics include color, reflectivity, pigment type, spatial configuration and scale pattern. Hair analysis can “rule in” or “rule out” suspected individuals. Recent technology involves analysis of mitochondrial DNA in hair shafts.
6. Genetic markers in blood, saliva, and semen: comparison of victim and suspect ABO blood group antigens and the ability to secrete such antigens in bodily fluids (secretor status) may “rule in” or “rule out” suspects. Other genetic markers are phosphoglucomutase and peptidase A.
7. DNA typing: the most specific type of forensic analysis. Polymerase chain reaction (PCR) methods can detect DNA in small samples, yield faster results, and be used to detect DNA fragments in partially degraded samples.
C. **Coordination with requesting agency**

Most victims of acute sexual assault are referred or transported to the hospital by law enforcement; the remainder are reported to law enforcement upon presentation to the hospital emergency department. Law enforcement is also responsible for transporting collected evidence to the appropriate forensic science or medical examiner facility. The “results” of forensic analysis are generally not reported back to the clinician that collected the evidence. The clinician, therefore, is not responsible for describing or interpreting forensic analysis results in court proceedings.

Law enforcement may also request that forensic evidence be collected from suspects for comparison with evidence secured from the victim. Most of the evidence collection procedures for victims can be utilized for suspects as well.

When children or adolescents that are not sexually active are infected with a sexually transmitted disease (STD), a question arises: “Should the suspected perpetrator be tested?” Since the majority of suspects are males and most STD’s are difficult to isolate in males, testing the suspect is rarely helpful. A negative test in a suspect may hinder legal representation of the case as the clinician strives to explain why a suspect can still be the suspect even when the disease that the child has is not detected in him. While serologic tests for hepatitis, syphilis, and AIDS can identify these diseases in a suspect and and child, the presence of the same disease in two individuals does not imply transmission between them.

C. **References**


9) Written Documentation of Findings, Assessment, and Conclusions
Sheela Lahoti, MD, and Nancy D. Kellogg, MD

The medical record serves as a legal document to aid in the investigation of child sexual abuse allegations. Clear and concise documentation provides the best information to law enforcement officers, district attorneys, and Children’s Protective Services.

The medical history includes a review of anogenital complaints such as discharge, bleeding, pain or irritation and a history of sexually transmitted diseases, enuresis, encopresis or frequent urinary tract infections. A history of consensual sexual activity, and pregnancy in adolescents is noted. Somatic complaints resulting from psychological stress, such as frequent abdominal pain, headaches or sleep disturbances, are noted. School problems, aggressive behaviors, anxiety, and especially sexualized behavior are documented (see Chapter 3).

The questions directed to the child and the child’s responses should be carefully documented, preferably using direct quotes. It is also useful to include who is present in the room at the time these questions are asked. The child’s responses are often allowed as part of the examiner’s court testimony as an ‘exception to hearsay’ since these questions are asked as part of diagnosis and treatment.

Findings on the physical examination describe bodily injury, anogenital trauma (recent or healed), erythema, discharge, or presence of lesions. Photographs (or sketches if photographic documentation is unavailable) are essential for follow-up comparison examinations and legal proceedings. Tests obtained for sexually transmitted diseases, and their results, are noted.

An overall impression of the medical evaluation includes findings from the examination and an assessment of the likelihood of abuse. Appropriate documentation is essential for the best legal outcome for the child.

A. Use of standardized protocols
   Protocol forms may be provided by the state, or may be hospital- or clinic-based. Protocol forms should incorporate all procedures, patient demographic/contact information, appropriate case identification numbers, a parent or patient permission form, physical symptoms reported by the child, emotional/behavioral symptoms reported by the child, history of event(s), body diagrams, genital/anal diagrams, and a diagnostic impression section. The purpose of such forms is to ensure a standardized and comprehensive clinical approach and to provide clear and concise information to investigative agencies. Socolar et al (1996) found that the use of standardized protocols significantly improved physicians’ documentation of relevant historical and physical findings. A sample protocol form is provided in the Appendix.

B. Use of standardized terminology for anatomic and clinical findings (APSAC terminology)
   The American Professional Society on the Abuse of Children (APSAC) has published a list of standardized terms for describing anatomical structures and examination findings when performing an examination for suspected sexual abuse or assault. Clinicians are encouraged to familiarize themselves with this list and to adhere to its use as much as possible.
C. Use of standardized terminology for assessment and conclusions

Over the past decade, numerous studies of the findings on anogenital examination of children and their relationship with child sexual abuse have been published (see Chapter 12). As a result, many findings previously thought to be indicative of sexual abuse are now recognized to be normal variants or nonspecific abnormalities. A few authors have published systems for classifying medical findings and their forensic implications. The most recently-published evidence-based classification system is that of Adams (2001), which is reproduced in the Appendix.

Because of the rapidly-changing nature of the field, clinicians should make strenuous efforts to stay abreast of advances in this area through reading, attending scientific meetings, and ongoing peer review.

D. Summarizing history/interview findings

There is considerable debate on how to document clinical impressions and diagnoses in sexual abuse assessments. Since the majority of victims that are examined within an acute (<72 hours) and nonacute (>72 hours) time frame have normal or nonspecific examination findings (even with a history of vaginal, anal, or oral penetration), a normal examination is the expected finding with child and adolescent victims of abuse or assault (Adams et al, 1994). Given this premise, some suggestions for documentation follow:

1) “Normal or nonspecific findings are the most common examination results, regardless of time lapse and type of sexual contact or penetration. The history is consistent and detailed for fondling; the exam, as expected, is normal and does not refute the history.”

2) “Normal or nonspecific findings are the most common examination results, regardless of time lapse and type of sexual contact or penetration. History is consistent and detailed for vaginal-penile penetration. The exam is normal, but does not refute the history.”

3) “Normal or nonspecific findings are the most common examination results, regardless of time lapse and type of sexual contact or penetration. The exam reveals (acute or healed) findings that further support the sexual acts and time frame described by the child.”

4) “A normal anogenital examination does not support nor does it refute the history of sexual abuse.”

5) “The examination of this child was normal. The normal findings do not contradict the allegations, and do not rule out sexual abuse.”

E. References


Billing, Reimbursement, and Other Resources for Funding Child Sexual Abuse Evaluations

James L. Lukefahr, MD

Traditionally, clinicians have had great difficulty obtaining adequate reimbursement for the examination and treatment of children with suspected sexual abuse. This lack of compensation poses a severe drain on the practitioners and (usually small) agencies who provide these services.

This chapter gives an overview of the approaches to coding and billing for the care of sexually abused children, and also discusses several potential sources of compensation for this care. This information is subject to constant change and is not meant to be a comprehensive guide to this subject. However, the editors hope this chapter may suggest to the clinician additional options for obtaining the compensation that will allow him or her to continue to offer services to abused children, and to maintain professional expertise in this field.

This chapter will not include recommendations for the levels of reimbursement a clinician should request or expect for particular services, since these vary widely by payor and region, and change frequently.

A. ICD-9 and CPT codes

Familiarity with ICD-9 standardized diagnosis codes and the CPT-4 procedure codes are critical to successful fee-for-service medical billing. The American Academy of Pediatrics' Section on Child Abuse and Neglect has been active in improving coding options for child abuse clinicians; updates appear from time to time in the SCAN Newsletter as well as in various AAP and AMA publications.

For a comprehensive list of codes, please refer to one of the many coding handbooks available (two are listed in the References section of this chapter). Following are the codes that are most commonly employed when seeing child sexual abuse victims.

i) ICD-9 Diagnosis Codes

ICD-9 codes are divided into numerical codes, V-codes (for observation, health maintenance, and preventive services), and E-codes (which classify injury and illness due to external causes).

Numerical codes are the most widely used and the most suitable for fee-for-service billing. 995.5 Child Maltreatment Syndrome is the global diagnosis code for child abuse. When possible, specific codes using a 5th-digit modifier should be included. These more specific codes are:

- 995.50 Child abuse, unspecified
- 995.51 Child emotional/psychological abuse
- 995.52 Child neglect (nutritional)
- 995.53 Child sexual abuse
- 995.54 Child physical abuse (includes Battered Child Syndrome but excludes Shaken Baby Syndrome)
- 995.55 Shaken infant syndrome
- 995.59 Other forms of child abuse and neglect (includes multiple forms of abuse)

The clinician should also include additional codes for associated injuries or conditions. Additional
codes commonly associated with a child sexual abuse evaluation include (not an exhaustive list):

- 054.10 Genital herpes
- 054.11 Vulvovaginitis, herpetic
- 054.12 Genital herpes, vulva
- 054.13 Genital herpes, penis
- 054.19 Genital herpes, scrotum
- 098.0 Gonorrhea, acute (regardless of site)
- 099.41 Urethritis, chlamydial
- 099.53 Vulvovaginitis, chlamydial
- 112.1 Vulvovaginitis, candidal
- 131.01 Vulvovaginitis, trichomonal
- 616.10 Vulvovaginitis, nonspecific (includes bacterial vaginosis)
- 752.49 Adhesions, labial, congenital [sic—ICD-9 codes are infamous for their painfully outdated terminology]
- 911.x Injury, superficial, to any part of trunk (includes anus, genitalia, and perineum)

Use one of the following 4th digit modifiers:

- 0 abrasion or friction burn without mention of infection
- 1 abrasion or friction burn, infected
- 2 blister without mention of infection
- 8 other and unspecified superficial injury without mention of infection
- 9 other and unspecified superficial injury, infected

- 959.1 Injury to anus or genital organ, external (includes laceration; the more specific ICD-9 codes for genital lacerations apply specifically to childbirth and abortion)

**V-codes** are often disallowed for billing, particularly by Medicaid (see below), but in some situations (e.g., sexual assault, “rule-outs,” or where no firm diagnosis of abuse is possible) must be used since they most accurately reflect the diagnosis.

- V71.5 Observation following alleged rape or seduction (includes examination of victim or culprit [sic])—this is the most appropriate code for sexual assault examination.
- V71.6 Observation following other inflicted injury
- V71.81 Abuse and neglect (excludes 995.50-995.59 child abuse and neglect codes). This code is appropriate for “rule-out” findings when a clinician performs an evaluation and is unable to make a specific diagnosis of abuse or neglect.

**E-codes** are usually not accepted for billing purposes by third-party payors, but do allow detailed coding by alleged perpetrator and by method of injury, which may be useful for research or other documentation. Refer to a coding handbook for a listing of these.

**ii) CPT Procedure Codes**

The core CPT codes for a sexual abuse evaluation are the Evaluation and Management (or E&M) Codes, which indicate the extent of care given over the course of the encounter. The E&M Code can be determined either by tabulating the complexity of three key components (history, examination, and medical decision-making) according to guidelines found in the CPT reference book; or by the length of time the clinician spends in face-to-face contact with the patient and/or family. For the purposes of brevity, length of time rather than complexity will be used in the discussion that follows. (Note: if the clinician wishes to use length of time as the criterion for level of billing, the time spent should be carefully documented in the medical record.)

In general, **initial child sexual abuse evaluations** should be coded using one of the following E&M codes:
• 99204 Office or other outpatient visit, New patient, moderate to high severity, (typical time spent face-to-face with patient and/or family: 45 minutes)
• 99205 Office or other outpatient visit, New patient, high severity (60 minutes)

Followup visits will usually fall within one of the following codes:
• 99213 Office or other outpatient visit, established patient, low to moderate severity (15 minutes)
• 99214 Office or other outpatient visit, established patient, moderate to high severity (25 minutes)
• 99215 Office or other outpatient visit, established patient, moderate to high severity (40 minutes)

Coding sexual abuse evaluations as **Office Consultations** (which often allows the billing of slightly higher fees) is acceptable if:
- Opinion or advice has been requested regarding evaluation and/or management of a specific problem;
- A written or verbal request for consultation has been made by a physician or other appropriate source and is documented in the patient’s medical record;
- The consultant’s opinion and any services rendered is documented in the medical record and is communicated by written report to the requesting physician or source; and
- The “consultation” has not been initiated by a patient or family member

Consultation codes most likely to be used for sexual abuse evaluations are:
• 99243 Office consultation, new or established patient, moderate severity (40 minutes)
• 99244 Office consultation, new or established patient, moderate to high severity (60 minutes)
• 99245 Office consultation, new or established patient, moderate to high severity (80 minutes)

Separate E&M codes exist for Inpatient and Emergency Department services. Please consult a reference source for these codes.

**Specific procedures** are billed along with the E&M codes. In the past, “exploratory colposcopy” in girls could be billed using code 57542, while code 46600 (“exploratory anoscopy”) was used for male patients. Thanks to the efforts of the AAP Section on Child Abuse and Neglect, a new code was introduced in 2000:
• 99170 Anogenital examination with colposcopic magnification in childhood for suspected trauma (in either sex)

The June 2000 issue of the SCAN Newsletter (published by the AAP Section on Child Abuse and Neglect) contains a worksheet for calculating the rate of reimbursement the clinician should request for this code.

Other procedure codes that may be of value to child sexual abuse examiners are listed below. *No guarantee* of success in billing with these codes is implied. However, they may be useful to clinicians in other ways. For instance, providers who work for larger institutions may be able to use these codes to account more precisely for their clinical time or effort.
• 99000 Handling and/or conveyance of specimen for transfer from the physician’s office to a laboratory
• 99070 Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered (specify). As there is no CPT code for *medical photography*, this code is probably the most appropriate way to account for film and related expenses.
• 99071 Educational supplies, such as books, tapes, etc., provided by the physician for the patient’s education at cost to physician
• 99075 Medical testimony
• 99080 Special reports such as insurance forms, more than the information conveyed in the usual medical
communications or standard reporting form

- 99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present), approximately 30 minutes
- 99362 Medical conference (see previous), approximately 60 minutes

B. Medicaid reimbursement

Another option when treating a child covered by Medicaid is billing for the examination as a Texas Health Steps (or EPSDT) health maintenance visit. If the child has already had the Texas Health Steps visit for his/her age group, or if this information is unknown, the clinician may wish to bill the visit as an Exception to Periodicity Health Steps visit (examinations for child abuse are one of the conditions for which Exceptions to Periodicity are allowed).

The advantage of billing the encounter as a Health Steps visit is that even under most of the Medicaid managed-care plans, any EPSDT provider can provide EPSDT services to any Medicaid-covered child without precertification. The reimbursement rate for a Health Steps visit is significantly higher than for a regular office visit, although billing for additional procedures, such as colposcopy, may not be successful.

In order to successfully bill for a Texas Health Steps visit, the following conditions must be met:

- The child must be covered under Medicaid, and the provider must be able to access the child’s Medicaid number;
- A consent to treat from the child’s parent or guardian must be on file;
- The clinician must be an EPSDT provider; and
- All the required components of the Health Steps visit for the patient’s age group must be documented (e.g., history, mental health assessment, lead screening, tuberculin screening, etc.)
- The claim must be filed within 120 days of service (Note: retroactive billing is allowed—i.e., a child not covered by Medicaid may be examined, and Medicaid may be billed for the exam up to 120 days later if the child subsequently receives coverage.)

C. Private insurance (referral, PCP issues, etc.)

Many clinicians who examine children for suspected sexual abuse have discovered that even if the children have private medical insurance, there is no guarantee the evaluation will be covered. This has become particularly problematic with managed-care plans. Most physicians who perform these examinations are pediatricians. Since there is as yet no board certification available for forensic pediatrics, and since many also are either in private practice or have other clinical duties, these pediatricians are often considered by the plans to be primary-care providers rather than specialists. Most managed-care plans do not honor consultation requests from one PCP to another (PCP-to-PCP referrals).

In at least one area of Texas, however, PCP’s were able to exert sufficient pressure on several managed-care plans so that the plans agreed to cover referrals to the area’s chief facility for child abuse evaluations. Thus, clinicians specializing in child abuse may consider working with their area pediatric society or medical society to address this issue on a local or case-by-case basis.

D. Examinations requested by law enforcement

Under Texas law, “A law enforcement agency that requests a medical examination of a victim of an alleged sexual assault for use in the investigation or prosecution of the offense shall pay all costs of the examination” (Code of Criminal Procedure, Article 56.06). Many law enforcement officials believe that this
rule applies only to examinations where forensic sexual assault evidence collection kits are used, but bills passed in this session (e.g., HB 131) have reiterated that in fact this rule applies to any examination requested by a law enforcement agency as part of an investigation.

In the case of prepubertal children, the cost of tests for sexually-transmitted diseases may also be billed to law-enforcement, since a positive finding in this age group may be prima facie evidence that a crime has been committed. However, clinicians should remember that law enforcement agencies are only responsible for the costs of the parts of the examination pertaining to investigation or prosecution, and specifically are not responsible for any treatment-related costs (including testing for STD’s, pregnancy, etc., in postpubertal victims).

Law-enforcement agencies typically will press for a predetermined flat rate per examination and a unified bill (i.e., professional and facility charges not billed separately). Clinicians or centers should contact the individual law-enforcement agencies from whom they receive referrals, and should be prepared to negotiate separate billing arrangements with each of them.

E. Children’s Protective Services

In some communities, the local Children’s Protective Services office has negotiated reimbursement agreements with clinicians to perform examinations for abuse investigations and/or to provide other medical services such as foster care placement examinations, regular checkups for children in CPS custody, etc. These agreements have varied from occasional, case-by-case arrangements to (in larger cities) fully functioning medical clinics. Clinicians or agencies that regularly perform medical services for their local CPS office may wish to discuss the issue with the CPS program director for their area.

F. Crime Victims Compensation

The Texas Attorney General’s Office administers the state’s Crime Victims Compensation Fund, which has come to represent a substantial source of fee-for-service revenue for providers of care to child abuse victims. In order to file a successful claim, there must be documentation (e.g., a police report) that a person has been the victim of a violent crime, and the victim or family must complete the application. The clinician should remember that only those diagnosis and treatment costs that are the direct result of the crime may be billed to the Crime Victims fund.

A clinician wishing to establish a billing arrangement with the Crime Victims fund or to obtain more information may contact the Victim Assistance Coordinator in the office of his/her county’s District Attorney, or may contact the Attorney General’s office directly. The clinician or sponsoring agency should strongly consider designating one staff member to assist families with the Crime Victims application and follow up with them until it is completed.

G. Non-fee-for-service-based funding (private grants and Criminal Justice Division funds)

Clinicians are advised that most foundations and governmental agencies only award grants to nonprofit entities (i.e., 501(c) 3 organizations), not to private physicians or profit-making entities.

Private foundations generally do not award grants to underwrite direct patient services or ongoing operating costs, but instead prefer to direct funds towards ‘tangibles,’ such as capital construction, the purchasing of equipment, or ‘seed money’ for the startup expenses of new agencies. Although there are exceptions, most grants from private foundations are one-time or one-year awards.
By contrast, the Criminal Justice Division of the Office of the Governor (CJD) disburses money that can be used to support the care of child abuse victims over a period of years. The most important of these are Victims of Crime Act (VOCA) funds and “421” grants. These funds do not directly underwrite medical costs, but instead provide monies for personnel, equipment purchases, and similar expenditures.

**VOCA funds** can only be used to support direct services to crime victims. When used for payroll support, the funded position(s) must be new, full-time, and interact directly with victims. Thus, the funds are often used to create positions such as counselors or victim advocates. The cap on the amount that may be sought is too low to fund a full-time physician, but the award may be sufficient to allow the hiring of one or more ancillary service providers (nurses, receptionists, counselors, etc.). VOCA funds can also be used to purchase equipment that will provide direct services, including medical devices.

**421 grants** are used to fund services that support or enhance a community’s prosecution of perpetrators of crime. Thus, these monies can be used to fund a variety of positions or needs that might help support child sexual abuse clinicians. The maximum amount that can be requested is somewhat lower than for VOCA funds.

In order to apply for CJD funds, the agency must first contact its regional Council of Governments (COG) and ask for a copy of the region’s Community Plan for identifying and addressing social and environmental problems. If the planned use of funds meets one of the identified needs, the agency is eligible to apply for these and other CJD-administered funds.

CJD grants are awarded annually but have short application windows, highly specific requirements, and must compete for priority with other community projects. To learn the timetables and application procedures, an agency’s representative must typically request to be placed on the COG’s notification list for the grantee training sessions, where application procedures are reviewed in detail. A completed application must first be approved by a local review board, then is forwarded to the state level for final decision. Thus, an agency should realistically expect a delay of up to a year between identifying a need and the ability to access CJD funds to meet it.

An important positive aspect of CJD funds is that the grants can be substantial and may last for 3 to 5 years. The annual renewal procedures are fairly straightforward. For this reason, these funds, along with the Crime Victims Compensation account, have become very important funding sources for the provision of care to child sexual abuse victims.

**H. References**


SCAN (Newsletter of the Section on Child Abuse and Neglect). Elk Grove Village, IL; American Academy of Pediatrics. Published quarterly. See the June 2000 issue for a discussion of CPT code 99170.

*Texas Medicaid Provider Procedures Manual*. Austin, TX; Texas Department of Health.
11) Normal Anogenital Anatomy

William J. Reed, MD

A. Medical Embryology of the External Genitalia

Genetic sex is determined at the time of fertilization of the ovum, but the early genital system in the human fetus is undifferentiated. That is, during the first 12 weeks of embryonic life both male and female primordial tracts are present and develop in unison (Moore, 1982). This gonadal development results from the migration of primitive germ cells to the urogenital ridge near the fetal kidney and adrenal gland. The undifferentiated and therefore, bipotential gonad, begins to change after fertilization with the appearance of the female Müllerian ducts (6 weeks) and male differentiation at 6-7 weeks (Sertoli cells) and 8 weeks (Leydig cells) respectively (Sadler, 1995). This phase of development of dual gonadal ducts will now form the phenotypic external genitalia.

The gonadal primordia are influenced by the Sex-Determining Region (SRY) on the Y-chromosome. The presence of an anti-müllerian Hormone (AMH) also called Müllerian Inhibitory Substance (on chromosome 19) and produced by the Sertoli cells causes the Müllerian duct system to regress and hence the dissolution of the female pelvic structures while testosterone produced by the Leydig cells preserves the Wolffian ducts and the penis/scrotum. In the absence of the Sex Determining Region, whether or not an ovary is present, the phenotype will be female. Conversely, if a functioning testis is present, the phenotype will be male. The female genital tract results from the Müllerian ducts, urogenital sinus, and the vaginal plate. In the male, the Wolffian ducts, the genital tubercle, and the labioscrotal folds form the external genitalia. So, counter intuitively, M becomes Female, and W becomes Male.

Abnormalities at this early stage include congenital adrenal hyperplasia with subsequent virilization, or androgen receptor site defects/enzyme defects (5-a reductase) causing a lack of virilization which may lead to ambiguous genitalia in the female and incomplete or normal development in the male (albeit eventually a large penis).
B. Development of the External Genitalia in Girls

In the absence of the fetal testis, the female external genitalia develop from the genital groove and urogenital sinus. This begins at 3 weeks in the embryo and is completed by the 11-12th week of gestation. In the XX or Xp- mosaic female, oocytes are present at 16 weeks. The vaginal plate reforms from a tubular structure to a flat vestibule with final canalization of the vagina occurring at 20 weeks. The latter occurs caudad to cephalad and the distal portion of the sinovaginal bulb becomes the hymenal tissue. The genital tubercle enlarges but slows in the female to form the clitoris, while the urogenital folds form the labia minora. The area within the labia minora where the urethra, vagina, paraurethral glands (Skene’s) and the greater posterior ducts (Bartholin’s) open defines the vestibule. The labia minora encircle the clitoris anteriorly and form a hood posterior to the urethral and vaginal openings. Where they join to enclose the vestibule inferiorly is a frenulum of tissue known as the posterior fourchette. The concave space between the hymenal ring and the posterior fourchette is termed the fossa navicularis or posterior vestibule. Laterally, the labioscrotal folds develop, and in the absence of androgen, remains unfused forming the labia majora, which appear flat and unpigmented until puberty when the effect of estrogen and androgen enlarges and pigments them.

The mons pubis is derived from fusion at the anterior commissure and is formed inferiorly by the joining of the labia minora, which extend posteriorly and inferiorly ending at the skin between the vagina and anus. It is the round and fleshy prominence created by the fat pad overlying the symphysis pubis ion girls. The labia minora do not meet at this site. This structure is prominent in the newborn female due to maternal estrogen and any pigmentation is directly related to those infants with darker skin colors. This includes the linea nigra extending vertically from the mons to the umbilicus.

As previously noted, virilization may cause partial or complete fusion of the labioscrotal folds, but there is no testis present. Oftentimes, inguinal hernias are present in the infant who is both a phenotypic and genotypic female. In girls, the Müllerian ducts differentiate and the Wolffian system regresses. There are major changes noted in the external genitalia at birth and again at puberty. The labia and hymen are estrogenized by the transplacental passage of maternal estrogen. There may occasionally be withdrawal vaginal bleeding in the first 4-6 weeks.
The prepuce (foreskin) is an anatomical structure formed by a midline collision of ectoderm, neuro-ectoderm, and mesenchyme forming a penta-laminar tissue covering the male and female glans, as well as the male urethra. The clitoral prepuce develops independently of the urogenital and labioscrotal folds. The urogenital groove on the under (ventral) surface of the clitoris permits circumferential development and results in a hood-like appearance. Functionally, this hood is mucocutaneous tissue and seems to provide physiologic protection against irritation and perhaps, bacterial contamination.

Of historical note, absence of the prepuce (Aposthitis) is rare. It was reported in Jewish Law (1567 CE) relative to a male “being born uncircumcised” (Baskin, 2000). Most likely, this represented hypospadias. Canalization of the urethra requires complete development of the prepuce. However, both hypospadias and epispadias have been described with otherwise normal development.

C. Anatomical Variations in Girls

- **Partial or complete virilization:** usually due to non-salt losing Congenital Adrenal Hyperplasia. Clinical expression varies from clitoromegaly (clitoral index 3mm L x 2mm W = 6mm²) to ambiguous genitalia without palpable testes.
- **Partial Androgen Insensitivity Syndromes:**
  a. lichen sclerosis
  b. labial fusion
  c. blind vas deferens
  d. testes in the labioscrotal folds (46 XY)
- **Labial hypertrophy:** one/both labia minora
- **Vulvar or vaginal:**
  a. Hydrometrocolpos - bulging vestibule due to imperforate hymen present at birth through post menarche. Abdominal pain & primary amenorrhea. Rare recessive syndrome with genital anomalies (McKusick-Kaufman). Also consider vaginal septum & absence of the cervix.
  b. Midline perineal fusion defect - mucosal exposure anywhere on a line from the fossa navicularis to the anus. This is mesodermal, resolves at puberty, and requires a note from the examiner so as to preclude any misdiagnosis of non accidental trauma.
  c. Congenital midline pit (Clayton)
  d. Vaginal prolapse (procidentia): reported in a newborn resolved at 6 months, common in adolescents with Meningomyelocele.
f. **Linea vestibularis** - see text.

