

Sexual Assault

Victimization Across the Life Span
A Clinical Guide



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To Bernadette Toner, whose tireless efforts in assisting me with both my academic and administrative responsibilities made it possible to effectively organize the massive effort it takes to produce a scholarly publication such as this. Bernadette's attention to detail was invaluable for getting everything done and her heart for all who suffer trauma was a consistent confirmation of the necessity of this work.

— APG

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— EMD

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— JBA

Sexual Assault

Victimization Across the Life Span A Clinical Guide

Angelo P. Giardino, MD, PhD

Associate Chair – Pediatrics
Associate Physician-in-Chief
St. Christopher's Hospital for Children
Associate Professor in Pediatrics
Drexel University College of Medicine
Philadelphia, Pennsylvania

Elizabeth M. Datner, MD

Assistant Professor
University of Pennsylvania School of Medicine
Department of Emergency Medicine
Assistant Professor of Emergency Medicine in Pediatrics
Children's Hospital of Philadelphia
Philadelphia, Pennsylvania

Janice B. Asher, MD

Assistant Clinical Professor
Obstetrics and Gynecology
University of Pennsylvania Medical Center
Director
Women's Health Division of Student Health Service
University of Pennsylvania
Philadelphia, Pennsylvania



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CONTRIBUTORS

Randell Alexander, MD, PhD

Associate Professor
Clinical Pediatrics
Morehouse School of Medicine
Forensic Pediatrician
Department of Pediatrics
Morehouse School of Medicine
Atlanta, Georgia

Sarah Anderson, RN, MSN

University of Virginia
Department of Emergency Medicine (Registered Nurse)
School of Nursing (Doctoral Student)
Charlottesville, Virginia

Joanne Archambault

Training Director
Sexual Assault Training and Investigations (SATI, Inc.)
Retired Sergeant
San Diego Police Department
Sex Crimes Unit

Tracy Bahm, JD

Senior Attorney
Violence Against Women Program
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Kathy Bell, RN

Forensic Nurse Examiner
Tulsa Police Department
Tulsa, Oklahoma

Sandra L. Bloom, MD

CEO, Community Works
Philadelphia, Pennsylvania

Duncan T. Brown, JD

Staff Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Mary-Ann Burkhart, JD

Senior Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Michael Clark, MSN, CRNP

Nurse Practitioner
Department of Emergency Medicine
Hospital of the University of Pennsylvania
Clinical Lecturer
University of Pennsylvania School of Nursing
Philadelphia, Pennsylvania

Sharon W. Cooper, MD, FAAP

Adjunct Associate Professor of Pediatrics
University of North Carolina School of Medicine
Chapel Hill, North Carolina
Clinical Assistant Professor of Pediatrics
Uniformed Services University of Health Sciences
Bethesda, Maryland
Chief
Developmental Pediatric Service
Womack Army Medical Center
Fort Bragg, North Carolina

Thomas Ervin, RNC, FN, BSc †

Reception and Release Coordinator
California State Prison at Corcoran
Department of Corrections
State of California

Martin A. Finkel, DO, FACOP, FAAP

Professor of Pediatrics
Medical Director
Center for Children's Support
School of Osteopathic Medicine
University of Medicine and Dentistry of New Jersey
Stratford, New Jersey

Marla J. Friedman, DO

Fellow, Pediatric Emergency Medicine
Emergency Medicine
Alfred I. duPont Hospital for Children
Wilmington, Delaware

Donna Gaffney, RN, DNSc, FAAN

Associate Professor, Acute Care Nurse Practitioner Program
College of Nursing
Seton Hall University
South Orange, New Jersey

Ann E. Gaulin, MS, MFT

Director of Counseling Services
Women Organized Against Rape
Philadelphia, Pennsylvania

Eileen R. Giardino, PhD, RN, CRNP

Associate Professor
LaSalle University, School of Nursing
Nurse Practitioner
LaSalle University, Student Health Center
Philadelphia, Pennsylvania

Holly M. Harner, CRNP, PhD, MPH, SANE

Assistant Professor
William F. Connell School of Nursing
Boston College
Chestnut Hill, Massachusetts

†Deceased

Caren Harp, JD

Senior Attorney/Director
National Juvenile Justice Prosecution Center
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

William C. Holmes, MD, MSCE

Assistant Professor of Medicine and Epidemiology
Philadelphia Veterans Affairs Medical Center
Center for Clinical Epidemiology and Biostatistics
University of Pennsylvania School of Medicine
Philadelphia, Pennsylvania

Jeffrey R. Jaeger, MD

Assistant Professor of Medicine
University of Pennsylvania Health System
Clinical Faculty, Institute for Safe Families
Philadelphia, Pennsylvania

Susan Bieber Kennedy, RN, JD

Senior Attorney
Violence Against Women Program
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Lisa Kreeger, JD

Senior Attorney
Violence Against Women Program Manager
DNA Forensics Program Manager
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Susan Kreston, JD

Deputy Director
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Linda E. Ledray, RN, PhD, SANE-A, FAAN

Director
Sexual Assault Resource Service
Hennepin County Medical Center
Minneapolis, Minnesota

Patsy Rauton Lightle

Supervisory Special Agent
Lieutenant, Department of Child Fatalities
South Carolina Law Enforcement Division
Columbia, South Carolina

Judith A. Linden, MD, FACEP, SANE

Assistant Professor
Emergency Medicine
Boston University School of Medicine
Associate Residency Director
Boston University School of Medicine
Boston Medical Center
Boston, Massachusetts

John Loiselle, MD

Associate Professor of Pediatrics
Jefferson Medical College
Assistant Director, Emergency Medicine
Alfred I. duPont Hospital for Children
Wilmington, Delaware

Kathi Makoroff, MD

Mayerson Center for Safe and Healthy Children
Cincinnati Children's Hospital Medical Center
Cincinnati, Ohio

Jeanne Marrasso, MD, MPH

Assistant Professor
Department of Medicine
Division of Allergy and Infectious Diseases
University of Washington
Seattle, Washington
Medical Director
Seattle STD/HIV Prevention Training Center
Seattle, Washington

Patrick O'Donnell, PhD

Supervising Criminalist, DNA Laboratory
San Diego Police Department
San Diego, California

