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# Sexual Assault

Victimization Across the Life Span  
A Clinical Guide



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# Sexual Assault

## Victimization Across the Life Span A Clinical Guide

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## FOREWORD

Sexual assault is broadly defined as unwanted sexual contact of any kind. Among the acts included are rape, 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 where the perpetrator gradually escalates the type of sexual contact with the child and often does not use the force implied in the term sexual assault. But it is assault, both physically and emotionally, 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 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 rape over the course of their lives. The incidence of male victims is lower because of the reluctance 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 healthcare consequences, such as unwanted pregnancy, sexually transmitted diseases, serious emotional upheavals, inability to carry out normal daily activities, decreased productivity, and, in some cases, loss of life. Longer-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, myalgias, 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 lifespan. 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 the 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 to help them carry out their roles most effectively. This book offers 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.

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## FOREWORD

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 non-reproductive 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 (e.g., 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 (i.e., 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 (i.e., 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 potential perpetrators before they commit sexual abuse (primary 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.

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## PREFACE

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.

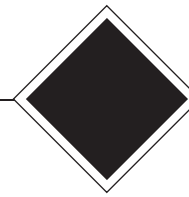
Who commits these acts? While there is no classic profile of an offender, child sex abusers tend to be males who are known to the child's caregivers, and 80% of the women who are assaulted know their attackers as well—they are their ex-husbands, their stepfathers, their boyfriends, and other friends 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 healthcare professionals and other mandated reporters, *Sexual Assault 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.

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# TABLE OF CONTENTS

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## CHAPTER 1: OVERVIEW OF CHILD SEXUAL ABUSE

Historical Perspective . . . . .	1
Definition . . . . .	2
Scope . . . . .	3
Victims . . . . .	5
Offenders . . . . .	6
Indicators of Sexual Abuse . . . . .	8
Support Systems . . . . .	10
Outcomes . . . . .	11
Avoidant Coping . . . . .	12
Internalized Coping . . . . .	12
Angry Coping . . . . .	13
Active/Social Coping . . . . .	13

## CHAPTER 2: ANOGENITAL ANATOMY: DEVELOPMENTAL, NORMAL, VARIANT, AND HEALING

Medical Embryology of the External Genitalia . . . . .	17
Development of the External Genitalia in Boys . . . . .	18
Anatomic Variations in Boys . . . . .	18
Development of the External Genitalia in Girls . . . . .	20
Anatomic Variations in Girls . . . . .	21
Urethral Variations . . . . .	23
Variations of the Internal Genitalia . . . . .	23
Ovary . . . . .	23
Uterus . . . . .	24
The Hymen . . . . .	24
Variations in Configuration . . . . .	24
Hymenal Configurations . . . . .	25
Prevalence in Studies . . . . .	26
Clinical Features of the Normal Hymen . . . . .	26
Variations in Morphology . . . . .	26
External Vaginal Ridge . . . . .	26
Hymenal Tag . . . . .	26
Longitudinal Intravaginal Ridge . . . . .	26
Hymenal Notches or Clefts . . . . .	28
Vaginal Rugae . . . . .	29
Periurethral and Perihymenal Vestibular Bands . . . . .	29
Labial Agglutination/Adhesions . . . . .	29
Erythema of the Vestibular Sulcus . . . . .	29
Linea Vestibularis . . . . .	29
Hymenal Bumps or Mounds . . . . .	29
Lymphoid Follicles . . . . .	30
Posterior Hymenal Measurement . . . . .	30
Transhymenal Diameter . . . . .	30
Effect of Estrogen on the Hymen . . . . .	32
Female Puberty . . . . .	32
Thelarche . . . . .	33
Pubarche . . . . .	34
Internal Genitalia . . . . .	34

Cervix . . . . .	34
External Genitalia . . . . .	35
Pubertal Variations in Girls . . . . .	36
Pubertal Changes and Variations in Male Sexual Development . . . . .	36
Pubertal Variations in Males . . . . .	37
Sexual Maturity Rating . . . . .	38
Development of the Anorectum . . . . .	38
Normal Perineum and Anorectum . . . . .	39
Color Changes . . . . .	39
Red . . . . .	39
Brown . . . . .	41
Blue . . . . .	41
White . . . . .	41
Anatomic Variations . . . . .	41
Variations in Genitoanal Development . . . . .	42
Healing After Anogenital Injury . . . . .	42
<b>CHAPTER 3: EVALUATION OF CHILD SEXUAL ABUSE</b>	
History . . . . .	53
Physical Examination . . . . .	59
Initial Assessment and Examination . . . . .	61
Typical Anatomy . . . . .	61
Sexually Transmitted Diseases . . . . .	66
Differential Diagnosis . . . . .	70
Forensic Evidence . . . . .	70
Definitive Care . . . . .	73
Documentation and Photographs . . . . .	74
Conclusion . . . . .	77
<b>CHAPTER 4: FORENSIC EVALUATIONS FOR SEXUAL ABUSE IN THE PREPUBESCENT CHILD</b>	
Principles of Evidence Collection . . . . .	81
Determination of Team Composition . . . . .	82
Contamination Control . . . . .	82
Documentation . . . . .	82
Prioritization of Evidence Collection . . . . .	82
Collection and Preservation of Evidence . . . . .	83
Limitations of the Forensic Evaluation . . . . .	83
Forensic Evidence Collection: When Do You Collect Evidence? . . . . .	83
The Process of Collection . . . . .	84
Basic Evidence Collection Techniques . . . . .	84
Forensic Evaluations . . . . .	87
More than 72 Hours Later or with Chronic Abuse . . . . .	87
Chronic Abuse with the Most Recent Occurrence within 72 Hours . . . . .	87
Interview Process . . . . .	87
Physical Examination . . . . .	88
Special Evidence Collection Techniques in the Evaluation of Sexual Abuse . . . . .	88
Forensic Photography . . . . .	88
Colposcopy . . . . .	89
Alternate Light Sources . . . . .	89
Double Swab Technique . . . . .	89
Saline Float/Irrigation of Hymenal Tissue . . . . .	90
Foley Catheter Technique . . . . .	90
Toluidine Blue . . . . .	90
Bite Mark Impressions and Evidence Collection . . . . .	90
Documentation . . . . .	90
Peer Review of Cases . . . . .	91
Testing for Sexually Transmitted Diseases (STDs) . . . . .	91
Conclusion . . . . .	91



<b>CHAPTER 5: SEXUALLY TRANSMITTED DISEASES IN SEXUALLY ABUSED CHILDREN</b>	
Overview . . . . .	93
Epidemiology . . . . .	94
Specific Disorders . . . . .	96
Chlamydia Trachomatis . . . . .	96
Neisseria Gonorrhoeae . . . . .	100
Human Immunodeficiency Virus . . . . .	101
Syphilis . . . . .	102
Herpes Simplex . . . . .	104
Trichomonas . . . . .	104
Human Papillomavirus . . . . .	105
Bacterial Vaginosis . . . . .	107
Hepatitis B . . . . .	108
<b>CHAPTER 6: DIFFERENTIAL DIAGNOSIS</b>	
Variations of Normal Anatomy . . . . .	113
Genitalia . . . . .	113
Anus . . . . .	114
Nonabusive Trauma . . . . .	114
Dermatologic Disorders . . . . .	116
Infectious Disorders . . . . .	117
Inflammatory Disorders . . . . .	120
Miscellaneous Disorders . . . . .	120
Conclusion . . . . .	121
<b>CHAPTER 7: SCREENING FOR AND TREATMENT OF SEXUAL ABUSE HISTORIES IN BOYS AND MALE ADOLESCENTS</b>	
Introduction . . . . .	125
The Problem . . . . .	125
The Solution . . . . .	128
How Should Providers Do This? . . . . .	129
Conclusion . . . . .	139
<b>CHAPTER 8: DISABILITY AND SEXUAL VIOLENCE</b>	
Incidence of Abuse . . . . .	146
Hate Crimes Against Persons with Disabilities . . . . .	147
Nursing Home and Group Home Residents . . . . .	148
Evaluation of the Child or Adult with a Disability . . . . .	149
Disclosure . . . . .	151
Hearing-Impaired Victim . . . . .	152
Visually Impaired Victim . . . . .	153
Cognitively or Behaviorally Impaired Victim . . . . .	154
Motor-Impaired Victim . . . . .	155
Interview Techniques . . . . .	156
Physical Examination . . . . .	158
Sexual Assault and Homicide . . . . .	163
Multidisciplinary Considerations . . . . .	164
Summary . . . . .	167
Appendix: Directory of Service Providers . . . . .	168
<b>CHAPTER 9: MULTIDISCIPLINARY TEAMWORK ISSUES RELATED TO CHILD SEXUAL ABUSE</b>	
Team Approach . . . . .	173
Reporting . . . . .	175
Collaborative Investigation and Intervention . . . . .	176
Child Protective Services . . . . .	176
Law Enforcement Agencies . . . . .	177
Mental Health Professionals . . . . .	177
Courts and Judicial Proceedings . . . . .	180

Juvenile Courts . . . . . 180  
 Criminal Court . . . . . 182  
 Expert Versus Fact Testimony . . . . . 182  
 Support for the Child During Court Proceedings . . . . . 182  
 Impact on the Child . . . . . 183  
 Conclusion . . . . . 184

**CHAPTER 10: DOCUMENTATION AND REPORT FORMULATION: THE BACKBONE OF THE MEDICAL RECORD**

Documenting the Clinical Evaluation . . . . . 189  
 The Medical Record . . . . . 190  
     Purpose of the Medical Examination . . . . . 190  
     Establishing the Diagnosing and Treating Physician Relationship . . . . . 191  
     Medical History Documentation . . . . . 192  
     Components of the Medical Record . . . . . 193  
     Review of Systems . . . . . 193  
     Recording the Physical Examination Findings . . . . . 195  
     Describing the Physical Examination . . . . . 195  
 Putting It All Together: Formulating a Diagnosis . . . . . 196  
 Case Studies . . . . . 197  
 Conclusion . . . . . 200

**CHAPTER 11: NETWORKS AND TECHNOLOGIES**

Networks . . . . . 201  
     Designing a Telemedicine System That Protects Children . . . . . 202  
     State Networks . . . . . 203  
     Distance Learning . . . . . 204  
     Funding . . . . . 205  
 Technologies . . . . . 206  
     Colposcopy: Imaging Sexual Abuse . . . . . 206  
     Evaluations . . . . . 207  
 Electronic Record . . . . . 208  
 Summary . . . . . 209

**CHAPTER 12: OVERVIEW OF ADOLESCENT AND ADULT SEXUAL ASSAULT**

Epidemiology . . . . . 212  
 Public Health Implications . . . . . 213  
 Populations at Risk . . . . . 214  
 Immediate Reactions to Sexual Trauma . . . . . 215  
 Delayed Effects on the Survivor . . . . . 215  
 Components of an Effective Response . . . . . 217  
 Prevention . . . . . 218

**CHAPTER 13: GENITAL INJURY AND SEXUAL ASSAULT**

Terminology Related to Sexual Contact . . . . . 223  
 The Nature of Physical Findings . . . . . 223  
 Mechanisms and Types of Injury . . . . . 226  
     Abrasions . . . . . 227  
     Contusions and Bruises . . . . . 227  
     Erythema . . . . . 228  
     Lacerations . . . . . 228  
 Research on Injuries and Sexual Assault . . . . . 228  
 Factors Influencing Injury . . . . . 230  
     Consensual Intercourse and Epithelial Changes . . . . . 230  
     The Victim's History and Determinants of Injury . . . . . 231  
         Factors Related to the Victim . . . . . 231  
             Anatomy and Physiology of the Reproductive Organs . . . . . 231  
             Health and Developmental Status . . . . . 233  
             Condition of the Genital Structures . . . . . 233  
             Previous Sexual Experience . . . . . 234

Lubrication . . . . .	234
Partner Participation . . . . .	235
Positioning and Pelvic Tilt . . . . .	235
Psychologic Response . . . . .	236
Factors Related to the Assailant . . . . .	236
Object of Penetration . . . . .	236
Lubrication . . . . .	236
Sexual Dysfunction . . . . .	236
Force of Penetration . . . . .	236
Factors Related to Circumstances . . . . .	236
Factors Related to the Environment . . . . .	237
When Physical Findings Are Not Observed . . . . .	237
Documentation . . . . .	237

#### **CHAPTER 14: THE EVALUATION OF THE SEXUAL ASSAULT VICTIM**

Obtaining the History of the Sexual Assault . . . . .	242
Role of the Healthcare Provider . . . . .	242
Setting . . . . .	242
History of the Adult Victim . . . . .	243
The Physical Examination . . . . .	244
Laboratory Tests . . . . .	247
Chain of Evidence . . . . .	247
Documentation . . . . .	248
Follow-up Care . . . . .	249
Prevention Education . . . . .	249

#### **CHAPTER 15: FORENSIC ISSUES IN CARING FOR THE ADULT SEXUAL ASSAULT VICTIM**

Establishing Victim Safety . . . . .	251
Medical and Assault History . . . . .	252
Health History . . . . .	252
Assault History . . . . .	252
The Assault . . . . .	252
The Perpetrator . . . . .	253
The Crime Scene . . . . .	253
The Victim's Post-Crime Behaviors . . . . .	253
Acute Care of the Sexual Assault Victim . . . . .	253
Assessing Physical Trauma . . . . .	253
Nongynecologic Injuries . . . . .	253
Gynecologic Injuries . . . . .	254
Pharmacologic Needs . . . . .	254
Prevention of Pregnancy . . . . .	254
Prevention of Sexually Transmitted Diseases . . . . .	256
Forensic Evidence Collection . . . . .	257
Documentation After Sexual Assault . . . . .	257
Assault History . . . . .	259
Physical Examination . . . . .	259
Medical Management . . . . .	260
Evidence Collected . . . . .	260
Support Services . . . . .	260
Collaboration with Other Disciplines . . . . .	260
Conclusion . . . . .	261

#### **CHAPTER 16: DNA EVIDENCE IN SEXUAL ASSAULT**

Importance of DNA Evidence . . . . .	263
Understanding the Serologic Past . . . . .	264
The Forensic DNA Revolution . . . . .	265
Restriction Fragment Length Polymorphism Analysis . . . . .	266
Polymerase Chain Reaction Analysis . . . . .	267
Diversity of PCR Forensic Tests . . . . .	267

Convicted Offender Databases . . . . .	268
Combined DNA Index System . . . . .	268
CODIS Success Stories . . . . .	269
The DNA Testing Resource Crisis . . . . .	270
Collaboration Among Law Enforcement, the Judicial System, and DNA Laboratories . . . . .	272
Important Biologic Evidence in Sexual Assault . . . . .	272
DNA Case Histories . . . . .	274
Scenario #1 . . . . .	274
Scenario #2 . . . . .	274
Scenario #3 . . . . .	275
DNA Collection . . . . .	275
Gaining Cooperation and Consent . . . . .	276
Forensic Evidence Collection . . . . .	276
Collection Procedures . . . . .	279
Unknown Specimens . . . . .	279
DNA on Clothing . . . . .	279
Oral Swabs in Cases of Oral Copulation . . . . .	279
Dental Floss in Cases of Oral Copulation . . . . .	279
Biologic Material in Hair . . . . .	279
Biologic Material on Skin . . . . .	279
Semen . . . . .	279
Saliva and Bite Marks . . . . .	279
DNA on Miscellaneous Items and Surfaces . . . . .	280
Condoms . . . . .	280
Shoes . . . . .	280
DNA from an Unknown Hair . . . . .	280
Known Reference Specimens . . . . .	280
Law Enforcement Investigation . . . . .	280
DNA as a Prosecutorial Weapon . . . . .	280
Lack of DNA Training for Law Enforcement and Forensic Examiners . . . . .	281
Suspect Exams . . . . .	281
Reexamining Unsolved Sexual Assault Cases . . . . .	282
Critical Shortage of Crime Laboratory Resources . . . . .	282
Case-to-Case Cold Hits . . . . .	288
Resource Management . . . . .	289
Improving Communication Between Investigators and Criminologists . . . . .	289
Appendix I: DNA Case Studies . . . . .	291
Appendix II: Documentation and Warrants . . . . .	307

**CHAPTER 17: SEXUALLY TRANSMITTED DISEASES AND PREGNANCY  
PROPHYLAXIS IN ADOLESCENTS AND ADULTS**

Recognition and Treatment of Common Sexually Transmitted Diseases and Associated Syndromes . . . . .	320
Gonorrhea . . . . .	320
Chlamydia Infection . . . . .	322
Syphilis . . . . .	322
Chancroid . . . . .	323
Trichomoniasis . . . . .	323
Herpes Simplex . . . . .	324
Human Papillomavirus . . . . .	324
Bacterial Vaginosis . . . . .	325
Mucopurulent Cervicitis . . . . .	325
Pelvic Inflammatory Disease . . . . .	325
Proctitis and Proctocolitis . . . . .	326
Pubic Lice . . . . .	327
Scabies . . . . .	327
Viral Hepatitis . . . . .	327
History and Physical Examination . . . . .	328
Diagnostic Evaluation . . . . .	328

Treatment and Prophylaxis of STDs . . . . .	331
HIV Postexposure Prophylaxis . . . . .	331
Emergency Oral Contraception . . . . .	334
Conclusion . . . . .	335

## **CHAPTER 18: DATING VIOLENCE AND ACQUAINTANCE RAPE**

Epidemiology . . . . .	339
Risk Factors . . . . .	339
The Role of Drugs and Alcohol in Acquaintance Rape . . . . .	340
A Victim's Response to Dating Violence and Acquaintance Rape . . . . .	340
Jennifer's Story . . . . .	340
Psychologic Consequences . . . . .	341
When the Victim is Male . . . . .	341
A Perpetrator's Response to Dating Violence and Acquaintance Rape . . . . .	341
Michael's Story . . . . .	341
An Effective Clinical Response . . . . .	342
The Need for Active Screening . . . . .	342
After an Assault Has Occurred . . . . .	343
Preventing Sexually Transmitted Diseases . . . . .	343
Preventing Pregnancy . . . . .	343
Providing Psychologic Support . . . . .	343
Preventing Dating Violence and Acquaintance Rape . . . . .	343
Conclusion . . . . .	344
Appendix: Safety Tips for Acquaintance Rape Prevention . . . . .	344

## **CHAPTER 19: DOMESTIC VIOLENCE AND PARTNER RAPE**

Domestic Violence Overview . . . . .	347
Rape and Domestic Violence . . . . .	347
Prevalence . . . . .	348
The Role of Coercion . . . . .	350
Clinical Presentation and Sequelae . . . . .	350
Physical Injuries and Symptoms . . . . .	351
Psychologic Effects . . . . .	351
Health Status and Disease Prevention . . . . .	352
Associated Behaviors . . . . .	352
Identification of Abuse . . . . .	352
The Clinician's Response to Domestic Violence . . . . .	354
Documentation . . . . .	354
Intervention . . . . .	354
Safety Is the Paramount Goal in Abuse Intervention . . . . .	355
Safety Assessment is Essential . . . . .	355
Immediate Safety . . . . .	355
Long-Term Safety Issues . . . . .	356
Societal Reaction to Marital Rape . . . . .	356
Special Populations . . . . .	357
Immigrants . . . . .	357
Women with Disabilities . . . . .	357
Gay and Lesbian Relationships . . . . .	358
Future Study and Interventions for Intimate Partner Rape . . . . .	358
Appendix I: RADAR Algorithm . . . . .	359
Appendix II: Safety Tips When There is Violence in the Home . . . . .	359

## **CHAPTER 20: SEXUAL ASSAULT AND PREGNANCY**

Sexual Assault in the Context of Domestic Violence During Pregnancy . . . . .	363
Epidemiology . . . . .	363
Increased Abuse During Pregnancy . . . . .	364
Pregnancy as a Window of Opportunity for Intervention . . . . .	364
Intersection of Domestic Violence and Child Abuse . . . . .	365
Sexual Assault and Abuse of Pregnant Women . . . . .	365
Clinical Manifestations . . . . .	365

Inadequate Prenatal Care . . . . .	365
Abdominal and Genital Trauma . . . . .	366
Adverse Outcome of Pregnancy . . . . .	366
Unintended Pregnancy and Sexually Transmitted Diseases . . . . .	366
Depression . . . . .	366
Drug and Alcohol Abuse . . . . .	367
Pregnancy Termination . . . . .	367
Steps in Identifying Abuse and Assault in Pregnancy . . . . .	367
Clinician Response to Abuse During Pregnancy . . . . .	367
Safety is the Critical Issue . . . . .	368
The Role of Pediatricians in Preventing Both Child Abuse and Domestic Violence . . . . .	368
Abuse and Assault in Adolescent Pregnancy . . . . .	369
Sexual Assault Resulting in Pregnancy . . . . .	370
Prophylaxis and Treatment of STD's in Pregnancy . . . . .	370
Genital Herpes (Herpes Simplex Virus [HSV] Type II) . . . . .	370
HPV (Condyloma Accuminata, or Genital Warts) . . . . .	371
Trichomonas . . . . .	371
Chlamydia . . . . .	371
Gonorrhea . . . . .	371
Syphilis . . . . .	371
Hepatitis B . . . . .	371
Human Immunodeficiency Virus (HIV) . . . . .	371
Conclusion . . . . .	371
 <b>CHAPTER 21: RAPE AND SEXUAL ABUSE IN OLDER ADULTS</b>	
Incidence of Sexual Abuse Among Older Adults . . . . .	377
Defining Rape and Sexual Assault of Older Adults . . . . .	378
Limits of Existing Data Collection Methods . . . . .	379
Exposure to Sexual Abuse . . . . .	380
Sexual Abuse of Older Adults Residing in Institutional Settings . . . . .	381
Sexual Abuse of Older Adults Residing in Noninstitutional Settings . . . . .	383
Immediate and Long-Term Responses of Older Sexual Assault Victims . . . . .	383
Framework for Working with Older Sexual Assault Victims . . . . .	384
Effective Clinical Response to Elder Sexual Abuse . . . . .	385
Screening . . . . .	385
Interview . . . . .	386
Examination . . . . .	387
Provision of Care and Resources . . . . .	388
Reporting Requirements . . . . .	389
Conclusion . . . . .	389
 <b>CHAPTER 22: SEXUAL ASSAULT IN CORRECTIONAL SETTINGS</b>	
Overview of the Problem . . . . .	393
Role of the Medical Professional . . . . .	398
Infectious Disease Complications in Prison Rape . . . . .	398
Role of Social Services Professionals and Prison Staff . . . . .	399
Gang-Related Incidents . . . . .	400
Sexual Predators . . . . .	400
From Victim to Predator . . . . .	400
Disposition of Cases . . . . .	400
Summary . . . . .	401
 <b>CHAPTER 23: REVISED TRAUMA THEORY: UNDERSTANDING THE TRAUMATIC NATURE OF SEXUAL ASSAULT</b>	
Introduction . . . . .	405
Trauma Theory: Understanding the Impact of Sexual Assault . . . . .	406
Psychologic Trauma Defined . . . . .	406
Heredity's Legacy: The Autonomic Nervous System . . . . .	407
Heredity Off-Track . . . . .	407
The Fight-or-Flight Response . . . . .	408

Learned Helplessness . . . . .	408
Thinking Under Stress—Action, Not Thought . . . . .	409
Remembering Under Stress . . . . .	410
Emotions and Trauma—Dissociation . . . . .	412
Endorphins and Stress—Addiction to Trauma . . . . .	413
Trauma—Bonding . . . . .	414
Traumatic Reenactment . . . . .	414
The Consequences of Traumatic Experience . . . . .	414
Posttraumatic Stress Disorder . . . . .	415
Trauma and Substance Abuse . . . . .	416
Sexual Assault and Neurobiologic Changes . . . . .	417
The Health Consequences of Trauma . . . . .	417
Stress, Moods, and Immunity . . . . .	418
Chronic Violence and Health . . . . .	418
Sexual Assault and Revictimization . . . . .	419
Prostitution . . . . .	419
Victim to Victimizer Behavior . . . . .	420
Sexual Assault and Parenting . . . . .	421
Responding to Sexual Assault: Creating Sanctuary . . . . .	423
Summary . . . . .	424

## **CHAPTER 24: SOCIAL SUPPORTS**

History . . . . .	433
Nature of Social Supports . . . . .	434
Social Services . . . . .	434
Rape Crisis Centers . . . . .	434
Domestic Violence Programs . . . . .	434
Victim Assistance Programs . . . . .	435
Healthcare System . . . . .	435
Acute Care . . . . .	435
Sexual Assault Nurse Examiner and Sexual Assault Response Team Programs . . . . .	435
Postacute Care Medical Support . . . . .	436
Churches and Religious Groups . . . . .	437
Other Social Supports . . . . .	437
Program Development . . . . .	438
First Steps . . . . .	438
Involve Multiple Disciplines . . . . .	438
Recruit Top-Level Support . . . . .	438
Use Existing Personnel and Space . . . . .	439
Coordination of Services . . . . .	439
Risk Reduction and Education . . . . .	439
Funding . . . . .	440
One City's Experience: Philadelphia's Partnership for Quality Services . . . . .	440
Conclusion . . . . .	441
Appendix: State Coalitions . . . . .	441

## **CHAPTER 25: MOVING BEYOND A DON'T-ASK-DON'T-TELL**

### **APPROACH TO ABUSE AND ASSAULT**

Don't Ask: Acknowledged Barriers . . . . .	447
"I Haven't Been Trained to Do This" . . . . .	447
"I Don't Have Time" . . . . .	448
"It's Not My Job; It's Not a Medical Problem" . . . . .	448
"I'm Not a Domestic Violence Expert" . . . . .	449
"Abuse Doesn't Happen in my Patient Population" . . . . .	449
"This is a Personal Problem and Is Not My Business" . . . . .	449
"Why Doesn't She Just Leave?" . . . . .	450
"What's the Point?" . . . . .	450
Don't Ask: Unacknowledged Barriers . . . . .	450
Too Close For Comfort . . . . .	451
Medical Training as an Abusive Experience . . . . .	451

Sexual and Gender-Based Harassment . . . . . 452  
 Victims of Abuse as Difficult Patients . . . . . 452  
 Pandora's Box . . . . . 452  
 Don't Tell: Barriers to Disclosure by the Victim . . . . . 453  
 Treating Victims Without Feeling Hopeless . . . . . 453  
 Stages of Behavior Change . . . . . 455  
 Conclusion . . . . . 455

**CHAPTER 26: CARING FOR THE CAREGIVER: AVOIDING AND TREATING VICARIOUS TRAUMATIZATION**

What Is It? . . . . . 459  
 Who Gets It? . . . . . 461  
 What Causes It? . . . . . 462  
     Biologic Causality: Emotional Contagion . . . . . 462  
     Psychologic Causality: Loss of Positive Illusions . . . . . 463  
     Social Causality: Inability to Use Normal Social Obstacles . . . . . 463  
     Organizational Causality: Sick Systems . . . . . 464  
     Moral, Spiritual, and Philosophical Causality: Theoretical Conflicts . . . . . 464  
 What Can Be Done About It? . . . . . 466  
     Personal-Physical . . . . . 466  
     Personal-Psychologic . . . . . 466  
     Personal-Social . . . . . 466  
     Personal-Moral . . . . . 466  
     Professional . . . . . 466  
     Organizational/Work Setting . . . . . 466  
     Societal . . . . . 467  
 Conclusion: Developing Organizational Universal Precautions . . . . . 467

**CHAPTER 27: SANE-SART HISTORY AND ROLE DEVELOPMENT**

The Need for SANE Programs . . . . . 471  
 History of SANE Program Development . . . . . 472  
 What is a SANE? SAFE? FE? . . . . . 473  
 SANE Scope of Practice . . . . . 473  
     Medical Care . . . . . 473  
     Reporting . . . . . 474  
     Emotional Support and Crisis Intervention . . . . . 474  
     Education, Training, Research, and Program Evaluation . . . . . 474  
     SANE Standards of Practice . . . . . 474  
 How a Model SANE Program Operates . . . . . 474  
     Hospital-Based SANE Programs . . . . . 474  
     Community-Based SANE Programs . . . . . 475  
         Community Response and Responsibilities . . . . . 475  
         SANE Responsibilities . . . . . 476  
 SANE Training . . . . . 476  
     State Level Certification . . . . . 476  
     National Certification . . . . . 477  
     SANE Training Components Program . . . . . 477  
     SANE Training Trends . . . . . 478  
 SART: A Community Approach . . . . . 479  
     Who is on a SART? . . . . . 479  
     Two SART Models . . . . . 479  
         Joint Interview SART Model . . . . . 479  
             Joint Interview SART Model Limitations . . . . . 480  
         Cooperative SART Model . . . . . 480  
             Cooperative SART Model Limitations . . . . . 481  
 Evidence of SANE Efficacy . . . . . 481  
     Better Collaboration with Law Enforcement . . . . . 481  
     Higher Reporting Rates . . . . . 481  
     Shorter Examination Time . . . . . 482  
     Better Forensic Evidence Collection . . . . . 482  
     Improved Prosecution . . . . . 483  
 Summary . . . . . 483



<b>CHAPTER 28: ROLE OF EMS PREHOSPITAL CARE PROVIDERS</b>	
Psychology of Victims . . . . .	487
Forensic Evidence . . . . .	488
Preserve Crime Scene Evidence Regarding Clothing . . . . .	489
Preserve Crime Scene Evidence Regarding Wounds . . . . .	489
Preserve Crime Scene Evidence Regarding Body Fluids . . . . .	490
Transporting Victims to Hospitals . . . . .	491
<b>CHAPTER 29: LAW ENFORCEMENT ISSUES</b>	
Processing the Scene and Collecting Evidence . . . . .	495
The Interview Process . . . . .	498
Search Warrants . . . . .	500
Corroborating Evidence . . . . .	501
Bite Marks . . . . .	502
Other Considerations . . . . .	502
Conclusion . . . . .	504
<b>CHAPTER 30: THE ROLE OF POLICE AS FIRST RESPONDERS</b>	
Preparation for First Responders . . . . .	507
Victim Contact . . . . .	508
Medical Examinations . . . . .	510
Investigative Interviews . . . . .	511
Criminal Prosecution . . . . .	511
Victim Reactions . . . . .	512
Ongoing Contact and Victim Support . . . . .	513
Conclusion . . . . .	513
<b>CHAPTER 31: LEGAL ISSUES IN SEXUAL ASSAULT FROM A PROSECUTOR'S PERSPECTIVE</b>	
Crimes of Sexual Assault . . . . .	515
Statute of Limitations . . . . .	516
The Criminal Justice Process . . . . .	516
Preliminary Arraignment . . . . .	517
Appointment of Counsel . . . . .	518
The Preliminary Hearing . . . . .	518
Corroboration . . . . .	519
The Expert Witness . . . . .	519
The Trial . . . . .	520
Sexual Assault of Males . . . . .	520
Domestic Violence and Sexual Assault . . . . .	521
Jury Selection . . . . .	521
Admissibility of Evidence . . . . .	522
Defenses . . . . .	522
Conclusion . . . . .	523
<b>CHAPTER 32: HEARING THE CRY: INVESTIGATING AND PROSECUTING ADULT SEXUAL ASSAULT CASES</b>	
Introduction . . . . .	525
Investigation of Sexual Assault Cases . . . . .	525
Corroborating the Victim's Statement . . . . .	525
Interrogation of Suspect . . . . .	526
Rape Kit . . . . .	528
DNA . . . . .	529
Pretrial Motion Practice in Sexual Assault Cases . . . . .	533
The Rules of Evidence . . . . .	533
Other Bad Acts . . . . .	533
Hearsay Exceptions . . . . .	534
Other Evidentiary Considerations . . . . .	535
Rape Shield Statutes . . . . .	535
History . . . . .	535

The Four Models of Rape Shield Statutes . . . . .	536
The Michigan Model . . . . .	536
The Federal Model . . . . .	536
The Arkansas Model . . . . .	536
The California Model . . . . .	537
Constitutional Issues . . . . .	537
Problematic Cases . . . . .	538
Date Rape/Acquaintance Rape . . . . .	538
Alcohol-Facilitated Sexual Assaults . . . . .	539
Alcohol and Memory . . . . .	539
Alcohol and Reduced Inhibitions . . . . .	540
Drug-Facilitated Sexual Assaults . . . . .	541
Mentally Retarded Victims . . . . .	544
The Investigation . . . . .	544
Pretrial Motions . . . . .	546
Trial Considerations . . . . .	546
Computer-Assisted Sexual Exploitation of Adult Victims . . . . .	548
Preparing for the Interview . . . . .	548
Question Areas . . . . .	549
Forensic Evaluation . . . . .	550
Marital Rape and Domestic Violence . . . . .	555
Trial Strategies . . . . .	556
Voir Dire . . . . .	556
Direct Examination of Sexual Assault Nurse Examiners (SANE) . . . . .	558
Establishing a Protocol . . . . .	558
Rules of Evidence Every Sexual Assault Examiner Should Know and Understand . . . . .	559
Surviving Cross-Examination . . . . .	569
Cross-Examination of Defendant . . . . .	570
Opening Statements . . . . .	573
Establish Goals . . . . .	573
The Importance of the Theme and Theory . . . . .	573
Covering the Issues . . . . .	574
Paint a Picture . . . . .	574
Closing Argument . . . . .	574
Reiterate the Theme . . . . .	574
Deal with the Defense Case . . . . .	574
Show Corroboration of the State's Case . . . . .	575

# Sexual Assault

Victimization Across the Life Span  
A Clinical Guide



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# OVERVIEW OF CHILD SEXUAL ABUSE

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## HISTORICAL PERSPECTIVE

The sexual abuse of children has been discussed in writings dating back to the late 19th century. Freud (1961) publicly noted in 1896 that many of his patients with hysterical illnesses had a history of a sexual experience in their childhood. He thus theorized that hysteria was a direct result of childhood seduction. Unfortunately, he supported this seduction theory for only a short time, and by 1905 his belief had shifted. He renounced his previous views and stated that the sexual events recalled by his patients were unconscious fantasies rather than real events. He claimed that his patients' memories of sexual abuse were merely projections of their own desire for the parent of the opposite sex. Freud's adoption of this oedipal theory was a setback to the widespread acceptance of child sexual abuse because it caused others to question the existence of the problem as well as its psychologic effects (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995b).

Over the next sixty years, child sexual abuse did receive occasional mention but almost always as it related to incest. Most of Freud's followers questioned the impact of sexual experiences on children as well as the role the children played in these activities. Between 1920 and 1950, investigators conceded that family members did sometimes involve children in sexual activities but that this contact did not have a damaging effect on the children (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995a). Furthermore, some proposed that these experiences may even have had a beneficial effect on the children involved. Children were characterized as active participants in the sexual activities, often being labeled as the initiators of their own seduction (Bender & Blau, 1937).

In 1953 Kinsey et al. published the results of their study, which revealed that sexual abuse was indeed common in childhood. Even though they showed that almost 10% of women admitted to being sexually abused before age 18 years, their results received little attention (Whetsell-Mitchell, 1995a). It was not until the release of the landmark paper of "The Battered Child Syndrome," in 1962 that the medical profession began to take notice (Kempe et al., 1962). In 1971 the first child sexual abuse program was opened in San Jose, California. The Child Protective Movement began to campaign for legislation that would confront the problem of child sexual abuse on a national level. In 1974 the Child Abuse Prevention and Treatment Act was passed, which "mandated mental health professionals and educators to assist in the detection and reporting of child sexual abuse" (Cosentino & Collins, 1996; Whetsell-Mitchell, 1995b).

The publication of "Sexual Abuse, Another Hidden Pediatric Problem" by C. Henry Kempe (1978) forced the healthcare community to address the importance of the diagnosis and treatment of child sexual abuse. Works in the early 1980s focused on the child as the victim and the offender as the initiator. Blame

*Key Point:*

*Sexual abuse of children is not a new problem, but has only been accepted as a bona fide problem deserving professional attention since the 1970s.*

was put on the offender, not the child (Sgroi et al., 1982). At the same time, the publication of books by survivors of child sexual abuse and the release of television movies on the topic brought the issue of child sexual abuse to the public forefront (Whetsell-Mitchell, 1995b).

## DEFINITION

The characterization of child sexual abuse is subject to interpretation on multiple levels. Institutional, societal, medical, and legal terminology all differ in their definition or emphasis. It is impossible to find a single universally accepted definition. Child sexual abuse encompasses a wide spectrum of activities ranging from the less serious to the more serious. Sexually abusive actions may or may not involve direct contact with the child. 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” (Kempe, 1978). Most legal definitions emphasize certain elements such as the age of the perpetrator and victim, description of specific acts or categories of sexual abuse, and who is considered a mandated reporter. The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 provided a federal legal standard that all states were mandated to follow to be eligible for funds for child abuse programs. This act defined sexual abuse as “the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct” (Child Abuse Prevention and Treatment Act, 1974). All 50 states have written statutes regarding sexual abuse based on this standard, but many differ in the specific wording. A child, in almost all instances, is defined as a person under age 18 years. Exceptions are made when that person is married. Certain laws are more specific with regard to the age of the perpetrator and victim when specific sexual acts are involved. Most statutes emphasize the discrepancy between the ages of the perpetrator and the victim. These laws also take into consideration the developmental level of the abused child. For purposes of reporting and involving specific legal agencies, laws distinguish who is considered a caretaker or guardian of the child. The involvement of a caretaker in the abuse necessitates the involvement of the local child protective services agency, as well as law enforcement. When the alleged perpetrator is considered a child, intervention may be limited to child protective services alone. When the assailant is unknown, unrelated, or not considered to be someone involved in the care of that child, the abuse may be a purely criminal case.

### *Key Point:*

*Sexual abuse is a term that covers a broad range of developmentally inappropriate sexual behaviors that span both contact and non-contact type activities.*

Sexual abuse encompasses a large variety of actions. Whereas all states include a provision for rape or intercourse, some states use general terms in defining actions that constitute sexual abuse, while others are far more specific. The degree of detail can be crucial in certain cases; for example, medical and legal definitions do not require actual vaginal entry to occur for an act to be considered rape (Kempe, 1978). Genital fondling, oral-genital, genital-genital, and anal-genital contact are generally recognized forms of sexual abuse. The perpetrator does not need to have direct physical contact with the child for sexual abuse to occur. Exhibitionism, voyeurism, and viewing, producing, or distributing pornography are included under most definitions. Exposing a child to sexually explicit material or acts is also considered abuse. Laws making the use of computers and the Internet in producing, compiling, possessing, or disseminating child pornography a crime had been instituted by 27 states and the District of Columbia as of December 31, 1999. Violations are included under the heading of sexual abuse or sexual exploitation of children. Other laws address the use of computers to seduce or attract children with the intent of sexual misuse. The failure to protect a child is an important component of many definitions of child abuse and is relevant to sexual abuse when a caretaker is aware that such abuse is occurring and takes no action to stop or prevent it.