- **Urethral Variations:**
  - *Prolapse*
    - age 5-8
    - girls of African-Caribbean descent
    - resolves with symptomatic Rx, topical estrogen
    - if necrotic may need resection reported in a newborn
  - **Paraurethral cysts**
    - mesonephric remnants of the urogenital sinus
    - Gartner duct canal cyst with ectopic ureterocele: “always wet” urinary incontinence, associated upper tract anomaly
    - paramesonephric cyst of the cervix or vaginal wall
    - *Clinical pearl:* imperforate hymen is not covered with capillaries
  - **Urethral caruncle**

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### D. The Hymen

#### i.) Development

The hymen (Gr. *god of marriage*) is a recessed structure at the entrance to the vaginal opening. Andreas Vesalius, the father of anatomy first described it, in 1615. It arises from the embryonal urogenital septum developing as mesenchymal tissue advances into the epithelial mass at the junction of the pelvic part of the urogenital sinus and the tubular vaginal plate. It is present in ALL females even when other anomalies exist (Capraro 1971) Absence of the hymen does not exist on an embryological basis as an isolated anomaly. Two studies* (U.S., Israel) examined 26,199 newly born females and found a hymen in all instances. Even with vaginal agenesis, hymenal remnants have been found. (Mor, Merlo288, Jenny, et al 1987)

**Imperforate hymen** is the only anatomic variation of configuration in which no opening is present. This can be diagnosed early in life once the effect of estrogen on the female vulva diminishes. Unfortunately, it is many times not recognized until much later and can be associated with abdominal pain and amenorrhea. Botash and Jean-Louis (2001) recently reported a case of *acquired* imperforate hymen, possibly secondary to genital trauma.
ii.) Variations in configuration

That the hymen may have different configurations is well described. Other factors that influence the anatomical appearance include; estrogenization, ageing and development, the patient’s position during the examination, the examiners experience and/or bias, relaxation by the patient, and the use of labial traction or labial separation. The latter is not recommended in prepubertal girls.

Pokorny and Kozinetz (1988) studied the hymenal configuration in 265 girls and additionally reviewed the descriptions by six previous authors. They proposed 3 basic hymenal types:

1. **Fimbriated** (denticulate, sleeve-like, scalloped)
2. **Annular** (concentric, symmetrical)
3. **Posterior rim** (crescentic, semilunar)

Pokorny (1987) noted redundant hymenal and paraurethral tissue in newborns through age 4 (e.g., hymenal tag). Other types of configuration including septate, cribriform, microperforate with a small ventrally placed opening, and imperforate have all been well documented (Herman-Giddens and Frothingham, 1987). McCann and his colleagues (1990) categorized the hymen as being either crescentic or concentric and additionally noted the former was more common, particularly when examined in the knee-chest position. Berenson (1990-93) examined a large cohort of newborns over a 3 year period and described the changes following both the loss of maternal estrogen effect and the evolution of changes over time. She noted that 79% NBs were annular in appearance with smooth circumferential tissue in 71%, fimbriated with folded edges in 21%, and ruffled with 3 or more clefts in 35%. The annular configuration was more common in caucasians, the fimbriated in blacks. There were no crescentic hymens noted in newborns. With the exception of the sleeve-like form, 65% of hymens changed morphologically by one year and all edges were sharply defined by age three. As the newborn estrogen effect waned, there was an increase in crescentic (posterior rim predominant) shaped hymens. 77% of those noted as newborns to have a notch in the 12 o'clock position also became crescentic. By age 2-4 years, the crescentic configuration was the most common and 90% had developed a notch between the 11 and 1 o’clock position (Berenson, 1995).

In a study of 123 newborns, Kellogg and Parra (1991) described a white midline avascular structure and termed it *linea vestibularis*. This linea was noted in the posterior vestibule in 13 infants (10%) while another 17 (14%) had a white spot or, partial linea vestibularis. This white line or spot was noted most often on ‘mature’ genitalia, was never asymmetrical and had no associated neovascularization or scarring present. Its prominence both increased and decreased during longitudinal followup.
Types of hymen (using APSAC definitions):

- **Fimbriated** - also called denticular- having multiple projections and indentations along the edge, creating a ruffled or flowery appearance

- **Annular or circumferential** - essentially equal amounts of hymenal tissue completely encircles the entire vaginal opening
- **Crescentic** - (posterior rim) hymenal attachments at 11 and 1 o’clock positions with no tissue present between them

- **Septate** - the hymenal opening is bisected by a band of tissue creating two openings. Estrogen may lyse this leaving opposing remnants. While not necessarily associated, look for a vaginal septum
- **Cribriform** - or microperforate with multiple small openings

- **Imperforate** - no identifiable hymenal opening, avascular

**Prevalence in studies:**
- Annular or fimbriated is the most common at birth
- Fimbriated decreases with age, more common in blacks
- Crescentic increases with age to become the most common at 2-4 years
- Septal remnants common
- Imperforate hymen < 8/1000

iii.) **Clinical features of the “normal” hymen**
- Flowery, fluted, ruffled, rolled edges: see picture, page 70.
- **External vaginal ridge:**
  - definition-a midline longitudinal ridge of tissue on the external surface of the hymen
  - Usually located anteriorly, extending to the edge of the hymenal membrane
  - very common in newborns (82%)
  - decreases with age 17% at 1 year, 7% at 3 years
- **Hymenal tags**
  - definition- an elongated projection of tissue arising from the rim of the hymenal membrane
  - commonly found in the midline at the 6 o'clock position
  - may be an extension of the posterior column
  - may be a septal remnant with opposing teat-like projections.
  - common in the newborn but resolve post estrogen (26%)
- **Longitudinal intravaginal ridges**
  - anterior and posterior columns
  - sagittal columns prominent on the anterior vaginal wall (bladder) and also posterior wall, occasionally laterally
  - prevalence as high as 90%
  - under the hymenal rim

- **Hymenal Notches (clefts)**
  - definition- angular or V-shaped indentation on the edge of the hymenal membrane
  - referred to as a concavity when curved and smooth does not extend to the junction of the hymenal ring and vestibule
  - V-shaped post injury as elastic fibers retract from injured edge of hymen
  - anterior notches common between 11 & 1 o’clock and decrease with age
  - posterior notches (between 4 & 8 o’clock) increase with age and none reported in studies on non-abused girls (McCann <6%)
  - Prevalence
    - Korns & Ritter (1992): 12.6% prevalence, >57% posterior, 35% anterior
    - Posterior, acute angle, multiple, irregular associated with acquired or penile abuse (p<.001)
  - Notches/clefts from 4-8 o’clock are ABNORMAL.

- **Vaginal rugae**
  - redundant folds in the vaginal wall
  - anecdotally seem to flatten out with chronic fingering

- **Periurethral and perihymenal vestibular bands**
  - support ligaments lateral to the urethra connecting periurethral tissues to the wall of the vestibule
  - symmetrical most of the times
  - number increases with age
  - creates semi lunar spaces (ventricles) adjacent to the urethra
  - pubovaginal bands lateral to the hymen connecting to the lateral vestibular wall
  - present in up to 95-100% of girls
• **Labial agglutination**
  - adhesions, usually posterior, common (5-18%)
  - may be increased post irritation/injury
  - resolve with topical estrogen
  - 2-3 times more common after chronic irritation or injury

• **Asymmetrical insertion of the hymenal ring**
  - not uncommonly seen between 5-7 o’clock
  - confused with fold which disappears in KC position

• **Erythema of the sulci**
  - common and due to vascularity
  - especially when estrogen effect has resolved
  - increased with irritation or after a hot bath
  - no disruption of vessels on colposcopy

• **Linea vestibularis**
  - white dot mottling or line noted in the *midline* of the posterior vestibule(fossa navicularis) but not extending to the hymen
  - occurred in 24% of 123 newborns (LV 10%, Partial LV 14%) (Kellogg, Parra 1991)
  - associated with "mature" genitalia
  - no evidence of neovascularization/or vessel transection
  - prominence may increase or decrease
  - ? variant of urogenital fold development (Reed, unpublished observation)

• **Hymenal bumps or mounds**
  - definition-firm elevation of hymenal tissue which is as wide as it is long located on the edge of the hymenal membrane primarily at 3 & 9 o’clock
  - commonly associated with & attach to naturally occurring intravaginal ridges
  - their exposure, not existence, may prove meaningful
  - prevalence the same in cross sectional study
  - histologically not scar tissue
  - originally felt to be post traumatic when uncovered in normative study by McCann; 90% were under or behind the hymenal membrane rim
  - prevalence-18-34% varies with exam position
• Lymphoid follicles
  - definition-yellow white minute 1-2mm prominences of follicular hyperplasia seen in the vestibule in about 1/3 of girls

iv.) The Transhymenal Diameter:
Prior to Cantwell (1987) this criterion was not mentioned in the literature on child abuse. Great discussions, controversy, and many studies have followed her notion that a transhymenal opening > 4mm measured with “a slight spreading of the labia” were present in 80% of girls who described having been sexually abused. (Huffman 1981) earlier noted that the size of the hymenal opening increased with age and over the next 5-6 years, several other studies agreed. Woodley (1986) proposed the “rule of thumb” that after the age of five years, the normal transhymenal diameter equaled the child’s age in millimeters. Several other investigators confirmed this observation. (Claytor 1989, Emans 1989). Emans (1987) noted that the hymenal diameters were significantly larger in abused girls, especially those who gave a clear history of penile-vaginal intercourse. McCann, et al (1990) reported and compared the size of hymenal openings in prepubertal girls chosen for nonabuse using three different examination techniques. The colposcopic measurements were in line with previous studies (Adams 1988, Paradise 1989) and showed the greatest diameter in all age groups examined in the knee-chest position. TH diameters without standard deviations were:

- Preschool children (2-4.5 years old) 3.9-5.2mm (range 1-8.5mm)
- Early school (age 5-711/12) 4.2-5.6mm (range 1-9mm)
- Preadolescent (8 ys/ to Tanner II) 5.7-7.3mm (range 3-11mm)

Finally, Berenson’s data (1990) would seem to confirm the <4-mm rule below age 5, and an increase of approximately 1mm per year of age. She confirmed that the transhymenal diameter increases with age and using labial traction measured up to 8 mm at three years of age. The size of the hymenal opening can vary depending on the development of the hymenal ring, type of opening, relaxation by the patient, amount of traction on the labia, position of the patient during the examination, and finally and probably by the amount of time since any injury, as healing has lead to the misimpression of imperforation (Berkowitz 1987). The assessment of the hymenal diameter is also made more difficult by the alterations caused by estrogen (Rimza 1989). Elasticity varies from person to person and there are no criteria or objective means to measure “stretching”. While it is difficult to quantify stretching or distensibility, penetration may tear, “stretch”, or cause no injury, and because of this, the diagnosis is not precluded by the normal exam. Similarly, the diameter is also affected more by the knee-chest position, than labial traction, than by the supine position. Maximum size in all studies available is 10 mm prior to puberty (McCann 1990). Size alone (without evidence of injury) has a low predictability of abuse. Perhaps combined with thinning, increased exposure, narrowing of the posterior rim (<2mm), and irregularity, this will again be revisited as a “co-criterion” in the future.

v.) The effects of estrogen
The effect of estrogen is first noted in the newborn female and is caused by maternal estrogen crossing the placenta. It results in the prominence of the labia minora, clitoris, and paraurethral tissue. The hymenal tissue is also thickened, pale, and with fewer surface capillary vessels seen. There are major changes seen at birth (and again during puberty) including morphology and size, mucosa and secretions, environmental pH, and bacterial flora. Estrogen may cause pigmentation of the external genitalia, a thick white creamy discharge, and occasionally, withdrawal vaginal bleeding in the first 4-6 weeks.
By 1-2 months the genitalia begin to appear prepubertal although evidence of estrogenization may last 2-4 years. As the level of maternal estrogen decreases, the epithelium and mucosa begin to thin, secretions diminish, and the labia appear smaller. The entire vestibule appears more reddened and vascular. Because of vasodilatation, this redness increases with heat, irritation, and after baths.

At 8-10 years, there is rapid increase in velocity of linear height and breast budding occurs. Pubarche occurs about 3-6 months after thelarche and menarche follows 2 years later at Tanner III-IV. Early changes in the hymen again show estrogen effect and this may be the earliest sign of puberty. Vaginal secretions thicken and become white about 6-12 months before the onset of menses.

During puberty, both pairs of labia enlarge. The mucosa thickens and becomes pinker. The hymen becomes thicker, more elastic, and takes on a scalloped appearance. Additionally, the hymenal opening becomes less sensitive to pain. Adolescent females may have multiple monomorphic papillae that cover some or all of the entire surface of the mesial labia minora and vestibule. This papillomatosis does often appear warty like HPV, but is uniform in appearance and does not blanch with acetic acid or stain with Lugol's iodine. These vestibular "growths" occur at Tanner 3-4 during peak maturation and their embryologic location is quite similar to the male. Could this be the counterpart to pearly pink papules of the penis in males? The age of onset and speed of pubertal changes varies individually, but the sequence is relatively constant. Precocious puberty is that puberty occurring before age 8 and represents physiological true puberty 90% of the time. There may also be isolated premature thelarche and pubarche. The lack of development of secondary sexual characteristics may be due to immaturity of the hypothalamic-pituitary-ovarian axis, chromosomal (Turner Syndrome), CNS causes, or ovarian causes. Primary amenorrhea with normal breast and pubertal development should focus on anatomic variants (such as imperforate hymen), or müllerian agenesis.

E. Development of the External Genitalia in Boys

In boys, external genital development begins at 6-16 weeks and does not require high concentrations of testosterone, but does require conversion of 6-8% of testosterone to 5-dihydrotestosterone (5-DHT). The genital tubercle continues to grow to form the penis and the urogenital fold fuse to enclose the penile urethra. The opening of the penile urethra, which may be covered by the foreskin, is called the meatus. Where the foreskin attaches to the corona of the glans penis is termed the frenulum. Laterally,
the labioscrotal folds develop and in the presence of testosterone and 5-DHT, become fused in the midline to form the **scrotum**. This line may be very prominent on inspection and is referred to as the **median raphe**. The testes descend into the scrotal sac at 28-32 weeks. The scrotal content may include fluid from a patent process vaginalis, intestine from a hernia defect, or a discolored and indurated mass caused by torsion of the testis occasionally seen in breech presentations. The absence of one or both testes requires differentiating between an undescended or absent testis, and the more common retractile testis. The spermatic cord and epididymis lie posteriorly to the testis, which is anchored to the scrotum by the gubernaculum-a reticular strand that also helps to form the labia majora in girls.

Testosterone is responsible for the evolution of the mesonephric duct system (2nd kidney, remember?) into the vas deferens, epididymis, ejaculatory ducts, and the seminal vesicle. At puberty testosterone leads to spermatogenesis and the development of the secondary sexual characteristics. Dihydrotestosterone results in the development of the male external genitalia, prostate and the bulbourethral glands (**of Cowper**).

**F. Anatomical Variations in Boys**
- **Phimosis:** the prepuce (foreskin) remains tight and cannot be retracted to/over the corona of the glans penis by age 5-6.
- **Paraphimosis** refers to venous obstruction and pain caused by a tight and sometimes irreducible foreskin retracted behind the coronal sulcus. If manual reduction fails, a surgical slit in the dorsal prepuce may be required.
- **Hypospadias:** is the underdevelopment of the urogenital folds resulting in a **ventral (anterior) positioned urethral opening** anywhere on a line between the corona of the glans penis and the perineal body, **incomplete prepuce** which looks like a dorsal hood and a curvature of the penis (**chordee**) ventrally towards the floor. It occurs in 1/250 live male births, and may be associated with an undescended testis. A karyotype should be obtained on any infant/child with a mid or proximal hypospadias and cryptorchidism. A VCUG may be indicated for penoscrotal hypospadias in that 5-10% will have Müllerian remnants. The incidence of hypospadias has been increasing the past 26 years (20.3 to 39.7/10,000) either due to endocrine or polygenic reasons. (Dolk 1998) Hypospadias is the **ONLY** absolute contraindication to circumcision. Relative contraindications include: chordee without hypospadias, a small penis, or a dorsal hood anomaly
- **Dorsal hood/chordee:** with a distal meatus: circumcision is contra-indicated. This will require a urethroplasty. (Baskin 2000)
- **Circumcision adhesions and bridging bands:** may cause penile curvature. Easily separated in the first 9-12 months, but later may be tenacious and require surgery.
- **Erythema or hyperpigmentation:** of the shaft immediately proximal to the glans caused by circumcision and or natural friction from self-manipulation.
- **Smegma:** white creamy substance adherent to the coronal sulcus mainly in probably all uncircumcised males and in 0.5% of circumcised males. It consists of desquamated epithelium, LCFAs, sterols, and squalene. Etiology is probably the atypical organism Mycobacterium *smegmatis*.
- **Uric acid crystals in the urine:** may leave a pinkish red spot on the anterior diaper in an infant and should be easily discernible from blood from a circumcision (or withdrawal in the female).
- **Pink Pearly Papules of the Penis:** see section on pubertal changes.
- **Urethral meatal stenosis:** this complication that occurs in 5-10% of male infants who have been circumcised (another story). Probably from disruption of the frenular artery blood supply. (Bukowski 2001)
- **Epispadias:** urethral meatus is found on the dorsum of the penis when the genital tubercle forms in the urorectal septum. Incidence is 1/30,000-1/40,000.
- **Exstrophy of the bladder:** a lack of primitive streak mesoderm results in externalization of the bladder mucosa. The prepuce is present only ventrally and epispadias is a constant feature in boys. In girls, the clitoris is bifid and the urethra is split dorsally. Incidence- 1/117,000 boys, 1/480,000 girls.
- **Micropenis:** less than 1.9mm in length, associated with Prader-Willi Kallmann and Lawrence-Moon-Biedl Syndromes.
- **Agenesis of the penis:** XY genotype, incidence <1/1million.
- **Diphallia:** ranges from small accessory penis to complete duplication.
- **Urethral duplication, atresia, fistula, parameatal cysts, or megalourethra:** rare, s/c Prune Belly (Eagle-Barrett) Syndrome.
- **Penile torsion:** rare, usually CCW rotation.

G. **Sexual Maturity Ratings and Normal Pubertal Development**

A systematic classification of pubertal development in boys was first proposed by Greulich in 1942. Sexual Maturity Ratings (SMR’s) came later (Marshall and Tanner, 1969) and divided the process into 5 stages, with Stage I being prepubertal or childlike and Stage V being adult. A child enters into SMR stage II of development when the first signs of puberty become apparent. In girls, breast budding and sparse labial hair characterize this stage. In boys, testicular enlargement is the earliest recognizable sign of puberty. The Tanner staging system does not include changes in the nipple to distinguish between Tanner II and III breast development. Recent studies have suggested using nipple size, breast diameter/circumference, and even ultrasound to better assess actual glandular tissue. Finally, changes in axillary hair (adrenarche) are not part of the system in boys or girls.

These are strictly guidelines used in assessing the progression of pubertal development in adolescents. They are not criteria for video review of probable chronological age in child/adolescent pornography trials. (Rosenbloom and Tanner, 1998)

i.) **Sexual maturity ratings in girls**

- **Breast SMR:**
  - **Stage I** (prepubertal) elevation of the papilla
  - **Stage II** (breast budding) with areolar enlargement and later tenderness
  - **Stage III** enlargement with no separation of breast/nipple contour
  - **Stage IV** projection of the areola and papilla to form a clear mound (nipple) above the breast
  - **Stage V** the mature stage with areolar recession

- **Pubic hair SMR:**
  - **Stage I** (preadolescent) only vellus over the pubes, no pubic hair
  - **Stage II** (pubarche) sparse growth downy hair, straight, little curl, hairs easily counted
  - **Stage III** hair darker, coarser, curlier, mainly over the pubes, still countable
  - **Stage IV** adult type hair over the mons and labia, counting now requires compulsive behavior
  - **Stage V** mature stage spreads to medial thighs and forms the female escutcheon (inverted triangle)
ii.) Sexual maturity ratings in boys

Stage I: (pre-adolescent) infantile, no enlargement of penis, testes (1.5 ml)
Stage II: Testes enlarge (1.6-6ml), early pubic hair
Stage III: hair increases, both testes (6-12ml) and penis grow
Stage IV: hair now thickened, scrotum more rugated, volume of testes (12-20ml)
Stage V: adult male hair thighs, penis and testes full size (20-30ml); escutcheon triangular shaped

iii.) Normal pubertal findings

- Female
  - Variation in distensibility & tightness of the vaginal orifice (opening)
  - Ectropy –homogeneous erythema due to columnar epithelium on the cervix
  - Adolescent vestibular growth
  - Urethral and paraurethral cysts
  - Elongation of the vestibule in obese girls
  - Myrtiform caruncles-hymenal remnants separated by complete clefts in sexually active girls.

- Male
  - Varicocele-common (10-15%), most are left sided “bag of worms”. Grades 1-3, size of testis should be equal; to or greater than right
  - Hyperpigmentation of the distal shaft caused by recurrent and natural friction during self-stimulation
  - Pink Pearly Papules of the Penis-occur in 12-19% of boys ages 11->21, Tanner 3-4, 1-3 mm papillae along the coronal margin of the penis, usually anteriorly, 1-5 rows, uniform in size, and pearly white in color. Do not blanch with acetic acid like lesions of HPV. Occur at peak of pubertal development, same as adolescent vestibular growths in females?
  - Spermatocele-cystic not tender mass smaller than and superior to testis

H. Development of the Anorectum

Theories of anorectal development are based on pig and human embryological investigations as well as histological studies postnatally on babies with anomalies. There is recent disagreement on all earlier theories of anorectal evolution (VanDer Putte, 1986). The principle event in the normal development has proved to be a shift of the dorsal part of the cloaca and hindgut to the body surface of the tail groove (Moore, 1992). The hindgut develops at 4 weeks and will ultimately form the spleen, bladder, descending colon, sigmoid and rectum as far inferiorly as Hilton’s white line (see drawing). The allantoic diverticulum arises from the cloaca, which is then closed off. At 5-6 weeks the anorectal bar of mesenchyme coronally bisects the cloaca into a dorsal anorectal compartment and ventral urogenital sinus. This area of fusion between the urorectal septum and the cloacal membrane forms the perineal body (tendinous part) of the perineum. At 6 weeks the dorsal anal fossa terminates the GI tract and gives rise to the distal anal canal and anus. This anorectal septum divides the cloacal sphincter into an anterior part (ischio & bulbocavernous muscles) and a posterior part (external anal sphincter). Absence of the posterior (or dorsal) membrane leads to agenesis of the anus. Mesenchyme proliferates to produce an elevation of the surface ectoderm around the anal membrane. This is located centrally in an ectodermal depression termed the proctoderm or anal pit. At 8 weeks the membrane ruptures forming the anal canal. The superior 2/3 of the hindgut (mesoderm) measures about 2.5 cm in adults. The inferior 1/3 arises from proctoderm and
measures about 13mm. The junction of these two, at the inferior limits of the valves of Houston is called the pectinate line. Approximately 2 cm superior is the anocutaneous line (Hilton’s white line) and this is where columnar and stratified squamous epithelium meet.

i.) Normal perineum and anorectum

The perianal area is fairly nondescript and less complex than the vestibule of the female. Additionally, it is predictable both before and after non-accidental trauma in that injury is easy to see (Wissow, 1990). The anus is normally located in the middle of any pigmentation and has circumferential rugal folds formed by the corrugator cutis ani muscle. The perianal tissue overlying the external anal sphincter is called the anal verge. This extends from the edge of the primitive protoderm (anoderm) to the margin of the anal canal. Where the anoderm meets the rectal ampulla is called the dentate or pectinate line. The pectinate line receives its name from the alternating columns and sinuses, which appear scalloped, and less pink. Deep to this tissue circumferentially in the perianal space are the inferior or external hemorrhoidal veins. Because these veins have no valves, they are easily distended and or obstructed. The finding of a hemorrhoid in children should initiate a search for an intra-abdominal mass or left renal vein obstruction.

Normative data have been well documented. McCann and colleagues (1989) described the following in children chosen for nonabuse. I have taken the liberty of presenting these in a more colorful manner.
• **Color changes**
  - **red**: erythema is noted in >40% of children. This is more noticeable with colposcopy (>50%) than with visual inspection (33%). It may include a radius or width of up to 1.5 cm, but none of these children were cultured for **GABHS**. Consider and do Strep antigen/ culture on vaginal or anal erythema. Throat culture correlates in 65-99%.
  - **brown**: hyperpigmentation is common and increased in almost 30% of children, predominantly those with darker skin. The incidence increases after puberty.
  - **blue**: venous congestion is noted at mid-valsalva in over 50% of children and is due to decreased outflow of the pelvic venous system.
  - **white**: or pallor associated with lichen sclerosis (partial androgen insensitivity) or autoimmune disorders such as vitiligo.

ii.) **Anatomical variations**
- **Diastasis ani** - smooth area(s) near the anal verge in 26% of children. Midline, mostly at 12 o’clock position Knee Chest 47% had a depression, dimple, or pit. This fanning, cupping, or funneling appearance is felt to be due to a congenital absence of the superficial division of the external anal sphincter.
- **Anal tags** (11%) have been noted more often on visual inspection and may be redundant **perineal raphe** or thickening. Present in same proportion all age groups out of midline consider deflated hematoma or autoimmune disease.
- **Anal opening** is symmetrical in 89% and irregular in 3 %. Radial folds or rugae present in 81% and decrease to 37% at midpoint dilatation. 98.8% of dilatation of the anus <20mm without the presence of stool in the ampulla. Dilatation of the internal anal sphincter is probably due to distension of the rectum, which disinhibits external anal constriction.
- **Superficial fissures** may be due to hard stools, encopresis, or proctitis (6-26%). (Agnarsson, et al, 1990)
I. References


References on the development of the hymen


**Trans hymen al diameter references**


**References on pubertal development**


**Ano-rectal References:**


**General References**


Cupoli JM Sewell PM (1988) 1,059 children with a complaint of sexual Abuse *Child Abuse & Neglect*: 2,151-162

Finkel MA DeJong AR (1994) Medical Findings in Child Sexual Abuse, in Reece RM *Child Abuse: Medical Diagnosis and Treatment*, Lea Feibiger, Pennsylvania, Chapter 9, 185-247.


12) Acute and Nonacute Anogenital Findings Associated with Sexual Abuse/Assault
Nancy D. Kellogg, MD, Rebecca Girardet, MD, and William J. Reed, MD

Only 10-30% of children and adolescents presenting for sexual abuse or assault evaluations will have a genital or anal injury suggestive or definitive for sexual abuse trauma (Adams, 1994; Berenson, 2000). In a recent survey (Kellogg and Adams, 2001, submitted) of clinicians averaging more than 1700 examinations performed, the mean percentage of abnormal genital findings was 17% and the mean percentage of abnormal anal examinations was 5%. Reasons for the high proportion of normal exams include: 1) the type of sexual contact may not result in visible tissue damage; 2) trauma resulting from sexual abuse heals within a few days (McCann et al, 1992; McCann et al, 1993; Finkel, 1989) without residua; 3) pubertal females may heal more quickly due to the presence of estrogen (McCann et al, 1992); and 4) children typically delay disclosure of abuse and present for medical evaluations after acute injuries have healed. It is “normal to be normal” (Adams, 1994) but “normal” does not mean “nothing happened.”

Two factors have been shown to increase the likelihood of visible acute or healed genital trauma in females: examinations conducted within 72 hours of the assault (42% vs. 8%; p<.001) and victim reports bleeding after the assault(46% vs. 8%, p<.001; Adams et al, 1994). Factors such as physical activity and tampon use do not alter genital anatomy (Emans et al, 1994). Anatomical variations and conditions confused with sexual abuse are discussed in Chapters 11 and 13. In contrast to straddle, non-penetrative and torque injuries to the genitalia, penetrating trauma due to sexual abuse are more likely to be severe and symmetric, and to transect the hymen (Pokorny et al, 1992).