Christine M. Peterson, MD

Director of Gynecology
Department of Student Health
Assistant Professor of Clinical Obstetrics and Gynecology
University of Virginia School of Medicine
Charlottesville, Virginia

Millicent Shaw Phipps, JD

Staff Attorney
Violence Against Women Program
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Hannah Ufberg Rabinowitz, MSN, ARNP, FNA, NCGNP

Clinical Education
Aventura Hospital
Aventura, Florida

William J. Reed, MD, FAAP

Assistant Professor of Pediatrics
Texas A&M College of Medicine
Behavioral and Adolescent Medicine
Driscoll Children's Hospital
Corpus Christi, Texas

Iris Reyes, MD, FACEP

Assistant Professor
Emergency Medicine
Hospital of the University of Pennsylvania
Assistant Medical Director
Emergency Medicine
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

Laura L. Rogers, JD

Senior Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Mimi Rose, JD

Chief Assistant District Attorney
Family Violence and Sexual Assault Unit
Philadelphia District Attorney Office
Philadelphia, Pennsylvania

Pamela Ross, MD

Assistant Professor of Emergency Medicine & Pediatrics
University of Virginia Health System
Charlottesville, Virginia

Rena Rovere, MS, FNP

Sexual Assault Program Director
Clinical Nurse Specialist
Department of Emergency Medicine
Albany Medical Center
Albany, New York

Bruce D. Rubin, MD

Clinical Instructor
Department of Emergency Medicine
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

Maureen S. Rush, MS

Vice President for Public Safety
University of Pennsylvania
Division of Public Safety
Philadelphia, Pennsylvania

Charles J. Schubert, MD

Associate Professor of Pediatrics
Division of Emergency Medicine
Cincinnati Children's Hospital Medical Center
Cincinnati, Ohio

Margot Schwartz, MD

Virginia Mason Medical Center
Infectious Diseases Section
Seattle, Washington
Clinical Instructor
Department of Medicine
University of Washington
Seattle, Washington

Philip Scribano, DO, MSCE

Assistant Professor
Pediatrics and Emergency Medicine
University of Connecticut School of Medicine
Director, Child Protection Program
Connecticut Children's Medical Center
Hartford, Connecticut

Christina Shaw, JD

Staff Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Jeanne L. Stanley, PhD

Executive Director of Academic Services
Graduate School of Education
University of Pennsylvania
Philadelphia, Pennsylvania

Cari Michele Steele, JD

Staff Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Jacqueline M. Sugarman, MD

Assistant Professor of Pediatrics
Department of Pediatrics
College of Medicine
University of Kentucky
Lexington, Kentucky

Kathryn M. Turman

Program Director
Office of Victim Assistance
Federal Bureau of Investigation
Washington, DC

Victor I. Vieth, JD

Director
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

J. M. Whitworth, MD

Professor of Pediatrics
University of Florida
State Medical Director
Child Protection Team Program
Children's Medical Services
Department of Health
State of Florida

Dawn Doran Wilsey, JD

Senior Attorney
National Center for Prosecution of Child Abuse
American Prosecutors Research Institute (APRI)
Alexandria, Virginia

Janet S. Young, MD

Assistant Professor
University of North Carolina-Chapel Hill
Department of Emergency Medicine
Chapel Hill, North Carolina

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.

Robert M. Reece, MD

Director, MSPCC Institute for Professional Education
Clinical Professor of Pediatrics, Tufts University School of Medicine
Executive Editor, the *Quarterly Child Abuse Medical Update*

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.

Randell Alexander, MD, PhD
Atlanta, Georgia

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.

Angelo P. Giardino, MD, PhD

Philadelphia, Pennsylvania



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OUR MISSION

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

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

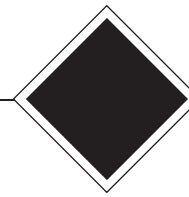


TABLE OF CONTENTS

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
CHAPTER 3: EVALUATION OF CHILD SEXUAL ABUSE	
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
CHAPTER 4: FORENSIC EVALUATIONS FOR SEXUAL ABUSE IN THE PREPUBESCENT CHILD	
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

CHAPTER 5: SEXUALLY TRANSMITTED DISEASES IN SEXUALLY ABUSED CHILDREN	
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
CHAPTER 6: DIFFERENTIAL DIAGNOSIS	
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
CHAPTER 7: SCREENING FOR AND TREATMENT OF SEXUAL ABUSE HISTORIES IN BOYS AND MALE ADOLESCENTS	
Introduction	125
The Problem	125
The Solution	128
How Should Providers Do This?	129
Conclusion	139
CHAPTER 8: DISABILITY AND SEXUAL VIOLENCE	
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
CHAPTER 9: MULTIDISCIPLINARY TEAMWORK ISSUES RELATED TO CHILD SEXUAL ABUSE	
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
 CHAPTER 21: RAPE AND SEXUAL ABUSE IN OLDER ADULTS	
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
 CHAPTER 22: SEXUAL ASSAULT IN CORRECTIONAL SETTINGS	
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
 CHAPTER 23: REVISED TRAUMA THEORY: UNDERSTANDING THE TRAUMATIC NATURE OF SEXUAL ASSAULT	
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

CHAPTER 28: ROLE OF EMS PREHOSPITAL CARE PROVIDERS	
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
CHAPTER 29: LAW ENFORCEMENT ISSUES	
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
CHAPTER 30: THE ROLE OF POLICE AS FIRST RESPONDERS	
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
CHAPTER 31: LEGAL ISSUES IN SEXUAL ASSAULT FROM A PROSECUTOR'S PERSPECTIVE	
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
CHAPTER 32: HEARING THE CRY: INVESTIGATING AND PROSECUTING ADULT SEXUAL ASSAULT CASES	
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

John Loisel, MD
Marla J. Friedman, DO

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.

Incest, or sexual relations between persons closely related by blood, is a category of sexual abuse that carries with it a different level of psychosocial problems, prognosis, and family dysfunction. Incest includes sexual relations with members of adoptive families and stepfamilies. For the purposes of reporting and meeting a legal definition of sexual abuse, the terms are the same.

Sexual play occurs between young children of similar developmental levels and frequently involves viewing or touching. Sexual play or exploration is considered a normal part of childhood development and curiosity. The distinction between sexual play and sexual abuse is not always clear. Most definitions focus on the discrepancy in age between the two participants, the level of control or authority the older child holds over the younger one, the degree of coercion, and the actual activity involved.

