WARNING — This excerpt is intended for use by medical, legal, social service, and law enforcement professionals. It contains graphic images that some may find disturbing or offensive. Minors and/or nonprofessionals should not be allowed to access this material.
OUR MISSION

To become the world leader in publishing and information services on child abuse, maltreatment, diseases, and domestic violence. We seek to heighten awareness of these issues, and provide relevant information to professionals and consumers.

A portion of our profits is contributed to nonprofit organizations dedicated to the prevention of child abuse and the care of victims of abuse and other children and family charities.
Sexual Assault

Victimization Across the Life Span


Evaluation of Children and Adults

Angelo P. Giardino, MD, PhD
Professor and Section Chief
Academic General Pediatrics
Baylor College of Medicine
Senior Vice President/Chief
Quality Officer
Texas Children's Hospital
Houston, Texas

Diana K. Faugno, MSN, RN, CPN,
SANÉ-A, SANÉ-P, FAAFS, DF-IAFN
Forensic Nurse Examiner
Barbara Sinatra Children's Hospital
Emergency Room
Rancho Mirage, California

Mary J. Spencer, MD, FAAP
Clinical Professor of Pediatrics
University of California, San Diego School of Medicine
Medical Director
Child Abuse Prevention and SART
Palomar Pomerado Health
San Diego, California

Michael L. Weaver, MD, FACEP, CDM
Medical Director, Clinical Forensic Core Program
Emergency Medicine
Saint Luke's Health System
Kansas City, Missouri

Patricia M. Speck, DNSc, APN,
FNP-BC, DF-IAFN, FAAFS, FAAN
Associate Professor
University of Alabama at Birmingham
School of Nursing
Program Director for Global Affairs
Department of Family, Community, & Health Systems
Birmingham, Alabama

STM Learning, Inc.

Leading Publisher of Scientific, Technical, and Medical Educational Resources
Saint Louis
www.stmlearning.com
CONTRIBUTORS

Norrell K. Atkinson, MD
Child Abuse Pediatrician (fellow)
Department of Pediatrics
Children’s Hospital of The King’s Daughters, Child Abuse Program
Norfolk, VA

Colby Bruno
Senior Legal Counsel
Victim Rights Law Center
Boston, Massachusetts

Megan Cahn, PhD, MPH
Postdoctoral Research Fellow
College of Public Health & Human Sciences
Oregon State University
Portland, Oregon

Joseph Catania, PhD
Professor
Oregon State University
Corvallis, Oregon
Professor Emeritus
University of California
San Francisco, California

Michael Clark, DrNP, GNP-BC, CNL, DCC
Adjunct Faculty
School of Nursing
Rutgers Camden School of Nursing
Camden, New Jersey

Mary J. Elam, BA Psychology
Director of Program Operations
Alaska Native Justice Center
Anchorage, Alaska

Heidi Collins Fantasia, PhD, RN, WHNP-BC
Assistant Professor
College of Health Sciences, School of Nursing
University of Massachusetts Lowell
Lowell, Massachusetts

Diana K. Faugno, MSN, RN, CPN, SANE-A, SANE-P, FAAFS, DF-IAFN
Forensic Nurse Examiner
Barbara Sinatra Children’s Hospital
Eisenhower Medical Center
Emergency Room
Rancho Mirage, California

Lauren Fontanarosa, MPH
Portland, Oregon

Rebecca Girardet, MD
Director, Division of Child Protection Pediatrics
Pediatrics
McGovern Medical School at the University of Texas Health Sciences Center at Houston
Houston, Texas

Tanya Hinds, MD, FAAP
Child Abuse Pediatrician
Child and Adolescent Protection Center
Children’s National Medical Center
Assistant Professor of Pediatrics
Department of Pediatrics
The George Washington University
Washington, DC

William C. Holmes, MD, MSCE
Medical Director
Department of Patient Safety and Surveillance
AstraZeneca Pharmaceuticals
Wilmington, DE

Annie Lewis-O’Connor, PhD, NP-BC, MPH, FAAN
Sr Nurse Scientist
Founder & Director – C.A.R.E. Clinic
Brigham and Women’s Hospital
Connors Center for Women’s Health and Gender Biology
Instructor – Harvard Medical School

Judith A. Linden, MD, SANE, FACEP
Associate Professor
Vice Chair for Education
Emergency Medicine
Boston University School of Medicine
Attending Physician
Boston Medical Center
Boston, Massachusetts

Carol Anne Marchetti, PhD, RN, PMHNP-BC
Clinical Associate Professor
William F. Connell School of Nursing
Boston College
Chestnut Hill, Massachusetts

Jeanne M. Marrazzo, MD, MPH, FACP, FIDSA
Director, Division of Infectious Diseases
Professor of Medicine
University of Alabama at Birmingham School of Medicine
Birmingham, Alabama

Bernie Sue Newman, PhD, LCSW
Associate Professor
Temple University College of Public Health
School of Social Work
Philadelphia, Pennsylvania

Roberto Orellana, PhD, MPhil, MPH, MSW, BA
School of Social Work
Portland State University
Portland, Oregon

C. Jill Poarch, BSN, RN, SANE-A, SANE-P
Sauk Prairie Healthcare
Emergency Department
Prairie du Sac, Wisconsin
Contributors

Devika Singh, MD, MPH
Safety Physician
Division of Infectious Diseases
Department of Global Health
Harborview Medical Center
Seattle, Washington

Patricia M. Speck, DNSc, APN, FNP-BC, DF-IAFN, FAAFS, FAAN
Associate Professor
University of Alabama at Birmingham
School of Nursing
Program Director for Global Affairs
Department of Family, Community, & Health Systems
Birmingham, Alabama

Jeff R. Temple, PhD
Associate Professor
University of Texas Medical Branch-Galveston
Director, Behavioral Health and Research
Department of Obstetrics & Gynecology
Galveston, Texas

Angelia Clark Trujillo, DNP, MS, RN, SANE-P
Associate Professor
University of Alaska Anchorage
School of Nursing
Anchorage, Arkansas

Detective John Vandervalk, BS
Special Victims Unit
Major Crime Scenes Team
Anchorage Police Department
Anchorage, Alaska

Michael L. Weaver, MD, FACEP, CDM
Medical Director, Clinical Forensic Core Program
Emergency Medicine
Saint Luke’s Health System
Kansas City, Missouri

Image Contributors
Lori Clark, RN, BSN, SANE-A, FNE
Carolinas Health Care
Monroe, NC
It is well established that sexual assault can have a significant negative and lifelong impact on the physical and emotional well-being of a person. The impact of victimization extends far beyond immediate physical or emotional trauma and may cause short- and long-term health consequences, socioeconomic instability, significant changes to civil or criminal legal outcomes, and psychotherapeutic treatment challenges.

Forensically trained professionals, whether they be advocates, nurses, scientists, lawyers, or law enforcement, use their knowledge to break down barriers for victims seeking help following sexual assault. They are more likely to conduct trauma-informed investigations; provide enhanced medical examinations; improve the quality of evidence collection and processing; provide comfort, care, advocacy, and other victim services; and participate in sexual assault response teams (SARTs). Knowledgeable professionals are more likely to recognize the neurobiology of trauma and how it impacts memory recall abilities and behavior, screen for patterns of abuse or prior assault, test for date rape drugs, offer emergency contraception and preventive medications against sexually transmitted infections, and direct survivors to supportive services. Quality forensic care fosters a believing atmosphere that supports a survivor’s multifaceted path toward recovery.

*Sexual Assault Victimization Across the Life Span* is the most comprehensive text on its subject to date and truly covers the expansive set of circumstances and complex issues that arise with sexual assault. It is filled with useful statistics and provides a solid foundation of knowledge that is translatable to common practice situations. Key terms listed at the beginning of chapters help to inform and provide consistency in language throughout the community. The authors provide expert, multidisciplinary perspectives imperative to creating and sustaining successful SARTs and subsequently paving the way for improved, comprehensive victim experiences. I appreciate the emphasis on complex circumstances, vulnerable populations, and all-too-common scenarios involving college, military, and correctional settings. The usefulness of this text extends beyond a basic understanding of the subject and provides expansive and detailed information for even the most expert reader. I anticipate and look forward to reading and referencing this text many times in the future.

**Heather K. DeVore, MD**
Assistant Professor of Emergency Medicine
Georgetown University School of Medicine
Executive and Medical Director
District of Columbia Forensic Nurse Examiners
MedStar Washington Hospital Center
Washington, DC
FOREWORD TO THE SECOND EDITION

Sexual assault is a significant public health issue with long-lasting effects on individuals and communities. It is vital that health care professionals have the necessary information and tools to provide the best care to victims of sexual assault. Written by current experts in the field, Sexual Assault Victimization Across the Life Span, Second Edition provides a comprehensive guide to issues of sexual assault.

This revised and updated second edition covers current sexual assault issues as well as historical perspectives on services and treatment, and it includes underrepresented populations such as sexually assaulted males, the elderly, rural populations, tribal peoples, and people with physical and developmental disabilities. Even more cutting-edge and current is the inclusion of information on sexual assault in the military and among LGBTQ populations. Some of the highlights from this exemplary new collection follow.

In Volume 1 Chapter 3, “Cultural and Linguistic Aspects of Gender-Based Violence Care,” Michael Weaver helps health care providers to acquire or improve their knowledge and skills to provide culturally and linguistically appropriate care to diverse populations. Of specific focus is helping health care providers to improve communication with patients and learn to “convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.”

Because it is crucial that health care providers understand informed consent as it relates to victims and perpetrators, Volume 1 Chapter 4, “Informed Consent and Sexual Assault,” succinctly defines and explains the 4 aspects of informed consent and explains the need to understand these aspects as they apply to victim- and patient-centered care.

In order to avoid misdiagnosis, it is essential that health care providers be aware of normal and nonspecific findings in children evaluated for sexual abuse. To that end, Farah Brink, Philip Scribano, and Christine Julian clearly explain how to conduct a medical evaluation for suspected child sexual abuse and to avoid misdiagnosis in Volume 1 Chapter 8, “Differential Diagnosis of Child Sexual Abuse.”

In order to serve victims more efficiently, health care providers must work cooperatively with law enforcement, prosecutors, and victim advocates. In Volume 1 Chapter 11, “SANE/SART History and Role Development,” Linda Ledray and Patricia Powers provide a history of sexual assault nurse examiner (SANE) and sexual assault response team (SART) programs and instructions to develop and implement SANE/SART programs.

Volume 2 Chapter 4, “Dating Violence in Teens and Young Adults,” gives an excellent overview of adolescent and young adult dating violence and the necessary information that health care professionals need to effectively screen and provide services for victims of teen dating violence. This chapter also specifically explains the prevalence, consequences, and predictors of teen dating violence and the effect of teen dating violence on physical and mental health.

Volume 2 Chapter 5, “Overview of Adolescent and Adult Sexual Assault,” is perhaps the cornerstone of Sexual Assault Across the Life Span. By providing “historical perspective, epidemiology, and costs to society, components of an effective interdisciplinary response, the crucial development of sexual assault nurse examiner (SANE) programs, as well as theories behind preventive strategies and promising models,” this chapter offers vital information that ties together overarching subject matter from across the 3-volume set.
Sexual assault against men is just beginning to enter the public consciousness, and it continues to be underreported, under-recognized, and undertreated. In Volume 2 Chapter 7, "Adult Male Sexual Assault," the authors provide a review of recent literature and research on the prevalence of male sexual assault, barriers to reporting, and the effects of sexual assault on the male victims. Most importantly this chapter offers recommendations for "comprehensive and compassionate care and support" of male survivors.

Sexual assault of the elderly is believed to be seriously underestimated and underreported, and it is neither well understood nor well identified by health care professionals. Volume 2 Chapter 8, "Sexual Assault Among Older Adults," will help health care professionals provide informed care to older adult sexual assault victims.

In Volume 3 Chapter 3, "Sexual Assault and Abuse in LGBTQ Populations," the authors provide a brief history of sexual assault and violence in LGBTQ communities as well as a literature review on sexual identities, identification of patterns of sexual assault and violence, and the impact of homophobia and heterosexism on current practices in care of LGBTQ sexual assault victims. The most helpful tool in understanding these issues is the author's inclusion of case studies demonstrating cultural considerations for LGBTQ sexual assault victims.

*Sexual Assault Victimization Across the Life Span* is a comprehensive guide for up-to-date and effective response to sexual assault among the diverse populations of an ever-changing society. While written primarily for health care professionals who deal specifically with sexual assault, it will make a vital resource for anyone working with issues related to sexual assault.

**Amy Caffrey, MA, LMFT**
Licensed Marriage & Family Therapist in Private Practice
Santa Clara County Domestic Violence Council Commissioner (SCCDVC)
SCCDVC Chair of the LGBTQ Domestic Violence/Intimate Partner Violence Committee
San Jose State University Part-Time Professor (Psychology Dept)
Community Lecturer on Domestic Violence, Sexual Assault and LGBTQ Issues
SEXUAL ASSAULT IS BROADLY DEFINED AS UNWANTED SEXUAL CONTACT OF ANY KIND. AMONG THE ACTS INCLUDED ARE RAPES, INCEST, MOLESTATION, FONDLING OR GRABBING, AND FORCED VIEWING OF OR INVOLVEMENT IN PORNOGRAPHY. DRUG-FACILITATED BEHAVIOR WAS RECENTLY ADDED IN RESPONSE TO THE RECOGNITION THAT PHARMACOLOGIC AGENTS CAN BE USED TO MAKE THE VICTIM MORE MALLEABLE. WHEN SEXUAL ACTIVITY OCCURS BETWEEN A SIGNIFICANTLY OLDER PERSON AND A CHILD, IT IS REFERRED TO AS MOLESTATION OR CHILD SEXUAL ABUSE RATHER THAN SEXUAL ASSAULT. IN CHILDREN, THERE IS OFTEN A “GROOMING” PERIOD DURING WHICH THE PERPETRATOR GRADUALLY ESCALATES SEXUAL CONTACT WITH THE CHILD AND OFTEN DOES NOT USE THE FORCE IMPLIED IN THE TERM SEXUAL ASSAULT. BUT IT IS ASSAULT, BOTH PHYSICAL AND EMOTIONAL, WHETHER THE VICTIM IS A CHILD, AN ADOLESCENT, OR AN ADULT.