A. Findings in acute sexual assault

Acute injuries associated with penile-vaginal penetration include lacerations, edema, and petechial or small ecchymoses. Most injuries occur in the posterior vestibule or posterior rim of the hymen between 3 and 9 o’clock. More severe injuries may extend to the perineum, labia majora or minora, and intravaginal tissues. Anterior vaginal lacerations are rare but more likely to require surgical repair. The severity of the injury does not necessarily correlate with the force or nonconsensual nature of the sexual contact. In addition, anal or genital trauma may be present in asymptomatic victims.

Acute anal findings include lacerations, hematomas, edema and anal sphincter spasm or dilatation. Traumatic lacerations should be differentiated from superficial fissures that may result from a variety of non-traumatic causes.

Based on published research, various anogenital findings may be interpreted as either suspicious or definite evidence of penetrating injury (Adams, 2001). Suspicious or concerning acute findings include abrasions, lacerations or bruising of the labia, perihymenal tissues, penis, scrotum or perineum and marked, immediate dilatation of the anus without the presence of stool. Acute findings that may be interpreted as definitive evidence of penetrating trauma include hymenal lacerations, transections, or ecchymoses, and perianal lacerations extending to the external anal sphincter.

B. Healing of acute anogenital injuries

Most injuries of sexual abuse heal by regeneration of the epithelium without formation of granulation tissue (Finkel, 1989). Regeneration may be complete in 1-7 days (Finkel, 1989; McCann and
Voris, 1993). Deeper injuries require both regeneration and repair, and involve the formation of granulation tissue and possible scarring. Scars may appear within a week of the acute injury, but continue to change and mature for up to 60 days.

Submucosal hemorrhages or petechiae of the hymen, vestibule and perianal tissues generally resolve within 1-5 days but may persist for a few weeks with more severe injuries. Concurrent infection with Herpes simplex, staphylococcus, streptococcus, gonorrhea or Trichomonas may extend the healing time for genital and anal erythema and abrasions associated with sexual assault injuries.

C. Residua of anogenital injuries

Longitudinal studies (McCann, Voris and Simon, 1992; McCann and Voris, 1993) of genital healing after sexual assault report that irregular hymenal edges and partial or complete clefts are the most persistent findings. These findings appear to smooth off with time and become more obscure with puberty. In these studies, there was little apparent scar tissue.

Perianal lacerations resulting from sexual abuse or assault heal in 1-11 days. Deeper perianal wounds may take up to 5 weeks to heal and result in narrow bands of scar tissue (McCann and Voris, 1993). Third-degree perianal lacerations requiring surgical repair may resolve completely over several (12-14) months. Permanent residua include avulsed anal tags and scars. Immediate and marked anal dilatation in the absence of encopresis, constipation, neurologic deficits and stool in the ampulla is a concerning finding for penetrating trauma and may persist for months. Encopresis is a nonspecific sign for sexual abuse but does develop in some sexually abused children who chronically withhold defecation.

Nonacute findings concerning for genital penetrating trauma include posterior hymenal clefts extending more than 50% of the width of the rim and scarring of the posterior fourchette and perianal tissues (Adams, 2001). Nonacute findings that are considered definite evidence of penetrating trauma include posterior clefts extending to the base of the hymen, and absence of hymenal tissue in the posterior aspect of the hymen (Adams, 2001). In some cases, a comparison of photographs taken at different times may reveal distinct changes in anatomy consistent with intervening incident(s) of penetrating trauma.

D. Controversies: transhymenal diameter, reflex anal dilatation, nontraumatic “lacerations,” and hymenal narrowing

Over time, the significance of some anogenital findings has varied. In the 1980’s, the transhymenal diameter was thought to be an important indicator of penetration (Cantwell 1983, White 1989). Normative studies have demonstrated the variability in this measurement with age, size of the child, and degree of the child’s relaxation during the examination. Huffman (1981) earlier noted that the size of the hymenal opening increased with age and over the next 5-6 years, several other studies agreed. Woodley (1986) proposed the “rule of thumb” that after the age of five years, the normal transhymenal diameter equaled the child’s age in millimeters. Several other investigators confirmed this observation. (Claytor 1989, Emans 1989). Emans (1987) noted that the hymenal diameters were significantly larger in abused girls, especially those who gave a clear history of penile-vaginal intercourse. McCann et al (1990) reported and compared the size of hymenal openings in prepubertal girls chosen for nonabuse using three different examination techniques. The colposcopic measurements were consistent with previous studies and showed the greatest diameter in all age groups examined in the knee-chest position.

Transhymenal diameters without standard deviations were:
Preschool children (ages 2-4 years) 3.9-5.2mm (range 1-8.5mm)
Early school (ages 5-7) 4.2-5.6mm (range 1-9mm)
Preadolescent (8 yrs to Tanner II) 5.7-7.3mm (range 3-11mm)

The transhymenal diameter is also increased more in the knee-chest position, as compared to the supine position. Maximum size in all studies available is 10 mm prior to puberty. Size alone (without evidence of injury) has a low predictability of abuse. With the onset of pubertal changes, the assessment of the hymenal diameter is made much more difficult by the alterations caused by estrogen (Rimza 1989). Elasticity varies from person to person and there are no criteria or objective means to measure “stretching” or distensibility. Most importantly, penetrating injury may tear the hymen, “stretch” it, or cause no discernible injury; because of this, the diagnosis of sexual abuse is not precluded by a normal exam. These studies have reduced the significance of the transhymenal diameter such that most examiners no longer document this measurement.

The interpretation of anal dilatation has also varied over time. Normative studies and more extensive clinical observations have established specific parameters for interpreting the causative mechanisms associated with anal dilatation. Physiologic causes include the presence of stool in the ampulla, the urge to defecate, and recent defecation. Chronic constipation and encopresis are other non-traumatic causes of anal dilatation. Dilatation occurring after 30 seconds in the prone knee-chest position is also considered to be physiologic. Anal dilatation of 2 centimeters or greater that occurs immediately when the child is placed in the prone knee-chest position without the presence of stool is a concerning finding for anal penetration. In the absence of bruising or lacerations, such a finding is considered non-acute.

Abrasions and lacerations of the posterior vestibule, commissure, and anus should not be confused with non-traumatic excoriations associated with proctitis/vaginitis, a copious vaginal discharge, anal fissures, or a dehisced labial adhesion. The posterior commissure and anus are common sites for both traumatic and non-traumatic bleeding lesions. A follow-up examination 2-3 weeks following the initial assessment may help differentiate traumatic and non-traumatic lesions. Lesions that persist at the follow-up examinations may be non-traumatic if no intervening sexual contact has occurred. The examiner performing the follow-up evaluation should inform investigative agencies if the interpretation of the initial findings is altered and deemed less specific for trauma.

The relationship between the width of the posterior hymenal rim and the likelihood of sexual abuse remains a subject of considerable controversy. Berenson (1992) found, in a cross-sectional study of 211 prepubertal girls, none had a posterior rim <0.9mm in thickness. In a series of 22 girls whom she examined at ages 1 and 3 years, Berenson (1995) found that the width of the posterior rim on examination in the supine position changes little between these two ages, and also that the 3-year-olds’ posterior rims varied between 2.5 and 4 mm, with a mean of 3.2 mm. The 2nd standard deviation below the mean was 2.4mm. Partly on the basis of these studies, many clinicians consider a posterior hymenal width of <2 mm to be a “suspicious” finding for vaginal penetration, and a width of <1 mm to be particularly concerning for healed injury. Berenson herself (1998) cautions that the normative data currently available neither support nor refute such impressions.

Clinicians should also be cautioned that measurement of the posterior rim to such a high level of
precision is fraught with the potential for error, given the variability of appearance of the hymen in relation to the child’s position, degree of relaxation, examiner technique, and method of measurement. Further, this measurement should be verified in the prone knee-chest position, as the hymen may “fold” on itself in the supine position, producing an artifactsually smaller measurement.

E. **Assessment of children presenting with nonspecific symptoms or signs, or when there is no clear outcry of sexual abuse**

(See Chapter 14 for further discussion of specific diagnostic entities)

Sexual abuse must be considered in the differential diagnosis of nonspecific anogenital symptoms and signs in children. Assessment begins with a thorough medical history that includes questions about the character and duration of the complaint, exacerbating and ameliorating factors, and attempted remedies. A complete review of systems is obtained, paying particular attention to genitourinary, dermatologic, gynecologic, gastroenterologic, and psychiatric systems. A thorough past medical, medication and family history may also provide useful information. In addition, the child and his or her caretaker are questioned separately whenever possible about the child’s social environment, current emotional state, school performance (if applicable), and behavioral changes.

The general medical history is followed by an effort to elicit information from the child concerning possible sexual abuse. As has been discussed previously, this part of the medical encounter must be carried out as carefully as possible, as it is often the strongest or only substantive piece of forensic evidence. All precautions discussed above should be followed, including: asking the caretaker to leave the room for crucial parts of the interview whenever feasible; using “open-ended,” non-leading questions as much as possible; verbatim documentation (as opposed to summation) of the questions asked and the child’s responses; and recording the persons present and the child’s behavior and affect.

The physical examination of children with nonspecific anogenital symptoms and signs requires the same careful attention as that given to children with suspected sexual abuse. The child deserves a complete head-to-toe evaluation. The anogenital examination must be performed using direct illumination. A colposcope should be used if available. The examiner should be comfortable with the use of and indications for various examination techniques including labial traction, the knee-chest position, and judicious speculum use.

Basic laboratory tests performed in the office such as a urine dipstick or wet mount can sometimes elucidate an innocent explanation for the child’s genitourinary complaints. Spatulas for pinworm collection can be given to caregivers of children with the complaint of itching or “excessive masturbation,” or the practitioner may choose to simply give a trial of mebendazole. More elaborate tests or subspecialist consultation may occasionally be indicated.

When no innocent explanation for the child’s complaint is apparent, the practitioner must assess the likelihood that sexual abuse has occurred. If not already done, the case may need to be reported to law enforcement or Children’s Protective Services for further investigation. The reporting guidelines published by The American Academy of Pediatrics are a useful resource when the indications for abuse are unclear (See Appendix).
Occasionally a health care provider will note a concerning anogenital finding on a routine examination when there is no outcry of sexual abuse and no suspicion of abuse on the part of the caretaker. In one study (Kellogg, Parra & Menard, 1998) of children referred to a specialized sexual abuse clinic because of concerning anogenital symptoms or signs, 85% had normal or nonspecific findings of abuse.
<table>
<thead>
<tr>
<th>PRESENTING COMPLAINT</th>
<th>EXAMINATION RESULTS</th>
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| Genital/anal bleeding/bruising | • acute nonaccidental penetrating injury  
• acute accidental penetrating injury  
• lichen sclerosis et atrophicus  
• urethral prolapse  
• shigella vaginitis  
• benign excoriations of labia majora/minora  
• dehisced labial adhesions  
• hemangiomomas  
• vulvar varicosities  
• Group A beta streptococcus infection  
• candida vulvitis  
• anal fissures  
• rectal prolapse  
• diaper dermatitis  
• excoriations due to diarrhea |
| Genital lesions | • Herpes Simplex (type 1 or type 2)  
• Human papillomaviruses: condyloma, verruca vulgaris, molluscum contagiosum, Condylomata lata (secondary syphilis)  
• lymphangioma circumscriptum  
• nevi  
• lymphoid follicles  
• ingrown hair  
• external vaginal ridges  
• benign papillomatosis  
• urethral/paraurethral cysts  
• pink pearly papules of the penis  
• spermatocele  
• Behcet’s disease  
• varicella |
| Vaginal discharge | • Gonorrhea infection  
• chlamydia infection  
• trichomonas infection  
• Group B streptococcus  
• bacterial vaginosis  
• leukorrhea (physiologic vaginal discharge)  
• semen  
• smegma  
• healing trauma  
• candida vaginitis  
• overgrowth of “usual or normal genital flora”  
• foreign body |
| Genital/anal erythema | • genital trauma  
• diaper dermatitis  
• diarrhea  
• constipation |
| “No hymen”/“opening too big” | • complete/partial hymenal cleft (sexual abuse)  
• areas with absent hymen (sexual abuse) |
• normal variations in size
• anal dilatation associated with presence of stool, encopresis or neurologic defect

<table>
<thead>
<tr>
<th>Genital/anal scar</th>
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<tbody>
<tr>
<td>• true scar</td>
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<tr>
<td>• labial adhesion</td>
</tr>
<tr>
<td>• diastasis ani</td>
</tr>
<tr>
<td>• perineal defect</td>
</tr>
<tr>
<td>• perihymenal /periurethral bands</td>
</tr>
<tr>
<td>• linea vestibularis</td>
</tr>
</tbody>
</table>

F. References


A. Conditions that mimic trauma

The following conditions have non-traumatic etiologies but may exhibit features resembling trauma such as redness or disruptions in surface tissues.

i.) Lichen sclerosus et atrophicus

An idiopathic process of the vulva and/or the perianal skin seen predominantly in pre-pubertal girls but may be seen in either sex. Girls most often manifest symptoms and signs before the age of 7 and two thirds will have complete resolution by puberty. A partial androgen insensitivity syndrome has been proposed as an etiologic mechanism.

Dermal atrophy causes thinning and fragility of the overlying epidermis. The resulting irritation results in chronic changes such as hypopigmentation and wrinkling. Intermittent and recurrent irritation, burning, bleeding and scratching are common presenting complaints. Physical examination often reveals a well-demarcated hourglass “halo” or “figure of 8” pattern of pallor or hypopigmentation. Fissures and subepithelial hemorrhages that may be bright red or purple in color are seen centrally. The friable skin may become macerated with superinfection particularly in the anal area. A distinguishing feature from penetrating trauma is the absence of involvement of the hymen, vestibule or vaginal vault. The diagnosis can often be made clinically although biopsy is an option. Treatment is symptomatic with topical use of emollients, sitz baths and temporary use of estrogen or hydrocortisone creams.

ii.) Streptococcal cellulitis

Infection with group A beta hemolytic streptococcus is responsible for a number of clinical conditions, including strep throat, impetigo, cellulites, erysipelas, and pneumonia. Infection involving the genitalia may produce and vulvovaginitis, vaginitis or perianal cellulitis.

When the vulvar tissue is involved, fiery redness, fissuring and bleeding may be prominent creating a concern for acute trauma. However, careful inspection often reveals other features of streptococcal skin involvement such as golden crusting, scaling or peeling at the periphery of erythema or typical circular lesions in close proximity of the orifices or elsewhere on the body. The diagnosis can be confirmed by isolating the organism on routine microbiologic culture. Group A Strep can also be isolated from the throats of at least half of these children (Dhar et al, 1993). Treatment is a course of systemic antibiotics such as penicillin or cephalixin.

iii.) Urethral Prolapse

Urethral prolapse is a circular eversion of urethral mucosa that protrudes though the meatus. It is relatively rare, occurring exclusively in girls and with a predilection for children of African or Caribbean descent. The average age of onset is before 7 years when girls commonly present with painless bloody spotting thought to come from the vagina. Pain is not frequent but dysuria and rarely urinary retention have been described. Physical examination reveals a friable, red-blue annular mass in the area of the urethral meatus. The center may be ulcerated, infected, or even gangrenous creating a “rosette”. The hymen must be distinguished and should be posterior to the mass. The knee chest position may help in separating and
identifying the 2 orifices. For most children conservative management with antibiotics, estrogen cream and sitz baths and follow up will suffice. Surgical options such as excision and ablation are rarely used and reserved for recurrent symptomatic cases where conservative management fails.

iv.) Foreign Bodies
Intravaginal foreign bodies are not rare in prepubertal girls. They often present with bloody or foul-smelling discharge, causing concern for trauma. The most common foreign body in girls is amalgamated bits of toilet tissue that creep up and adhere to the vaginal vault causing inflammation and erosion of the mucosa. Supernervous mixed bacterial infection may occur. Other objects that have been recovered include bits of crayons, beads and small plastic toys. Physical examination shows redness and irritation of the vaginal mucosa and the offending objects may be seen. Occasionally even with strong clinical suspicion a foreign body may not be visualized and an examination by a gynecologist under anesthesia may be indicated. If the offending foreign body is toilet paper, flushing of the vaginal vault with saline solution via a small butterfly catheter is usually successful. Systemic antibiotics are occasionally necessary to treat superinfection. Close follow-up is indicated until symptoms completely resolve. The clinician should bear in mind that foreign bodies are occasionally deliberately inserted into sexually-abused children.

v.) Hemangiomas
These hypervascular lesions of the labia, hymen or perihymenal area may bleed from minimal trauma or give the appearance of bruising or submucosal hemorrhage. They can be distinguished by their somewhat uniform texture, demarcated edges, and failure to change appearance on followup examination. Their vascular structure may be perceived with high magnification. Small lesions do not typically need specific management.

D. Accidental anogenital trauma
i.) Straddle trauma
Children often present with a history of a fall involving a straddle mechanism such as falling with legs apart over a slide or handlebars of a bicycle. Straddle trauma is characteristically asymmetric with bruising and lacerations that run along the sagittal plane of the superficial genital structures such as the clitoris, labia majora, and labia minora. Depending on the mechanism, the posterior fourchette may also be involved. In contradistinction to the penetrative trauma of sexual abuse, the vestibule, hymen and vagina are usually not involved. However, a few cases of accidental trauma have been reported where objects such as bedposts, broomsticks, the foot of a toy plastic horse, have caused impalement-type injury that involved the hymen. Falling while water-skiing has also been reported to have caused hymenal injury.

ii.) Anal fissures
Midline anal fissures are a common feature of childhood and most often are due to the passage of hard stool. However, they may also be caused by anal assault and should be interpreted carefully if found in the context of a strong history of recent sodomy or anal object penetration.

E. Infectious diseases, or conditions that mimic infections, not specific for sexual abuse
i.) Vulvovaginitis
This is the most common gynecologic problem in prepubertal girls. In the majority of instances, the origin is nonspecific and unrelated to sexual abuse. Young girls are vulnerable to local irritation or inflammation of the vestibular tissues for a variety of reasons both anatomic and physiologic. Anatomic
reasons include the relatively unprotected status of the vulva and vestibule due to the absence of labial fat pads and pubic hair. Their smaller labia minora tend to open and expose the mucosal surfaces when the child squats. Fecal contamination is frequent due to the close proximity of the anus. Physiologically, the prepubertal epithelium is thin and uncornified due to the lack of estrogen. Lactobacilli, which induce an acidic vaginal environment, do not commonly colonize children. These factors contribute to a warm, moist environment that is neutral to alkaline in pH and is a perfect medium for microbial growth once inoculated. A key developmental factor is the poor perineal hygiene of young girls who are learning privacy but have not yet developed independent and consistent cleaning practices. Girls usually complain of pain, pruritus, dysuria, and (usually sparse) vaginal discharge. Examination reveals reddened, friable vulvar tissue with or without specific vaginal discharge. A variety of organisms may be involved. Specific bacterial causes include Group A streptococcus, shigella, staphylococcus, and coliforms. Pinworm infestation causes also a common cause.

In some instances a state of “chronic infection/inflammation” may occur in which little girls set up a vicious cycle of digging and scratching. Management includes instruction in proper perineal hygiene, use of loose absorbent cotton underwear, sitz baths and cleansing the vulva with clear water after gentle bathing with no (or at least non-perfumed) soap. Bland emollients to create a barrier may be useful. Recurrent or intractable cases may be treated with systemic broad-spectrum antibiotics, temporary use of estrogen cream, and empirical mebendazole.

ii.) Bacterial Vaginosis
Bacterial vaginosis is a polymicrobial infection apparently due to the interaction of Gardnerella vaginalis with several anaerobic bacteria. The diagnosis of bacterial vaginosis is made by examination of the vaginal secretions for clue cells (vaginal epithelial cells heavily covered with bacteria), the development of a fishy odor after the addition of 10% KOH to vaginal secretions ("whiff test"), and a vaginal pH of more than 4.5. Although bacterial vaginosis has been noted to be very common in adult women, it is diagnosed infrequently in children.

Bacterial vaginosis is a rare cause of vaginitis or vulvitis in prepubertal children, and the significance of a positive culture is controversial. The isolation of the organism in vaginal secretions or urine is usually unaccompanied by the other markers of bacterial vaginosis as described above. In the past, experts have worried that G. vaginalis may be an indicator of sexual abuse in children due to its strong association with sexual activity in adults. However, G. vaginalis is not exclusive to sexually active adults, and studies in children have suggested that G. vaginalis may be a part of the normal vaginal flora. G. vaginalis has been isolated from 13.5% of the vaginal cultures from a group of children (presumably not sexually abused) who had no vaginal discharge. Currently most examiners in the field regard the isolation of G. vaginalis as non-specific for sexual transmission, but would carefully assess the child for other indicators of sexual abuse. Symptomatic children may be treated with a course of metronidazole. Clindamycin is an alternative treatment.

iii.) Behçet's Disease
This condition of unknown etiology is characterized by recurrent oral or genital ulcers and eye inflammation. Pathologically, there is vasculitis of small and medium-sized arteries with cellular infiltration leading to fibrinoid necrosis and narrowing and obliteration of vessel lumens. The syndrome may produce painful and necrotic genital ulcers that present as single lesions or in crops on the inner labial mucosa. The
work-up for STD’s is usually negative. Management is mostly symptomatic as no effective treatment exists. Lesions usually resolve over time although recurrences can be seen.

iv.) Varicella-zoster infection (chickenpox and shingles)
Vesicular genital lesions associated with the generalized lesions of chicken pox are not uncommon. However, the occasional child with chicken pox may present with isolated genital lesions and mild systemic findings, creating a concern of herpes simplex infection. In rare instances herpes zoster (shingles) may present as a crop of vesicles localized to the genital region. To differentiate varicella zoster from herpes simplex infection, vesicle scraping can be submitted for tissue culture and/or viral DFA. Also, a significant increase in serum varicella IgG antibody by any standard serologic assay can retrospectively confirm the diagnosis.

v.) Molluscum Contagiosum
This presumed viral lesion presents initially as small, firm, flesh-colored papules that progress to very characteristic waxy dome-shaped papules with central umbilication. The papules often contain a pulpy core that can be removed. Usually 2-5 mm in diameter, a molluscum lesion may occasionally grow as large as 15 mm, particularly if in a moist area or if excoriated. Molluscum lesions are extremely common in children. Although they are usually found on the face, trunk or extremities, lesions may involve the anus or external genitalia. These may be sexually acquired (a common mode of spread in adults) or can result from close nonsexual contact with an infected individual, or from autoinoculation. Treatment modalities include various topical agents, cryosurgery and electrocautery.

vi.) Verruca Vulgaris (common warts)
Common warts most frequently appear on the hands and feet but may be seen anywhere else on the body, and are caused by type 1 and 2 strains of human papillomavirus (HPV). Such warts may autoinoculate to sites near orifices, raising the concern of sexual transmission. Features that help to distinguish common warts from condylomata include non-involvement of mucosa, single lesions, and the coexistence of warts on the digits. HPV hybridization tests to positively identify type 1 and 2 lesions are not commonly performed as the more easily available DNA hybridization probes are targeted to genital strains of HPV.

vii.) Perianal Lymphangioma Circumscriptum
These are benign hamartomatous malformations that consist of dilated lymph channels lined by normal, single-cell lymphatic endothelia. They are thought to arise from progressive dilatation of maldeveloped, sequestered primitive lymphatic sacs. These sacs lack connections with the rest of the lymphatic system.

viii.) Lymphangiomas
Classic cases result in lesions at birth or in early childhood. They appear as one or more plaques of grouped, deep-seated, thick walled vesicles. The most common sites of involvement include the proximal limbs and adjacent regions of the trunk, such as the axillary folds, neck, pectoral, scapular, and inguinal regions and perineum. Lesions occur uncommonly in the anogenital region and in some instance may be difficult to distinguish from other lesions in which case a biopsy may be indicated.
F. Other conditions seen in both abused and non-abused children
   i. Labial Adhesions
   These are adhesions of the labia minora which present as a thin, central line of adherence running from a point immediately posterior to the clitoris to a point immediately anterior to the posterior fourchette, causing a flat appearance to the vulva. Partial adhesions are seen in 20-50% of the patients. Most children present before 6 years of age, the finding is most often seen in girls 2 months to 2 years. Children are usually asymptomatic but a few may have urinary tract symptoms. The acquired adhesions are thought to be secondary to local inflammation and the low estrogen levels of childhood. The isolated presence of labial adhesions is not a specific indicator of sexual abuse, although sexual abuse involving genital rubbing might be a contributor in older girls with the condition. Spontaneous resolution usually occurs and free flow of urine is rarely blocked. No specific therapy is required in the majority of cases. If visualization of the hymen is desired for sexual abuse evaluation or strong parental concern regarding the genital anatomy, temporary use of topical estrogen cream is an option.

G. References


A. Psychological sequelae of child sexual abuse and sexual assault

In sexually abused children, residual psychological symptoms are manifested in a variety of behaviors. The most common behaviors are fear, nightmares, withdrawal, suicidal behaviors, poor self-esteem, somatic complaints, aggressive anti-social behaviors, cruelty, delinquent behaviors, sexualized behaviors, promiscuity, school and learning problems, hyperactivity, regression or immaturity, self-destructive behaviors, running away, and substance abuse (Kendall-Tackett, 1993). Children under 6 years of age more frequently experience symptoms of anxiety, nightmares, post-traumatic stress, and sexualized behaviors. School-age children have more fear, aggression, nightmares, school problems, hyperactivity, regression and immaturity; adolescents more frequently have symptoms of depression, withdrawal, suicidal ideation, self-injurious behavior, somatic complaints, running away, substance abuse and delinquent behaviors (Koverola and Friedrich, 2000). Greater psychological stress is associated with father/father figure perpetrators, abuse involving genital contact, and the use of force during acts (Finkelhor and Browne, 1986). About 30% of sexually abused children are asymptomatic.

Having experienced sexual abuse during childhood appears to predispose victims to psychologic disorders well into adulthood. In a meta-analysis of 12 studies (mostly of female victims) published since 1990, Fergusson and Mullen (1999) concluded that adults reporting childhood sexual abuse are at significantly increased risk for depressive disorders, anxiety disorders, and suicidal behaviors. Childhood sexual abuse also appeared to be associated (although not as strongly) with substance abuse and eating disorders. Adult victims of childhood sexual abuse also appeared more likely than the general adult population to experience difficulties with sexual functioning and with establishing satisfactory interpersonal relationships (Mullen et al, 1994; Kinzl et al, 1995).