# ANOGENITAL ANATOMY: DEVELOPMENTAL, NORMAL, VARIANT, AND HEALING

William J. Reed, MD, FAAP

## MEDICAL EMBRYOLOGY OF THE EXTERNAL GENITALIA

Genetic sex is determined at the time of fertilization of the ovum. The early genital system in the human fetus is undifferentiated and bipotential. That is, during the first 12 weeks of embryonic life both male and female primordial tracts are present and develop in unison (Moore, 1982). In the female the cortex develops into the ovary at 10 to 11 weeks, while the medulla regresses. In the male the medulla differentiates into the testis, and the cortex regresses. This gonadal development results from the migration of primitive germ cells to the urogenital ridge near the fetal kidney and adrenal gland. After fertilization, the undifferentiated gonad begins to change with the appearance of the müllerian ducts in the female at 6 weeks gestation. In the male, differentiation is present with the appearance of Sertoli cells at 6 to 7 weeks and Leydig cells at 8 weeks, respectively (Sadler, 1995). This phase of development of dual gonadal ducts then forms the phenotypic external genitalia.

The gonadal primordia are influenced by the sex-determining region (SRY) on the Y chromosome. If there is a deletion of the short arm (p-) of the Y chromosome or of the SRY gene, male differentiation does not occur. Deletions of the long arm (q-) of the Y chromosome result in normally developed males with short stature and azoospermia. The presence of an anti-müllerian hormone (AMH) or müllerian inhibitory factor (MIF) produced by the Sertoli cells in the testis causes the müllerian duct system to regress with dissolution of the female pelvic structures, that is, the uterus and fallopian tubes. This MIF is characterized as a glycoprotein whose gene locus has been localized to chromosome 19 (Simpson, 2000). Testosterone produced by the Leydig cells stabilizes the wolffian ducts and through 5- $\alpha$  reductase produces dihydrotestosterone, which virilizes the male external genitalia. The Sertoli and Leydig cell lines and their respective hormones function separately from the morphogenesis of the testis (Bhatnagar, 2000). Specifically, they direct gonadal development as opposed to being products of the testis. Therefore, if a functioning testis is present, the phenotype will be male. Conversely, in the absence of the sex determining region, whether or not an ovary is present, the phenotype will be female (Mittwoch et al., 1993). The uterus, fallopian tubes, and upper vagina will develop independently of the ovary. The female genital tract results from the müllerian ducts, urogenital sinus, and vaginal plate. In the male, the wolffian ducts, the genital tubercle, and the labioscrotal folds form the external genitalia. So, counterintuitively, M becomes female, and W becomes male.

*Key Point:*

*Genetic sex is determined at the time the ovum is fertilized. The early genital system in the human fetus is undifferentiated and bipotential, meaning that during the first 12 weeks of embryonic life, both male and female primordial tracts are present and develop in unison.*

*Key Point:*

*External genital development in boys occurs between 10 and 16 weeks of gestation and does not require high concentrations of testosterone, but does require the conversion of 6% to 8% of the total testosterone to 5-dihydrotestosterone.*

## DEVELOPMENT OF THE EXTERNAL GENITALIA IN BOYS

In boys, external genital development occurs between 10 and 16 weeks gestation and does not require high concentrations of testosterone, but does require the conversion of 6% to 8% of total testosterone to 5-dihydrotestosterone. The genital tubercle continues to grow to form the penis, and the urogenital folds fuse to enclose the penile urethra (Bukowski & Zeman, 2001). The distal head of the penis is the glans penis and the proximal shaft is joined at the corona. The opening of the penile urethra, which may be covered by the foreskin, is called the meatus. Where the foreskin attaches to the corona of the glans penis is termed the frenulum. Laterally, the labioscrotal folds develop and, in the presence of testosterone and 5-DHT, become fused in the midline to form the scrotum. This line may be very prominent on inspection and is referred to as the median raphe. At approximately 11 weeks, the processus vaginalis is present at the internal inguinal ring. It is contiguous with the gubernaculum, which inserts on the mesonephric (wolffian) duct. At 17 weeks the testis is now at the same site and begins to elongate along its vertical axis (Rohn, 1998). This phase of descent is androgen dependent. At 28 weeks the “inguinal scrotal” stage of descent begins. The testis descends into the scrotal sac between 28 and 32 weeks, depending on regression of the gubernaculum. The scrotal content may include fluid from a patent process vaginalis, intestine from a hernia defect, or a discolored and indurated mass caused by torsion of the testis, occasionally seen in breech presentations. The apparent clinical absence of one or both testes requires differentiating between an undescended or absent testis and the more common retractile testis. The spermatic cord and epididymis lie posteriorly to the testis, which is anchored to the scrotum by the gubernaculum, which now becomes a reticular strand.

Testosterone is responsible for the evolution of the mesonephric duct system into the vas deferens, epididymis, ejaculatory ducts, and seminal vesicle. Dihydrotestosterone results in the development of the male external genitalia, including the prostate gland, which arises from the urogenital sinus, and the bulbourethral glands of Cowper. At puberty, testosterone leads to spermatogenesis and the development of the secondary sexual characteristics as well as a five to seven-fold enlargement of the prostate gland, epididymis, and testes (Moore, 1982).

## ANATOMIC VARIATIONS IN BOYS

During examination of the male from infancy through puberty stage Tanner G5, many variations of normal as well as some previously unrecognized problems may be present. Many of these findings are frequent and easily noted and managed. Others are not so obvious and may be missed. The more common variations in genital findings are discussed throughout the following sections.

***Leydig cell aplasia or hypoplasia*** (Rapaport, 2000) produces a phenotypic female with mild virilization. The testes, epididymis, and vas deferens are present. There is no uterus or fallopian tubes and no secondary sexual changes at puberty. Testosterone levels remain prepubertal, that is, at a serum level defined as less than 10ng/dL (Lee, 2002), but pubic hair can appear appropriately normal as a result of adrenal function. Abnormalities at this early stage also include congenital adrenal hyperplasia with subsequent virilization, or androgen receptor site/enzyme defects (5- $\alpha$  reductase) causing a lack of virilization and incomplete or normal development in the male (albeit eventually a large penis). It may lead to ambiguous genitalia in the female.

***Partial androgen insensitivity*** produces the most common form of male pseudohermaphroditism. This occurs at a frequency of less than one in 20,000 genetic males and is an X-linked disorder with the androgen receptor gene locus at Xq11-12 (Simpson, 2000). All are 46XY and may appear with female genitalia,



# EVALUATION OF CHILD SEXUAL ABUSE

Jacqueline M. Sugarman, MD

The evaluation of the child who may have been sexually abused is multifaceted, containing components such as obtaining a history; conducting a physical examination; initiating diagnostic and forensic testing when deemed necessary; and making appropriate referrals. This chapter primarily focuses on evaluation of the child who comes to medical attention in the acute medical setting (emergency department or physician's office) because he or she has made a specific disclosure of developmentally inappropriate sexual contact (Hymel & Jenny, 1996). The chapter subsequently addresses the case of the child who has made no specific disclosure of sexual abuse but comes to medical attention because of either physical or behavioral symptoms about which a caregiver is concerned (Hymel & Jenny, 1996).

## HISTORY

Physical evidence in child sexual abuse cases is often lacking because the majority of children who are sexually abused have normal examinations (Adams et al., 1994; Bays & Chadwick, 1993). When the examination is normal or nonspecific, the diagnosis of sexual abuse rests solely on the history, which is given by the child. Hence, obtaining and documenting an accurate account of what happened are crucial in diagnosing sexual abuse. If the child is deemed an ineffective witness, the state's ability to protect him or her through the legal system may be undermined (Meyers, 1986). The child's recitation of the abusive event or events to a physician treating the patient may be admissible in court as an exception to the laws restricting hearsay testimony (Meyers, 1986). When this situation occurs, preservation of verbal evidence through the proper questioning of the child and documentation of the child's history by the physician directly affects the state's ability to take legal action on behalf of the child (Meyers, 1986). Not only does the interview detail for the examiner what happened, it also provides the examiner an opportunity to establish rapport with the child, assess the child's developmental level and overall emotional status with regard to the abuse, and gauge how cooperative the child might be with further assessment (Faller, 1993; Poole & Lamb, 1998).

Every attempt should be made to interview the child separate from parents, guardians, or accompanying caregivers so that the presence of these individuals does not inhibit the child's full disclosure of the events. It should not be assumed that the child's caregiver believes the child and will protect the child from further abuse. Even a protective caregiver might inhibit a child's disclosure if the child perceives that the information might upset the caregiver. Furthermore, the absence of a caregiver during the interview helps negate the argument that the child is merely repeating what the caregiver told the child to say or what the child perceives the caregiver wants to hear.

It is often easier to first interview the accompanying caregiver separate from the child (Giardino et al., 1992). This allows the examiner to obtain a history from the caregiver as well as a better understanding of the child's world, which will aid in

### *Key Point:*

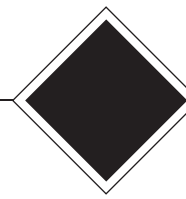
*Because the physical examination of children who have been abused is often normal, the diagnosis may be based solely on the child's history. Thus, obtaining and accurately documenting the child's story are essential in diagnosing sexual abuse.*



Initially the interviewer should introduce himself or herself and try to establish rapport with the child, asking questions such as, “What’s your name? Do you have a nickname? How old are you? Do you go to school? Who lives in your house?” The interviewer should try to gauge the child’s developmental level. Does the

**Table 3-1. Common Presenting Complaints of Sexually Abused Children and Adolescents in the Medical Setting**

<b>Physical Signs and Symptoms</b>		
Genital discharge, bleeding	Genital skin lesions	Seizures
Genital pruritis (itching)	Genital or urethral trauma	Short stature
Pregnancy, including pregnancy with genetic disorders	STDs: typical, atypical, or disseminated	Appetite disturbance
Other genital infections	Recurrent urinary tract infections	Sleep disturbance
Muscle weakness	Drug overdose	Fatigue or exhaustion
Migraine headache	Abdominal pain	Enuresis and/or encopresis
	Numbing of body parts	
<b>Psychosomatic Disorders</b>		
Diffuse somatic complaints		
Hysterical or conversion reactions		
Abdominal pain		
Anorexia		
<b>Sexual Problems</b>		
Sexualized play	Promiscuity or prostitution	
Sexual self-abuse	Sexual dysfunction	
Excessive masturbation	Sexual revictimization	
Sexual perpetration to others	Fear of intimacy	
<b>Social and Behavioral Problems</b>		
School adjustment problems	Suicidal ideation, gestures, or attempts	Family conflicts
Taking on parental roles	Neurotic or conduct disorders	Impulsive behavior
Phobias, avoidance behavior	Social withdrawal	Self-mutilating behavior
Temper tantrums	Aggressive behavior	Truancy or runaway behavior
Substance abuse		
<b>Other Psychologic Problems</b>		
Excessive guilt	Altered states of consciousness	Anxiety
Irritability	Depression	Multiple personalities
Feelings of helplessness	Self-hate, self-blame	Identity diffusion
Low self-esteem	Mistrust	Dissociation
Amnesia	Hyperalertness	Obsessive ideas
Fear of criticism or praise	Terrified of rejection	Flashbacks
Rage		
<b>Other</b>		
Asymptomatic sibling of a victim	Association with a known offender (Schmitt, 1982a)	
<p><i>Data from Hunter et al. (1983), Krugman (1986), and Massie &amp; Johnson (1989). Reprinted with permission from Jenny C. Medical issues in sexual abuse. In: Briere J, Berliner L, Buckley JA, Jenny C, Reid T, eds. The APSAC Handbook on Child Maltreatment. Thousand Oaks, Calif: Sage Publications; 1996:197-199.</i></p>		



# INDEX

## A

- Abdominal trauma in pregnancy, 366  
ABO blood type, 264  
Abrasion, 227  
Abscess, Bartholin's gland, 233-234  
Abuse  
    child sexual. *See* Child sexual abuse  
    spousal/partner. *See* Domestic violence  
Abuse-specific therapy for child, 13  
Access barrier to disabled person, 158-159  
Access to computer, remote, 550-551  
Accidental injury  
    child sexual abuse and, 70  
    in differential diagnosis, 114-115  
Accusation, false, 5  
Acquaintance rape, 212, 339-344  
    clinical response to, 342-343  
    drugs and alcohol in, 340  
    epidemiology of, 339  
    incidence of, 212  
    perpetrator's response to, 341-342  
    prevention of, 218, 344  
    prosecution of, 538-539  
    risk factors for, 339-340  
    stranger rape vs, 507-508  
    victim's response to, 340-341  
Acquiescence in domestic violence, 349t  
Acronym  
    RADAR, 356  
    TEARS, 227  
Act of opportunity, rape as, 213  
Acting out by child, 59  
Action, stress and, 409-410  
Active coping, 13  
Acute care for victim, 435  
Acyclovir  
    for herpes simplex, 321t  
    in pregnancy, 370  
Adaptability to stress by older person, 385  
Adaptive response, 438  
Addiction  
    creating sanctuary and, 424  
    to trauma, 413-414  
Adhesion  
    circumcision, 19  
    labial, 29  
Admissible evidence, 522  
Adolescent  
    date rape drugs and, 244  
    male survivor of abuse, 127  
    pregnant, 369-370  
    relationship with physician, 191-192  
    response of sexual assault, 406  
    revictimization of, 419-422  
    sexually transmitted disease in, 319-335. *See also*  
        Sexually transmitted disease  
    substance abuse and, 416  
Adolescent sexual assault, 211-219  
    delayed effects of, 215-217  
    effective response to, 217-218  
    epidemiology of, 212-213  
    immediate reactions to, 215  
    prevention of, 218-219  
    public health implications of, 213-214  
    risk for, 214-215  
Adrenarche, 36  
Adult sexual assault, 211-219  
    delayed effects of, 215-217  
    effective response to, 217-218  
    epidemiology of, 212-213  
    immediate reactions to, 215  
    prevention of, 218-219  
    public health implications of, 213-214  
    risk for, 214-215  
Adult survivor of child abuse, 184  
Advocate  
    for child in court, 183  
    victim's, 260-261  
Affidavit, 501  
African American, puberty in, 33  
Age  
    older victim, 377-389. *See also* Older sexual abuse victim  
    as risk factor for sexual assault, 214  
    statute of limitations and, 516  
Agenesis  
    mullerian, 22  
    vaginal, 22  
Agglutination, labial, 21, 29  
    in child, 68t  
    in differential diagnosis of assault, 121  
Aggression as outcome of child sexual abuse, 12  
Alarm, bedwetting, 116  
Alcohol abuse  
    pregnancy and, 367

- as reaction to assault, 216
- Alcohol-facilitated assault
  - in acquaintance rape, 340
  - prosecution of, 539-541
- Algorithm, RADAR, 359t
- Allantoic diverticulum, 38
- Allegation, false, 5
- Allergic dermatitis, 116
- Allergy, latex, in spina bifida, 160
- Altered consciousness, 277
- Alternate light source in forensic evaluation, 89
- Alzheimer's Association, 168
- Amastia, 34
- Ambient temperature for disabled person, 159
- Ambiguous genitalia, 18
- American Academy of Pediatrics, 83-84
- American Association on Mental Retardation, 169
- American Council of the Blind, 168
- American Public Welfare Association, 177
- Americans with Disabilities Act, 168
- Amygdala, 410
- Anal dilation, 68t
- Anal infection, genital warts, 118
- Anal injury
  - in child, 65
  - in disabled homicide victim, 163
  - nonabusive, 115
- Anal intercourse, 226t
- Anal membrane, 39
- Anal opening, 42
- Anal tag, 41
- Anaphylaxis, latex allergy causing, 160
- Anatomical variation
  - in female, 21-32
    - androgen insensitivity syndrome, 22
    - in differential diagnosis of assault, 113-114
    - erythema of vestibular sulcus, 29
    - labial agglutination, 29
    - labial hypertrophy, 22
    - linea vestibularis, 29
    - lymphoid follicles, 30
    - ovarian, 23
    - periurethral and perihymenal vestibular bands, 29
    - urethral, 23
    - vaginal, 22-23
    - vaginal rugae, 29
    - virilization, 21
    - vulvar, 22
  - in male
    - circumcision adhesions, 19
    - diphallia, 20
    - epispadias, 20
    - exstrophy of bladder, 20
    - hypospadias, 19
    - micropenis, 20
    - partial androgen insensitivity, 18-19
    - phimosis, 19
    - pink pearly papules of penis, 19
    - shawl defect, 20
    - smegma, 19
    - urethral, 20
    - urethral meatal stenosis, 19
- Androgen insensitivity
  - in female, 21
  - in male, 18-19
- Anger, 13
- Anilingus, 226t
- Annular hymen, 24, 25, 26
  - child sexual abuse examination and, 64
  - definition of, 224
- Anogenital anatomy, 17-45
  - embryology in, 17
  - in female
    - anatomic variations in, 21-32
    - external genital development, 20-21
    - puberty and, 32-36
  - in male
    - anatomical variations, 18-20
    - external genital development, 18
    - puberty and, 36-38
- Anogenital examination of child, 196t
- Anogenital findings in child, 68-69t
- Anogenital injury, healing of, 42-45
- Anogenital wart in child, 105
- Anorectum
  - anatomy of, 39, 42
  - development of, 38-39
- Antacid for labial agglutination, 29
- Anti-mullerian hormone, 17
- Antibiotic
  - for gonorrhea in child, 101
  - for prophylaxis in child, 73, 75
- Antigen, blood group, 247
- Antigen test, hepatitis B, 108
- Antisocial personality disorder, 420
- Antiviral drug
  - for child, 102
  - for herpes simplex, 324
  - for postexposure HIV prophylaxis, 332-333
- Anus
  - in child victim, 65, 67
  - definition of, 224
  - examination of, 247
  - imperforate, 42
  - normal variations in, 114
- Anxiety
  - in child, 11-12
  - examination-related, 219
- AOL instant messaging, 553
- Aplasia, Leydig cell, 18
- Aposthitis, 20
- Appointment of counsel, 518
- Arc of the United States, 169
- Argument, closing, 574-575

- Arkansas model of rape shield statute, 536-537
- Arm injury, 226
- Arrest, preliminary, 517
- Arthritis, reactive, chlamydia and, 322
- Artificial lubrication, 234-235
- Assault history, 252-253
- Assay, polymerase chain reaction, 267-268
- Assertiveness by expert witness, 563
- Assessment
  - by child protective services, 179t
  - family, 179t
  - virtual, 202
- Assistance program, victim, 435
- Athelia, 34
- Athetosis, 155
- Atlantoaxial instability in Down syndrome, 163-164
- Atresia, vaginal, 23
- Attachment
  - child abuse and, 421
  - traumatic experience disrupting, 407
- Attempted rape, adjustment after, 438
- Autoinoculation of human papilloma virus, 105
- Autonomic dysreflexia, 159-160
- Autonomic nervous system response, 407-408
- Avoidant coping, 12
- Azithromycin
  - for chlamydia, 257t, 321t, 322
  - as postexposure prophylaxis, 331t
  - in pregnancy, 371
  - for syphilis, 323
- ## B
- Bacillus, Döderlein's, 35
- Background crime scene investigation, 496
- Bacterial vaginosis
  - in child, 107-108
    - diagnosis of, 98
    - transmission of, 94t
    - treatment of, 100t
  - diagnosis and treatment of, 325
  - drugs for, 321t
  - incidence of, 320
  - prophylaxis for, 257
- Balanitis, 19
- Band
  - perihymenal vestibular, 29
  - vestibular, 113
- Barrier
  - don't-ask-don't-tell approach as, 447-453
  - handicap access, 158-159
  - to reporting, 175
- Bartholin's gland abscess, 233-234
- Battered child syndrome, 1
- Battered Women's Justice Project, 169
- Battering, prosecution of, 521, 555-556
- Bay Area Women Against Rape, 433
- Bedding, collection and preservation of, 85t
- Bedwetting, 116
- Behavior
  - of adult or adolescent victim, 215
  - aggressive, 12
  - of child victim, 59, 198
  - of cognitively impaired victim, 154-155
  - descriptions of, 489
  - of disabled victim, 151
  - domestic violence and, 352
  - don't-ask-don't-tell approach and, 454
  - as indication of child sexual abuse, 8-10
  - postassault, 253
  - violent, in assault history, 252
- Behavior therapy, 13
- Behavioral problem
  - in child sexual abuse evaluation, 54
  - as result of sexual abuse, 184
- Behaviorally impaired victim, 154-155
- Behçet's disease, 120
- Belief, vicarious traumatization affecting, 460
- Benzodiazepine
  - in acquaintance rape, 340
  - date rape and, 541
- Best interests of child, 181
- Betrayal, 11
- Bias in prevalence statistics, 4
- Biologic evidence, 272-274
  - in hair, 279
  - on skin, 279
- Biologic causality in vicarious traumatization, 462-463
- Bite mark
  - in assault history, 252
  - as evidence, 502
  - impression of, 90
  - specimen collection of, 279-280
- Bladder, exstrophy of, 20
- Bleeding
  - from anogenital injury, 43
  - in child sexual abuse, 61
  - in nonabusive injury, 115
  - urethral, 121
- Bleeding disorder, 504
- Blister, herpes simplex, 324
- Blitz rape, 212, 213
- Blood
  - in child sexual abuse examination, 59
  - collection of, 86, 259
  - in prosecution of assault, 530
- Blood group antigen, 247
- Blood type, 264
- Blood vessel, lubrication and, 234
- Blue perineum, 41
- Blunt force in child sexual abuse, 69, 70
- Body fluid
  - collection and preservation of, 86t
  - as crime scene evidence, 490-491, 496-497
  - for DNA analysis, 277

- serologic testing of, 264-265
  - vaginal, in child, 72t
  - Body language of expert witness, 563
  - Boundary, personal, 59
  - Bowel, irritable, 216
  - Brain
    - memory and, 410
    - response to trauma and, 407
    - stress and, 409-410
  - Breast
    - development of, 33-34
    - in male, 37
    - supernumerary, 34
  - Brown perineum, 41
  - Bruise
    - characteristics of, 227
    - determinants of, 231
  - Bruising
    - as evidence, 504
    - hymenal, 44
  - Budding, breast, 33
  - Budget, resource management and, 289
  - Bullous disease, 117
  - Bump, hymenal, 29-30
  - Burnout, 460
  - Buttocks, examination of, 247
- ## C
- Calcinosis cutis, 120
  - California model of rape shield statute, 537-538
  - Camera
    - for forensic photography, 88
    - in telemedicine, 207-208
  - Campylobacter, proctitis caused by, 327
  - Candidal dermatitis, 120
  - Caregiver
    - child's medical history and, 193
    - disabled victim's description of, 157
    - emotions and, 463
    - legal issues involving, 2
    - vicarious traumatization of, 459-468. *See also* Vicarious traumatization
  - Caregiver-resident relationship, 150
  - Caruncle, urethral, 23
  - Case, peer review of, 91
  - Case history
    - DNA evidence, 274-276, 291-306
    - of prison rape, 396-397
  - Case management, 502-503
  - Case planning by child protective services, 179t
  - Case progression in joint investigation, 178t
  - Case study
    - in child sexual abuse, 197-200
    - of disabled victim, 146, 162
  - Case-to-case cold hits, 288
  - Casual transmission of human papilloma virus, 105
  - Catecholamine, memory and, 410
  - Catharsis, 463
  - Catheter
    - Foley, 90
    - latex-free, 160
  - Caucasian, puberty in, 33
  - Caudal müllerian agenesis, 22
  - Cause, probable, 517
  - Cavernous hemangioma, 117
  - Cefixime
    - for gonorrhea, 321, 321t
    - in pregnancy, 371
  - Cefotetan, 326t
  - Cefoxitin, 326t
  - Ceftriaxone
    - for gonorrhea, 257t, 321t, 321
    - for pelvic inflammatory disease, 326t
    - as postexposure prophylaxis, 257t, 331t
    - in pregnancy, 371
  - Cell
    - Leydig, 17
    - Sertoli, 17
  - Cell proliferation in anogenital healing, 43
  - Cephalosporin, 101
  - Cerebral palsy, 155
  - Certification, SANE, 476-477
  - Cervical neoplasia, 324
  - Cervical spine injury, 163-164
  - Cervix
    - in consensual intercourse, 230-231
    - definition of, 224
    - injury to, 230
    - puberty and, 34-35
  - Chain of custody of forensic evidence, 83, 84, 490
    - for DNA analysis, 277
    - maintenance of, 247-248
  - Chain reaction assay, polymerase, 267-268
  - Chancre, 322
  - Chancroid, 323
  - Chaperone during examination, 244
  - Character evidence, 535-536
    - in computer-assisted exploitation, 549-550
  - Checklist, assault examination, 75t
  - Chewing gum as crime scene evidence, 497
  - Child. *See also* Child sexual abuse
    - health consequences of trauma, 419
    - legal defense of, 522
    - neurobiologic change in, 417-418
    - as perpetrator, 2
    - relationship with physician, 191-192
    - response of sexual assault, 406-407
    - sexually transmitted disease in, 91, 93-109
    - stress-addicted, 413-414
    - traumatization of, 412, 413, 414-417
  - Child abuse. *See also* Child sexual abuse
    - domestic violence and, 365, 422
    - pediatrician's role in preventing, 368-369

- Child Abuse Prevention and Treatment Act, 1  
as legal standard, 2
- Child advocacy in court, 183
- Child and family social services, 176
- Child pornography  
disabled victim of, 163  
outlawing of, 2-3
- Child Protection Team Program, 203-204
- Child protective movement, history of, 1
- Child protective services  
multidisciplinary approach and, 173  
in multidisciplinary investigation, 176  
petition of, 181  
process of, 179t
- Child sexual abuse. *See also* Prepubescent child  
anogenital anatomy and, 17-45. *See also* Anogenital anatomy  
corroborating evidence of, 501-502  
cost of, 406  
definition of, 2-3  
differential diagnosis of, 113-121. *See also* Differential diagnosis  
disabled victim of  
caregiver-resident relationship in, 150  
disclosure by, 151-152  
evaluation of, 149-156  
hearing-impaired, 152-153  
incidence of, 146-147  
visually impaired, 153-154  
evaluation of, 53-77  
checklist for, 75t  
definitive care and, 73, 74  
of disabled victim, 149-156  
documentation of, 74, 77  
forensic evidence and, 70, 72-73t  
history in, 53-59  
initial examination in, 61  
interview in, 57-58  
physical examination of in, 59-70  
presenting complaints, 55t  
reporting and, 76t  
sexually transmitted disease and, 66, 69-70  
typical anatomy and, 61-66  
forensic evaluation of, 81-91. *See also* Forensic evidence  
historical perspective on, 1-2  
history in, 197-200  
indicators of, 8-10  
male victim of, 125-139. *See also* Male victim  
offenders of, 6-8  
outcomes of, 11-14  
overview of, 1-14  
posttraumatic stress disorder in, 416  
revictimization and, 419-422  
scope of, 3-5  
sexually transmitted disease and, 93-109. *See also* Sexually transmitted disease, in child  
statute of limitations for, 516  
support systems for, 10  
telemedicine and, 202-203  
trauma theory and, 406  
victims of, 5-6
- Childhelp USA/Forrester National Child Abuse Hotline, 169
- Chlamydia trachomatis*  
in child, 91, 96-100  
diagnosis of, 97t  
transmission of, 94t  
treatment of, 99t  
diagnosis and treatment of, 322  
drugs for, 321t  
incidence of, 320  
mucopurulent cervicitis and, 325  
nucleic acid amplification test for, 328  
pelvic inflammatory disease and, 325-326  
in pregnancy, 371  
proctitis caused by, 327  
prophylaxis for, 257
- Choking, 252
- Chromosome, Y, 17
- Chronic sexual abuse  
of disabled person, 145  
examination within 72 hours of, 87-88
- Chronic violence, health effects of, 418-419
- Church group as support for victim, 437
- Ciprofloxacin, 321t
- Circumcision  
adhesions from, 19  
hypospadias as contraindication to, 19
- Civil lawsuit, 515
- Cleft, hymenal, 28  
definition of, 224  
differential diagnosis of assault and, 113
- Clindamycin  
for bacterial vaginosis, 321t  
for pelvic inflammatory disease, 326t
- Clinical evaluation, documentation of, 189-190
- Clinician, vicarious traumatization of, 461
- Clinician response  
to abuse in pregnancy, 368  
to acquaintance rape, 342  
to domestic violence, 354  
to older sexual abuse victim, 385-389
- Clitoral prepuce, 20-21
- Clitoris  
definition of, 224  
hair tourniquet syndrome of, 121  
in puberty, 36
- Cloaca, 38-39
- Cloacal exstrophy, 42
- Cloacal sphincter, 39
- Closing argument at trial, 574-575
- Clothing  
in child sexual abuse, 72t  
collection and preservation of, 85, 86t

- DNA on, 279
- documentation form for, 315-316
- as evidence, 245, 489-490
  - collection of, 258t
  - at trial, 526
- number of specimens analyzed, 283
- packaging of, 86
- Clues in victim's statement, 526
- Cluster, computer, 553-554
- CODIS, 263, 268-270
- Coercion in partner rape, 350
- Cognitive behavior therapy for child, 13
- Cognitive disability, 165
  - evaluation of victim with, 154-155
- Cognitive distortion, 184
- Cognitive restructuring, 12
- Cognitive testing, standardized, 165
- Collaborative investigation
  - adult victim and, 260-261
  - case progression in, 178t
  - child protective services and, 176, 179t
  - DNA testing and, 272
  - impact of abuse on child and, 183-184
  - judicial proceedings and, 180-183
  - law enforcement and, 177
  - mental health professionals, 177, 179-180
  - multidisciplinary, 176-183
  - SANE program and, 481-482
- Collection, evidence, 247, 257, 435, 495-498
  - bedding, 85t
  - bite mark, 279-280
  - blood, 86t, 259t
  - body fluid, 86t
  - in child sexual abuse, 81-83
  - clothing, 85t, 86t, 258
  - condom, 280
  - debris, 85t
  - diaper, 85t
  - DNA, 275-280
    - consent for, 276
    - procedures for, 279-280, 283-287
  - fibers, 85t
  - gastric contents, 86t
  - from genitalia, 259
  - grass, 85t
  - guidelines for, 258-259t
  - hair, 85t
  - leaves, 85t
  - from nails, 258t
  - from older victim, 379-380
  - from oropharynx, 258
  - paint chips, 85t
  - police dispatcher's instructions about, 488-489
  - from prepubescent child, 61, 70, 73
    - within 72 hours, 87-88
    - bite mark impression in, 90
    - collection of, 81-83
    - documentation of, 90
    - double swab technique in, 89-90
    - Foley catheter technique in, 90
    - hymenal tissue, 90
    - limitations of, 83
    - more than 72 hours later, 87
    - peer review of cases, 91
    - photography in, 88-89
    - physical examination in, 88
    - procedure for collecting, 84-87
    - protocol for, 72-73t
    - STD testing, 91
    - toluidine blue in, 90
    - when to collect, 83-84
  - preservation and, 488-491
  - saliva, 279-280
  - SANE program and, 482-483
  - semen, 86t, 279
    - from shoe, 280
    - from skin, 258t
  - universal precautions and, 82
  - urine, 86t
  - vegetation, 85t
- Color
  - of bruise, 227
  - perineal and anorectal, 39, 41
- Colposcopy
  - in child sexual abuse examination, 61-62
  - in forensic evaluation, 89
  - for genital injury, 229, 246-247
  - in sexually transmitted disease diagnosis, 328
  - in telemedicine, 206-207
- Columnar epithelium, ectopy of, 35
- Combined DNA Index System, 263
- Communication
  - by first responders, 510
  - improving of, 289-290
  - in interview of disabled victim, 156-158
  - motor-impaired victim and, 155
  - by police dispatcher, 509-510
  - vicarious victimization and, 467
- Community
  - social support in, 433-441. *See also* Social support
  - telemedicine, 202-203
- Community-based SANE program, 475
- Compassion fatigue. *See* Vicarious traumatization
- Compassionate homicide of disabled, 147
- Competence
  - of disabled victim, 165, 167
  - of mentally disabled victim, 546
- Compliance
  - by disabled victim, 152
  - of mentally retarded victim, 155
- Computer, child pornography on, 2-3
- Computer-assisted exploitation, 548-555
  - forensic evaluation of, 550-555
  - interview in, 548-550



- Condom  
 domestic violence and, 352  
 specimen collection from, 280
- Condyloma acuminatum  
 in pregnancy, 371  
 in child, 103, 106  
 perianal, 70
- Confidence rape, 213
- Confidentiality, 219  
 for domestic violence victim, 356  
 for pregnant adolescent, 370  
 in prehospital care, 488
- Conflict  
 on multidisciplinary team, 174-175  
 vicarious victimization and, 463
- Congenital hemangioma, 117
- Congenital infection  
 syphilis, 102-103  
 trichomonas, 104-105
- Congestion, venous, 41
- Consciousness, altered, 277
- Consensual intercourse, 230-231
- Consent  
 by disabled person, 166  
 for DNA evidence collection, 276  
 legal, 519  
 by mentally disabled victim, 544-545
- Constitutional issues in rape shield statute, 537-538
- Contact abuse, male victim of, 128
- Contact dermatitis, 116
- Contagion, emotional, 462-463
- Contamination of forensic evidence, 82
- Context evidence, 535
- Continuing education for first responder, 508
- Contraception, emergency, 254-256, 334, 334t
- Control  
 in domestic violence, 347  
 prehospital care and, 488
- Control sample of forensic evidence, 83
- Contusion  
 characteristics of, 227  
 forensic definition of, 489-490
- Convicted offender database, 268-270
- Cookies, computer, 551-552
- Cooperation for DNA evidence collection, 276
- Cooperative SART model, 480-481
- Coordination  
 multidisciplinary, 174  
 of services, 439
- Coping mechanism, 12-14
- Coronal ridge, 225
- Correctional institution, 393-401  
 disposition of cases in, 400-401  
 gang-related incidents in, 401  
 medical professional in, 398-399  
 overview of, 393-398  
 prison officials and, 399-400  
 sexual predators in, 400  
 social services professionals and, 399-400
- Corroboration  
 of evidence, 501-502  
 in prosecution of assault, 519  
 search warrant for, 501  
 of victim's statement, 525-526
- Cortisol response to stress, 417
- Cost of sexual victimization, 213-214
- Counsel, legal, 518
- Counseling for domestic violence victim, 356, 434-435
- Counselor, sex offenders and, 461
- Countertransference, 460
- Couples counseling, 356
- Court, 180-183  
 case preparation for, 503-504  
 criminal, 182  
 juvenile, 180-181  
 support for child in, 182-183  
 testimony in  
 disabled victim's competence for, 167  
 expert vs fact, 182  
 of male sexual abuse, 134  
 by mentally disabled victim, 547-548
- Creating sanctuary, 423-424
- Credibility of victim, 263-264, 526
- Crescentic hymen, 25, 27  
 definition of, 224
- Cribriform hymen, 26, 224
- Crime  
 child sexual abuse as, 5  
 sexual assault as, 515-516
- Crime laboratory, shortage of, 282, 288
- Crime Laboratory Improvement Program, 529
- Crime scene  
 description of, 253  
 disabled victim and, 160-161  
 preservation of, 488-490  
 processing of, 495-498  
 prosecutor's inspection of, 526
- Criminal court, 182
- Criminal justice process, 516-520  
 appointment of counsel, 518  
 corroboration, 519  
 expert witness in, 519-520  
 preliminary arraignment and, 517  
 preliminary hearing in, 518-519  
 trial and, 520
- Criminal justice system, 515
- Criminal prosecution. *See* Prosecution
- Criminal trial, 520
- Criminologist, 289-290
- Crisis center, rape, 433-434
- Crisis intervention, SANE and, 474
- Crohn's disease, 120
- Cross-dressing, 9



- Cross-examination
  - of defendant, 570-573
  - of defense witness, 532
  - of expert witness, 563, 569-570
- Crystal, uric acid, 19
- Cultural myths about disabled, 147-148
- Culture
  - in child, 91
  - child sexual abuse and, 59, 71, 73
  - domestic violence and, 357
  - gonorrhea, in child, 101
  - male gender socialization and, 125-128
  - Trichomonas vaginalis*, 328
  - trichomoniasis and, 323
  - varicella, 119
  - vicarious victimization and, 463-464
- Cunnilingus, 226
- Custody
  - chain of
    - of forensic evidence, 83, 84
    - maintenance of, 247-248
  - domestic violence and, 352
- Cyst
  - Gartner duct canal, 23
  - mesonephric duct, 23
  - ovarian, 23
  - paramesonephric, 23
  - paraurethral, 23
  - retention, 23
  - Skene's duct, 22
- D**
- Daily routine
  - child sexual abuse evaluation and, 56
  - interview with disabled child and, 158
- Damaged merchandise myth about disabled, 147
- Data collection on older victim, 379-380
- Date of computer file, 552-553
- Date rape, 339-344. *See also* Acquaintance rape
- Date rape drug, 244, 340
- Daubert v Merrell Dow Pharmaceutical, Inc.*, 530
- Death
  - domestic violence as risk for, 351
  - fear of, 215
- Debriefing with prosecutor, 563, 569
- Debris
  - collection and preservation of, 85t
  - from hair, 246
- Decision making under stress, 409
- Defendant, cross-examination of, 570-573
- Defense
  - legal, 522-523
  - social, 463-464
  - suspect's, 526-527
- Defense attorney, DNA evidence and, 530
- Defensive wound in disabled person, 161-162
- Defensiveness, tactile, 153-154
- Dehumanization myth about disabled, 147
- Delayed disclosure of child sexual abuse, 8, 10
- Delayed effects of assault, 215-217
- Delayed medical care in nursing or group home, 148-149
- Demonstrative aid, 562
- Denticular hymen, 63
- Dentist, forensic, 502
- Depression
  - in abused pregnant woman, 366
  - as indicator of child sexual abuse, 9-10
  - marital rape and, 351-352
  - posttraumatic, 413
  - as reaction to assault, 216
- Dermatitis
  - allergic, 116
  - in differential diagnosis of assault, 120
- Dermatologic disorder, genital, 116-117
- Detective, 217-218
- Developmental level of child, 56
- Developmentally disabled
  - consent and, 166
  - disclosure of assault by, 151
  - evaluation of, 154-155
  - hate crime against, 147-148
  - incidence of assault of, 146
  - sexual assault of, 145
  - visual impairment with, tactile defensiveness and, 153-154
- Diagnosing physician, 191-192
- Diagnosis
  - of child sexual abuse, 196-200
  - statement for, 535, 559-560
- Diameter, transhymenal, 30-32
- Diaper, collection and preservation of, 85
- Diaper dermatitis, 120
- Diastasis ani, 41
- Dichlordiphenyl dichloroethene, 33
- Didanosine, 333t
- Didelphys vagina, 24
- Differential diagnosis
  - dermatologic disorder, 116-117
  - idiopathic calcinosis cutis, 120-121
  - infection, 117-120
  - inflammatory disorder, 120
  - miscellaneous disorders, 120-121
  - nonabusive trauma, 114-116
  - normal anatomical variations, 113-114
- Digital camera, 88
- Digital imaging in telemedicine, 207-208
- Digital photography as electronic record, 208
- Dilation, anal, 68
- Diphallia, 20
- Diphenhydramine antacid for labial agglutination, 29
- Direct examination of sexual assault nurse examiner, 558-570
- Disabled menace myth, 148
- Disabled person, 145-170
  - case study of, 146, 162-163
  - domestic violence and, 357