THE REPORTED STATISTICS ARE ONLY AN ESTIMATE OF THE PROBLEM’S SCOPE, WITH THE ACTUAL REPORTING RATE BEING A MERE FRACTION OF THE TRUE INCIDENCE. SURVEYS OF ADULTS SHOW AS MANY AS 18% OF ALL WOMEN IN THE UNITED STATES HAVE BEEN THE VICTIM OF AN ATTEMPTED OR COMPLETED RAPES OVER THE COURSE OF THEIR LIVES. THE INCIDENCE OF MALE VICTIMS IS LOWER BECAUSE OF RULANTICE OF BOYS AND MEN TO REPORT THEIR VICTIMIZATION.

THE FINANCIAL COSTS OF SEXUAL ASSAULT ARE ENORMOUS. INTANGIBLE COSTS, SUCH AS EMOTIONAL SUFFERING AND RISK OF DEATH FROM BEING VICTIMIZED, ARE BEYOND MEASUREMENT. SHORT TERM, THERE ARE HEALTH CARE CONSEQUENCES, SUCH AS UNWANTED PREGNANCY, SEXUALLY TRANSMITTED DISEASES, SERIOUS EMOTIONAL UPEHEAVALS, INABILITY TO CARRY OUT NORMAL DAILY ACTIVITIES, DECREASED PRODUCTIVITY, AND IN SOME CASES, LOSS OF LIFE. LONG-TERM DISABILITIES CAN BE BOTH EMOTIONAL AND PHYSICAL. IT IS WELL DOCUMENTED THAT SURVIVORS OF SEXUAL ABUSE HAVE A MUCH HIGHER INCIDENCE OF SERIOUS AND CHRONIC MENTAL HEALTH PROBLEMS THAN CONTROL POPULATIONS OF NONABUSED PATIENTS. POSTTRAUMATIC STRESS DISORDER, DEPRESSION, SUICIDAL IDEATION, AND SUBSTANCE ABUSE ARE ALL OVER-REPRESENTED AMONG ABUSED GROUPS IN CASE-CONTROL STUDIES. CHRONIC PHYSICAL SYMPTOMS, SUCH AS PAIN SYNDROMES (PELVIC, ABDOMINAL, CHEST, MYALGIA, HEADACHES) AND VARIOUS SOMATIZATION DISORDERS, ARE REPORTED IN A WIDE VARIETY OF PEER-REVIEWED MEDICAL SPECIALTY JOURNALS.

THIS BOOK IS THE FIRST TO BRING TOGETHER THE BEST INFORMATION AVAILABLE CONCERNING SEXUAL VICTIMIZATION ACROSS THE ENTIRE LIFE SPAN. RECOGNIZING THE RADICAL DIFFERENCES REQUIRED IN APPROACHING CHILD, ADOLESCENT, AND ADULT VICTIMS, THE CHAPTERS ARE ORGANIZED TO PRESENT INFORMATION FROM THE MEDICAL AND MENTAL HEALTH LITERATURE SPECIFIC TO VARIOUS AGE GROUPS. VICTIM AND PERPETRATOR CHARACTERISTICS ARE DESCRIBED. MOST IMPORTANTLY, THOSE WHO PROVIDE CARE FOR THESE VICTIMS AND WHO HANDLE THE DISPOSITION OF THE PERPETRATORS ARE GIVEN SPECIFIC INFORMATION FOR ALL WHO CARE FOR THE VICTIMS—THE CRISIS HOTLINE STAFF, LAW ENFORCEMENT PERSONNEL, PREHOSPITAL PROVIDERS, SPECIALIZED DETECTIVES, MEDICAL AND MENTAL HEALTH STAFF, SPECIALIZED SEXUAL ASSAULT EXAMINERS, AND COUNSELORS. THE INFORMATION IS AS CURRENT, ACCURATE, AND SPECIFIC AS IT CAN BE IN A RAPIDLY EVOLVING FIELD. IT WILL FILL A NEED IN MANY VENUES WHERE SEXUAL VICTIMIZATION IS SEEN AND CARE IS GIVEN TO VICTIMS.

ROBERT M. REECE, MD
DIRECTOR, MSPCC INSTITUTE FOR PROFESSIONAL EDUCATION
CLINICAL PROFESSOR OF PEDIATRICS, TUFTS UNIVERSITY SCHOOL OF MEDICINE
EXECUTIVE EDITOR, QUARTERLY CHILD ABUSE MEDICAL UPDATE
FOREWORD TO THE FIRST EDITION

Sexual abuse is not just an epidemic—it is at pandemic proportions. In the United States, perhaps 20% to 25% of adults sustain some form of sexual abuse during their childhood. These numbers are somewhat higher or lower in other countries but certainly do not vary by a factor of even 5. With such a high percentage of the world having been sexually abused, it may be legitimate to ask, is sexual abuse a “normal” behavior? Similarly, what is sexual abuse and why does it exist?

Anthropologically, concepts of appropriate sexual behaviors with young humans incorporate both biologically and culturally derived premises. Biologically, prepubertal animals are not frequent targets for sexual activity. This relative taboo is reasonably ubiquitous across species. Males and females of a given species usually wait until they achieve sexual maturity before they engage in sexual activity. This is utilitarian in that effort is not wasted on a nonreproductive member of the species. Besides olfactory, behavioral, and other cues that the individual is mature (and receptive), there are visual indicators of immaturity that seem to inhibit adults of most species. However, once having achieved sexual maturity an individual is fair game. Through most of human history, this biologic distinction of maturity has also apparently held. When the human life expectancy was a mere 30 years, however, one could not wait until the late teen years to begin reproduction.

In more recent historical times (and within certain cultures), a cultural overlay has developed that acknowledges a “delayed” maturity. Thus the age of consent is more likely to be 16 years or so, not age 10 or 11 years when some girls are having their first menstrual period. The concept especially derives from the notion that children need prolonged education and parental nurturance before they should have to compete with the adult population and its risks. The adult is supposed to ignore the development of secondary sexual characteristics (biologic maturity) and focus on chronological age with a somewhat arbitrary cutoff (eg, what is the difference between a 15 year old and a 16 year old?).

Both the biologic cutoff and the chronological cutoff are respected by most adults in society. Yet some overlook the cultural cutoff and some even ignore the biologic cutoff (ie, have sex with young children). For the latter, this is a violation of both cultural and biologic taboos.

Another biology-related taboo is having sex with close kin. The genetic implications could not have been consciously appreciated by humans through most of history, nor by some species, which also abide by this taboo. Yet nearly all human cultures respect the incest taboo—a sign of a relative biologic underpinning for this behavior. Nevertheless, some adult humans also fail to respect this distinction and commit what we consider incest.

Views about appropriate and inappropriate sexual activity with younger humans have been codified into law and society as sexual abuse crimes. These are crimes about sex and reflect the perpetrator’s sexual drive. While sexual drives help to maintain the species and are overall a necessary biologic imperative, sexual abuse incorporates biologically useless activity (ie, sex with biologically immature children) and/or activity that is culturally shunned. In some instances the perpetrator may “love” the child and perhaps be the better caregiver. Yet the violation of taboos elicits a strong reaction by most members of society—reflecting a lack of concern for the child’s well-being and trampling of the society’s biologic and cultural ideations.

What can be done about this? One option would be to ignore the abuse. Yet this historically has not been done if the act becomes known, and it fails to meet the developmental needs of children. Another option would be to mount an aggressive prevention campaign aimed at perpetrators before they commit sexual abuse (pri-
mary and secondary prevention). This has not been done to any significant extent as yet. The third option is what most of this book is about—identifying sexual abuse when it has occurred and providing the types of interventions that might minimize its impact. We can treat the child and treat and/or incarcerate the offender. Considerable progress has occurred in the last three decades that enables us to better understand, identify and intervene with child sexual abuse. The results of this progress are reflected in the state-of-the-art descriptions within this volume. These approaches make a real difference in children’s lives and help us to respect the boundaries we place on sexual activity with our young.

One unanswered question remains: When will we as a society care enough about our children to make the substantial efforts required to implement the very best in primary, secondary, and tertiary prevention for our children? Until this becomes a cultural imperative of its own, we will continue to need books such as these, and the misery of lost childhoods will contribute to a sordid reality. Let us hope that some future generation can appreciate the brilliance of the work portrayed herein, but is also able to view child sexual abuse as an extinct historical oddity.

Randell Alexander, MD, PhD, FAAP
Professor of Pediatrics and Chief
Division of Child Protection and Forensic Pediatrics
Department of Pediatrics
University of Florida
Jacksonville, Florida
Preface to the Second Edition

It is incumbent upon those responsible for survivors’ well-being to continually interrogate and reevaluate best practices in investigation, prosecution, medical care, and prevention of sexual violence. To that end, we offer the revised and updated second edition of *Sexual Assault Victimization Across the Life Span*. This latest edition is re-conceived as a 3-volume set, lending focus to 3 overarching subjects: the role of the multidisciplinary team, response to specific age groups, and the unique concerns of special survivor populations.

*Volume 1: Investigation, Diagnosis, and the Multidisciplinary Team* details principles of investigation in sexual assault and the responsibilities of multidisciplinary team members across fields, including medicine, medical forensic examination, emergency medical services, law enforcement, prosecution, and victim advocacy. It is of vital importance that readers in every branch of the multidisciplinary team recall the essential value of interdisciplinary cooperation in the interest of resilient recovery for those in our care.

*Volume 2: Evaluation of Children and Adults* and *Volume 3: Special Settings and Survivor Populations* outline response strategies tailored to the needs of specific survivor groups. The second volume addresses sexual assault and abuse in survivors across the life span, including chapters on teen dating violence, campus sexual assault, sexual abuse of the elderly, STIs in children, and sexually assaulted adolescent males. The third volume examines the role of environment and survivor identity in cases of sexual assault. Readers will enjoy the benefit of chapters geared toward sexual assault survivors in the military, correctional settings, LGBTQ communities, and others.

We are pleased to offer the new and expanded second edition of *Sexual Assault Victimization Across the Life Span* to our readers and colleagues. We sincerely hope and believe that its contents and the collective expertise of its contributors will prove valuable in research, response, and care for survivors of sexual violence.

Angelo P. Giardino, MD, PhD
Diana K. Faugno, MSN, RN, CPN, SANE-A, SANE-P, FAAFS, DF-IAFN
Mary J. Spencer, MD, FAAP
Michael L. Weaver, MD, FACEP, CDM
Patricia M. Speck, DNSc, APN, FNP-BC, DF-IAFN, FAAFS, FAAN
What is sexual assault? It is a crime of violence, where the assailant uses sexual contact as a weapon, seeking to gain power and control. Often youths and adolescents are disproportionately targeted, although sexual assault can occur at any age. Sexual assault is also an act of opportunity. Particularly vulnerable populations include children, especially young females, and individuals who are less able to care for themselves, such as the homeless or physically or mentally handicapped persons. Their vulnerability and ease of manipulation makes them prey.

Who commits these acts? While there is no classic profile of an offender, child sex abusers tend to be males who are known to the child's caregivers, and 80% of the women who are assaulted know their attackers, as well—they are their ex-husbands, their stepfathers, their boyfriends, and other friends or relatives. Men may also experience victimization.

To protect victims from these offenders will require a change in the attitude of society toward its most vulnerable members. Society must value these individuals before anything will be done. Education plays a key role in accomplishing this change in attitude. This book was prepared with the goal of disseminating the information required to bring about change, to better protect and care for victims of sexual assault. Written for health care professionals and other mandated reporters, Sexual Assault Victimization Across the Life Span offers a complete approach to the topic. The problem is defined, all aspects are explored, and treatment and interventions are outlined. Victim characteristics are explored, especially those seen in children. But most importantly, useful information is offered to those who provide care for these victims and those who handle the disposition of the perpetrators. We see the problem through the eyes of many professionals: physicians, paramedics, law enforcement personnel, the judicial system, social workers, and people who work with children. This covers everyone from the crisis hotline staff, to police and law enforcement personnel, to prehospital providers, to specially trained detectives, to skilled medical staff, to trained sexual assault examiners, to rape crisis counselors. Finally, the text offers information on programs that are in place or are under consideration to aid in the prevention of sexual assault.

Knowledge gives us the power to intervene, and this book offers current, accurate, and specific data concerning the problem of sexual assault. With the information at hand, we can become empowered and participate in effective interventions to prevent sexual assault as well as care for its victims.

Angelo P. Giardino, MD, PhD
Reviews

The second edition of Sexual Assault Victimization Across the Life Span is a comprehensive, evidence-based collection of resource material for the sexual assault nurse examiner (SANE) written by experts in the field of forensic medicine and nursing. Chapters address the holistic health needs of the sexual assault patient. Chapters of particular interest for the SANE include those addressing the medical forensic exam and evidence collection. Several chapters address the sensitive needs of special populations such as children, the elderly, victims of gender-based violence, and male patients. The chapters are well written, with attention to detail and current research. There are a plethora of case studies and photographs to illustrate the key points in chapters. Each chapter ends with discussion questions, challenging readers to thoughtfully consider adoption into their practice. These books are a must-have for SANEs and SANE programs.

Ann Adlington, MS, BSN, RN, SANE-A
South Region SANE Coordinator
Advocate Health Care
Hazel Crest, Illinois

Sexual Assault Victimization Across the Life Span, Second Edition is an expansive, thorough 3-volume resource for medical professionals and multidisciplinary partners working on behalf of sexual assault victims. Unique to this collection is the focus on evidence-based investigation, diagnosis, evaluation, and the needs of special populations. One author highlights the complex need for understanding the cultural background and semantic/linguistic nuances essential to a compassionate approach to sexual assault victims. Others emphasize the critical importance of a thoughtful, trauma-informed approach to the victim, underscored by a core principle—“Start by believing”—which may be the key to safe disclosure, participation in a medical forensic evaluation, and cooperation with investigation and prosecution, all of which enhances the likelihood of justice for victims. Each chapter includes current foundational information, clearly delineated lists of symptoms or suggestions, and discussion questions. This should be a go-to reference for sexual assault response team partners in health care, criminal justice, and victim advocacy.

Eugenia Barr, PhD, LMFT-S
Eugenia Barr Counseling and Consulting, LLC
Denison, Texas

Sexual Assault Victimization Across the Life Span, Second Edition is a comprehensive text that will be a valuable resource for all health care providers involved in the evaluation and management of sexual assault victims. The full, 3-volume set consists of 39 chapters, each dealing with a different aspect of sexual assault, including assault of boys and male adolescents, persons with disabilities, and assault among LGBTQ populations. Chapters are comprehensive and detailed. Of particular value are the sections referred to as “Tips from the Bench,” that include comments beyond the medical assessment that may have relevance to child protective services, law enforcement, and mental health providers. In addition, each chapter starts off with a section designated “Purpose of the Chapter” that sets the agenda for the chapter, followed by the chapter’s learning objectives. This book will serve as an invaluable guide to those who care for sexual assault victims.