Between 20 and 40% of adults reporting childhood sexual abuse do not have measurable psychologic sequelae. Similar to the studies cited above of children who report sexual abuse, factors that appear to distinguish resilient adults from those who develop long-term mental-health problems include (Fergusson and Mullen, 1999):

- Severe abuse (whether actual or attempted penetration occurred); a long duration of abuse; the use of physical restraint or violence; and incestuous abuse involving fathers or stepfathers were all associated with a higher risk of long-term sequelae. Victims of non-contact abuse were least likely to develop mental-health problems.
- A supportive, nurturing family environment appears to reduce the risk of long-term harm, whereas adverse family circumstances, particularly the presence of domestic violence, increases the risk of harmful outcomes.
- Victims who reported sympathetic, pro-social peer and partner relationships during the time they were abused had a lower risk of long-term harm.
- Individual coping styles appeared to influence long-term outcome. Certain personality traits, particularly internal locus of control and high self-esteem, reduced the risk of harmful outcomes.
**B. Physiologic sequelae of child sexual abuse**

A growing body of scientific research has documented long-term physiologic consequences of childhood sexual abuse. Berkowitz (2000), Horwitz and Fisher (2001), and Hanson, Davis, et al (2001) recently reviewed the subject and noted the following:

- Several studies support a link between irritable bowel syndrome, fibromyalgia, and other functional disorders with adult or childhood sexual victimization.
- Chronic pelvic pain has also been reported more often among sexual abuse victims, although methodologic issues have confounded efforts to confirm or refine these reports.
- Women who reported sexual abuse or assault during childhood appears more likely to develop long-term menstrual or other reproduction-related disorders, whereas women who were first sexually assaulted during late adolescence or adulthood more often developed chronic non-genital physical disorders.
- At least one researcher (Felitti, 1991) has observed that obesity is both more frequent and more severe among sexual abuse victims than among adults not reporting abuse. In this study, the onset of obesity often followed the abuse, and morbid obesity was particularly associated with incest.
- Victims of sexual abuse were much more likely to be “high utilizers” (defined as 10 or more physician office visits per year) than either a control group or the general population. Paradoxically, sexual abuse victims received Pap smears at a lower frequency than the general population.
- Sexual promiscuity and substance use (including alcohol and tobacco) was increased among sexual abuse survivors, and these may have been responsible for some of the medical sequelae of abuse.

Some neurodevelopmental researchers (Perry et al, 1996) have argued that there are critical and sensitive periods in central nervous system development, and that experiencing traumatic sexual (or other) abuse during those periods may “hard-wire” a child for chronic autonomic dysfunction, hypervigilance, and distrustful or avoidant behaviors towards adults. This hypothesis may provide a unifying biologic explanation for many of the long-term physiological and psychological symptoms that follow sexual victimization.

**C. Overview of psychotherapy for sexual abuse victims and their families**

Most Children’s Advocacy Centers and medical facilities for sexual abuse victims offer (or refer to) short-term mental-health services for sexual abuse victims and their families. Longer-term psychotherapy is less readily available and less often utilized by victims and families. Thus, clinicians who care for abuse victims should be familiar with the indications and goals of both short-term and long-term psychotherapy, and where families may obtain therapy that meets the specific needs of abuse victims. Clinicians should be able to identify those victims for whom long-term therapy is indicated, and encourage those families to initiate and continue treatment.

**i.) Short-term psychotherapy**

Lanktree and Briere (1995) examined the outcomes of abuse-focused treatment in children between 8 and 15 years old. Using two standardized instruments that measure depression, anxiety, post-traumatic stress, sexual concerns, anger, and dissociation in children, the authors found that most symptom scales improved after 3 months of therapy. Sexual concerns did not improve until 6 months of therapy, suggesting that sexual preoccupation and/or sexualized behavior is more refractive to short-term therapy. A shorter time interval between the end of the abuse and the beginning of therapy was associated with greater improvement, especially in depressive symptoms.
The modality of psychotherapy that has been investigated most thoroughly in this context is Cognitive Behavioral Therapy (CBT). In their recent review, Olafson and Boat (2000) state that CBT “seeks to change negative patterns of thought and behavior by teaching the relationships among thoughts, feelings, and actions and applying practical behavioral solutions to specific problems.” CBT is generally represented as short-term therapy, lasting between 12 and 40 sessions. Deblinger and Hefflin (1996) describe in detail the application of CBT to abuse victims and their families, and summarize the focus of CBT as follows:

- To alleviate posttraumatic, generalized anxiety, oppositional, and depressive symptoms in the child;
- To correct misconceptions or distortions the child has about the abuse; and
- To ameliorate behavior problems developed by the child as a consequence of the abuse.

Cohen and Mannarino (1996) and other researchers have found that CBT usually provides significant improvement in symptoms after as few as 12 sessions. In a study by King et al (2000), post-traumatic stress symptoms in a group of sexually abused children improved significantly after CBT as compared to a control group, parent involvement was not necessary for the improvement, and the improvement persisted for at least 12 weeks after therapy. Clinicians are cautioned that few true long-term outcome studies of CBT or any modality exist due to the logistical problems in carrying out such research.

ii.) Longer-term psychotherapy

At present, the clearest indication for recommending longer-term psychotherapy is the presence of symptoms of post-traumatic stress disorder or severe dissociative reaction, since these symptoms appear to resolve very slowly (Olafson and Boat). Building on the findings of Lanktree and Briere, discussed above, Grayson (1996) and others argue that the typical allowance of most managed-care plans for 10 therapy sessions is inappropriate for treatment of sexual abuse victims. Some children (e.g., who have been abused by trusted caretakers) require six months of treatment just to establish a trusting relationship with a therapist, and that one to two years of treatment may be necessary to address the known sequelae of sexual abuse, as described above.

Evidence of the appropriateness and efficacy of the various treatment modalities for the long-term psychotherapy for sexual abuse victims is sparse; most claims of treatment effectiveness have been based on individual therapists’ clinical experiences (Fergusson and Mullen).

iii.) Treatment of non-offending parents and siblings

Non-offending parents of child sexual abuse victims often have symptoms of trauma that may cause serious psychosocial distress as long as two years after the discovery of the abuse (Olafson and Boat). As discussed previously, the ability of the parent to support and nurture the victim is a key component of her/his recovery; thus, offering psychotherapy to the parent is a very important responsibility of the treatment team. General considerations and guidelines for parental therapy are discussed by Olafson and Boat and others.

Despite the limited documentation of treatment efficacy noted above, the current consensus on the standard of mental health care for sexual abuse victims calls for the clinician to refer most (if not all) sexually abused children and adolescents and their parents for therapy (Fergusson and Mullen). Long-term outcomes are variable and dependent not only on the child’s ability to cope and characteristics of the abuse, but also in the responses of the non-abusive caretakers. Emotional recovery is more likely when the non-abusive caretaker is supportive and believes the child.
iv.) Pharmacotherapy for psychological and behavioral sequelae

Relatively few scholarly publications exist that discuss pharmacotherapeutic issues specific to sexual abuse victims. Most references advocate a symptom-specific approach (Olafson and Boat). The two most common symptom sets requiring pharmacologic treatment in abuse victims are mood and anxiety disorders. Depressive symptoms severe enough to cause prolonged sleep disruption, appetite disturbance, anhedonia, or exacerbation of chronic pain should be treated pharmacologically. The selective serotonin reuptake inhibitors (SSRIs) are most commonly prescribed for these symptoms (Cohen, Mannarino and Rogal, 2001). Pharmacologic intervention should also be considered for intrusive or disruptive anxiety symptoms, such as panic attacks or compulsive behaviors. As benzodiazepines are not generally recommended for pharmacologic therapy of anxiety disorders in the pediatric age group, SSRIs or atypical anxiolytics (e.g., buspirone) should be considered. The clinician is strongly urged to consult with or refer to a child/adolescent psychiatrist or behavioral pediatrician knowledgeable in the treatment of these disorders.

D. References


15) Legal Issues in Child Sexual Abuse Investigations  
Sarah Guidry, JD and Sarah Webster  

(Note: Excerpts from Texas statutes are current as of August 2001 and do not reflect changes that may have been enacted on September 1.)

A. Definitions of Sexual Abuse

The definitions of “child abuse”, including “sexual abuse”, and “neglect” are contained in Chapter 261 of the Texas Family Code (“TFC”). The acts or omissions that fall within the definition of “abuse” include various acts that constitute sexual conduct harmful to the child and failure to remove the child from a situation in which there is exposure to harmful sexual conduct. The Texas Department of Protective and Regulatory Services (TDPRS or “the department”) is mandated to promptly and thoroughly investigate any report of child abuse or neglect committed by a person responsible for a child’s care, custody, or welfare (1). TDPRS may bring an action against a parent for conservatorship of a child who has been the victim of abuse and whose continuation in their home would be contrary to the child’s welfare (2).

The Texas Penal Code (“TPC”) contains various statutes that proscribe criminal acts involving children. Actions under the penal code are brought by criminal prosecutors (District Attorneys or County Attorneys) on behalf of the State.

i.) Family Code Definitions

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<thead>
<tr>
<th>Texas Family Code Sec. 261.001</th>
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<tbody>
<tr>
<td>In this chapter:</td>
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<tr>
<td>(1) &quot;Abuse&quot; includes the following acts or omissions by a person:</td>
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<tr>
<td>(A) mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;</td>
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<tr>
<td>(B) causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;</td>
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<td>(C) physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;</td>
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<td>(D) failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;</td>
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<td>(E) sexual conduct harmful to a child's mental, emotional, or physical welfare;</td>
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<td>(F) failure to make a reasonable effort to prevent sexual conduct harmful to a child;</td>
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<td>(G) compelling or encouraging the child to engage in sexual conduct as defined by Section 43.01, Penal Code;</td>
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<td>(H) causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene as defined by Section 43.21, Penal Code, or pornographic;</td>
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<tr>
<td>(4) &quot;Neglect&quot; includes:</td>
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<td>(B) the following acts or omissions by a person:</td>
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<tr>
<td>(i) placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child;</td>
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<tr>
<td>(5) &quot;Person responsible for a child's care, custody, or welfare&quot; means a person who traditionally is responsible for a child's care, custody, or welfare;</td>
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103
care, custody, or welfare, including:
(A) a parent, guardian, managing or possessory conservator, or foster parent of the child;
(B) a member of the child’s family or household as defined by Chapter 71;
(C) a person with whom the child's parent cohabits;
(D) school personnel or a volunteer at the child's school; or
(E) personnel or a volunteer at a public or private child-care facility that provides services for the child or at a public or private residential institution or facility where the child resides.

(6) "Report" means a report that alleged or suspected abuse or neglect of a child has occurred or may occur.

ii. Texas Penal Code Sections

**TPC Sec. 21.11. Indecency With a Child**
(a) A person commits an offense if, with a child younger than 17 years and not his spouse, whether the child is of the same or opposite sex, he:
(1) engages in sexual contact with the child; or
(2) exposes his anus or any part of his genitals, knowing the child is present, with intent to arouse or gratify the sexual desire of any person.

(b) It is an affirmative defense to prosecution under this section that the actor:
(1) was not more than three years older than the victim and of the opposite sex;
(2) did not use duress, force, or a threat against the victim at the time of the offense; and
(3) at the time of the offense:
(A) was not required under Chapter 62, Code of Criminal Procedure, as added by Chapter 668, Acts of the 75th Legislature, Regular Session, 1997, to register for life as a sex offender; or
(B) was not a person who under Chapter 62 had a reportable conviction or adjudication for an offense under this section.

(c) An offense under Subsection (a)(1) is a felony of the second degree and an offense under Subsection (a)(2) is a felony of the third degree.

**TPC Sec. 22.04. Injury to a Child, Elderly Individual, or Disabled Individual**
(a) A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual:
(1) serious bodily injury;
(2) serious mental deficiency, impairment, or injury; or
(3) bodily injury.

(b) An omission that causes a condition described by Subsections (a)(1) through (a)(3) is conduct constituting an offense under this section if:
(1) the actor has a legal or statutory duty to act; or
(2) the actor has assumed care, custody, or control of a child, elderly individual, or disabled individual.

(c) In this section:
(1) "Child" means a person 14 years of age or younger.
(2) "Elderly individual" means a person 65 years of age or older.
(3) "Disabled individual" means a person older than 14 years of age who by reason of age or physical or mental disease, defect, or injury is substantially unable to protect himself from harm or to provide food, shelter, or medical care for himself.

(d) The actor has assumed care, custody, or control if he has by act, words, or course of conduct acted so as to cause a reasonable person to conclude that he has accepted responsibility for protection, food, shelter, and medical care for a child, elderly individual, or disabled individual.

**TPC Sec. 22.011. Sexual Assault**
(a) A person commits an offense if the person:
A person commits an offense:

1. if the person:
   (A) intentionally or knowingly:
      (i) causes the penetration of the anus or female sexual organ of another person by any means, without that person's consent;
      (ii) causes the penetration of the mouth of another person by the sexual organ of the actor, without that person's consent; or
      (iii) causes the sexual organ of another person, without that person's consent, to contact or penetrate the mouth, anus, or sexual organ of another person, including the actor; or
   (B) intentionally or knowingly:
      (i) causes the penetration of the anus or female sexual organ of a child by any means;
      (ii) causes the penetration of the mouth of a child by the sexual organ of the actor;
      (iii) causes the sexual organ of a child to contact or penetrate the mouth, anus, or sexual organ of another person, including the actor;
      (iv) causes the anus of a child to contact the mouth, anus, or sexual organ of another person, including the actor; or
      (v) causes the mouth of a child to contact the anus or sexual organ of another person, including the actor;

2. if:
   (A) the person:
      (i) causes serious bodily injury or attempts to cause the death of the victim or another person in the course of the same criminal episode;
      (ii) by acts or words places the victim in fear that death, serious bodily injury, or kidnapping will be imminently inflicted on any person;
      (iii) by acts or words occurring in the presence of the victim threatens to cause the death, serious bodily injury, or kidnapping of any person;

(c) In this section:
   (1) "Child" means a person younger than 17 years of age who is not the spouse of the actor.
   (2) "Spouse" means a person who is legally married to another.

(d) It is a defense to prosecution under Subsection (a)(2) that the conduct consisted of medical care for the child and did not include any contact between the anus or sexual organ of the child and the mouth, anus, or sexual organ of the actor or a third party.

(e) It is an affirmative defense to prosecution under Subsection (a)(2) that:
   (1) the actor was not more than three years older than the victim and at the time of the offense:
      (A) was not required under Chapter 62, Code of Criminal Procedure, as added by Chapter 668, Acts of the 75th Legislature, Regular Session, 1997, to register for life as a sex offender; or
      (B) was not a person who under Chapter 62 had a reportable conviction or adjudication for an offense under this section; and
   (2) the victim was a child of 14 years of age or older.

(f) An offense under this section is a felony of the second degree.
(iv) uses or exhibits a deadly weapon in the course of the same criminal episode; 
(v) acts in concert with another who engages in conduct described by Subdivision (1) directed toward the same victim and occurring during the course of the same criminal episode; or
(vi) administers or provides flunitrazepam, otherwise known as rohypnol, or gamma hydroxybutyrate to the victim of the offense with the intent of facilitating the commission of the offense;
(B) the victim is younger than 14 years of age; or
(C) the victim is 65 years of age or older.

(b) In this section, "child" has the meaning assigned that term by Section 22.011(c).

(c) An aggravated sexual assault under this section is without the consent of the other person if the aggravated sexual assault occurs under the same circumstances listed in Section 22.011(b).

(d) The defense provided by Section 22.011(d) applies to this section.

(e) An offense under this section is a felony of the first degree.

TPC Sec. 25.02. Prohibited Sexual Conduct
(a) An individual commits an offense if he engages in sexual intercourse or deviate sexual intercourse with a person he knows to be, without regard to legitimacy:
   (1) his ancestor or descendant by blood or adoption;
   (2) his stepchild or stepparent, while the marriage creating that relationship exists;
   (3) his parent's brother or sister of the whole or half blood;
   (4) his brother or sister of the whole or half blood or by adoption; or
   (5) the children of his brother or sister of the whole or half blood or by adoption.

(b) For purposes of this section:
   (1) "Deviate sexual intercourse" means any contact between the genitals of one person and the mouth or anus of another person with intent to arouse or gratify the sexual desire of any person.
   (2) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(c) An offense under this section is a felony of the third degree.

TPC Sec. 43.01. Definitions
In this subchapter:
   (1) "Deviate sexual intercourse" means any contact between the genitals of one person and the mouth or anus of another person.
   (2) "Prostitution" means the offense defined in Section 43.02.
   (3) "Sexual contact" means any touching of the anus, breast, or any part of the genitals of another person with intent to arouse or gratify the sexual desire of any person.
   (4) "Sexual conduct" includes deviate sexual intercourse, sexual contact, and sexual intercourse.
   (5) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

TPC Sec. 43.25. Sexual Performance by a Child
(a) In this section:
   (1) "Sexual performance" means any performance or part thereof that includes sexual conduct by a child younger than 18 years of age.
   (2) "Sexual conduct" means actual or simulated sexual intercourse, deviate sexual intercourse, sexual bestiality, masturbation, sado-masochistic abuse, or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.
   (3) "Performance" means any play, motion picture, photograph, dance, or other visual representation that can be exhibited before an audience of one or more persons.
   (4) "Produce" with respect to a sexual performance includes any conduct that directly contributes to the creation or
manufacture of the sexual performance.

(5) “Promote” means to procure, manufacture, issue, sell, give, provide, lend, mail, deliver, transfer, transmit, publish, distribute, circulate, disseminate, present, exhibit, or advertise or to offer or agree to do any of the above.

(6) “Simulated” means the explicit depiction of sexual conduct that creates the appearance of actual sexual conduct and during which a person engaging in the conduct exhibits any uncovered portion of the breasts, genitals, or buttocks.

(7) “Deviate sexual intercourse” has the meaning defined by Section 43.01.

(b) A person commits an offense if, knowing the character and content thereof, he employs, authorizes, or induces a child younger than 18 years of age to engage in sexual conduct or a sexual performance. A parent or legal guardian or custodian of a child younger than 18 years of age commits an offense if he consents to the participation by the child in a sexual performance.

(c) An offense under Subsection (b) is a felony of the second degree.

(d) A person commits an offense if, knowing the character and content of the material, he produces, directs, or promotes a performance that includes sexual conduct by a child younger than 18 years of age.

B. Reporting Issues

i.) Reporting.

The requirement for reporting child abuse is simple: if you have cause to believe that a child has been abused or neglected, you must make a report. Anyone who suspects that a child is or has been a victim of abuse has a legal duty to make a report. Reports of abuse may be made to different entities depending on the allegations and circumstances involved (3). Reports of child abuse by caregivers are made to TDPRS’ Child Protective Services Program by calling the Texas Abuse Hotline at 1-800-252-5400. Reports are taken 24 hours a day, 7 days a week.

The person making the report should provide the name and address of the child as well as the name and address for the child’s parent or caregiver and any available information regarding the alleged or suspected abuse.

TFC Sec. 261.101. Persons Required to Report; Time to Report

(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.

(d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

(1) as provided by Section 261.201; or

(2) to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

TFC Sec. 261.102. Matters to be Reported

A report should reflect the reporter’s belief that a child has been or may be abused or neglected or has died of abuse or neglect.

TFC Sec. 261.103. Report Made to Appropriate Agency

(a) Except as provided by Subsection (b), a report shall be made to:

(1) any local or state law enforcement agency;

(2) the department if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child;

(3) the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred; or
(4) the agency designated by the court to be responsible for the protection of children.

(b) A report may be made to the Texas Youth Commission instead of the entities listed under Subsection (a) if the report is based on information provided by a child while under the supervision of the commission concerning the child's alleged abuse of another child.

TFC Sec. 261.104. Contents of Report
The person making a report shall identify, if known:
(1) the name and address of the child;
(2) the name and address of the person responsible for the care, custody, or welfare of the child; and
(3) any other pertinent information concerning the alleged or suspected abuse or neglect.

ii.) Failure to report.
Failure to make a required report of suspected child abuse can result in criminal penalties under both the Texas Family Code and the Texas Penal Code. Under the Texas Family Code, a person who fails to make a report commits a Class B misdemeanor. The Texas Penal Code provision below creates an affirmative duty to assist a child being sexually assaulted. This section provides for a Class A misdemeanor offense if a person observes a sexual assault of a child and fails to assist the child or immediately contact law enforcement, and they could have stopped or reported the aggravated sexual assault.

Two appeals courts have recently sustained challenges to the constitutionality of the failure to report statute contained in the family code(4). The Waco court of appeals equated “cause to believe” with “sufficient reason” to believe abuse had or is occurring in construing the mandate of the statute. The Houston court discussed the term “immediately” as contained in the statute. It should be noted that while the statute generally requires a report be made immediately, a more specific timeframe is stated in the reporting requirements of professional (discussed below).

TPC Sec. 38.17. Failure to Stop or Report Aggravated Sexual Assault of Child
(a) A person, other than a person who has a relationship with a child described by Section 22.04(4), commits an offense if:
(1) the actor observes the commission or attempted commission of an offense prohibited by Section 22.021(a)(2)(B) under circumstances in which a reasonable person would believe that an offense of a sexual or assaultive nature was being committed or was about to be committed against the child;
(2) the actor fails to assist the child or immediately report the commission of the offense to a peace officer or law enforcement agency; and
(3) the actor could assist the child or immediately report the commission of the offense without placing the actor in danger of suffering serious bodily injury or death.

(b) An offense under this section is a Class A misdemeanor.

TFC Sec. 261.109. Failure to Report; Penalty
(a) A person commits an offense if the person has cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect and knowingly fails to report as provided in this chapter.

(b) An offense under this section is a Class B misdemeanor.

iii.) Immunities
A person who in “good faith” makes a report of child abuse is immune from civil or criminal liability. This issue is most often raised in the civil context in regards to tort liability. Professionals have been sued
for reporting what they believe to be possible child abuse (5). One such case involved a psychologist who
determined that a child had been sexually abused by her father. The father, after being cleared of the child
abuse charges, sued the psychologist for negligence in diagnosing the child's condition. The court ruled in
favor of the psychologist, in part, because "[I]naccurate diagnosis of child abuse which is communicated in
a court proceeding is outweighed by the need to encourage the reporting of child abuse."(6)

Another court of appeals reached a similar result (7). In that case, an employee of the Texas
Department of Human Services requested that a minor female be examined by a doctor. The doctor
concluded that there had been sexual abuse. The father was charged with aggravated sexual abuse. After
that charge was dismissed, the father sued the doctor for negligence as well as for malicious prosecution.
Because there was no physician-patient relationship, the court declined to find a duty owed by the doctor to
the father.

One court may have explained it best, finding that where a life threatening injury was sustained by
the child before the doctor treated him and the doctor had set out an objectively reasonable basis for her
belief that the parent had abused the child, the immunity afforded by the family code is extended to the
doctor.

"Doctors and other health care professionals have an affirmative duty to report suspected
abuse. The law does not require them to be certain abuse has occurred before they
report, but merely "to have cause to believe." Given the language in the statute and the
burden imposed by it, we believe physicians should be afforded deference in reporting
such matters."(8)

It should be noted that an alleged abuser/perpetrator cannot escape liability or criminal prosecution
by simply reporting him/herself (9).

### TFC Sec. 261.106. Immunities

(a) A person acting in good faith who reports or assists in the investigation of a report of alleged child abuse or neglect or
who testifies or otherwise participates in a judicial proceeding arising from a report, petition, or investigation of alleged child
abuse or neglect is immune from civil or criminal liability that might otherwise be incurred or imposed.

(b) Immunity from civil and criminal liability extends to an authorized volunteer of the department or a law enforcement officer
who participates at the request of the department in an investigation of alleged or suspected abuse or neglect or in an action
arising from an investigation if the person was acting in good faith and in the scope of the person's responsibilities.

(c) A person who reports the person's own abuse or neglect of a child or who acts in bad faith or with malicious purpose in
reporting alleged child abuse or neglect is not immune from civil or criminal liability.

iv.) Professionals With Duty To Report

All professionals have a duty to report abuse or neglect. If a professional has cause to believe that
a child has been or abused or neglected, s/he must make a report not later than 48 hours after the
suspicion first arises. This duty to report cannot be delegated to another or abrogated because of the belief
that another has or will make the report.

Additionally, the fact that the information may have surfaced during an otherwise privileged
communication does not relieve the professional of the duty to make the report.
v.) Confidentiality & Privileged Communications

The identity of the “reporter” is always confidential and will only be disclosed: (1) with written approval of the reporter, (2) pursuant to court order, or (3) to law enforcement to aid the investigation.

CPS will redact the information in its file to protect the confidentiality of the identity of the reporter, and any other person whose life or safety may be endangered by disclosure, before providing copies of its files to persons otherwise entitled to the agency records.

TFC Sec. 261.101. Persons Required to Report; Time to Report

(d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

1. as provided by Section 261.201; or
2. to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

TFC Sec. 261.201. Confidentiality and Disclosure of Information

(a) The following information is confidential, is not subject to public release under Chapter 552, Government Code, and may be disclosed only for purposes consistent with this code and applicable federal or state law or under rules adopted by an investigating agency:

1. a report of alleged or suspected abuse or neglect made under this chapter and the identity of the person making the report; and
2. except as otherwise provided in this section, the files, reports, records, communications, audiotapes, videotapes, and working papers used or developed in an investigation under this chapter or in providing services as a result of an investigation.

(b) A court may order the disclosure of information that is confidential under this section if:

1. a motion has been filed with the court requesting the release of the information;
2. a notice of hearing has been served on the investigating agency and all other interested parties; and
3. after hearing and an in camera review of the requested information, the court determines that the disclosure of the requested information:

   A. essential to the administration of justice; and
   B. not likely to endanger the life or safety of:
   i. a child who is the subject of the report of alleged or suspected abuse or neglect;
   ii. a person who makes a report of alleged or suspected abuse or neglect; or
   iii. any other person who participates in an investigation of reported abuse or neglect or who provides care for the child.

(c) In addition to Subsection (b), a court, on its own motion, may order disclosure of information that is confidential under this section if:
(1) the order is rendered at a hearing for which all parties have been given notice;
(2) the court finds that disclosure of the information is:
   (A) essential to the administration of justice; and
   (B) not likely to endanger the life or safety of:
       (i) a child who is the subject of the report of alleged or suspected abuse or neglect;
       (ii) a person who makes a report of alleged or suspected abuse or neglect; or
       (iii) any other person who participates in an investigation of reported abuse or neglect or who provides care for the child; and
(3) the order is reduced to writing or made on the record in open court.

(g) Notwithstanding Subsection (b), the department, on request and subject to department rule, shall provide to the parent, managing conservator, or other legal representative of a child who is the subject of reported abuse or neglect information concerning the reported abuse or neglect that would otherwise be confidential under this section if the department has edited the information to protect the confidentiality of the identity of the person who made the report and any other person whose life or safety may be endangered by the disclosure.

(h) This section does not apply to an investigation of child abuse or neglect in a home or facility regulated under Chapter 42, Human Resources Code.

TFC Sec. 261.202. Privileged Communication

In a proceeding regarding the abuse or neglect of a child, evidence may not be excluded on the ground of privileged communication except in the case of communications between an attorney and client.

vi.) Criminal Penalties For False Reporting

False reports of abuse, especially sexual abuse can be damaging not only to the alleged perpetrator and family, but also to the child. One parent involved in an ongoing and seemingly endless child custody battle made repeated allegations of sexual abuse against the other parent. The child was repeatedly taken for sexual abuse examinations even though no physical evidence was ever found and the child would not confirm the allegations. The repeated examinations began to effect the child such that the possibility of emotional abuse by the alleging parent became a real issue.

Thus it is a criminal offense subject to prosecution by the local prosecution attorney to make a false report. Also, a court in a custody suit may consider a false report as grounds to change custody. In addition, a defendant may be awarded attorney’s fees and other expenses related to the defense of a claim a court finds to be frivolous, unreasonable, or without foundation.