- evaluation of, 149-156
  - cognitively or behaviorally impaired victim, 154-155
  - disclosure and, 151-152
  - hearing-impaired victim, 152-153
  - motor-impaired victim, 155-156
  - visually-impaired victim, 153-154
- hate crime against, 147-148
- incidence of abuse of, 146-147
- interview techniques for, 156-158
- multidisciplinary team for, 164-167
- murder of, 163-164
- in nursing or group home, 148-149
- physical examination of, 158-163
- resources for, 168-170
- Discharge
  - SANE program and, 476
  - vaginal
    - bacterial vaginosis causing, 325
    - in child, 101
    - in puberty, 35
    - in trichomoniasis, 323
- Disclosure
  - of child sexual abuse
    - to physician, 192
    - rate of, 4
    - suppression of, 8, 10
  - by disabled victim, 151-152
  - don't-ask-don't-tell approach and, 447-455
  - false, by disabled child, 152
  - by male victim, 128-139
- Disease prevention, 352
- Disorganization phase of rape trauma syndrome, 215
  - in older abuse victim, 384
- Dispatcher, police, 509-510
- Dissociation as response to trauma, 412-413
- Dissociative disorder, 422
- Distance learning, 204-205
- Distant examination, 201-206
- Distortion, cognitive and emotional, 184
- Distraction as coping mechanism, 12
- District attorney, 517
- Diverticulum, allantoic, 38
- Divorced spouse, 59
- DNA evidence, 263-316
  - case histories involving, 274-275, 291-306
  - case-to-case cold hits and, 288
  - on cigarette, 496
  - clothing documentation and, 315-316
  - collaboration with, 272
  - collection of, 275-280
    - consent for, 276
    - procedures for, 279-280, 283-287
  - communication and, 289-290
  - convicted offender database and, 268-270
  - disabled victim and, 161
  - federal funding for, 529
  - importance of, 263-264
  - laboratory resource shortage and, 282, 288
  - laboratory services request for, 311-312
  - law enforcement investigation and, 280-281
  - polymerase chain reaction assay, 267-268
  - preliminary rape case information and, 313-314
  - preservation of, 490
  - in prosecution of assault, 529-533
  - resource management of, 289
  - restriction fragment length polymorphism analysis of, 266-267
  - search warrants for, 307-310
  - serologic testing and, 264-265
  - sexually transmitted disease and, 329-330
  - suspect examinations of, 281-282
  - testing resource crisis of, 270-272
  - in unsolved assault cases, 282
- DNA Identification Act, 268-269
- Documentation, 189-200. *See also* Reporting of abuse
  - of assault of disabled victim, 149, 152, 164
  - of bite mark, 502
  - case studies and, 197-200
  - of child sexual abuse, 74-77
  - of clinical evaluation, 57, 189-190
  - for clothing, 315-316
  - of crime scene evidence, 491
  - of diagnosis, 196-197
  - of domestic violence, 354, 355
  - of evaluation of adult, 257-258
  - of evidence, 82, 84
  - by first responder, 510
  - of forensic evaluation, 90
  - of genital injury, 237
  - of investigation of mentally disabled victim, 545
  - by law enforcement, 495-496
  - medical record as, 190-196
  - of nongenital injury, 254
  - nonverbal, 154
  - of physical examination, 246, 248, 259-260
  - by prehospital personnel, 489
  - for search warrant, 307-310, 501
  - in telemedicine, 206
  - of witness testimony, 519
- Döderlein's bacillus, 35
- Domestic violence, 347-360
  - acquiescence to, 349t
  - algorithm for, 359t
  - associated behaviors, 352
  - child abuse and, 421-422
  - clinician's response to, 354
  - disabled victim of, 357
  - documentation of, 354
  - future studies of, 358
  - in gay or lesbian relationship, 358
  - health status of victim, 352
  - identification of, 352-354
  - immigrant victim of, 357
  - injuries and symptoms of, 351

- intervention for, 354-356
  - in pregnancy, 363-370
    - adolescent as victim, 369-370
    - child abuse and, 365
    - clinical manifestations of, 365-367
    - clinician response to, 367-368
    - epidemiology of, 363-364
    - identification of, 367-368
    - increase in, 364
    - intervention in, 364-365
    - pediatrician's role in preventing, 368-369
    - safety and, 368
  - prosecution of, 521, 555-556
  - psychological effects of, 351-352
  - rape and, 347-350
  - safety tips for, 359-360
  - social services for victim of, 434-435
  - vicarious victimization and, 463
- Dominating behavior, 12
- Don't-ask–don't-tell approach, 447-455
  - as acknowledged barrier, 447-450
  - as unacknowledged barrier, 450-453
- Double swab technique, 89-90
- Down syndrome
  - case study of, 162-163
  - in disabled homicide victim, 163
- Doxycycline
  - for chlamydia, 321t, 322
  - for pelvic inflammatory disease, 326t
  - as postexposure prophylaxis, 331t
- DQA1/Polymarker test kit, 267-268
- Dried evidence specimen, 276
- Dried secretion, 73
- Drug, date rape, 244, 340
- Drug abuse
  - in abused pregnant woman, 367
  - as reaction to assault, 216
- Drug-facilitated assault, prosecution of, 541-544
- Drug Induced Rape Prevention and Punishment Act, 211
- Duct
  - Gartner, cyst of, 23
  - mesonephric, cyst of, 23
  - Skene's, cyst of, 23
- Duct system, mesonephric, 18
- Duplication, ureteral, in female, 24
- Duty, wifely, 349t, 350
- Dysfunctional system in vicarious victimization, 464, 465
- Dysmenorrhea, 216
- Dysreflexia, autonomic, 159-160
- ## E
- E-mail, information from, 552-553
- Eagle-Barrett syndrome, 20
- Eastern Kentucky University survey, 270-271
- Eating disorder in child, 10
- Ecologic framework to prevent vicarious victimization, 466-467
- Ectopy of columnar epithelium, 35
- Ectropion, cervical, 34
- Education
  - distance learning, 204-205
  - of first responders, 507-508
  - prevention, 249
  - social support programs and, 439-440
- Ejaculation
  - in assault history, 252
  - in puberty, 36
- Elasticity, vaginal, 232-233
- Elder abuse, 377-389. *See also* Older sexual abuse victim
  - in nursing home, 148-149
- Electronic communication, 205-206. *See also* Telemedicine
- Electronic information, 201-206
- Electronic record, 208-209
- Embryology, genital, 17
- Emergency contraception, 254-256, 334-335
- Emergency department, 471
  - acute care in, 435
- Emergency medical services, 487-492
  - effective response from, 217
  - as first responder, 509-510
  - request for, 496
- Emotion, trauma and, 407, 412-413
  - creating sanctuary and, 424
- Emotional contagion in vicarious traumatization, 462-463
- Emotional distortion, 184
- Emotional support
  - by prehospital care providers, 488
  - SANE and, 474
- Encryption, 549
- Endocervical culture in child, 73t
- Endorphin, stress and, 413
- Endoscopy. *See also* Colposcopy
- Engorged blood vessel, 234
- Entamoeba histolytica*, 327
- Enterobius vermicularis*, 119-120
- Entrapment, zipper, 115
- Environment
  - creating sanctuary and, 423-424
  - of evaluation, 242-243
  - genital injury and, 237
  - investigation of, 497
  - multidisciplinary team, 173
  - vicarious victimization and, 464
- Epidemiology of adolescent sexual assault, 212-213
- Epispadias, 20
  - in female, 24
- Epithelium, columnar, ectopy of, 35
- Epstein-Barr virus, 119
- Equipment
  - for child sexual abuse examination, 60t
  - for disabled person, withholding of, 145
- Erythema
  - characteristics of, 228
  - of penis, 19
  - perineal and perianal, 41

- of vestibular sulcus, 29
- Erythromycin
  - for chlamydia, 321t
  - in pregnancy, 371
- Esteem, vicarious traumatization affecting, 460
- Estranged spouse, 59
- Estrogen
  - gynecomastia and, 37
  - hymenal effects of, 32, 234
- Etched fingerprint, 497
- Ethinyl estradiol, 334t
- Euthanasia of disabled, 147
- Evaluation
  - of adult victim, 241-249
    - chain of evidence and, 247-248
    - documentation of, 248, 257-258t
    - follow-up care and, 249
    - healthcare provider's role in, 242
    - history in, 243-244
    - laboratory tests in, 247
    - physical examination in, 244-247
    - prevention education and, 249
    - setting of, 242-243
  - of child sexual abuse, 53-77
    - checklist for, 75t
    - definitive care and, 73-75
    - documentation of, 74, 77
    - forensic evidence and, 70, 72-73
    - history in, 53-59
    - initial examination in, 61
    - interview in, 57-58
    - physical examination of in, 59-70
    - presenting complaints, 54
    - reporting and, 76t
    - sexually transmitted disease and, 66, 69-70
    - typical anatomy and, 61-66
  - of disabled victim, 149-156
    - cognitively or behaviorally impaired, 154-155
    - disclosure and, 151-152
    - hearing-impaired, 152-153
    - motor-impaired, 155-156
    - visually-impaired, 153-154
  - documentation of, 257-258t
  - telemedicine, 204
  - in telemedicine, 207-208
- Evidence
  - of assault of disabled victim, 164-165
  - biologic, 272-274
    - in hair, 279
    - on skin, 279
  - chain of
    - of forensic evidence, 83, 84
    - maintenance of, 247-248
  - character, 535-536
    - in computer-assisted exploitation, 549-550
  - clothing as, 245
  - flight as evidence of guilt, 535
  - forensic, 81-91. *See also* Forensic evidence
    - rules of, 533-535
  - Examination-related anxiety, 219
  - Examiner, sexual assault nurse, 217-218, 435-436. *See also* SANE program
  - Exception, hearsay, 534
  - Excited utterance, 535
  - Exclusive result of DNA test, 161
  - Exhibitionism, male victim of, 127-128
  - Expert on DNA evidence, 531
  - Expert vs fact testimony, 182
  - Expert witness, 519-520
    - cross-examination of, 569-570
    - questions for, 564-569
    - sexual assault nurse examiner as, 558-570
    - successful, 560-563
  - Explicit information
    - disabled child's disclosure of, 151-152
    - disabled child's knowledge of, 165-166
  - Exploitation
    - computer-assisted, 548-555
    - of disabled victim, 163, 166
  - Exstrophy
    - of bladder, 20
    - cloacal, 42
  - Extended care facility, 150
  - External genitalia
    - female, 224t
      - in puberty, 35-36
    - male, 225t
      - anatomical variations of, 18-20
      - development of, 18
  - External vaginal ridge, 26
  - Externalization of symptoms, 184
  - Extrafamilial child sexual abuse, 7
  - Extremity, spasticity in, 159
- F**
  - Fact testimony, 182
  - False accusation of child sexual abuse, 5
  - False disclosure by disabled child, 152
  - Famciclovir for herpes simplex, 321t
  - Family
    - assessment of, 179t
    - interview with, 500
    - in interview with disabled child, 158
    - of male victim, 137-139
    - outreach to, 440
    - sexual exploitation of, 166
  - Family member as abuser, 134
  - Family social services, 176
  - Family therapy, 13
  - Family violence. *See* Domestic violence
  - Family Violence Department's Resource Center on Domestic Violence, 169
  - Family Violence Prevention Fund/Health Resource Center, 169
  - Father-daughter incest, 7

- Father-son incest, 7
- Fear
  - lubrication and, 235
  - as reaction to assault, 215
- Federal funding for rape kits, 529
- Federal model of rape shield statute, 536
- Feeling no pain myth, 148
- Fellatio, 226t
- Felony
  - marital rape as, 521
  - statute of limitations for, 516
- Female
  - anatomical variations in, 21-32
    - androgen insensitivity syndrome, 22
    - erythema of vestibular sulcus, 29
    - labial agglutination, 29
    - labial hypertrophy, 22
    - linea vestibularis, 29
    - lymphoid follicles, 30
    - ovarian, 23
    - periurethral and perihymenal vestibular bands, 29
    - urethral, 23
    - vaginal, 22-23
    - vaginal rugae, 29
    - virilization, 21
    - vulvar, 22
  - chlamydia infection in, 322
  - genital development in, 20-21
  - gonorrhea symptoms in, 320
  - hymen in, 24-32. *See also* Hymen
  - Leydig cell aplasia and, 18
  - puberty in, 32-36
  - sexually transmitted disease evaluation in, 330t
  - as victim of child sexual abuse, 6
- Female police officer, request for, 509
- Female pseudohermaphroditism, 21
- Ferning, 35
- Fetal alcohol syndrome, 367
- Fetus, genital development in, 17
- Fibers as evidence, 85t
- Fight-or-flight response, 407
  - as response to trauma, 408
- File, computer, 552-553
- Fimbriated hymen, 24, 25, 63
  - definition of, 224t
- Fingernail scrapings, 278
- Fingerprints, 497
- First aid, 490
- First responder, 507-513
  - criminal prosecution and, 511-512
  - interview by, 511
  - medical examination and, 510-511
  - preparation of, 507-508
  - victim contact by, 508-510
  - victim reactions and, 512-513
  - victim support by, 513
- Fissure, superficial, 42
- Flashback, posttraumatic, 411
- Flight as evidence of guilt, 535
- Fluid, body
  - collection and preservation of, 86t
  - as crime scene evidence, 490-491, 496-497
  - for DNA analysis, 277
  - serologic testing of, 264-265
  - vaginal, in child, 72t
- Flunitrazepam, 244, 340
  - as date rape drug, 541
- Focused question, 57t
- Foley catheter technique, 90
- Follicle, lymphoid, 30
- Follow-up care, 249
- Follow-up services, lack of, 219
- Fomite transmission of human papilloma virus, 105
- Fondling, 2
- Force of penetration, 236-237
- Foreign body
  - anal injury from, 115
  - in differential diagnosis of assault, 120
  - as evidence, 245
- Forensic components of SANE program, 478
- Forensic dentist, 502
- Forensic evidence, 81-91
  - acute care of victim and, 253-257
  - admissibility of, 522
  - assault history and, 252-253
  - in child sexual abuse, 61, 70, 73
    - within 72 hours, 87-88
  - bite mark impression in, 90
  - collection of, 81-83
  - contamination control in, 82
  - documentation of, 82, 90
  - double swab technique in, 89-90
  - Foley catheter technique in, 90
  - hymenal tissue, 90
  - limitations of, 83
  - more than 72 hours later, 87
  - peer review of cases, 91
  - photography in, 88-89
  - physical examination in, 88
  - preservation techniques, 83
  - prioritization of, 82
  - procedure for collecting, 84-87
  - protocol for, 72t-73t
  - STD testing, 91
  - toluidine blue in, 90
  - when to collect, 83-84
- collaboration and, 260-261
- collection of, 247-248, 257, 435, 495-498
  - for DNA analysis, 275-280
  - guidelines for, 258t-259t
- computer, 550
- corroboration of, 501-502
- disabled victim and, 164-165
- dispatcher's instructions about, 507-508

- documentation and, 257, 260  
 health history and, 252  
 in prosecution of assault, 529-533  
 SANE program and, 482-483  
 securing of, 488-491  
 in trial, 526  
 victim safety and, 251
- Forensic examination as electronic record, 208-209  
 Forensic interview of adult victim, 243-244  
 Forensic photography, 88  
 Foreskin  
   definition of, 225t  
   in fetus, 18  
   phimosis and, 19
- Form  
   clothing documentation, 315-316  
   rape case information, 313-314
- Fossa navicularis, 224t
- Fourchette, posterior  
   anatomy of, 233  
   tear at, 229
- Fracture in disabled person, 159
- Frame of reference  
   in vicarious traumatization, 460  
   in vicarious victimization, 463
- Frenulum  
   anatomy of, 233  
   definition of, 225t
- Freud, Sigmund, on child sexual abuse, 1-2
- Friend of victim, interview of, 500
- Frog-leg position, 62, 84, 88
- Frottage, 226t
- Functional disorder, 183
- Funding  
   for DNA testing, 529  
   of social support programs, 440  
   for telemedicine, 205-206
- Fungal infection, 120
- Fusion, labial, 21
- Fusion defect, midline perineal, 22
- ## G
- Gamma hydroxybutyrate  
   in acquaintance rape, 244, 340  
   prosecution and, 542-543
- Gang-related assault in prison, 400
- Gartner duct canal cyst, 23
- Gastric contents, 86t
- Gastrointestinal disorder, 183
- Gastrointestinal system review, 193-194
- Gay relationship, domestic violence in, 358
- Gender identity conflict, 11
- Gender socialization, male, 125-128
- Genital dermatologic disorder, 116-117
- Genital examination of adult, 246
- Genital fondling, 2
- Genital-genital contact, 2
- Genital herpes. *See* Herpes simplex virus
- Genital injury, 223-237  
   in adult victim, 244-245  
   assessment of, 253, 254  
   documentation of, 237  
   evaluation of, 254  
   factors influencing, 230-237  
   mechanism of, 226-228  
   in murdered disabled person, 163  
   no findings of, 237  
   physical findings of, 223-226  
   in pregnancy, 366  
   research on, 228-230  
   terminology related to, 223
- Genital ulcer in Behçet's disease, 120
- Genital wart  
   in child, 105  
   in differential diagnosis of assault, 118  
   in pregnancy, 371
- Genitalia  
   embryology of, 17  
   evidence collection from, 259t  
   female, 224t  
     anatomical variations in, 21-32. *See also* Female,  
       anatomical variations in  
     development of, 20-21  
     in puberty, 34-36  
   male, 225  
     anatomical variations of, 18-20  
     development of, 18  
     normal variations in, 113-114
- Genitoanal development, 42
- Genitourinary system review, 193-194
- Gerontology, 384-385
- GHB. *See* Gamma hydroxybutyrate
- Gland, Bartholin's, abscess of, 233-234
- Glans, 225
- Glans clitoris in puberty, 36
- Gonadal primordia, 17
- Gonorrhea  
   in child, 71t, 91, 100-101  
   diagnosis of, 97t  
   transmission of, 94t  
   treatment of, 99t  
   in differential diagnosis of assault, 117-118  
   drugs for, 321t  
   incidence of, 319-320  
   in pregnancy, 371  
   prophylaxis for, 257t  
   recognition and treatment of, 320-322  
   screening for, 256-257
- Gram stain  
   for gonorrhea, 320  
   in sexually transmitted disease diagnosis, 328
- Grass as evidence, 85t
- Grief  
   creating sanctuary and, 424



- as indicator of child sexual abuse, 9
- Groove, urogenital, 20
- Group A beta hemolytic streptococcal infection
  - in child, 74
  - in differential diagnosis of assault, 118
- Group home
  - disabled victim of assault in, 148-149
  - law enforcement investigation of, 150
- Group therapy for child, 13
- Growth, vestibular, in puberty, 36
- Guilt, flight as evidence of, 535
- Gum as crime scene evidence, 497
- Gynecologic disorder, 183
  - as reaction to assault, 216
- Gynecologic injury. *See* Genital injury
- Gynecomastia, 37

## H

*Haemophilus ducreyi*, 323

### Hair

- biologic material in, 279
- collection and preservation of, 85t
- DNA analysis of, 278-279
- as evidence, 246, 259t
  - in child sexual abuse, 72t
- lice in, 327
- pubic
  - development of, 34
  - in male, 36-37
- Hair tourniquet syndrome, 121
- Handicap accessibility, 158-159
- Handicapped victim, 145-170. *See also* Disabled person
- Hate crime against disabled child, 147-148
- Healing of anogenital injury, 42-45
- Health
  - of domestic violence victim, 352
  - trauma affecting, 418-419
- Healthcare facility, victim's safety in, 251
- Healthcare practitioner
  - as expert witness, 182
  - on multidisciplinary team, 173
- Healthcare provider, role of, 242
- Healthcare system as social support, 435-437
- Hearing, preliminary, 518-519
- Hearing-impaired victim, 152-153
  - tactile defensiveness and, 153-154
- Hearsay exception, 150, 534
- Heart disease in disabled homicide victim, 163
- Height, 35
- Helplessness
  - attachment as protection against, 407
  - learned, 408-409
  - myth about disabled, 148
  - trauma theory concerning, 405
- Hemangioma, cavernous, 117
- Hematoma
  - labial, 70

- vulvar, 115
- Hemiplegia, 155
- Hemorrhage, submucosal, 246
- Hepatitis
  - in child, 75t, 108-109
    - diagnosis of, 98t
    - transmission of, 94t
    - treatment of, 100t
  - diagnosis and treatment of, 327
  - in pregnancy, 372
  - prophylaxis for, 75t, 257
- Hepatitis vaccine, 331t
- Heredity, 407
- Herpes simplex virus
  - in child, 70, 104
    - diagnosis of, 97t
    - treatment of, 99t
  - diagnosis and treatment of, 324
  - in differential diagnosis of assault, 119
  - drugs for, 321t
  - in pregnancy, 371
- Heteroinoculation of human papilloma virus, 105
- Hilton's white line, 38-39
- Hindgut, 38
- Hispanic victim, 441
- History
  - of assault, 242-244, 252-253
  - behavioral, 154-155
  - in child sexual abuse, 53-59, 197-200
  - of disabled victim, 157
  - medical, 192-193
    - in child sexual abuse, 199
    - of disabled victim, 157, 165
    - documentation of, 192-193
  - of SANE program, 472-473
  - of social support, 433-434
- HIV. *See* Human immunodeficiency virus infection
- Home safety
  - abuse in pregnancy and, 368
  - domestic violence and, 355-356
- Homicide of disabled victim, 147, 163-164
- Homosexual relationship, 358
- Hormonal emergency contraception, 334, 334t
- Hormone
  - anti-müllerian, 17
  - stress, 410
- Hospital-based SANE program, 474-475
- Hub, telemedicine, 203-204
- Human immunodeficiency virus infection
  - in child, 101-102
    - diagnosis of, 98
    - transmission of, 94t
    - treatment of, 100t
  - fear of, 215
  - prophylaxis against, 331-334
    - in child, 73, 75t
    - in pregnancy, 372

- screening for, 256  
 testing for, 247  
 vicarious traumatization of caregivers and, 462
- Human papilloma virus**  
 in child, 105-107  
   diagnosis of, 97t  
   transmission of, 94t  
   treatment of, 99t  
 diagnosis and treatment of, 324-325  
 in differential diagnosis of assault, 118  
 in pregnancy, 371
- Human sexual response, normal, 235**
- Hydrocolpos, 22**
- Hydrocortisone cream for lichen sclerosis, 116**
- Hymen, 24-32**  
   annular, 24, 25, 26, 64  
   bruising of, 44  
   bumps or mounds of, 29-30  
   child sexual abuse and, 62, 63, 64, 65  
   crescentic, 25, 27  
   cribriform, 25  
   definition of, 224  
   diameter of, 30-32  
   differential diagnosis of assault and, 113  
   estrogen effects on, 32, 234  
   fimbriated, 24, 63  
   imperforate, 24, 25, 26, 64  
   injury to, 230  
   longitudinal intravaginal ridge in, 26, 28  
   morphology of, 26, 224  
   notch or cleft in, 25, 28, 224  
   posterior measurement of, 30  
   posterior rim of, 24-25  
   of pregnant adolescent, 370  
   prepubertal, 26, 28  
   previous sexual experience and, 234  
   in puberty, 35  
   redundant, 25, 26  
   septate, 25-26, 27, 64  
   thickened, child sexual abuse and, 69
- Hymenal tag, 26**
- Hyperarousal**  
   dissociation and, 413  
   trauma causing 411-412
- Hyperpigmentation**  
   of penis, 19  
   in puberty, 37  
   perineal, 41
- Hyperreflexia, 159-160**
- Hypertensive autonomic crisis, 159-160**
- Hypertrophy, labial, 22**
- Hypoplasia, Leydig cell, 18**
- Hypospadias, 19**  
   in female, 24
- I**
- Identification evidence, 534**
- Identification phenomenon, 557-558**
- Identity conflict, 11**
- Idiopathic calcinosis cutis, 120**
- Illusion in vicarious victimization, 463**
- Image, 410**
- Imaging in telemedicine, 206-207**
- Immigrant as domestic violence victim, 357**
- Immune response in disabled person, 160**
- Immunity, trauma affecting, 418**
- Immunization, hepatitis, 108**
- Immunocompromised person, 149**
- Imperforate anus, 42**
- Imperforate hymen, 26**  
   as anatomical variation, 24-25  
   child sexual abuse examination and, 64  
   definition of, 224
- Impetigo, 117, 118**
- Impression**  
   bite mark, 90  
   present sense, 534-535
- Inappropriate sexual contact. See Child sexual abuse**
- Incest**  
   definition of, 3  
   male victim and, 134
- Incidence**  
   of abuse of disabled victim child, 146  
   of acquaintance rape, 212  
   of assault of developmentally disabled, 146  
   of bacterial vaginosis, 320  
   of child sexual abuse, 3  
   of *Chlamydia trachomatis*, 320  
   of elder abuse, 377-378  
   of gonorrhea, 319-320  
   of male abuse, 320  
   of sexually transmitted disease, 319-320
- Incident report, 496**
- Inclusive result of DNA test, 161**
- Inconclusive result of DNA test, 161**
- Incontinence, urinary, 23, 387-388**
- Indinavir, 333t**
- Individual Education Plan, 545**
- Individual therapy for child, 13**
- Infection**  
   in differential diagnosis of assault, 117-120  
   genital, 233-234  
   opportunistic, 101  
   prison rape and, 398-399  
   sexually transmitted. *See Sexually transmitted disease*  
   streptococcal, 74
- Inflammation**  
   anogenital, 43  
   in differential diagnosis of assault, 120  
   genital, 233



- Informal support network, 437, 438
  - Information
    - electronic, 201-206
    - medical history, 192-193
    - sexually explicit
      - disabled child's disclosure of, 151-152
      - disabled child's knowledge of, 165-166
  - Information form, rape case, 313-314
  - Information processing, 410-411
  - Inhibition, alcohol and, 540-541
  - Inhibitory factor, müllerian, 17
  - Injury
    - anal
      - in child, 64
      - in disabled homicide victim, 163
      - healing of, 42-45
    - arm, 226
    - in child, 64, 198
    - in disabled homicide victim, 163-164
    - domestic violence as cause, 353-354
    - first responders and, 513
    - forensic definition of, 490
    - genital, 223-237. *See also* Genital injury
    - homicide of disabled person, 163-164
    - hymenal, 44
    - mounting, 229
    - nonabusive trauma, 114-115
    - nongenital, 244-245
    - penetrating, in child, 69
    - personal, 515
    - photographs of, 245
    - in pregnancy, 366
    - psychologic
      - definition of, 406-407
      - as outcome of child sexual abuse, 11-13
    - requesting aid for, 496
    - spinal cord, 159-160
    - straddle, 70
  - Injury model of caregiving, 465-466
  - Inmate. *See* Correctional institution
  - Instability, atlantoaxial, 163-164
  - Instant messaging, 553
  - Institution
    - correctional, 393-401. *See also* Correctional institution
    - vicarious victimization and, 464
  - Institutionalization
    - older abuse victim and, 381-383
    - as risk factor for assault, 215
  - Instrument, colposcope, 206-207
  - Intake process of child protective services, 179
  - Intelligence
    - of disabled victim, 167
    - of mentally disabled victim, 545-546
    - of motor-impaired victim, 155
    - response to trauma and, 407
  - Intensive care nurse, 461-462
  - Intent in prosecution, 534
  - Interagency cooperation, 439
  - Intercourse
    - as child sexual abuse, 2
    - consensual, 230-231
    - definition of, 226
    - serologic evidence in, 264
  - Internal vaginal examination, 254
  - Internalization of symptoms, 184
  - Internalized coping, 12-13
  - Internet, 551-552
  - Interpersonal difficulty, 184
  - Interrogation of assault suspect, 499-500, 526-528
  - Intervention for domestic violence, 354-356
  - Interview
    - in child sexual abuse evaluation, 53, 58
    - of chronic sexual abuse victim, 87
    - in computer-assisted exploitation, 548-549
    - of disabled victim, 156-158
    - in drug-facilitated assault, 543
    - forensic, 243-244
    - of hearing-impaired victim, 152-153
    - of male victim, 128-139
    - of older sexual abuse victim, 386-387
    - by police first responder, 511
    - by sexual assault investigator
      - of offender, 499
      - of victim, 498-499, 500
      - of suspect, 526-528
  - Intimacy, vicarious traumatization affecting, 461
  - Intoxication as factor in acquaintance rape, 340
  - Intravaginal ridge, longitudinal, 26, 28
  - Introitus
    - definition of, 225
    - injury to, 232
  - Inventory of evidence, 498
  - Investigation
    - of computer-assisted exploitation, 548-549
    - corroboration of victim's statement in, 525-526
    - DNA evidence in, 529-533
    - of drug-facilitated assault, 543
    - by first responder, 512
    - interrogation of subject in, 526-528
    - by law enforcement, 495-505. *See also* Law enforcement investigation
    - mentally disabled victim and, 544-545
    - of nursing or group home assault, 148-149
    - rape kit in, 528-529
  - Investigator, vicarious traumatization of, 461
  - IQ information, 545-546
  - Irrigation of hymenal tissue, 90
  - Irritable bowel syndrome, 216
- J**
- Jail. *See* Correctional institution
  - Jarisch-Herxheimer reaction in pregnancy, 371
  - Jealousy, 364
  - Jeffreys, Dr. Alec, 265-266

Joint Commission on the Accreditation of Health Care Organizations, 471  
 Joint interview SART model, 479-480  
*Journal of Emergency Nursing*, 473  
 Jury selection, 521-522, 556-558  
 Juvenile court, 180-181

## K

Kawasaki's syndrome, 120  
 Kelly-Frye standard, 530  
 Ketamine, 340  
 Kit  
   physical evidence recovery, 84  
   rape  
     contents of, 245  
     for disabled victim, 149, 160  
     prosecution of assault and, 528-529  
 Knee-chest position, 84  
   in child, 65

## L

Labeling of domestic violence victim, 352  
 Labia  
   anatomy of, 233  
   in child sexual abuse examination, 65  
   definition of, 224  
   development of, 20  
   hematoma of, 70  
   injury to, 229-230  
   in puberty, 35  
 Labial adhesion, 29  
 Labial agglutination, 21-22, 29  
   child sexual abuse examination and, 69  
   in differential diagnosis of assault, 121  
 Labial fusion, 21  
 Labial hypertrophy, 22  
 Labial separation, 88  
 Labial traction, 62, 63  
 Labor in abused woman, 368  
 Laboratory expert, 531-532  
 Laboratory resources, shortage of, 282, 288  
 Laboratory services request, 311-312  
 Laboratory test for adult victim, 247  
 Laceration  
   characteristics of, 228  
   forensic definition of, 490  
   nonabusive, 115  
   perianal, 67  
 Lactobacillus acidophilus, 35  
 Lamivudine, 333t  
 Lamp, Wood's  
   DNA analysis and, 278  
   in forensic evaluation, 89  
   guidelines for, 258  
   for stains on skin, 246  
 Language  
   as barrier, 509

of disabled victim, 150-151  
   hearing-impaired, 149, 152-153  
   motor-impaired, 155  
 of immigrant victim, 357  
 Language delay in disabled victim  
   interview and, 157-158  
   visually impaired, 154  
 Latex allergy in spina bifida, 160  
 Law. *See also* Legal issues  
   on child sexual abuse, 1, 2-3  
   criminal, 515-516  
   on DNA evidence, 530  
 Law enforcement  
   DNA training for, 281  
   interrogation of suspect by, 526-528  
   probable cause standard and, 517  
   protocols of, 517  
   SANE program and, 481-482  
 Law enforcement investigation, 495-505  
   bite marks and, 502  
   case management in, 502-503  
   communication and, 289-290  
   corroborating evidence in, 501-502  
   crime scene processing and, 495-498  
   for disabled victim of assault, 150  
   DNA analysis in, 272, 280-281  
   interview in, 498-500  
   in multidisciplinary investigation, 177  
   preparation for court, 503-504  
   search warrant for, 500-501  
   suspect, 281-282  
 Lawsuit, civil, 515  
 Lawyer, appointment of, 518  
 Leadership for social support program, 438-439  
 Leading question, 57  
 Learned compliance by disabled victim, 152  
 Learned helplessness, 408-409  
 Learning, distance, 204-205  
 Leaves as evidence, 85  
 Leaving abuser, 355  
 Legal components of SANE program, 478  
 Legal consent, 519  
 Legal defense, 522-523  
 Legal issues, 515-523. *See also* Prosecution  
   acquaintance vs stranger rape, 507-508  
   in assault of disabled victim, 164-165  
   case preparation, 503-504  
   in child sexual abuse, 2-3, 53  
   child's medical record as, 194-195  
   court  
     criminal, 182  
     expert *versus* fact testimony in, 182  
     juvenile, 180-181  
     support for child in, 182-183  
   court proceedings, 180-183  
   crimes of assault, 515-516  
   criminal justice process, 516-520

- appointment of counsel, 518
  - corroboration, 519
  - expert witness, 519-520
  - preliminary arraignment, 517
  - preliminary hearing, 518-519
  - trial, 520
  - disabled victim's competence as, 167
  - documentation as, 248
  - domestic violence as, 521
  - interrogation as, 499-500
  - jury selection and, 521-523
  - male victim and, 520-521
  - older abuse victim and, 382-383
  - search warrant, 500-501
  - statute of limitations, 516
  - Legislation on mandated reporting, 175
  - Lesbian relationship, 358
  - Leukorrhea, physiologic, 35
  - Levofloxacin
    - for chlamydia, 321t, 322
    - for gonorrhea, 321t
    - for pelvic inflammatory disease, 326t
  - Levonorgestrel, 334t
  - Leydig cell, 17
    - aplasia of hypoplasia of, 18
  - Lice, pubic, 327
  - Lichen sclerosis
    - child sexual abuse and, 70, 74
    - in differential diagnosis, 116
    - pallor with, 41
    - premenarchal, 21
  - Lidocaine for labial agglutination, 29
  - Lifting fingerprints, 497
  - Ligase chain reaction assay
    - for gonorrhea, 320-321
    - for sexually transmitted disease, 328
  - Light source
    - in forensic evaluation, 89
    - in outdoor investigation, 498
  - Lindane, 327
  - Line
    - Hilton's, 38-39
    - pectinate, 38
  - Linea nigra, 20
  - Linea vestibularis, 23, 29, 113-114
  - Longitudinal intravaginal ridge, 26, 28
  - Longitudinal vaginal ridge, 224
  - Lower extremity, spasticity in, 159
  - Lubrication, vaginal, 234-235
  - Lymph node syndrome, mucocutaneous, 120
  - Lymphoid follicle, 30
- M**
- Male. *See also* Male victim
    - anatomical variations in, 18-20
      - circumcision adhesions, 19
      - diphallia, 20
      - epispadias, 20
      - exstrophy of bladder, 20
      - hypospadias, 19
      - partial androgen insensitivity, 18-19
      - phimosis, 19
      - pink pearly papules of penis, 19
      - shawl defect, 20
      - smegma, 19
      - urethral, 19
      - urethral meatal stenosis, 20
      - uric acid crystals, 19
    - embryology of, 18-20
    - external genital development in, 18
    - gender socialization in, 125-128
    - pseudohermaphroditism in, 18-19
    - puberty in, 36-38
    - in social support programs, 440
  - Male family member as abuser, 7, 134
  - Male pseudohermaphroditism, 18-19
  - Male victim, 7-9
    - of acquaintance rape, 341
    - chlamydia infection in, 322
    - gender socialization in, 125-128
    - genital examination of, 246
    - gonorrhea symptoms in, 320
    - of incest, 134
    - incidence of sexually transmitted disease in, 320
    - prosecution of assault of, 520-521
    - reporting of rape by, 212
    - screening of, 128-139
    - sexually transmitted disease evaluation in, 330t, 331
    - from victim to victimizer, 420-421
  - Maltreatment, health consequences of, 418-419
  - Mandated reporting of abuse
    - of child, 4
    - by healthcare provider, 242
    - legislation for, 175
    - by pediatrician, 10
    - SANE program and, 476
  - Manipulation in child sexual abuse, 8
  - Marital rape. *See also* Domestic violence; Partner rape
    - injury from, 351
    - prevalence of, 348, 350
    - prosecution of, 521, 555-556
    - risk factors for, 347
  - Masturbation, 115-116
  - Maternal estrogen, hymenal effects of, 32
  - Meatus, urethral
    - definition of, 225
    - stenosis of, 19
  - Media and child sexual abuse, 5
  - Median raphe, 114
    - in genital development, 18
  - Medical assistance, seeking of, 215
  - Medical care
    - delayed, in nursing or group home, 148-149
    - increased seeking of, 216