Carol D. Berkowitz, MD, FAAP, FACEP
Executive Vice Chair
Department of Pediatrics
Harbor-UCLA Medical Center
Distinguished Professor of Pediatrics
David Geffen School of Medicine at UCLA
Los Angeles, California

Chapter 1, “Overview of Sexual Assault, Abuse, and Exploitation” is the perfect synopsis of the history of sexual assault and abuse across the life span. Regardless of their background, multidisciplinary team members can glean critical knowledge from the text, which explains the history of sexual assault and child protection laws in the United States and across the world. The chapter “Sexually Transmitted Infections in Sexually Abused Children” concisely covers the epidemiology of the major STIs in children, testing methods, implications of the results, and treatment options. Diagnosing sexual abuse is intrinsically challenging but this chapter provides an exceptional overview for clinicians, while citing outstanding references.

“Screening for and Treatment of Sexual Abuse Histories in Boys and Male Adolescents” provides tools to appropriately care for these children. The authors discuss evidence-based research regarding trends in child sexual abuse and highlight slight but important differences between young male and female victims.

Laurie Charles, MSN, RN, SANE-A, SANE-P
Clinical Assistant Professor
Forensic Health Care
Texas A&M College of Nursing
Bryan, Texas

The new Sexual Assault Victimization Across the Life Span, Second Edition is a must-have resource for those who care for or respond to victims of sexual assault and abuse. There are several essential texts that I recommend programs consider keeping close at hand for reference, and this book is one of them. SANE programs and multidisciplinary collaborative team members should consider this for their professional bookshelves and libraries. It provides crucial information on the range of issues that may have potential impact on sexual assault victims of all ages. Included in this new edition are critical issues sexual assault examiners and the entire response team can tackle together as they work to provide competent, ethical, patient-focused care. These issues can impact the long-term health and well-being of their patients and ultimately the safety of their communities.

Kim Day RN, SANE-A, SANE-P
SAFE Technical Assistance Project Director
International Association of Forensic Nurses
Elkridge, Maryland

Sexual Assault Victimization Across the Life Span is an intricate and comprehensive compendium of information on all aspects of sexual assault. The breadth and depth of information is exceptional—from detailing the responsibilities of prosecutors and sexual abuse examiners, to a discussion of workplace sexual assault, and issues of dealing with sexual abuse in children with disabilities. This 3-volume compilation should be a mandatory resource in any organization engaged in any facet of sexual assault response or for anyone who wants a resource that deals with any or all of the multiple aspects of sexual abuse. The logical, functional structure of the volumes dividing the subject into investigation, evaluation of children and adults, and lastly, a volume on special settings and survivor populations greatly enhances the ease of using this material.

Theodore N. Hariton, MD, FACOG
Forensic Obstetrician and Gynecologist
Diplomate of the American Board of Obstetrics and Gynecology
Fellow of the American College of Obstetrics and Gynecology
Fellow of the American Academy of Forensic Scientists
Life Fellow of the Los Angeles Obstetrics and Gynecology Society
North American Society of Pediatric and Adolescent Gynecology
American Professional Society on the Abuse of Children
American Academy of Forensic Scientists
Tuscon, Arizona
Forensic nurses must command knowledge of many variables, including a wide array of patient traits, types of physical and emotional trauma, and appropriate treatment options. Sexual Assault Victimization Across the Life Span provides a rare combination of intricate procedural detail while maintaining an easy-to-follow tone that is instantly valuable to seasoned practitioners as well as professionals just gaining familiarity with the complexities inherent to sexual assault exams. Topics ranging from exam procedures to tips on preparing for testimony in court are readily accessible through the quick reference format. The text goes beyond theoretical ideas and definitions, providing step-by-step instructions for techniques to identify causality factors and detailed procedures for delivering appropriate treatment. This is a "one-stop shop" for current best practices that any professional associated with the sexual assault response community can instantly put into practical use.

Sarah L. Pederson, BSN, RN, SANE-A
SANE Coordinator
Rape Crisis Center
Marietta, Georgia

The new second edition of Sexual Assault Victimization Across the Life Span is an important contribution to the field of sexual assault and violence. It is probably the leading textbook in the field, and it is a must-have for all medical professionals who care for victims of sexual violence. The beauty of the book is that it truly covers victims across the life span and provides guidance and tools to address the needs of all survivors. The text is logically organized into 3 volumes: Investigation, Diagnosis, and the Multidisciplinary Team, Evaluation of Children and Adults, and Special Settings and Survivor Populations. Each chapter contains key points highlighting important concepts and principles for the benefit of the reader.

Ralph Riviello, MD, MS, FACEP
Professor and Vice Chair of Clinical Operations
Department of Emergency Medicine
Drexel University
Medical Director
Philadelphia Sexual Assault Response Center
Philadelphia, Pennsylvania
# CONTENTS IN BRIEF

**CHAPTER 1: OVERVIEW OF SEXUAL ASSAULT, ABUSE, AND EXPLOITATION** ............................................. 1  
**CHAPTER 2: SEXUALLY TRANSMITTED INFECTIONS IN SEXUALLY ABUSED CHILDREN** .............................. 23  
**CHAPTER 3: SCREENING FOR AND TREATMENT OF SEXUAL ABUSE Histories in Boys and Male Adolescents** .................................................................................................................. 35  
**CHAPTER 4: DATING VIOLENCE IN TEENS AND YOUNG ADULTS** ............................................................ 63  
**CHAPTER 5: OVERVIEW OF ADOLESCENT AND ADULT SEXUAL ASSAULT** ......................................... 83  
**CHAPTER 6: THE EVALUATION OF THE ADULT SEXUAL ASSAULT VICTIM** ............................................. 119  
**CHAPTER 7: ADULT MALE SEXUAL ASSAULT** .......................................................................................... 157  
**CHAPTER 8: SEXUAL ASSAULT AMONG OLDER ADULTS** ....................................................................... 169  
**CHAPTER 9: SEXUALLY TRANSMITTED INFECTIONS AND PREGNANCY PROPHYLAXIS IN ADOLESCENTS AND ADULTS** ................................................................. 203  
**CHAPTER 10: FORENSIC ISSUES IN CARING FOR THE ADULT SEXUAL ASSAULT VICTIM** .................. 229  
**CHAPTER 11: THE TEAM APPROACH TO CARING FOR PATIENTS WHO HAVE EXPERIENCED ALCOHOL- AND/OR DRUG-FACILITATED SEXUAL ABUSE** ...................................... 255  
**INDEX** .................................................................................................................................................. 301
With copyright.com, you can quickly and easily secure the permissions you want.

Simply follow these steps to get started:

— Visit copyright.com and enter the title, ISBN, or ISSN number of the publication you’d like to reuse and hit “Go.”
— After finding the title you’d like, choose “Pay-Per-Use Options.”
— Enter the publication year of the content you’d like to reuse.
— Scroll down the list to find the type of reuse you want to request.
— Select the corresponding bubble and click “Price & Order.”
— Fill out any required information and follow the prompts to acquire the proper permissions to reuse the content that you’d like.

For questions about copyright.com, please contact:

Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923
Phone: +1-(978) 750-8400
Fax: +1-(978) 750-4470

Additional requests can be sent directly to info@copyright.com.

About Copyright Clearance Center
Copyright Clearance Center (CCC), the rights licensing expert, is a global rights broker for the world’s most sought-after books, journals, blogs, music, and more. Founded in 1978 as a not-for-profit organization, CCC provides smart solutions that simplify the access and licensing of content that let businesses and academic institutions quickly get permission to share copyright-protected materials, while compensating publishers and creators for the use of their works. We make copyright work. For more information, visit www.copyright.com.
# CONTENTS IN DETAIL

## CHAPTER 1: OVERVIEW OF SEXUAL ASSAULT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of Chapter</td>
<td>1</td>
</tr>
<tr>
<td>Objectives</td>
<td>1</td>
</tr>
<tr>
<td>Key Points</td>
<td>1</td>
</tr>
<tr>
<td>Key Terms</td>
<td>1</td>
</tr>
<tr>
<td>History</td>
<td>4</td>
</tr>
<tr>
<td>Definition</td>
<td>7</td>
</tr>
<tr>
<td>Scope and Epidemiology</td>
<td>7</td>
</tr>
<tr>
<td>Evaluation of the Sexual Assault Survivor</td>
<td>9</td>
</tr>
<tr>
<td>Listening to the Survivor</td>
<td>9</td>
</tr>
<tr>
<td>Physical Examination of the Survivor</td>
<td>10</td>
</tr>
<tr>
<td>Anogenital Examination of the Survivor</td>
<td>12</td>
</tr>
<tr>
<td>Forensic Evidence Collection</td>
<td>15</td>
</tr>
<tr>
<td>Laboratory Testing and Treatment</td>
<td>16</td>
</tr>
<tr>
<td>Caring for Professionals Who Serve Survivors</td>
<td>17</td>
</tr>
<tr>
<td>Conclusion</td>
<td>17</td>
</tr>
<tr>
<td>Discussion Questions</td>
<td>17</td>
</tr>
<tr>
<td>References</td>
<td>17</td>
</tr>
</tbody>
</table>

## CHAPTER 2: SEXUALLY TRANSMITTED INFECTIONS IN SEXUALLY ABUSED CHILDREN

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of Chapter</td>
<td>23</td>
</tr>
<tr>
<td>Objectives</td>
<td>23</td>
</tr>
<tr>
<td>Key Points</td>
<td>23</td>
</tr>
<tr>
<td>Key Terms</td>
<td>24</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>24</td>
</tr>
<tr>
<td>STI Clinical Signs and Symptoms</td>
<td>25</td>
</tr>
<tr>
<td><em>Chlamydia</em></td>
<td>25</td>
</tr>
<tr>
<td><em>Gonorrhea</em></td>
<td>25</td>
</tr>
<tr>
<td><em>Syphilis</em></td>
<td>25</td>
</tr>
<tr>
<td><em>HIV</em></td>
<td>25</td>
</tr>
<tr>
<td><em>Trichomonas vaginalis</em></td>
<td>25</td>
</tr>
<tr>
<td><em>Anogenital Warts</em></td>
<td>26</td>
</tr>
<tr>
<td><em>Herpes Simplex</em></td>
<td>26</td>
</tr>
<tr>
<td><em>Chancroid, Granuloma Inguinale, and Pubic Lice</em></td>
<td>26</td>
</tr>
<tr>
<td><em>Bacterial Vaginosis</em></td>
<td>27</td>
</tr>
<tr>
<td><em>Infectious Hepatitis Types A, B, and C</em></td>
<td>27</td>
</tr>
<tr>
<td>Evidence for Sexual Transmission of STIs</td>
<td>27</td>
</tr>
<tr>
<td>Modern Methods for Diagnosis STIs in Children</td>
<td>29</td>
</tr>
<tr>
<td>Prophylaxis and Treatment</td>
<td>30</td>
</tr>
<tr>
<td>Conclusion</td>
<td>31</td>
</tr>
<tr>
<td>Discussion Questions</td>
<td>31</td>
</tr>
<tr>
<td>References</td>
<td>31</td>
</tr>
</tbody>
</table>
Vulnerable Populations .................................................. 88
  Younger Age .............................................................. 88
  Adolescents .............................................................. 88
  College-Aged ............................................................. 88
  Past Victimization ....................................................... 89
  Lesbian, Gay, Bisexual, Transgender, and Questioning Individuals .... 89
  Substance Abuse ........................................................ 89
  Evaluation and Treatment for Special Populations ..................... 89
  Adolescents .............................................................. 89
  Lesbian, Gay, Bisexual, Transgender, and Questioning Individuals ... 90
  Men ........................................................................ 90
  Older Women .............................................................. 91

State of the Science ......................................................... 91
  Sexual Assault Nurse Examiner Programs .................................. 91
  College Sexual Assault ................................................... 92
  Prevention Programs ...................................................... 93
  Future Research Needs .................................................... 97
  Discussion Questions ...................................................... 97
  Appendix 5-1: Adult Sexual Assault Photographic Reference ........ 98
  References ................................................................... 113

**CHAPTER 6: THE EVALUATION OF THE ADULT SEXUAL ASSAULT VICTIM** ................................................................. 119
Purpose of Chapter ........................................................... 119
Objectives ...................................................................... 119
Key Points ...................................................................... 119
Key Terms ...................................................................... 120
History .......................................................................... 121
State of the Science .......................................................... 122
Current Practices in the Care of the Sexual Assault Patient ........... 124
  Examination Components .................................................. 124
  Examination Process ........................................................ 125
  Head-to-Toe Examination .................................................. 129
  Exam Documentation ......................................................... 132
  After the Examination ....................................................... 134
Variations in the Sexual Assault Examination Process .................. 134
  Presence of Support Personnel ........................................... 134
  Culture ....................................................................... 135
  Male Victims .................................................................. 135
  Disabled Persons ............................................................ 136
  Elderly ....................................................................... 136
  Strangulation .................................................................. 139
Additional Equipment ......................................................... 140
Additional Considerations .................................................... 140
Follow-up Examinations ....................................................... 141
Conclusion ..................................................................... 142
Discussion Questions ........................................................ 142
Appendix 6-1: Adult Sexual Assault Photographic Reference ........ 143
References ...................................................................... 153

**CHAPTER 7: ADULT MALE SEXUAL ASSAULT** ............................................................ 157
Purpose of Chapter ........................................................... 157
Objectives ...................................................................... 157
Key Points ...................................................................... 157
Key Terms ...................................................................... 158
Prevalence of and Barriers to Reporting .................................... 158
Contents in Detail

Prevalence of Male Sexual Assault ........................................... 158
Barriers to Reporting and Disclosure ........................................ 159
Effects and Consequences ...................................................... 159
Male Rape Myths .................................................................. 160
Cultural Diversity .................................................................. 161
Hispanics and Latinos ............................................................ 162
Black or African American ..................................................... 162
American Indians .................................................................. 162
Care of the Male Victim of Sexual Assault ................................. 163
  Routine Universal Screening .................................................. 163
  Assessment for Male Sexual Assault ....................................... 163
  Care and Support of the Male Victim ....................................... 164
  Patient Education ................................................................ 164
Conclusion ........................................................................... 164
Discussion Questions ................................................................ 165
Appendix 7-1: Resources .......................................................... 165
References ............................................................................. 165