TFC Sec. 261.107. False Report; Penalty

(a) A person commits an offense if the person knowingly or intentionally makes a report as provided in this chapter that the person knows is false or lacks factual foundation. An offense under this section is a Class A misdemeanor unless it is shown on the trial of the offense that the person has previously been convicted under this section, in which case the offense is a state jail felony.

(b) A finding by a court in a suit affecting the parent-child relationship that a report made under this chapter before or during the suit was false or lacking factual foundation may be grounds for the court to modify an order providing for possession of or access to the child who was the subject of the report by restricting further access to the child by the person who made the report.

(c) The appropriate county prosecuting attorney shall be responsible for the prosecution of an offense under this section.

TFC Sec. 261.108. Frivolous Claims Against Person Reporting

(a) In this section:
(1) "Claim" means an action or claim by a party, including a plaintiff, counterclaimant, cross-claimant, or third-party plaintiff, requesting recovery of damages.
(2) "Defendant" means a party against whom a claim is made.

(b) A court shall award a defendant reasonable attorney's fees and other expenses related to the defense of a claim filed against the defendant for damages or other relief arising from reporting or assisting in the investigation of a report under this chapter or participating in a judicial proceeding resulting from the report if:
(1) the court finds that the claim is frivolous, unreasonable, or without foundation because the defendant is immune from liability under Section 261.106; and
(2) the claim is dismissed or judgment is rendered for the defendant.

C. Investigation

i.) Joint Investigations With Law Enforcement
To promote single interviews (and less likelihood of tainted testimony as discussed in the suggestibility section below) and utilized interdisciplinary expertise and participation in child abuse investigation, the legislature amended the Texas Family Code in 1995 to require joint investigations of reports of serious physical or sexual abuse. These investigations are to be conducted jointly by CPS and local law enforcement.

TFC Sec. 261.301. Investigation of Report
(a) With assistance from the appropriate state or local law enforcement agency, the department or designated agency shall make a prompt and thorough investigation of a report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare. The investigation shall be conducted without regard to any pending suit affecting the parent-child relationship.

(f) An investigation of a report to the department of serious physical or sexual abuse of a child shall be conducted jointly by an investigator from the appropriate local law enforcement agency and the department or agency responsible for conducting an investigation under Subchapter E.

(g) The inability or unwillingness of a local law enforcement agency to conduct a joint investigation under Subsection (f) does not constitute grounds to prevent or prohibit the department from performing its duties under this subtitle. The department shall document any instance in which a law enforcement agency is unable or unwilling to conduct a joint investigation under Subsection (f).

ii.) Priorities Of Investigation of Reports
The Department sets priorities in investigating reports of child abuse. This priority system is found in the Texas Administrative Code. Sexual abuse investigations may be assigned either a Priority I or a Priority II. A Priority I investigation must be initiated within 24 hours of receiving the report. A Priority II investigations must be initiated within 10 days of receiving the report.

A report of sexual abuse will typically be assigned a Priority I if the alleged perpetrator is reported to have continued access to the child.

40 TX ADC § 700.505 Priorities for Investigation and Assessment
(a) To establish time frames for investigations, Child Protective Services (CPS) assigns each report of child abuse or neglect to one of two priority groups. CPS must initiate an investigation:
(1) within 24 hours of receiving a Priority I report; and
iii.) Conduct Of The Investigation

An investigation will typically, at a minimum, include speaking with the child and the parent(s). A sexual abuse investigation will involve videotaping the interview with the child unless “good cause” exists for not videotaping, as defined in the Child Protective Services Handbook.

A medical examination, typically an examination by a physician, physician’s assistant, nurse practitioner, or Sexual Assault Nurse Examiner (“SANE”) will be undertaken. These and other medical personnel who are or have been involved with the child may also be interviewed.

iv.) Testing & Acquiring Medical Records

CPS may have a child who is believed to have been sexually abused tested, including HIV testing. The results of such testing are confidential except to the court having jurisdiction of the case involving the child, the foster parent(s), or other person responsible for the child’s care. This information may be invaluable evidence in gaining or maintaining custody of a child alleged to have been sexually abused or in prosecuting an alleged perpetrator.
Medical facilities, or other individuals, who make a report of abuse must release, as part of their report, its records regarding the abuse whether or not they have parental consent or a court order requiring the release of the information. If the department requests records from a hospital or health care provider as part of their investigation, then no fee may be charged for the records.

Parents may be court ordered to undergo a medical, psychological, or psychiatric examination or to turn over their existing mental health records for good cause shown by the Department. A court can only make such orders after notice and a hearing. Access to existing records does not waive confidentiality that may have existed and as such, these records and evidence may not ultimately be admissible at trial.

v. Psychological Evaluations

If a psychological evaluation is ordered or undertaken and neither the trial court nor the psychologist advises the parent that communications made in the course of evaluation would not be privileged, the testimony of the psychologist in termination of parental rights action should not be allowed (10).

To avoid this problem, either the court should advise the parent(s) on the record that communications made in the course of the assessment are not privileged or the order for appointment should require the examiner to give the advisement and/or the examiner should advise the parent that the communications will not be confidential and document the fact that it was given.

TFC Sec. 261.314. Testing

(a) The department shall provide testing as necessary for the welfare of a child who the department believes, after an investigation under this chapter, has been sexually abused, including human immunodeficiency virus (HIV) testing of a child who was abused in a manner by which HIV may be transmitted.

(b) Except as provided by Subsection (c), the results of a test under this section are confidential.

(c) If requested, the department shall report the results of a test under this section to:
   (1) a court having jurisdiction of a proceeding involving the child or a proceeding involving a person suspected of abusing the child;
   (2) a person responsible for the care and custody of the child as a foster parent; and
   (3) a person seeking to adopt the child.

TFC Sec. 261.303. Interference With Investigation; Court Order

(a) A person may not interfere with an investigation of a report of child abuse or neglect conducted by the department or designated agency.

(b) If admission to the home, school, or any place where the child may be cannot be obtained, then for good cause shown the court having family law jurisdiction shall order the parent, the person responsible for the care of the children, or the person in charge of any place where the child may be to allow entrance for the interview, examination, and investigation.

(c) If a parent or person responsible for the child's care does not consent to release of the child's prior medical, psychological, or psychiatric records or to a medical, psychological, or psychiatric examination of the child that is requested by the department or designated agency, the court having family law jurisdiction shall, for good cause shown, order the records to be released or the examination to be made at the times and places designated by the court.

(d) A person, including a medical facility, that makes a report under Subchapter B(1) shall release to the department or designated agency, as part of the required report under Section 261.103, records that directly relate to the suspected abuse or neglect without requiring parental consent or a court order.
TFC Sec. 261.305. Access to Mental Health Records
(a) An investigation may include an inquiry into the possibility that a parent or a person responsible for the care of a child who is the subject of a report under Subchapter B1 has a history of medical or mental illness.

(b) If the parent or person does not consent to an examination or allow the department or designated agency to have access to medical or mental health records requested by the department or agency, the court having family law jurisdiction, for good cause shown, shall order the examination to be made or that the department or agency be permitted to have access to the records under terms and conditions prescribed by the court.

(c) If the court determines that the parent or person is indigent, the court shall appoint an attorney to represent the parent or person at the hearing. The fees for the appointed attorney shall be paid as provided by Chapter 107.

(d) A parent or person responsible for the child's care is entitled to notice and a hearing when the department or designated agency seeks a court order to allow a medical, psychological, or psychiatric examination or access to medical or mental health records.

(e) This access does not constitute a waiver of confidentiality.

TFC Sec. 261.316. Exemption From Fees for Medical Records
The department is exempt from the payment of a fee otherwise required or authorized by law to obtain a medical record from a hospital or health care provider if the request for a record is made in the course of an investigation by the department.

vi.) Children’s Advocacy Centers
Children’s Advocacy Centers (CACs) are agencies designed to coordinate the activities of agencies involved in the investigation of child abuse. One purpose of these centers is to avoid multiple interviews of the child victim. Information regarding the establishment, funding, and duties of CACs is contained in Chapter 264, Subchapter E of the Family Code.

On-site individual and group therapy, forensic interviewing conducted by center staff, and on-site medical exams are services provided through some CACs. The range of services varies from center to center, based on community need, available funding, and the CACs board leadership. Centers generally serve victims of both sexual and physical abuse. The centers have developed protocols for multidisciplinary investigation and prosecution of cases that include steps for conducting forensic interviews. Several centers across the state co-house CPS caseworkers and law enforcement officers.

TFC Sec. 264.405. Duties
A center shall:
(1) assess victims of child abuse and their families to determine their need for services relating to the investigation of child abuse;
(2) provide services determined to be needed under Subdivision(1);
(3) provide a facility at which a multidisciplinary team appointed under Section 264.406 can meet to facilitate the efficient and appropriate disposition of child abuse cases through the civil and criminal justice systems; and
(4) coordinate the activities of governmental entities relating to child abuse investigations and delivery of services to child abuse victims and their families.

TFC Sec. 264.406. Multidisciplinary Team
(a) A center's board shall appoint a multidisciplinary team to work within the center to review new and pending child abuse cases for the purpose of coordinating the activities of entities involved in investigation, prosecution, and victim services.
(b) A multidisciplinary team may review a child abuse case in which the alleged perpetrator does not have custodial control or supervision of the child or is not responsible for the child's welfare or care.

(c) A multidisciplinary team shall consist of persons who are involved in the investigation or prosecution of child abuse cases or the delivery of services to child abuse victims and their families.

(d) A multidisciplinary team shall meet at the call of the board. The board shall call a meeting of the multidisciplinary team if:
   (1) a new child abuse case is received; or
   (2) a pending child abuse case requires attention.

(e) At each meeting, the multidisciplinary team shall discuss each active case and the actions of the entities involved in investigation, prosecution, and victim services.

(f) When acting in the member's official capacity, a multidisciplinary team member is authorized to receive information made confidential by Section 40.005, Human Resources Code, or Section 261.201 or 264.408.

**TFC Sec. 264.407. Liability**

(a) A person is not liable for civil damages for a recommendation made or an opinion rendered in good faith while acting in the official scope of the person's duties as a member of a multidisciplinary team or as a board member, staff member, or volunteer of a center.

(b) The limitation on civil liability of Subsection (a) does not apply if a person's actions constitute gross negligence.

**TFC Sec. 264.408. Use of Information and Records; Confidentiality and Ownership**

(a) The files, reports, records, communications, and working papers used or developed in providing services under this chapter are confidential and not subject to public release under Chapter 552, Government Code, and may only be disclosed for purposes consistent with this chapter. Disclosure may be to:
   (1) the department, department employees, law enforcement agencies, prosecuting attorneys, medical professionals, and other state agencies that provide services to children and families; and
   (2) the attorney for the child who is the subject of the records and a court-appointed volunteer advocate appointed for the child under Section 107.031.

(b) Information related to the investigation of a report of abuse or neglect under Chapter 261 and services provided as a result of the investigation is confidential as provided by Section 261.201.

(c) The department, a law enforcement agency, and a prosecuting attorney may share with a center information that is confidential under Section 261.201 as needed to provide services under this chapter. Confidential information shared with or provided to a center remains the property of the agency that shared or provided the information to the center.

(d) A videotaped interview of a child made at a center is the property of the prosecuting attorney involved in the criminal prosecution of the case involving the child. If no criminal prosecution occurs, the videotaped interview is the property of the attorney involved in representing the department in a civil action alleging child abuse or neglect. If the matter involving the child is not prosecuted, the videotape is the property of the department if the matter is an investigation by the department of abuse or neglect. If the department is not investigating or has not investigated the matter, the videotape is the property of the agency that referred the matter to the center. If the center employs a custodian of records for videotaped interviews of children, the center is responsible for the custody of the videotape. A videotaped interview may be shared with other agencies under a written agreement.

(e) The department shall be allowed access to a center's videotaped interviews of children.

**D. The CPS Case**

i.) **Removal (and Ex Parte Hearing)**

Section 262.105 of the Family Code authorizes the taking of a child by CPS, under certain circumstances, either with or without a court order. In practice, an *ex parte* order based on a sworn
affidavit is generally issued entitling CPS to take possession of an allegedly abused child. If a child is taken without the filing of a petition and an order, then a hearing must be held no later than the first working day after the date the child is taken into possession.

ii.) **Adversary Hearing**

Parents/custodians whose child has been removed pursuant to court order are entitled to a full adversary hearing within 14 days of the date the child was removed. **Section 262.201** sets out the findings the court is required to make if the court is not going to return a child home. The burden of proof is on the Department. It is incumbent upon an attorney to prepare for this “14-day hearing” as she would for any other hearing. The attorney should meet with her client, determine her client’s wishes and proceed accordingly. The attorney should interview witnesses and examine all available evidence. The attorney should not merely show up at the courtroom door at the time of the hearing and ask CPS staff what happened and how they wish to proceed. Such conduct would, in any other case, be malpractice, and it should be considered malpractice in PRS cases as well.

It is important to note that the TFC was amended in 1999 to specifically provide a mechanism for the court to review the need to remove a child after a full adversarial hearing where the requirements of prior emergency removal are difficult to meet but where court intervention may still be required. (11)

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### TFC Section 262.205

(a) In a suit requesting possession of a child after notice and hearing, the court may render a temporary restraining order as provided by Section 105.001. The suit shall be promptly set for hearing.

(b) After the hearing, the court may grant the request to remove the child from the parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession of the child if the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that:

1. reasonable efforts have been made to prevent or eliminate the need to remove the child from the child's home; and
2. allowing the child to remain in the home would be contrary to the child's welfare.

(c) If the court orders removal of the child from the child's home, the court shall:

1. issue an appropriate temporary order under Chapter 105; and
2. inform each parent in open court that parental and custodial rights and duties may be subject to restriction or termination unless the parent is willing and able to provide a safe environment for the child.

(d) If citation by publication is required for a parent or alleged or probable father in an action under this chapter because the location of the person is unknown, the court may render a temporary order without regard to whether notice of the citation has been published.

(e) Unless it is not in the best interest of the child, the court shall place a child who has been removed under this section with:

1. the child’s noncustodial parent; or
2. another relative of the child if placement with the noncustodial parent is inappropriate.

(f) If the court finds that the child requires protection from family violence by a member of the child’s family or household, the court shall render a protective order for the child under Title 4.

iii.) **Status Hearing and Service Plan**

If, at the 14-day hearing, it is determined that the child should stay in CPS custody, CPS is directed to formulate a permanency plan for the child, and prepare a service plan to be reviewed by the court at a 60-day status hearing (12).
TFC 263.202(b)
(b) A status hearing shall be limited to matters related to the contents and execution of the service plan filed with the court. The Court shall review the service plan that the department or other agency filed under this chapter for reasonableness, accuracy, and compliance with requirements for court orders and make findings as to whether:

(1) a plan that has the goal of returning the child to the child’s parents adequately ensures that reasonable efforts are made to enable the child’s parents to provide a safe environment for the child; and

(2) the child’s parents have reviewed and understand the service plan and have been advised that unless the parents are willing and able to provide the child with a safe environment, even with the assistance of the service plan, within the reasonable period of time specified in the plan, the parents’ parental and custodial duties and rights may be subject to restriction or to termination under this code or the child may not be returned to the parents.

It is very important to review the service plan in advance of the status hearing to see if it addresses the issues giving rise to the removal. CPS is required to file a service plan with the court within 45 days of the conclusion of the adversary (14-day) hearing. The service plan must comply with the requirements of Subchapter B, TFC Chapter 263, as well as with the CPS policy manual. Specifically:

TFC 263.102
(a) The service plan must:
(1) be specific;
(2) be in writing;
(3) be prepared by the department or other agency in conference with the child’s parents;
(4) state appropriate deadlines;
(5) state whether the goal of the plan is:
   (A) return of the child to the child’s parents;
   (B) termination of parental rights and placement of the child for adoption; or
   (C) because of the child’s special needs or exceptional circumstances, continuation of the child’s care out of the child’s home;
(6) state steps that are necessary to:
   (A) return the child to the child’s home if the placement is in foster care;
   (B) enable the child to remain in the child’s home with the assistance of a service plan if the placement is in the home under the department’s or other agency’s supervision; or
   (C) otherwise provide a permanent safe placement for the child;
(7) state the actions and responsibilities that are necessary for the child’s parents to take to achieve the plan goal during the period of the service plan and the assistance to be provided to the parents by the department or other authorized agency toward meeting that goal;
(8) state the name of the person with the department or other agency whom the child’s parents may contact for information relating to the child if other than the person preparing the plan; and
(9) prescribe any other term or condition that the department or other agency determines to be necessary to the service plan’s success.

(b) The service plan shall include the following statement:
TO THE PARENT: THIS IS A VERY IMPORTANT DOCUMENT. ITS PURPOSE IS TO HELP YOU PROVIDE YOUR CHILD WITH A SAFE ENVIRONMENT WITHIN THE REASONABLE PERIOD SPECIFIED IN THE PLAN. IF YOU ARE UNWILLING OR UNABLE TO PROVIDE YOUR CHILD WITH A SAFE ENVIRONMENT, YOUR PARENTAL AND CUSTODIAL DUTIES AND RIGHTS MAY BE RESTRICTED OR TERMINATED OR YOUR CHILD MAY NOT BE RETURNED TO YOU. THERE WILL BE A COURT HEARING AT WHICH A JUDGE WILL REVIEW THIS SERVICE PLAN.

(c) If both parents are available but do not live in the same household and do not agree to cooperate with one another in the development of a service plan for the child, the department in preparing the service plan may provide for the care of the child in the home of either parent or the homes of both parents as the best interest of the child requires.
The CPS Handbook dictates, with some limited exceptions, that the service plan be formulated with the parties to meet the needs of the parties as well as any conditions CPS may wish to impose (14). Attorneys may accompany their clients to the CPS office to assist in formulating a service plan for the parents and the children.

iv.) PPT (Permanency Planning Team) Meetings

Furthermore, the parties, their attorneys, the foster parents, therapist, caseworkers and supervisors, PPT convenors (who facilitate the meetings) and the children may attend all Permanency Planning Team meetings held at the CPS office to review service plans and address issues involved in the case. PPTs are, in theory, meetings to discuss case planning issues, which may include:

- the progress made in completing tasks and achieving goals specified in the last case plan,
- tasks and goals to be specified in the next case plan
- the appropriateness of the child’s current placement, and
- the child’s permanency plan

These meetings were originally intended to comply with the requirements of Section 427 of Title IV-B of the Social Security Act, and pursuant to that provision had to be held every 6 months, preferably prior to court review. They should be convened by a neutral party who is not in the line of management for the child’s care. PPTs can either be used to resolve issues or they can be simply be a “going through the motions” proceeding. When used to expose, address and resolve issues, these meeting can be invaluable to a prompt resolution to the case and as a information gathering tool for the CPS attorney.

v.) Permanency Hearings

These hearings, conducted pursuant to the provisions of TFC § 263.306, begin six months following the award of Temporary Managing Conservatorship to TDPRS, and are held at four-month intervals thereafter. These hearings are ongoing opportunities for the courts to review the appropriateness of a child’s placement and the actions which have been taken by the parties pursuant to temporary orders and the service plan, as well as--

the efforts of the department or another agency in
(A) attempting to locate all necessary persons;
(B) requesting service of citation; and
(C) obtaining the assistance of a parent in providing information necessary to locate an absent parent (15)

and

the department’s efforts to identify relatives who could provide the child with a safe environment, if the child is not returned to a parent or another person or entity . . .(16)

The requirements of the family code mandate that at each permanency hearing, the court shall determine he dismissal date, next permanency hearing date, and trial date and give notice thereof in open court (17). This hearing should not simply be a rehashing of the facts originally presented to the court. Each permanency hearing should be a reevaluation of what is necessary to achieve permanency for the child. Chapter 263 of the Family Code, which governs the permanency hearing, was revamped in 1997 to focus on the need for permanency for the child.
Under both 42 U.S.C.A. §§ 670-672 and the Texas Family Code, CPS is required to show that they did, in fact, make reasonable efforts to avoid having to remove the child (with some exceptions under certain circumstances). Again, the CPS Handbook is extremely helpful in making this determination, since it specifies other alternatives to court intervention and removal, e.g. Intensive Family Preservation, Family Preservation, In-home services, homemaker services, voluntary placements, etc.

vi.) Permanency Progress Reports

These reports are filed with the court prior to each permanency hearing. These reports should be reviewed and, if necessary returned to the caseworker (prior to filing) for any additions, modifications, deletions, etc. to ensure that the report complies with the requirements of § 263.303. This report must be filed “not later than the 10th day before the date set for each permanency hearing . . .” Any parent, parent’s attorney, or ad litem may file a response to the report “not later than the third day before that date of the hearing.”

A final order or an extension must be entered in CPS cases no later the Monday after the first anniversary of the order appointing PRS as Temporary Managing Conservator (TMC) or the case shall be dismissed by the court. A one-time extension of 180 days or less may be granted by the court (18). A final order is one that:
1. requires that a child be returned to the child’s parent;
2. names a relative of the child or another person as the child’s managing conservator;
3. without terminating the parent-child relationship, appoints the department as the managing conservator of the child; or
4. terminates the parent-child relationship and appoints a relative of the child, another suitable person, or the department as managing conservator of the child (19).

vii.) Placement Review Hearings

If a final order is entered which awards Permanent Managing Conservatorship to PRS, the court must hold Placement Review Hearings at least once every six months until the child either becomes an adult or is adopted (in the case of termination of parental rights). TFC Section 263.501 provides that the following persons are to be notified of these hearings:
(1) the department;
(2) the foster parent or director of the group home or institution in which the child is residing;
(3) each parent of the child;
(4) each possessory conservator or guardian of the child;
(5) the child’s attorney ad litem and volunteer advocate, if the appointments were not dismissed in the final order; and
(6) any other person or agency named by the court as having an interest in the child’s welfare (20).

A report must be filed for these hearings similar to the report filed prior to permanency hearings. At the Placement review hearing, the court is to determine whether:
(1) the child’s current placement is appropriate for meeting the child’s needs;
(2) efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child if the child is placed in institutional care;
(3) the services that are needed to assist a child who is at least 16 years of age in making the transition from substitute care to independent living are available in the community;
(4) other plans or services are needed to meet the child’s special needs or circumstances; and
(5) the department or authorized agency has exercised due diligence in attempting to place the child for
adoption if parental rights to the child have been terminated and the child is eligible for adoption
(21).

In most cases, efforts to achieve permanency, other than continuation in CPS care and custody
should continue after a final order has been entered naming PRS as a child’s Managing Conservator.
Therefore, Placement Review Hearings are an essential part in continuing to strive for “real”, as opposed to
“legal” permanency for every child that comes into CPS care.

viii.) Legal Representation of the Department in CPS cases

The practitioner working on a child abuse case should be aware that CPS may be represented by
any of four legal representatives: the District Attorney’s Office, the County Attorney’s Office, the Office of
the Attorney General or an attorney deputized by the Attorney General who may be a TDPRS employee.

The practitioner should not assume that because they have been working with and turning
information and evidence over to a criminal prosecutor that the information is also being given to an
attorney representing the Department in a civil child abuse case. It is not uncommon for the civil prosecutor
to never see or be aware of the evidence that has been turned over to a criminal prosecutor by a
practitioner. Please ask if a criminal prosecution has a companion civil custody case and if so, contact that
attorney to ensure that s/he also has the information you have previously turned over to the prosecutor.

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<tr>
<th>TFC  Sec. 264.009. Legal Representation of Department</th>
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<tr>
<td>(a) Except as provided by Subsection (b), (c), or (f), in any action under this code, the department shall be represented in</td>
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<td>court by the county attorney of the county where the action is brought, unless the district attorney or criminal district attorney</td>
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<td>of the county elects to provide representation.</td>
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<td>(b) If the county attorney, district attorney, or criminal district attorney is unable to represent the department in an action under</td>
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<td>this code because of a conflict of interest or because special circumstances exist, the attorney general shall represent</td>
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<td>the department in the action.</td>
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<td>(c) If the attorney general is unable to represent the department in an action under this code, the attorney general shall</td>
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<td>deputize an attorney who has contracted with the department under Subsection (d) or an attorney employed by the department</td>
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<td>under Subsection (e) to represent the department in the action.</td>
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<td>(d) Subject to the approval of the attorney general, the department may contract with a private attorney to represent the</td>
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<td>department in an action under this code.</td>
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<td>(e) The department may employ attorneys to represent the department in an action under this code.</td>
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<td>(f) In a county with a population of 2.8 million or more, in an action under this code, the department shall be represented in</td>
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<td>court by the attorney who represents the state in civil cases in the district or county court of the county where the action is</td>
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<td>brought. If such attorney is unable to represent the department in an action under this code because of a conflict of interest or</td>
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<td>because special circumstances exist, the attorney general shall represent the department in the action.</td>
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E. Child Statements

i.) Interviewing
Questions directed to a child must be open-ended and non-verbal communication (such as approving, affectionate pats, demonstrative use of dolls, refusal to accept undesired answers) and should not lead a child to a particular statement (22).

The reader should consult the Texas Evidence Collection Protocol for an expanded discussion of this and related issues.

ii.) Child Suggestibility Legal Issues
An area of research that has boomed over the last two decades is that having to do with proper child interview techniques and the effect of suggestion on children.

Children do get sexually abused. Some children who allege sexual abuse do lie. However, some children who allege sexual abuse do believe it occurred even if it has not. Some children internalize information elicited during interview processes. Some false allegations can be explained by an understanding of child memory patterns, children’s need to be good conversationalists, and how children conceptualize certain external stimuli.

Experts in the field of child suggestibility have identified circumstances in which child suggestibility should be most scrutinized. According to Dr. Stephen J. Ceci and Dr. Maggie Bruck, it is of the utmost importance to examine the conditions prevalent at the time of a child’s original report about a criminal event in order to judge the suitability of using that child as a witness in the court. Prosecuting attorneys and attorneys representing the Department will likely examine the following in evaluating the possibility of suggestibility:

- the circumstances under which the initial report was made,
- how many times the child was questioned,
- the hypotheses of the interviewers who questioned the child,
- the kinds of questions the child was asked,
- the consistency of the child’s report over a period of time,
- whether child’s disclosure was made in a nontreating, nonsuggestible atmosphere,
- whether or not the disclosure was made after repeated interviews,
- whether or not the adults who had access to the child prior to his or her testimony are motivated to distort the child’s recollections through relentless and potent suggestions and outright coaching, and
- whether or not the child’s original report remains highly consistent over a period of time.

The evaluation of these circumstances would not, in and of itself, invalidate a child’s testimony, but it are likely to raise cautions in the mind of the court (23).

As to the interviewer’s influence on a child, Ceci and Bruck found, in their studies on interviewing, evidence that suggestibility effects are influenced by the dynamics of the interview itself, the knowledge or beliefs possessed by the interviewer (especially one who is unfamiliar with the child), the emotional tone of the questioning, and the props used. Children attempt to be good conversational partners by complying with what they perceive to be the belief of their questioner. Their perceptions, and thus their suggestibility, may be influenced by subtle aspects of the interview such as the repetition of yes-no questions, but their
compliance is evidenced most fully in naturalistic interview situations in which the interviewer is allowed to question the child freely; this gives the child the evidence to make the necessary attributions about the purposes of the interview and about the intents and beliefs of the interviewer. Ceci and Bruck identify as one of the pitfalls in the legal arena, the fact that children are usually questioned repeatedly within and across sessions, sometimes about an ambiguous event by a variety of interviewers, each with their own agenda and beliefs. Children are sometimes interviewed formally and informally for many months preceding an official law-enforcement interview with anatomical dolls, providing an opportunity for the child to acquire scripted and stereotypical knowledge about what might have occurred (24). Therefore, it is of crucial importance to a prosecutor that s/he examine the circumstance of an interview and the interviewer prior to making a decision to introduce child testimony in the forensic setting.