- SANE and, 473  
 as social support, 435-437  
 vicarious victimization and, 468
- Medical components of SANE program, 478
- Medical diagnosis  
 of child sexual abuse, 196-200  
 statement for, 535, 559-560
- Medical examination, preparation for, 510
- Medical history  
 in child sexual abuse, 199  
 of disabled victim, 157  
     competence to give, 165  
 documentation of, 192-193
- Medical management, documentation of, 260
- Medical model of caregiving, 465
- Medical personnel as witness, 519
- Medical record, 189-200  
 components of, 193  
 electronic, 208-209  
 medical history in, 192-193  
 physical examination in, 195-196  
 physician-victim relationship and, 191-192  
 purpose of, 190-191  
 review of systems in, 193-195
- Medical services, emergency, 487-492
- Membrane  
 anal, 38  
 mucous, 231-232
- Memory  
 alcohol and, 539-540  
 of disabled victim, 157  
 response to trauma and, 407  
 stress and, 410-412  
     creating sanctuary and, 423-424  
 trauma affecting, 410-412  
 verbalized sensory, 151-152
- Menopause, 387
- Menorrhagia, 216
- Menstrual cycle, lubrication and, 234-235
- Mental health, symptom continuum of, 184
- Mental health professional, 177, 179-180
- Mental status of disabled victim, 157
- Mentally disabled victim  
 of domestic violence, 357  
 evaluation of, 155  
 hate crime against, 147-148  
 prosecution of assault of, 544-548  
 as risk factor for assault, 214-215
- Mesenchyme, 39
- Mesonephric duct cyst, 23
- Mesonephric duct system, 18
- Messaging, instant, 553
- Metronidazole  
 for bacterial vaginosis, 257t, 321t  
 for pelvic inflammatory disease, 326t  
 as postexposure prophylaxis, 331t  
 in pregnancy, 371  
     for *Trichomonas vaginalis*, 105, 321t, 323-324
- Michigan model of rape shield statute, 536
- Micropenis, 20
- Midline perineal fusion defect, 22
- Military as risk factor for assault, 215
- Minor, juvenile court for, 180-181
- Mobility device, 158
- Model  
 caregiving, 465-466  
 of incest, 7  
 of rape shield statute, 536-538  
 role, for boys, 126  
 SANE, 474-475
- Molluscum contagiosum, 119
- Mono-(2-ethylhexyl) phthalate, 33
- Mons pubis  
 definition of, 224  
 development of, 20
- Mood, trauma affecting, 418
- Moral causality of vicarious victimization, 465
- Mother, abusive, 421-422
- Mother-son incest, 7
- Mothers Against Drunk Driving, 169
- Motile sperm, 503
- Motive in prosecution, 534
- Motor-impaired victim, 155-156
- Mound, hymenal, 29-30
- Mounting injury, 229
- Mouth, examination of, 246
- Mucocutaneous lymph node syndrome, 120
- Mucous membrane injury, 231-232
- Mucopurulent cervicitis, 325
- Müllerian agenesis, 22
- Müllerian inhibitory factor, 17
- Multidisciplinary team, 173-185  
 adult victim and, 260-261  
 approach for, 173-175  
 collaboration in  
     case progression in, 178t  
     child protective services and, 176, 179t  
     impact of abuse on child, 183-184  
     judicial proceedings and, 180-183  
     law enforcement and, 177  
     mental health professionals, 177, 179-180  
 corroborating evidence and, 501-502  
 for disabled victim, 164-167  
 ideal, 173  
 protocol written by, 559  
 reporting in, 175-176  
 as support, 438-440
- Multigenerational violence, 405
- Multiple choice question in child sexual abuse evaluation, 57t
- Murder of disabled person, 163-164
- Myth  
 about disabled, 147-148  
 about rape, 226

## N

### Nails

- DNA analysis of, 278
- evidence collection from, 258

Napkin, sanitary, as evidence, 490

National Alliance for the Mentally Ill, 168

National Association of the Deaf, 168

National Center for Victims of Crime, 169

National certification, SANE, 477

National Child Abuse and Neglect Data System, 3, 4

National Children's Alliance, 169

National Clearinghouse on Child Abuse and Neglect Information, 169

National Coalition Against Domestic Violence, 169

National Crime Victimization survey, 377-378

National Criminal Justice Reference Service, 169

National Depressive and Manic-Depressive Association, 168

National Domestic Violence Hotline, 170

National Down Syndrome Congress, 169

National Elder Abuse Incident Study, 378

National Fraud Information Center, 170

National Incidence Studies, 176

National Incidence Study of Child Abuse and Neglect, 3

National Institute of Justice, 280-281

National Institute on Deafness and Other Communication Disorders, 168

National Organization for Victim Assistance, 170

National Organization of Women, 433

National Women's Study, 212

Natural lubrication, 234-235

Neighborhood canvass questionnaire, 500

*Neisseria gonorrhoeae*, 326t

- in child, 71t, 100-101

- in differential diagnosis of assault, 117

- mucopurulent cervicitis and, 325

- nucleic acid amplification test for, 328

- pelvic inflammatory disease and, 325-326

- in pregnancy, 371

- proctitis caused by, 326-327

- recognition and treatment of, 320-322

Nelfinavir, 333t

Neonatal infection

- herpes simplex, 104

- human papilloma virus, 105

- syphilis, 102-103

- trichomonas, 104-105

Neoplasia, cervical, 325

Nervous system in sexual response, 235

Network, 201-206

- design of, 202-203

- distance learning via, 204-205

- funding for, 205-206

- informal support, 437

- state, 203-204

Neurobiologic change, 417

Neurochemical, stress-related, 463

Newborn

- hymen of, 24-25

- infection in

- herpes simplex, 104

- human papilloma virus, 105

- syphilis, 102-103

- trichomonas, 104-105

Nipple, supernumerary, 34

Nonabusive trauma, 114-115

Noncontact abuse of male, 127-128

Nongenital injury

- in adult victim, 244-245

- assessment of, 253-254

- in child, 61

Nonpenetrating injury, nonabusive, 115

Nonperpetrating parent

- incest and, 7

- treatment of, 13

Nonspecific findings, 223, 226

Nonverbal documentation, 154

Nonverbal victim, 149-150

Norgestrel, 334t

Notch, hymenal, 28, 224

Nucleic acid amplification test

- for gonorrhea, 320-321

- for sexually transmitted disease diagnosis, 328

Nucleic amplification test, 328-330

Nurse

- vicarious traumatization of, 461-462

- as witness, 519

Nurse examiner, sexual assault, 217-218, 435-436. *See also*

SANE program

- as expert witness, 558-563

Nursing home

- disabled victim of assault, 148-149

- law enforcement investigation of, 150

- older sexual abuse victim and, 381-383

## O

Oath, mentally disabled victim and, 546-547

Object of penetration, 236

Obstacle, social, 463-464

Occult fracture in disabled person, 159

Odontologist, 502

Offender

- of child sexual abuse, 7-8

- childhood abuse of, 421

- victim's viewing of, 509

Office for Victims of Crime Resource Center, 170

Officer

- DNA training for, 281

- law enforcement, 177. *See also* Law enforcement

Official, prison, 399-400

Ofloxacin, 321t, 322

Older adult, 377-389. *See also* Elder abuse

Older sexual abuse victim

- clinical response to, 385-389

- data collection on, 379-380
  - definition of, 378-379
  - exposure to abuse by, 380-383
  - framework for working with, 384-385
  - incidence of, 377-378
  - response of, 383-384
  - Open-ended question in child sexual abuse evaluation, 56, 57
  - Opening
    - anal, 42
    - urethral, 225
  - Opening statement at trial, 573-574
  - Opportunistic infection, 101
  - Opportunity, act of, rape as, 213
  - Oral contraception, emergency, 254-256, 334, 334t
  - Oral copulation, DNA analysis and, 279
  - Oral examination, 246
  - Oral-genital contact, 2
  - Oral sodomy, 226
  - Oral swab, DNA on, 279
  - Organizational causality of vicarious victimization, 464
  - Organizational precautions against vicarious victimization, 467-468
  - Organizational strategies to prevent vicarious victimization, 466-467
  - Orogenital contact of male victim, 128
  - Oropharynx, evidence collection from, 258t
  - Orthotic equipment, withholding of, 145
  - Os, 224
  - Osteoporosis in disabled homicide victim, 164
  - Outdoor assault, evidence from, 497-498
  - Outreach to family of victim, 440
  - Ovarian cyst, 23
  - Ovary
    - anatomical variations in, 23
    - puberty and, 34
- ## P
- Packaging
    - of clothing, 86
    - of evidence, 83, 87
  - Pain
    - from anogenital injury, 43
    - pelvic, 216
  - Pain management for disabled victim, 158
  - Paint chips as evidence, 85t
  - Pallor, 41
  - Pantyliner as evidence, 490
  - Papilloma virus, human
    - in child, 105-107
      - diagnosis of, 97t
      - transmission of, 94t
      - treatment of, 99t
    - diagnosis and treatment of, 324-325
    - in differential diagnosis of assault, 118
    - in pregnancy, 371
  - Papillomatosis in puberty, 36
  - Papules of penis, pearly, 19, 38
  - Paramesonephric cyst, 23
  - Paraurethral cyst, 23
  - Parens patriae* doctrine, 181
  - Parent
    - in interview with disabled child, 158
    - outreach to, 440
  - Parenthood, teen, 369-370
  - Parenting
    - characteristics of, 6
    - sexual assault affecting, 421-422
    - trauma theory concerning, 405
  - Parents of Murdered Children, 170
  - Parking for disabled person, 158
  - Paroxysmal neurogenic hypertension, 159-160
  - Partial androgen insensitivity, 18-19
  - Partial virilization of female, 21
  - Partner participation in consensual sex, 235
  - Partner rape, 347-360
    - acquiescence to, 349t
    - algorithm for, 359t
    - associated behaviors, 352
    - clinician's response to, 354
    - disabled victim of, 357
    - documentation of, 354
    - future studies of, 358
    - in gay or lesbian relationship, 358
    - health status of victim, 352
    - identification of, 352-354
    - immigrant victim of, 357
    - injuries and symptoms of, 351
    - intervention for, 354-356
    - psychological effects of, 351-352
    - rape and, 347-350
    - safety tips for, 359-360
  - Partnership for support services, 440-441
  - Password, computer, 549
  - Past victimization as risk factor for assault, 214
  - Patent fingerprint, 497
  - Pearly papules of penis, 19, 38
  - Pectinate line, 39
  - Pediatrician
    - child sexual abuse and, 10
    - male victim of abuse, 134-135
    - in prevention of domestic violence, 368-369
  - Pediculosis, 327
  - Peer review of cases, 91
  - Pelvic examination
    - of adult, 246
    - of disabled person, 158-159
  - Pelvic inflammatory disease, 325-326
  - Pelvic pain, 216
  - Pelvic tilt, 235-236
  - Pemphigus, 117
  - Penetrating injury
    - in child, 69
    - forensic definition of, 490



- Penetration
  - force of, 236-237
  - object of, 236
- Penicillin
  - in pregnancy, 371
  - for syphilis, 257t, 323
- Penis
  - definition of, 225t
  - erythema of, 19
  - hair tourniquet syndrome of, 121
  - lichen sclerosis of, 116
  - micropenis, 20
  - pearly papules of, 19, 38
  - in puberty, 36
  - torsion of, 20
  - zipper entrapment of, 115
- People v Kelly*, 530
- Perception of police, 508
- Perianal condyloma in child, 70, 103
- Perianal erythema, 41
- Perianal infection, streptococcal, 74
- Perianal laceration, 67
- Perianal lesion of Crohn's disease, 120
- Perianal wart in child, 108
- Perihymenal vestibular band, 29
- Perinatal infection. *See* Neonatal infection
- Perineal erythema, 39
- Perineal fusion defect, midline, 22
- Perineal wart, 119
- Perineum
  - anatomy of, 39, 41
  - definition of, 224, 225
  - nonabusive injury to, 116
- Peripheral site, telemedicine, 203-204
- Periurethral vestibular band, 29
- Perivaginal infection, streptococcal, 74
- Permethrin, 327
- Perpetrator
  - of acquaintance rape, 342
  - disabled victim and, 161
  - exonerated by DNA evidence, 263
  - forensic information about, 253
  - known by victim, 212
  - as outcome of child sexual abuse, 12
  - in prison, 400
  - as revictimization behavior, 420-421
- Personal boundary, 59
- Personal injury, 515
- Personal safety for domestic violence victim, 355
- Personal strategies to prevent vicarious victimization, 466-467
- Petechiae, 227
- Petition by child protective services, 181
- Phenotypic female, Leydig cell aplasia and, 18
- Philadelphia's Women Organized Against Rape program, 440-441
- Philosophical causality of vicarious victimization, 464-465
- Phimosis, 19
  - lichen sclerosis and, 116
- Photography
  - alternate light source with, 89
  - of bite mark, 502
  - of child sexual abuse, 74, 76
  - in computer search, 550
  - as corroboration, 501
  - of crime scene, 526
  - of disabled person, 163
  - as electronic record, 208
  - as forensic evidence, 82, 88
  - of injury, 245, 254
  - mentally disabled victim and, 547-548
  - in telemedicine, 204, 207
- Phthalate, 33
- Physical evidence. *See* Forensic evidence
- Physical examination
  - of adult victim, 244-247
    - description of, 259-260
    - documentation of, 259-260
  - in child sexual abuse
    - presenting complaints, 54
    - sexually transmitted disease and, 66, 69-70
    - typical anatomy and, 61-66
  - of disabled victim, 158-163
  - distant, 201-206
  - documentation of, 195, 248
  - of male victim, 135-136
  - in medical record, 195-196
  - of older sexual abuse victim, 387-388
  - telemedicine and, 204
- Physical health of child, 183
- Physical signs and symptoms in child, 54
- Physically disabled. *See also* Disabled person
  - hate crime against, 147-148
  - sexual assault of, 145
- Physician
  - don't-ask—don't-tell approach and, 453, 455
  - testimony of, in male sexual abuse, 134
  - as witness, 519
- Physician-victim relationship, 191-192
- Physiologic leukorrhea, 35
- Pink pearly papules of penis, 19, 38
- Pinworm
  - child sexual abuse and, 74
  - in differential diagnosis of assault, 119-120
- Play, sexual, 3
- Play therapy, 13
- Pointer, 562
- Poland's syndrome, 34
- Polaroid camera for forensic photography, 88
- Police. *See also* Law enforcement investigation
  - DNA laboratories and, 272
  - documentation of involvement, 260
  - effective response from, 217
  - as first responder, 507-513
  - mentally disabled victim and, 545
  - in multidisciplinary investigation, 177

- photography by, 245
- probable cause standard and, 517
- reporting of abuse to, 242
- Police dispatcher, 508-510
- Police Executive Research Forum survey, 270-271
- Police Foundation, 177
- Polybrominated biphenyl, 33
- Polychlorinated biphenyl, 33
- Polymerase chain reaction assay
  - as DNA test, 267-268
  - for sexually transmitted disease, 320-321, 328
- Polymorphism analysis, restriction fragment length, 266-267
- Polythelia, 34
- Pornography
  - child, outlawing of, 2-3
  - disabled victim and, 152, 163, 165
- Position
  - for examination of child, 62
  - frog-leg, 84
  - knee-chest, 84
  - pelvic tilt, 235-236
- Postacute care medical support, 436-437
- Postassault behavior of victim, 253
- Postconviction DNA testing, 290-291, 532-533
- Posttraumatic stress disorder
  - after rape, 415-416
  - causality of, 462
  - in child, 184
  - as delayed effect of assault, 215-216
  - maternal, 422
  - memory and, 410
  - sexual assault and, 406
  - substance abuse and, 416-417
  - trauma theory and, 405
  - vicarious traumatization and, 459
- Posterior fossa, 65
- Posterior fourchette
  - anatomy of, 233
  - tear at, 229
- Posterior hymenal measurement, 30
- Posterior rim of hymen, 24-25
- Postexposure prophylaxis for HIV
  - in child, 102
  - in pregnancy, 371
- Postmenopausal woman, 388
- Postpartum period, partner violence in, 363-364
- Power
  - in domestic violence, 347
  - male victim and, 133
  - trauma theory concerning, 405
- Powerlessness as outcome of child sexual abuse, 11-12
- Precautions
  - universal, 82
  - against vicarious victimization, 467-468
- Precocious sexual development, 32-33
- Pregnancy
  - chlamydia treatment in, 322
  - domestic violence in, 363-370
    - adolescent as victim, 369-370
    - child abuse and, 365
    - clinical manifestations of, 365-367
    - clinician response to, 367-368
    - epidemiology of, 363-364
    - identification of, 367-368
    - increase in, 364
    - intervention in, 364-365
    - pediatrician's role in preventing, 368-369
    - safety and, 368
  - drugs for, 326t
    - as indication of child sexual abuse, 9
    - metronidazole and, 323
    - pelvic inflammatory disease and, 326
    - as public health concern, 214
    - sexual assault resulting in, 370-372
- Pregnancy prophylaxis, 254-256
  - acquaintance rape and, 343
  - for child, 75
  - for disabled person, 160
- Prehospital care, 487-492
  - effective response from, 217
  - forensic evidence and, 488-491
  - transport to hospital, 491-492
  - victim psychology and, 487-488
- Prejudice of jury, 557
- Preliminary arraignment, 517
- Preliminary hearing, 518-519
- Preliminary rape case information form, 313-314
- Premature delivery, 366
- Premature pubarche in male, 36
- Premature thelarche, 33
- Premenarchal lichen sclerosis, 22
- Prenatal care, 366
- Prepubescent child, 6
  - examination of, 62
  - forensic evidence collection and, 61, 70, 73
    - within 72 hours, 87-88
    - bite mark impression in, 90
    - collection of, 81-83
    - documentation of, 90
    - double swab technique in, 89-90
    - Foley catheter technique in, 90
    - hymenal tissue, 90
    - limitations of, 83
    - more than 72 hours later, 87
    - peer review of cases, 91
    - photography in, 88-89
    - physical examination in, 88
    - procedure for collecting, 84-87
    - protocol for, 72-73t
    - STD testing, 91
    - toluidine blue in, 90
    - when to collect, 83-84
  - normal hymen in, 28



- sexually transmitted disease in. *See also* Sexually transmitted disease, in child
- uterus/cervix ratio in, 34
- vagina of, 93
- vaginal discharge in, 101
- vulvovaginitis in, 117
- Prepuce
  - clitoral, 20
  - definition of, 225
  - phimosis and, 19
- Preschool child, male, 136
- Present sense impression, 534-535
- Preservation of evidence, 488-491
- Pretrial motion, 533-538
  - mentally disabled victim and, 546
  - rape shield statutes and, 535-538
  - rule of evidence and, 533-535
- Pretrial preparation of expert witness, 561
- Prevalence study of child sexual abuse, 3
- Prevention
  - of acquaintance rape, 344
  - education for, 249
  - of sexual assault, 218-219
  - social support and, 439-440
  - of vicarious victimization, 466-467
- Previous sexual experience, 234
- Primary care practitioner, mandatory reporting by, 10
- Primary prevention of sexual assault, 218
- Primary syphilis in child, 103
- Primordia, gonadal, 17
- Prison. *See* Correctional institution
- Prison Rape Reduction Act, 394-395
- Privacy in prehospital care, 488
- Probable cause, 517
- Problem-solving, 13
- Procidentia, vaginal, 22
- Proctitis/proctocolitis, 326-327
- Professional strategies to prevent vicarious victimization, 466
- Professionalism of expert witness, 561-562
- Programmatic components of SANE program, 477
- Prolapse
  - rectal, 121
  - urethral, 121
  - vaginal, 22
- Prophylaxis
  - antibiotic, 73, 75
  - hepatitis, 327
  - HIV infection, 256-257
    - in child, 102
  - pregnancy, 254-256
    - acquaintance rape and, 343
    - for disabled person, 160
  - for sexually transmitted disease
    - acquaintance rape and, 343
    - in pregnancy, 370-371
- Prosecution
  - of crimes of assault, 515-516
  - in criminal court, 182
  - criminal justice process and, 516-520
    - appointment of counsel, 518
    - corroboration, 519
    - expert witness, 519-520
    - preliminary arraignment, 517
    - preliminary hearing, 518-519
    - trial, 520
  - of domestic violence, 521
  - first responder and, 511-512
  - investigation for, 525-533
    - corroboration of victim's statement in, 525-526
    - DNA evidence in, 529-533
    - interrogation of subject in, 526-528
    - rape kit in, 528-529
  - jury selection and, 521-523
  - male victim and, 520-521
  - pretrial motion in, 533-538
    - rape shield statutes and, 535-538
    - rule of evidence and, 533-535
  - probable cause standard and, 517
  - of problematic case, 538-556
    - alcohol-facilitated assault, 539-541
    - computer-assisted exploitation, 548-555
    - date rape, 538-539
    - domestic violence, 555-556
    - drug-facilitated assault, 541-544
    - mentally retarded victim, 544-548
  - statute of limitations and, 516
  - trial strategies for, 556-575
    - cross-examination of defendant, 570-573
    - cross-examination of expert witness, 569-570
    - opening statement and, 573-575
    - questions for expert witness, 564-569
    - sexual assault nurse examiner as witness, 558-563
    - voir dire, 556-558
- Prosecutor, 503
- Prostitution
  - of disabled victim, 166
  - as outcome of child sexual abuse, 11
  - as revictimization, 420
- Protocol
  - for interview of child, 58
  - law enforcement, 517
  - rape kit and, 528-529
  - of sexual assault examination, 558-559
- Protozoan infection. *See* *Trichomonas vaginalis*
- Prozone phenomenon, 103
- Prune belly syndrome, 20
- Pseudohermaphroditism
  - female, 21
  - male, 18-19
- Psoriasis, 117
- Psychiatric indicator of child sexual abuse, 9-10
- Psychobiologic change, 405
- Psychologic components of SANE program, 478
- Psychologic response to assault, 236

- Psychologic therapy for male victim, 136-137
- Psychologic trauma of child, 11-13
- Psychologic effects
- of acquaintance rape, 341
  - first responders and, 513
  - of marital rape, 351
  - prehospital care and, 487-488
  - of vicarious victimization, 463
- Psychologic support, acquaintance rape and, 343
- Psychologic trauma, definition of, 406-407
- Psychoneuroimmunology, 418
- Psychosomatic disorder, 55t
- Pubarche in female, 34
- Puberty
- in female, 32-36
    - cervix in, 34-35
    - external genitalia development, 35-36
    - internal genitalia development, 34
    - pubarche in, 34
    - thelarche in, 33-34
    - variations in, 36
  - in male, 36-38
  - sexual maturity rating and, 38
- Pubic hair
- evidence collected from, 259t
  - as evidence in child sexual abuse, 72t
  - in puberty
    - in female, 34
    - in male, 36
- Pubic lice, 327
- Public health implications of sexual assault, 213-214
- ## Q
- Questionnaire, neighborhood canvass, 500
- Questions
- in child sexual abuse evaluation, 56, 57
  - for expert witness, 564-569t
  - for medical history, 192-193
- ## R
- RADAR, 356, 359t
- Range of motion in disabled person, 159
- Rape
- acquaintance, 339-344. *See also* Acquaintance rape
  - acquaintance vs stranger, 507-508
  - of child, 2
    - healing after, 67
  - definition of, 211
  - jury's view of, 556-557
  - marital, prosecution of, 521
  - myths about, 226
  - not reported, 212-213
  - partner, 347-360. *See also* Domestic violence; Partner rape
  - police interview about, 511
  - prehospital care of victim, 487-492
  - sexually transmitted disease and, 370-371
  - social supports for victim of, 433-441. *See also* Social support
    - as weapon of war, 211-212
  - Rape, Abuse & Incest National Network, 170, 433-434
  - Rape case information form, 313-314
  - Rape crisis center, 217, 244, 433-434
  - Rape kit
    - contents of, 245t
    - for disabled victim, 149, 160
    - prosecution of assault and, 528-529
  - Rape-related pregnancy, prophylaxis against, 254-256
  - Rape shield statute, 535-538
  - Rape trauma syndrome, 215, 433, 487
    - in older abuse victim, 383-384
  - Raphe, median, 114
    - in genital development, 18
  - Rapist, serial, childhood abuse of, 420-421
  - Rash
    - from bedwetting alarm, 116
    - scabies causing, 327
    - in syphilis, 322
  - Ratio, uterus/cervix, in prepuberty female, 34
  - Reactive arthritis, 322
  - Real-time evaluation, 208
  - Rebuttal case, 548
  - Recall bias in prevalence statistics, 4
  - Recovery
    - process of, 424
    - social support affecting, 437-438
  - Recovery kit, physical evidence, 84
  - Rectal bleeding in child, 61
  - Rectal injury in murdered disabled person, 163
  - Rectal prolapse, 121
  - Rectum, 225t
  - Red perineum, 39
  - Redundancy in interview of disabled victim, 156
  - Redundant hymen, 25, 26
    - definition of, 224t
  - Reenactment, traumatic, 414
  - Reference sample of forensic evidence, 83, 279, 280
  - Refusal
    - of care, 488
    - of examination, by child, 61
  - Regeneration in anogenital healing, 42-45
  - Registry of Interpreters for the Deaf, 168
  - Reiter's syndrome, 322
  - Relationship
    - caregiver-resident, 150
    - creating sanctuary and, 424
    - physician-victim, 191-192
    - response to trauma and, 407
  - Religious group as support for victim, 437
  - Remembering. *See* Memory
  - Remote access to computer, 550-551
  - Reorganization phase of rape trauma syndrome, 215
    - in older abuse victim, 383
  - Repair of anogenital injury, 44

- Report, incident, 496
  - Report on the Maltreatment of Children with Disabilities*, 146
  - Reporting of abuse
    - of child, 4, 76
      - by pediatrician, 10
    - confidentiality and, 219
    - of disabled person, 145
    - by healthcare practitioner, 173
    - by healthcare provider, 242
    - lack of, 438
      - by adolescents, 212
      - barriers causing, 175
      - of disabled person, 145
      - by males, 212
      - in nursing or group home, 149
    - male victim, 134-135
    - mandated, 175-176
    - of marital rape, 353
    - of older victim, 389
    - SANE program and, 474, 476
  - Request, laboratory services, 311-312
  - Research
    - on injury, 228-230
    - on rape, 434
  - Resignation as coping mechanism, 12-13
  - Resistance to assault, 236
  - Resources
    - for disabled, 168-170
    - DNA testing, 270-272
      - collaboration in, 272
    - management of, 289
    - for older victim, 388-389
  - Response team, sexual assault, 164-167. *See also* Multidisciplinary team
  - Responsibility
    - on multidisciplinary team, 174
    - reporting of abuse as, 175
  - Restriction fragment length polymorphism analysis, 266-267
  - Restructuring, cognitive, 12
  - Retention cyst, 23
  - Retrovirus. *See* Human immunodeficiency virus infection
  - Revictimization, 405
    - as consequence of trauma, 419-423
    - prevention of, 218
  - Review of systems in child's medical record, 193-195
  - Revised trauma theory. *See* Trauma theory
  - Ridge
    - coronal, 225t
    - longitudinal vaginal, 26, 224
  - Risk factors
    - for acquaintance rape, 339-340
    - for domestic violence, 347
    - for partner violence in pregnancy, 363
    - for sexual assault, 214-215
      - of child, 6
    - for sexually transmitted disease, 329t
    - for vicarious traumatization, 462
  - Risk reduction, 439-440
  - Rohypnol, 541, 542
  - Role model for boys, 126
  - Role on multidisciplinary team, 174
  - Room temperature for disabled person, 159
  - Rough sex, consensual, 231
  - Routine of disabled child, 158
  - Rugae, vaginal, 28
  - Rules of evidence, 533-535
- ## S
- Safety
    - abuse in pregnancy and, 368
    - creating sanctuary and, 423-424
    - of domestic violence victim, 355-356
    - in healthcare facility, 251
    - by prehospital care providers, 487
  - Safety tips
    - for acquaintance rape prevention, 344
    - for domestic violence victim, 359-360
  - Saline float of hymenal tissue, 90
  - Saline solution in examination of child, 62
  - Saliva
    - in child sexual abuse, 73t
    - as evidence, 246
    - specimen collection of, 279-280
  - Same-sex relationship, 358
  - Sample specimen, 83, 279, 280
  - Sanctuary, creating, 423-424
  - SANE program, 217-218, 436, 439
    - community approach to, 479-481
    - efficacy of, 481-483
    - history of, 472-473
    - hospital-based, 474-475
    - need for, 471-472
    - operation of, 474-476
    - scope of practice, 473-474
    - terminology and, 473
    - training for, 476-479
  - Sanitary device, 490
  - Sarcoptes scabiei*, 327
  - SART program, 164-167, 436, 439
    - community approach and, 479-481
    - evidence examination by, 286t
  - Scabene, 327
  - Scabies, 327
  - Scarring, genital, 233
  - Schistosomiasis, 119
  - Science, forensic, 488-491
  - Sclerosis, lichen. *See* Lichen sclerosis
  - Scoliosis, 164
  - Screening
    - for abuse
      - acquaintance rape, 342-343
      - domestic violence, 353-354
      - in male, 128-139
      - of older persons, 385-386

- in pregnancy, 367-368
  - for sexually transmitted disease, 256-257
- Scrotum, 225t
- Search and seizure of computer, 549, 550-555
- Search warrant, 307-310, 500-501
- Secondary prevention of assault, 218-219
- Secondary traumatic stress
  - definition of, 459-460
  - precautions against, 467
- Secretion
  - in child sexual abuse, 73t
  - serologic testing of, 264-265
- Security of healthcare facility, 251
- Seizure of computer, 550-555
- Self-blame, 12-13
- Self-esteem in vicarious traumatization, 460
- Self-mutilation in child, 9
- Semen
  - in child, 198
  - definition of, 225t
  - DNA analysis of, 278
  - in prosecution of assault, 530
  - specimen collection of, 86, 279
  - Wood's lamp for, 89, 246
- Sensory information from disabled victim, 152
- Sensory memory, verbalized, 151-152
- Separation, labial, 88
- Septate hymen, 25, 27
  - child sexual abuse examination and, 64
  - definition of, 224t
- Septum, urorectal, 39
- Serial rapist, 420
- Serologic test
  - limitations of, 264-265
  - for sexually transmitted disease, 331
- Sertoli cell, 17
- Setting of evaluation, 242-243
- Sex-determining region of Y chromosome, 17
- Sex offender, effect of, on counselor, 461
- "Sexual Abuse, Another Hidden Pediatric Problem," 1-2
- Sexual adjustment, 419
- Sexual assault. *See also* Child sexual abuse; Domestic violence; Partner rape; Rape
  - in adolescents and adults, 211-219
  - definition of, 211
  - equipment for examination of, 60t
  - public health implications of, 213-214
  - social support for victim of. *See* Social support
- Sexual assault case information form, 290
- Sexual assault nurse examiner, 217-218, 435-436. *See also* SANE program
  - as expert witness, 558-570
- Sexual assault response team, 164-167, 435-436
- Sexual behavior in child, 59
- Sexual coercion, 350
- Sexual conduct, definitions of, 226t
- Sexual development, precocious, 32-33
- Sexual dysfunction
  - child sexual abuse evaluation and, 54
  - of perpetrator, 236
  - as reaction to assault, 216
- Sexual experience, previous, 234
- Sexual intercourse, 226t
  - consensual, 230-231
- Sexual maturity rating, 38, 39
- Sexual offender
  - of child sexual abuse, 6-8
  - childhood abuse of, 421
  - victim's viewing of, 509
- Sexual play, 3
- Sexual predator in prison, 400
- Sexual response, normal, 235
- Sexual touch of male victim, 128
- Sexualized behavior in child, 9
- Sexually explicit information
  - disabled child's disclosure of, 151-152
  - disabled child's knowledge of, 165-166
- Sexually transmitted disease, 319-335
  - in abused pregnant woman, 366
  - acquaintance rape and, 343
  - in adolescent, 71t
  - bacterial vaginosis, 107-108, 325
  - chancroid, 323
  - in child, 66, 69-70, 75, 93-109, 198
    - bacterial vaginosis, 107-108
    - Chlamydia trachomatis*, 96-100
    - epidemiology of, 94-96
    - hepatitis B, 108-109
    - herpes simplex, 104
    - human immunodeficiency virus, 101-102
    - human papilloma virus, 105-107
    - Neisseria gonorrhoeae*, 100-101
    - overview of, 93-94
    - screening for, 71t
    - syphilis, 102-104
    - Trichomonas vaginalis*, 104-105
  - Chlamydia trachomatis*, 96-100, 322
  - diagnostic evaluation of, 328-331, 329t-330t
  - in differential diagnosis of assault, 117-118
  - in disabled person, 149, 160
  - drugs for, 321t
  - emergency oral contraception, 334
  - gonorrhea, 100-101, 320-322
  - hepatitis, 327
  - herpes simplex, 324
  - HIV postexposure prophylaxis, 331-333, 333t
  - human papillomavirus, 105-107, 324-325
  - incidence of, 319-320
  - as indication of child sexual abuse, 9
  - mucopurulent cervicitis, 325
  - pelvic inflammatory disease, 325-326, 326t
  - in pregnancy, 370-372
  - proctitis and proctocolitis, 326-327
  - prophylaxis against, 75, 256-257, 331t

- pubic lice, 327
- risk of, 319
- scabies, 327
- syphilis, 322-323
- testing for, 91
- trichomoniasis, 323-324
- Shaft of penis, 225t
- Shame of male victim, 137
- Shawl defect, 20
- Shigella*, proctitis caused by, 327
- Shoe as evidence, 280
- Short-term memory of disabled victim, 157
- Shortage of crime laboratory resources, 282, 288
- Sickness model of caregiving, 465
- Sign language, 149, 152-153
- Significant other as support, 438
- Signs and symptoms in child, 54
- Skene's duct cyst, 23
- Sketch
  - of crime scene, 497
  - as forensic evidence, 82
- Skin
  - biologic material on, 279
  - evidence collection from, 258t
  - stains on, 246
- Skin disorder, 116-117, 120-121
- Slack space on computer, 553-554
- Sleeve-like hymen, 26
- Smegma, 19
- Smoking at crime scene, 496-497
- Social causality of vicarious victimization, 463-464
- Social coping, 13
- Social defense, 463-464
- Social obstacle, 463-464
- Social problem, 54
- Social services
  - domestic violence programs, 434-435
  - prison rape and, 399-400
  - rape crisis center, 434
  - victim assistance programs, 435
- Social support, 433-444
  - first responders and, 513
  - funding for, 440
  - history of, 433-434
  - list of state coalitions, 441-444
  - nature of, 434-438
    - church and religious groups, 437
    - domestic violence programs, 434-435
    - healthcare system, 435-437
    - other, 437-438
    - rape crisis center, 434
    - victim assistance programs, 435
  - in Philadelphia, 440-441
  - program development in, 438-440
    - funding, 440
    - risk reduction and education, 439-440
    - steps in, 438-439
- Social withdrawal, 12-13
- Social worker
  - for disabled victim, 166
  - as witness, 519
- Socialization, male gender, 125-128
- Societal reaction to marital rape, 356-357
- Societal strategies to prevent vicarious victimization, 467
- SODDI defense
  - in computer-assisted exploitation, 549
  - prosecution and, 526-527
- Sodomy, 226t
- Somatization, 183
  - in child, 11
- Space on computer, 553-554
- Spasticity in lower extremity, 159
- Specimen. *See also* Forensic evidence
  - in child sexual abuse, 59, 72t
  - dried, 276
  - for sexually transmitted disease diagnosis, 328
- Spectinomycin, for gonorrhea, 321
- Speculum examination
  - of adult, 247
  - of prepubertal female, 62
- Speech delay
  - of disabled victim, 157-158
  - in visually impaired child, 154
- Speechless terror, 410, 411
- Sperm. *See also* Semen
  - examination of, 503-504
  - as indication of child sexual abuse, 9
- Spermarche, 36
- Spermatocoele, 37
- Sphincter, cloacal, 39
- Spina bifida, latex allergy in, 160
- Spinal injury
  - autonomic dysreflexia in, 159-160
  - cervical, in disabled homicide victim, 163-164
- Spiritual causality of vicarious victimization, 465
- Spouse
  - abuse of. *See* Domestic violence; Partner rape
  - in child sexual abuse evaluation, 59
- Squamous epithelium in puberty, 35
- Staff, trained, 435
- Stain on skin, 246
- Standard, Kelly-Frye, 530
- Standardized cognitive testing, 165
- Standards of practice, SANE, 474
- Staphylococcus aureus* infection, 117
- State coalitions, list of, 441-444
- State level certification, SANE, 476-477
- State network, telemedicine, 203-204
- State of mind in prosecution, 534
- Statement
  - corroboration of, 501-502, 525-526
  - for medical diagnosis and treatment, 535
  - opening, 573-574

- Statute  
  on child sexual abuse, 2  
  rape shield, 535-538
- Statute of limitations, 516
- Stavudine, 333t
- Stenosis, urethral meatal, 19
- Stepfather, abuse by, 6, 7
- Stigmatization, 12
- Straddle injury, 70  
  in differential diagnosis, 114-115
- Stranger assault  
  acquaintance rape vs, 507-508  
  of older person, 380-381  
  prosecution of, 517  
  risk of, 7-8
- Strangulation of disabled person, 163
- Strategy  
  of perpetrator of child sexual abuse, 8  
  to prevent vicarious victimization, 466-467  
  trial, 556-575  
  for cross-examination of defendant, 570-573  
  for cross-examination of expert witness, 569-570  
  opening statement and, 573-575  
  questions for expert witness, 564-569t  
  sexual assault nurse examiner as witness, 558-563
- Strawberry hemangioma, 117
- Streak ovary, 23
- Streptococcal infection  
  child sexual abuse and, 74  
  in differential diagnosis of assault, 117, 118
- Stress  
  addiction to, 413-414  
  biologic response to, 462-463  
  creating sanctuary and, 424  
  endorphins and, 413  
  health consequences of, 418-419  
  of older person, 385  
  partner violence in pregnancy and, 364  
  posttraumatic. *See* Posttraumatic stress disorder  
  secondary traumatic, 467  
  thinking under, 409-410
- Stress hormone, 410
- Stress incontinence, 387-388
- Stress-sex situation, 213
- Subacute trauma, hymenal, 44
- Submucosal hemorrhage, 246
- Substance abuse  
  maternal, 422  
  trauma and, 416
- Suggestive of abuse/penetration, 223
- Sulcus, vestibular, erythema of, 29
- Superficial fissure, 42
- Supernumerary breast, 34
- Supernumerary nipple, 34
- Supernumerary ovary, 23
- Supine position in examination of child, 65
- Support services, 433-444. *See also* Social support  
  for child, 10  
  in court, 182-183  
  documentation of, 260
- Suppression of disclosure, 10
- Survey  
  on DNA testing resources, 270-272  
  National Crime Victimization, 377-378
- Survivor of abuse, male, 127
- Suspect  
  DNA analysis of, 287t  
  interrogation of, 526-528  
  statement of, 502  
  victim's viewing of, 509
- Suspicious for abuse findings, 176, 223
- Swab  
  double, 89-90  
  nail, 278  
  oral, 246, 258  
  DNA on, 279  
  vaginal, 259  
  for antigen determination, 247
- Sympathetic nervous system in sexual response, 235
- Symphysis pubis, 20
- Synchronous evaluation, 208
- Syphilis  
  in child, 102-104  
  congenital, 102-103  
  diagnosis of, 97t  
  transmission of, 94t  
  treatment of, 99t  
  diagnosis and treatment of, 322-323  
  incidence of, 320  
  in pregnancy, 371  
  prophylaxis for, 257
- System, dysfunctional, 464, 465
- ## T
- T-I-N-E- test training device, 30, 31
- Tactile defensiveness, 153-154
- Tag  
  anal, 41  
  hymenal, 26
- Tampon as evidence, 490
- Tanner stage, 38  
  in female, 62  
  guidelines for, 38  
  in male, 36, 62  
  in puberty, 35  
  pubic hair and, 34
- Target consumer of telemedicine, 202
- Task force, development of, 438
- Team  
  forensic, 82  
  multidisciplinary. *See* Multidisciplinary team  
  in Philadelphia support program, 441  
  sexual assault response, 435-436
- Tear of posterior fourchette, 229