The variation in the definition of child sexual abuse and the wide spectrum of activities covered within these definitions lead to confusion in the minds of mandatory reporters. Those who have a responsibility for the welfare of children should be familiar with their own state statutes. Statistics regarding the incidence of child sexual abuse are also highly dependent on the definition used.

SCOPE

The true magnitude of child sexual abuse is unknown. Incidence rates are based on reports filed with central agencies or cases that otherwise come to the attention of professionals. These rates are generally considered to underestimate the actual number of cases of sexual abuse because they are subject to substantial underreporting. An unknown number of cases are never disclosed or detected. Other cases are disclosed by victims but never reported to authorities. Prevalence statistics are based on surveys of adults regarding childhood experiences of sexual abuse. These studies have their own set of limitations, including variations in study definitions and methodology.

In 1993 the US Department of Health and Human Services conducted the Third National Incidence Study of Child Abuse and Neglect (NIS-3). The findings were based on a nationally representative sample of community professionals and included children who were reported to child protective services agencies as well as those who came to the attention of other professionals. The estimated number of sexually abused children in 1993 was 217,700, a rate of 3.2 cases/1000 children (Sedlak & Broadhurst, 1996). This was almost a two-fold increase from NIS-2 figures from 1986, which reported 119,200 cases or 1.9 cases/1000 children.

The National Child Abuse and Neglect Data System (NCANDS) collects and analyzes data from reports made to individual state child protective services agencies on an annual basis. In 1998, 48 states reported a total of 99,000 cases of child sexual abuse for an overall rate of 1.6 cases/1000 children. Female victims had a higher rate (2.3/1000) than male victims (0.6/1000) (US Department of Health and Human Services, 2000).

Prevalence studies report much higher rates of child sexual abuse. A national survey conducted in 1985 by the Los Angeles Times Poll included a random sample of 2626 American men and women over age 18 years. Some form of child sexual abuse was reported by 27% of women and 16% of men. One third of victimized women and 40% of victimized men never disclosed the incident to anyone (Finkelhor et al., 1990).

In a survey of a random sample of 930 adult women in San Francisco, Russell (1983) reported that 38% experienced at least one form of sexual abuse before age 18 years. Less than 10% of cases were ever reported to the police.

Several obstacles limit the ability of current research to provide truly reliable numbers regarding child sexual abuse. Victims seldom disclose episodes of sexual

abuse for reasons discussed later in this chapter. This fact is supported by the low disclosure rates found in adult surveys. Furthermore, cases that are disclosed or eventually recognized by others are not always reported. A broader awareness of child sexual abuse and the passage of mandated reporting laws have resulted in a higher reporting rate. The consistent percentage of reports that are substantiated suggests that this increase reflects actual cases rather than a higher number of unfounded cases.

Despite improved reporting, physicians and other mandated reporters fail to report all cases of sexual abuse (Kempe, 1978). Barriers to reporting are substantial and well documented. In one study fewer than half of the physicians surveyed stated they would report all cases of sexual abuse that came to their attention (James et al., 1978). A study of mandated reporters also found dramatic inconsistencies in reporting practices among pediatricians (Zellman, 1990). The most common reasons provided for not reporting sexual abuse were a perceived lack of sufficient evidence, concern that a report would disrupt the patient-physician relationship or would be harmful to the family, and distrust of the local child protective services agency.

Most practitioners and mandated reporters, as well as the general public, concede that child sexual abuse represents a significant problem in the United States (Tabachnick et al., 1997). Still, the misperception exists that “Child sexual abuse happens, but not in my neighborhood.” This belief is contradicted by substantial evidence showing sexual abuse is not related to socioeconomic status or race (Feldman et al., 1991; Finkelhor, 1993; Hymel & Jenny, 1996; Kempe, 1978; Leventhal, 1998; Sedlak & Broadhurst 1996). As a result of misperceptions, the threshold for reporting potential cases remains unacceptably high. The estimated rate of child sexual abuse in the United States is equal to the rate of asthma in childhood, which is considered one of the leading medical disabilities in this age group and an affliction routinely diagnosed and treated in the average pediatric practice (Future directions, 1998).

A different set of potential biases influences prevalence statistics. Recall bias may affect the quoted prevalence in these studies in several ways. False childhood memories overestimate the true prevalence of child sexual abuse, while denial, repressed memories, and a continued unwillingness to disclose these traumatic events give an underestimate of the actual prevalence. Critics point out that many surveys are conducted among select populations limited to college students or specific geographic regions. This limits the ability to extrapolate results to the general population. The definition of sexual abuse, the acts that constitute sexual abuse, and the age at which such acts occur differ between studies.

Despite these limitations, comparative numbers between most studies remain consistent, and experts agree that approximately 20% of women and 9% of men experience some form of inappropriate sexual contact during childhood (Hymel & Jenny, 1996; Kerns et al., 1994). There is a wide discrepancy between the actual number of cases of child sexual abuse and the number of cases reported to authorities.

Child protective services agencies have noted a continued rise in the number of reported cases of child sexual abuse since the 1970s, when these numbers were first recorded. Researchers disagree as to whether this reflects improved recognition and reporting of cases, an actual increase in the occurrence of child sexual abuse, or both. The paucity of data before 1980 makes definitive conclusions difficult. To date there is no firm evidence that the rate of sexual abuse has, in fact, increased (Feldman et al., 1991; Leventhal, 1998).

The most recent data from the National Child Abuse and Neglect Data System and the Annual Fifty State Survey shows an actual decline in reports of child sexual abuse beginning in the early 1990s. These studies show a 26% reduction in child

Key Point:

A number of incidence and prevalence studies have been done over the past several decades and, despite their scientific limitations, both types of studies demonstrate that children in our society are at risk for sexual abuse.

sexual abuse reports and a 30% decline in the number of substantiated reports in the period from 1992 to 1998. It is not clear whether this decline represents a true decrease in the incidence of sexual abuse or changes in the policies or definitions used to tally these numbers. Jones and Finkelhor (2001) offer several possible explanations for the decline. Several theories are currently being investigated. The basis for this trend will have significant implications for future interventions.

