To Jim Hmurovich, President and CEO of Prevent Child Abuse America, who I have come to know as an effective child and family advocate who leads by example and makes the case everywhere he can that prevention of child abuse and neglect is possible and our collective responsibility.

— APG —

To David Chadwick, Henry Kempe, Ray Helfer, Robert Reece, Jay Whitworth, and the other pioneers of child abuse advocacy for deeply caring about children in a world that sometimes does not care as well as it should.

— RA —

“Every day counts in the life of a child.” Thanks for the support from our families, friends, and colleagues.

— DEJ —

To my family for your patience, my colleagues for your acceptance, and to all those who have left the world a bit better, and made so many little lives breathe easier — this is to have succeeded.

— JT —
Chadwick’s

Child Maltreatment

Sexual Abuse and Psychological Maltreatment

Encyclopedic Volume 2 of 3
Fourth Edition

David L. Chadwick, MD
Director Emeritus
Chadwick Center for Children and Families
Children’s Hospital—San Diego
Adjunct Associate Professor
Graduate School of Public Health
San Diego State University
San Diego, California

Randell Alexander, MD, PhD, FAAP
Professor of Pediatrics and Chief
Division of Child Protection and Forensic Pediatrics
Department of Pediatrics
University of Florida
Jacksonville, Florida

Debra Esernio-Jenssen, MD, FAAP
Professor of Pediatrics
University of Florida at Gainesville
Medical Director
Child Protection Team
Gainesville, Florida

Angelo P. Giardino, MD, PhD, MPH, FAAP
Vice President/Chief Medical Officer
Medical Affairs
Texas Children’s Health Plan
Clinical Professor, Pediatrics and Section Chief
Academic Pediatrics
Department of Pediatrics
Baylor College of Medicine
Houston, Texas

Jonathan D. Thackeray, MD, FAAP
Physician
The Center for Family Safety and Healing
Division of Child and Family Advocacy
Department of Pediatrics
Nationwide Children’s Hospital
Columbus, Ohio

STM Learning, Inc.
Leading Publisher of Scientific, Technical, and Medical Educational Resources
Saint Louis
www.stmlearning.com
Publishers: Glenn E. Whaley and Marianne V. Whaley
Graphic Design Director: Glenn E. Whaley
Managing Editor: Elizabeth S. Fergus
Associate Editor: Caoimhe Ní Dhónaill
Editorial Intern: Mia Garchitorena
Public Relations: Sapna Bhakta
Book Design/Page Layout: G.W. Graphics
Jenn Carter
John Krus
Linh Dao
Print/Production Coordinator: G.W. Graphics
Jenn Carter
Cover Design: G.W. Graphics
Color Prepress Specialist: Kevin Tucker
Acquisition Editor: Glenn E. Whaley
Developmental Editor: Elaine Steinborn
Copy Editor: Caoimhe Ní Dhónaill
Proofreader: Caoimhe Ní Dhónaill
Lindsay Westbrook
Copyright © 2014 by STM Learning, Inc.
All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.
Printed in China.
Publisher: STM Learning, Inc.
8045 Big Bend Blvd., Suite 202, Saint Louis, Missouri 63119-2714 USA
Phone: (314)993-2728 Fax: (314)993-2281 Toll Free: (800)600-0330
http://www.stmlearning.com

Library of Congress Cataloging-in-Publication Data
p. ; cm.
Child maltreatment
Includes bibliographical references and index.
RJ375
618.92’858223—dc23
2013039457
Contributors

Joyce A. Adams, MD, FAAP, FSAM
Professor of Clinical Pediatrics
Division of General Academic Pediatrics and Adolescent Medicine
School of Medicine
University of California—San Diego
Specialist in Child Abuse Pediatrics
Rady Children's Hospital
San Diego, California

Lisa Amaya-Jackson, MD, MPH
Associate Director
UCLA Duke National Center for Child Traumatic Stress
Associate Director
Center for Child and Family Health
Duke University School of Medicine
Durham, North Carolina

Robert Anda, MD, MS
Senior Scientific Consultant
Centers for Disease Control and Prevention
Atlanta, Georgia

Catherine P. Bradshaw, PhD, MEd
Deputy Director
Johns Hopkins Center for the Prevention of Youth Violence
Co-Director
Johns Hopkins Center for Prevention and Early Intervention
Johns Hopkins Bloomberg School of Public Health
Baltimore, Maryland

Ernestine C. Briggs, PhD
Assistant Professor
Department of Psychiatry and Behavioral Sciences
Duke University School of Medicine
Durham, North Carolina

Sonja Pauline Brubacher, MA, PhD
Banting Postdoctoral Fellow
Department of Psychology
Central Michigan University
Mount Pleasant, Michigan