- TEARS, 227
- Technology
  - in prosecution, 532
  - telemedicine, 201-206
- Telemedicine, 201-206
  - design of, 202-203
  - distance learning via, 204-205
  - funding for, 205-206
  - state network of, 203-204
- Telephone at crime scene, 495-496
- Temperature, ambient, for disabled person, 159
- Termination of pregnancy, 367
- Terminology for interview of disabled victim, 157
- Terror, speechless, 410, 411
- Tertiary prevention of sexual assault, 219
- Testicle, definition of, 225t
- Testimony
  - disabled victim's competence for, 167
  - expert vs fact, 182
  - of male sexual abuse, 134
  - by mentally disabled victim, 547-548
- Testing of child
  - for HIV, 102
  - for sexually transmitted disease, 69-70, 95
  - for syphilis, 103
- Testing resource crisis, DNA, 270-272
- Testis
  - development of, 18
  - in puberty, 36
- Testosterone
  - in embryology, 17
  - gynecomastia and, 37
  - in male genital development, 18
  - in puberty, 36
- The Bleeding*, 265
- Thelarche, 33-34
  - premature, 33
- Theory, trauma, 405-425. *See also* Trauma theory
- Therapist, vicarious traumatization of, 461
- Therapy
  - for child sexual abuse, 13
  - for male victim, 136-137
- Thinking under stress, 409, 424
- Tilt, pelvic, 235-236
- Toluidine blue in forensic examination, 90
- Torsion, penile, 20
- Tourniquet syndrome, hair, 121
- Traction, labial, 62, 88
- Training
  - for first responders, 507-508
  - SANE, 476-477
- Transhymental diameter, 30-32
- Transmission of infection
  - in child
    - HIV, 101-102
    - likelihood of, 96t
    - types of, 94t
  - human papilloma virus, 105
- Transport to hospital
  - by emergency medical personnel, 491-492
  - by police, 510
- Trauma. *See* Injury
- Trauma-bonding, 414
- Trauma model of caregiving, 465
- Trauma theory, 405-425
  - consequences of trauma and, 414-416
    - posttraumatic stress disorder, 415-416
    - substance abuse, 416
  - creating sanctuary and, 423-424
  - dissociation and, 412
  - endorphins and, 413
  - health consequences and, 418-423
    - chronic violence and, 418-419
    - parenting, 421-423
    - prostitution, 419
    - revictimization, 422
    - stress, moods, and immunity, 418
    - victim to victimizer behavior, 420-421
  - heredity and, 407-408
  - learned helplessness and, 408-409
  - memory and stress in, 410-412
  - neurobiologic changes, 417
  - psychological trauma and, 406-407
  - thinking under stress and, 409
  - trauma-bonding in, 414
  - traumatic reenactment in, 414
- Traumatic reenactment, 414
- Traumatic sexualization of child, 11
- Traumatic stress, secondary, 459-460, 467
- Traumatization, vicarious, 459-468. *See also* Vicarious traumatization
- Treatment Advocacy Center, 168
- Treponema pallidum
  - in child, 102-104
    - diagnosis of, 97t
    - transmission of, 94t
    - treatment of, 99t
  - diagnosis and treatment of, 323
  - in pregnancy, 370
  - proctitis caused by, 326
- Treponemal test, 323
- Triage, prehospital, 487
- Trial. *See* Prosecution
- Trichomonas vaginalis*
  - in child, 71t, 104-105
    - diagnosis of, 97t
    - transmission of, 94t
    - treatment of, 99t
  - culture for, 328
  - diagnosis and treatment of, 97t, 323-324
  - drugs for, 321t
- Trigger for autonomic dysreflexia, 160t
- Trust in child sexual abuse, 8
- Truth vs lie, 167



- Tumor  
  hemangioma, 117  
  ovarian, 23  
Turner's syndrome, 23
- U**
- Ulcer  
  in Behçet's disease, 120  
  herpes simplex, 324  
Unallocated space on computer, 554-555  
Unconscious victim  
  DNA analysis and, 277  
  search warrant for, 309-310  
Uncooperative victim, 56  
Unintended pregnancy  
  domestic violence and, 365  
  as public health concern, 214  
United State Department of Justice, 377  
United States Model Penal Code, 211  
Universal precautions  
  in forensic evidence collection, 82  
  against vicarious victimization, 467-468  
Ureter, female, 23  
Urethra  
  bleeding of, 121  
  caruncle of, 23  
  paraurethral cyst, 23  
  prolapse of, 121  
Urethral meatus, definition of, 225t  
Urethral opening, 225t  
Uric acid crystal, 19  
Urinary incontinence in female, 23  
Urinary urgency, 387-388  
Urine, collection and preservation of, 86  
Urogenital groove, 20  
Urogenital injury, nonabusive, 115  
Urologic disorder, 183  
Urorectal septum, 39  
Uterus, 225t  
Uterus/cervix ratio in prepuberty female, 34  
Utterance, excited, 535
- V**
- Vaccination, hepatitis, 327, 331t  
Vagina  
  anatomical variations of, 22  
  in consensual intercourse, 230-231  
  definition of, 225t  
  didelphys, 24  
  elasticity of, 232-233  
  internal examination of, 254  
  of prepubertal child, 93  
  in puberty, 35  
  smear from, in child sexual abuse, 72t  
Vaginal agenesis, 23  
Vaginal atresia, 23  
Vaginal bleeding  
  anogenital injury and, 43  
  in child sexual abuse, 61  
Vaginal discharge  
  bacterial vaginosis causing, 325  
  in child  
    bacterial vaginosis causing, 107  
    in congenital trichomonas, 104-105  
    gonorrhea causing, 101  
  in puberty, 35  
  in trichomoniasis, 323  
Vaginal fluid, in child sexual abuse, 72t  
Vaginal injury, in murdered disabled person, 163  
Vaginal intercourse, serologic evidence in, 264  
Vaginal lubrication, 234-235  
Vaginal procidentia, 22  
Vaginal ridge  
  external, 26  
  longitudinal, definition of, 224t  
Vaginal rugae, 29  
Vaginal swab for antigen determination, 247  
Vaginal wall of older woman, 387  
Vaginitis  
  in differential diagnosis of assault, 117-118  
  trichomoniasis causing, 323-324  
Vaginosis, bacterial, in child, 107-108  
  diagnosis of, 98t  
  treatment of, 100t  
Valacyclovir, 321t  
Valsalva maneuver, varicocele and, 37-38  
Variation, normal anatomical, 113-114  
Varicella, 118-119  
Varicocele, 37-38  
Vasculitis, Kawasaki's, 120  
Vasodilation, 234  
Vasogestation, 234  
Vegetation as evidence, 85t  
Vehicle as crime scene, 498  
Venereal Disease Research Laboratory test, 323  
Venous congestion, 41  
Verbal child, interview with, 87-88  
Verbalized sensory memory, 151  
Verbally based memory, 410  
Vertebral anomaly in disabled homicide victim, 163  
Vertical transmission of HIV in child, 101-102  
Vessel, blood, lubrication and, 234  
Vestibular band, 113  
  periurethral and perihymenal, 29  
Vestibular growth in puberty, 36  
Vestibular sulcus, 29  
Vestibule  
  definition of, 225t  
  in hydrocolpos, 22  
Vicarious traumatization, 459-468  
  causality of, 462-466  
  biological, 462-463  
  moral, spiritual, and philosophical, 464-465  
  organizational, 464  
  psychologic, 463



- social, 463-464
  - definition of, 459-461
  - epidemiology of, 461-462
  - symptoms of, 459
  - treatment of, 466-467
  - universal precautions for, 467-468
- Victim
- of child sexual abuse, 6
    - male, 7-8
  - first responders and, 508-510, 512-513
- Victim assistance programs, 435
- Victimization
- cost of, 213-214
  - posttraumatic stress disorder and, 415
  - as risk factor, 214
- Victimizer, 420-421
- Victimology, 384
- Victim's advocate, 260-261
- Victim's credibility, 263-264
- Victim's response to acquaintance rape, 340-341
- Victim's statement, corroboration of, 525-526
- Videotape
- as electronic record, 208
  - as forensic evidence, 82
  - pornographic, 152
- Violence
- dating, 339-344. *See also* Acquaintance rape
  - against disabled person, 161-162
  - domestic, 347-360. *See also* Domestic violence
  - exposure to, 464
- Violent behavior in assault history, 252
- Violent Crime Control and Law Enforcement Act, 471
- Viral infection
- in child
    - hepatitis B, 108-109
    - herpes simplex, 104
    - human immunodeficiency virus, 101-102
    - human papilloma virus, 105-107
  - hepatitis, 108-109, 327
  - herpes simplex. *See* Herpes simplex virus
  - human immunodeficiency, 101-102, 331-333, 333t
  - human papillomavirus, 105-107, 324-325
- Virilization, 21
- lack of, 18
- Virtual assessment, 202
- Visual documentation in telemedicine, 206
- Visually impaired victim, 153-154
- Voir dire, 556-558
- mentally disabled victim and, 546
- Vulva
- anatomical variations of, 22
  - definition of, 225t
  - lichen sclerosis of, 116
  - smear from, 72t
- Vulvar hematoma, nonabusive, 115
- Vulvovaginitis
- in child, 107-108
  - in differential diagnosis of assault, 117-118
- ## W
- Wambaugh, Joseph, 265
- Warrant, search, 500-501
- Wart, genital
- in child, 105
  - in differential diagnosis of assault, 118
  - in pregnancy, 371
- Weapon
- in assault history, 252
  - of war, rape as, 211-212
- Website, information from, 551-552
- Wet mount preparation, 323
- Whiff test, 328
- White line, Hilton's, 38-39
- White perineum, 41
- Wifely duty, 349t, 350
- Williams syndrome, 163
- Wishful thinking as coping mechanism, 12
- Withdrawal, social, 12-13
- Witness
- to abuse, child as, 365
  - of assault, 495, 496
  - expert, 182, 519-520
    - cross-examination of, 569-570
    - sexual assault nurse examiner as, 558-570
    - successful, 560-563
  - mentally disabled victim and, 547-548
- Women Organized Against Rape program, 440-441
- Wood's Lamp
- DNA analysis and, 278
  - in forensic evaluation, 89
  - guidelines for, 258t
  - for stains on skin, 246
- Work setting strategies to prevent vicarious victimization, 466-467
- Wound
- anogenital, 42-45
  - defensive, in disabled person, 161-162
  - as evidence, 490
- ## X
- X-linked disorder, 18-19
- Xp-mosaic female, 20
- ## Z
- Zidovudine
- as HIV prophylaxis, 256-257
  - for postexposure HIV prophylaxis, 333t
- Zipper entrapment, 115

# Sexual Assault

Victimization Across the Life Span  
A Color Atlas



G.W. Medical Publishing, Inc.  
St. Louis

# Sexual Assault

## Victimization Across the Life Span A Color Atlas

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## FOREWORD

Whether in the pediatric emergency room, the adult sexual assault clinic, the nursing home or even the morgue, high quality photography of visible lesions remains an essential documentation and investigation tool. The value of photographic documentation cannot be overstated. Indeed, all medical providers who evaluate sexual assault victims should be familiar with the basic principles and techniques of clinical photography and should assure adequate photographic documentation of visible lesions. Such images, whether still or video, may be used in court, although less commonly than photographs of physical abuse (sometimes judges and juries have a hard time understanding the significance of, for example, a subtle hymenal tear). Photographs are also important for peer review, peer consultation and teaching. Perhaps most significantly, photographs may allow a second opinion by opposing council experts without subjecting the victim to a repeat examination.

The evolution in photodocumentation techniques in sexual assault has often followed, sometimes paralleled, and even sometimes led the evolution in the medical examination and interpretation of sexual assault injuries. Early published photographs of anogenital trauma were of such poor quality as to be virtually uninterpretable. At the same time clinical interpretation of findings were based on limited empirical research. With the advent of close-up photographic techniques such as 35mm camera macro lenses and colposcopes, the quality of published images increased dramatically. It was as if a shroud had been removed from the eyes of the examiner, who could now finally see and document microtrauma. Unfortunately at that time, the research base for interpreting these new findings was still undeveloped. It has only been in the last several years that well controlled studies, often using close-up photography to collect and analyze data, have clarified what is and what is not trauma. Only now have visualization techniques and interpretive skills found equivalency.

The variety of sexual assault photodocumentation tools in use today is astonishing: 35mm cameras, instant processing cameras, digital cameras, video cameras, colposcopes and most recently specialized stand alone, base mounted cameras. In virtually every case, however, where a new photodocumentation technology has developed, sexual assault documentation has been an afterthought. Close-up 35mm photography was first used in plastic surgery. Colposcopic photography, a combination of magnification, lighting, and photography, was, of course, first developed for gynecologic use. Even the latest trend in stand alone, base mounted, still and video cameras with attached light sources first saw their use in the dental office. Perhaps the next generation of photodocumentation tools—the combination of high quality digital video with high quality digital still imaging suitable for telemedicine consultation—will be developed specifically with the sexual assault victim in mind.

Though not demonstrated in this text, digital photography will soon equal if not exceed 35mm film photography in resolution, ease of use, and cost. Even then, still photography remains potentially limited since still images can easily miss significant findings and in some cases appear to show findings that are not present, all depending on when the shutter is released. Video photography represents still another advance, taking a 2 dimensional image and virtually creating 3 dimensions by recording the entire examination. Perhaps the next version of this text will have CD or web based digital video examples of traumatic findings.

Sexual trauma, whether at age 6 months or at age 60 years, demands the best skills of the best available examiner, the most sensitive and caring approach, and in virtually

all cases the highest quality photodocumentation available. Not only does this text amply illustrate the variety of findings at each age group, but it also illustrates the similarities and differences across the lifespan. This text is a testament to the skill of the many examiners who took these excellent photographs. Discerning readers should come away from viewing these images with a clearer sense of how to document and how to interpret anogenital findings in sexual assault victims of all ages.

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## FOREWORD

Healthcare professionals have a unique opportunity in making a difference in how a victim of sexual assault will assimilate that event into the rest of their lives. The primary purpose of the sexual assault examination by the healthcare professional is to provide for medical diagnosis and treatment. To appropriately provide this care, the professional needs an understanding of the anatomical and physiological changes through the life span and how those changes will effect the observations made in a sexual assault examination.

These observations are important. The examiner needs to keep in mind that observations may be the result of normal development, a result of trauma caused by accident or abuse, or the result of a disease condition. The evidence collection portion of the examination will assist law enforcement in linking the victim, the suspect, the crime scene, and the evidence. Documentation of this portion of the examination is just as important as documenting the history and the physical assessment. The text provides photographic examples of evidence as well as the anatomical observations intertwined in the discussion of the many unique situations in which a sexual assault may occur.

The examiner that is aware of and sensitive to the patient and their response to the examination process will go a long way in beginning the emotional healing process necessary to integrate the events. Giving control back to the victim of rape is therapeutic and should be utilized all through the examination.

This text shows a wide variety of findings and variations that illustrate the observations and histories in sexual assault examinations. It provides a base of observations that sexual assault examiners can utilize as they provide details necessary for the thorough medical forensic examination.

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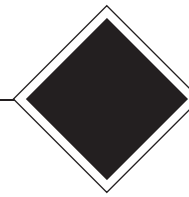
## PREFACE

Moses identified the presence of sex crimes among the Israelites 3500 years ago: “If a man meets a girl and rapes her, the man who has done this shall die” (Deuteronomy 22:25). Accountability was instituted for different situations by death, required marriage, or a fine, but it is not clear how the crime was discovered or evidence established.

Sex crimes still exist today with all the morbidity that they bring to individuals, families and society. However, identifying and documenting the presence of physical injury has helped in corroborating the victim’s history, contributing to the investigation of possible sexual abuse or assault and holding offenders accountable for their crime. The quality of photographic, colposcopic, video and narrative documentation continues to improve. Secured computer programs are being used to transmit photographs for consultation on injury. Crucial research is being conducted into assault injury that continues to support that the presence of injury does not prove assault, nor does the absence of injury prove consent. The interdisciplinary Sexual Assault Response Team (SART) approach with an expert nurse examiner or physician, a sex crimes detective, an advocate, and an experienced, specialized prosecutor has streamlined the process for the victim. Emotional care beginning at the time of the examination has softened the blow and helped to jettison the victim towards recovery. More efficient and better funded DNA profiling at the local, state, and national level is allowing for more timely identification of stranger and serial offenders.

This color atlas complements volume one, *Sexual Assault Victimization Across the Lifespan: A Clinical Guide* as a photographic elaboration including over 1600 photographs arranged by cases of injury, nonassault, and normal findings. The chapters follow the developmental stages of infancy (0–3 years), childhood (4–8 years), preadolescence, Tanner stage 1 (9–12 years), adolescence (13–17 years), adulthood (18–39 years), middle-age (40–64) and the elderly (65 and older). Many of the photographs show Hispanic victims or perpetrators because some of the contributing SARTs are located along the southern border of the United States. This does not imply that victims or sexual predators are more typically Hispanic. The photographs that show ungloved hands were drawn from archived records before gloves became the standard of practice. The adult chapter includes photographs not typically found in a text on sexual abuse or assault: findings following consensual intercourse and findings of the genitalia in the sexually inexperienced female, in females after sexual experience, and after one to multiple vaginal deliveries. This serves as a valuable basis of comparison for assault injury. Cases are presented of victims who were drugged and then raped, victims who were raped and sodomized in prison, as well as cases when DNA was used in the investigation. The goal of the text is to provide better care to victims of sexual violence and to hold offenders accountable to society for their crimes.

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# TABLE OF CONTENTS

---

<b>CHAPTER 1: INFANT SEXUAL ABUSE (0–3 YEARS)</b> . . . . .	1
<b>CHAPTER 2: YOUNG CHILD SEXUAL ABUSE (4–8 YEARS)</b> . . . . .	69
<b>CHAPTER 3: PRE-ADOLESCENT (TANNER STAGE 1) SEXUAL ABUSE (9–12 YEARS)</b> . . . . .	155
<b>CHAPTER 4: ADOLESCENT SEXUAL ABUSE AND ASSAULT (13–17 YEARS)</b> . . . . .	199
<b>CHAPTER 5: ADULT SEXUAL ASSAULT (18–39 YEARS)</b> . . . . .	357
<b>CHAPTER 6: MIDDLE-AGED ADULT SEXUAL ASSAULT (40–64 YEARS)</b> . . . . .	645
<b>CHAPTER 7: ELDERLY SEXUAL ASSAULT (65 AND OLDER)</b> . . . . .	701

---

<b>CHAPTER 1: INFANT SEXUAL ABUSE (0–3 YEARS)</b>	
History of Sexual Abuse . . . . .	2
Acute Findings . . . . .	2
Normal and Nonspecific Findings . . . . .	16
Special Cases . . . . .	30
Males . . . . .	30
Disabled . . . . .	34
Nonassault Variants . . . . .	35
Accidents . . . . .	35
Labial Adhesions . . . . .	38
Foreign Object Penetration . . . . .	40
Infection . . . . .	42
Viral . . . . .	42
Bacterial . . . . .	45
Fungal . . . . .	48
Breech Delivery . . . . .	50
Friable Fourchette . . . . .	50
Scratches . . . . .	51
Urethral Prolapse . . . . .	52
Balinitis . . . . .	52
Constipation . . . . .	53
Normal Findings . . . . .	54
Annular Hymens . . . . .	54
Crescentic Hymens . . . . .	62
Septate Hymen . . . . .	66
Median Raphe Ridge . . . . .	67

<b>CHAPTER 2: YOUNG CHILD SEXUAL ABUSE (4–8 YEARS)</b>	
History of Sexual Abuse . . . . .	71
Acute Findings . . . . .	71
Penile Penetration of the Vagina . . . . .	71
Digital Penetration of the Vagina . . . . .	72



Cunnilingus . . . . .	77
Normal and Nonspecific Findings . . . . .	79
Penile Penetration of the Vagina . . . . .	79
Digital Penetration of the Vagina . . . . .	80
Special Cases . . . . .	89
Males . . . . .	89
Revictimization . . . . .	95
Incest . . . . .	99
Adolescent Perpetrators . . . . .	104
Healing . . . . .	115
Nonassault Variants . . . . .	117
Accidents . . . . .	117
Labial Adhesions . . . . .	122
Infections . . . . .	125
Viral . . . . .	125
Bacterial . . . . .	129
Fungal . . . . .	130
Parasitic . . . . .	131
Friable Fourchette . . . . .	132
Failure to Fuse . . . . .	135
Urethral Prolapse . . . . .	135
Oral Findings . . . . .	136
Anal Findings . . . . .	137
Skin Findings . . . . .	138
Normal Findings . . . . .	140
Hymen . . . . .	140
Annular . . . . .	140
Crescentic . . . . .	145
Septate . . . . .	151
Anus . . . . .	152

**CHAPTER 3: PRE-ADOLESCENT (TANNER STAGE 1)**

**SEXUAL ABUSE (9–12 YEARS)**

History of Sexual Abuse . . . . .	156
Friend of the Family Perpetrator . . . . .	156
Incest . . . . .	164
Incest Involving Multiple Victims . . . . .	176
Adolescent Perpetrator . . . . .	182
Stranger Perpetrator . . . . .	187
Nonassault Variants . . . . .	189
Infection . . . . .	189
Viral . . . . .	189
Bacterial . . . . .	189
Spirochetal . . . . .	190
Parasitic . . . . .	190
Normal Findings . . . . .	191
Varied Examiner Technique . . . . .	191
Hymen . . . . .	193
Annular . . . . .	193
Crescentic . . . . .	194
Sleeve-like . . . . .	195
Redundant . . . . .	196
Septate . . . . .	196
Failure to Fuse . . . . .	197
Anus . . . . .	198

**CHAPTER 4: ADOLESCENT SEXUAL ABUSE  
AND ASSAULT (13–17 YEARS)**

History of Sexual Abuse or Assault . . . . .	201
Penile-Vaginal Penetration . . . . .	201
Characteristics of the Injury . . . . .	201
Acute Findings . . . . .	201
Healing Injury . . . . .	215
Revictimization . . . . .	228
Characteristics of the Victim . . . . .	233
Alcohol-related . . . . .	233
Not Previously Sexually Active . . . . .	236
Stated Bisexual . . . . .	243
Prostitute . . . . .	245
Developmentally Disabled . . . . .	247
Pregnant . . . . .	247
Characteristics of the Assault . . . . .	251
Foreign Object . . . . .	251
Internet-related . . . . .	253
Drug-facilitated . . . . .	258
Characteristics of the Perpetrator . . . . .	262
Incest . . . . .	262
Gang-related . . . . .	270
Multiple Perpetrators . . . . .	271
Adolescent Perpetrators . . . . .	276
Victim and Perpetrator Photodocumentation . . . . .	281
Digital-Vaginal Penetration . . . . .	284
Sodomy . . . . .	287
Fellatio . . . . .	290
General Injuries . . . . .	294
Nonassault Variants . . . . .	300
Consenting Sexual Intercourse . . . . .	300
Previously Sexually Active . . . . .	300
Not Previously Sexually Active . . . . .	318
Skin-Related . . . . .	324
Lichen sclerosus . . . . .	324
Folliculitis . . . . .	325
Scratching . . . . .	325
Accidents . . . . .	326
Labial Adhesions . . . . .	328
Vaginal Ridge . . . . .	329
Cervical Polyp . . . . .	329
Infection . . . . .	330
Viral . . . . .	330
Bacterial . . . . .	332
Fungal . . . . .	333
Normal Findings . . . . .	334
Hymen . . . . .	334
Previously Sexually Active . . . . .	334
Never Sexually Active . . . . .	335
Septate . . . . .	342
Bands . . . . .	343
Labia . . . . .	344
Asymmetrical Labia . . . . .	346
Clitoris . . . . .	348
Vagina . . . . .	349

Cervix . . . . .	350
Anal/Rectal . . . . .	352
Mouth . . . . .	349
<b>CHAPTER 5: ADULT SEXUAL ASSAULT (18-39 YEARS)</b>	
History of Sexual Assault . . . . .	359
Alcohol-Related . . . . .	359
Bites . . . . .	366
Clothing Evidence . . . . .	372
Debris . . . . .	372
Torn or Displaced . . . . .	378
Crime Scene . . . . .	386
Deceased Victims . . . . .	389
Defense Injury . . . . .	394
DNA-Related Cases . . . . .	396
Digital Penetration . . . . .	401
Disabled Victims . . . . .	403
Domestic Violence . . . . .	415
Drug-Facilitated Rape . . . . .	426
Emotionally Disabled Victims . . . . .	430
Foreign Object . . . . .	432
Gay and Lesbian Victims . . . . .	437
Homeless . . . . .	445
Internet-Related Assault . . . . .	449
Male Victims . . . . .	450
Military . . . . .	464
Multiple Perpetrators . . . . .	469
Oral Injury . . . . .	477
Prison Rape . . . . .	485
Psychic Healing . . . . .	488
Revictimization . . . . .	489
Self-Inflicted . . . . .	492
Sexually Inexperienced . . . . .	498
Stranger Perpetrator . . . . .	506
Strangulation . . . . .	520
Suspects . . . . .	525
Trace Evidence . . . . .	537
Victim and Perpetrator . . . . .	539
Nonassault Variants . . . . .	554
Findings in Consenting Intercourse . . . . .	554
Not Previously Sexually Active . . . . .	554
Unknown Previous Sexual Experience . . . . .	557
Previously Sexually Active . . . . .	559
Skin-Related Findings . . . . .	564
Marks on the Neck . . . . .	564
Slash Marks . . . . .	564
Tire Abrasion . . . . .	565
Gunshot Wound . . . . .	565
Poison Oak . . . . .	565
Irritation of the Medial Thighs . . . . .	566
Cesarean Section Scar . . . . .	567
Folliculitis . . . . .	567
Piercings . . . . .	568
Labial and Vaginal Findings . . . . .	570
Folliculitis . . . . .	570

Lichenification . . . . .	570
Crust and Erythema . . . . .	571
Transection of the Labium Minus . . . . .	572
Vulvectomy . . . . .	572
Vaginal Band . . . . .	573
Vaginal Septum . . . . .	573
Post-Hysterectomy . . . . .	573
Cystocele/Rectocele . . . . .	574
Episiotomy . . . . .	574
Post-Speculum Examination . . . . .	576
Breast Findings . . . . .	577
Breast Augmentation Scars . . . . .	577
Birthmark . . . . .	578
Burns . . . . .	578
Breast Reduction Scars . . . . .	579
Nipple Erythema . . . . .	579
Perineum and Perianal Findings . . . . .	580
Skin Irritation . . . . .	580
Hemorrhoid and Perianal Tag . . . . .	581
Perianal Abscess . . . . .	582
Oral Findings . . . . .	582
Infection . . . . .	583
Viral . . . . .	583
Bacterial . . . . .	588
Fungal . . . . .	589
Techniques . . . . .	590
Genital Examination . . . . .	590
Probe/Balloon . . . . .	592
Toluidine Blue Dye . . . . .	596
Photographic Techniques . . . . .	600
Avoiding Pitfalls of Examination . . . . .	604
Normal Findings . . . . .	606
Anatomy of the Female Genitalia . . . . .	606
Tanner Stages in the Female . . . . .	606
Tanner Stage 1 . . . . .	606
Tanner Stage 2 . . . . .	607
Tanner Stage 3 . . . . .	607
Tanner Stage 4 . . . . .	608
Tanner Stage 5 . . . . .	608
Labia Majora . . . . .	609
Clitoral Hood and Clitoris . . . . .	609
Labia Minora . . . . .	610
Vestibule . . . . .	611
Inferior to the Anterior Commissure . . . . .	611
Vestibular Papillations . . . . .	613
Open Bartholin Duct . . . . .	613
Periurethral and Perihymenal Bands . . . . .	614
Hymenal Tag . . . . .	616
Crescentic Hymen . . . . .	617
Tampon Within the Vagina . . . . .	617
Hymens Related to Sexual Experience, Pregnancy, and Number of Vaginal Deliveries . . . . .	618
Sexually Inexperienced Women . . . . .	618
Sexually Experienced Women . . . . .	621
Never Been Pregnant . . . . .	621

Pregnant Once or More, No Vaginal Deliveries . . . . .	625
One Vaginal Delivery . . . . .	627
Two Vaginal Deliveries . . . . .	630
Three Vaginal Deliveries . . . . .	631
Four Vaginal Deliveries . . . . .	632
Five and Six Vaginal Deliveries . . . . .	633
Vaginal Wall . . . . .	634
Cervix . . . . .	636
General Findings . . . . .	636
Intrauterine Device (IUD) String . . . . .	639
Anus and Rectum . . . . .	640
Perianal . . . . .	640
Rectal . . . . .	641
Oral . . . . .	642
Other . . . . .	644
<b>CHAPTER 6: MIDDLE-AGED ADULT SEXUAL ASSAULT (40–64 YEARS)</b>	
History of Sexual Assault . . . . .	647
Characteristics of the Victim . . . . .	647
Alcohol-related . . . . .	647
Homeless . . . . .	652
Developmentally Disabled . . . . .	654
Revictimization . . . . .	657
Characteristics of the Perpetrator . . . . .	666
Acquaintance . . . . .	666
Stranger . . . . .	671
Intimate Partner . . . . .	677
Nonassault Variants . . . . .	689
Consenting Intercourse . . . . .	689
Nevus . . . . .	691
Nabothian Cyst . . . . .	691
Post-Vulvectomy . . . . .	692
Vulvar Dystrophy . . . . .	694
Breasts . . . . .	696
Eyes . . . . .	697
Normal Findings . . . . .	698
Genital . . . . .	698
Anal/Rectal . . . . .	699
<b>CHAPTER 7: ELDERLY SEXUAL ASSAULT (65 AND OLDER)</b>	
History of Sexual Assault . . . . .	702
Nonassault Variants . . . . .	724
Friable Fourchette . . . . .	724
Rectal Polyp . . . . .	724
Normal Findings . . . . .	725
Smooth Vaginal Wall . . . . .	725
Perianal Laxity . . . . .	725

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# Sexual Assault

Victimization Across the Life Span  
A Color Atlas



G.W. Medical Publishing, Inc.  
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# INFANT SEXUAL ABUSE: 0–3 YEARS OLD

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This chapter consists of cases of very young children within the approximate age range of newborn to 3 years. Sexual abuse in this age group often goes unreported. When it is reported, weeks or months may have passed since the abuse occurred. There are rarely conclusive physical findings, even in witnessed abuse, not only because of delays in reporting, but also because the sexual abuse of the young child is more often related to fondling than penetration. When there is acute injury, as would be more likely in attempted penetration of the infant's vagina with the adult penis, it resolves quickly, without significant scarring of the mucous membranes. Nonspecific findings, such as erythema, often resolve even sooner than conclusive findings do. And if parents do notice redness in their child's genital area, they may relate it to diaper irritation or skin tenderness. Because injuries in this age group often go unnoticed or are healed before abuse is reported, a normal medical examination is common in child victims of sexual abuse. This means that there may be no findings to corroborate the history. It is important to note, however, that a normal physical examination does not rule out sexual abuse.

A medical examination should be performed as soon as possible after an abuse is reported, even if weeks or months have passed since the incident. An examination with colposcopy and photodocumentation provides vital evidence for the current report and a baseline for the future. Photodocumentation also helps avoid repeated examinations. If photographs are available, Child Abuse Team members and consulting examiners can discuss the findings without re-traumatizing the child. To accurately interpret the findings, the medical examiner must be familiar not only with the signs of abuse, but also nonassault variants and normal findings.

There are three sections in this chapter: cases with a history of sexual abuse, cases of nonassault variants, and cases of normal findings. Each section includes brief case histories and key photographs. The cases with abuse histories include both females and males, a developmentally disabled female, and an abusive injury that occurred on a surgical scar. Nonassault variants of the genitalia include accidental injury, labial adhesions, injury from foreign object penetration, infection, edema secondary to breech delivery, friable fourchette, and others. Perianal injury from constipation is also shown. The chapter concludes with normal findings in this age group, including annular, crescentic, and septate hymens, and the median raphe.

Most photographs are magnified from 6 to 16x. Those photographs not magnified are listed as 35mm. The designation of body parts as "left" and "right" is from the point of view of the patient, not the examiner.

## HISTORY OF SEXUAL ABUSE

### ACUTE FINDINGS

#### Case Study 1-1

This 5-month-old female was brought to the emergency department the day after the perineal bruises were found by the mother. The day-care provider had sent her home with thick diaper cream completely covering these bruises. The mother noticed the bruises while changing the baby.

**Figure 1-1-a.** 24 hours postassault shows ecchymosis posterior to the labia majora (35mm).

**Figure 1-1-b.** General erythema of the hymen, periurethral area and medial labia minora. She has a patulous urethra.

**Figure 1-1-c.** Five days after the first examination, there is resolution of the erythema.

*Key Point:*  
Examination of the child in the first 24 hours reveals more physical and forensic evidence of assaults than examinations done after this time.



Figure 1-1-a



Figure 1-1-b

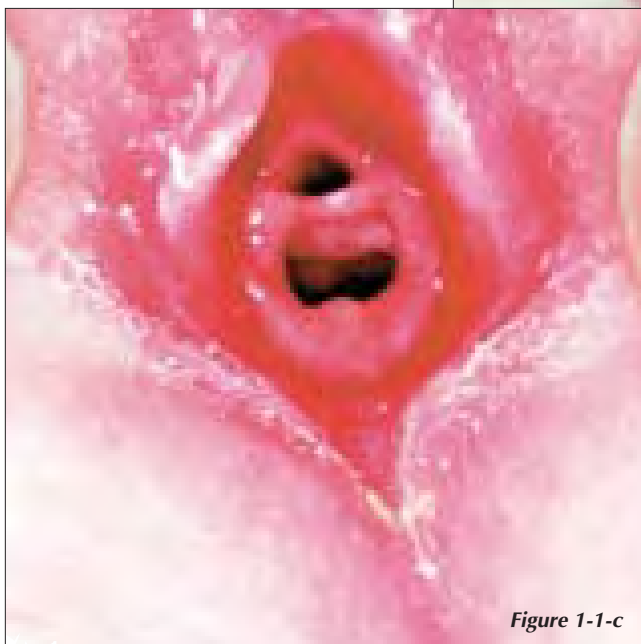


Figure 1-1-c



# YOUNG CHILD SEXUAL ABUSE: 4–8 YEARS OLD

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The young children in this chapter are between the ages of 4 and 8 years. Prepubertal children of this age are usually verbal. If they are victims of sexual abuse, they are generally capable of giving a coherent history of the events that occurred. However, a capable child may not disclose abuse because he or she has been coerced into keeping it a secret. The child may be frightened by the perpetrator's threats to harm the child or a family member if he or she discloses the abuse. As a more pervasive tactic, the perpetrator may have convinced the child that the abuse is a normal activity, so the child may not recognize the behavior as abusive. A young child's eventual disclosure is often delayed until the child can overcome his or her fear of the perpetrator or realizes that abusive behavior is not normal.

Even when a child discloses abuse, there are still hurdles to be overcome in obtaining a history of the event and physical evidence to support that history. The perpetrator is often a relative or trusted family friend who may be more credible than the child in the eyes of the parents or other authority figures. Physical evidence of sexual abuse in this age group is rare because force is seldom used, disclosure and report is typically delayed, and if injury does occur, genital tissues heal quickly, possibly before disclosure or examination. The most common sexual abuse scenarios for 4 to 8-year-old females are genital fondling, digital penetration of the vagina, or forced cunnilingus or fellatio. Sexually abused males in this age group experience forced receptive anal penetration or fellatio of the perpetrator.

The perpetrator is often a relative, an authority figure, or a teenaged acquaintance, particularly those involved in the social or recreational activities of children. Child pornography is frequently associated with child sexual abuse. Disclosure may be prompted by a variety of events. The child may discover that abusive behavior is abnormal and disclose spontaneously. The incident may be witnessed by a sibling or friend of the child or an intimate of the perpetrator, and he or she may report the incident or confront the perpetrator or victim. A care provider, teacher, or adult friend of the family may identify dramatic changes in the victim's behavior, like loss of bladder control, sexualized behavior, increased irritability or distractibility. The care provider may seek medical assessment, which may eventually result in disclosure. Disclosure is judged to be most credible if the child's interview is conducted by a professional specifically trained for this purpose. The story told by the child is the most important evidence in child sexual abuse cases and should not be discredited just because the victim is a child. The physical examination of the female child consists of visual inspection of the entire body including the genitalia. Labial traction is used to visualize the contour of the hymenal rim and perhaps the

## HISTORY OF SEXUAL ABUSE

### ACUTE FINDINGS

#### Digital Penetration of the Vagina

##### Case Study 2-2

This 5-year-old Caucasian was kidnapped from a playground near her apartment by a stranger who put his finger in her vagina one time. She was examined within 48 hours of her abduction.