Not all cases of reported child sexual abuse result in criminal charges. Cases are selectively prosecuted. This may depend on the particular acts involved in the case, the age of the child, and the age and relationship of the perpetrator. A high number of cases prosecuted end in guilty pleas, and 60% to 90% of cases that go to trial result in convictions (De Jong & Rose, 1991; Martone et al., 1996; San Lázaro et al., 1996). Some reports show that three fourths of perpetrators convicted of child sexual abuse were sentenced to jail time (Martone et al., 1996; San Lázaro et al., 1996). All 50 states include laws requiring convicted sex offenders to register with the local law enforcement agency.

The media has been vilified as well as praised for its role in the area of child sexual abuse. Some experts argue that the increasing use of graphic images contributes to the problem. Movies and television have been accused of showing increasingly sexually explicit images. Advertisements have been accused of exploiting children by depicting them in adult, sexually stimulating poses and situations. The Internet has made possible on-line sharing of child pornography. Sexual predators have used the Internet as a means to gain access to young children. Highly publicized cases of child sexual abuse have increased public awareness and contributed to widespread recognition of the issue. In one survey, over 90% of respondents reported having seen or heard a news media report during the previous year regarding child sexual abuse (Tabachnick et al., 1997). A Dutch study demonstrated the ability of a mass media campaign to increase the rate of disclosure by sexually abused children by over 300% (Hoefnagels & Baartman, 1997).

False accusations or the fear of such complicates the investigation of reports. False allegations of sexual abuse are an uncommon, but existent, feature of custody battles. The American Bar Association reports that relatively few custody disputes involve sexual abuse allegations (Nicholson & Bulkley, 1988). One literature review found sexual abuse allegations were involved in only 2% of custody disputes, and only 8% to 16.5% of these were false (Penfold, 1995). One report found that 11 of 551 reported cases over a 1-year period involved false allegations of sexual abuse (Oates et al., 2000). These included three cases in which the allegation was made in collusion with a parent. In a survey of New York State teachers, 56% reported knowledge of a false allegation of abuse made against a teacher in their school district (Anderson & Levine, 1999). Differentiating false allegations from true cases can be exceedingly difficult, because most sexual abuse cases tend to be based on circumstantial or hearsay evidence. Investigators are faced with the difficult choice between the potential prosecution of an innocent person versus the devastating situation of not believing a victimized child and providing protection from future abuse. A detailed evaluation of each case by an experienced investigator seeking inconsistencies in the story or evidence that a child's responses have been coached is often necessary.

VICTIMS

Extensive research has been done on sexual abuse victims. The main conclusion from the literature is that there is no classic profile of a sexually abused child. Finkelhor (1993) states that "no identifiable demographic or family characteristics of a child may be used to exclude the possibility that a child has been sexually

abused. Some characteristics are associated with greater risk...none of these factors bear a strong enough relationship to the occurrence of abuse that their presence could play a confirming or disconfirming role in the identification of actual cases.” Although it is important to consider every child as a possible victim of sexual abuse, some consistencies have been established in the research.

Most literature has focused on females as the victim of sexual abuse. This is in part because female victims account for more than three times the number of male victims in reported cases of child sexual abuse (Finkelhor, 1993; Guidry, 1995). This discrepancy exists partly because of a boy’s increased reticence to admit that he was a victim of sexual abuse. Although female victims are much more highly represented in the literature, the number of male victims is greater than once believed. A collaboration of eight studies revealed that girls are 2.5 times more likely to be victims of sexual abuse than boys (Finkelhor & Baron, 1986). It is imperative that healthcare workers acknowledge the problem of child sexual abuse and not overlook the potential victimization of any child, male or female.

Key Point:

Both boys and girls are at risk for sexual abuse, with male victims, on average, being younger than female victims.

Most experts agree that the risk for sexual abuse is highest during preadolescence, with a smaller peak in the early school-age years (Finkelhor, 1993; Nieves-Khouw, 1997; Pierce & Pierce, 1985). Pierce and Pierce (1985) demonstrated that sexually abused boys are, in general, younger than their female counterparts. The male victim averaged 8.6 years (mode = 7 years) and the female 10.6 years (mode = 14 years). Another study quoted a median age of 7 years for male victims and 10 years for females (Nieves-Khouw, 1997).

Although the number of reported cases of child sexual abuse shows a larger percentage of children from lower socioeconomic groups, the epidemiologic research to date does not support this. Similarly, race and ethnicity do not seem to be risk factors for abuse. Overall, no demographic feature has been identified to increase the risk of child sexual abuse (Finkelhor, 1993).

Conversely, certain victim and parenting characteristics have been associated with child sexual abuse. Studies show that most children who become victims of abuse have a tendency to be easily controlled. These children may be physically or mentally disabled and often have needs for love and belonging that are not being met at home.

In general, children living without one or both of their natural parents are at an increased risk of being abused. Females who live apart from their mothers or are not emotionally close to their mothers are at increased risk of sexual abuse (Finkelhor, 1982). Abused males were more likely to live with their mothers and have no father figure in the home (Pierce & Pierce, 1985). The single most important risk factor, for both females and males is the presence of a stepfather in the household (Finkelhor, 1982, 1993; Pierce & Pierce, 1985; Whetsell-Mitchell, 1995a). Other parenting impairments that pose a greater risk of abuse include a mother who is ill, disabled, or extensively out of the home. Substance abuse, parental conflict, or violence in the home are also risk factors for abuse (Finkelhor, 1982, 1993; Finkelhor & Baron, 1986; Whetsell-Mitchell, 1995a). Children of adolescent parents, foster parents, or parents who were sexually abused themselves are often at increased risk of abuse. Finally, siblings of abused children are at increased risk of being abused themselves (Herendeen, 1999).

OFFENDERS

Much has been written on the epidemiology and psychopathology of child sex offenders, but one thing remains constant: there is no classic profile of an abuser. Studies have shown that child sex abusers are usually older men. However, one fourth to one third of male perpetrators are reported to be adolescents (Leventhal,

1998). Women have been found to be offenders in up to 5% of cases involving female children and 20% of cases involving male children (Guidry, 1995). Most often, the perpetrator is well known to the child. Male family members, such as the father, stepfather, and uncle, are the most common offenders (Guidry, 1995; Nieves-Khouw, 1997). Children living with a stepfather are at substantially greater risk of being abused than those living with a biologic father. Stepfathers molest girls more often than boys. However, biologic fathers reportedly molest a similar number of girls and boys (Kendall-Tackett & Simon, 1992; Leventhal, 1998; Pierce & Pierce, 1985; Whetsell-Mitchell, 1995a).