Some questionable interviewing techniques that have been identified are:

- leading questions
- stereotype inducements - painting the alleged perpetrator as a “bad person”
- selective reinforcements - rewarding the provision of certain types of information
- guided imagery - e.g., the use of anatomical dolls or drawings
- peer pressure (or “cross germination”) - peer pressure or interaction with other children has effects on the accuracy of what the child reports (25)

It has been suggested, however, that the concerns identified by the current research on child suggestibility presents a distorted picture of suggestibility problems in the typical case, in which interviews are likely less coercive and children less vulnerable to suggestion (26).

**The Attorney’s Focus in Proposing and Opposing Admissibility of Suggestibility Testimony**

Expert testimony on child suggestibility is admissible under *Daubert* criteria (discussed below) (27). However there are two aspects of such testimony that would be objectionable. As an opponent of the introduction of such testimony, considers the following:

- Does the testimony attempt to comment on the credibility of the child?
- Does testimony, suggesting a practice of suggestibility in the case, attempt to link those practices to the credibility of the particular child?

If either of the above is the proposed subject of testimony, a proper objection should be made to preserve error on appeal. *Case law provides that an expert may not testify as to the credibility of the child witness.* Assessing the reliability or credibility of a victim’s accusations is the exclusive function of the jury (28). Further, if an expert is allowed to testify to whether there was a practice of suggestibility employed in a particular case, objection can be made to any inference that the employment of any questionable techniques caused a particular witness to give false or manufactured testimony (29).

In the highly publicized *Kelly Michaels* case (involving allegations of sexual abuse of children by a nursery school teacher), the New Jersey Supreme Court held that if a criminal defendant demonstrates a substantial likelihood that a child witness’s testimony was the product of pretrial suggestion, the child cannot be called to testify unless the state provides clear and convincing evidence that the testimony is reliable (30).

Constitutional “due process” rights may also be asserted when evidence admitted for criminal conviction is tainted by suggestion. The United States Supreme Court held in *United States v. Wade*, in
overturning a conviction of a defendant who was identified by a witness who had made previous identification under suggestive conditions, that reversal is mandated when the totality of the circumstances indicates that the “procedure was so impermissibly suggestive as to give rise to a substantial likelihood of irreparable misidentification” (31). This same argument can be used by analogy to interview statements given by children in criminal cases involving child sexual abuse.

iii.) **Use Of Anatomical Dolls**

Anatomically Correct Dolls are designed to represent the physical anatomy of males and females, and adults and children. The adult male doll has distinct developmental characteristics such broad shoulders, slender hips, and possibly facial hair. The male doll also has a penis, and testicles within the scrotum. The adult female doll exhibits the distinct developmental characteristics of a woman. The female doll has small shoulders and usually broader and rounder hips compared to that of the male doll. The adult female doll also has breasts (some with nipples) and a vagina and/or vaginal cavity. The dolls have buttocks and a few have a rectum. Some of the adult dolls exhibit pubic hair. The dolls usually have movable body parts.

The anatomically correct doll had been traditionally most widely accepted in the field of mental health as a therapeutic assessment and intervention instrument used with children. The use of anatomically correct dolls gained widespread popularity among many mental health professionals who provide assessment and treatment to children, particularly children with a history of sexual abuse, sexual molestation, or incest. They have also been used to assist in the disclosure of a child sexual abuse and to help in the judicial process of proving that a child has been the victim of sexual abuse (32).

Recent research has shown, however, that the use of anatomical dolls as an assessment tool for sexual abuse is riddled with problems. For this reason, Anatomical Dolls should be used in the therapeutic context only and not in the forensic arena due to the high probability of suggestibility in children.

Interpretations of the responses to anatomically correct dolls do not have regional or national statistical psychometric properties. There are no correct or incorrect answers, and no numerical scores based on the interpretation of the responses. Despite the lack of standardization, anatomically correct dolls, have been and continue to be used as an assessment instrument for suspected sexual abuse among children, with responses subject only to the interpretation of the clinician evaluating the child.

Although it has been widely accepted in the past that the way a child responds to, or plays with an anatomically correct doll may be indicative of sexual abuse, current research provides a number of alternative explanations as to why children may engage in what appears to be sexualized play with these dolls:

- the simple curiosity of children during play may cause them to insert their fingers into the anal or genital cavities or try to fit the dolls together just as they would with holes in other toys (33);
- the dolls may be thought of as just a toy in the child’s mind and thus be used by the child as mere fantasy play (34);
- younger children sometimes cannot understand how the dolls are to be used as symbolic of themselves (their thinking is more concrete) and therefore cannot use the dolls to roleplay themselves in an event (35); and
- the suggestibility of children is found to occur with the use of dolls for interviewing and assessments (36).
Stephen J. Ceci conducted a study that entailed children being examined by a pediatrician on video and then recounting the examination with the use of anatomically detailed dolls. The study showed that children not only failed to accurately recount the examination, but, in some cases, also vastly exaggerated the event. One little girl involved in the study recounted that the pediatrician wrapped a string around her neck tightly and inserted something into her vaginal cavity, both completely untrue.

Therefore, while anatomically correct dolls may still questionably be appropriate for use in child therapy or to elicit the child’s terminology for body parts, they should never be used to determine if sexual abuse has occurred or whether the child perceives that abuse occurred (37). Furthermore, the use of anatomically correct dolls should be avoided by professionals who have little or no training in their use because of the potential for inducing serious error. The American Psychological Association is quoted as stating:

*There are no uniform guidelines for using [Anatomical Dolls (AD)] and no evidence that the dolls should be viewed as a psychological or diagnostic test . . . To elevate AD to the status of a psychological test grants implications of utility and benefit that are undeserved and without basic foundation. Concern about the misinterpretation of children’s behavior with dolls began with studies of how abused and nonabused children respond to AD dolls. In almost every study, some nonabused children inspected and touched sexual body parts (38).*

Another area of concern has been that the dolls, while anatomically detailed, are not anatomically correct. The genitals are often oversized, which may lead the child to believe that in order to satisfy the interviewer he or she should say something about the genitals (39).

**The Attorney’s Focus in Proposing and Opposing Admissibility of Testimony Regarding Anatomical Dolls.** While the use of anatomically correct dolls is still popular among many mental health professionals, there is minimal literature that identifies the standardization, norms, reliability, and validity of dolls as an assessment instrument for children who have been victims of sexual abuse. According to the literature there is no standardized data on the use of anatomically correct dolls. In addition, there are no uniformed standards for conducting clinical interviews with the anatomically correct dolls (40). Furthermore, the American Professional Society on the Abuse of Children (APSAC) has issued a policy statement indicating that caution should be exercised in the use of anatomical dolls and that they should not be used as a diagnostic tool or considered conclusory evidence that sexual abuse has occurred (41). Thus, the use of anatomical dolls may be subject to challenge on Daubert grounds for lack of reliability and validity.

One Texas court, that ruled on the admissibility of testimony regarding anatomical dolls, held that such testimony was admissible under the circumstances of that case (42). The Defendant challenged the admissibility of the testimony asserting that (1) their scientific reliability was not established, (2) they were overly suggestive to the child and prejudicial to the [Defendant], and (3) it was not established that the dolls were anatomically correct. The court, in holding that this testimony was properly admitted, found that reliability, under *Kelly v. State*, 824 S.W.2d 568 (Tex. Crim. App. 1992), only applied to novel scientific evidence. In addition, the court found that since the testimony was limited to a description of the use of the dolls during the interview of the child and did not describe what the child said or did with the dolls, that this evidence did not bolster the child’s credibility. The court implied harmless error in stating that “we fail to see how a description of the interview process could be more prejudicial than the direct, unequivocal
testimony of [Defendant’s] eight-year-old stepdaughter, the mother’s account of the incident, or [the
doctor’s] narration of the details as related to him by the child." (43)

In Reyna v. State, 797 S.W.2d 189 (Tex.App.BCorpus Christi 1990), the court of appeals ruled that
the use of anatomically correct dolls as demonstrative evidence was not improper. In that case, each child
used the dolls to identify the areas of the body during her testimony. Furthermore, the court found it
“noteworthy that appellant did not object to the use of the dolls on the ground that the State had not met the
‘Kelley Frye’ test; his objections were that the use of the doll was suggestive and that they were trained in
their use. Appellants’s objection on appeal does not comport with his objection at trial. Therefore, his claim
is not properly before this court for review.” (44)

In another Texas case, in which the use of anatomical dolls is raised on appeal, Matz v. State, 989
S.W.2d 419 (Tex.App.BFort Worth 1999, pet. granted 10/20/99), the issue of admissibility was not
addressed because the issue was not properly preserved for appeal.

Other jurisdictions, however, in directly addressing the issue of the admissibility of anatomical dolls,
have found that testimony regarding their use is inadmissible. A California Court of Appeals, in In re Amber
B., 191 Cal.App.3d 682, 236 Cal. Rptr. 623 (Cal.App. 1st Dist. 1987), ruled that the use of anatomical dolls
did not meet the Frye standard for admissibility. In State v. Mueller, 344 N.W.2d 262 (Iowa App. 1983), the
Iowa Court of Appeals ruled that admitting the testimony of a psychologist interpreting a child’s behavior
with dolls as showing sexual abuse has occurred amounted to nonverbal hearsay and was reversible error.
The 9th Circuit circumspectly ruled on the issue in U.S. v. Gillespie, 852 F.2d 475 (9th Cir.(Cal.) 1988),
holding that expert opinion based on play therapy with anatomically correct dolls must be preliminarily
supported by evidence to establish scientific reliability in order to meet the Frye test for admissibility (45).

The best trial strategy, when the use of anatomical dolls is at issue, may be to find another method
of addressing the sexual abuse issue without reference to having used the dolls. Another option is to argue
that the dolls are not being used to prove that abuse occurred but rather as demonstrative evidence. In
either case, once the use of anatomical dolls (in the interview process or in therapy) has been raised, you
may still find yourself having to overcome the hurdle of proving that such use is not suggestive.

F. Proof at trial

i.) Admissibility Of Child Statements

Most prosecutors will make every attempt not to have to have a child testify in court. Such a task
can be daunting for adults and must be extremely frightening for children. However, there are times when
evidence of the abuse cannot be introduced to the court without the testimony of the child victim.

The statement of the child may be an issue involving a number of concerns including child
suggestibility, ability of the child to clearly communicate events, interviewer techniques, and other external
situations that may be influencing the child (e.g., pending divorce, increased household discipline, or sexual
promiscuity). Children do sometimes make false allegations of sexual abuse. A child’s credibility may be
considered questionable given their tendency to retract their initial story and the possibility that s/he had
been coached or programmed (46).
A child called to testify must be shown to be competent. Children will only be found incompetent if “after being examined by the court, [they] appear not to possess sufficient intellect to relate transactions with respect to which they are interrogated.” Texas Rules of Evidence (“TRE”) 601(a)(2). For example, where a five-year-old victim of sexual assault answered questions coherently, the fact that she had difficulty placing events in a time frame and gave answers that were conflicting and showed confusion does not mean she was an incompetent witness (47).

If a child’s testimony is necessary, the Texas Family Code offers alternatives to facilitate the process and minimize harm to the child.

**TFC Sec. 104.001. Rules of Evidence**
Except as otherwise provided, the Texas Rules of Civil Evidence apply as in other civil cases.

**TFC Sec. 104.002. Prerecorded Statement of Child**
If a child 12 years of age or younger is alleged in a suit under this title to have been abused, the recording of an oral statement of the child recorded prior to the proceeding is admissible into evidence if:
1. no attorney for a party was present when the statement was made;
2. the recording is both visual and aural and is recorded on film or videotape or by other electronic means;
3. the recording equipment was capable of making an accurate recording, the operator was competent, and the recording is accurate and has not been altered;
4. the statement was not made in response to questioning calculated to lead the child to make a particular statement;
5. each voice on the recording is identified;
6. the person conducting the interview of the child in the recording is present at the proceeding and available to testify or be cross-examined by either party; and
7. each party is afforded an opportunity to view the recording before it is offered into evidence.

**TFC Sec. 104.003. Prerecorded Videotaped Testimony of Child**
(a) The court may, on the motion of a party to the proceeding, order that the testimony of the child be taken outside the courtroom and be recorded for showing in the courtroom before the court, the finder of fact, and the parties to the proceeding.
(b) Only an attorney for each party, an attorney ad litem for the child or other person whose presence would contribute to the welfare and well-being of the child, and persons necessary to operate the equipment may be present in the room with the child during the child's testimony.
(c) Only the attorneys for the parties may question the child.
(d) The persons operating the equipment shall be placed in a manner that prevents the child from seeing or hearing them.
(e) The court shall ensure that:
1. the recording is both visual and aural and is recorded on film or videotape or by other electronic means;
2. the recording equipment was capable of making an accurate recording, the operator was competent, and the recording is accurate and is not altered;
3. each voice on the recording is identified; and
4. each party to the proceeding is afforded an opportunity to view the recording before it is shown in the courtroom.

**TFC Sec. 104.004. Remote Televised Broadcast of Testimony of Child**
(a) If in a suit a child 12 years of age or younger is alleged to have been abused, the court may, on the motion of a party to the proceeding, order that the testimony of the child be taken in a room other than the courtroom and be televised by closed-circuit equipment in the courtroom to be viewed by the court and the parties.
(b) The procedures that apply to prerecorded videotaped
testimony of a child apply to the remote broadcast of testimony of a child.

**TFC Sec. 104.005. Substitution for In-Court Testimony of Child**

(a) If the testimony of a child is taken as provided by this chapter, the child may not be compelled to testify in court during the proceeding.

(b) The court may allow the testimony of a child of any age to be taken in any manner provided by this chapter if the child, because of a medical condition, is incapable of testifying in open court.

**TFC Sec. 104.006. Hearsay Statement of Child Abuse Victim**

In a suit affecting the parent-child relationship, a statement made by a child 12 years of age or younger that describes alleged abuse against the child, without regard to whether the statement is otherwise inadmissible as hearsay, is admissible as evidence if, in a hearing conducted outside the presence of the jury, the court finds that the time, content, and circumstances of the statement provide sufficient indications of the statement's reliability and:

1. the child testifies or is available to testify at the proceeding in court or in any other manner provided for by law; or
2. the court determines that the use of the statement in lieu of the child's testimony is necessary to protect the welfare of the child.

A child's out-of-court statement describing abuse or identifying a perpetrator would ordinarily be inadmissible as hearsay if offered for the truth of the matter asserted. The alternatives summarized below authorize admission of this type of evidence, if the requisite statutory criteria are met:

- **Excited Utterance — Hearsay Exception TRE 803(2)**
  
  An excited utterance is a statement relating to a startling event or condition made while the child was under the stress of excitement caused by the event or condition.

  **Example:**
  - Two-and-one-half-year-old's statement to social worker that defendant burned her with hot water in bathtub, made soon after worker's arrival at the hospital, admissible as spontaneous exclamation, based on proximity of statement to injury, severity of injuries and child's behavior (restless, crying and fighting the intravenous medication). Though given in response to questions, the child's age, fear and pain make it improbable the answer was falsified. *Woodard v. State*, 696 S.W.2d 622, 626 (Tex. App.—Dallas 1985, no pet.).

- **State of Mind — Hearsay Exception TRE 803(3)**
  
  This is a statement by the child that indicates the child's then existing state of mind, emotion, sensation, or physical condition (such as intent, plan, motive, design, mental feeling, pain, or bodily health), but not including a statement of memory or belief to prove the fact remembered or believed.

  **Examples:**
  - Children's statement concerning their desire to be adopted admissible under state of mind exception to hearsay and relevant to show whether mother's conduct had endangered their emotional well-being. *Melton v. Dallas County Child Welfare Unit of Texas Dept. of Human Resources*, 602 S.W.2d 119, 121-122 (Tex. Civ. App.—Dallas 1980, no writ).
  - Child's statement that he had been beaten, was afraid he would be beaten again and that the children had seen letters and photographs described as sexually explicit admissible in termination of parental rights action to show child's state of mind. *Baxter v. Texas Dept. of Human Resources*, 678 S.W.2d 265, 267 (Tex. App.—Austin 1984, no writ).
  - Child's statement, "[g]ive me your doll, and I'll show you with mine how daddies sex their little girls" not offered to prove truth of statement but to show emotional well-being and state of mind relevant in termination of parental rights action based on endangerment. *Posner v. Dallas County Child Welfare Unit of the Texas Dept. of Human Services*, 784 S.W.2d 585, 587 (Tex. App.—Eastland 1990, writ denied).
“State of mind” exception does not extend to statements of past external facts or conditions, such as testimony of child’s father, stepmother and the police officer regarding child’s complaint of alleged sexual abuse. *Ochs v. Martinez*, 789 S.W.2d 949, 959 (Tex. App.—San Antonio 1990, writ denied).

Children’s statements describing sexually and emotionally abusive conduct of their parents unrelated to state of mind and parent’s conduct, not children’s state of mind, was relevant. *James v. Texas Dept. of Human Services*, 836 S.W.2d 236, 243 (Tex. App.—Texarkana 1992, no writ).

- **Statement Made for Medical Diagnosis – Hearsay Exception TRE 803(4)**
  These are statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment. This will be the most often used exception to introduce statements made by a child to a medical professional that would otherwise be considered hearsay and inadmissible.

  **Examples:**
  - Testimony of sexual assault nurse regarding statements children made identifying abuser was pertinent to physical and psychological treatment and diagnosis. *In the Interest of L.S.*, 748 S.W.2d 571, 576 (Tex. App.—Amarillo 1988, no writ).
  - Hospital records (affidavit of treating physician, progress report, consultation report, nurses’ reports and discharge summary) relating to medical personnel’s prognosis, diagnosis, progress and causation and source of child’s burn and bruise injuries admissible collectively under Rule 803 (4) (statement for purpose of medical diagnosis), Rule 803 (6) (business records) and Rule 805 (hearsay within hearsay not excluded if hearsay exception applies to each). *Ziegler v. Tarrant County Child Welfare Unit*, 680 S.W.2d 674, 679-680 (Tex. App.—Fort Worth 1984, writ ref’d n.r.e.).

- **Party Opponent Admission - TRE 801(e)(2)**
  To the extent a parent has made a statement to a caseworker, doctor or other witness, in most instances, it is not excludable on hearsay grounds. A statement that is offered against a party that is his own statement, or one he has manifested his adoption or belief in, or one made by a person authorized by him or by an agent or co-conspirator is not hearsay.

  **Example:**
  - A statement made by defendant to clinical social worker regarding his explanation for the child’s injuries is a party opponent admission and not excludable as hearsay. *Barcenes v. State*, 940 S.W.2d 739, 748 (Tex. App. — San Antonio 1997, pet. ref’d).

**ii.) Admissibility Of Documentation (Foundations)**

Often, key evidence will only be admissible through the introduction of documentary evidence. Other times, the introduction of such evidence may be importance to the case simply because it allows the
jury to actually view the events or circumstances described. As the old cliché goes, a picture is often worth a thousand words.

In order to have documentary or tangible evidence admitted, an attorney must “lay the foundation” for admissibility. In plain terms, the attorney must ask certain questions and receive affirmative responses to those questions before a judge will allow tangible items into evidence. As a witness, you should be familiar with the following foundations and advise the attorney if you are for any reason unable to respond affirmatively to a given foundation question.

• **Business Records Exception - TRE 803 (6).**
  With a properly executed affidavit of custodian, business records are self-authenticating. Rule 902 (10). Records of regularly conducted activity are not excludable on hearsay grounds if a foundation can be laid (either by affidavit or testimony) that:
  1. the record was made in and kept in the course of a regularly conducted business activity;
  2. it was the regular practice of the business to make such record;
  3. the record was made at or near the time of the event recorded;
  4. the record was made by or from information provided by a person with knowledge, acting in the regular course of business.

• **Photographs**
  1. The witness’s familiarity with the subject of the photo at the relevant time
  2. The photo “accurately represents (or depicts)” the subject at the relevant time (or describe any changes).

• **Tangible Object**
  1. Witness identify object (showing relevance, if necessary).
  2. Is the item in the same or similar condition as at the time of the occurrence in question?
  3. If there may be a question regarding misidentification or contamination, establish chain of custody, e.g.:
  4. How did it come into your possession?
  5. Describe where the item has been since the time of the occurrence, and who had access to it
  6. Has it been altered or tampered with?
  7. Has anyone else had access to it while in your control?
  8. (If applicable): Are there identifying marks on the item (or on the container) indicating that it is what you say it is?
  9. (If the witness knows): Does it appear to be in substantially the same condition?

• **Private Writing (contract, memo, letter, deed, &c.)**
  1. The witness identifies document
  2. (If applicable): The witness identifies signature or other handwriting by one of these methods:
  3. The witness signed or saw the signing; or
  4. The witness is familiar with the handwriting
  5. Familiarity and relationship with writer
  6. When, where and how often seen his/her handwriting or signature
  7. Identification of signature or writing as that of the person in question
  8. (If signed as an agent): authority of signer
  9. (If necessary): Signature may be authenticated by expert testimony or comparison by jury
• Letter Sent by Proponent's Witness
  1. Witness identify the exhibit as a carbon or photocopy of the original
  2. The witness dictated (or otherwise prepared) the letter
  3. The witness saw original and copy (Exhibit) before mailing
  4. The witness signed original
  5. The original letter was placed in a properly addressed envelope, bearing a proper return address and proper postage
  6. The envelope was deposited in a U.S. mail box
  7. The original letter was never returned

• Reply Letter
  1. Witness identify the document
  2. It was received in the mail (state when)
  3. It was in response to previous correspondence
  4. The name of the purported signer

• Computer Printout
  In addition to the necessary business record or public record hearsay predicate described above:
  1. The witness has knowledge of how the computer system operates
  2. The type of computer used and that it is reliable for the purposes for which used
  3. The computer operator(s) was/were competent to operate it and did so in the regular course of their duties
  4. The procedure for input and output of information (including checks for accuracy)
  5. Usual business records or official records predicate

• Audiotape or Videotape Recording
  1. The recording device was capable of recording sound (& pictures, if video)
  2. The operator was competent
  3. The recording is correct and authentic
  4. There are no changes, deletions or additions
  5. Describe how the recording was preserved
  6. State the identify of the speakers
  7. State whether the statements on the tape were made voluntarily

• Visual Aid (chart, model, blackboard, &c.)
  1. The witness is familiar with the thing portrayed
  2. Identify what is portrayed
  3. It is a correct representation of the thing portrayed
  4. Who prepared it — and if someone else did, state that the witness has personal knowledge that it accurately represents the underlying data

• Present Recollection Refreshed (when the witness can't recall a fact and the attorney wishes to use a document to refresh the witness's recollection)
  1. The witness cannot presently recall the fact
  2. The writing (or other object) would refresh the witness’s recollection
  3. Show the writing (or object) to the witness and ask the witness to read (or examine) silently
  4. Ask whether it refreshes recollection
  5. Ask questions regarding the fact

• Past Recollection Refreshed
  1. The witness once had personal knowledge of the fact
2. The record was made or adopted by the witness when the matter was fresh in his/her memory
3. The record reflects correctly the witness’s prior knowledge
4. The witness now has insufficient recollection to allow him/her to testify fully and accurately

- **X-Ray (As Photograph)** (For introduction by treating physician)
  1. The witness is familiar with the patient’s physical condition on the date the x-ray was made
  2. The x-ray was taken by a qualified technician or doctor
  3. Identify x-ray by patient, date, and part of body
  4. The x-ray fairly and accurately shows the condition of that part of the patient’s body at that time

- **X-Ray (As Business Record)** (For introduction by any records custodian)
  1. The witness has personal knowledge of the hospital's x-ray filing system, and the x-ray came from the correct file
  2. Identify the x-ray by the name of the patient, date, and part of body to which it pertains
  3. **Hearsay (Business Record) Predicate:**
     a. The x-ray was made at or near the time of the conditions appearing in it
     b. The x-ray and label were made by a person with personal knowledge of the facts (or the label was
        made from information transmitted by such a person)
     c. The x-ray was made as part of the regular practice of the hospital
     d. The x-ray was kept in the course of a regularly conducted business activity

H. “Good” Testimony”/Explaining In Common-Everyday Terms

   i.) **Expert Testimony**

- **Daubert Revisited**
  
  This brief overview of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786 (1993), and its Texas progeny *Gammill* (47) and *Robinson* (48), is intended only to provide sufficient background on the requirement for admissibility of expert testimony for the purposes of the discussions concerning *Daubert* challenges that are sprinkled throughout this article. This should, in no way, be considered a thorough examination of the admissibility of expert testimony.

  In general, in order for expert testimony to be admissible the following conditions must be met: (1) the expert must be qualified, (2) the opinion must be relevant, (3) the probative value of the evidence must substantially outweigh the prejudicial effect, and (4) the evidence must be scientifically reliable. The burden of showing admissibility is on the proponent if an objection to the evidence is made (49).

  “Qualification” means that the witness has sufficient experience in his/her field of expertise encompassing knowledge, skill, experience, training or education. “Scientific reliability” refers to two separate context within the scientific arena, both reliability and validity. In very simplistic terms, “reliability” refers to consistent results or results capable of consistent replication. In the case of syndromes, the measure of reliability would mean that the symptoms enumerated equal to the diagnosis on a measurable and consistent basis. “Validity”, within the scientific context, means that the test measures what it actually purports to measure. These simplistic definitions make the difficulty of introducing “soft science” or psychological expert testimony readily apparent. Application of the factors to be considered in determining
reliability, as expressed in *Robinson*, may be an insurmountable challenge for the proponent of any psychology-based testimony and especially in regards to syndrome testimony.

The *Robinson* court made clear that the trial court is the “gatekeeper” for the admissibility of expert testimony and listed several factors that may be considered in performing this function. The following is the list of factors, enumerated by the *Robinson* court, that may be considered but that are not to be construed as all-inclusive:

- the extent to which the theory has been or can be tested;
- the extent to which the technique relies upon the subjective interpretation of the expert;
- whether the theory has been subjected to peer review and/or publication;
- the technique’s potential rate of error;
- whether the underlying theory or technique has been generally accepted as valid by the relevant scientific community; and
- the non-judicial uses which have been made of the theory or technique

In the case of *S.V. v. R.V.*, 933 S.W.2d 1 (Tex. 1996), involving the issue of repressed memory, while the majority did not specifically address the admissibility of expert testimony, but rather reached their decision based on application of the discovery rule to a Statute of Limitations question, Judge Cornyn addressed the applicability of *Robinson* to psychological testimony. Judge Cornyn’s concurrence, expressing his concern about applying *Robinson* standards to all expert testimony, stated in part:

Unlike some other scientific theories, theories or opinions about behavior, memory, and psychology depend largely on the subjective interpretation of the expert and usually do not have demonstrable rates of error. Scholars have observed that “the nature of certain social and behavioral science theories may be inherently inconsistent with Daubert criteria such as falsifiability and error rates” and that some theories “have simply not been sufficiently developed as theories to allow for proper consideration of the guidelines offered by Daubert” (citing Richardson et al., *The Problems of Applying Daubert to Psychological Syndrome Evidence*, 79 Judicature 10, 10-12 (1995).