**Figure 2-2.** There is erythema and edema on the hymen from 1 to 7 o'clock.

The perpetrator pled innocent to charges of abduction and child molestation, but was convicted.



Figure 2-2

##### Case Study 2-3

This 6-year-old Hispanic was fondled by a 31-year-old male cousin and examined within 48 hours.

**Figure 2-3-a.** There is focal erythema of the hymen at 1, 4 and 11 o'clock, visualized using labial traction.

**Figure 2-3-b.** The erythema is evident at 4 o'clock. There is a thin hymenal band attached at 5 and 10 o'clock.



Figure 2-3-a



Figure 2-3-b

# PRE-ADOLESCENT SEXUAL ABUSE: 9–12 YEARS OLD

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This chapter consists of older children who are still Tanner stage 1, within the approximate age range of 9 to 12 years. There are a few cases of children older than 12 years, but they are Tanner stage 1. Cases of incest with multiple victims may include older or younger siblings outside the 9 to 12 age range. They were added here to illustrate the abuse of multiple children in a family. Sexual abuse in this age group is typically ongoing, and the perpetrator is generally a family member or trusted acquaintance. Genital fondling and digital or penile penetration of the vagina are the most common types of sexual abuse of children in this age group. The child is often coerced or bribed by the perpetrator to participate. Stranger abuse is less common, and when it does occur, it is more likely to be associated with physical and genital injury.

Sexually abused children may disclose the abuse to a friend, relative, parent, care provider, teacher or other school official. In some cases, the abuse has been witnessed by others or is reported by school officials. The history given by the child is critical to the investigation, especially since physical findings are rare. Perpetrators will often refrain from full penetration to avoid physically injuring the child in any detectable manner, so if any findings are present, they are generally nonspecific, often erythema or increased vascularity. If there is any injury to be found, an examination for abuse conducted within 72 hours, or as early after the assault as possible, is most likely to identify any injury. The examiner should be trained in child sexual abuse examination techniques. Vaginal speculum examination in the prepubertal child should be avoided if possible, but the vagina may be visualized using the labial traction technique. Visual inspection can be documented with 35mm or colposcopic photographs. The identity of the perpetrator can be confirmed with DNA obtained from ejaculate stains on clothing or saliva from kissing or licking. The nature of the offense may be corroborated if saliva is found on the breasts or genitalia of the victim.

The photographs in this chapter are divided into cases with a history of sexual abuse, cases of nonassault variants, and cases of normal prepubescent findings. Those with a history of sexual abuse have been subdivided by characteristics of the perpetrator, including perpetrators who are friends of the family, cases of incest and incest with multiple victims, adolescent perpetrators and perpetrators who are strangers to the victims. Nonassault variants include viral, bacterial, spirochetal, and parasitic infections. Normal findings include natural hymenal variants and photographs of the anus free of injury.

Most photographs are magnified from 6 to 16x. Those photographs not magnified are listed as 35mm. The designation of body parts as “left” and “right” is from the point of view of the child, not the examiner.

## HISTORY OF SEXUAL ABUSE

### FRIEND OF THE FAMILY PERPETRATOR

#### Case Study 3-1

This 7-year-old African-American female and her sister (Case Study 3-2) were 2 of 5 frequent visitors to a 56-year-old male neighbor. He gave them money for ice cream, took pictures of them “humping” each other, and touched their privates, according to the child’s history.

**Figure 3-1-a.** This is a normal annular hymen with sharp edges. A nevus is noted at the left inferior labium minus. Periurethral bands are also visible.

**Figure 3-1-b.** Mild clitoral erythema is evident. There is a band inferior to the clitoris.

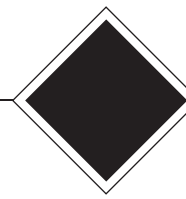
The suspect pled guilty and was sentenced to 18 years in prison and must register as a sex offender.



Figure 3-1-a



Figure 3-1-b



# INDEX

## A

### Abdomen

- burns on, 578
- erythema of, 692
- scratches on, 413
- striae on, 308

### Abduction of young child, 72

### Abortion, 626

### Abrasion

- anal, 649
- at anterior commissure, 682
- appearing as erythema, 268
- on arm, 470
- on back
  - of adolescent, 298
  - in adult, 372, 450, 518
  - in elderly adult, 719, 722
  - in middle-aged adult, 670
- blanching around, 371
- of breast, 421
- of buttocks, 458
- cervical
  - in adult, 434
  - in middle-aged adult, 668, 678
- of cheek, 677
- chemical, 496
- clitoral, in pre adolescent, 187
- of clitoral hood
  - in adult, 427
  - in toddler, 13
- facial
  - in adolescent, 288
  - in adult, 449, 552
- of foot, 663
- on forehead, 295, 658
- on fossa navicularis
  - in adolescent, 227, 283, 318, 322
  - in adult, 360, 409, 430, 464, 473, 502, 507, 540, 562
  - in middle-aged adult, 688
- of hymen, 684
- on knee
  - in adolescent, 272
  - in adult, 430, 449, 544
- labial, 440
  - in adolescent, 240, 285, 307, 317

in adult, 448

in middle-aged adult, 648, 650, 666, 674

in toddler, 9, 13-14

in young child, 107, 109

### on lip

in adolescent, 293

in adult, 481, 517

in middle-aged adult, 658

### of mucous membrane, 311

### on neck, 442

### in outline of bra, 281

### of penis, 454

in adolescent, 288

in adult, 453

### perianal, 462

### perineal

in adolescent, 204

in adult, 563

### periurethral, 311

### of posterior fourchette

in adolescent, 208, 227, 228, 255, 283, 300

in adult, 430, 490, 491, 558, 560, 576

in elderly adult, 720

in middle-aged adult, 648

in young child, 115

### punctate, 90

### of scrotum, 453

### on shoulder, 469

### on thigh, 414

### tire, 565

### on torso, 458

### urethral, 273

### Abscess, perineal, 582

### Accident

in adolescent, 326-327

in infant or toddler, 35-37

in young child, 117-121, 138

### Acquaintance as perpetrator

middle-aged adult as victim, 666-670

pre adolescent as victim, 156-163

### Acrylic nail

intact, 471

pulled off, 680

ripped off, 424

### Adhesion, labial

in adolescent, 328

- in infant, 38
- scarred, 34, 82
- in toddler, 20, 39
- in young child, 77, 84, 123, 124
- Adolescent, 199-355
  - bisexual, 243-244
  - consenting sexual intercourse, 300-323
    - not previously sexually active, 318-323
    - previously sexually active, 300-317
  - digital-vaginal penetration of, 284-286
  - forced fellatio, 290-293
  - general injuries of, 294-299
  - internet-related assault of, 253-257
  - nonassault variants in
    - accident, 326-327
    - infection, 330-333
    - labial adhesions, 328
    - skin-related, 324-325
    - vaginal ridge, 329
  - normal findings
    - anal/rectal, 352-354
    - bands, 343
    - cervix, 350-351
    - clitoris, 348
    - hymen, 334-342
    - labia, 344-347
    - mouth, 355
    - vagina, 349
  - penile-vaginal penetration of, 201-283. *See also* Penile-vaginal penetration
  - as perpetrator
    - adolescent as victim, 276-280
    - pre adolescent as victim, 182-186
    - young child as victim, 104-114
  - sodomy of, 287-289
- Adrenogenital syndrome, 34
- Adult, 357-644
  - alcohol-related assault of, 357-365
  - bite marks on, 366-371, 512, 518, 546, 600
  - clothing evidence of assault, 372-385
    - debris, 372-377
    - torn or displaced, 378-385
  - crime scene and, 386-388
  - deceased, 366, 389-393
  - defense injury in, 394-395
  - digital penetration of, 401-402
  - disabled, 403-414
  - DNA-related case, 396-400
  - domestic violence, 415-425
  - drug-facilitated rape, 426-429
  - emotionally disabled, 430-431
  - foreign object in, 432-436
  - homeless, 445-448
  - internet-related assault of, 449
  - lesbian, 437-441
  - male transvestite, 442-444
  - male victim, 450-463
  - military-related assault, 464-468
  - multiple perpetrators, 469-476
  - nonassault variants in, 554-605
    - breast findings, 577-579
    - consensual intercourse, 554-563
    - cystocele/rectocele, 574
    - episiotomy, 574-576
    - genital examination, 590-605
    - infection, 583-589
    - labial and vaginal findings, 570-573
    - perianal findings, 580-582
    - piercings, 568-569
    - post speculum examination, 576
    - skin-related findings, 564-567
  - normal findings in, 606-644
    - anus and rectum, 640-641
    - breastfeeding, 644
    - cervix, 636-639
    - eye, 644
    - female anatomy, 606
    - hymen, 618-633
    - labia in, 609-610
    - oral, 642-643
    - sperm, 644
    - Tanner stages in female, 606-608
    - vaginal wall, 634-635
    - vestibule in, 611-617
  - oral injury in, 477-484
  - prison rape of, 485-487
  - psychic healing, 488
  - sexually inexperienced, 498-505
  - stranger assault of, 506-519
  - strangulation of, 520-524
  - victim and perpetrator, 539-553
- African-American adolescent
  - alcohol-related assault of, 323
  - clitoral laceration of, 210
  - condyloma acuminata in, 330
  - erythema of fossa navicularis in, 261
  - estrogenized hymen in, 267
  - hymenal erythema in, 217
  - normal perineal area in, 352
  - vascular cervix in, 350
- African-American adult
  - DNA-related case, 398
  - facial edema in, 418
  - foreign body in, 432
  - frenulum in, 642
  - knife injury of, 433
  - protruding clitoris in, 609
  - ridge in, 611
  - torn clothing of, 383
- African-American infant or toddler

- bleeding from dermatitis in, 48
- excoriations on buttocks, 7
- photodocumentation of, 57
- touching of, 26
- African-American pre adolescent
  - friend of family as perpetrator, 156
  - incest victim, 166, 171-173
  - penile-vaginal penetration of, 163
- African-American young child
  - cunnilingus in, 85
  - estrogenized hymen in, 82
  - fondling of, 79
  - intravaginal ridge in, 145
  - labial laceration in, 107
  - parasitic infection in, 131
  - urethral prolapse in, 135
- Aged skin, 724
- Agglutination, 122
- Aging genitalia, 705, 717
- Alcohol-related assault
  - of adolescent, 209, 210, 213, 221, 226, 233-235, 239, 240, 242, 252, 297, 323
    - bisexual, 243-244
    - fellatio and, 292
    - fimbriated hymen in, 239
  - of adult, 357-365, 397, 418, 464, 498, 534
  - of adult male, 450, 456
  - of middle-aged adult, 647-651, 657-658
- Amphetamine in infant, 30
- Ampulla, rectal, stool in
  - in adolescent, 218
  - in pre adolescent, 177
  - of young child, 94
- Anal abrasion, 649
- Anal canal abrasion, 541
- Anal edema, 651
- Anal erythema
  - in adult, 404, 475
  - in middle-aged adult, 647, 651
- Anal fissure, 137
- Anal fold
  - asymmetry of
    - in adolescent, 263
    - in young child, 88, 93, 152
- Anal laceration
  - in adolescent, 216, 261, 273
  - in adult, 362, 404, 407, 412
  - in male toddler, 33
  - in middle-aged adult, 661, 695
  - in young child, 98
- Anal penetration
  - of adolescent, 230, 231
    - bisexual, 243
  - of infant, 5
  - of male toddler, 33
    - of pre adolescent, 178, 179, 186
    - of young child, 94
      - male, 90, 91
- Anal tag
  - in adolescent, 234, 236, 305
  - in elderly adult, 713
  - in middle-aged adult, 700
  - in pre adolescent, 180, 181
- Anal verge
  - in adolescent, 354
  - in adult, 399, 640
  - in deceased victim, 391
  - erythema of
    - in adolescent, 266
    - in adult, 399
  - laceration of, 306
    - in pre adolescent, 198
- Anatomy, normal female genital, 606-608
- Anesthesia, relaxed hymen and, 133
- Angularity of hymen in young child, 103
- Ankle, ligature line on, 497
- Annular hymen
  - in infant or toddler, 7, 24, 27, 54-61
  - in pre adolescent, 156, 193
  - in toddler, 56, 59
  - in young child, 77, 79, 80, 84, 101, 107, 110, 140-144
- Anorexia, 514, 590
- Anoscopy
  - in adolescent, 222, 275, 306, 354
  - in adult, 363, 404, 406, 456, 475, 548, 605, 641
  - in elderly adult, 703
- Anterior commissure
  - abrasion at, 682
  - erythema at
    - in adult, 361, 426, 507
    - in young child, 104
  - ridge inferior to, 611, 612
- Anus
  - blue-gray ring around, 19
  - condyloma acuminata on, 126
  - debris around, 475
  - in deceased victim, 390
  - ecchymosis of, 362
  - edema around, 487
  - erythema of
    - in adolescent, 211, 289
    - in elderly adult, 713
  - focal erythema of, 14
  - general anesthesia and, 133
  - hyperpigmentation of, 236
  - laceration of, in infant, 3
  - laceration superior to, 230, 275
  - normal
    - in adolescent, 218, 232, 234, 243, 263, 315
    - in adult, 640

- in middle-aged adult, 700
  - in preadolescent, 178, 192
  - in young child, 153
  - normal perianal folds in, 26
  - oozing lesion superior to, 217, 287
  - pencil in, 289
  - penetration of. *See* Anal penetration
  - pigmentation around, 152
  - pinworm at, 131, 404
  - relaxed
    - in preadolescent, 181, 198
    - of preadolescent, 159
    - in young child, 85, 88
  - residual dye on, 214
  - shaved, 453
    - in adolescent, 305
  - Arch
    - palatoglossal
      - erythema of, 293, 484
      - vascular pattern on, 451
      - in adult, 643
  - Areola
    - sucking ecchymosis of, 380
    - suture line at, 313
  - Arm
    - abrasion of, 470
    - bite mark on
      - in adult, 368, 600
      - in middle-aged adult, 677
      - in young child, 99
      - in cerebral palsy, 410
    - defense injury of, 677
    - ecchymosis of
      - in adolescent, 243
      - in adult, 372, 516, 517, 543, 545
      - in elderly adult, 719, 722
      - in middle-aged adult, 648, 659, 662, 667, 687, 692
    - erythema of
      - in adolescent, 297
      - in adult, 371
      - handcuffs causing, 399
    - grab mark on, 677
    - previous injury to, 422
    - scar on, 403
    - scratches on
      - in adolescent, 303
      - in adult, 529
    - slash marks on, 243
  - Asian adolescent
    - hymenal contusion in, 221
    - periurethral bands in, 343
    - redundant hymen in, 334, 338
    - rubbing of, 307
  - Asian adult
    - asymmetrical labia in, 610
    - pregnant, 420
  - Asian toddler, touching of, 19
  - Asymmetry
    - of anal folds
      - in adolescent, 263
      - in young child, 152
    - of hymen, 88
    - labial
      - in adolescent, 212, 226, 277, 316, 344, 346, 347
      - in adult, 610
      - in young child, 143
    - of perianal fold, 249
    - of vascular pattern, 80
  - Atrophy
    - cervical, 716
    - of vaginal rugae, 714
  - Augmented breast
    - in adolescent, 313
    - in adult, 577
    - in middle-aged adult, 696
  - Autistic victim, 407, 430
  - Avulsion, 252
  - Axilla, scratches on, 549
- ## B
- Back
    - abrasion of
      - in adolescent, 298
      - in adult, 372, 450, 518
      - in elderly adult, 719, 722
      - in middle-aged adult, 670
    - contusion on, 450
    - erythema of, 297
    - scratches on
      - of adolescent, 296
      - in adult, 529, 545
      - in middle-aged adult, 688
  - Bacterial infection
    - Chlamydia trachomatis*, 332
      - in adolescent, 332
      - in adult, 588
      - in infant, 46
      - in young child, 100
    - Gardnerella vaginalis*. *See* *Gardnerella vaginalis*
    - streptococcal, 129-130
      - in toddler, 45
  - Balanitis, 52
  - Balloon, technique for, 592-593
  - Balloon catheter, 594
  - Band
    - hymenal, 557
      - in adolescent, 340
      - in adult, 614-615



- in young child, 72
- perihymenal
  - in adult, 614-615, 620
  - hymenal tag appearing as, 339
- periuethral
  - in adolescent, 244, 247, 343
  - in adult, 427
  - in preadolescent, 156, 162
  - in toddler, 16, 56
  - in young child, 87, 110, 144
- Bartholin duct, 613
- Base, hymenal, vascular, 150
- Beating
  - of adolescent, 294, 296-299
  - of adult, 517
- Bedroom as crime scene, 386
- Belt, torn, 379, 385
- Belt mark
  - on adolescent, 294, 297
  - on adult, 422
- Birthmark, on breast, 578
- Bisexual adolescent, 243-244
- Bisexual adult male, 461
- Bite mark
  - on arm
    - in adult, 368, 600
    - in middle-aged adult, 677
    - of young child, 99
  - on breast, 425
    - in adult, 369
    - in middle-aged adult, 673, 696
  - on buttocks
    - in adult, 366
    - in infant, 31
  - on chest, 368, 512, 518
  - darkening of, 299
  - on hip, 516
  - on lip, 582
  - on nipple, 518
  - on penis
    - of adult, 546
    - of young child, 94
  - on shoulder, 370
  - on thigh, 369
  - on tongue, 370
- Black fiber in perianal folds, 315
- Black lesion, 708
- Blanching around abrasion, 371
- Bleeding
  - anal, in preadolescent, 186
  - from dermatitis, 48
  - friable fourchette and, 132
  - green filter for photographing, 603
  - of laceration, 219
    - hymenal, 219, 228
    - labial, 447
  - perianal, 503
  - of polyp, 655
  - urethral prolapse and, 52
  - vaginal
    - in toddler, 20
    - in young child, 79, 121
- Blister on hymen, 271
- Blood
  - around mouth, 469
  - on clothing
    - of adolescent, 201
    - blouse, 382
    - cunnilingus and, 13
    - past history of, 27
    - of preadolescent, 182
    - from straddle injury, 35
    - streptococcal infection and, 129
    - touching and, 17
    - vaginal bleeding and, 20
    - in young child, 133
    - of young child, 113
  - on diaper, 3, 8, 47
    - constipation and, 53
    - history of, 38
    - scratches and, 51
    - in straddle injury, 35
  - dried
    - in adult, 400, 407, 449
    - on lip, 543
  - on floor, 71
  - green filter for photographing, 603
  - on hymen, 416
  - on labium minus, 119
  - menstrual
    - in adult, 381, 400, 416, 418, 438, 475
    - from cervical os, 636
    - on hymen, 233
  - oozing. *See* Oozing lesion
  - on underwear
    - of adult, 374, 377
    - dried, 494
    - of middle-aged adult, 656
    - of suspect, 529
  - on urination, 75
  - in venous plexus, 88
- Blood clot, 114, 117
- Blouse
  - blood on, 382
  - torn, 385
- Blue-gray ring around anus, 19
- Blue nevus, 139
- Blue vein, 345
- Bra
  - dirt and debris on, 373

- fastened around buttocks, 413
  - pulled down, 381
  - torn, 380
  - Breast
    - abrasion of, 421
    - augmented
      - in adolescent, 313
      - in adult, 577
      - in middle-aged adult, 696
    - birthmark on, 578
    - bite mark on
      - in adult, 369, 425
      - in middle-aged adult, 673, 696
    - burn on, 578
    - chains beneath, 494
    - ecchymosis of
      - in adolescent, 302
      - in adult, 380, 516
      - in middle-aged adult, 673, 696
    - exposed, 258
    - fondling of, in adolescent, 229
    - healing injury of, 215
    - injury to, in young child, 138
    - in middle-aged adult, 696
    - scratches on, 303
      - of male adult, 553
  - Breastfeeding, 644
  - Breast reduction scar, 579
  - Breech delivery, 50
  - Bridge, hymenal, 28
  - Broken tooth, 450
  - Broom handle, 252
  - Brown hair, kinky, on toddler, 8
  - Burn, on breast, 578
  - Buttock
    - abrasion of, 459
    - bite mark on, 366-367
    - bra fastened around, 413
    - contusion on, 459
    - ecchymosis of, 512
      - in adult, 459
      - in elderly adult, 707
      - of infant, 5
    - erythema of
      - in adolescent, 235
      - from diaper dermatitis, 49
      - in middle-aged adult, 692
    - excoriations on, 7
    - folliculitis on
      - in adolescent, 232
      - in adult, 567
    - gunshot wound of, 565
    - pustule on, 705
    - scrape on, 538
    - scratches on
      - of adolescent, 296
      - in adult, 471
      - stool on, 496
      - tissue between, 535
      - warts on, 43
  - Buttoning of sweater, 379
- ## C
- Can, foot powder, 386
  - Canal, anal, abrasion of, 542
  - Cancer
    - hysterectomy for, 573
    - vulvectomy for, 572
  - Candida albicans*
    - in adolescent, 261, 332, 333
    - in adult, 589
    - diaper dermatitis from, 49
    - in disabled toddler, 34
    - in preadolescent, 185, 190
    - in young child, 130
  - Candleholder as foreign body, 106
  - Canker sore, 652
  - Caries, milk bottle, 136
  - Caruncula, hymenal, 315, 510, 628, 632, 633
    - transection on side of, 334
  - Catheter, balloon, 594
  - Cauliflower lesion, 43
  - Cerebral palsy, 410
  - Cervical bleeding, 396
  - Cervical os
    - in adolescent, 301
    - edema of, 511
    - erythema of, 511
    - erythema superior to, 273
    - eversion at, 561
    - menstrual blood in, 274, 636
    - mucus on, 509, 561
    - open
      - in adolescent, 350, 351
      - in adult, 419, 636
      - in postpartum adolescent, 351
    - postpartum
      - in adolescent, 351
      - in adult, 638
    - purulent discharge from, 511
    - small, 675
    - vascularity around, 163
    - white discharge from, 359
  - Cervical polyp, 329
  - Cervix
    - abrasion of
      - in adult, 434
      - in middle-aged adult, 668, 678
    - after first consensual intercourse, 558
    - contusion of, 221

- debris on, 475  
erythema of  
  in adolescent, 223  
  in middle-aged adult, 677  
healing of, 711  
hypervascularity of, 509  
mucus on  
  in adult, 588  
  in elderly adult, 715  
normal  
  in adolescent, 202, 253, 350  
  in adult, 403  
open, 351  
petechiae of  
  in adult, 388, 493, 604  
  in elderly adult, 716  
  in middle-aged adult, 675  
  in preadolescent, 171  
  vascular pattern on, 301, 332, 350  
Cesarean delivery, 625  
Cesarean section scar, 567  
Chains  
  suspect in, 527, 528-529  
  victim in, 494  
Chancre in preadolescent, 190  
Cheek  
  abrasion of, 677  
  ecchymosis of  
    in adult, 483  
    in middle-aged adult, 670  
  injury to, in preadolescent, 173  
  laceration of, 483  
  scar on, 533  
  scratches on, 469, 516, 543  
  silicone implant in, 442  
Cheesy coating, 652  
Cheesy discharge, 589  
Chemical abrasion, 496  
Chest  
  bite mark on, 368, 518  
  ecchymosis of, 370, 545  
  scratches on  
    in adult, 549  
    in middle-aged adult, 657  
Chin  
  abrasions of, 449  
  scratches on, 517  
*Chlamydia trachomatis*  
  in adolescent, 332  
  in adult, 588  
  in infant, 46  
  in young child, 100  
Choking  
  of adolescent, 281  
  of adult, 369, 446, 521, 523, 524  
Cigarette burn on breast, 578  
Circular hymen, 60  
Clavicle, ecchymosis of, 545  
Cleft  
  in adolescent, 202, 231, 312  
  in adult, 398, 419, 601, 621, 625, 628, 629, 630, 632  
  in preadolescent, 163, 171  
  in young child, 79, 85, 116, 134  
Clipping injury, 478  
Clitoral hood  
  abrasion of, 427  
  blue nevus on, 139  
  clitoris protruding from, 609  
  ecchymosis of, 100, 102  
  edema of, 9, 14  
  erythema of, 571  
    in adolescent, 324  
    in adult, 426  
    in toddler, 17, 20  
    in young child, 111  
  hypertrophy of, 262  
  in infant  
    edema of, 9  
    large, 10  
  laceration of  
    in adolescent, 212, 309  
    in adult, 471  
    in middle-aged adult, 664  
    in preadolescent, 174  
  large  
    in adolescent, 262  
    in infant, 10  
    in toddler, 11  
  normal, of toddler, 25  
  skin breaks lateral to, 325  
Clitoris  
  abrasion inferior to, 187  
  ecchymosis inferior to, 430  
  elongated, 139  
  erythema of  
    in adolescent, 209, 253  
    in elderly adult, 704  
    in preadolescent, 156, 158  
    in young child, 75, 77, 104  
  failure to fuse, 135  
  laceration of  
    in adolescent, 210  
    in adult, 508  
    in elderly adult, 706  
  large, 438  
  normal, 348  
  protruding, 609  
Closed hymen, 242  
Clot, blood, 114, 117  
Clothing. *See also* Underwear

- belted at pubis, 452
- blood on
  - of adolescent, 201
  - cunnilingus and, 13
  - past history of, 27
  - of preadolescent, 182
  - from straddle injury, 35
  - of toddler, 13, 17, 20, 27, 35
  - touching and, 17
  - vaginal bleeding and, 20
- debris on, 372-374, 376, 475
  - vegetative, 467
- dirt on, 279, 323
- grass on, 279, 377
- ripped, 235
- stains on, 375
- straw on, 382
- torn, 378, 383, 384
  - bra, 380
  - shirt, 384, 687
  - underwear, 385
- victim's, 550
- wet, 533
- Wood's lamp examination of, 437
- Coated tongue, 685
- Coating on labium majus, 664
- Coccygeal erythema, iatrogenic, 512
- Collar, neck, 460
- Color of hymen, 80
- Color of nipple, 697
- Colposcopy, 435, 602, 604
  - of soft palate, 643
  - of toddler, 24
- Column, intravaginal, 79
- Columnar epithelium, 636
  - ectropion, 208
- Commissure, anterior
  - abrasion at, 682
  - in adult, 609
  - erythema inferior to, 426
  - erythema of
    - in adult, 361, 507
    - in young child, 104
  - ridge inferior to, 611, 612
- Condom, 440
  - as foreign body, 251, 252
- Condyloma acuminata
  - in adolescent, 315, 330-331, 331
  - in adult, 467, 583-587, 586, 587
  - in infant or toddler, 42-44
  - in young child, 125, 126
- Congestion, venous, 431, 454
  - in adolescent, 265
  - in middle-aged adult, 655
  - in preadolescent, 180, 184, 188
- in young child, 90
- Conjunctiva, palpebral, 644
- Conjunctival hemorrhage, 520
- Conjunctival petechiae in deceased victim, 389
- Consenting sexual intercourse
  - by adolescent
    - not previously sexually active, 318-323
    - previously sexually active, 300-327
  - by adult
    - middle-aged, 689-690
    - not previously sexually active, 554-556
    - previously sexually active, 559-563
    - unknown previous sexual experience, 557-558
- Constipation
  - in infant, 53
  - in toddler, 8
- Contusion
  - on back, 450
  - on buttocks, 459
  - of cervix, 221
  - of eye, 516
  - hymenal
    - in adolescent, 221, 224, 237, 252
    - in young child, 119, 120, 121
- Cord, beating with
  - of adolescent, 296
  - of adult, 362
- Cream, Premarin, 124
- Crescentic hymen
  - in adult, 617
  - in infant or toddler, 21, 22, 34, 62-65
  - in preadolescent, 160, 168, 191, 194
  - in young child, 95, 103, 104, 145-150
- Crime scene, 386-388
- Crotch of trousers, wet, 533
- Cuff
  - hand, 399, 486
    - wrist marks from, 525
  - leg, 486
  - vaginal
    - in middle-aged adult, 683
    - posthysterectomy, 573
- Culture
  - Candida albicans*, 49
    - in preadolescent, 185
  - Chlamydia trachomatis*
    - in adolescent, 332
    - in adult, 588
    - in infant, 46
    - in young child, 100
  - Escherichia coli*, 47
  - Gardnerella vaginalis*. *See Gardnerella vaginalis*
  - Neisseria gonorrhoeae*
    - in male adult, 588
    - in male toddler, 33

- in young child, 130
  - Staphylococcus*, 8
  - Streptococcus*, 46
- Cunnilingus
  - of adult, 401
  - in preadolescent, 187
  - of toddler, 13-14, 26
  - by young child, 89
  - of young child, 77-78, 81, 85
- Cut
  - on arm, 492
  - on back, 518
  - in deceased victim, 389
  - facial, 418
  - on neck, 433
- Cyst
  - nabothian, 313, 691
  - sebaceous, labial, 513
- Cystocele, 574
- D**
- Debris
  - around anus, 476
  - on cervix, 475
  - on clothing, 372, 373, 374, 376
  - fecal, 431
    - in preadolescent, 178
  - on floor, 475
  - on labium minus, 119
  - on perineum of toddler, 27
  - vegetative, 442, 467
- Deceased victim, adult, 366, 389-393
- Deep fold, 96
- Defense injury, 394-395
  - of arm, 677
  - of hand, 518, 544
- Delivery
  - breech, 50
  - vaginal, 627-633
- Dental hygiene, poor, 685
- Denuded skin on buttocks, 7
- Dermatitis
  - diaper, 48, 49
  - perianal, 431
- Developmentally delayed victim
  - adolescent, 247
    - fondling of, 262
    - as incest victim, 262
  - adult, 403-404, 409
    - anal laceration of, 412
    - middle-aged, 654-656
  - preadolescent, 160
    - anal penetration of, 186
    - Gardnerella vaginalis* and, 175
    - incest, 176, 177
      - as incest victim, 175, 177
      - toddler, 11
- Device padlocked to penis, 460
- Diabetes, 206
- Diaper, blood on, 47
  - constipation and, 53
  - history of, 38
  - scratches and, 51
  - in straddle injury, 35
- Diaper dermatitis
  - bleeding from, 48
  - erythema from, 49
  - fissures from, 53
- Diarrhea stool, 570
- Diethylstilbestrol, 613
- Digital contact of preadolescent child, 161
- Digital penetration
  - of adolescent, 209, 230, 231, 284-286
    - incest victim, 264, 266
  - of adult, 401-402, 416
  - of bisexual adolescent, 243
  - of disabled toddler, 34
  - of infant, 5-6, 38
  - of preadolescent, 158-159, 164-166, 169, 172, 175, 179, 181, 189
  - of young child, 74-76, 80-88, 98, 112
    - adolescent perpetrator, 104-105
- Dirt
  - around anus, 476
  - on clothing, 279, 323, 373
  - on hymen, 537
  - on perianal area, 538
- Dirty feet, 671
- Disabled victim, 34. *See also* Developmentally delayed victim
- Discharge
  - in adolescent, 261
  - cheesy, 589
  - in infant, 46
  - normal mucus, 339
  - periurethral, 109
  - physiologic, 264, 350
  - purulent, from cervical os, 511
  - vaginal, in infant, 46
  - white
    - in adolescent, 238, 237, 309, 316, 332, 333, 350
    - in adult, 359, 434
    - in elderly adult, 720
    - in middle-aged adult, 654, 662, 682
    - perineal, 665
    - in preadolescent, 157
    - in young child, 130
  - yellow
    - in adolescent, 202
    - in elderly adult, 716
    - in preadolescent, 175

Divot laceration, 204  
DNA-related case, 396-400, 426  
    hands in plastic bags to preserve, 605  
Documentation, 601  
Domestic violence, 415-425  
Double vaginal orifices  
    in adolescent, 342  
    in adult, 573  
    in toddler, 66  
Down syndrome, 262  
Dried blood, 400, 407, 449, 543  
Dried grass on clothing, 377  
Drug-facilitated assault  
    of adolescent, 258-261  
    of adult, 426-429  
Duct, Bartholin, 613  
Duct tape, 506, 702  
Dystrophy, vulvar, 694  
Dysuria  
    in adolescent, 327  
    in toddler, 27

## E

### Ear

ecchymosis behind, 424, 478  
petechiae behind, 446

### Ecchymosis

anal, 362  
of arm  
    in adolescent, 243  
    in adult, 372, 516, 517, 543, 545  
    in elderly adult, 719, 722  
    in middle-aged adult, 648, 662, 667, 687, 692  
around eye, 502  
on back, 256  
behind ear, 424, 478  
on body of young child, 99  
on breast, 302  
    in adult, 380, 516  
    in middle-aged adult, 673, 696  
    in young child, 138  
on buttock, 512  
of buttocks  
    in adult, 459  
    in elderly adult, 707  
of cheek  
    in adult, 483  
    in middle-aged adult, 670  
of chest, 370, 545  
of clavicle, 545  
of clitoral hood  
    in adult, 427  
    in young child, 100, 102  
in deceased victim, 389  
of eye, 516, 543

facial, 364  
of foot, 470, 497  
of forehead, 658  
of groin, 519  
of hand, 544  
of hip, 443  
hymenal, 209, 225, 252  
    in adolescent, 271, 327  
    in adult, 501  
iatrogenic, 587  
inferior to clitoris, 430  
on knee, 272  
labial  
    in adult, 515  
    in deceased victim, 391  
    in middle-aged adult, 651  
of labium majus, 362  
of leg, 433  
    in adolescent, 298  
    in adult, 512  
    in elderly adult, 712  
of lip, 479  
    in adolescent, 245  
    in adult, 425, 477, 481, 482, 483, 517, 543  
    in middle-aged adult, 658  
    in preadolescent, 173  
of neck  
    in adult, 424, 520, 522, 523  
    in middle-aged adult, 659  
over pubic bone, 100  
over spinal column, 514  
of penis  
    in adult, 546  
    in infant, 31, 32  
    in toddler, 52  
    in young child, 94, 121  
perianal  
    in adolescent, 265  
    in middle-aged adult, 655  
perineal, in infant, 2  
periorbital, 396  
of posterior fourchette, 121, 324  
punctate, 659, 676  
of scapula, 514-515  
scrotal, in infant, 32  
of shoulder  
    in adult, 515  
    in elderly adult, 707  
suction  
    in adolescent, 295, 303, 308  
    in adult, 502, 526  
of thigh  
    in adolescent, 258, 272, 294  
    in adult, 458, 526  
    in middle-aged adult, 650, 671

- in young child, 92
  - of wrist, 543
- Ectropion
  - in adolescent, 313, 329, 350
  - in adult, 636, 638
- Ectropion columnar epithelium, 208
- Edema
  - anal
    - in adolescent, 211
    - in adult, 408, 487
    - in middle-aged adult, 651
  - of cervical os, 511
  - of clitoral hood, 14
  - of eyebrow, 707
  - facial, 418
  - of fossa navicularis, 651
  - of hand, 564
  - of hemorrhoid, 581
  - hymenal, 537
    - in adult, 395
    - in middle-aged adult, 688
    - in young child, 72, 117
  - of hymenal tag, 185
  - labial
    - in adult, 409
    - in elderly adult, 709, 720
    - in toddler, 19
  - of labium majus, 570
  - of lip, 245, 418, 420, 478
  - of nose, 528, 552
  - orbital, 516
  - penile, in infant, 31
  - perianal
    - in adolescent, 265
    - in adult, 362, 363
    - in middle-aged adult, 660
    - in preadolescent, 174, 185
  - periorbital, 396
  - periurethral
    - in toddler, 25
    - in young child, 106
  - of posterior fourchette, 300
- Edentulous adult, 431
- Elbow, ecchymosis of, 667
- Elderly adult, 701-725
  - nonassault variants in, 724-725
  - sexual assault of, 702-723
- Electric cord, beating with, 362
- Elongated clitoris, 139
- Epileptic adult, 407
- Episiotomy scar
  - in adult, 574-576
  - in middle-aged adult, 699
- Epithelium, columnar, 208, 636
- Erythema
  - abrasion appearing as, 268, 560
- anal
  - in adolescent, 222, 289
  - in adult, 404, 408, 476
  - in deceased victim, 391
  - in elderly adult, 713
  - in middle-aged adult, 647, 651
- of anal verge, 266
- at anterior commissure, 104, 361, 507
- of arm
  - in adolescent, 297
  - in adult, 371
- around pustule, 705
- of back, 297
- of buttocks
  - of adolescent, 235
  - in middle-aged adult, 692
- of cervical os, 511
- of cervix
  - in adolescent, 223, 274
  - in middle-aged adult, 677
- clitoral
  - in adolescent, 209, 253
  - in elderly adult, 704
  - in preadolescent, 156, 158
  - in young child, 75, 77
- of clitoral hood, 571
  - in adolescent, 324
  - in adult, 426
  - in toddler, 17, 20
  - in young child, 111
- coccygeal, iatrogenic, 512
- condyloma acuminata and, 586
- diaper dermatitis causing, 49
- of fingernails, 288
- of fossa navicularis, 238
  - in adolescent, 261, 281, 286, 320, 322, 323
  - in adult, 360, 502, 597
  - in elderly adult, 704, 718
  - in middle-aged adult, 673
- generalized, 108
- of palatoglossal arch, 293
- handcuffs causing, 399
- of hard palate, 292
- of hymen, 537
  - in adolescent, 204, 207, 216, 217, 218, 230, 307, 315, 320, 322, 332, 337
  - in adult, 485, 505, 555, 557
  - in elderly adult, 704, 714
  - from fondling, 21
  - in middle-aged adult, 674, 675
  - from penetration by another child, 37
  - in preadolescent, 164, 176, 179
  - of preadolescent, 178
  - straddle injury causing, 36