Key Point:

No all-encompassing profile has emerged for describing sexual abuse perpetrators.

Incest is one of the most commonly reported types of abuse. It has been suggested that the occurrence of incestuous abuse may match or even exceed the incidence of physical child abuse. Experts agree that between 75% and 90% of incest victims are female children. Sexual contact between father and daughter and between stepfather and daughter is encountered most frequently (Guidry, 1995). Father-son abuse is revealed less often because it involves two social taboos: the incest taboo and the homosexual taboo. Mother-son abuse is a rare occurrence (Pierce & Pierce, 1985). Models of the incestuous family have been elucidated and typically involve a family in which multiple stressors exist. The father-daughter model illustrates many characteristics of the incestuous family (Justice & Justice, 1979). There is parental conflict leading to absence of sexual relations between the father and mother. The father longs for a source of physical intimacy, often looking to his daughter for comfort and love. The daughter may be depressed and withdrawn and have a poor self-image. She, too, yearns for attention and affection and may be happy to fill a need in her father's life. The mother feels completely dependent on her husband, to the point of being powerless. She subconsciously suggests and allows her daughter to assume her role of wife. She abandons her husband and daughter both emotionally and physically and finds a way to be increasingly absent from the home (Guidry, 1995).

Unfortunately, incestuous abuse is a difficult pattern to break. Commonly, the nonperpetrating parent does not believe the disclosure of abuse when it is revealed, thus allowing it to continue. Often, the nonperpetrating parent is physically or emotionally ill and is unable or unwilling to end the abuse. Some nonperpetrating parents fear violence from the perpetrator. Others are afraid of losing emotional or economic support. Pierce and Pierce (1985) reported that up to 15% of nonperpetrating parents actually encouraged the abuse.

Extrafamilial abuse is more common among boys than girls (Kendall-Tackett & Simon, 1992; Leventhal, 1998; Pierce & Pierce, 1985). Boys younger than age 6 years are at highest risk of abuse by family and friends. Boys older than age 12 years have a greater risk of being abused by strangers (Holmes & Slap, 1998). Extrafamilial abuse is two times more likely to be "very serious" (vaginal/anal intercourse, oral sex) than familial abuse (Leventhal, 1998). Pierce and Pierce (1985) showed that perpetrators of male sexual abuse engaged the boys in three or more sexual acts almost twice as often as perpetrators of female sexual abuse. However, the duration of molestation is shorter on the average for male than for female victims (3.9 years vs. 5.6 years) (Whetsell-Mitchell, 1995a). Kendall-Tackett and Simon (1992) propose several reasons for this. Perpetrators of sexual abuse of boys are more likely to be from outside the home, without continued access to the child; male victims sustain more physical injury, bringing them to medical attention sooner; and males are more likely to possess the physical strength to end the abuse.

Fewer than 50% of child sex offenders are mentally ill (Hilton & Mezey, 1996; Pierce & Pierce, 1985). However, the majority have an emotional disorder that prohibits them from forming intimate relationships with partners their own age. Most offenders feel a sense of excitement when anticipating the abuse of a child and experience both emotional and sexual gratification when the act is complete.

Perpetrators often view their abuse of a child as proof to themselves that they have the power to control one aspect of their lives (Hilton & Mezey, 1996). This partly explains the motivation of abusers who have been victims of sexual abuse themselves. The “victim-to-victimizer” cycle is particularly true of adolescent perpetrators and seems most frequently to involve male victims of male offenders. The characteristics of the chosen victim, including age and physical appearance, as well as the characteristics of the abuse often closely parallel the offender’s own memory of abuse (Hilton & Mezey, 1996).

To help understand the events leading up to sexual abuse, Finkelhor (1984) proposed a set of four preconditions that must be overcome before the victimization of a child can occur. The first step is arousal, in which the abuser has sexual desires surrounding children. The perpetrator must then overcome his internal inhibitions relating to the abuse of children. This step is facilitated if the perpetrator experienced a traumatic childhood sexual event of his own (Hilton & Mezey, 1996). The offender must then find a way to have repeated physical contact with the child. This explains why perpetrators usually are people on whom the child depends for emotional, physical, financial, educational, or religious support. Finally, the abuser must overcome the child’s resistance to the sexual interaction (Hilton & Mezey, 1996).

Key Point:

Finkelhor (1984) has described a set of 4 preconditions that are typically present in cases of sexual abuse. Sgroi (1982) has described a longitudinal model of how sexual abuse typically occurs over time, progressing from nonsexual contact to sexual abuse to the point at which the abuse is discovered.

The strategies employed by the perpetrator to gain the child’s trust involve many forms of manipulation (Nieves-Khouw, 1997). This “engagement” is the first step in Sgroi’s model, which describes the progression of sexual abuse. The abuser targets the child, and they begin to share nonsexual activities. The abuser may use bribery, including gifts, favors, or privileges to entice the child. He may shower the child with encouragement and compliments. He may use persuasion to deceive the child into believing that they share a special friendship. Over time there is an escalation of activity, with each subsequent interaction becoming more sexual in nature. Once the sexual intimacy occurs, the perpetrator focuses on maintaining the secret. He now uses a different form of manipulation to intimidate the child. Playing upon the child’s guilt, he may threaten to stop loving the child. He may use threats of physical harm either to the child or to a family member. He may actually use force or violence. The child feels confused, alone, and betrayed and so perpetuates the secret. This progression of events details the next two steps in model developed by Sgroi et al. (1982): sexual interaction and secrecy (Hilton & Mezey, 1996)

INDICATORS OF SEXUAL ABUSE

The disclosure of sexual abuse, the next stage in the model, may be suppressed for a long time (Sgroi et al., 1982). There are many barriers to disclosure. Children may not reveal a history of sexual abuse because they fear that no one will believe them. Often the child feels guilt and shame surrounding the event and worries about being blamed for the abuse. Children often do not want to get the perpetrator in trouble, and they fear retaliation if they tell (Hilton & Mezey, 1996). For these reasons, children rarely provide a direct disclosure of sexual abuse. When they do, the disclosure may come at any time and to any of a multitude of people. It may occur in a place that reminds the child of the event or in a place where the child feels safe. Children may disclose a history of sexual abuse to a parent at bathtime or at bedtime. It may be made to a sibling to a playmate. The disclosure may be revealed to a teacher or guidance counselor after a sexual abuse prevention program in school. The disclosure may even be confided to the child’s physician during a routine health examination (Guidry, 1995; Whetsell-Mitchell, 1995a). More commonly, a nonspecific indicator prompts an evaluation for sexual abuse. A common early warning sign is the use of broad general statements. These statements are used by the child to gauge the response of a trusted listener. Some statements might be relatively general, such as, “Date rape has been a common topic on the news lately.” Other examples might be more specific: “Mr. Smith wears

tight underwear.” These subtle suggestions should alert the listener to the possibility of sexual abuse (Guidry, 1995; Whetsell-Mitchell, 1995a).