Chapter 8: Sexual Assault Among Older Adults ......................... 169
Purpose of Chapter .................................................................. 169
Objectives ............................................................................ 169
Key Points ............................................................................ 169
Key Terms ............................................................................ 170
Defining the Problem: Rape, Sexual Assault, and Sexual Abuse in Older Adults ...................................................... 172
Defining the Older Adult Population ......................................... 173
  General Considerations .......................................................... 173
  Chronologic Descriptors of the Older Adult Population .......... 173
  Health Indices in the Older Adult Population ......................... 174
  Cohort Issues of Population Aging ........................................ 174
  Similarities and Differences Between Older and Younger Sexual Assault Victims ...................................................... 175
Epidemiology of Sexual Assault in the Older Adult Population .............................................................................. 175
  National Crime Reporting Data .............................................. 176
  Research Data ..................................................................... 177
Sexual Assault in Older Men ...................................................... 177
  Need for Standardized Data Sets and Conceptual Framework for Research .................................................. 178
  Development of a Core Data Set Tool for Older Adult Females .............................................................. 178
  Developing a Conceptual Model of Sexual Assault for Older Adults .............................................................. 178
Temporal Characteristics .......................................................... 179
Victim Characteristics .............................................................. 180
  Frailty and Functional Status ................................................... 180
  Living Situations ................................................................ 181
  Frail, Dependent Older Adults ............................................... 181
  Older Adults Residing in Nursing Homes ................................. 182
  Patterns of Sexual Abuse ........................................................ 182
  Older Adults Living in Residential Care Facilities ..................... 182
Offender Characteristics ........................................................... 182
Assault Characteristics: Investigation and Follow-up of Sexual Assault .............................................................. 183
  Problems With Follow-up on Sexual Abuse and Assault ........ 184
Emergency Care of the Older Adult Sexual Abuse Victim .......... 184
  Current Recommendations for Emergency Care of Older Adult Sexual Assault Victims .............................................. 185
  Assessing Cognition in Older Adult Sexual Assault Victims in Emergency Rooms ............................................. 186
  Cognitive Assessment Tools for Emergency Department Clinicians .............................................................. 186
  Emergency Department Screening for Sexual Assault in Older Adults .............................................................. 187
  Assessment of Trauma Patterns and Severity .......................... 187
  Interview ........................................................................... 187
Contents in Detail

  Sexual Assault Examination and Evidence Collection ........................................... 188
  Education and Certification of Clinicians ......................................................... 189
  Trauma Care ........................................................................................................... 190
  Emergency Department Coordination of Services .............................................. 191
   Emergency Medical Services ............................................................................. 191
   Law Enforcement ................................................................................................. 192
   Need for Systems Improvement ......................................................................... 192
   Education of Emergency Personnel. .................................................................. 192
   Emergency Department Education and Design Issues .................................... 192
  Future Directions: Institutional and Policy Considerations ............................. 193
  Conclusion ............................................................................................................. 194
  Discussion Questions ............................................................................................ 194
  References ............................................................................................................. 194

Chapter 9: Sexually Transmitted Infections and Pregnancy Prophylaxis in Adolescents and Adults .... 203
  Purpose of Chapter ................................................................................................. 203
  Objectives ............................................................................................................. 203
  Key Points ............................................................................................................. 203
  Key Terms ............................................................................................................. 204
  Recognition and Treatment of Common Sexually Transmitted Infections and Associated Syndromes  ......................................................................................................................... 206
    Gonorrhea ............................................................................................................. 206
    Gonococcal Resistance ....................................................................................... 206
    Chlamydia ............................................................................................................. 208
    Syphilis ................................................................................................................ 209
    Chancroid ............................................................................................................. 209
    Trichomoniasis ..................................................................................................... 210
    Herpes Simplex ..................................................................................................... 210
    Human Papillomavirus ....................................................................................... 211
    Bacterial Vaginosis. ............................................................................................. 211
    Mucopurulent Cervicitis ....................................................................................... 212
    Pelvic Inflammatory Disease ............................................................................. 212
    Proctitis and Proctocolitis ................................................................................... 214
    Pubic Lice ............................................................................................................. 214
    Scabies ................................................................................................................ 214
    Viral Hepatitis ...................................................................................................... 214
    History and Physical Examination ...................................................................... 215
    Diagnostic Evaluation ........................................................................................ 217
    Treatment and Prophylaxis of Sexually Transmitted Infections .................... 217
      Human Immunodeficiency Virus Postexposure Prophylaxis ......................... 218
      Emergency Contraception ................................................................................. 220
    Conclusion ........................................................................................................... 222
    Discussion Questions .......................................................................................... 222
    References .......................................................................................................... 222

Chapter 10: Forensic Issues in Caring for the Adult Sexual Assault Victim ................. 229
  Purpose of Chapter ................................................................................................. 229
  Objectives ............................................................................................................. 229
  Key Points ............................................................................................................. 229
  Key Terms ............................................................................................................. 230
  Definitions of Key Concepts. .............................................................................. 230
  Sexual Assault ...................................................................................................... 231
  Review of the Literature ....................................................................................... 231
  Current Promising Practices in Care of Sexual Assault Victims ....................... 232
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary Collaboration</td>
<td>232</td>
</tr>
<tr>
<td>Establishing Victim Safety</td>
<td>233</td>
</tr>
<tr>
<td>Health and Assault History</td>
<td>233</td>
</tr>
<tr>
<td>Health History</td>
<td>233</td>
</tr>
<tr>
<td>Assault History</td>
<td>233</td>
</tr>
<tr>
<td>The Assault</td>
<td>233</td>
</tr>
<tr>
<td>The Perpetrator</td>
<td>234</td>
</tr>
<tr>
<td>The Crime Scene</td>
<td>234</td>
</tr>
<tr>
<td>The Victim’s Postcrime Behaviors</td>
<td>234</td>
</tr>
<tr>
<td>Acute Care of the Sexual Assault Victim</td>
<td>236</td>
</tr>
<tr>
<td>Victim Consent</td>
<td>236</td>
</tr>
<tr>
<td>Assessing Physical Trauma</td>
<td>236</td>
</tr>
<tr>
<td>Gynecologic Injuries</td>
<td>237</td>
</tr>
<tr>
<td>Nongynecologic Injuries</td>
<td>239</td>
</tr>
<tr>
<td>Prevention of Pregnancy</td>
<td>240</td>
</tr>
<tr>
<td>Prevention of Sexually Transmitted Infections</td>
<td>242</td>
</tr>
<tr>
<td>Forensic Evidence Collection</td>
<td>243</td>
</tr>
<tr>
<td>Chain of Custody</td>
<td>243</td>
</tr>
<tr>
<td>Documentation After Sexual Assault</td>
<td>243</td>
</tr>
<tr>
<td>The Medical Forensic History of the Event</td>
<td>246</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>246</td>
</tr>
<tr>
<td>Medical Management</td>
<td>246</td>
</tr>
<tr>
<td>Evidence Collected</td>
<td>246</td>
</tr>
<tr>
<td>Support Services</td>
<td>246</td>
</tr>
<tr>
<td>Legal Representation</td>
<td>246</td>
</tr>
<tr>
<td>Victim's Private Information</td>
<td>247</td>
</tr>
<tr>
<td>The Role of the Health Care Provider</td>
<td>248</td>
</tr>
<tr>
<td>Subpoenas</td>
<td>248</td>
</tr>
<tr>
<td>Criminal Cases</td>
<td>248</td>
</tr>
<tr>
<td>Civil Cases</td>
<td>249</td>
</tr>
<tr>
<td>The Future</td>
<td>250</td>
</tr>
<tr>
<td>Research Needs</td>
<td>250</td>
</tr>
<tr>
<td>Evidence-Based Prevention</td>
<td>251</td>
</tr>
<tr>
<td>Conclusion</td>
<td>251</td>
</tr>
<tr>
<td>Discussion Questions</td>
<td>251</td>
</tr>
<tr>
<td>References</td>
<td>251</td>
</tr>
</tbody>
</table>

**CHAPTER 11: THE TEAM APPROACH TO CARING FOR PATIENTS WHO HAVE EXPERIENCED ALCOHOL-AND/OR DRUG-FACILITATED SEXUAL ABUSE**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of Chapter</td>
<td>255</td>
</tr>
<tr>
<td>Objectives</td>
<td>255</td>
</tr>
<tr>
<td>Key Points</td>
<td>255</td>
</tr>
<tr>
<td>Key Terms</td>
<td>256</td>
</tr>
<tr>
<td>Introduction</td>
<td>257</td>
</tr>
<tr>
<td>History</td>
<td>257</td>
</tr>
<tr>
<td>Overarching Team Approach to Care</td>
<td>259</td>
</tr>
<tr>
<td>The Evolution of the Sexual Assault Forensic Examiner</td>
<td>262</td>
</tr>
<tr>
<td>Initial Presentation</td>
<td>262</td>
</tr>
<tr>
<td>The Acute Presentation</td>
<td>263</td>
</tr>
<tr>
<td>The Prehospital Evaluation and Treatment</td>
<td>263</td>
</tr>
<tr>
<td>Hospital Evaluation and Treatment</td>
<td>263</td>
</tr>
<tr>
<td>Emergency Department Triage</td>
<td>263</td>
</tr>
<tr>
<td>History</td>
<td>263</td>
</tr>
<tr>
<td>Medical Forensic Examination</td>
<td>264</td>
</tr>
<tr>
<td>Vital Signs</td>
<td>264</td>
</tr>
</tbody>
</table>
Contents in Detail

Behavior .............................................. 265
Clothing ............................................. 265
The Physical Examination ......................... 265
   Head .............................................. 265
   Eyes .............................................. 266
   Face .............................................. 266
   Mouth ............................................. 266
   Neck .............................................. 266
   Breasts .......................................... 266
   Torso ............................................. 266
   Extremities ....................................... 266
   Nails .............................................. 267
   Genital Examination .............................. 267
   Anal Examination ................................ 267
Medical Treatment .................................. 267
   Delayed Presentation ............................ 268
   Emergency Department Triage ................. 268
   Patient History .................................. 269
   Medical Forensic Examination .................. 270
   Medical Treatment ............................... 270
Unique ADFSA Versus NADFSA Considerations .... 270
   Photographic Imaging ............................ 270
   Evaluation of Sexually Transmitted Infections. 270
   Pregnancy Evaluation ............................ 271
   Discharge Instructions ........................... 271
Toxicologic Testing ................................ 271
ADFSA Protocol/Kit .................................. 272
   Collecting Urine for Toxicology ............... 275
   Refrigeration or Freezing ....................... 275
   Collecting Blood for Toxicology ............... 277
   Hair Collection .................................. 277
   Other Biological Samples ....................... 277
Drugs of DFSA ...................................... 277
   Ethanol ......................................... 278
   Pharmacodynamics ................................ 278
   Benzodiazepines ................................ 280
   Pharmacodynamics ................................ 280
   Nonbenzodiazepine Hypnotics ................. 280
   Pharmacodynamics ................................ 281
   Gamma-hydroxybutyrate (GHB) ............... 281
   Pharmacodynamics ................................ 281
   Marijuana ....................................... 281
   Pharmacodynamics ................................ 281
   Ketamine ........................................ 282
   Pharmacodynamics ................................ 282
   Methyleneoxyamphetamine (MDMA) ............ 282
   Pharmacodynamics ................................ 282
Patient Consent and Competency .................. 282
   Consent ......................................... 282
   Competency ..................................... 286
Conclusion .......................................... 287
Discussion Questions ............................... 287
Appendix 11-1: ADFSA Photographic Reference .... 288
References .......................................... 296

INDEX ..................................................... 301
Sexual Assault

Victimization Across the Life Span

Evaluation of Children and Adults
OVERVIEW OF SEXUAL ASSAULT, ABUSE, AND EXPLOITATION

Tanya Hinds, MD
Norrell Atkinson, MD

PURPOSE OF CHAPTER
This chapter provides a historical, legal, and medical overview of sexual violence and sexual exploitation of children and adults. Factors that have impacted the awareness of sexual violence, and the misconceptions that persist about sexual violence, will be highlighted. Finally, best-practice standards for clinical evaluation, management and treatment of prepubertal, teen, and adult survivors will be discussed.

OBJECTIVES
By the end of this chapter, the reader will be able to:
— Discuss legal, medical, and societal landmarks related to sexual assault, abuse, and exploitation.
— Discuss standards to which professionals should adhere during sexual violence evaluations.
— Understand why the majority of anogenital exams following childhood sexual trauma are normal.
— Understand how approaches to forensic evidence collection and sexually transmitted infections differ in the prepubertal versus teen and adult populations.

KEY POINTS
1. Most perpetrators of sexual violence are not strangers.
2. Evaluations of sexual violence survivors should be impartial. Historical elements that should be elicited in a neutral open-ended fashion during a medical history or forensic interview include the relationship of the perpetrator(s) to the sexual assault survivor, the nature of the assault, and when and where the assault occurred.
3. Care must be taken to minimize further trauma during the examination of a sexual violence survivor.
4. Anogenital examinations are usually normal following childhood sexual trauma. By 2004, clinicians and researchers had established that the majority of physical examinations, even those following penetrating sexual trauma in children, were normal.

KEY TERMS
— Acute sexual violence: Sexual abuse, assault, or exploitation that has occurred recently, typically defined as within the prior 72-120 hours; this is the optimal time period for forensic evidence recovery and for identifying anogenital injuries.
— Colposcope: An examination device that provides illumination, magnification, and photodocumentation for the anogenital exam.
HISTORY

Sexual assault, abuse, and exploitation have occurred since time immemorial along with attempts at prosecution of sexual violence. Greek texts describe prostitution, sexual contact between adolescent and adult males, and incest in the Byzantine Empire (324 AD -1453 AD). Legal proceedings involving allegations of incest and other forms of sexual violence in the 16th through 18th centuries are documented in the criminal archives of Venice. In 1856 in the United States, a rape conviction involving the assault of a 13-year-old girl reached California’s Supreme Court where the conviction was reversed. Factors involved in the reversal included that a minor child provided uncorroborated testimony. In 1857, French forensic physician Auguste Ambroise Tardieu may have been the first physician in the modern era to describe a large case series of sexually abused female and male adults and children. Subsequently, psychiatrist Sigmund Freud promoted, then by 1897 largely disavowed, his own theory that child sexual abuse was the genesis of adult neurosis. Dr. Freud’s suggestion that infantile sexual fantasies rather than actual sexual abuse caused neurosis did not increase the medical community’s incentive to consider the diagnosis of child sexual abuse or add training about sexual abuse and assault of children and adults to medical school curricula. However, by the late 19th and early 20th century, nongovernmental organizations and juvenile courts in many jurisdictions of the United States attempted to formally address child maltreatment, albeit generally concentrating on neglect and child physical abuse.