Judith A. Cohen, MD
Medical Director
Center for Traumatic Stress in Children and Adolescents
Allegheny General Hospital
Professor of Psychiatry
Drexel University College of Medicine
Pittsburgh, Pennsylvania

Michelle Ditton, RN, SANE-A, SANE-P
Chief Nursing Officer, Executive Director
Fort Wayne Sexual Assault Treatment Center
Fort Wayne, Indiana

Marcella M. Donaruma-Kwoh, MD
Assistant Professor of Pediatrics
Program Director, Child Abuse Pediatrics
Baylor College of Medicine
Houston, Texas

Donna M. Drohan-Jennings, MA, Psychology
PhD Candidate
Department of Psychology
Wilfrid Laurier University
Waterloo, Ontario, Canada

Marc D. Feldman, MD
Clinical Professor of Psychiatry
Adjunct Professor of Psychology
University of Alabama, Tuscaloosa
Tuscaloosa, Alabama

Vincent J. Felitti, MD
Founding Chairman, Preventive Medicine
Kaiser Permanente Medical Care Program
Clinical Professor of Medicine
University of California
San Diego, California

Martin A. Finkel, DO, FAAP
Professor of Pediatrics, Medical Director
Child Abuse Research Education & Service Institute
Rowan University School of Osteopathic Medicine
Stratford, New Jersey

Monica Fitzgerald, PhD
Assistant Professor
The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
Department of Pediatrics, School of Medicine
Aurora, Colorado

Lori D. Frazier, MD
Clinical Professor
University of Utah School of Medicine
Director of the Fellowship in Child Abuse Pediatrics
University of Utah
Salt Lake City, Utah

James Garbarino, PhD
Maude Clarke Professor Humanistic Psychology
Loyola University
Chicago, Illinois

Kristi A. Green, MSN, ARNP
Advanced Registered Nurse Practitioner
Department of Pediatrics
University of Florida
Keri Jowers, MEd, PhD  
Research Manager  
Walter R. McDonald & Associates, Inc.  
Rockville, Maryland  

Julie Kenniston, MSW, LSW  
Director of Training and Education  
Butler County Children Services  
Executive Director  
The Center for Family Solutions  
Mason, Ohio  
Consultant  
Office of Juvenile Justice and Delinquency Prevention  
Department of Justice  
Washington, District of Columbia  

Anthony P. Mannarino, PhD  
Chairman, Department of Psychiatry  
Director of the Center for Traumatic Stress in Children and Adolescents  
Allegheny General Hospital  
Pittsburgh, Pennsylvania  
Professor of Psychiatry  
Drexel University College of Medicine  
Philadelphia, Pennsylvania  

Renee S. Moore, EdD, MPA, BS-CFD  
Associate Professor and Department Head  
Child and Family Development  
Missouri State University  
West Plains, Missouri  

Laura K. Murray, PhD  
Assistant Scientist  
Department of Mental Health  
John Hopkins Bloomberg School of Public Health  
Baltimore, Maryland  

Peggy Tuter Pearl, EdD  
Emeritus Professor  
Missouri State University  
Springfield, Missouri  

Lawrence R. Ricci, MD  
Co-Director  
Spurwink Child Abuse Program  
Associate Clinical Professor  
Maine Medical Center  
Tufts Medical School  
Portland, Maine  

Kim P. Roberts, PhD, Psychology  
Professor  
Department of Psychology  
Wilfrid Laurier University  
Waterloo, Ontario  

Jason Schulman, MD  
Pediatrician  
Miami, Florida  

Mary Sheridan, PhD, ACSW  
Emeritus Professor of Social Work  
Hawaii Pacific University  
Honolulu, Hawaii  

Kimberly Shipman, PhD  
Assistant Professor  
The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect  
Department of Pediatrics, School of Medicine  
Aurora, Colorado  

Andrew Sirotnak, MD, FAAP  
Professor of Pediatrics and Vice Chair for Faculty Affairs  
University of Colorado School of Medicine  
Department Head, Child Abuse and Neglect  
Director, Child Protection Team  
University of Colorado School of Medicine  
Aurora, Colorado  

John Stirling, MD, FAAP  
Director, Center for Child Protection  
Santa Clara Valley Medical Center  
Medical Director, SCAN Team  
Department of Pediatrics  
Lucile Packard Children's Hospital  
Clinical Professor (affiliated) of Pediatrics  
Stanford University  
Palo Alto, California  

Richard Thompson, PhD  
Senior Research Consultant  
Juvenile Protective Association  
Chicago, Illinois  

Jill Trammell, MS, MS  
Research Assistant  
The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect  
Department of Pediatrics, School of Medicine  
Aurora, Colorado  

Joseph A. Vorrasi, MA  
PhD candidate  
Graduate Research Assistant  
Family Life Development Center  
Cornell University  
Ithaca, New York  

Joyce Wientzen, LCSW  
Co-Director  
Spurwink Child Abuse  
Portland, Maine
FOREWORD

How fitting that this book is titled Chadwick's Child Maltreatment. The title is a richly deserved tribute to one of the world’s leading authorities on the subject—a pediatrician cut from the same cloth as his mentor, C. Henry Kempe. David Chadwick’s long and storied career may be slowly drawing to a close, but his legacy lives on in these pages, in the Chadwick Center for Children and Families that bears his name, in the San Diego International Conference on Child and Family Maltreatment, which Dr. Chadwick started nearly thirty years ago, and which is the best conference of its kind in the world, and in the hearts and minds of countless professionals. Dr. Chadwick truly has made the world a better place for children.