In a literature review, Friedrich (1993) concluded that, overall, the most consistent indicator of sexual abuse in all age groups is the demonstration of sexualized behavior. This is defined as age-inappropriate knowledge of both sexual language and behaviors. Victimized children often masturbate when stressed. They may unknowingly use seductive vocabulary or exhibit sexually aggressive intentions. Younger children may use dolls to portray sexual play, whereas older girls may demonstrate promiscuous sexual activity. Male victims have a high rate of cross-dressing (Friedrich, 1993; Sansonnett-Hayden et al., 1987; White et al., 1988). It is important to note that some sexual behavior is considered normative rather than pathognomonic for sexual abuse. The most frequent normative sexual behaviors appear to be self-stimulating behaviors, exhibitionism, and behaviors related to personal boundaries. There seems to be an inverse relationship between normal age and sexual curiosity and exploration, with the overall frequency peaking at 5 years for both boys and girls, then decreasing over the next 7 years. More intrusive or excessive sexual behavior seems to indicate a psychosocial problem. Some issues to consider include family sexuality, life stress, domestic violence, and sexual abuse (Friedrich et al., 1998).

There are many other broad, nonspecific indicators of child sexual abuse, and these can be divided into three categories: physical signs, behavioral signs, and psychiatric signs. In terms of physical indicators, few are diagnostic of sexual abuse. The presence of a sexually transmitted disease in a young child, including gonorrhea, chlamydia, syphilis, genital warts, and herpes simplex type 2, is strongly suggestive of abuse (Whetsell-Mitchell, 1995a). Still, fewer than 7% of cultures for sexually transmitted diseases are positive in suspected cases of sexual abuse (Atabaki & Paradise, 1999). The presence of sperm in or on the body or the discovery of a childhood/teenage pregnancy is a strong indicator of abuse, especially if there is no history of sexual interaction with a peer (Whetsell-Mitchell, 1995b). However, it is rare to find such blatant physical signs of assault (DeJong & Rose, 1991). More often the proof of sexual assault is in scars that are not visibly evident (Friedrich, 1993; Guidry, 1995; Whetsell-Mitchell, 1995a). Other broad indicators that may bring a child to medical attention include chronic abdominal pain, enuresis or encopresis, constipation secondary to anal discomfort, recurrent urinary tract infections, vaginal discharge, or the presence of a vaginal foreign body (Friedrich, 1993; Guidry 1995; Herendeen, 1999; Whetsell-Mitchell, 1995a).

Behavioral indicators of abuse are often the first signs noticed by people close to the child. However, these issues are not unique to victims of sexual abuse. They may also be seen in children experiencing other forms of severe stress (Whetsell-Mitchell, 1995a). Some of these behaviors include temper tantrums or running away from home. Children may begin to demonstrate developmentally regressive behaviors, such as thumbsucking or bedwetting. Victims may become fixated on obsessive cleanliness, or they may begin to neglect their bodies. They may engage in self-mutilating behaviors or self-stimulating behaviors such as excessive masturbation. Abused children often exhibit poor school attendance and performance. They may begin to experiment with delinquency or substance abuse. Finally, they may become involved in sexual relationships prematurely (Guidry, 1995; Herendeen, 1999; Hilton & Mezey, 1996; Whetsell-Mitchell, 1995a).

The psychiatric indicators of abuse must also be recognized. Victims of sexual abuse often become victims of depression. This may be exhibited as social withdrawal and the inability to form or maintain meaningful peer relations. Victims experience a profound grief in response to the many losses that they incur after the abuse. These include the loss of innocence and the loss of childhood, the loss of trust in oneself

Key Point:

Sexual abuse often presents with nonspecific indicators that fall into 3 categories:

- 1. physical signs and symptoms*
- 2. behavioral signs and symptoms*
- 3. psychiatric signs and symptoms*

and the loss of trust in adults. The pain of the abuse may be expressed as a sleeping disorder, with fear of the dark and nightmares preventing rest. Children may adopt changes in their eating habits: anorexia, overeating, or avoiding certain foods, such as milk, which reminds them of semen. Victims may attempt suicide to rid themselves of their psychological pain (Guidry, 1995; Herendeen, 1999; Hilton & Mezey, 1996; Whetsell-Mitchell, 1995b).

The final stage of the model developed by Sgroi et al. (1982) follows either purposeful or accidental disclosure of abuse. At this time the victim's caregivers and/or the offender attempt to suppress the allegation of abuse to restore the perceived state of peace that existed before the disclosure. This suppression accounts for many of the effects described by survivors of child sexual abuse. The short-term effects can range from physical to psychological derangements, closely paralleling the aforementioned indicators of abuse. If unrecognized or untreated, these effects can lead to severe long-term issues (Guidry, 1995).

SUPPORT SYSTEMS

As the issue of child sexual abuse has come increasingly to the national forefront, support services have slowly been increasing. Specialty divisions have arisen in several areas. Special police units are trained specifically to deal with child sexual abuse victims. Social workers receive specialized training to deal with childhood sexual abuse cases. Multidisciplinary child abuse evaluation teams or Child Advocacy Centers consisting of social workers, nurses, and physicians assist in evaluating potential cases. A 1988 survey of 29 pediatric hospitals with accredited residency programs reported that 69% had a designated pediatric sexual assault center (Smith et al., 1988). Protocols have been developed to improve the accuracy and thoroughness of evaluation and the recommended management of the sexually abused child. Legal services for victims are available, including the appointment of a guardian ad litem when necessary.