In the first half of the twentieth century, discussions about sexual violence continued to be relatively rare. In the 1950s, sexual abuse and assault of adults and children remained largely unrecognized despite Alfred Kinsey’s 1953 publication, Sexual Behavior in the Human Female, which stated that 24% of females had either been approached while they were preadolescents by adult males who appeared to make sexual advances or had sexual contact with adult males as preadolescent girls. Additionally, only sporadic formal study of teen and adult sexual assault experiences, including acquaintance rape, existed.

More widespread acknowledgement of sexual violence by social services, medical, lay, and legal communities occurred in many, mostly Western, countries in the 1960s and 1970s. In the 1970s, rape crisis centers and sexual assault nurse examiner programs began to open across the United States. Sexual assault nurse examiners (SANEs) provided clinical care, collected forensic evidence, completed written and photodocumentation of injuries related to sexual abuse or assault, and often testified in court about their patients’ experiences and injuries. SANE programs contributed to the healing of traumatized survivors, complimented law enforcement investigations and evidence collection efforts, and increased conviction rates and guilty pleas.

In lay communities in the 1970s, Take Back the Night© and Reclaim the Night© events in the United States, Australia, India, and Europe highlighted sexual violence against women. Feminist writers debated the social, economic, and political factors that contributed to female oppression and sexual violence. In a text that was both seminal and controversial, Susan Brownmiller described the use of rape as an instrument of control, oppression, and war and defined rape in terms of a woman’s ability to consent. In part, this increased awareness of sexual violence in other sectors of society and resulted in rape shield laws, which barred attorneys from introducing the sexual histories of mostly adult women plaintiffs in legal cases. Additionally, the concept of consent described by Brownmiller© became a critical element of criminal and civil state laws governing sexual assault.

In the pediatric domain in the 1960s, child abuse pediatrician C. Henry Kempe and child protection pioneer Vincent DeFrancis successfully advocated for statewide child abuse reporting laws. These laws mandated reports of suspected child maltreatment, including sexual abuse, to public child protection agencies. With the Federal government’s passing of the Child Abuse Prevention and Treatment Act (CAPTA) of
1974,\textsuperscript{11} of which former Vice President Walter Mondale was the chief author, child sexual abuse was nationally recognized as a specific form of child maltreatment. By the middle of the 1970s, the United States had a national child protection services (CPS) system. However, in spite of these advances, in 1975 Sgroi\textsuperscript{12} noted sexual abuse of children “is the last remaining component of the maltreatment syndrome in children that has yet to be faced head-on.” Ongoing obstacles included unwillingness to consider or report child sexual abuse and inadequate medical evaluations.\textsuperscript{12} Further, the concept of a coordinated, multidisciplinary response to child sexual abuse was still approximately a decade away.

By the 1980s, speaking out about adult and child sexual abuse and assault was increasingly common as were prevention efforts by sociologists, mental health professionals, forensic nurses, and physicians. In the pediatric population, prevention involved teaching young children about appropriate and inappropriate touches.\textsuperscript{13} Among teens and older adults, efforts were made to increase awareness that sexual violence was more than a random blitz attack by a stranger. Acquaintance rape among college students was studied once again by Kanin,\textsuperscript{14} and more famously in a 1982 Ms. magazine project on sexual assault, which described the sexual violence experiences of 6159 female and male college students. In the Ms. project, 15% of women were raped (defined as unwanted sexual penetration perpetrated by force, threat of harm, or mental or physical inability to give consent), 84% of whom were raped by a known male acquaintance.\textsuperscript{15} Similarly, it was recognized that children are most likely to be sexually abused by a family member or acquaintance than a stranger.\textsuperscript{16} Pioneering child abuse pediatrician Dr. Martin Finkel\textsuperscript{17} highlighted familial and societal factors that contributed to failure to prevent or protect a child from sexual assault, including incest. Finkel\textsuperscript{17} also highlighted the limited ability of the medical examination to diagnose sexual abuse and spoke to the value of carefully speaking with the child about the child’s perception of events.\textsuperscript{17} Certainly, child-serving professionals were speaking with children; however, the interviews they conducted were often repetitious and redundant. Interviews were also conducted by professionals with various levels of training about how to interview children in a nonleading fashion about sexual abuse. In 1985, former Alabama Congressman Robert E. Cramer envisioned law enforcement, attorneys, social workers, clinicians, and other child serving professionals working as part of a coordinated multidisciplinary team (MDT) at a single site to minimize trauma to children and reduce repetitious interviewing during sexual abuse investigations. His vision led to the creation of the first child advocacy center (CAC) in Huntsville, Alabama. As CACs proliferated across the United States, these centers offered children a safe, supportive environment in which to speak about their victimization. The standard of care following sexual violence was evolving into a combination of skilled, careful forensic interviewing and a medical examination, particularly in the pediatric population.

The late 1980s and 1990s were characterized by high-profile successes and adverse experiences for survivors of sexual violence. The 1994 enactment of the Violence Against Women Act (VAWA)\textsuperscript{18} strengthened federal penalties for repeat sexual offenders, increased the training of law enforcement officers who responded to sexual violence, mandated national recognition of local protective orders, lessened the financial costs of services for survivors, and created the National Domestic Violence Hotline. However, the utilization of increasing resources by adult survivors of sexual violence by the 1990s resulted in increased scrutiny and calls to demonstrate the effectiveness of these survivor services. Around the same time, the diverse experiences CPS organizations and their opponents, Victims of Child Abuse Laws (VOCAL), were highlighted in a 1994 publication \textit{The Backlash} edited by John Myers, JD.\textsuperscript{19} Forensic interviewing of children, children’s suggestibility, and interviewer motives were being heavily scrutinized and questioned in the lay media and scientific literature, most notably in the McMartin Preschool case in the United States.\textsuperscript{20} Ultimately, the importance of careful history taking by clinicians and forensic interviews by trained
those outlined in the booklet *Engaging Bystanders in Sexual Violence Prevention*. There is now robust evidence that sexual violence may not typically result in visible or lasting physical injury but nevertheless has adverse mental health and other life altering consequences decades after victimization. Clinical attention and research to understand and possibly mitigate the pathology and recidivism among rapists, child molesters, and juvenile sex offenders is also ongoing. One hundred and fifty years after Dr. Auguste Tadieu wrote of adult and child sexual abuse, clinicians and law enforcement professionals not only struggle with the psychosocial factors that contribute to sexual violence and its sequelae but must also simultaneously confront added dimensions to sexual violence such as the proliferation of child pornography on the Internet and human sex trafficking by organized multinational criminal gangs.

**DEFINITION**

In 1978, Dr. C. Henry Kempe published "Sexual Abuse, Another Hidden Pediatric Problem" in an attempt to raise awareness among physicians of the problem of child sexual abuse. Kempe defined sexual abuse as "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles." He further defined sexual abuse as sexual activities that may include all forms of oral-genital, genital, or anal contact by or to the child. Kempe also described noncontact sexual abuse acts such as exhibitionism, voyeurism, or using the child in the production of pornography. His work was instrumental in the passing of statewide child abuse reporting laws in the 1960s mandating reports of suspected child maltreatment, including sexual abuse. With the federal government’s passing of the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, child sexual abuse was recognized as a specific form of child maltreatment. CAPTA set forth a minimum definition of abuse and neglect to guide states. Sexual abuse as defined by CAPTA includes: "the employment, use, persuasion, inducement, enticement or coercion of any child to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct [or]...the rape, and in cases of caregiver or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children or incest with children."

Since the mid-1990s, the Internet has had a vast impact on the media and simultaneously broadened the definition of sexual abuse to include the production and distribution of pornographic materials. Child pornography is a form of child sexual exploitation defined by federal law as any visual depiction of sexually explicit conduct involving a minor (individuals aged younger than 18 years) and constitutes these images as child sexual abuse images. The production, distribution, importation, reception, or possession of any child pornography images is federal crime in every state. In addition it makes it a crime "to persuade, induce, entice, or coerce a minor to engage in sexually explicit conduct for purposes of producing visual depictions of that conduct."

The scope of actions classified as sexual abuse or assault is vast. These actions may involve a power differential where the offender asserts dominance over the victim, has a more sophisticated understanding of the significance and implications of the sexual encounter, or both. Overall, sexual abuse or assault encompasses actions performed for sexual gratification of the perpetrator.

**SCOPE AND EPIDEMIOLOGY**

Various federal agencies compile statistics on sexual abuse and assault. The US Bureau of Justice tracks data on violent crimes, including rape. The *National Crime Victimization Survey (NCVS)* tracks rape and sexual assault cases while the Federal Bureau of Investigation’s (FBI) *Uniform Crime Report* measures nonfatal violence. Between 1995 and 2005, sexual violence against women aged 12 years and older decreased by 64% from 5 cases per 1000 to 1.8 cases per 1000 and remained unchanged through 2010 (Tables 1-1 and 1-2).
Table 1-1. Selected Maltreatment Types of Victims by Age, 2011 (Unique Count)

<table>
<thead>
<tr>
<th>AGE</th>
<th>MEDICAL NEGLECT</th>
<th>NEGLECT</th>
<th>PHYSICAL ABUSE</th>
<th>PSYCHOLOGICAL MALTREATMENT</th>
<th>SEXUAL ABUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>PERCENT</td>
<td>NUMBER</td>
<td>PERCENT</td>
<td>NUMBER</td>
</tr>
<tr>
<td>&lt;1-2</td>
<td>5212</td>
<td>34.6</td>
<td>159753</td>
<td>30.1</td>
<td>28565</td>
</tr>
<tr>
<td>3-5</td>
<td>2313</td>
<td>15.3</td>
<td>110335</td>
<td>20.8</td>
<td>19394</td>
</tr>
<tr>
<td>6-8</td>
<td>2046</td>
<td>13.6</td>
<td>86282</td>
<td>16.2</td>
<td>19644</td>
</tr>
<tr>
<td>9-11</td>
<td>1820</td>
<td>12.1</td>
<td>68212</td>
<td>12.8</td>
<td>16779</td>
</tr>
<tr>
<td>12-14</td>
<td>1965</td>
<td>13.0</td>
<td>58603</td>
<td>11.0</td>
<td>18207</td>
</tr>
<tr>
<td>15-17</td>
<td>1695</td>
<td>11.2</td>
<td>46660</td>
<td>8.8</td>
<td>15579</td>
</tr>
<tr>
<td>Unborn, Unknown, and 18-21</td>
<td>23</td>
<td>0.2</td>
<td>1568</td>
<td>0.3</td>
<td>657</td>
</tr>
<tr>
<td>Total</td>
<td>15074</td>
<td>100%</td>
<td>531413</td>
<td>100%</td>
<td>118825</td>
</tr>
</tbody>
</table>

Adapted from US Department of Health and Human Services.39

Table 1-2. Perpetrators by Maltreatment Type, 2011 (Duplicated Count)

<table>
<thead>
<tr>
<th>MALTREATMENT TYPE</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical neglect</td>
<td>7142</td>
<td>0.8</td>
</tr>
<tr>
<td>Neglect</td>
<td>539647</td>
<td>61.0</td>
</tr>
<tr>
<td>Other</td>
<td>34207</td>
<td>3.9</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>85456</td>
<td>9.7</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>30210</td>
<td>3.4</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>54906</td>
<td>6.2</td>
</tr>
<tr>
<td>Unknown</td>
<td>115</td>
<td>0.0</td>
</tr>
<tr>
<td>Two or more maltreatment types</td>
<td>133320</td>
<td>15.1</td>
</tr>
<tr>
<td>Total</td>
<td>885003</td>
<td>100%</td>
</tr>
</tbody>
</table>

Adapted from US Department of Health and Human Services.39

In 2010, there were approximately 270 000 female sexual assault victims aged 12 years or older with an annual average of 283 200 sexual assault victimizations from 2005 to 2010.31 Males had lower rates of sexual victimization than women. These official statistics represent a fraction of the adult and pediatric population that is victimized.40 The majority of sexual violence against women and children involved someone known to the victim.

The incidence or number of new cases of child sexual abuse that occur each year are estimated by major data sources, including criminal justice agencies, the National Child Abuse and Neglect Data System (NCANDS) and National Incidence Surveys.31
However, the varying societal, medical, and legal definitions of sexual abuse can make a true assessment of the exact incidence and prevalence of sexual abuse problematic. Despite an increased awareness about sexual violence, this problem remains underreported and misdiagnosed. In 1979, there was an estimated 44,700 cases of child sexual abuse; by 2011, this number had risen to 61,472 substantiated cases of child sexual abuse making up approximately 9.1% of all cases of child maltreatment. Of these children, 26% were aged between 12 and 14 years, with over 50% of child victims aged less than 11 years.

The NCANDS is a national data collection system that gathers information from every state about reports of child abuse and neglect based on statistics compiled by child protection agencies and includes all reported cases of child maltreatment. Statistics are compiled by child protection agencies across the country. This annually collected data is used to examine trends in child abuse and neglect across the country. Key results are published in child welfare outcomes reports to Congress and annual child maltreatment reports, with the most recent report showing a decline in sexual abuse by 62% between 1992 and 2009. NCANDS, however, significantly underrepresents the incidence of abuse when compared with other studies as many cases of abuse are never referred to child protection agencies and states have varying criteria for abuse.

The National Incidence Study of Child Abuse and Neglect (NIS) is a congressionally mandated study to provide updated estimates of the incidence of child abuse and neglect in the United States. The NIS measures changes in incidence from the earlier NIS studies and is published every 10 years. NIS uses 2 standards in assessing cases of child maltreatment: (1) the harm standard and (2) the endangerment standard. The harm standard counts only children who have been harmed by maltreatment. The endangerment standard includes children at risk of experiencing harm as a result of ongoing maltreatment. NIS-4, the most recent report published in 2010, estimated the number of sexually abused children under the harm standard decreased from 217,700 in 1993 to 135,300 from 2005 to 2006, representing a 38% decrease in the number of sexually abused children and a 44% decrease in the rate of sexual abuse. The incidence of children with endangerment standard sexual abuse decreased from 300,200 in 1993 to 180,500 from 2005 to 2006, reflecting a 40% decrease in numbers and a 47% decline in the rate. The NIS under represents the prevalence of abuse when compared with population surveys because many cases of abuse are not picked up by community sentinels. Furthermore, the harm standard underrepresents potential for abuse, while the endangerment standard is less objective.