Since sexual abuse cannot readily be duplicated and tested in a lab, the validity (or as the court terms it, “reliability”) of any theories regarding behavioral or psychological-based effects is almost impossible to test. Therefore, the debate rages on as to whether *Daubert, Gammill, Robinson, et al*, does or should apply in the “soft science” context. (50)

Syndromes, some of which have been used for diagnostic and treatment purposes in child abuse and neglect cases for years, can be characterized as a set of symptoms. These “symptoms” are often problematic because they may apply to persons for whom the condition does not apply, as well as, for those to whom the condition diagnosed does apply. Even if abuse indicators or “symptoms” are generally accurate, new medical research and new technology have the potential to uncover new explanations, other than abuse, for the presence of such indicators. The admissibility of syndrome evidence is generally subject to questions of reliability and validity. A *Daubert* challenge is always a possibility (51). A careful review of all available studies and medical research should always be undertaken before relying on a final assessment that abuse has occurred.
Child Sexual Abuse Accommodation Syndrome Testimony

According to Dr. Roland Summit, a sexually abused child reacts to the abuse in unexpected ways. His theory, called “Child Sexual Abuse Accommodation Syndrome” (CSAAS) describes five characteristics commonly observed in child sexual abuse victims:

1. Secrecy - molestation typically occurs in private and the child is warned not to tell
2. Helplessness - caused by the power - imbalance relationship between the child and the abuser
3. Entrapment and Accommodation - child feels powerless to stop what is happening and fails to retaliate, thus “accommodating” the abuse
4. Delayed, Conflicted, and Unconvincing Disclosure - may be caused for many reasons including shame, guilt, or fear
5. Retraction - may be due to pressure from abuser, family or the stress of litigation

The purpose of CSAAS is to explain behaviors of sexual abuse victims that may be viewed as inconsistent with societal beliefs about how victims should respond. The syndrome was not designed to “diagnose” or otherwise validate that sexual abuse has, in fact, occurred. Authorities in this field have concluded that using these criteria as a means of defining who has been abused results in faulty logic because, among other things, these behavioral characteristics or changes can be caused by factors other than abuse (52). Researchers point out that these symptoms have not been found sufficiently and substantially associated with sexual abuse so as to constitute a syndrome with diagnostic competence (53). Therefore, it should be kept in mind that this is by no means an exact science and that there is no battery of psychological tests that will allow a person to determine with certainty that a child exhibits characteristics of a person who has been abused.

Since the proper use of CSAAS is to explain seemingly inconsistent or bizarre behaviors, the clinician should proceed from the fact of the abuse to explaining the behaviors, instead of proceeding from the observation of existing symptoms to a diagnosis of sexual abuse (54). The proper prosecutorial use of CSAAS is to provide information to the jury that will help overcome preconceived notions about the behaviors of abused children that the jury might otherwise relate to lack of credibility or reliability.

Proposing and Opposing Admissibility. This syndrome has been admitted as expert testimony by courts to explain a child’s seemingly contradictory conduct after abuse has allegedly occurred (55). However, as with other types of expert witness testimony, case law provides that an expert may not testify as to the credibility of the child witness. Assessing the reliability or credibility of a victim’s accusations is the exclusive function of the jury (56). In addition, testimony that, while not directly commenting on the credibility of a witness, but that may have the effect of bolstering a witness’ credibility, may be objectionable if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, or needless presentation of cumulative evidence (57). When proposing admissibility, it should always be kept in mind that the intended use of this syndrome evidence is as an explanation of behaviors after abuse has occurred and not to validate that abuse occurred.

In order to have CSAAS evidence admitted, the proponent must be able to address the following issues:
1. the evidence is relevant (TRE 401);
2. the probative value is not outweighed by prejudicial effect (TRE 403);
3. expert testimony will assist the trier of fact in understanding the evidence or determining a fact in issue
and falls outside the scope of common knowledge of the average juror (TRE 702; Robinson, 923 S.W.2d at 556); and

4. evidence meets the Daubert standards for reliability and validity.

Courts that have rejected admissibility of this syndrome evidence have done so because:

1. it goes to the ultimate question and invades on the province of the jury,
2. it is used to bolster the credibility of the witness,
3. its probative value is not outweighed by its prejudicial effect, and
4. it is unreliable.

The major argument for opposing admissibility is that the expert witness, in describing the syndrome characteristics and relaying which of those characteristics are present in the alleged victim, is in effect commenting on the credibility of the witness (59). Syndrome testimony, as a practical matter, is designed to establish that if a “victim” exhibits certain characteristics, then that victim has suffered abuse. Therefore, if the victim at issue also exhibits those characteristics, then that person has been abused. This type of evidence in effect bolsters the credibility of the victim witness. However, the opposite premise, that an alleged victim who fails to exhibit such characteristics is therefore not a victim of abuse, is a dangerous proposition. Therefore, the reliability of syndrome evidence is questionable.

A number of Texas Courts have mentioned CSAAS, accepting the testimony without commenting on its admissibility. The Court of Criminal Appeals, in Duckett v. State, 797 S.W.2d 906 (Tex.Crim.App. 1990), however, recognized the existence of “Child Sexual Abuse Accommodation Syndrome” and held expert testimony on the syndrome admissable to explain a child’s seemingly inconsistent behavior after an alleged incident of abuse. The court, however, also held that such testimony would not be admissable to directly comment on the credibility of the alleged victim witness (60).

One Texas court has rejected CSAAS testimony on the grounds that the prejudicial effect outweighed the probative value. The El Paso court, in Dunnington v. State, 740 S.W.2d 896, 898 (Tex. App.B El Paso 1987, writ ref’d), held that the probative value of rebuttal testimony of the purported expert in field of child sexual abuse, in defendant's prosecution for indecency with a child, was outweighed by its potential for prejudice in infringing upon jury's role as ultimate finder of fact. The testimony was offered to rebut the contention that children were falsely pursuing allegations due to adult manipulation, to explain timing of children's belated outcries to ex-wife, and her delay in subsequently reporting allegations to police. The court found, however, that although the expert identified fear for safety of victims and fear of loss of attachment as two factors explaining belated outcries, and spousal denial in explaining wife's delay, such factors were not such complicated motivations as to necessitate expert explanation. Thus, also holding that the “expert” evidence was not admissable as information which “falls outside the scope of common knowledge of the average juror.” (61)

Some courts, in holding that expert testimony on CSAAS is inadmissible testimony, have found that the syndrome fails to meet the Daubert test for admissibility. In State v. Foret, the Louisiana Supreme Court held a child psychologist's testimony using the dynamics of CSAAS to diagnose whether abuse had occurred did not pass the test for scientific validity and, was therefore inadmissible. The court further noted that use of the syndrome was seen as having highly dubious value by members of the psychological treatment community and that psychodynamic theories on expansion of human behavior was a science difficult to impossible to test for accuracy. (The opinion in this case has an excellent discussion of the
failure of this syndrome to meet Daubert reliability and validity standards, citing relevant studies to support that decision.) (62)

Some courts have refused to admit CSAAS on the ground that the underlying theory or technique has not been generally accepted as valid by the relevant scientific community. The Kentucky Supreme Court in Lantrip v. Commonwealth, 713 S.W.2d 816, 817 (Ky. 1986) held that testimony involving “sexual abuse accommodation syndrome” was inadmissible because there was no evidence that the syndrome had obtained scientific acceptance by clinical psychologists or psychiatrists (63).

One of the greatest danger in admitting syndrome testimony involves the battle of the experts over whether the child meets the characteristics of child sexual abuse accommodation syndrome (which can be difficult to assess, at best, once a child has undergone multiple interviews), and if the use of “profiles” is allowed, the question becomes whether the alleged perpetrator exhibits the characteristics of a child molester. It has been suggested that the most prudent course for a prosecutor is to “avoid eliciting direct comments on credibility and character traits and to artfully phrase questions that will elicit answers that will explain why the dynamics of child sexual abuse (shame, guilt, fear) cause the child to delay reporting the sexual abuse.” (64)

- Colposcopes
  
The most widely accepted means of photo documentation in Sexual Assault Examination is now the colposcope. With the addition of video, computer technology, and telemedicine, it is now the basis for international research and peer review. During the past decade photographs have been used to clarify terminology, improve accuracy of data, and promote regional and national peer review (65). Colposcopic or video images are captured during the examination and transmitted to other centers with similar technical capabilities for consultation and peer review. For example, the state of Florida has installed ImageQuest, a software program for colposcopic and video images, at all 25 child protection team sites in the state. Texas is currently pilot-testing this software and telemedicine communications among 13 “hub” (expert consultants) and “satellite” (less experienced, lower volume) sites.

  A colposcope is a device that magnifies images for capture photographically (camera or video) or digitally (computer images). This device may be used in assessing physical abuse as well as sexual abuse. Physical abuse involving a small area of the skin, small patterned bruises, puncture wounds or other internal wounds can be photographed with a colposcope. The colposcopic equipment creates photographic documentation that becomes part of the casefile. These images may be reviewed by various practitioners, eliminating the need for numerous examinations.

  With the help of computer technology, these images may be sent via modem to various practitioners, in varying locations, for real time second opinions and consultations. The software programs typically allow for notations to be made to copies of the images to identify particular areas of concern. Magnifications varying from low (7-8) to high (15) allow for optimal visualization of genitalia and perianal regions, and small physical abuse injuries (66).

  A concern with this procedure, as with any computer image, is the ability to alter the image. Another concern, in the context of forensic usage, is the chain of custody concept. The software used with computer colposcopic imaging generally provides safeguards that identify who operated the equipment at
the time a particular image was taken, who has viewed the image, whether any alterations have occurred to
the image, and specific identifications of any actions taken in regards to the image (e.g. notations to the
image, size alteration, markings, transmission of the image).

Several courts across the country have held that the use of colposcopic images and testimony
regarding coloscope use is admissible evidence. These cases have generally held that the use of
colposcopic images in child sexual abuse prosecution is not a novel field or scientific technique subject to
proof of reliability and general acceptance in the scientific community and that the probative value
outweighs any prejudicial effect (67).

ii.) Potential Subjects of Expert Testimony
There are a number of players commonly called as experts in child abuse and neglect cases.
Among the potential experts are CPS staff (including caseworkers, supervisors, program directors,
possibly program administrators, and regional directors), medical personnel (including physicians, nurses,
EMS staff, and other technicians), psychiatrists, psychologists, licensed social workers, and other
therapists, Children’s Advocacy Center personnel (centers which conduct interviews of alleged sexual
abuse victims), SANE Nurses (specially trained nurses who perform sexual abuse exams), law
enforcement staff, teachers, school counselors, and daycare providers. Some of the witnesses may be
exclusively expert witnesses while others may be fact witnesses as well as expert witnesses. Some of the
potential witnesses may also be called as fact witnesses only. This chapter describes key testimony by
some of the more commonly called experts.

• Common Topics of Expert Testimony
  Common topics of expert testimony include such items as:
  ◆ nature and characteristics of child abuse or neglect
  ◆ results of medical examinations for abuse
  ◆ possible causes of unexplained injuries
  ◆ reasons why certain explanations are implausible
  ◆ Syndromes:
    ◆ Battered Child
    ◆ Shaken Baby
    ◆ Munchausen Syndrome (Factitious Disorder) by Proxy
    ◆ Child Development issues
    ◆ Interviewing techniques for alleged child victims
    ◆ suggestibility of children
    ◆ recantation issues
    ◆ inconsistencies in statements by children
    ◆ delayed or piecemeal reporting by child
    ◆ bearing of age on child’s ability to testify
    ◆ behavioral manifestations and other reactions (or the lack thereof) as a result of abuse or neglect
    ◆ perpetrator and/or non-offending parent profiles
• **Common Issues**

  A paramount issue in regards to any proposed expert testimony, is whether the proposed testimony is relevant and somehow related to the parties or child(ren) at issue.

  Any proposed testimony should be examined in light of cultural, gender and religious diversities. An expert should be prepared to explain how each of these (and perhaps other factors, e.g. age, IQ, national origin, and perhaps language barriers) were taken into account in reaching whatever assessments or conclusions to which they testified.

  All experts should be questioned regarding the circumstances of their engagement. A fundamental question is how the initial information received affected their assessment and why. Clarification should be sought as to whether all documentation or other case records were reviewed and, in appropriate cases, whether all parties and witnesses were interviewed. Some inquiry should focus on the ethical obligations of the professional, in their particular capacity in the case, and whether those ethical guidelines were followed.

  Another factor to be considered is how the clinician’s personal experiences may have effected their judgments. One study conducted to assess the prevalence of childhood abuse among clinicians found the following: a total of 21% of the initial 655 clinicians sampled reported physical abuse, sexual abuse, or both with 14% reporting sexual abuse only, 4% reporting physical abuse only, and 3% reporting both physical and sexual abuse (68). The study concluded that the prevalence of abuse within the clinician population is within the range reported by the nonclinician population, that although clinicians, on average, tended to believe alleged victims; that a clinician with a history of childhood abuse produced significantly higher levels of belief than nonabused participants. The study further found that childhood abuse history can affect clinical evaluation of data and clinical decision-making. The study could not, however, conclude whether clinicians with a history of childhood abuse where more empathic than nonabused peers, and therefore, more sensitive to the detection of abuse, or are biased as a result of over identification with the abused (69). At least one Texas case has held that the mental health records of a court-appointed counselor making a recommendation regarding conservatorship issues are discoverable (69). It must be noted, however, that this decision was rendered prior to the revisions of the Texas Rules of Evidence.

• **Child Protective Services Workers**

  **General Description.** Generally, the hierarchy among CPS staff is caseworkers, supervisors, program directors, program administrators, and regional directors. Typically the persons who would have direct contact with any case would be the caseworker and their supervisors. A number of caseworkers may be assigned to a particular case, at a given time, or over the life of the case. A typical case might involve a parent’s worker, a child’s worker, a foster worker, and an adoption worker. The designations apply to the facet of the case in which the particular worker is involved. Testimony may be provided by one worker familiar with the entire case or all of the workers involved. The stage of the case would be a factor in determining which of the workers would be needed to testify.

  **Potential Subjects of Expert Testimony.** The potential subjects about which a CPS staff person might be called upon to testify include child development, best interests, grounds for termination, child adoptability, services available to assist the family, and risk assessment.

  Child adoptability refers to the probability that a particular child has of being adopted if termination of parental rights occur. Factors that are considered in making this assessment include the child’s age, any behavioral problems, the child’s ethnicity, and any disabilities. While all children do have the potential of being adopted, some children will be adopted much faster than others due to individual characteristics.
Risk assessment refers generally to the decision-making process that guides child welfare decision-making. Specifically, risk assessment tools are used to identify factors that might lead to child abuse or neglect. The intent is that by identifying such factors, services may be offered as preventive measures rather than waiting for a specific incident to occur. The current Texas risk assessment tool incorporates data from the recently completed Texas Child Fatality Study, previous Texas research, U.S. and Canadian studies, and extensive field experience. The risk assessment tool integrates the following concepts: child vulnerability, home environment, caregiver capability, quality of care, social environment, response to CPS, and maltreatment pattern. The current risk assessment tool is called the WISDOM model and plans are underway to have this risk assessment tool incorporated into the agency’s automated system, Child and Adult Protection System (CAPS).

- **Pediatricians**

  **Description of Role in CPS Cases.** Physicians, may at times be the reporter of a possible child abuse allegation as a result of an examining a child. In addition, children taken into protective custody will always undergo a physical examination. The pediatrician doing the exam may be called upon as a fact witness as to his medical finding and also as an expert as to his conclusions regarding the cause of any physical injuries. Pediatricians may also be called strictly as an expert to explain particulars of some illness or injury that gives the appearance of abuse or neglect.

  Pediatricians will generally testify in CPS cases as to the nature and extent of a child’s injuries as well as whether or not they are consistent with the history given by the parent(s) or the caretaker. Qualifications beyond being licensed in good standing with the appropriate state medical licensing board (here, the Texas Board of Medical Examiners) should include the number of years practicing pediatrics as a specialty, number of patients, age range, etc. If the pediatrician is to be further relied upon as an expert in child sexual abuse, the party proffering the expert testimony might want to elicit further testimony regarding the expert’s qualifications, by asking about any specialized training the expert has obtained, the extent of the expert’s experience with child sexual abuse cases, the expert’s familiarity with literature and publications on child sexual abuse and any membership in societies or professional organizations devoted to the subject.

  **Potential Subjects of Expert Testimony.** Expert testimony may include testimony regarding syndromes, why certain explanations are not consistent with a given injury, and child development issues. In addition, this witness may testify to substance abuse issues or other parental disabilities. What constitutes medical neglect and its effects on the child are also potential topics, as well as general issues of neglect.

  Physicians are well accepted as experts on medical diagnoses in the courts. A survey of Texas case law did not turn up any cases excluding pediatricians as experts in child abuse cases, however, opponents to the pediatrician’s testimony could question the extent of experience the expert has with child abuse cases and whether the injuries that the pediatrician treated were conclusive of abuse, i.e. can the expert say with absolute certainty that the injuries were not accidental.

- **Psychiatrists**

  **Description of Role in CPS Cases.** Psychiatrists in CPS cases typically provide information to the caseworker regarding the mental health treatment of a parent or other caregiver. In addition, the psychiatrist may be treating a child in CPS conservatorship with mental disorders.

  **Potential Subjects of Expert Testimony.** Psychiatrists may be called upon to give expert testimony as to the effects of certain medications on the parent or the child. Additional issues might be common treatment methods and their potential side effects. Testimony may also include discussion of
some of the syndromes listed in this Chapter, as well as, explanations regarding issues of psychological neglect and the effects of abandonment.

- **Psychologists**
  **Description of Role in CPS Cases.** Psychologists are often used in CPS cases to conduct Psychological Evaluations of the parents. These evaluations are used to assist in making decisions involving the parents’ ability to parent; determination of any potential for mental disorders; assessing stress indicators; and services to be provided. In addition, a psychologist may serve as therapist to any of the parties to the suit, including the child.

  **Potential Subjects of Expert Testimony.** This professional may testify about a wide array of matters. Questions regarding the parents’ IQs and their ability to function are frequently raised. An almost limitless number of diagnostic tests may be performed by the psychologist. Routinely performed tests include IQ tests, MMPI, Stress Index tests, and sometimes the Child Abuse Potential Inventory.

  Psychologists may also be called upon to testify as to child credibility or suggestibility. The effects of substance abuse on the parent, the child, or family dynamics.

  Testimony may include explanations regarding issues of psychological neglect and the effects of abandonment. In addition, this professional may be called to testify to issues involving the effects of physical abuse on the child’s behavior and future functioning.

- **Nurses, Nurse Practitioners, and Physician Assistants**
  **Description of Role in CPS Cases.** These other medical professionals may testify to some of the same subjects as the medical doctors; their testimony may be limited to the medical histories or appropriate treatment protocols of or for the patients, as opposed to the ultimate diagnosis.

  The qualifications for nurses as experts in CPS cases are similar to those for medical doctors or pediatricians. Licensure by an appropriate state licensing board, number of years spent practicing with a pediatrician or with children, any national certifications, etc. Additionally, any specialized training the expert has obtained, the extent of the expert’s experience with child abuse cases, the expert’s familiarity with literature and publications on child abuse and any membership in societies or professional organizations devoted to the subject will also be relevant.

  One specialized area of expertise for this field that may be used in CPS cases is that of the Sexual Assault Nurse Examiner or S.A.N.E. These specialized professionals are generally found in hospital emergency rooms and perform a complete physical examination of the sexual assault victim, collect, preserve, and document physical evidence, and testify as an expert witness (70). The Texas Office of the Attorney General, Sexual Assault Prevention & Crisis Services, has developed a training protocol for these specialized professionals and administers S.A.N.E. programs across the state of Texas. The qualifications for these nurses include a number of clinical hours and experience in addition to didactic training with a pre- and post-training test.

  **Potential Subjects of Expert Testimony.** SANE Nurses and other medical staff might testify as to findings, equipment used, testing done, assessment analysis techniques (validity and reliability), and other protocols.

  As with pediatricians, a survey of Texas case law did not turn up any cases excluding nurses as experts in child abuse cases, however, questions as to their relevant experience should still be asked, and, in sexual abuse cases, whether or not the expert has any training or is certified as a Sexual Assault Nurse Examiner.
Children’s Advocacy Centers Staff

**Description of Role in CPS Cases.** Children’s Advocacy Centers (CACs) are agencies designed to coordinate the activities of agencies involved in the investigation of child abuse. The purpose of these centers is to avoid multiple interviews of the child victim. Information regarding the establishment, funding, and duties of CACs is contained in the Chapter 264, Subchapter E of the Family Code.

On-site individual and group therapy, forensic interviewing conducted by center staff, and on-site medical exams are services provided through some CACs. The range of services varies from center to center, based on community need, available funding, and the CACs board leadership. Centers generally serve victims of both sexual and physical abuse. The centers have developed protocols for multidisciplinary investigation and prosecution of cases that include steps for conducting forensic interviews. Several centers across the state co-house CPS caseworkers and law enforcement officers.

**Potential Subjects of Expert Testimony.** This group of individuals could include staff from a number of professions: CPS staff, law enforcement personnel, forensic interviewers, SANE nurses, psychologists, and other therapists.

CAC staff testimony would likely focus on the initial assessment of abuse. Potential areas of testimony would include the interview process and protocols, child suggestibility, any issues regarding the use of dolls, or drawings in making assessments, and any of the other dynamics of children’s disclosures.

The medical staff might testify as to findings, equipment used, testing done, assessment analysis techniques (validity and reliability), and other protocols.

**H. References and Footnotes**

1. **TEX. FAM. CODE** §261.301(a) (emphasis added); A person responsible for a child’s care, custody, or welfare is defined at **TEX. FAM. CODE** §261.001(5).

2. **TEX. FAM. CODE** §262.113; 262.201.

3. **TFC** § 261.103.


9. **TFC** §261.106(c); *Rodriguez v. State, ___ S.W.3d ____, 2001 WL 395399 (Tex.App.-Houston [14th], April 19, 2001).*

10. *Subia v. Texas Dept. of Human Services, 750 S.W.2d 827 (Tex. App.—El Paso 1988, no writ).*

141
11. TFC §§ 262.113 & 262.205: Filing Suit Without Taking Possession of Child and Hearing When Child Not in Possession of Governmental Entity

12. TFC §§ 263.201-263.202

13. TFC § 263.101

14. CPS Handbook § 6412

15. TFC § 263.306(2)

16. TFC § 263.306(5)

17. TFC § 263.306(a)(11)(A-C)

18. TFC § 263.401

19. TFC § 263.401(d)

20. TFC § 263.501(d)

21. TFC § 263.503


24. Ibid. at 425


26. Thomas D. Lyon, The New Wave in Children's Suggestibility Research: A Critique. 84 Cornell L. Rev. 1004, 1013 (May, 1999). Article provides counter-arguments for the proponent of evidence that may be called into question on child suggestibility grounds.

27. See United States v. Rouse, 111 F.3d 561 (8th Cir. 1997).


29. United States v. Rouse, 111 F.3d at 572


37. This is consistent with the American Psychological Association position on this issue.


43. Ibid. at 327


49. *Robinson*, 923 S.W.2d at 557.


51. See *State v. Black*, 537 A.2d 1154 (Me. 1988) (holding that in the absence of any showing of scientific reliability, such evidence is improperly admitted; stating that “whether described in terms of ‘indicators’, ‘syndromes,’ ‘patterns,’ or ‘clinical features’ the objective of such evidence is to establish on the basis of present conduct that in the past someone has been subjected to a specific trauma.”).


57. Tex. R. Evid. 403; Duckett v. State, 797 S.W.2d 906, 917-918 (Tex. Crim. App. 1990) (explaining the exception to bolstering in the case of impeachment of the alleged victim witness); But see, Cohn v. State, 849 S.W.2d 817 (Tex. Crim. App. 1993) (disapproving Duckett to the extent that it is construed to hold that relevant expert testimony is inadmissible unless it serves some rehabilitative function. Further, the court limited the definition of “bolstering” to “any evidence the sole purpose of which is to convince the factfinder that a particular witness or source of evidence is worthy of credit, without substantively contributing to make the existence of a fact that is of consequence to the determination of the action more or less probable than it would be without the evidence.”).

58. See also, Judge Harvey Brown, Eight Gates for Expert Witnesses, 36 Hous. L. Rev. 743, 746 (Fall 1999).


66. Nancy D. Kellogg, M.D., The Use of Colposcopy in the Assessment for Sexual Abuse/Assault, University of Texas Heath Science Center at San Antonio pamphlet (Published by Leisegang Medical, Inc.).


Courtroom Procedures in Sexual Abuse Cases
Sarah Guidry, JD, Juan M. Parra, MD, and Nancy D. Kellogg, MD

A. Introduction
In addition to the responsibilities of evaluation, documentation, reporting and protection, the pediatrician will often have the responsibility of giving testimony in legal proceedings (AAP, 1999; Baum et al, 1987; Landwirth, 1987). Literature exists on the legal outcome of proceedings relating to physical evidence and the child’s testimony but little is known on outcomes based on physician testimony (DeJong & Rose, 1989; DeJong & Rose, 1991; Theodore & Runyan, 1999). It has been reported that one of the deterrents to report a case of abuse is the reluctance of physicians to get involved in the court system (Badger, 1989; Saulsbury, 1985). This is mainly due to uncomfortable experiences in the judicial system.

A pediatrician may be asked to give medical testimony in a variety of court proceedings in different capacities. Regardless of the level of testimony, reliance on a well documented medical record will be key in that testimony (Parra et al, 1997). Without adequate documentation of the history, physical findings and a diagnostic impression, the physician or any other professional will have difficulty interpreting that record.

B. Fact and Expert Witnesses
Physicians can testify as a fact and or expert witness depending on their level of training and involvement in a case (Halverson et al, 1993; Myers, 1993). Fact witnesses testify to the objective facts of the case. A fact witness will generally testify on what is observed, historical information, physical examination and the impression of the evaluation. Expert witnesses form opinions based on the facts and can offer opinions whether abuse occurred or not based on medical reasonable certainty. Experts or fact witnesses should not testify on legal issues such as innocence or guilt but testify only on the factual issues (Myers, 1993).

C. Judicial Forums
There are various judicial forums that a physician can be asked to testify in. Courtroom proceedings can be civil (juvenile, family and custody hearings) and criminal prosecution. Civil litigation usually involves decisions for protection of the child and other family members and criminal prosecution involves proof of innocence or guilt and punishment (Halverson et al, 1993; Myers, 1993, Hanes & McAuliff, 1997). The burdens of proof are different for civil and criminal proceedings. The burden of proof in most civil cases is for the preponderance of the evidence (the notable exception of “clear and convincing evidence” in termination of parental rights cases) and in criminal cases it is proof beyond a reasonable doubt.

Depositions are sworn statements taken by a court reporter (Halverson, et al, 1993; Hanes & McAuliff, 1997). Depositions can be taken by defense attorneys before a criminal trial and are also often used in civil proceedings. Depositions can be used at a later time to impeach previous testimony or to provide witness testimony when their live testimony is not readily available. It is important to have a copy and review depositions before a court proceeding to refresh one’s memory of prior testimony.