Even with these expanded services and referral sources, the pediatrician and family practitioner play a key role in child sexual abuse assessment and evaluation. The practitioner is often the person a family feels most comfortable turning to when there are concerns regarding this issue. He or she may be the person to whom a child discloses the abuse. This person must remain vigilant about detecting subtle clues and recognizing signs and symptoms of sexual abuse. The physician is a mandatory reporter of child sexual abuse and must be familiar with local state law with regard to reportable offenses, as well as the process of reporting such suspicions (American Academy of Pediatrics, 1999; Botash, 1994; Kempe, 1978; Kerns et al., 1994). The primary care physician can provide emotional as well as medical support to the child and family. The physician must be familiar with potential resources in terms of referrals and consultants that deal with this problem in the community. The increasing number of reports suggests that a growing number of physicians are willing to consider sexual abuse a possibility. Primary care practitioners can provide parental education through anticipatory guidance. Young children can be taught to discriminate between "a good touch and a bad touch." Families can be alerted to behaviors or physical signs that are cause for concern or be reassured regarding normal childhood play and curiosity. The physician who routinely performs a genital examination continually reviews the normal anatomy and increases the likelihood that abnormal physical findings will be detected. Regardless of the sophistication and specialty resources eventually incorporated into the system, the primary care physician remains a crucial link. The extent of the evaluation performed by the pediatrician or family practitioner depends on the experience and competency of the physician, the availability of adequate time and equipment to perform an appropriate evaluation or obtain forensic specimens, and the accessibility of a referral site for performing the necessary examination.

Key Point:

Sexual abuse is a problem that could affect any child. Therefore, professionals who come in contact with children need to be aware of the problem, need to know how it presents, and need to know what resources exist in their communities to assist in the evaluation and investigation.

OUTCOMES

Finkelhor and Browne (1985) describe a set of four traumagenic dynamics as a framework for understanding the link between the experience of sexual abuse and its sequelae. **Traumatic sexualization** refers to the inappropriate and dysfunctional development of a victim's sexuality as a result of the abuse. These children are burdened with confusion and misconceptions surrounding their sexuality. They have distorted perceptions of sexual activities. They emerge from the abuse with sexual preoccupations, such as compulsive masturbation, sexualized play, sexual aggression, and seductive behaviors. They often suffer from gender identity conflict and may engage in cross-gender behavior. Several studies reveal a high rate of prostitution among sexual abuse victims. Adult survivors tend to question the role of sex in affectionate relationships and often complain of sexual dysfunction or disinterest. For most victims of sexual abuse, sexual contact will forever bear a negative connotation (Cosentino & Collins, 1996; Finkelhor & Browne, 1985; Guidry, 1995). Certain abuse experiences tend to result in more severe traumatic sexualization. Invasive abuse is probably more sexualizing than when the offender just uses the child to masturbate. Older children who can understand the implications of the abuse are more likely to suffer traumatic sexualization than younger victims (Finkelhor & Browne, 1985).

Key Point:

Finkelhor and Browne (1985) describe a conceptual framework that helps explain the damaging effects of sexual abuse on the developing child—the traumagenic model.

A sense of betrayal emerges when victims realize that someone they trusted has caused them harm. This betrayal is often three-fold. First is the betrayal by the perpetrator in the form of manipulations and misconceptions about sex and love. Second is the child's betrayal by her own body. The child is often convinced that if her body responded to the sexual stimulation then she must have somehow wanted the abuse (Bass & Thornton, 1983). The third betrayal, committed by the victim's family, often confounds the other violations. A family who disbelieves the child's allegation or attempts to suppress it further violates the child's trust (Finkelhor & Browne, 1985).

Children respond to these betrayals in different ways. Some children express their betrayal as anger, with risk-taking behavior and delinquency representing attempts at retaliation (Finkelhor & Browne, 1985; Whetsell-Mitchell, 1995a). Other victims suffer from dissociation in which they separate themselves from their bodies and from the world (Briere & Runtz, 1988; Guidry, 1995). Yet other children display excessively clingy behavior in an effort to restore trust and security in their lives. Adult survivors describe a constant search for a redeeming relationship. Often these early betrayals are a lifelong deterrent to successful marriages. Intrafamilial sexual abuse can produce a more severe and long-lasting sense of betrayal than that involving strangers. Furthermore, the degree of betrayal is also related to the family's response to disclosure. A family who minimizes or blames the child for the abuse compounds the child's sense of betrayal. Finally, when an offender is not held accountable for his crime, the victim's sense of betrayal by the legal system and the norms of society is heightened (Finkelhor & Browne, 1985).

Powerlessness develops when a child feels that her will and her desires are continually superseded. In sexual abuse this occurs when the child's body is repeatedly misused or invaded without her consent. This loss of power is intensified with each manipulation to which the child falls victim. Each unsuccessful attempt by the child to end the abuse further magnifies her sense of disempowerment (Finkelhor & Browne, 1985). Many of the effects of sexual abuse are related to the fear and anxiety that stem from this loss of power. Nightmares, phobias, eating disorders, and somatic complaints all result from the excessive anxiety associated with the abuse (Finkelhor & Browne, 1985). **Somatization** refers to the preoccupation with bodily dysfunction that many victims of sexual abuse experience (Briere & Runtz, 1988). Some common manifestations of somatization include headaches, nausea and vomiting, heart palpitations, dizziness, fatigue, and

muscle aches (Guidry, 1995; Whetsell-Mitchell, 1995a). Most survivors fear their susceptibility to repeat victimization and express their feelings of helplessness through runaway behavior, self-mutilation, and suicide attempts. Other victims display aggressive and dominating behaviors, often becoming abusive themselves, to compensate for frustration resulting from their powerlessness. If left untreated, many victims develop posttraumatic stress disorder (Cosentino & Collins, 1996; Hilton & Mezey, 1996). Frequent abusive interactions and lengthy duration of abuse both contribute to an increased sense of disempowerment. The use of force, threats, or excessive coercion by the perpetrator all create a greater degree of psychologic trauma. This is also true of a situation in which the child tries to end the abuse with a disclosure and is disbelieved (Finkelhor & Browne, 1985).