Prevalence studies estimate the number of children at any given time who have been victimized at least once in their lifetime. Prevalence studies have the ability to potentially capture more cases than are officially reported. Early studies have reported prevalence rates as low as 3% for males and 12% for females; however, with improved survey technique, rates of 25% or higher have been identified. Overall, studies have consistently shown a decline in the overall number of child sexual abuse cases in the United States. Between 1992 and 1999, a 39% decline in the annual incidence of child sexual abuse based on NCANDS data was identified. In 2013, Finkelhor et al reported a 63% decline in the number of sexual abuse cases between 1992 and 2011. It is believed that although this decline has not been associated with changes in the economy, economic downturn will likely threaten conditions and programs that have promoted an improved professional and societal response to child sexual abuse.

**Evaluation of the Sexual Assault Survivor**

**Listening to the Survivor**

A sexual abuse or assault survivor is typically identified when the survivor makes a disclosure. This disclosure may result in a series of events that include an investigatory
interview, the taking of a medical history, or both. An appreciation of the value of each type of interview is important, and consideration should be given to minimizing the number of times a survivor is interviewed. The purpose of the medical interview is diagnosis and treatment. The purpose of a forensic interview or interview by a law enforcement officer is to have the survivor relate their experience accurately and in the greatest possible detail. At the beginning of the medical encounter, consent, or assent in the case of a child, should be obtained. It is important to inform the parent, patient, or both about the circumstance under which disclosed information will be divulged to other clinicians, social services or law enforcement professionals. A child whose interview is being watched via a 2-way mirror should ideally be told that there are individuals behind the mirror. An adult sexual abuse survivor should be made aware that content, which is a part of a criminal proceeding, will more likely than not become public record.

Historical elements that should be elicited in a neutral open-ended fashion during a medical history or forensic interview include the relationship of the perpetrator(s) to the sexual assault survivor, the nature of the assault, and when and where the assault occurred. During a disclosure, the clinician, chaperone, patient advocate, or parent should refrain from interrupting the patient. Both adult and pediatric patients may be embarrassed, ashamed, or fearful to speak of all aspects of their assault. The clinician or investigator needs to clearly understand words being used by the survivor to describe the body parts involved in the sexual assault(s). Children in particular may use nonstandard language or substitute words to describe their genitalia and the genitalia of the opposite sex. Attention to each detail of the survivor's history is critical. A complaint of pain or difficulty with urination is not as dramatic as bleeding or abdominal pain; however, in the setting of a normal examination, dysuria could help substantiate elements of an anogenital assault. Ideally, both questions and responses should be documented verbatim. “Daddy put his pee-pee in my pee-pee” may be a disclosure made by a child to caregiver. This statement can mean the genitalia of the father made contact with the genitalia of the child. It can also mean the father urinated into the toilet into which the child had just urinated without first flushing the toilet. Follow-up questions that are nonleading will likely distinguish between these 2 possibilities. Without open-ended follow-up questions, the alternative benign possibility may be lost. Finally, it bears emphasizing that a child's disclosure, not the physical examination, is the single most important diagnostic feature in evaluating whether a child has been sexually abused.26

**Physical Examination of the Survivor**

Attention to language should continue during the physical examination. Each component of the medical and forensic examination must be explained, and informed consent must be obtained in language that is culturally and or developmentally appropriate. Physicians and nurses must communicate in a sensitive manner during all components of the evaluation. “Let your knees fall apart” and “I’m going to touch your vagina with my glove” are suitable alternatives to “Open your legs” or “I’m going to touch your vagina with my hand.”

The physical examination should be completed by a health care provider with appropriate training and experience. The examiner should have attained competence in recognizing normal versus abnormal anogenital findings.47 The timing of the examination depends on when the sexual abuse or assault occurred as well as whether or not the survivor is experiencing symptoms that warrant immediate medical attention.47 Forensic evidence collection may also be appropriate in conjunction with the medical examination. When the sexual violence has taken place within 72-120 hours of a disclosure or when an acute injury is present, the medical examination should take place immediately. Forensic evidence collection may include swabbing of external body parts, oral, anal, or genital orifices for the collection of deoxyribonucleic
acid (DNA) (Figure 1-6). Blood, saliva, and clothing worn at the time of the event are also frequently collected. In nonacute cases of sexual violence, the examination should be scheduled as soon as possible after the alleged incident.\textsuperscript{47,48} Although the majority of pediatric sexual abuse examination findings are normal, the likelihood of finding an anogenital abnormality is increased if a child is examined within 7 days of the last episode of sexual abuse.\textsuperscript{49,50} Teenagers and adults have anogenital injury following consensual sex and nonconsensual anogenital assault. In some reports, in excess of 70\% of teenagers and adult women have anogenital trauma following assault.\textsuperscript{51,52} In general, postmenopausal women are more likely to sustain genital injuries after sexual assault than younger women.\textsuperscript{53}

The medical evaluation following sexual abuse or assault should be approached similarly to any other medical evaluation. The examination is intended to reassure the sexual violence survivor and determine what medical and mental health interventions are needed. The exam may also identify injuries or abnormal physical findings that may support the allegations of sexual abuse.\textsuperscript{47,54} It is also important to evaluate the child survivor for signs of physical abuse (Figure 1-7) or neglect as well as to assess for evidence of self-inflicted injuries that could be a symptom of an undiagnosed psychiatric disorder.\textsuperscript{47} The purpose and limitations as well as noninvasive nature of the examination should be explained to the child’s caregiver beforehand.\textsuperscript{47,48} Many caregivers will be under the assumption that the examination will confirm or refute the child’s statements by the presence or absence of physical injury to the genital structures. However, the majority of children who have been sexually abused will have normal anogenital findings on examination, as seen in Figure 1-1.\textsuperscript{47} A minority of all children referred for sexual abuse evaluation will have abnormal examinations; even with a history of penetrating anogenital trauma, abnormal anogenital findings are only seen in 5.5\% of cases.\textsuperscript{23,26}
INDEX

A
Abandonment, 170
ABP. See American Board of Pediatrics (ABP)
Abuse behaviors, 36
Abuse-relevant screening questions, 45
Accreditation Counsel for Graduate Medical Education (ACGME), 6
ACEP. See American College of Emergency Physicians (ACEP)
ACOG. See American Congress of Obstetricians and Gynecologists (ACOG)
Acquaintance rape, 4, 5, 93
Acute alcohol influence/intoxication, 279t
Acute care, forensic health care needs, 236
assessing physical trauma, 236
gynecologic injuries, 236–239
nongynecologic injuries, 239–240
pregnancy, prevention of, 240
Sexually transmitted infection, prevention of, 241–243
victim consent, 236
Acute sexual violence, 1
ADFSA. See Alcohol- and/or drug-facilitated sexual assault (ADFSA)
ADFSA Protocol/Kit, 272–274
blood collection for toxicology, 277
hair collection, 277
other biological sample, 277
urine collection for toxicology, 275–276
Adolescent and adult sexual assault, 85
Campus Sexual Violence Elimination Act of 2012 (Campus SaVE Act), 84
college sexual assault, 92–93
designation of a mature minor, 84
emancipation of a minor, 84
future research needs, 97
history, 85–87
Jeanne Clery Act, 84
prevention programs, 93–95
primary prevention, 84
rape, 85
rape law reforms, 85–86
Rape Prevention Education (RPE) Program, 85
secondary prevention, 85
sexual assault nurse examiner programs, 91–92
societal costs, 87
tertiary prevention, 85
victim advocacy, 86
vulnerable populations, 86
college-aged, 88–89
LGBTQ individuals, 89
past victimization, 89
special populations, evaluation and treatment for, 89–91
substance abuse, 89
younger age, 88
Adult male sexual assault
American Indian, 158
anoscope, 158
care of
assessment for, 163–164
care and support of, 164
patient education, 164
routine universal screening, 163
cultural diversity, 161–163
drug-facilitated sexual assault (DFSA), 158
effects and consequences, 159–160
gender, 158
homosexuals, 158
prevalence of, 158–159
rape myths, 158, 160–161
reporting and disclosure, barriers to, 159
sanctuary trauma, 158
sex, 158
sexual victimization, 158
Adult protective services' (APS), 177–178, 183

Appendix, figures and tables are indicated by a, f, and t respectively
Adverse childhood events (ACEs), 86
Alcohol and drugs, domestic and dating violence, 69
Alcohol- and/or drug-facilitated sexual assault (ADFSA), 255–257
ADFSA Protocol/Kit, 272–274
collecting blood for toxicology, 277
collecting urine for toxicology, 275–276
hair collection, 277
other biological sample, 277
competency, 286–287
definition, 256
delayed presentation, 268
emergency department triage, 268–269
patient history, 269–270
drugs of DFSA, 277–278, 279–280
benzodiazepines, 280
ethanol, 278
gamma-hydroxybutyrate (GHB), 281
ketamine, 282
marijuana, 281
methylenedioxymethamphetamine (MDMA), 282
nonbenzodiazepine hypnotics, 280–281
history, 257–258
initial presentation, 262
acute presentation, 263
hospital evaluation and treatment, 263–264
medical-forensic examination, 264
physical examination, 265–268
overarching team approach to care, 259–261
patient consent, 282–286
patient presentation, 262t
Sexual assault forensic examination, evolution of, 262
toxicologic testing, 271–272
unique ADFSA Versus NADFSA considerations, 270
discharge instructions, 271
photographic imaging, 270
pregnancy evaluation, 271
sexually transmitted infection, evaluation of, 270
American Nurses Association (ANA), 122
American With Disability Act (ADA), 136
ANA. See American Nurses Association (ANA)
Anal examination, 13, 14f, 267
Anal rape, 164
Anger rape, 182
Anogenital examination
anal examination in males and females, 13, 14f
colposcope use in, 1, 12
findings, 6
follow-up examination, 15
photodocumentation in, 12
of survivor, 12–15, 13f, 14f
unestrogenized hymen, 12, 13f
Anogenital warts, 26, 27–29
Anoscopy, 120, 120f, 123, 127, 132, 135, 158
Antigen detection, 211
AODSA. See Alcohol- or drug-enabled sexual assault (AODSA)
APTIMA T. vaginalis assay, 210
Aseptic meningitis, 211
Assailant and victim, relationship characteristics, 180
Assault history, 230
forensic health care, 233–236
Assessing physical trauma, 236
Attitudes towards dating violence, 69
AVPU, 264

B
Baby boomer, 170, 173
Bacterial vaginosis (BV), 24, 27, 207t
Behavior, 265
Behavioral problems and CSA screening, 43, 43t
Benign senescent forgetfulness, 170, 181
Benzodiazepines, 280
“Blacking out,” 280
Boys and male adolescents, sexual abuse histories in
abuse interview, 47–48
childhood sexual abuse disclosure patterns, 38–42
contact sexual abuse, 36
epidemiology, 36–38
examination, 48–52
minor, 36
noncontact sexual abuse, 36
reporting abuse and expert testimony, 52–53
screening, clinical setting, 42–47
solutions in community settings, 53–54
Breasts, 12, 189, 222, 239, 266
C

CAC. See Child advocacy center (CAC)
CAM. See Confusion Assessment Method (CAM)
Campus SaVE Act, 92
Campylobacter sp, 214
CAPTA. See Child Abuse Prevention and Treatment Act (CAPTA)
Caregiver
  in anogenital examination of survivor, 12–15
  child’s statements, 11
  in emergency department screening, 187
  for older adults, 182
  during physical examination of survivor, 12
  in sexual exploitation of children, 7
Ceftriaxone, 208
Centers for Disease Control and Prevention (CDC), 164, 206, 242
Certified nursing assistants (CNAs), 182
Cervical Gram stain, 217
Cervicitis, 211
Chain of custody, 230
Chancroid, 24
Chancroid, 24, 26, 209
Child Abuse Prevention and Treatment Act (CAPTA), 4–5, 7
Child abuse reporting laws, 4–5
Child advocacy center (CAC), 5, 6
Childhood sexual abuse (CSA)
  abuse interview, 47–48
  contact sexual abuse, 36
  childhood sexual abuse disclosure pattern
    conditions for, 39
    gay or bisexual males, 38–39
    heterosexual males, 38–39
    keeping secrets, 40
    prevention, 38
    sexuality surveys, 38–39, 39t
    social-developmental and, 40–42
  epidemiology, 36–38
  examination
    forensic-level, 48
    group therapy, 50
    health care provider role, 48
    parents/family members, recommendations for, 51, 51t–52t
    physicians, 48–49
    play therapy, 50
    psychological care, 50–51
    sexual abuse specialty clinic, 49
    shame of abuse, 51
  minor, 36, 52
  noncontact sexual abuse, 36
  reporting abuse and expert testimony, 52–53
  screening, clinical setting, 42–47
  solutions in community settings, 53–54
  Child maltreatment, 2, 4, 7, 9
  Child pornography, 7
  Child Protective Services (CPS), 53, 90
  system, 5
  Children, sexually transmitted infections in sexually abused, 24
    chancre, 24
    clinical signs and symptoms
      anogenital warts, 26
      bacterial vaginosis (BV), 27
      chancroid, 26
      Chlamydia, 25
      gonorrhea, 25
      granuloma inguinale, 26
      hepatitis infection, 27
      herpes simplex, 26
      HIV, 25
      pubic lice, 26
      syphilis, 25
      Trichomonas vaginalis, 25–26
    diagnosing methods, 29–30, 30t
    epidemiology, 24
    evidence for sexual transmission of, 27–29
    gummas, 24
    highly active antiretroviral therapy (HAART), 24
    latent syphilis, 24
    neurosyphilis, 24
    nontreponemal test, 24
    opportunistic infection, 24
    positive predictive value (PPV), 24
    postexposure prophylaxis (PEP), 24
    prophylaxis and treatment, 30–31
    treponemal test, 24
  Child sexual abuse
    child maltreatment, 7, 9
    definitive signs, 6, 6f
    evaluation of survivors, 9–17
    pornography production, 7
    See also Sexual abuse
  Chlamydia, 25, 28, 204, 207t, 242
    antibiotics for, 31
  Chlamydia trachomatis, 24, 25, 204, 205, 208
  Chronic pelvic pain, 232
  Ciprofloxacin, 218
Clinical Laboratory Improvement Amendments (CLIA), 206
Clock-Drawing Test, 186
Clothing, 265
CNAs. See Certified nursing assistants (CNAs)
Coaching Boys Into Men Campaign, 94, 94t–95t
Cognitive coping responses, 40
College sexual assault, 92–93, 93t
Colposcope, 1, 12, 120
Community-based advocates, 134–135
Community-level sexual assault prevention, 95
Community-wide interventions, 93
Comorbidities and life problems, 45–46
Complete blood count (CBC), 243
Comprehensive Sexual Assault Assessment Tool (CSAAT), 178
Comprehensive Sexual Assault Assessment Tool-Elder (CSAAT-E), 178–179
Condylomata acuminata, 27
Confidential surveys, CSA, 37
Confusion Assessment Method (CAM), 186
Contact interactions, CSA, 36
CPS. See Child protective services (CPS)
Crescentic unestrogenized hymen, 13, 14f
Crime scene, documentation, 234, 235f
Criminal justice system (CJS), 184
Criminal vs. civil justice systems, 230
CSAAT. See Comprehensive Sexual Assault Assessment Tool (CSAAT)
CSAAT-E. See Comprehensive Sexual Assault Assessment Tool-Elder (CSAAT-E)
Cultural competency and forensic examination, 135
Cultural diversity, adult male sexual assault
American Indians, 162–163
Black or African American, 162
Hispanics and Latinos, 162
Cyber dating abuse, 63, 65