D. Ethical issues for expert witnesses
Ethical standards in expert witness testimony has been written mostly for medical malpractice litigation (Brent, 1982; AAP, 1989; Luria & Agliano, 1997). The American Academy of Pediatrics in its guidelines and Brent point out several issues that are applicable to medical expert testimony in sexual abuse cases. These points are:

- Review of medical facts and court testimony should be impartial and presented with objectivity.
• A physician who testifies as an expert witness should work in the medical field of which he is testifying
  and or conduct research in this field.
• Peer review should occur for testimony given.

Williams (1993) writes about the points concerning objectivity and experience in the medical field
as it applies to child abuse cases.

Presenting facts and opinions with an honest and objective approach is the best way to achieve
credibility in the legal arena and to promote justice.

E. Testifying in legal proceedings

i) The subpoena
Subpoenas are court orders and response to them is mandatory. Subpoenas usually are directives
for one to appear in court and or to bring medical records (Reece, 1994). Communication with the attorney
who issued the subpoena is permitted and favored. This conversation is to identify the role of the physician
in court, address errors such as a physician not having knowledge about a case and placing oneself on
stand-by minimizes the waiting in lengthy courtroom proceedings

ii) Court testimony
As mentioned previously, one of the best methods to prepare for legal proceedings is to have a
well documented medical record. Regardless if one has evaluated the child or not, it is important to review
pertinent medical records if a physician is asked to testify as a fact and or an expert witness (Halverson et
al, 1993; Hanes & McAuliff, 1997; Torrey & Ludwig, 1987; Vieth, 2000). Review of a previous deposition is
also important to do. The following points summarize how to prepare to testify in legal proceedings.

When you talk to the attorney before your testimony:
1. Place yourself on stand-by for a case
2. Meet with the attorneys if possible
3. Clarify your role in court
4. Alert the court or attorneys to changes or conflicts in your schedule and availability

Testifying in court:
1. Listen carefully to each question
2. Speak in a clear voice
3. Testify only to what you know
4. Answer only what is asked
5. Have records available for your review on the stand
6. Wait until the question is asked to answer
7. Ask for a question to be repeated if not understood
8. Be honest and objective
9. Provide answers in laymens terms whenever possible or describe technical response in such terms
  when possible.
10. To assist the court in only having admissible and appropriate evidence presented, it is prudent not to
answer a question or stop talking when an attorney stands up to make an objection. It is important to
maintain one’s composure on the witness stand and not get upset or mad.

Types of questions to expect when testifying:
It is difficult to predict what questions will be asked during a court proceeding. Usually the attorney that
issues the subpoena will directly examine the physician first and other attorneys such as defense council,
ad litem attorney and juvenile attorney will cross examine (Halverson et al, 1993; Hanes & MCAuliff, 1997; Reece, 1994; Torrey & Ludwig, 1987; Vieth, 2000). Common lines of questioning are as follows.

Initial lines of questions:
1. Name and occupation
2. Qualifying as an expert (e.g., educational background, training in forensic examinations, experience)
3. Description of protocol used for medical evaluation
4. Historical information
5. Medical evaluation
6. Conclusions or diagnosis

Supplemental Lines of Questions
1. Behavioral/physical indicators of sexual abuse
2. Child's developmental/cognitive abilities
3. Patterns of disclosure/recantation
4. Patterns of injury and healing

Supplemental lines of questions will vary on level of knowledge and expertise. In order to better present information it is advisable to use illustrations and diagrams and alert the attorney to have imaging equipment available to present photographs.

iii) Presenting “lack of medical evidence” in court

In most circumstances, the clinician will be challenged to explain why there are no genital or anal injuries, why there is no forensic evidence, and why there are no sexually transmitted diseases in children and adolescents with seemingly detailed and consistent histories of sexual abuse or assault. Of all the evaluation components, the history is the most important evidence. References such as Joyce Adams' “It's Normal to be Normal” paper may assist in the legal representation of these cases.

There are at least 3 situations where the examination may be normal but there is other compelling evidence of sexual contact:

1. Normal follow up examinations in children or adolescents that initially presented with acute definitive injuries of sexual assault or successful recovery of the assailant's sperm or semen.
2. Normal examinations in children or adolescents whose perpetrator has confessed to specific penetrating sexual acts.
3. Normal examinations in adolescents who are pregnant.

Discussion and presentation of these points may facilitate acceptance and understanding of why so many examinations in children and adolescents alleging penetrating sexual acts are normal. With other non-penetrative sexual acts medical evidence is also unlikely.

F. Conclusion

The clinician who evaluates a child for sexual abuse and advocates for a child and family should have the necessary knowledge and expertise to conduct such an evaluation. It is equally important to prepare before testifying in a case and present the testimony in an honest and objective manner and to present testimony that is medically and scientifically sound (Brown, 2001).

G. References


Brent RL. The irresponsible expert witness: a failure of biomedical graduate education and professional accountability. Pediatrics 1982; 70:754-762.


Halverson KC, Elliot BA, Ribin MS, Chadwick DL. Legal considerations in cases of child abuse. Primary Care 1993; 20:407-416.


A. Children's Advocacy Centers Defined

A Children's Advocacy Center is:

- A safe place where law enforcement, prosecutors, child protective services case workers, and medical and mental health professionals can investigate child abuse without subjecting young victims to repeated interviews and re-victimization by the very system designed to protect and provide for them.
- A safe place that offers a child-friendly, non-institutional environment where young victims are not afraid to tell what has happened.
- A safe place where physically and sexually abused children can go to ensure they receive the medical and mental health services needed to relieve the physical, emotional and psychological trauma caused by abuse.
- A safe place where the needs of child victims can be appropriately addressed, in a collaborative manner, by those entities and agencies involved with the investigation and prosecution of child abuse cases and the assessment and treatment of child abuse victims at the local level.
- A safe place where law enforcement, child protective services, prosecution, medical and mental health professionals can receive training to ensure they develop and maintain the expertise necessary to adequately meet the needs of the child victims and facilitate the prosecution of individuals who perpetrate such crimes.
- A safe place where communities can establish opportunities for individuals and organizations to aid child abuse victims and their families by providing them with vital support as well as the tools they will need to heal and eventually grow into healthy and productive citizens capable of making a positive contribution to society.

B. Improving Community Response to Child Abuse

A Children's Advocacy Center (CAC) is a child-focused, facility-based program where representatives from many disciplines meet to discuss and make decisions about the investigation and prosecution of child abuse cases, the assessment and treatment of child victims, and the prevention of further child victimization.

This multidisciplinary team approach brings together the many professionals needed to offer comprehensive services: law enforcement, child protective services, prosecution, medical, mental health and others. CACs are locally-based programs designed by professionals and volunteers to meet the special and varied needs of this unique and vulnerable population of crime victims within a community.

Communities that have developed a CAC experience a myriad of benefits that include immediate follow-up to child abuse reports; more efficient and effective medical and mental health services; reduction in the number of forensic or investigative interviews child victim interviews must endure; increased successful prosecutions; enhanced public awareness regarding child abuse; better informed potential jurors; and consistent support for child victims and their non-offending family members.

C. The Multidisciplinary Team

This comprehensive approach, with follow-up services provided by the CAC, ensures that these children receive child-focused services in a child-friendly environment – one in which the child’s needs remain the primary focus from the first report of alleged abuse through case disposition and beyond.

Establishment of a Children's Advocacy Center is a laudable goal for any community. It is also a huge challenge. Bringing together the various professional disciplines involved with child abuse cases and
child abuse victims is a complex and often delicate task. While they may have a shared end goal -- to prosecute and punish those who hurt our children and to provide those children who have been hurt with the necessary tools to survive and heal -- each has a very specific role and responsibility in that process. Often times, those roles are in conflict or are duplicative and it is sometimes this reality that leads to the re-victimization of the child victims and their non-offending family members as they and their cases proceed through our criminal and civil justice systems. The multidisciplinary approach to this problem is intended to assist these professionals in finding a common ground and in developing strategies for compromise and collaboration. These strategies must allow each of them to meet their specific obligations without further harming the very children they have dedicated themselves to protecting and providing for.

D. The Community Component

Communities must also have a place at the table if efforts to establish a Children’s Advocacy Center are to succeed. These children belong to the community and, long after the professionals have done their jobs, these children will still belong to that community for they are its future.

Therefore, it is the community that must rise to meet the continued needs, heal the remaining wounds and acknowledge and understand the enduring scars. It is the community that must pick up where the professionals leave off and ensure that these children are provided with the tools they will need to become healthy, happy, law-abiding and productive citizens capable of making a positive contribution to their community – wherever it might be. Fortunately, communities are recognizing their obligations and responsibilities to their children and – through the establishment of Children’s Advocacy Centers – are responding to the call for help.

Communities can provide vital encouragement and support to the professionals charged with investigating and prosecuting child abuse cases as well as those charged with assessing and treating the physical and emotional needs of child victims. Communities can provide financial support of these professionals and their agencies to ensure they maintain the necessary level of expertise so vital to doing this work well. Communities can provide a neutral and professionally appropriate yet child-friendly facility where the needs of the professionals and the children can both be met. Communities can demand a more effective response to child abuse – from each and every entity that becomes involved in the lives of these children as a result of the abuse and communities can provide the resources to ensure that this improved response is attainable and is comprehensive. Communities can provide all these things through the establishment of Children’s Advocacy Centers.

Working together and building a strong foundation is key to the successful development of both a Children’s Advocacy Center and the multidisciplinary team it represents. This is not an easy task. Few things this important and this worthwhile are.

E. Primary Goals of a Children’s Advocacy Center

Because Children’s Advocacy Centers are community-based, non-profit organizations they are inherently structured in ways that are reflective of the specific needs and resources of the community in which they exist. Consequently, CACs each have their own unique character, appearance and program structure. It is this variation in programs across the state of Texas and across the nation that has, in many ways, ensured the continued success of this model in large urban areas as well as small, sparsely-populated rural communities as well.

However, while CACs are unique and different in some ways, the primary goals of children’s advocacy centers are shared ones:

- To minimize re-victimization of child victims and their supportive family members throughout the investigative and prosecutorial stages of their cases and beyond.
- To facilitate prosecutions of perpetrators through effective fact finding and strong case development.
F. Key Components of Children’s Advocacy Centers

- **Organizational Structure**
  - 501(c)(3) Not-for-Profit Corporation
  - Community Board of Directors (must include partner agency representation)
  - Designated Staff
  - In-House Volunteer Components

- **Facility**
  - Child Friendly and Task Appropriate Environment
  - Physically and Psychological Safe Environment
  - Neutral and physically separate from day-to-day operations of partner agencies (i.e. CPS, law enforcement, prosecution)

- **Multidisciplinary Team**
  - Core members: law enforcement, prosecution, Child Protective Services, medical and mental health professionals, CAC program staff (others are optional)
  - Executed interagency agreement outlines and documents agency commitment
  - Executed working protocols or guidelines outline and document how team members will work cases together

- **Coordinated Joint Investigations**
  - CPS, law enforcement and prosecution form investigative partnership at onset of cases
  - Shared/joint development of investigative strategies
  - Efforts made to minimize duplicative efforts and conflicting messages to victim families

- **Forensic Interview**
  - Non-threatening approach and location for forensic interviews with children
  - Team approach to interview process – investigative personnel present for interview, monitor from observation room via closed circuit and/or one-way mirror
  - Specialized training mandated for individuals conducting interviews
  - Minimal occurrence of multiple interviews

- **Medical Component**
  - Specialized forensic examinations conducted by professionals, trained in child abuse field, either on site at CAC or off site (i.e. clinic, hospital, provider’s private office, etc.)
  - Medical professionals participate as active members of multidisciplinary team
  - Medical professional participate in case review process, training opportunities

- **Mental Health Component**
  - Specialized assessment and treatment by professionals, trained in child abuse field, either on site at CAC or off site
  - Mental Health professionals participate as members of multidisciplinary team
  - Mental Health professionals participate in case review process, training opportunities

- **Case Review Process**
  - Team meets on regular basis for purpose of case review
  - Share information, expertise and experience
  - Track case progress through system
  - Instills accountability by all entities involved
  - Provides conflict resolution opportunities for team members

- **Training**
  - Ensures elevated level of specialization and expertise among professionals conducting child abuse investigations and prosecutions and providing services to child abuse victims

G. Governing Documents of Texas Children’s Advocacy Centers

- Texas Family Code, Chapter 264, Subchapter E
• Texas Standards for Children’s Advocacy Centers (text follows)

To be recognized by Children's Advocacy Centers™ of Texas, Inc. as a children’s advocacy center program, hereinafter referred to as “CAC” program, CAC staff, volunteers, board of directors, and public agency partners must comply with the following minimum standards:

**General**

1. A CAC program must have a mission and purpose in keeping with the mission and purpose of the National Children's Alliance.
2. A CAC program shall be affiliated with Children’s Advocacy Centers™ of Texas, Inc. and shall abide by all reporting, evaluation and other requirements of Children’s Advocacy Centers™ of Texas, Inc. and the Office of the Attorney General.
3. A CAC program shall be an inclusive organization whose staff, board members and volunteers reflect the children they serve and their community in terms of gender, ethnicity, and cultural and socioeconomic backgrounds.
4. A CAC program shall operate under the auspices of a nonprofit 501(c)(3) board of directors or under 501(a) of the Internal Revenue Service Code. Total board of director memberships shall not include a disproportionate number of public agency staff.
5. A CAC must operate in a neutral and physically separate space from the day-to-day operations of any public agency partner.
6. Before a children’s advocacy center can be established, an interagency agreement shall be entered into by the local Child Protective Services, local law enforcement agencies and by the county, district attorney and/or criminal district attorney who has statutory authority to prosecute child abuse cases in the area to be served. It is strongly recommended that a representative of the local medical community who actually participates in the collection of forensic evidence also sign the interagency agreement with the public agency partners.
7. The interagency agreement at a minimum must include the following assurances:
   - development of a cooperative, team approach to investigating child abuse;
   - reduction to the greatest extent possible of the number of interviews required of a victim of child abuse to minimize the negative impact of the investigation of the child;
   - the development, maintenance, and support through the center, of an environment that emphasizes the best interests of children and that provides investigative and rehabilitative services.
8. A children’s advocacy center must hold multidisciplinary staffings on new and pending child abuse cases at regularly scheduled intervals. The multidisciplinary team shall consist of persons who are involved in the investigation or prosecution of child abuse cases or the delivery of services to child abuse victims and their families.
9. A CAC shall develop a method of uniform statistical information gathering on children receiving services through the center. In this regard, a CAC shall use a uniform method of reporting statistical information consistent with guidelines approved by Children’s Advocacy Centers™ of Texas, Inc. These statistics shall be reported to Children’s Advocacy Centers™ of Texas, Inc. and the Office of the Attorney General in a timely manner as required by either Children’s Advocacy Centers™ of Texas, Inc. or the Office of the Attorney General.
10. A CAC shall make referral to and/or provision for appropriate therapeutic treatment programs for child victims and non-offending family members.
11. A CAC shall make referral of child victims to appropriate medical providers for assessment and treatment as indicated.
12. A CAC shall develop an in-house volunteer program.
13. All CAC’s shall have liability insurance in adequate amounts as prescribed by Children’s Advocacy Centers™ of Texas, Inc. for the facility, board, and volunteers, Professional liability insurance is recommended.

Staff
14. Minimum staffing requirements shall include the hiring of a paid executive director who is answerable to the board of directors. The executive director shall not be the exclusive salaried employee of any public agency partner.
15. New CAC executive directors shall receive training approved by Children’s Advocacy Centers™ of Texas, Inc. and within time limits established by Children’s Advocacy Centers™ of Texas, Inc.
16. A CAC program shall not employ applicants if they have been convicted, or have prior charges, or have charges pending for a felony or misdemeanor involving a sex offense, violent act, child abuse or neglect, or related acts that would pose risks to children or the CAC program’s credibility. Criminal record checks shall be completed on all CAC staff prior to employment.

Volunteers
17. A CAC direct services volunteer shall have attained majority age (18 years or older) and shall have successfully passed screening requirements which include a written application, personal interview, written references, and criminal records check, and shall have proof of current automobile liability insurance and a current driver’s license if a licensed driver. CAC volunteers under 18 years of age may assist in day to day operational tasks; provided, however, that they do not provide direct services.
18. A CAC volunteer shall not become inappropriately involved in a child’s case by engaging in activities which jeopardize the safety of the child, the integrity of the program or activities which are likely to result in conflict of interest or expose the program or volunteer to criminal or civil liability.
19. A CAC volunteer respects the right to privacy of clients by keeping information that would identify CAC clients confidential.

H. Role of Medical Professionals on CAC Multidisciplinary Teams

The medical professional is a core component of the Multidisciplinary Team within a children’s advocacy center environment because of their role in assessing and treating child victims of physical and sexual abuse and neglect. Depending on the dynamics of the specific case, that role may take on a variety of forms. The following are examples of the various roles the medical professional may play as a member of the MDT.

It is not uncommon for the first indicators and/or disclosure of abuse to be presented initially to a medical professional during the course of an examination for unrelated purposes or for treatment of injuries or symptoms directly resulting from unreported abuse. In such cases, it becomes the responsibility of the medical professional to report the alleged abuse to the appropriate authorities (i.e. law enforcement and child protective services). In such cases, the medical professional becomes the reporting entity and, in many cases, the outcry witness (first person over the age of 18 the child told about the abuse), as well as the treatment provider.

However, in the event the alleged abuse has already been reported to law enforcement and/or child protective services and an investigation has been initiated, medical assessment and treatment may be requested by those agencies for both forensic and treatment purposes. In these cases, a videotaped forensic interview may already have been conducted with the child at the children’s advocacy center. While it is still important in these cases for the medical professional to request from the child a detailed history that includes specific information about the alleged abuse, it is unlikely that information will represent the legal “outcry” as defined in the Texas Penal Code. In addition, it becomes critically important that the medical professional’s subsequent “interview” with the child not unduly duplicate the forensic interview already conducted by investigators as such activity can be unnecessarily re-victimizing for the child and can even, in some circumstances, jeopardize the integrity of the investigative process.
Regardless of whether the medical assessment is conducted prior to or following a video-taped forensic interview, it is critical that the medical professional have an ongoing relationship with the other disciplines on the multidisciplinary team (i.e. child protective services, law enforcement and prosecution) to ensure a shared and accepted understanding of appropriate protocols and procedures to be followed throughout the investigative, prosecutorial and intervention processes.

The medical professional on a CAC multidisciplinary team also provides vital expertise and perspective at team meetings for the purpose of case review, sharing information with other disciplines regarding whether or not specific medical findings are consistent with allegations and other evidence of the alleged abuse. In addition, participation by medical professionals at case review meetings can provide valuable, informal training opportunities for other disciplines in regard to recognizing and identifying signs and symptoms of child abuse.

The medical professional on a CAC multidisciplinary team may also participate as a key witness in the prosecutorial process (civil and criminal) – as an outcry witness, as a fact witness and/or as an expert witness. A medical professional with specialized training and experience in this field can provide vital education for jurors and judges in the courtroom regarding child abuse findings – both specific to the case at hand and in regard to the incidence of child abuse in general.

i.) Overview of Various CAC Medical Components

Beyond the core components required of all children’s advocacy centers (see Standards, Family Code), there is much variation within these programs across the state and the country. This unique configuration of CACs is, in many ways, one of the factors that has made this model successful in small, rural communities as well as large, urban areas – the programs are reflective of both the needs and the resources of the community in which they exist. For this reason, the medical components of children’s advocacy centers also differ from one community to another. The following information is provided as an overview of some of the different ways a CAC medical component might look.

In some cases CAC facilities include medical examination rooms where children can be seen in a child-friendly, non-threatening environment and where the medical assessment can be scheduled in conjunction with other services the child is receiving on site at the CAC, i.e. the videotaped forensic interview, therapy sessions, family support services, etc. It is more common for examinations involving non-acute or chronic cases to be conducted on site at CACs, while acute sexual abuse exams and/or assessment and treatment of physical abuse injuries are more likely to be handled at a traditional medical facility better equipped for emergency-type services.

Many CACs have facility space constraints that would prohibit providing for appropriate medical examination capabilities on site at the center. In addition, an on site medical examination room requires that the medical professionals – unless they are housed fulltime at the CAC, which is rare – travel to the facility to conduct these examinations and such an arrangement is not always feasible. In these cases, medical professionals may conduct the examinations at a hospital, clinic and/or the office of a private physician. It is preferred that, whenever possible, a child-friendly and non-threatening environment be provided for the child during this experience. Many local hospitals and clinics have dedicated appropriately decorated rooms in their emergency or pediatric departments where child sexual abuse examinations can be conducted in a manner which will not re-victimize the child in the process of conducting the examination. Another approach that also helps in minimizing re-victimization is special scheduling to ensure the highest level of privacy, confidentiality and time-appropriate attention by the provider.

The type of medical professional who provides the specialized medical assessments of child abuse victims and participates on the multidisciplinary team of a CAC may also vary – depending on the
resources available within a given community. Many CACs utilize the services of Sexual Assault Nurse Examiners, in addition to those of local physicians, to conduct child sexual abuse examinations for forensic purposes either on site or off site from the CAC.
A. Prevention

Identifying, diagnosing, treating, and intervening in child sexual abuse is costly and labor-intensive. As suggested by the complexity and multidisciplinary nature of the material presented in this manual, the reactive approach to sexual abuse requires the concerted efforts and sustained cooperation of a number of professionals. Not surprisingly, there has been a growing interest in primary and secondary prevention of child sexual abuse over the past decade.

Although figures from national data sets of child abuse reports (Sediak & Broadhurst, 1996) suggest that low socioeconomic status places children at higher risk for sexual abuse, several prospective studies indicate that poverty is much less a risk factor for sexual abuse than it is for other forms of maltreatment. Stronger risk factors appear to be the presence of one or more of the following in the home:

- Marital discord, including divorce, separation, or spousal violence;
- Changes in family makeup, particularly the presence of stepparents;
- Parental dysfunction, particularly alcoholism or criminal behavior; and
- Dysfunctions in parent/child attachment.
- Prolonged or repeated lack of supervision of children, e.g., after school. (Fergusson and Mullen, 1999).

Since most community-based child abuse prevention programs have attempted to address the risk factors for child abuse in general (i.e., teen parenting, lack of education, lack of access to health care, etc.), the above evidence suggests that these approaches may not significantly impact the specific problem of child sexual abuse. Two different strategies attempting to address the prevention of sexual abuse have recently emerged: (1) prevention of victimization; and (2) prevention of perpetration (Ryan, 1997).

i. Prevention of victimization.

Several prevention programs aimed at large groups of school-aged children are currently utilized in the United States (Finkelhor and Daro, 1997). Typically, these programs teach children to distinguish appropriate from inappropriate body contacts (“Good touch/bad touch”) and use role-play and other techniques to offer children avoidance and response techniques. Many observers have objected to these programs since they place the onus of prevention on the potential victims—children. Since most sexual abuse occurs within the confines of the home at the hands of adults who otherwise are to be obeyed, the effectiveness of such approaches has been vigorously questioned. However, such programs do appear to reduce the likelihood of sexual victimization in at least three ways: by increasing children’s knowledge of sexual abuse and avoidance skills (which appear to endure much longer than initially expected); by increasing the likelihood that parents will discuss sexual abuse prevention with their children; and by raising the general level of community awareness (Finkelhor and Daro, and Hebert, Lavoie, et al.). To date, only one study (a recall survey of female college students) exists that documents a possible decrease in sexual abuse among children who participated in such programs (Gibson and Leitenberg).

ii. Prevention of perpetration.

Many perpetrators of sexual abuse appear to begin offending as juveniles. Efforts to identify sex offenders early in life—presumably when they are more amenable to intervention—may also be useful preventive approaches. Ryan and Blum (1995) and others have developed education programs to help adults recognize, confront, and extinguish the precursors of abusive behavior in children and adolescents.
Numerous specialized treatment programs exist in the United States for sexually abusive adolescents. As those programs are identified that successfully reduce recidivism among youthful offenders, these should also impact the number of cases of child sexual abuse.

B. **Integration of Services**

Child sexual abuse rarely presents as a single, isolated problem. As discussed in the previous paragraphs on Prevention, families of sexually abused children are commonly dysfunctional and violent. In one study (Kellogg, Menard and Villarreal, 2001), 54% of children interviewed in a sexual abuse clinic described violence among adults living in their home. Sexually abused children are also more likely than not to be victims of physical abuse (hit with an object, punched, or hit in the face), and live with adult members who have “an alcohol or drinking problem” (Kellogg, Burge and Taylor, 2000). In one study (Burge, Katerndahl, and Kellogg, 2001) 85% of the family members of sexually abused children had been arrested for drugs or assault, were substance abusers, or had mental health problems. These children lack appropriate role models, and often associate with peer groups that practice delinquent or health risky behaviors. The mothers of sexually abused children are often ineffectual in the protection of their children and selection of appropriate and protective father/husband partners.

Services for sexually abused children may need to incorporate long-term mentorship programs for both children and adults, violence prevention services when appropriate, counseling for all family members, and healthy peer group activities. This integrated approach may help sexually abused child avoid health risky behaviors of adolescence, including re-victimization, and may help the adults of the sexually abused child avoid self-destructive behaviors, enabling them to be better parents. The long-term goals of such family-focused, integrative services are to enable the parent of the sexually abused child to better protect his or her children now and to enable the sexually abused child to better protect her or his own children in the future.

C. **Self-Preservation**

Child abuse is the dark side of pediatrics. Traumatized children, devastated parents, non-believing relatives, and overworked investigators are common. Adequate compensation for evaluations and legal testimony is uncommon. Court testimony can be time-consuming and intimidating. It is not surprising that the turnover for professionals working in this field is high.

Support for professionals in this field may come from many sources: individual commitment, community support and appreciation, and professional networking. Individual commitment arises from the recognition of a need; sustained involvement arises from the realization that one’s work is meaningful or valuable. The rewards of this work may range from the relieved smile of a child who is told their exam is normal to a token of appreciation from one’s community. The community may offer monetary support and other resources, such as equipment. Professional networking at conferences and peer review meetings offer opportunities to share the unique frustrations, joys, and sorrows inherent in child abuse work. While recognition and sharing of “war stories” are valuable, the strongest means of self-preservation may derive from an understanding and respect for the abused child. An appreciation for the resiliency and strength of children can provide the motivation for the professional to persist.

“Children are the guests of humanity, and should be treated with all honor, care, and kindness.”

---Robert Owen

D. **References.**


19) **Appendix**
   a) TPS Committee on Child Abuse Resource List
   b) AAP and CDC policy statements re: testing for sexually transmitted diseases in sexually abused children
   c) TPS Child Sexual Abuse Protocol Form
   d) Adams Classification System for Assessing Physical, Laboratory, and Historical Information in Suspected Child Sexual Abuse
   e) TPS Clinical Practice Guidelines (proposed, 2001)
   f) AAP Guidelines for Reporting Suspected Sexual Abuse
   g) Roster of Children’s Advocacy Centers
   h) Texas Department of Health Communicable Diseases Reporting Form

20) **Supplemental Materials**
   a) TPS Child Abuse Pocketguide
   b) Texas Evidence Collection Protocol