Stigmatization, the final dynamic, describes the negative connotations that become a part of the child's self-image after the abuse. This can happen in various ways. First are the demeaning comments made directly to the child by the offender. Furthermore, the pressure from the perpetrator to maintain secrecy sends a strong message of badness and shame to the child. Second, the child may know that this sort of sexual behavior is wrong, and thus, must deal with her own internal stigma of guilt. Finally, the stigmatization may be magnified if the family reacts with disgust or blames the child for the abuse. The victimized child feels different and alone and often associates with other stigmatized groups of society. This may explain why victims get involved with substance abuse, delinquency, and prostitution. Children often tend to alienate themselves from family and friends who may view them as "damaged goods" (Cosentino & Collins, 1996; Finkelhor & Browne, 1985). Their low self-esteem may contribute to the fact that many survivors of child sexual abuse develop multiple personality disorder (Cosentino & Collins, 1996; Guidry, 1995; Hilton & Mezey, 1996). Children who receive support from their families as well as from professional treatment programs often are less stigmatized than those who are made to feel different (Finkelhor & Browne, 1985).

It is well known that child sexual abuse leaves its victims with substantial psychologic trauma. Furthermore, the variability of abuse experiences seems to cause a wide range of outcomes. However, little is known about the effect of different coping mechanisms on the outcome of abuse. Chaffin et al. (1997) studied the strategies used by a group of sexual abuse victims to cope with their abuse, as well as their self-reported abuse-related symptoms. From the data, they developed a model of four coping mechanisms used by victims of sexual abuse and the group of characteristics associated with each. They defined the coping strategies as avoidant coping, internalized coping, angry coping, and active/social coping (Chaffin et al., 1997).

AVOIDANT COPING

Avoidant coping involved distraction, wishful thinking, and cognitive restructuring. Children who received greater social support after disclosure seemed to display more avoidant coping than others. It has been suggested that avoidant coping produces short-term benefits, but long-term problems. Victims who employed avoidant mechanisms seemed to have more negative attitudes and anxieties about sexuality. Their data revealed, however, that avoidant coping was associated with fewer behavioral problems than the other strategies (Chaffin et al., 1997).

INTERNALIZED COPING

Internalized coping included social withdrawal, self-blame, and resignation. This strategy seemed to be more common in children who received negative reactions from others after disclosure. Their data revealed that these victims displayed more hyperreactive behaviors after the abuse, perhaps leading to the development of post-traumatic stress reactions. Although their study did not differentiate between male and female behaviors, prior research has suggested a distinction (Friedrich et al.,

1986). Female victims seem to display internalized behaviors such as dissociation and depression more commonly than males. Furthermore, they (females) tend to develop phobias, regressive behaviors, and multiple somatic complaints. The research of Chaffin et al. (1997) demonstrated that children rated internalized coping the least helpful of the strategies.

ANGRY COPING

Angry coping involved the cathartic release of emotions and the tendency to blame others. Abuse situations in which the perpetrator had a more distant relationship to the child seemed to instigate angry behaviors. Similarly, a high frequency of abuse interactions and forceful abuse were noted to be antecedents of angry coping. Older victims seemed to react with anger more often than younger ones. This coping mechanism, termed externalization in other research, seems to be more common in male victims (Friedrich et al., 1986; Sansonnett-Hayden et al., 1987). The data of Chaffin et al. (1997) revealed that this strategy was associated with the greatest number of behavioral problems. Such behaviors include physical as well as sexual aggression used to prove their masculinity. Conversely, females demonstrate a greater tendency toward sexually reactive behaviors, which may put them at an increased risk of revictimization.

ACTIVE/SOCIAL COPING

Active/social coping consisted of the utilization of the child's problem-solving abilities as well as social support resources. Children who experienced less severe sexual experiences seemed to implement this coping strategy. The data demonstrated that active/social coping was the only strategy not associated with negative abuse-related behaviors. However, this coping mechanism did not produce any measured benefits either, suggesting that this was a neutral strategy (Chaffin et al., 1997).

There is a paucity of literature to date regarding guidelines for the intervention and treatment of child sexual abuse. The first intervention following disclosure is to ensure the child's safety from further abuse. The next intervention involves the family or nonperpetrating parent (Cosentino & Collins, 1996). The goal of family therapy is to facilitate a supportive and protective environment for the child (Cosentino & Collins, 1996). No available data delineate which type of personalized therapy is best for the child. The treatment, however, must be targeted to the appropriate developmental level of each child. Younger children may benefit from play therapy (Hilton & Mezey, 1996). Group therapy seems to be helpful with adolescent victims because it provides peer support and may reduce the sense of isolation and stigmatization that they feel (Cosentino & Collins, 1996; Hilton & Mezey, 1996). However, group treatment may be too threatening initially for some victims. They may be unable to openly discuss their experience or hear others' accounts of abuse in the early stages of healing. For these victims, individual therapy can help them regain trust and begin to achieve control in their lives once again (Hilton & Mezey, 1996). Recent research has focused on the success of directed abuse-specific therapy. Studies comparing abuse-specific cognitive behavioral therapy to nondirective supportive therapy reveal that both groups show improvement in posttraumatic stress symptoms, but those in cognitive behavioral therapy have significantly greater improvement. Furthermore, involving the nonoffending parent in the treatment of their sexually abused children has proved beneficial as well. Parents engaged in treatment describe a greater decline in their children's externalizing behaviors, as well as a greater improvement in their parenting skills. Cognitive behavioral therapy aims to instill in the nonoffending parent an increased level of confidence and encourages them to model appropriate coping mechanisms for their children. Subsequently, their children report a significantly greater reduction in their level of depression (Deblinger et al., 1996). One reason that this treatment modality may be helpful is its utilization of well-established treatment strategies to handle abuse specific symptoms. Furthermore,

the treatment focuses on both amelioration of current symptoms and prevention of later behavioral problems and further victimization (Saywitz et al., 2000). The larger question is whether therapy has a beneficial effect on the well-documented long-term effects of child sexual abuse.

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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- α 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.

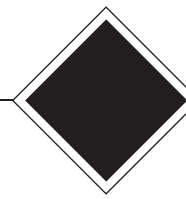
Testosterone is responsible for the evolution of the mesonephric duct system into the vas deferens, epididymis, ejaculatory ducts, and seminal vesicle. Dihydrotestosterone results in the development of the male external genitalia, including the prostate gland, which arises from the urogenital sinus, 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- α 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,



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
- Procidencia, 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