D
“Date rape” drugs, 277
Dating violence in teens and young adults, 64
characteristics, 64
consequences, 67–68
cyber dating abuse, 63, 65
health care providers, implications for, 69–70
photographic reference, 71f–77f
physical dating violence, 64
predictors, 68–69
prevalence of
biannual national survey, 65
ethnicity, 67
gender, 67
high-risk adolescents, 67
multi-school–based sample, 65
psychological dating violence, 66
rates of, 65–66
sexually aggressive acts, 67
psychological dating violence, 64–65
reproductive coercion, 64–65
sexual coercion, 64–66
sexual dating violence, 64–66
sexual violence, 68
stalking, 64–65
victimization, 68
Delayed disclosure, CSA, 38
Delta-9-tetrahydrocannabinol (THC), 281
Deoxyribonucleic acid (DNA), 10, 15–16, 208
amplification, 28–29
evidence, 234
hybridization probe test, 210, 212
See also DNA
Department of Justice (DOJ), 176
Designation of a mature minor, 84
DFSA. See Drug-facilitated sexual assault (DFSA)
DFSA, drugs of, 278–280
benzodiazepines, 280
ethanol, 278–280
gamma-hydroxybutyrate (GHB), 281
ketamine, 282
marijuana, 281
methylenedioxymethamphetamine (MDMA), 282
nonbenzodiazepine hypnotics, 280–281
Diazepam (Valium), 280
Digital camera, 2
Diphenhydramine (Benadryl), 278
Direct screening, 44–45
Disabled persons
forensic examination, variations in, 136
Discharge instructions, 271
DNA
amplification tests, 29
analysis techniques, 15
hybridization probe test, 210
See also Deoxyribonucleic acid (DNA)
Dorsal lithotomy position, 2, 12
Drug- and alcohol-facilitated rape (DFR), 258
Drug-facilitated sexual assault (DFSA), 84, 88–89
Dypareunia, 189
Dyspareunia, 232
Dysuria, 10, 206
### E

**Elder**
- abuse, 170, 181
  - forensic examination, variations in, 136, 137f–138f
  - *See also* Older adults, sexual assault among

**Emancipation of minor**, 84

**Emergency care, sexual abuse victim**
- cognitive status assessment, 186–187
- emergency department coordination of services, 191–192
- emergency department screening, 187
- emergency personnel, education, 192–193
- examination and evidence collection, 188–190
- interview, 187–188
- recommendations for, 185–186
- services, 184–185
- trauma care, 190–191
- trauma patterns and severity assessment, 187

**Emergency contraception**, 220–222, 230, 240
- oral contraceptives, 220–222

**Emergency department (ED)**, 257
- education and design issues, 192–193
- RCC medical advocates, 86
- triage, 268–269

**Emergency medical services (EMS)**, 191–192, 259, 263

**Emergency medical technician (EMT) training**, 191

**Endangerment standard**, 2

**Entamoeba histolytica**, 214

**Epidemiology, sexual assault in older adult population**
- assailant and victim, relationship characteristics, 180
- conceptual model of sexual assault for older adults, 178, 179t
- core data set tool for older adult females, 178
- National Crime Reporting Data, 176–177
- offender characteristics, 182–183
- in older men, 177–178
- temporal characteristics, 179–180
- victim characteristics, 180–182

**Epididymitis**, 206

**Ethanol**, 278–280

**Evaluation**
- child sexual abuse, survivors of, 9–17
- pregnancy, 271
- sexual assault survivor, 141
- sexually transmitted infections, 270
  - *See also* Sexual assault survivor, evaluation

**Evidence-based prevention**, 250–251

**Exhibitionism**, 7

**External genitalia or vulva**, 120

**Extremities**, 266

**Eyes, physical examination**, 266

### F

**Face, physical examination**, 266

**FBI.** *See* Federal Bureau of Investigation (FBI)

**Federal Bureau of Investigation (FBI)**, 7, 158, 176

**Female assault survivor**, 205

**Female oppression and sexual violence**, 4

**Financial abuse or exploitation**, 170

**Flunitrazepam (Rohypnol)**, 277, 280

**Fluoroquinolones**, 209

**Foley catheter**, 12, 13f

**Follow-up examinations**
- sexual assault survivor, evaluation of, 141

**Forced sex, lifetime prevalence of**, 141

**Forcible rape**, 255

**Forensic evidence collection**, 10–11, 11f, 15, 15f, 243
- chain of custody, 243
- documentation after sexual assault, 243–245
- evidence collected, 246
- medical forensic history of event, 246
- medical management, 246
- physical examination, 246
- support services, 246

**Forensic examination, variations in**
- culture, 135
- disabled persons, 136
- elderly, 136, 137f–138f
- male victims, 135
- strangulation, 139, 139f
- support personnel, presence of, 134–135

**Forensic health care needs of adults**
- acute care, 236
  - assessing physical trauma, 236
  - gynecologic injuries, 237–239, 237f–238f
  - nongynecologic injuries, 239–240
  - prevention of pregnancy, 240
  - prevention of sexually transmitted infections, 242–243
  - victim consent, 236
- assault history, 233–236
- establishing victim safety, 233
- evidence-based prevention, 250–251
- forensic evidence collection, 243
  - chain of custody, 243
  - documentation after sexual assault, 243
  - evidence collected, 246
  - medical forensic history of event, 246
  - medical management, 246
  - physical examination, 246
  - support services, 246
Health and assault history, 233
Health history, 233
Legal representation, 246–247
Health care provider, role of, 248–250
Victim's private information, 247–248
Multidisciplinary collaboration, 232–233
Sexual assault, 231
Frailty, 170, 174
Functional family context, 40

G
γ-Aminobutyric acid (GABA), 280
Gamma-hydroxybutyrate (GHB), 271, 281
GAPS. See Guidelines for Adolescent Preventive Services (GAPS)
Gardnerella vaginalis, 212
Gatifloxacin, 218
Genital examination, 267
Genital HPV, 211
Genital injuries, 237, 237f–238f
Genital ulcer disease, 209
Gerontophile, 170, 182
Glasgow Coma Scale (GCS), 264
Gonococcal conjunctivitis, 206
Gonococcal Isolate Surveillance Project (GISP), 206
Gonorrhea, 25, 204, 206, 242
gonococcal resistance, 206–208
Granuloma inguinale, 26
Guidelines for Adolescent Preventive Services (GAPS), 54
Guidelines for evidence collection, 244t–245t
Gummas, 24
Gynecologic injuries, 237–239, 237f–238f
See also Genital injuries

H
Haemophilus ducreyi, 209
Harm standard, 2, 9
HBsAg-positive, 205, 215
Head, physical examination, 265
Head-to-toe examination, sexual assault survivor, 129–132
Health care providers
adult male sexual assault, 163–164
CSA screening, 42
dating violence in teens and young adults, implication, 69–70
forensic health care needs of adults, 248–249
LGBTQ community, 90
social-developmental and childhood sexual abuse disclosure pattern, 41
Health expectancy, 170, 174
Health Insurance Portability and Accountability Act (HIPAA), 247
Hemodilution, 277
Hepatitis A (HAV), 214
Hepatitis B, 205
Hepatitis B immune globulin (HBIG), 215
Hepatitis B viruses (HBV), 214, 215
Hepatitis infection, 27
Hepatitis viruses, 206
Herpes simplex virus (HSV), 26–27, 204, 206, 207t
Herpes simplex virus type 1 (HSV-1) infections, 210
Herpes simplex virus type 2 (HSV-2) infections, 210–211
HERS. See The Hymen Estrogen Response Scale (HERS)
Heterosexual hyper-masculinity, 41
Hierarchy rule, 176
Highly active antiretroviral therapy (HAART), 24
Homeless youth and foster children, CSA, 37
Homophobia
social-developmental and child sexual abuse disclosure pattern, 41
HSV. See Herpes simplex virus (HSV)
Human immunodeficiency virus (HIV), 25, 203, 230, 231
postexposure prophylaxis, 218–220
STIs in children, 24, 25
Human papillomavirus, 211
Hymenal and anogenital injuries, 6
Hymenal tissue, 239
Hymenal tracing, 12–13, 13f
Hymen Estrogen Response Scale (HERS), 191

I
IAFN. See International Association of Forensic Nurses (IAFN)
ICARIS-2. See The Second Injury Control and Risk Survey (ICARIS-2)
Ignorance, male sexual assault, 161
Injury prevalence after sexual assault, 236t
INPEA. See International Network for the Prevention of Elder Abuse (INPEA)
Internal genitalia, 120
International Association of Forensic Nurses (IAFN), 6, 122, 190, 231
International Federation of Gynecology and Obstetrics (FIGO), 204
International Network for the Prevention of Elder Abuse (INPEA), 193
Interpreters in forensic examination, 135
Intimate partner violence (IPV)
adolescent and adult sexual assault, 85
routine universal screening, 163
Intramuscular (IM) injection, 206
Intrauterine device (IUD), 222
Intervene, Act and Motivate (I. A.M.) STRONG campaign, 95

J
Jeanne Clery Act, 84

K
Ketamine, 282

L
Labial separation, 2, 2f
Labial traction, 2, 3f, 13, 14f
Labia majora, 239
Labia minora, 239
Laboratory testing and treatment, in sexual abuse
herpes simplex virus type 1 (HSV-1)/type 2 (HSV-2)
infecTIONS, 16–17
HIV testing, 16
nucleic acid amplification tests (NAATs), 16
sexually transmitted infections (STIs), 16–17
See also Medical-forensic examination
Laparoscopy, 212
Latent syphilis, 24
Law enforcement officers, 192
Legal representation, 248–250
Lesbian, gay, bisexual, transgender, questioning (LGBTQ)
child and adult sexual assault, 88
community, 86, 90
individuals, 89
Level of consciousness (LOC) should, 263
Levofloxacin, 218
Levonorgestrel formulations, 220
Life expectancy, 170, 173–174
Lymphadenopathy, 216

M
Male rape myths, 161
Male victims
forensic examination, variations in, 135
human immunodeficiency (HIV) transmission, 91
See also Boys and male adolescents, sexual abuse histories in
Mandatory reporting, 183–184
Marijuana, 281
Marital rape, 233
Masculine gender socialization, 41–42
Medical forensic examination, 265, 270
behavior, 264
breasts, 266
clothing, 265
extremities, 266
eyes, 266
face, 266
genital examination, 267
head, 265
mouth, 266
nails, 267
neck, 266
torso, 266
vital signs, 264
Medical forensic interview, 123
Mental health issues in survivors. See Sexual assault survivor,
evaluation
Men who have sex with men (MSM), 206
Methylenedioxymethamphetamine, 266
Methylenedioxymethamphetamine (MDMA), 282
Metronidazole, 212
Metropolitan Organization to Counter Sexual Assault (MOCSA) advocacy group, 259
Military sexual trauma (MST), 160
The Mini-Mental State Examination (MMSE), 186
Minor, 36, 52
MMSE. See The Mini-Mental State Examination (MMSE)
Mobiluncus spp., 212
Mouth, 266
Moxifloxacin, 218
Mycoplasma, 204
MPC. See Mucopurulent cervicitis (MPC)
MST. See Military sexual trauma (MST)
Mucocutaneous lesions, 209
Mucopurulent cervicitis (MPC), 204, 206, 212
Multidisciplinary collaboration, 232–233
Multidisciplinary team (MDT), 250
Multi-drug ingestion, 265
National Center for Injury Prevention and Control (NCIPC), 95
National Child Abuse and Neglect Data System (NCANDS), 2, 8, 9
National Clearinghouse on Abuse in Later Life (NCALL), 194
National Crime Reporting Data, 176–177
National Crime Victimization Survey (NCVS), 7, 87, 176–177, 257
National Domestic Violence Hotline, 5
National Elder Mistreatment Study, 177, 180

N
NAAT. See Nucleic acid amplification test (NAAT)
Nails examination, 267
National Domestic Violence Hotline, 5
National Elder Mistreatment Study, 177, 180
National Incidence Study (NIS) of Child Abuse and Neglect, 2, 9
National Incidence Surveys, 8
National Incident-Based Reporting System (NIBRS), 176
National Intimate Partner and Sexual Violence Survey (NISVS), 87t, 158
National Sexual Assault Hotline, 86
National Violence Against Women Study (NVAWS), 67, 85, 87t, 158–159, 160
National Women’s Study (NWS), 87t
NCALL. See National Clearinghouse on Abuse in Later Life (NCALL)
NCANDS. See National Child Abuse and Neglect Data System (NCANDS)
NCVS. See National Crime Victimization Survey (NCVS)
Neck, 266
Neglect, older adults, 170, 172, 173, 177
Neisseria gonorrhoeae, 24, 204, 207t
Neurosyphilis, 24
NGU. See Nongonococcal urethritis (NGU)
NIBRS. See National Incident-Based Reporting System (NIBRS)
NISVS. See National Intimate Partner and Sexual Violence Survey (NISVS)
Nonbenzodiazepine hypnotics, 280–281
Nonceftiraxone regimen, 208
Noncontact interactions, CSA, 36
Noncontact sexual abuse, 7
Non–drug-facilitated sexual assault (NADFSA), 258
Nongonococcal urethritis (NGU), 204, 206
Nongynecologic injuries, 239–240
See also Gynecologic injuries
Non–life-threatening trauma, 233
Nontreponemal test, 24
Nucleic acid amplification test (NAAT), 16, 29–30, 204, 206, 208
NVAWS. See National Violence Against Women Study (NVAWS)