- in toddler, 47
- in young child, 72, 76, 77, 107, 109
- at hymenal base, 23, 25, 45, 318
- of hymenal perimeter, 16
- of hymenal remnants, 710
- iatrogenic, 353
- infection causing, 127
- on knuckles, 506
- labial, 537
  - in adolescent, 211, 265, 276, 318
  - in adult, 401, 409, 414, 426, 448, 449, 562, 571, 572, 580
  - in deceased victim, 392
  - in elderly adult, 704, 709, 712, 714
  - Gardnerella vaginalis* causing, 129
  - in homicide victim, 602
  - in infant, 46
  - in middle-aged adult, 650, 652, 661
  - in preadolescent, 167
  - in toddler, 13, 17, 20, 23
  - in young child, 105, 108, 112, 120
- of labium majus, 571
  - in elderly adult, 712
- from laceration, 428
- of lip, 652
- of mouth, 657
- of mucous membrane, 290
- of neck, 524
  - in adult, 384, 420, 522, 564
  - in middle-aged adult, 657, 680
- of nipple, 579
- as nonspecific finding in infant, 11
- of palatoglossal arch, 484
- penile, in infant, 30, 32
- perianal
  - in adolescent, 265
  - in adult, 360, 489
  - in infant, 30, 53
  - in male adult, 399
  - in middle-aged adult, 660, 690
  - in preadolescent, 178, 185
  - in toddler, 15
  - in young child, 90
- perineal
  - in adult, 403, 570, 640
  - in middle-aged adult, 650
- periurethral
  - in adolescent, 240, 276
  - in infant, 9
  - in toddler, 26
  - in young child, 77, 102, 106
- of posterior fourchette, 314, 662
  - in adolescent, 279
  - in adult, 421, 492, 493, 562
  - in elderly adult, 718
  - in middle-aged adult, 647, 652, 673, 675, 690
  - in preadolescent, 166
- punctate
  - in adult, 487
  - in infant, 9
  - in preadolescent, 167
  - in young child, 102
- rectal, 656
- resolution of
  - in infant, 2
  - in toddler, 21
- on shoulder, in infant, 31
- of soft palate, 292
  - in adult, 643
- streptococcal infection causing, 129
- superior to cervical os, 273
- of thigh
  - in adult, 570
  - in preadolescent, 187
- urethral, 89
- of vaginal wall, 684, 711
- of vestibule
  - in infant, 4
  - in toddler, 11, 50, 51
- vulvar, 403
- of wrist, 506
- Escherichia coli*, 47
- Estrogen stimulation, 199
- Estrogenized hymen
  - in adolescent, 203, 264, 266, 267, 270, 276, 278, 279, 286, 312, 334, 336
  - in adult, 489
  - in preadolescent, 179
  - in young child, 82
- Eversion at cervical os, 561
- Examination technique
  - in adult, 590-605
  - genital examination, 590-591
  - photographic, 600-603
  - pitfalls of, 604-605
  - in preadolescent, 191-192
  - probe/balloon, 592-595
  - toluidine blue dye, 596-599. *See also* Toluidine blue dye uptake
  - varied, in preadolescent, 191-192
- Excoriation on buttocks, 7
- Extraction of tooth, traumatic, 136
- Eye
  - ecchymosis around, 396, 502, 516, 543
  - scleral hypervascularity in, 697
- Eyebrow
  - edema above, 707
  - gash above, 528
  - shaved, 463



## F

- Face
- abrasion of, 288, 449
    - in adult, 552
    - in elderly adult, 702
    - in middle-aged adult, 658
  - bruises on, 364
  - gash on, 528
  - petechiae on, 520
  - scratches on, 543
- Facial cut, 418
- Facial edema, 418
- Failure to fuse, 135
  - of preadolescent, 197
- Failure to thrive, 31
- Fall by young child, 117
- Fecal debris
  - in adult, 431
  - in preadolescent, 178
- Feet, dirty, 671
- Fellatio, forced
  - adolescent and, 290
  - adult and, 480, 481
  - preadolescent and, 184, 186, 187
  - young child and, 85, 92
- Fiber
  - as evidence, 235
  - in perianal folds, 315
- Filipino child
  - accidental fall by, 119
  - median raphe ridge in, 67
- Filter, photographic, 603
- Fimbriated hymen
  - in adolescent, 229, 235, 239, 247, 278, 286, 304, 320, 338, 339
  - in adult, 619
  - in young child, 82
- Finger, knife wound of, 256, 394
- Fingernail. *See* Nail
- First consensual intercourse
  - by adolescent, 318-323
  - by adult, 554-556
- Fissure
  - anal, 137
  - perianal, in infant, 53
- Flap, hymenal
  - in preadolescent, 170
  - in toddler, 22, 23
- Floor, debris on, 475
- Focal erythema
  - anal, 14
  - of hymen, 72
  - in infant, 32
  - in toddler, 21
- Fold
  - anal
    - asymmetry of, 263
    - in young child, 88, 93
  - deep, 96
  - hymenal
    - in adolescent, 239
    - in adult, 593, 630
  - perianal
    - in adolescent, 249
    - black fiber in, 315
    - in infant, 26, 30
    - laceration of, 90
    - in middle-aged adult, 699
    - in young child, 97, 134
- Follicle
  - on hymen, 230
  - lymphoid, 344
  - prominent, 612
- Folliculitis, 464
  - in adolescent, 325
  - in adult, 567, 570
  - on buttocks
    - in adolescent, 232
    - in adult, 567
  - from shaving, 474, 567, 570
  - of unknown cause, 567
- Follow-up photograph, 15
- Fondling. *See also* Touching
  - of adolescent, 203, 229
    - developmentally delayed, 262
  - of disabled toddler, 34
  - of preadolescent, 164, 171, 179, 185
  - of toddler, 9, 17, 18, 20-21, 22, 25
  - of young child, 72, 74, 79, 81, 87, 89, 95, 97, 105, 122, 124, 132, 146, 148
- Foot
  - abrasion of
    - in adult, 470
    - in middle-aged adult, 663
  - dirty, 671
  - ecchymosis of, 497
  - sand on, 376
- Foot powder can, 386
- Forced fellatio
  - adolescent, 290
  - adult, 480, 481
  - preadolescent, 184, 186
  - young child, 92
- Forearm. *See* Arm
- Forehead
  - abrasion of
    - in adolescent, 288, 295
    - in middle-aged adult, 658
  - scratches on, 543

- Foreign body  
 in adolescent, 224, 251  
 in adult, 432  
 condom as, 252  
 gingerroot as, 460  
 IUD as, 436  
 letter as, 435  
 in toddler, 41  
 in young child, 109
- Foreign body penetration, 40
- Foreskin, ecchymosis on, 52
- Fossa navicularis  
 abrasion of  
 in adolescent, 227, 283, 318, 322  
 in adult, 360, 409, 430, 464, 473, 502, 540, 562  
 in middle-aged adult, 688  
 dye uptake on, 234  
 edema of, 651  
 erythema of  
 in adolescent, 237, 261, 286, 320, 322, 323  
 in adult, 360, 502, 597  
 in elderly adult, 704, 718  
 in middle-aged adult, 673  
 granulation tissue in, 316  
 hymen rolled over, 257  
 laceration of  
 in adolescent, 323, 335  
 in adult, 397, 401  
 in elderly adult, 714  
 in middle-aged adult, 679  
 laceration on  
 in adolescent, 268, 280  
 in adult, 365, 414  
 in infant, 8
- Fourchette  
 friable  
 in infant or toddler, 50-51  
 in young child, 132-134  
 posterior. *See* Posterior fourchette entries
- Fracture, nasal  
 in adolescent, 288  
 in adult, 449
- Fragmented hymen, 315
- Frenulum  
 intact, 290  
 normal, 642  
 split of, 477  
 torn, 253
- Friable area, 324
- Friable fourchette  
 in infant or toddler, 50-51  
 in young child, 132-134
- Friend of family as perpetrator, 156-163
- Fungal infection  
 in adolescent, 332, 333  
 in adult, 589  
 in preadolescent, 185, 190  
 in young child, 130
- Furrow appearing as oozing lesion, 612
- Fuse, failure to  
 in preadolescent, 197  
 in young child, 135
- ## G
- Gang-related assault, 220, 270, 293, 297
- Gaping anus in deceased victim, 390
- Gardnerella vaginalis*  
 in adolescent, 202, 230, 248, 261, 300, 332  
 in middle-aged adult, 654  
 in preadolescent, 163, 166, 171, 175, 181, 189  
 in toddler, 43  
 in young child, 112, 129
- Gash above eyebrow, 528
- Genital bleeding, urethral prolapse and, 52
- Genital tract, double  
 in adolescent, 342  
 in adult, 573  
 in toddler, 66
- Genital wart. *See* Condyloma acuminata
- Genitalia  
 aging, 705, 717  
 normal adult, 364, 606-608  
 sand on, 284, 537
- Gingerroot as foreign body, 460
- Glans penis. *See also* Penis  
 abrasion on, 288  
 ecchymosis of  
 in adult, 546  
 in young child, 94  
 erythema of, in infant, 30
- Globe, hypervascularity around, 697
- Glue from tape, 506
- Gonorrhea, 130
- Grab mark  
 on arm, 677  
 in elderly adult, 719  
 in middle-aged adult, 662
- Graffiti on leg, 297
- Granulating laceration, 574
- Granulation tissue  
 at base of hymen, 4  
 in infant, 4  
 in elderly adult, 711  
 in fossa navicularis, 316  
 on hymen, 318
- Granuloma, 114
- Grass on clothing, 279, 373, 377
- Green filter, photographic, 603
- Green mucus, 47
- Groin, ecchymosis of, 519

- Groove  
 in adult, 611  
 linear, 709  
 vertical, 609
- Group A beta-hemolytic streptococcus, 129
- Gums  
 normal vascular pattern in, 92  
 pigmentation of, 642
- Gunshot wound, 565
- ## H
- Haemophilus influenzae*, 83
- Hair  
 as evidence, 235  
 kinky brown, on infant, 8  
 pubic  
 in elderly adult, 708, 712  
 in middle-aged adult, 650, 698  
 shaved, 308, 567  
 in young child, 86, 112  
 trace evidence in, 603
- Hair piece, 442
- Hand. *See also* Nail  
 in cerebral palsy, 410  
 edema of, 564  
 erythema of, 506, 564  
 knife wound of, 394  
 laceration of, 518  
 ligature line on, 496  
 in plastic bags, 605  
 self-inflicted scratches on, 291
- Handcuffs, 486  
 erythema from, 399  
 hands in plastic bags and, 605  
 wrist marks from, 525
- Hanging, 496
- Hard palate  
 erythema of  
 in adolescent, 292  
 in adult, 643  
 normal, 642  
 petechiae of  
 in adolescent, 261, 291  
 in adult, 480
- Healed puncture, 564
- Healing  
 in adolescent, 215-227, 253  
 of breast, 215  
 of posterior fourchette laceration, 220  
 in adult  
 perianal, 457  
 of tongue, 484  
 urethral, 591  
 of breast, 215  
 of canker sore, 652  
 of cervix, 711  
 of hymenal transection  
 in adolescent, 257  
 in young child, 71  
 of laceration  
 in adolescent, 218, 219, 220, 319  
 in adult, 502  
 anal, 98  
 cervical os, 511  
 labial, 723  
 penile, 183  
 perianal, 457  
 perineal, 405  
 posterior fourchette, 220  
 tongue, 484  
 urethral, 591  
 in young child, 114-116  
 of nasal abrasion, 677  
 in preadolescent, 170  
 psychic, 488  
 in young child, 98  
 of hymen, 118  
 of laceration, 114-115  
 perianal, 93
- Hematoma, 324
- Hemorrhage  
 conjunctival, 520  
 periurethral  
 in middle-aged adult, 666  
 in young child, 78  
 petechial, 74, 75  
 scleral, 445, 697  
 subcutaneous, 710  
 submucosal  
 in adolescent, 237, 271  
 in adult, 413  
 in elderly adult, 716  
 on hymen, 237  
 in young child, 119
- Hemorrhagic area of hymen, 675
- Hemorrhagic urethral prolapse, 716
- Hemorrhagic vesicle, 307
- Hemorrhoid, 454, 488, 581
- Hemorrhoidal tag, 444
- Herpes simplex virus  
 in adolescent, 234, 273, 314  
 in adult, 583  
 dye uptake in, 272, 314  
 in preadolescent, 189  
 in toddler, 42  
 in young child, 127
- Hip  
 bite marks on, 516  
 ecchymosis of, 443  
 scratches of, 531

- tire abrasion on, 565
- Hispanic adolescent
  - asymmetrical labia in, 347
  - continuous hymen in, 341
  - estrogenized hymen in, 203
  - hyperpigmentation in, 345
  - laceration of fossa navicularis in, 268
  - pregnant, 250
  - revictimization of, 230, 231
  - sodomy of, 287
- Hispanic adult
  - continuous hymen in, 615
  - episiotomy scar in, 575
  - pregnant, 413
  - Tanner stage of, 607, 608
- Hispanic infant, clitoral hood edema in, 9
- Hispanic preadolescent
  - fondling of, 185
  - as incest victim, 166, 176, 181
  - periurethral bands in, 162
  - touching of, 157
  - uninterrupted hymen in, 193
  - victim of adolescent perpetrator, 182
  - vulvar contact with, 161
- Hispanic toddler
  - anal penetration of, 33
  - cunnilingus of, 14
  - diaper dermatitis in, 49
  - fondling of, 9
  - posterior fourchette laceration in, 12
  - touching of, 23, 28
- Hispanic young child
  - anal findings in, 137
  - bite mark on, 99
  - cunnilingus of, 77
  - digital penetration of, 72, 86
  - foreign body in, 109
  - labial adhesions in, 124
  - rubbing of, 111
  - streptococcal infection in, 130
  - vaginal bleeding in, 121
- HIV infection, 583
- Homeless victim
  - adult, 445-448
  - middle-aged adult, 652-653
- Homicide victim, adult, 366, 389-393, 602
- Homosexual female, 437-444
- Homosexual male, 463
- Hook of bra, 380
- Human immunodeficiency virus infection, 583
- Human papilloma virus. *See* Condyloma acuminata
- Hygiene, dental, 685
- Hymen. *See also* Hymenal entries
  - abrasion of, 684
  - adhesions hiding, 124
  - after 5 or 6 vaginal deliveries, 633
  - after 4 vaginal deliveries, 632
  - after one vaginal delivery, 627-629
  - after 3 vaginal deliveries, 631
  - anesthesia affecting, 133
  - angularity of, 103
  - annular
    - in infant, 54
    - in toddler, 4, 7, 24, 27, 55, 59
    - in young child, 77, 79, 80, 110
  - asymmetrical, 88
  - blister on, 271
  - blood on, 416
  - caruncula on, 510, 628, 633
  - circular, 61
  - closed, 242
  - color of, 80
  - condyloma acuminata on, 583
  - contusion of, 221, 224
    - in adolescent, 221, 224, 237, 252
    - in young child, 119, 120, 121
  - crescentic
    - in adult, 617
    - in infant or toddler, 21, 22, 34, 62-65
    - in preadolescent, 160, 168, 191, 194
    - in young child, 95, 103, 104, 145-150
  - debris on, 510
  - dirt on, 537
  - ecchymosis of
    - in adolescent, 209, 225, 252, 327
    - in adult, 501
    - in infant, 2
  - edema of, 537
    - in adult, 395
    - in middle-aged adult, 688
  - in elderly adult, 716
  - laceration of, 721
  - erythema of, 537
    - in adolescent, 204, 207, 216, 217, 218, 230, 307, 315, 320, 322, 332, 337
    - in adult, 485, 505, 555, 557
    - in elderly adult, 704, 714
    - in middle-aged adult, 674, 675
    - in preadolescent, 164, 176, 178, 179
    - in toddler, 16, 21, 26, 36
    - in young child, 72, 76, 77, 107, 109
  - estrogenized
    - in adolescent, 203, 264, 266, 267, 270, 276, 278, 279, 286, 312, 334, 336
    - in adult, 489
    - in preadolescent, 179
    - in young child, 82
  - fimbriated
    - in adolescent, 235, 239, 247, 278, 286, 304, 318, 320, 338, 339

- in adult, 619
- fold of, 239, 593
- follicles on, 230
- fragmented, 315
- granulation tissue on
  - in adolescent, 318
  - in infant, 4
- healing of
  - in adolescent, 219, 223
  - in young child, 118
- hemorrhagic area of, 675
- in infant or toddler
  - annular, 54-61
  - crescentic, 22, 62-65
  - erythema of, 21, 23, 25
  - penile penetration, 2-4
  - redundant, 18, 28
  - septate, 66
- laceration of
  - in adolescent, 209, 219, 228-229, 318-319
  - in adult, 501, 505, 554
  - in young child, 115
- menstrual blood on, 233
- in middle-aged adult, 648, 678, 689
  - abrasion of, 683
  - ecchymosis on, 676
  - erythema of, 674
- mound on, 81
- mucus on, 208
- in never been pregnant adult, 621-624
- in never sexually active adolescent, 335-341
- no vaginal delivery and, 625-626
- normal, 45
- open, 213
- papillations around, 613
- petechiae of, 104
- posterior rim of, 86, 95
- in preadolescent
  - annular, 193
  - crescentic, 168, 194
  - redundant, 196
  - septate, 165, 196-197
  - sleeve-like, 195
  - translucent, 162, 168
  - uninterrupted, 161
- in pregnant adolescent, 248
- in previously sexually active adolescent, 334
- punctate ecchymosis of, 676
- redundant
  - in adolescent, 233, 235, 239, 247, 263, 300, 304, 312, 316, 320, 321, 322, 334, 335, 338, 340, 341
  - in adult, 409, 618, 619, 629, 630
  - in middle-aged adult, 647, 678
  - in preadolescent, 247
  - in toddler, 18, 20, 28, 55, 56, 58, 59, 60, 62, 64
  - in young child, 110
- relaxed, 57
- rolled, 257, 336
- scalloped, 336
- septate
  - in adolescent, 342
  - in infant or toddler, 66
  - in preadolescent, 165, 196-197
  - in toddler, 66
- in sexually inexperienced adult, 618-620
- sleeve-like
  - in adolescent, 262, 335
  - in infant, 54
  - in toddler, 18, 24, 55
- submucosal hemorrhage on, 237, 413
- tears of, 17
- thick, 23
- thin
  - in adolescent, 249
  - in young child, 86
- three-leaf-clover-like, 337
- transection of, 121
  - in adolescent, 205, 206, 219, 220, 224, 225, 227, 231, 233, 243, 253, 254, 257, 271, 331, 334
  - in adult, 625, 631, 632
  - in deceased victim, 392, 393
  - healing, 71, 229
  - in pregnant adolescent, 250
  - in young child, 100
- translucent, 162, 168
- transparent, 262
- two vaginal deliveries and, 630
- uninterrupted
  - in adolescent, 208, 232, 260, 280, 304, 340, 344
  - in adult, 615, 621
  - in preadolescent, 161, 172, 193
  - in pregnant preadolescent, 247
  - in toddler, 21
  - in young child, 105, 147, 148
- vascular pattern of. *See* Vascular pattern, hymenal
- white discharge on, 333
- in young child
  - angularity of, 103
  - annular, 140-144
  - crescentic, 145-150
  - septate, 151
- Hymenal band, 557
  - in adolescent, 340
  - in adult, 614-615, 620
  - in young child, 72
- Hymenal base
  - erythema of
    - in adolescent, 318
    - in toddler, 23, 25, 45
  - vascular, 150

Hymenal bridge, 28  
Hymenal cleft. *See* Cleft  
Hymenal edge  
    irregular, 109  
    thick, 158  
    translucent, 169  
Hymenal flap  
    in preadolescent, 170  
    in toddler, 22, 23  
Hymenal fold, 630  
Hymenal orifice in preadolescent, 165  
Hymenal remnant  
    in adult, 474, 631, 633  
    in elderly adult, 709, 710  
Hymenal rim  
    narrowed, 79, 85  
    posterior, 242  
    in preadolescent, 191, 192  
    translucent, 149  
Hymenal tag, 616  
    in adolescent, 209, 244, 265, 278, 337  
    in adult, 616  
    appearing as perihymenal band, 339  
    in elderly adult, 713, 720  
    in infant or toddler, 17, 29  
    in middle-aged adult, 688  
    in preadolescent, 185, 196  
    in young child, 76  
Hymenal tear, 206  
Hymenal wing, 29  
Hyperpigmentation  
    in adolescent, 236  
    labial, 489  
    at labial-thigh crease, 344  
    of penis, 527  
    perianal, 443, 535  
        in elderly adult, 702  
        in middle-aged adult, 699  
        in young child, 96, 100  
    perineal  
        in adolescent, 345  
        in adult, 474  
        in middle-aged adult, 663  
        in preadolescent, 172  
    skin thickening and, 580  
    of thigh  
        in adult, 566  
        in middle-aged adult, 663  
    in young child, 138  
Hypertrophy of clitoral hood, 261  
Hypervascularity  
    of cervix, 509  
    of periurethral area, 74  
    scleral, 697  
Hypopigmentation, 324

Hysterectomy, 635  
    for cancer, 573

## I

Iatrogenic injury  
    ecchymosis, 587  
    erythema, 353  
    photograph to rule out, 12  
    in young child, 134  
Implant  
    in breast  
        in adolescent, 313  
        in adult, 577  
        in middle-aged adult, 696  
    in cheek, 442  
Incest  
    of adolescent, 203, 262-269  
        pregnancy and, 250  
    of preadolescent, 156-163  
    of young child, 99-103  
Indian adolescent, touching of, 325  
Infant or toddler, 2-67  
    accidents in, 35-37  
    acute findings in, 2-15  
        anal erythema, 14-15  
        anal penetration, 5-6  
        edema of clitoral hood, 9  
        erythema of clitoral hood and vestibule, 10  
        excoriations on buttocks, 7  
        labial erythema, 16  
        labial lacerations, 13  
        large clitoral hood in, 11  
        penile penetration, 2-4  
        perineal lacerations, 8  
        posterior fourchette lacerations, 12-15  
    foreign body penetration in, 40-41  
    infection in  
        bacterial, 45-47  
        fungal, 48-49  
        friable fourchette, 50-51  
        infection, 42-49  
        labial adhesions, 38-39  
        scratches, 51  
        urethral prolapse, 52  
    normal or nonspecific findings in, 18-29  
        anus, 19  
        blood in underwear, 27  
        clitoral hood, erythema at, 17, 20  
        crescentic hymen in, 22  
        erythema of fossa navicularis, 18  
        of fondling, 18, 20, 22  
        hymenal erythema, 16, 21, 23, 25  
        hymenal tag, 17, 29  
        periurethral erythema, 25, 26  
        redundant hymen, 18, 28

- reported vaginal bleeding, 20
  - sexual acting out, 24
  - special case
    - anal penetration of male, 33
    - bite marks on buttocks of male, 31
    - disabled, 34
    - ecchymosis of penis, 31, 32
    - male, 30-33
    - sperm in urine of, 27
  - Infection
    - in adolescent
      - bacterial, 202, 332
      - viral, 272, 315, 330-331
    - in adult, 583-589
      - bacterial, 588
      - fungal, 589
      - viral, 583-587
    - bacterial
      - in adolescent, 202, 332
      - in adult, 588
      - in infant or toddler, 45-47
      - in young child, 130
    - Candida albicans*
      - in adolescent, 261, 332, 333
      - in adult, 589
      - diaper dermatitis from, 49
      - in disabled toddler, 34
      - in preadolescent, 185, 190
      - in young child, 130
    - Chlamydia trachomatis*, 100
      - in adolescent, 332
      - in adult, 588
      - in infant, 46
      - in young child, 100
    - fungal
      - in adolescent, 238
      - in adult, 589
      - in infant or toddler, 48
    - Gardnerella vaginalis*. *See Gardnerella vaginalis*
    - in middle-aged adult, 654
    - parasitic, 131
    - in preadolescent
      - spirochetal, 190
      - viral, 189
    - spirochetal, 190
    - staphylococcal
      - in infant, 8
      - in toddler, 45
    - viral
      - in adolescent, 272, 315, 330-331
      - in adult, 583-587
      - condyloma acuminata. *See Condyloma acuminata*
      - herpes simplex. *See Herpes simplex virus*
      - HIV, 583
      - in infant or toddler, 42-44
      - in preadolescent, 189
      - in toddler, 42, 43
      - in young child, 89, 125-128
  - Injury, general
    - to arm, 421
    - beating
      - of adolescent, 294-299
      - of adult, 517
    - from belt, 294, 297, 422
    - clapping, 478
    - defense, 394-395
    - iatrogenic, 132, 134
      - ecchymosis, 587
      - erythema, 353
      - photograph to rule out, 12
      - in young child, 132, 134
    - self-inflicted. *See Self-inflicted injury*
    - straddle, 35
      - in adolescent, 327
      - in toddler, 35
    - wrist, 213
  - Insignia, military, 532
  - Internet-related assault
    - of adolescent, 253-257
    - of adult, 449
  - Intimate partner assault, 677-688
  - Intrauterine device string, 436, 639
  - Intravaginal column, 79, 143
  - Intravaginal ridge
    - in preadolescent, 158, 166, 168, 197
    - in toddler, 22
    - in young child, 111, 141, 145
  - Intravaginal tag, 349
  - Introitus, herpes simplex virus on, 127
  - irregular hymenal edge, 109
  - Irritation, skin, 580
  - IUD string, 436, 639
- ## J
- Jacket, debris on, 475
  - Jail-related assault
    - of female, 485, 493
    - of male, 398-399
- ## K
- Kinky brown hair on infant, 8
  - Knee
    - abrasion of, 430
      - in adolescent, 272
      - in adult, 449, 470, 544
    - scratches on, 474
  - Knife, 387
  - Knife wound
    - in deceased victim, 393
    - defense, 394



on finger, 256  
 on hand, 433  
 on neck, 270

## L

### Labial adhesion

in adolescent, 328  
 in infant, 38  
 scarred  
     in disabled toddler, 34  
     in young child, 82  
 in toddler, 20, 39  
 in young child, 77, 84, 123, 124

### Labial separation technique, 590-591

### Labial-thigh crease, hyperpigmentation at, 344

### Labial traction

technique of, 591  
 in young child, injury related to, 132

### Labium, shaved

in adolescent, 347  
 in adult, 427

### Labium majus

abrasion of, 307  
 coating on, 664  
 ecchymosis of  
     in adolescent, 327  
     in adult, 362  
     in infant, 2  
     in young child, 100  
 edema of, 570  
 erythema of, 571  
     from diaper dermatitis, 49  
     in elderly adult, 712  
     in middle-aged adult, 650  
 folliculitis of, 325  
 herpes simplex lesion on, 42, 127  
 hyperpigmentation of, 138  
 laceration of  
     in adolescent, 269  
     in adult, 360  
     in deceased victim, 391  
     in toddler, 37  
 lichenification of, 570  
 nevus on, 609  
 sagging  
     in elderly adult, 705  
     in middle-aged adult, 660, 698  
 shaved, 320

### Labium minus

abrasion of, 440  
     in adolescent, 240, 285, 307, 317  
     in adult, 448  
     in middle-aged adult, 648, 666, 674  
 asymmetrical, 212, 226, 277, 316, 344, 346, 347  
 black lesion on, 708

cheesy coating over, 652  
 condyloma acuminata on, 583, 584, 586

### ecchymosis of

in adolescent, 327  
 in adult, 515  
 in deceased victim, 391  
 in middle-aged adult, 651

### edema of

in elderly adult, 709, 720  
 in toddler, 9, 19

### erythema of, 537

in adolescent, 211, 276, 318  
 in adult, 401, 414, 426, 448, 449, 562, 571, 572, 580  
 in deceased victim, 392  
 in elderly adult, 704, 709, 712, 714  
 in homicide victim, 602  
 in infant, 46  
 in middle-aged adult, 650, 652, 657, 661  
 in preadolescent, 167  
 in toddler, 17, 20, 23, 26, 36, 47  
 in young child, 105, 108, 112, 120

### *Gardnerella vaginalis* and, 129

### healing of, 15

### herpes simplex lesion on, 127

### hyperpigmentation of, 489

### intact, 321

### laceration of

in adolescent, 206, 207, 212, 215, 240, 246, 264  
 in adult, 409, 447, 485, 513, 519, 549  
 in disabled toddler, 34  
 in elderly adult, 720, 721, 723  
 by foreign body, 435  
 in middle-aged adult, 683, 686  
 in toddler, 19  
 in young child, 73, 76, 107

### large, 610

### mucus, blood, and debris on, 119

### nevus on

in preadolescent, 156  
 in young child, 143

### normal, of toddler, 25

### oozing lesion of, 508

### petechiae of, 668

### pigmentation of, 346

### sebaceous cyst of, 513

### submucosal hemorrhage of, 666

### transection of, 572

### underdeveloped, 610

### vascular pattern of, 80

## Laceration

### anal

in adolescent, 216, 273  
 in adult, 362, 404, 407, 412  
 in male toddler, 33



- in middle-aged adult, 661, 695
    - in young child, 98
  - of anal verge, 306
  - of cheek, 483
  - clitoral, 706
    - in adolescent, 210
    - in adult, 508
  - of clitoral hood
    - in adolescent, 212, 309
    - in adult, 471
    - in middle-aged adult, 664
    - in preadolescent, 174
  - divot, 204
  - erythema from, 428
  - of fossa navicularis
    - in adolescent, 268, 280, 323, 335
    - in adult, 365, 397, 401, 414
    - in elderly adult, 714
    - in middle-aged adult, 679
  - granulating, 574
  - of hand, 518
  - healing
    - in adolescent, 219, 220
    - in adult, 502
    - of cervical os, 511
    - in preadolescent, 170
  - hymenal, 501, 505
    - in adolescent, 209, 219, 228
    - in young child, 115, 117
  - labial
    - in adolescent, 206, 207, 212, 215, 240, 246, 259, 264
    - in adult, 409, 447, 485, 513, 519, 549
    - in deceased victim, 391
    - in elderly adult, 720, 721, 723
    - by foreign body, 435
    - in middle-aged adult, 683, 686
    - in toddler, 19, 34, 37
    - in young child, 73, 76, 107
  - on labial adhesion, 328
  - of labium majus
    - in adolescent, 269
    - in adult, 360
  - of lip
    - in adolescent, 294
    - in adult, 420, 481, 482, 531
  - on mons pubis, 694
  - mucosal, 452
  - penile, of perpetrator, 183
  - perianal
    - in adolescent, 222, 223, 265
    - in adult, 363, 374, 417, 422, 451, 456, 463, 495, 499, 502, 541, 548
    - healing, 457
    - healing of, 93
  - in infant, 5, 6
    - in middle-aged adult, 668
    - in preadolescent, 188
    - in toddler, 7
    - in young child, 91
  - of perianal fold, 90
  - perineal
    - in adolescent, 241, 275, 276, 286, 305
    - in adult, 361, 415, 466, 487, 563, 598, 599
    - in elderly adult, 702
    - healing of, 405
    - in middle-aged adult, 649
  - of posterior fourchette. *See* Posterior fourchette
  - laceration
    - in preadolescent, 175
    - psychic healing of, 488
  - rectal, 548, 605
  - of scalp, 517
  - superior to anus, 230, 275
  - of tongue, 484
  - vaginal, 71
  - of vermillion border, 477
  - in young child, 133
- Lacy vascular pattern, hymenal
- in toddler, 21, 23, 24, 63
  - in young child, 95
- Large clitoral hood
- in adolescent, 261
  - in infant, 10, 11
  - in toddler, 10
- Large labium minus, 610
- Leg
- in cerebral palsy, 410
  - ecchymosis of, 433
    - in adolescent, 298
    - in adult, 512
    - in elderly adult, 712
  - erythema of, 692
  - graffiti on, 297
  - knife wound of, 395
  - scratches on
    - of adolescent, 296
    - in adult, 474
  - whip mark on, 458
- Leg chain, 527
- Leg cuffs, 486
- Lesbian victim, 437-444
- Letter as foreign body, 435
- Lichen sclerosis
- in adolescent, 324
  - in elderly adult, 717-718
- Lichenification
- in adult, 570
  - in young child, 138

- Ligature line
  - on ankle, 497
  - on hand, 496
  - on neck, 446
- Ligature mark, on neck, 523
- Linear groove, 709
- Lip
  - abrasion of
    - in adolescent, 293
    - in adult, 481, 517
    - in middle-aged adult, 658
  - bite marks on, 582
  - chancre on, 190
  - dried blood on, 543
  - ecchymosis of
    - in adolescent, 246
    - in adult, 425, 477, 478, 482, 483, 517, 543
  - edema of, 418, 420, 478
  - erythema of, 652
  - injury to, in preadolescent, 173
  - laceration of
    - in adolescent, 294
    - in adult, 420, 481
  - petechiae of, 482
  - swelling of, 245
  - vascularization of, 290
  - viral lesions on, 89
- Lips, laceration of, 531
- Longitudinal intravaginal ridge, of preadolescent, 158
- Longitudinal ridge, intravaginal, 22
- Lymphoid follicle, 344
- M**
- Maceration, 708
- Macular lesion
  - in infant, 53
  - perianal, 89
- Magnification, 598, 602
- Male adolescent
  - general injuries of, 298
  - sodomy of, 287-289
- Male adult, 450-463
  - anal laceration in, 407-408
  - broken tooth of, 450
  - deceased, 393
  - disabled, 407-408
  - DNA-related case, 398-399
  - emotionally disabled, 431
  - healing perianal laceration in, 451
  - jail-related assault, 398-399
  - middle-aged, 656
  - in military, 467
  - mucosal laceration in, 452
  - Neisseria gonorrhoeae* in, 588
  - normal perianal tissue in, 455
  - penile abrasion in, 453-454
  - perianal abrasion in, 462
  - perianal laceration in, 456, 457
  - rubbing erythema of, 580
  - shaved pubic hair in, 527
  - of strangulation, 522
  - as suspect, 525-536
  - transvestite, 442-444
  - whip marks on, 458
- Male infant or toddler
  - anal penetration of, 33
  - balanitis in, 52
  - bite marks on, 31
  - ecchymosis of penis, 31, 32
  - erythema of glans penis in, 30
  - excoriations on buttocks, 7
  - median raphe in, 33
  - Neisseria gonorrhoeae* in, 33
- Male preadolescent
  - anal penetration of, 184, 185
  - fellatio by, 185
  - incest and, 178
  - penile-anal penetration of, 184
- Male young child
  - anal penetration of, 90
  - bite on penis, 94
  - fondling and cunnilingus, 89
  - forced sodomy, fellatio, and masturbation, 92-93
  - penile-anal penetration of, 90, 91
  - toilet seat falling on penis of, 121
  - viral infection in, 125-128
- Masturbation by young child, 92
- Median raphe, 152
  - in male toddler, 33
  - normal, 326
- Median raphe ridge
  - in preadolescent, 186
  - in toddler, 19, 67
  - in young child, 89, 153
- Membrane, mucous
  - abrasion of, 311
  - erythema of, 290
- Menstrual blood
  - in adult, 381, 400, 416, 418, 438, 475
  - in cervical os, 274, 636
  - on hymen, 233
- Middle-aged adult, 645-700
  - acquaintance as perpetrator, 666-670
  - alcohol-related assault of, 647-651
  - consenting intercourse, 689-690
  - developmentally disabled, 654-656
  - homeless, 652-653
  - intimate partner assault of, 677-688
  - nonassault variants
    - anal/rectal, 699

- breasts, 696
- eyes, 697
- genital, 698
- nevus, 691
- postvulvectomy, 692-693
- vulvar dystrophy, 694-695
- revictimization of, 657-665
- Military insignia, 532
- Military-related assault, 464-468
- Milk bottle caries, 136
- Molluscum contagiosum, 44
- Mongolian spot, 138
- Mons pubis
  - folliculitis of, 325
  - laceration of, 694
  - partially shaved, 513
  - shaved
    - in adolescent, 347
    - in adult, 426, 621
- shaving of, 474
- Mound
  - in adolescent, 230
  - hymenal, 21
  - in preadolescent, 157, 159, 160, 166, 176, 182, 194
  - in toddler, 58, 65
  - in young child, 81, 85, 87, 103, 107, 109, 110, 134, 140, 150
- Mouth. *See also* Oral findings
  - erythema of, 657
  - healing laceration of, 502
  - penile penetration of, 480
- Mucosa
  - rectal, normal, 462
  - viral lesions on, 89
- Mucosal laceration, 452
- Mucous discharge, normal, 339
- Mucous membrane
  - abrasion of, 311
  - erythema of, 290
- Mucus
  - on cervical os, 351, 509, 561
  - on cervix
    - in adult, 588
    - in elderly adult, 714
  - green, 47
  - on labium minus, 119
  - near hymen, 208
  - white, 40
- Multiple perpetrators
  - adolescent victim of, 271-275
  - adult victims of, 469-476
  - gang-related, 220, 270, 293, 297
- Multiple posterior fourchette lacerations, 226
- Multiple sclerosis, 414
- Multiple victims of incest, 176-181
- Murder victim, 366, 389-393
  - adult, 602
- Muscle wasting, 461
  - in anorexia, 514
  - in HIV infection, 461
  - in multiple sclerosis, 414
- N**
- Nabothian cyst, 313, 691
- Nail
  - acrylic, 471
    - intact, 471
    - pulled off, 680
    - ripped off, 424
  - broken, 415
  - erythema of, 288
  - intact, 547
  - torn, 364
  - of transvestite, 443
- Nail scratches, 420
- Nares, healing abrasion of, 677
- Narrowed hymenal rim, 79, 85
- Nasal fracture
  - in adolescent, 288
  - in adult, 449
- Neck
  - abrasion of, 442
  - choking and
    - of adolescent, 281
    - of adult, 369
  - cut on, 433
  - ecchymosis of
    - in adult, 424, 520, 522, 523
    - in deceased victim, 389
    - in middle-aged adult, 659
  - erythema of
    - in adult, 384, 420, 522, 524
    - in middle-aged adult, 657, 680
  - injury to, 299
  - knife wound of, 395
    - in deceased victim, 393
  - ligature marks on, 446, 523
  - marks on, 564
  - scratches on, 687
  - suction ecchymosis on, 308, 526
    - in adolescent, 303
- Neck collar, 460
- Neisseria gonorrhoeae*
  - in male adult, 588
  - in male toddler, 33
  - in young child, 130
- Nevus
  - in adolescent, 266, 326, 349
  - in adult, 362
    - HIV-positive, 461

- labial, 609
- perianal, 465
- blue, 139
- in elderly adult, 702
- in preadolescent, 156
- in young child, 139, 143
- Nipple
  - bite marks on, 518, 696
  - color of, 697
  - erythema of, 579
  - pierced, 569
  - suck injury to, 579
- Nodule on vaginal wall, 653
- Nonassault variant
  - in adolescent, 324-333
  - in adult, 554-605
  - in elderly adult, 724-725
  - in infant or toddler, 35-52
  - in middle-aged adult, 691-699
  - in young child, 117-139
- Normal anatomy in adult, 606-608
- Normal anus
  - in adolescent, 218, 263
    - bisexual, 243
  - in adult, 640
  - in middle-aged adult, 700
  - in preadolescent, 178, 192
  - in young child, 153
- Normal cervix
  - in adolescent, 253, 350
  - in adult, 403
- Normal examination
  - of toddler, 24, 65
    - with history of touching, 16
    - with history of vaginal bleeding, 20
  - of young child, 97
- Normal genitalia, 364
- Normal hard palate, 642
- Normal mouth, 355
- Normal perineal area, 352
- Nose
  - edema of, 528
    - in adult, 552
  - healing abrasion of, 677
- Notch
  - of preadolescent, 159
  - in toddler, 22, 58, 60
- O**
- Oozing lesion
  - in adolescent, 217, 227, 246, 287, 300-301, 314
    - on penis, 326
  - in adult, 464
    - on fossa navicularis, 414
  - from anus, 489
    - in elderly adult, 721
    - furrow as, 612
    - in infant, 48
    - labial, 508
    - laceration, 440
    - of lip, 482
    - perianal, 548
    - perineal, 487
    - polyp, 655
    - in toddler, 14
    - in young child, 71
- Open anus in deceased victim, 390
- Open Bartholin duct, 613
- Open cervical os
  - in adolescent, 350
  - in adult, 419, 636
  - in postpartum adolescent, 351
- Open cervix, 351
- Open hymen, 213
- Oral findings
  - in adolescent, 245
    - fellatio causing, 302
    - forced fellatio causing, 290-293
    - laceration, 294
    - normal, 355
  - in adult, 418, 420, 425, 450-452, 469, 477-484, 502, 517, 582
    - normal, 642-643
    - on suspect, 531
  - blood around mouth, 469
  - in middle-aged adult, 652, 658, 685
  - in preadolescent, 161, 173
  - in young child, 136
- Orbital edema, 516
- Orifice
  - hymenal, in preadolescent, 165
  - vaginal
    - in adult, 572
    - condom in, 251
    - double, 342
    - green mucus in, 47
    - in preadolescent, 193
- Os, cervical. *See* Cervical os
- P**
- Padlocked device, penile, 460
- Pain, perineal, 327
- Painful urination, 27
- Palate
  - hard
    - in adult, 642
    - erythema of, 292, 643
    - petechiae of, 261, 291, 480
  - soft
    - in adult, 643

- erythema of, 292
- petechiae of, 302
- Palatoglossal arch
  - in adult, 643
  - erythema of, 293, 484
  - vascular pattern on, 451
- Pale hymen, 80
- Palpebral conjunctiva, 643
- Papillations, vestibular, 613
- Papular lesion, 89, 127
- Parasitic infection, pinworms, 96, 131
- Partial laceration of hymen, 118
- Partial tear, hymenal, 206
- Patterned marks on scrotum, 459
- Patulous urethra
  - in adult, 633
  - in infant, 42
  - in preadolescent, 164
  - in toddler, 65
  - in young child, 88, 133, 149, 150
- Peeling skin on buttocks, 7
- Pencil in anus, 289
- Penetration
  - anal. *See* Anal penetration
  - by another child, 37
  - penile-vaginal. *See* Penile-vaginal penetration
- Penile-anal penetration of male preadolescent, 183
- Penile contact of preadolescent, 161
- Penile penetration of mouth, 480
- Penile-vaginal contact, 101
- Penile-vaginal penetration
  - of adolescent, 201-282
    - acute findings in, 201-214
    - adolescent perpetrators, 276-280
    - alcohol-related, 233-235
    - developmentally disabled, 247
    - drug-facilitated, 258-261
    - with foreign object, 251-252
    - gang-related, 270
    - healing injury, 215-227
    - incest victim, 261-269
    - Internet-related, 253-257
    - multiple perpetrators, 271-275
    - not previously sexually active, 236-242
    - photodocumentation of, 281-283
    - pregnant, 247-250
    - prostitute, 245-246
    - revictimization, 228-232
    - stated bisexual, 243-244
    - of adult, alcohol-related, 359
    - of disabled toddler, 34
    - of infant, 2
    - of infant or toddler, 3-4
    - of preadolescent, 157, 163, 166, 171, 172, 178, 181
    - of young child, 71, 79, 85, 86, 99-100, 109, 113, 166
- Penis
  - abrasion of, 454
    - in adolescent, 288
    - in adult, 453
  - of adolescent perpetrator, 183
  - bite mark on
    - in adult, 546
    - in young child, 94
  - circumcised, 429
  - condyloma acuminata on, 587
  - device padlocked to, 460
  - ecchymosis of
    - in adult, 546
    - in infant, 31
    - in young child, 121
  - ecchymosis on, 52
  - erythema of, in infant, 30, 32
  - herpes lesions on
    - in preadolescent, 189
    - in young child, 127
  - hyperpigmentation of, 527
  - nevus on, 461
  - oozing lesion on, 326
  - pierced, 540
  - removed from deceased victim, 393
  - ring on, 540
  - toilet seat falling on, 121
  - touching genitals of young child, 104
  - uncircumcised, 283, 530, 531, 536
  - uninjured, 534
- Perianal area
  - abrasion of, 462
  - bleeding in, 503
  - condyloma acuminata in, 584
    - in toddler, 42
    - in young child, 125, 126
  - dermatitis of
    - in adult, 431
    - diaper, 48
  - dirt on, 538
  - dried blood in, 407
  - edema of
    - in adult, 362, 363
    - in preadolescent, 174, 185
  - erythema of
    - in adult, 360, 489
    - in infant, 53
    - infection causing, 127
    - in male adult, 399
    - in preadolescent, 178, 185
    - in toddler, 15
    - in young child, 90, 137
  - fissure in, in infant, 53
  - healing laceration of
    - in adult, 457

- in preadolescent, 223
- in young child, 93
- hyperpigmentation of
  - in adult, 443, 535
  - in young child, 96, 100
- laceration of
  - in adolescent, 222, 265
  - in adult, 363, 374, 417, 422, 451, 456, 463, 495, 499, 541, 548
  - in infant
    - digital penetration and, 5
    - toluidine blue dye uptake of, 6
  - in preadolescent, 188
  - in toddler, 15
    - constipation causing, 7
  - in young child, 91
- normal, 97
- pinworm on, 131
- Perianal ecchymosis
  - in infant, 5
  - in middle-aged adult, 655
- Perianal edema, 660
- Perianal erythema
  - in infant, 30
  - in middle-aged adult, 660, 690
- Perianal fold
  - in adolescent, 249
  - black fiber in, 315
  - laceration of, 90
  - in middle-aged adult, 699
  - normal
    - in male toddler, 33
    - in toddler, 26
    - in young child, 134
- Perianal fold in infant, 30
- Perianal hyperpigmentation, 702
- Perianal laceration, 668
- Perianal lesion
  - oozing, in infant, 48
  - in young child, 89
- Perianal nevus, 465
- Perianal pigmentation, 352
- Perianal tag
  - in adolescent, 353
  - in adult, 581, 640
  - in toddler, 29
- Perianal thickening, 100
- Perianal tissue, normal, 455
- Perianal venous congestion, 184
- Perianal venous ring, 198
- Perihymenal band
  - in adult, 614-615, 620
  - hymenal tag appearing as, 339
- Perihymenal erythema, 129
- Perineal area, normal, 352
- Perineal bruise in infant, 2
- Perineal laceration
  - in adolescent, 241, 286, 305
  - in adult, 361, 415, 466, 487
  - healing of, 405
- Perineal pain, 327
- Perineal tenderness, 242
- Perineum
  - abrasion of, 204, 563
  - abscess of, 582
  - debris on, 27
  - erythema of
    - in adult, 403, 570, 640
    - in middle-aged adult, 650
  - herpes lesions on
    - in adolescent, 273
    - in toddler, 42
  - hyperpigmentation of, 345, 474
    - in middle-aged adult, 663
  - laceration of
    - in adolescent, 276
    - in adult, 563, 598, 599
    - in elderly adult, 702
    - in infant, 3, 8
    - in middle-aged adult, 649
    - in toddler, 8
  - sagging, 660
  - sand on, 284
  - scratches on, 580
  - shaved, 485
  - white discharge on, 665
- Periorbital ecchymosis, 396, 528
- Periurethral area
  - abrasion of, 311
  - discharge in, 109
  - erythema of, 102, 112
  - foreign body removed from, 41
  - hypervascularity of, 74
  - punctate erythema of, 9
  - recessed, 60
- Periurethral band
  - in adolescent, 247, 343, 344
  - in adult, 427, 614-615
  - in preadolescent, 156, 162
  - in toddler, 16, 56
  - in young child, 87, 110, 144
- Periurethral edema
  - in toddler, 25
  - in young child, 106
- Periurethral erythema
  - in adolescent, 240, 276
  - in young child, 77
- Periurethral hemorrhage
  - in middle-aged adult, 666
  - resolved, 120

- in young child, 78
- Periurethral tissue, prominent, 310
- Perpetrator
  - acquaintance as, 666-670
  - adolescent
    - adolescent as victim, 276-280
    - preadolescent as victim, 182-186
    - young child as victim, 104-114
  - of assault of adult, 525-536
  - of drug-facilitated rape, 429
  - friend of family as, 156-163
  - handcuffs on, 399, 486, 525
  - leg cuffs on, 486
  - photodocumentation of, 282
- Persistent erythema in infant, 4
- Petechiae
  - behind ear, 446
  - cervical
    - in adult, 388, 493, 604
    - in elderly adult, 716
    - in middle-aged adult, 675
  - in deceased victim, 389
  - facial, 520
  - of hard palate
    - in adolescent, 261, 291
    - in adult, 480
  - hymenal, 104
  - labial, 668
  - of lip, 482
  - of soft palate, 302
  - urethral, 686
  - of uvula, 478
  - on vaginal wall, 383
- Petechial hemorrhage, 74, 75
- Photodocumentation, 598
  - of clothing, 35
  - follow-up, 15
  - of perpetrator, 282, 283
  - of toddler, 57
- Photographic technique, 600-603
- Physiologic discharge, 264, 350
- Pierced nipple, 569
- Pierced penis, 540
- Pierced tongue, 568, 569
- Pierced umbilicus, 569
- Pigmentation. *See also* Hyperpigmentation
  - anal
    - in toddler, 26
    - in young child, 152
  - of gums, 642
  - labial, 346
  - perianal, 352
  - in preadolescent, 167
- Pigmented nevus, 326
- Pinched genitals in infant, 31
- Pinworms, 96, 131, 404
- Pitfalls of examination, 604-605
- Plastic bags, hands in, 605
- Plexus, venous, blood in, 88
- Poison oak, 565
- Polyp
  - bleeding, 655
  - cervical, 329
  - rectal, 724
- Polypoid tag, 278
- Pooling of venous blood
  - in adult, 406, 408
  - in preadolescent, 180
- Posthysterectomy, 573, 635, 683
- Postvulvectomy, 692
- Posterior fourchette
  - abrasion of
    - in adolescent, 227, 228, 255, 283
    - in adult, 430, 490, 491, 507, 558, 560, 576
    - in elderly adult, 720
    - in middle-aged adult, 648
  - cheesy coating over, 652
  - ecchymosis of
    - in adolescent, 324
    - in middle-aged adult, 651
  - erythema of, 662
    - in adolescent, 279
    - in adult, 421, 492, 493, 562
    - in elderly adult, 718
    - in middle-aged adult, 652, 673, 675, 690
    - in preadolescent, 166
  - uninjured, 671
  - white coating on, 694
- Posterior fourchette laceration
  - in adolescent, 205, 207, 208, 211, 214, 216, 220, 241, 246, 254, 259, 269, 272, 274, 275, 276, 278, 279, 300, 307, 310, 314, 317, 324
  - in adult, 365, 400, 401, 416, 440, 464, 466, 473, 495, 498, 499, 500, 501, 505, 540, 562, 596, 597
    - first consensual intercourse and, 556
    - granulating, 574
  - in deceased victim, 392
  - in elderly adult, 706, 710, 711, 724
  - healing of, 220
  - in homicide victim, 602
  - iatrogenic, 134
  - in infant, 8
  - in middle-aged adult, 649, 661, 662, 663, 664, 665, 667, 668, 679, 681, 683, 686
  - multiple, 226, 260
  - photographing of, 604
  - in preadolescent, 173, 185
  - from straddle injury, 36
  - in straddle injury, 35
  - in toddler, 12



- cunnilingus and, 13-14
  - in young child, 71, 76, 106, 114, 121, 132, 134
  - Posterior hymenal rim
    - in adolescent, 242
    - in young child, 86, 88, 95
  - Postmenopausal adult, 654
  - Postpartum adolescent
    - foreign object in, 251
    - open cervical os in, 351
  - Postpartum adult, 561, 638
  - preadolescent, 155-198
    - adolescent perpetrator, 182-186
    - friend of family perpetrator, 156-163
    - incest victim, 164-181
    - infection in, 189-190
    - normal findings in, 191-198
      - annular hymen, 193
      - anus, 198
      - crescentic hymen, 194
      - failure to fuse, 197
      - redundant hymen, 196
      - septate hymen, 196-197
      - sleeve-like hymen, 195
      - varied examiner techniques, 191-192
    - pregnant, 247
  - Pregnancy
    - diethylstilbestrol during, 613
    - history of, 624-633
  - Pregnant victim
    - adolescent, 247-250
    - adult, 413, 420
      - of prison-related assault, 494
      - self-inflicted injury in, 494-495
  - Premarin cream, 124
  - Prison-related assault
    - of female, 485, 494
    - of male, 398-399, 486-487
  - Probe, 592-593
  - Prolapse
    - urethral
      - in elderly adult, 716
      - in toddler, 52
      - in young child, 135
    - uterine
      - in elderly adult, 718
      - in middle-aged adult, 657, 689
    - vaginal, 714
  - Prominent follicle, 612
  - Prostitute
    - adolescent, 245-246
    - DNA-related case and, 398
  - Protruding clitoris, 609
  - Psychic healing, 488
  - Pubic bone, ecchymosis over, 100
  - Pubic hair
    - in elderly adult, 708, 712
    - in middle-aged adult, 650, 698
    - in preadolescent, 157
    - shaved
      - in adolescent, 308, 345
      - in adult, 567, 610
    - Tanner staging and, 606-608
    - young child and, 86, 112
  - Pubis, shaved
    - in adolescent, 344
    - in deceased victim, 392
  - Punctate abrasion, 90
  - Punctate ecchymosis, 659, 676
  - Punctate erythema
    - in adolescent, 211
    - in adult, 487
    - in elderly adult, 711
    - in infant or toddler, 9
    - in preadolescent, 167
    - in young child, 102, 106
  - Punctate laceration, perineal, 275
  - Punctate periurethral hemorrhage, 78
  - Puncture, healed, 564
  - Purulent discharge from cervical os, 511
  - Pustule on buttock, 705
- ## R
- Raphe, median
    - in male toddler, 33
    - in middle-aged adult, 695
    - in young child, 152
  - Rash
    - in middle-aged adult, 692
    - poison oak, 565
    - on thigh, 571
  - Recessed periurethral area, 60
  - Rectal ampulla, stool in
    - in adolescent, 218
    - in preadolescent, 177
    - of young child, 94
  - Rectal laceration, 548
  - Rectal mucosa, normal, 462
  - Rectal polyp, 724
  - Rectocele, 574
  - Rectum
    - in adult, 406
    - erythema of, 656
    - laceration of, 605
  - Red brown stain on clothing, 375
  - Red vagina
    - in infant, 8
    - in toddler, 8
  - Redness
    - in infant, 10, 46
    - on toddler's bottom, 10



- vaginal, 37
- Redundant hymen  
 in adolescent, 229, 233, 235, 239, 247, 257, 263, 300, 304, 312, 316, 320, 321, 322, 334, 335, 338, 340, 341  
 in adult, 409, 618, 619, 629, 630  
 of infant, 46  
 in middle-aged adult, 647, 678  
 in preadolescent, 181, 196, 247  
 in toddler, 18, 20, 28, 55, 56, 58-60, 62, 64  
 in young child, 84, 110, 130
- Relaxed anus  
 in preadolescent, 159, 181, 198  
 in young child, 85, 88
- Relaxed hymen, 133
- Remnant, hymenal  
 in adult, 474, 631-633  
 in elderly adult, 709, 710
- Residual toluidine blue dye uptake, 237
- Resolution of erythema  
 in adolescent, 218, 223  
 in infant, 2  
 in toddler, 21
- Resolved injury  
 in infant, 6  
 in young child, 120
- Resolving injury, 722, 723
- Revictimization  
 of adolescent, 228-233  
 of adult, 489-491  
 of middle-aged adult, 657-665  
 of young child, 95-98
- Ridge  
 intravaginal  
 in preadolescent, 166, 168, 197  
 of preadolescent, 158  
 in toddler, 22  
 in young child, 111, 141, 145  
 median raphe  
 in preadolescent, 186  
 in toddler, 19, 67  
 in young child, 89, 153  
 rolled hymen appearing as, 336  
 vaginal, 329
- Ridged median raphe, 695
- Rim, hymenal. *See also* Hymen  
 narrowed, 79, 85  
 posterior, 86, 95, 242  
 in preadolescent, 191, 192  
 translucent, 147  
 in young child, 147, 149  
 uninterrupted, 105  
 in adolescent, 344  
 in pregnant preadolescent, 247
- Ring  
 penis, 540  
 perianal venous, 198
- Rip in underwear, 382
- Ripped shirt, 384
- Ripped underwear, 385
- Rock, fall on, 120
- Rounded hymenal edge, 193
- Rubbing  
 of adolescent, 232, 266, 307  
 erythema from, 580  
 hyperpigmentation caused by, 663  
 of infant, 46  
 of preadolescent, 164, 187  
 of toddler, 18  
 of young child, 73, 108, 111  
 with toy, 106
- Rugae, vaginal  
 in adolescent, 312, 349  
 in adult, 634-635  
 in elderly adult, 714  
 in middle-aged adult, 661, 681
- ## S
- Sagging labium majus, 705  
 in middle-aged adult, 660, 698
- Sagging perineum, 660
- Sagging thigh, 698
- Sand  
 around anus, 475  
 on feet, 376  
 on genitalia, 284, 537  
 on perianal area, 538
- Sandals, dirt on, 376
- Sausage as foreign body, 432
- Scab, labial, 571
- Scalloped hymen, 336
- Scalp  
 laceration of, 517  
 staples in, 442
- Scapula, ecchymosis of, 514, 515
- Scar  
 on arm, 403  
 breast augmentation  
 in adolescent, 313  
 in adult, 577  
 in middle-aged adult, 696  
 breast reduction, 579  
 cesarean section, 567  
 on cheek, 533  
 episiotomy, 574-576  
 in middle-aged adult, 699  
 in young child, 115, 116
- Scarred labial adhesion  
 in disabled toddler, 34  
 in young child, 82
- Scene of crime, 386-388
- Scleral hemorrhage, 445, 697

- Scleral hypervascularity, 697
- Scleral petechiae, 389
- Scleral vascularity, 502, 643
- Sclerosis
  - lichen
    - in adolescent, 324
    - in elderly adult, 717-718
  - multiple, 414
- Scrape on buttocks, 538
- Scratch. *See also* Injury, general
  - on abdomen, 413
  - on arm
    - in adolescent, 303
    - in adult, 529
  - on axilla, 549
  - axillary, 549
  - on back, 296
    - in adolescent, 296
    - in adult, 518, 529, 545
    - in middle-aged adult, 688
  - on breast
    - in adolescent, 215, 303
    - in adult, 421
    - in adult male, 553
  - on buttocks
    - in adolescent, 296
    - in adult, 471
  - on cheek, 469, 516, 543
  - on chest
    - in adult, 549
    - in middle-aged adult, 657
  - on chin, 517
  - of clitoral hood, 325
  - on forehead, 543
  - on hand, 291
  - on thigh, 474
  - on hip, 531
  - in infant or toddler, 51
  - on knee, 474
  - on leg, 474
    - of adolescent, 296
    - in adult, 474
  - on neck, 687
  - perineal, 580
  - on perpetrator, 420, 545, 549
  - on shoulder, 687
  - on thigh, 513
    - in adult, 474, 512
- Scrotum
  - abrasion of, 453
  - ecchymosis of, 32
    - in infant
      - iatrogenic, 587
  - edema of, 31
  - erythema from rubbing by, 580
    - patterned marks on, 459
- Sebaceous cyst, labial, 513
- Self-inflicted injury
  - of arm, 320
  - on arm, 403, 492
  - bite marks as, 368
    - on lip, 582
  - by hanging, 496
  - possible, 493
  - scratches on hand, 291
  - slash mark on wrist, 486
  - of wrist, 564
- Semen, DNA analysis of, 396-400
- Septate hymen
  - in adolescent, 342
  - in infant or toddler, 66
  - in preadolescent, 165, 196-197
  - in young child, 151
- Septum, vaginal, 573
- Sexually inactive adolescent
  - acute findings, 205
  - Candida* infection, 238
  - consenting sexual intercourse, 320-323
  - healing injury, 221, 224
  - hymenal transection, 225
  - hyperpigmentation, 236
  - incest victim, 236, 264, 268
  - Internet-related assault, 253
  - labial laceration, 240-241
  - no visible injury, 242
  - penile-vaginal penetration of, 236-242
  - revictimization, 230-232
  - stranger assault, 279
- Sexually inactive adult, 498-505
  - erythema of fossa navicularis in, 504
  - hymen in, 618-620
  - laceration of posterior fourchette, 498-501, 505
  - perianal laceration in, 503
- Shaved anus, 305
  - in adult, 453
- Shaved eyebrows, 463
- Shaved labium majus
  - in adolescent, 320
  - sand on, 285
- Shaved labium minus, 427
- Shaved mons pubis, 474
  - in adolescent, 344, 347
  - in adult, 426, 513, 621
  - in deceased victim, 392
- Shaved perineum, 485
- Shaved pubic hair
  - in adolescent, 308, 345
  - in adult, 567, 610
  - in adult male, 527
- Shaving, folliculitis from, 464

- Shirt, ripped or torn, 384, 439, 687
- Shoe, dirt on, 376
- Shoulder
- abrasion on, 469
  - bite mark on, 370
  - ecchymosis of
    - in adult, 515
    - in deceased victim, 389
    - in elderly adult, 707
  - scratches on, 687
  - tattoo on, 437
- Silicone implant in cheek, 442
- Skin
- aged, 724
  - hyperpigmentation of, 138
  - irritation of, 580
  - peeling and denuded, 7
  - rash on
    - in middle-aged adult, 692
    - poison oak, 565
    - on thigh, 571
  - thickening of, 580
- Skin break
- on buttocks, 431
  - near clitoral hood, 325
  - on thigh, 566
- Slash mark
- on adolescent, 243
  - in adult, 564
  - self-inflicted, 486
- Sleeve-like hymen
- in adolescent, 262, 335
  - in infant, 54
  - in preadolescent, 195
  - in toddler, 18, 24, 55
- Small cervical os, 675
- Smoked sausage as foreign body, 432
- Smooth vaginal wall, 725
- Sodomy
- of adolescent, 287, 298
  - of adult, 431
  - of young child, 92
- Soft palate
- erythema of
    - in adolescent, 292
    - in adult, 643
  - petechiae of, 302
- Sore, canker, 652
- Speculum examination of young child, 134
- Sperm, 440
- active, 644
  - in urine of toddler, 27
- Spinal column, ecchymosis over, 514
- Spirochetal infection, 190
- Split frenulum, 477
- Spot, Mongolian, 138
- Stab wound in deceased victim, 393
- Staging, Tanner, 606-608
- Stain on clothing, 375, 385
- of suspect, 529
- Staphylococcal infection, in infant, 8
- Staphylococcus*, 8
- Staphylococcus epidermidis*, 45
- Staples in scalp, 442
- Stick
- falling on, 121
  - hit with, 298
  - poked with, 371
- Stimulation, estrogen, 199
- Stool
- in ampulla
    - in adolescent, 218
    - in preadolescent, 177
    - of young child, 94
  - in anal folds, 90
  - in anus
    - in adolescent, 354
    - in adult, 641
  - on buttock, 496
  - diarrhea, 570
  - in elderly adult, 703
- Straddle injury
- in adolescent, 327
  - in toddler, 35, 36
- Stranger assault
- of adolescent, 279-280
  - of adult, 506-519
  - of middle-aged adult, 671-676
  - of preadolescent, 187-188
  - of young child, 72, 115
- Strangulation
- conjunctival hemorrhage in, 520
  - scleral hemorrhages in, 445
- Straw on clothing, 381
- Streptococcus*
- in infant, 43, 46
  - in young child, 129
- Striae
- abdominal, 308
  - on breast, 644
- String, IUD, 436, 639
- Subcutaneous hemorrhage, 710
- Submucosal hemorrhage
- in adolescent, 271
  - on hymen, 237
  - in adult, 413
  - in elderly adult, 716
  - in middle-aged adult, 666
  - in young child, 119
- Suck injury to nipple, 579

- Suction ecchymosis  
in adolescent, 295, 303, 308  
in adult, 380, 502  
on neck, 526
- Suicide, attempted, 486
- Surgical repair  
scarred labial adhesion at, 34  
in young child, 115
- Suspect, 525-536
- Suture, 115
- Suture line at breast, 313
- Swab, technique for, 592, 593
- Sweater  
buttoned incorrectly, 379  
torn, 521
- Swelling. *See* Edema
- Syphilis in preadolescent, 190
- ## T
- Tag  
anal  
in adolescent, 234, 236, 305  
in elderly adult, 713  
in middle-aged adult, 700  
in preadolescent, 180, 181  
hemorrhoidal, 444  
hymenal  
in adolescent, 209, 244, 265, 337  
in adult, 616  
appearing as perihymenal band, 339  
in elderly adult, 713  
in preadolescent, 185, 196  
in young child, 76, 141  
intravaginal, 349  
perianal  
in adolescent, 353  
in adult, 581, 640  
in toddler, 29  
polypoid, 278  
vaginal, 34
- Tampon, 436, 617
- Tanner staging, 606-608
- Tape, duct, 506, 702
- Tattoo, 532  
on shoulder, 437
- Tear  
in clothing, 378, 379, 381  
of frenulum, 253  
hymenal  
in adolescent, 206  
in toddler, 17
- Technique  
genital examination, 590-591  
photographic, 600-603  
for preadolescent, 191-192  
probe/balloon, 592-595  
toluidine blue dye, 596-599. *See also* Toluidine blue dye uptake
- Tenderness, perineal, 242
- Testicle removed from deceased victim, 393
- Thick hymen  
of infant or toddler, 23  
of preadolescent, 158
- Thickening  
perianal, 100  
skin, 580
- Thigh  
abrasion of, 414  
bite mark on, 369  
ecchymosis of  
in adolescent, 272, 294  
in adult, 458, 526  
of infant, 5  
in middle-aged adult, 650, 671  
in young child, 92  
erythema of  
in adult, 570  
in preadolescent, 187  
from rubbing, 580  
hyperpigmentation of  
in adult, 474  
in middle-aged adult, 663  
irritation of, 566  
linear grooves on, 709  
maceration of, 708  
poison oak on, 565  
rash on, 571  
sagging, 698  
scratches on, 474, 513
- Thin hymen  
in adolescent, 249  
in young child, 86
- Three-leaf-clover-like hymen, 337
- Thumb  
healed puncture at base of, 564  
knife wound of, 394
- Tire abrasion, 565
- Tissue between buttocks, 535
- Toddler  
anal erythema in, 14  
annular hymen in, 7  
blood in clothing of, 13  
clitoral hood of, 9, 10, 11  
cunnilingus of, 13-14  
erythema in, 11  
labial, 13  
of vestibule, 11  
excoriation of buttocks in, 7  
fondled, 17

- kinky brown hair on, 8  
 labial abrasion in, 9, 13-14  
 perianal laceration from constipation in, 7  
*Staphylococcus* culture from, 8  
 touching of, 11  
 Toe, abrasion of, 470  
 Toilet seat falling on penis, 121  
 Toluidine blue dye uptake  
   by clitoral laceration, 210  
   episiotomy scar and, 576  
   in fissure, 53  
   by fossa navicularis abrasion, 562  
   by fossa navicularis laceration, 397, 414, 507  
     in adult, 402, 464  
     in elderly adult, 714  
     in middle-aged adult, 668  
   by healing laceration, 170  
   by herpes lesions, 234, 272  
   by labial abrasion, 109  
   by labial laceration, 269, 435  
     in adolescent, 215, 259  
     in adult, 360, 485, 519  
     in elderly adult, 721  
     in infant, 6  
     in preadolescent, 188  
     in young child, 93  
   by laceration  
     in adult, 468  
     in preadolescent, 185  
   by lip laceration, 531  
   in male toddler, 33  
   of mons pubis laceration, 694  
   by mucous membrane, 311  
   by multiple lacerations, 428  
   by oozing lesion, 14, 48, 246, 287, 314  
   by perianal erythema, 690  
   by perianal laceration, 374  
     in adult, 541, 548  
     in young child, 91  
   by perineal laceration  
     in adolescent, 286  
     in adult, 361, 415, 466, 599  
   by periurethral abrasion, 311  
   as pitfall of examination, 604  
   by posterior fourchette abrasion, 490, 491, 576  
   by posterior fourchette laceration, 499, 560, 653  
     in adolescent, 205, 208, 214, 226, 241, 246,  
       255, 272, 274, 280, 317  
     in adult, 365, 400, 411, 500, 505, 559, 596  
     in elderly adult, 706, 724  
     in middle-aged adult, 661, 662, 663, 664, 676  
     in toddler, 14  
   in preadolescent, 174  
   residual, 237  
   technique for, 596-599  
     in young child, 76, 93  
 Tongue  
   bite mark on, 370  
   coated, 685  
   healing laceration of, 484  
   pierced, 568, 569  
 Tooth  
   broken, 450  
   milk bottle caries of, 136  
   traumatic extraction of, 136  
 Torn clothing, 378, 383, 384  
   belt, 379, 385  
   blouse, 385  
   bra, 380  
   shirt, 384, 439, 687  
   sweater, 521  
   underwear, 379, 381, 385  
 Torn nail, 364  
 Touching. *See also* Fondling  
   of adolescent, 325  
   of preadolescent, 156, 167, 170, 197  
   of toddler, 7, 12, 16, 18-21, 23, 24, 26, 28  
     developmentally delayed, 11  
   of young child, 75, 80, 83, 84, 88, 110, 122  
 Toy, genitals rubbed with, 106  
 Trace evidence, 377, 537, 538  
   background for, 603  
 Transection  
   of hymen, 227  
     in adolescent, 205, 206, 219, 220, 224,  
       225, 231, 233, 243, 253, 271, 331, 334  
     in adult, 625, 631, 632  
     in deceased victim, 392, 393  
     in pregnant adolescent, 250  
     in young child, 100, 121  
   of labium minus, 572  
 Translucent hymen in preadolescent, 162, 168, 169  
 Translucent hymenal rim, 147, 149  
 Transparent hymen, 262  
 Transvestite, 442  
 Traumatic extraction of tooth, 136  
  
**U**  
 Umbilicus, pierced, 569  
 Uncircumcised penis, 283, 530, 531, 536  
 Underdeveloped labia minora, 610  
 Underwear  
   blood on  
     of adolescent, 201  
     of adult, 374, 377, 381  
     dried, 494  
     of middle-aged adult, 656  
     streptococcal infection and, 129  
     of toddler, 13, 17, 20, 27, 35  
     of young child, 113, 133

- on sideways and inside out, 539
  - stain on, 375, 385
    - of suspect, 529
  - straw in, 382
  - torn, 379, 381, 385
  - vegetative debris on, 467
  - white stain on, 376
  - Wood's lamp examination of, 551
- Uninterrupted hymen
- in adolescent, 208, 232, 260, 261, 263, 280, 304, 340, 344
  - in adult, 405, 615, 621
  - in preadolescent, 172, 193
    - pregnant, 247
  - in young child, 105, 141, 146, 147, 148
- Urethra
- abrasion of, 274
  - condyloma acuminata and, 331, 585
  - erythema of
    - in preadolescent, 176
    - in young child, 89
  - healing laceration of, 591
  - patulous
    - in adult, 633
    - in infant, 2
    - in preadolescent, 164
    - in toddler, 65
    - in young child, 88, 133, 149, 150
  - petechiae of, 686
  - in toddler, 28, 65
  - weeping abrasion superior to, 693
- Urethral prolapse
- in elderly adult, 716
  - in toddler, 52
  - in young child, 135
- Urination
- blood on, 75
  - painful, 27
- Uterine prolapse
- in elderly adult, 718
  - in middle-aged adult, 657, 689
- Uvula, petechiae of, 478
- ## V
- Vagina
- condom in, 252
  - double, 66
  - redness of, 8, 37
- Vaginal band, 573
- Vaginal bleeding
- in toddler, 20
  - in young child, 121
- Vaginal cuff
- in middle-aged adult, 683
  - posthysterectomy, 573
- Vaginal delivery, 627-633
- Vaginal discharge. *See* Discharge
- Vaginal infection. *See* Infection
- Vaginal laceration, 71
- Vaginal orifice
- in adult, 572
  - condom in, 251
  - double
    - in adolescent, 342
    - in adult, 573
    - in toddler, 66
  - green mucus in, 47
  - in preadolescent, 193
  - two, 342
- Vaginal prolapse, 714
- Vaginal ridge, 329
- Vaginal rugae
- in adolescent, 312, 349
  - in adult, 634-635
  - in elderly adult, 714
  - in middle-aged adult, 661, 681
- Vaginal septum, 573
- Vaginal tag, in disabled toddler, 34
- Vaginal wall
- in adolescent, 203, 213
  - in adult, 631, 634-635
  - in elderly adult, 711, 725
  - erythema of, 684, 711
  - in middle-aged adult, 647, 684
  - nodules on, 653
  - normal, 430
  - petechiae on, 383
  - in preadolescent, 193
  - in toddler, 57, 65
  - in young child, 77, 140
- Varied examiner techniques, 191-192. *See also* Technique
- Vascular cervix, 301, 350
- Vascular hymen
- in toddler, 37
  - in young child, 88, 149
- Vascular hymenal base, 150
- Vascular pattern
- on cervix, 332
  - on glossopalatal arch, 451
  - in gums of young child, 92
  - hymenal
    - normal, 17, 18
    - in preadolescent, 162
    - in toddler, 21, 23, 24, 63
    - vivid, 22
    - in young child, 81, 83, 84, 95, 111, 140, 141, 146
  - labial
    - in toddler, 17
    - in young child, 80
- Vascularity
- of hymen, anesthesia affecting, 133

- of lip, 290
    - in preadolescent, 163, 169
    - scleral, 502, 643
  - Vegetable foreign body, 41
  - Vegetative debris, 442, 467
  - Vein, blue, 345
  - Venous congestion, 431, 454
    - in adolescent, 265
    - in adult, 640
    - in middle-aged adult, 655
    - in preadolescent, 180, 184, 188
    - in young child, 90
  - Venous plexus, blood in, 88
  - Venous pooling, 406, 408
  - Venous ring, perianal, 198
  - Verge, anal
    - in adolescent, 354
    - in adult, 640
    - in deceased victim, 391
    - erythema at, 399
    - erythema of, 266
    - laceration of, 306
    - in preadolescent, 198
  - Vermillion border laceration, 477
  - Verruca vulgaris, 128
  - Vertical groove, 609
  - Vertical ridge, 611
  - Vesicle, hemorrhagic, 307
  - Vestibule
    - erythema of
      - in infant, 4
      - in toddler, 50, 51
    - homogeneous, 19
    - normal, 611-617
    - papillations of, 613
    - in toddler, erythema of, 11
    - white tissue or mucus in, 40
  - Violence
    - domestic, 415-425
    - homicide, 366, 389-393, 602
  - Viral infection
    - condyloma acuminata. *See* Condyloma acuminata
    - herpes simplex. *See* Herpes simplex virus
    - HIV infection, 583
    - verruca vulgaris, 127
  - Vulva
    - dystrophy of, 694
    - erythema of, 403
  - Vulvectomy, 572, 692
- W**
- Wall, vaginal
    - in adolescent, 203, 213
    - in adult, 631, 634-635
    - in elderly adult, 725
    - erythema of, 684, 711
    - in middle-aged adult, 647
    - nodules on, 653
    - normal, 430
    - petechiae on, 383
    - in preadolescent, 193
    - in toddler, 57, 65
    - in young child, 77, 140
  - Wart, genital. *See* Condyloma acuminata
  - Wart-like lesion, 650
  - Wasting
    - in anorexia, 514
    - in HIV infection, 461
    - in multiple sclerosis, 414
  - Watch, 387
  - Weeping abrasion, 693
  - Wet crotch of trousers, 533
  - Wheelchair, 411
  - Whip mark, 458, 459
  - White coating on posterior fourchette, 694
  - White discharge
    - in adolescent, 203, 238, 309, 316, 332, 333, 350
    - in adult, 359, 434
    - in elderly adult, 720
    - in infant, 46
    - in middle-aged adult, 654, 662, 678, 682
    - perineal, 665
    - in preadolescent, 157
    - in young child, 130
  - White discoloration, 454
  - White mucus on cervix, 588
  - White stain on underwear, 376
  - White tissue or mucus, 40
  - Wing, hymenal, 29
  - Wood's lamp examination
    - in deceased victim, 390
    - nonreactive, 437, 549
    - of suspects underwear, 551
    - of white stain, 376
  - Wound, gunshot, 565
  - Wrist injury
    - ecchymosis, 543
    - erythema and, 506
    - in preadolescent, 213
    - self-inflicted, 486
    - slash marks, 564
    - tape marks causing, 506
- Y**
- Yeast infection, 589
  - Yellow discharge
    - in adolescent, 202
    - in elderly adult, 716
    - in preadolescent, 175
  - Young child
    - acute findings in

- cunnilingus, 77-78
- digital penetration, 72-76
- penile penetration, 71
- nonassault variants in
  - accident, 117-121
  - anal findings, 137
  - annular hymen, 140-144
  - anus, 152-153
  - crescentic hymen, 145-150
  - failure to fuse, 135
  - friable fourchette, 132-134
  - infection, 125-131
  - labial adhesion, 122-124
  - oral findings, 136
  - septate hymen, 151
  - skin findings, 138-139
  - urethral prolapse, 135
- normal or nonspecific findings in
  - anus, 198
  - crescentic hymen, 194
  - digital penetration, 80-88
  - failure to fuse, 197
  - penile penetration, 79
  - redundant hymen, 196-197
  - sleeve-like hymen, 195
  - varied examiner technique, 191-192
- special cases in
  - adolescent perpetrator, 104-114
  - healing, 115-116
  - incest victim, 99-103
  - males, 89-94
  - revictimization, 95-98