O
Office for Victims of Crimes (OVC), 91–92
Older adults, sexual assault among
abandonment, 170
baby boomer, 170, 173
benign senescent forgetfulness, 170, 181
defining problem, 172–173
der elder abuse, 170, 181
demergency care, 184–193
epidemiology of, 175–183
evidence-based practice approach, 171
financial abuse or exploitation, 170
frailty, 170
gerontophile, 170, 182
health expectancy, 170, 174
institutional and policy considerations, 193–194
investigation and follow-up, 183–184
life expectancy, 170, 173–174
neglect, 170, 172, 173, 177
physical abuse, 170, 177
population characteristics, 173
chronologic descriptors of, 173–174
cohort issues of, 174–175
health indices in, 174
psychological or emotional abuse, 171, 177
rape, 171–173
sexual abuse or abusive sexual contact, 171
sexual assault, 171, 173
sexual assault/forensic examiner (SAFE), 171
sexual assault/nurse examiner (SANE), 171
very old or old-old, 171
Older women, sexual assault, 91
One-parent household and CSA, 37
Opportunistic infection, 24
Oral contraceptives, 220–222
Other incapacitated sexual assault, 84
Overarching team approach to care, 259–261

P
Painful intercourse, 189
Painful menstrual periods, 232
Parental involvement in prevention programs, 53
“Passing out,” 280
Past victimization, 89
Patient consent, 282, 285–287
Patient education, adult male sexual assault, 164
Patient re-engagement, CSA screening, 46–47
Pediatricians, CSA screening, 43
Pediculosis (Phthiriasis) pubis, 206
Pelvic inflammatory disease (PID), 204, 206, 212–213
treatment for, 213t
Penicillin, 209
Perpetrator, 234
Pharyngeal infection, 206
Pharyngitis, 206
Phencyclidine (PCP), 282
Photodocumentation in anogenital examination, 12
sexual assault survivor, evaluation of, 127, 127f, 131f

Phthirus pubis (pubic lice), 214

Physical abuse, older adults, 170, 177

Physical dating violence, 64

Physical examination of survivor
- bruising on face, 11–12, 11f
- child, physical abuse signs in, 11, 11f
- colposcope use in anogenital examination, 1, 12
- forensic evidence collection, 10–11, 11f
- health care provider, 10
- in nonacute cases, 11
- normal vs. abnormal anogenital findings, 10
- oral cavity, 12, 13f
- physicians and nurses communication, 10
- postmenopausal women, 11
- self-injurious behaviors, 12
- sexual maturity rating (SMR), 12

Physical injury, adult male sexual assault, 160

PID. See Pelvic inflammatory disease (PID)

Plantar warts, 28

Polymerase chain reaction (PCR), 206

Polymerase chain reaction–based (PCR-based) urine screening tests, 242

Polymorphonuclear leukocytes (PMN), 208

Positive predictive value (PPV), 24, 29

Postexposure prophylaxis (PEP), 24, 205

for HIV, 242

Posttraumatic stress disorder (PTSD), 231, 271

PPV. See Positive predictive value (PPV)

Preadolescent girls, 4

Pregnancy, 6, 17

evaluation, 271

prevention of, 240

unintended, 88

Prevention programs

Army’s Intervene, Act and Motivate (I. A.M.) STRONG campaign, 95

Coaching Boys Into Men Campaign, 94, 94t–95t

community-level sexual assault prevention, 95

community-wide interventions, 93

individual-level influences, 94

relationship-level prevention, 94

Safe Dates program, 94

school-based, 93

social-ecological model, 93f

societal-level influences, 95

Violence Against Women Act, 95

Prevotella spp, 212

Primary prevention, 84

Proctitis, 206, 214

and proctocolitis, 204

Proctocolitis, 204, 214

Prompt disclosure, CSA, 38

Prone knee-chest position, 2, 3f

Prophylaxis, 205

PSAs. See Public service announcements (PSAs)

Psychological dating violence, 64–65, 66

Psychological or emotional abuse, 171, 177

Pubertal girls and women, 12, 16

Pubic lice, 26, 214

Public service announcements (PSAs), 53

Q

Quick confusion scale, 264

R

RAINN. See Rape, Abuse, and Incest National Network (RAINN)

Rape, 85

California penal code specification, 88

crisis centers, 4

definition, 4, 5, 256

kits, 6

by known male acquaintance, 5

law reforms, 85–86

older adults, 171–173

See also Sexual abuse

Rape, Abuse, and Incest National Network (RAINN), 86

Rape crisis advocate (RCA), 249

Rape crisis centers (RCCs), 85–86, 91, 231

Rape myths acceptance (RMA), 161

Rape myths, adult male sexual assault, 158, 160–161

Rape Prevention and Education (RPE) program, 85, 95, 251

Rape treatment center (RTC), 86, 92–93

Rapid plasma reagin (RPR), 209

Refrigeration or freezing, 275–276

Reiter syndrome, 25, 208

Repetition, social-developmental and child sexual abuse disclosure pattern, 41

Reproductive coercion, 64–65

Residential care facilities, 182

Respiratory depression, 268

Risk assessment, in male victims of sexual assault, 164

RMA. See Rape myths acceptance (RMA)

Routine universal screening, adult male sexual assault, 163

Rule of thirds, 241f

S

SAE. See Sexual assault examiner (SAE)
SAEM. See Society for Academic Emergency Medicine (SAEM)
SAFE. See Sexual assault forensic examiner (SAFE)
Safe Dates program, 94
SAFER Act of 2013, 234
SANE program. See Sexual assault nurse examiners (SANEs)
SANEs. See Sexual assault nurse examiners (SANEs)
SARRT. See Sexual assault response and resource team (SARRT)
SART. See Sexual assault response team (SART)
SART vs. SARRT, 260t
Scabies (Sarcoptes scabiei), 206, 214
School-based prevention programs, 53–54, 93
Screening
  abuse-relevant questions, 45
  adult male sexual assault, 163
  behavioral problems and CSA, 43, 43t
  CSA, clinical setting
    abuse-relevant screening questions, 45
    behavioral problems, 43, 43t
    comorbidities and life problems, 45–46
    direct, verbal screening, 44
    health care provider role, 42
    patient re-engagement, 46–47
    pediatricians, 43
    response to disclosure, 46
    unobtrusive screening strategies, 43, 43t
    direct, verbal, 44
    emergency department, 187
    intimate partner violence (IPV), 163
    unobtrusive screening strategies, 43, 43t
Secondary prevention, 85
Second Injury Control and Risk Survey (ICARIS-2), 87t
Sexual abuse, 4
  abusive sexual contact, 171
  child, 5
  definition, 7
  Internet and, 7
  investigations, 5
  maltreatment types
    perpetrators, 7, 8t
    of victims, 7, 8t
  medical interview, 10
  noncontact, 7
  See also Child sexual abuse; Physical examination of survivor
Sexual assault, 255
  definition, 256
  evidence collection kit, 120, 120f
  older adults, 171, 173
Sexual assault examiner (SAE), 255
Sexual assault forensic examiner (SAFE), 171, 190, 256
Sexual assault nurse examiners (SANEs), 4, 6
  older adults, 171
  program, 230, 231–232, 248–250, 262
  programs, 91–92
  sexual assault survivor, evaluation of, 120, 122, 129
Sexual assault response and resource team (SARRT), 255, 256
  6 Cs, 261t
Sexual assault response coordinator (SARC), 274
Sexual assault response team (SART), 86, 255, 259
  sexual assault survivor, evaluation of, 120, 124–125
Sexual assault survivor, evaluation
  additional considerations, 140–141
  additional equipment, 140, 140f
  anogenital examination, 12–15
  anoscope, 120, 120f
  colposcope, 120
  external genitalia or vulva, 120
  follow-up examinations, 141
  forensic evidence collection, 15
  forensic examination variations
    culture, 135
    disabled persons, 136
    elderly, 136–138
    male victims, 135
    strangulation, 139, 139f
    support personnel, presence of, 134–135
  history, 121–122
  internal genitalia, 120
  laboratory testing and treatment, 16–17
  listening to, 9–10
  of photodocumentation in anogenital examination, 12
  physical examination, 10–12
  practices in care of
    ALS aids, 125
    documentation, 132–134
    equipment, 127, 128f
    evidence collection kit, 127, 128f
    examination components, 124–125, 126f
    examination worksheet, 126f
    head-to-toe examination, 129–132, 130f–133f
    law enforcement professionals, 124
    photodocumentation, 127, 127f, 131f
    recommendation after examination, 134
    sexual assault evidence collection kit, 120, 120f
sexual assault nurse examiner (SANE), 120, 122, 129
sexual assault response team (SART), 120, 124–125
state of the science, 122–124
strangulation, 120
Sexual coercion, 64–66
Sexual Contact Beyond the Neonatal Period, 27t
Sexual dating violence, 64–66
Sexual identity concerns
  social-developmental and childhood sexual abuse
  disclosure pattern, 40
Sexually transmitted infections (STIs), 6, 16
  untreated, 88
  See also Children, STIs in sexually abused
Sexually transmitted infection (STI), 203, 204, 230, 231
  in adult and adolescent survivors of sexual assault, 216t
  antibiotic regimens, 207t
  bacterial vaginosis, 211–212
  chancroid, 209–210
  Chlamydia, 208–209
  diagnostic evaluation, 217
  evaluation of, 270
  gonorrhea, 206–208
  herpes simplex, 210–211
  history and physical examination, 215–217
  human papillomavirus, 211
  mucopurulent cervicitis, 212
  pelvic inflammatory disease (PID), 212–213
  post-assault incidence, 203
  prevalence of, 205, 205t
  prevention of, 242–243
  proctitis and proctocolitis, 214
  prophylactic treatment, 243t
  pubic lice, 214
  recognition and treatment, 206
  scabies, 214
  survivor of sexual assault in assessment of risk for, 215t
  syphilis, 209
  treatment and prophylaxis, 217–222
  trichomoniasis, 210
  viral hepatitis, 214–215
Sexual maturity rating (SMR), 12
Sexual trauma, penetrating, 6
Sexual violence, 4, 68
  awareness, 4, 5, 9
  dating violence in teens and young adults, 68
  psychosocial factors contribute to, 7
  survivors, 1
  women and children, 8
Shigella sp, 214
SMR. See Sexual maturity rating (SMR)
Social-developmental and childhood sexual abuse
  disclosure pattern
  cognitive coping responses, 40
  ethical considerations, 41
  functional family context, 40
  health care providers, 41
  heterosexual hyper-masculinity, 41
  homophobia, 41
  homophobic society, 40
  masculine gender socialization, 41–42
  repetition, 41
  sexual identity concerns, 40
Social-ecological model, prevention programs, 93f
Societal costs, adolescent and adult sexual assault, 87
Society for Academic Emergency Medicine (SAEM), 192
Sodium fluoride, 277
Stalking, 64–65
STI. See Sexually transmitted infection (STI)
Strangulation, 120, 139, 139f
Subpoena, 248–249
  civil cases, 248–249
  criminal cases, 248
Substance abuse, 89, 231
Substance use, domestic and dating violence, 69
Suicide, 231
  and intentional self-harm, 160
Supine frog-leg position, 2, 3f, 12
Suspected drug-facilitated sexual assault, 84
Symptomatic urethritis, 211
Syphilis, 25, 204, 209
  antibiotics for, 31
T
Tachycardia and hypotension, 281
Tertiary prevention, adolescent and adult sexual assault, 85
Tetrahydrozoline eye drops (Visine), 278
Torso, 266
Touces, appropriate and inappropriate, 5
Toxicologic testing, 271–272
  blood for, 277
  hair collection, 277
  urine for, 275
T. pallidum particle agglutination (TPPA), 209
Trafficking Victims Protection Act (TVPA), 6
Transcription mediated amplification (TMA) assays, 206
Trauma care, older adult sexual abuse victim, 190–191
Treponemal test children, STIs in sexually abused, 24
Treponema pallidum, 206
Trichomonas, 25–26
  antibiotics for, 31
diagnosis, 28
Trichomonas vaginalis, 27
Trichomoniasis, 204, 210
  men with, 210
  women with, 210
Trichomoniasis, 207t
Tubo-ovarian abscess, 212

U
UCR. See Uniform Crime Report (UCR)
Unestrogenized hymen, 12, 13f
Uniform Crime Report (UCR), 158, 176
Unobtrusive screening strategies, 43, 43t
Unplanned pregnancy, 231
Unwanted sexual penetration, 5
Ureaplasma urealyticum, 204
Urethritis, 206

V
Vaginal discharge, 210
Vaginal injuries, 13, 14f
Vaginal wet mounts (WM), 123
Vaginitis, 210
VAWA. See Violence Against Women Act (VAWA)
Very old or old-old, 171
Veterans Administration (VA), 159, 163
Victim
  advocacy, 86
  characteristics
    frail, dependent older adults, 181
    frailty and functional status, 180–181
    living situations, 181
    older adults residing in
      nursing homes, 182
      residential care facilities, 182
    consent, 230, 236
    safety, 233
Victimization
  adolescent and adult sexual assault, 89
  adult male sexual assault, 158
  dating violence in teens and young adults, 68
  past, 89
Victim's medical chart, 246
Victims of Child Abuse Laws (VOCAL), 5–6
Victim's postcrime behaviors, 234–236
Victim's private information, 247–248
Violence Against Women Act (VAWA), 5, 6, 15, 92
Viral Hepatitis, 214–215
Vital signs, 264
VOCAL. See Victims of Child Abuse Laws (VOCAL)
Voyeurism, 7
Vulnerability, 180
Vulnerable populations, sexual assault, 86
  college-aged, 88–89
  LGBTQ individuals, 89
  past victimization, 89
  special populations, evaluation and treatment for, 89–91
  substance abuse, 89
  younger age, 88

W
Wart viruses, autoinoculation, 28
WEAAD. See World Elder Abuse Awareness Day (WEAAD)
Weapons of opportunity, 230
World Elder Abuse Awareness Day (WEAAD), 193
World Health Organization (WHO), 204

Y
Youth Risk Behavior Survey, 37