One gets a sense of the esteem in which Dr. Chadwick’s colleagues hold him by looking at the contributors to this book. Many of the authors are leading experts in the academic world of child maltreatment. Experts like these, with years of experience and many publications to their credit, are often less than enthusiastic when asked write yet another chapter. But when David Chadwick calls and asks for a chapter, it is hard to say “no.” When Chadwick says “jump,” most of us simply ask “How high?”

Because Dr. Chadwick and his fellow editors have pulled together such a star-studded cast of authors, this book is an extremely valuable contribution to the literature. The chapters are well-written, up to date, and packed with information that is relevant to busy professionals on the front lines of child protection. Chadwick’s Child Maltreatment Fourth Edition is so good, even Dr. Chadwick might learn a thing or two from its pages, although I have my doubts.

John E. B. Myers, BS, JD
Professor of Law
Director
Criminal Justice Concentration
McGeorge School of Law
University of the Pacific
Sacramento, California
FOREWORD

The multi-sectoral response to allegations or suspicions of child maltreatment is a complex and delicate undertaking that requires sensitivity and skill. At its core are health, social work and child protection, law enforcement, and court-related professionals. Each sector must function effectively to accomplish its part, and must interact with the others to share information, make decisions, and coordinate actions in order to maximize their chance of success. Together the sectors have the ability and authority to intervene at all three levels of child maltreatment prevention.

In primary prevention, health, social, and legal professionals can set up programs to give all children and families the best chance of living together in harmony. Where family or child characteristics comprise risk factors for child maltreatment, secondary prevention entails support to prevent violence from emerging. Finally, where a child has been ill-treated, the multi-sectoral response can mount a coordinated response to provide protection, support, and treatment services for the child victim and non-offending family, with sanction and rehabilitation for the offender.

The health sector is in an advantageous position to contribute to primary prevention by providing anticipatory guidance to families covering discipline and problem childhood behaviors. Similarly, it can identify families and children with risk factors for violence and offer support services to mitigate their impact. Finally, it has the knowledge and skills to examine children for signs of maltreatment, conduct a thorough evaluation of a child’s physical and mental health, and determine whether the child’s overall findings constitute evidence of maltreatment or another condition.

Although all physicians need to be familiar with the indicators of maltreatment so as to be able to raise the suspicion and initiate further investigation, child abuse pediatricians have the specialized training required to carry out child maltreatment evaluations. They need to be in constant touch with reference material and up-to-date evidence-based information that allow them to recognize the difference between normal variants, accidental and inflicted injury, as well as organic conditions that mimic abuse. By making reliable, valid, and defensible reports they contribute to multi-sectoral interventions that can proceed to a satisfactory and beneficial resolution with the least disruption for the child and family while making the most efficient use of resources.

The two types of maltreatment that are the focus of this volume are among the most challenging to address. Child sexual abuse can be difficult for professionals and authorities to consider or tackle. This is particularly true in societies where sex is a taboo subject, and where cultural norms require that family honor be preserved above anything else. Psychological maltreatment is often difficult to define, particularly in culturally meaningful terms, which can make identifying and protecting affected children a very challenging undertaking.

This volume furnishes reference material by leading experts for health professionals who look after children, whether as primary care providers or as child abuse pediatricians. By providing a comprehensive overview of the signs and consequences of these forms of maltreatment, case studies, and images, it will assist physicians to identify findings and to interpret them correctly so as to reach valid conclusions. The photographic atlas is particularly useful to recognizing the subtle signs that distinguish normal variants from signs of trauma, and signs of accidental trauma from those of sexual abuse. Chapter 14, Psychological Assessment and Treatment Approaches, will be of immense help when caring for children where this is an issue.
An accurate medical evaluation to identify child sexual abuse and psychological maltreatment is of critical importance and this textbook will be an invaluable resource for this to occur.

Marcellina Mian, MDCM, MHPE, FAAP, FRCPC
Professor of Pediatrics
Weill Cornell Medical College
Doha, Qatar
Although clear medical descriptions of physical and sexual abuse were published in the middle of the 19th century, they were not taken seriously for about 100 years. The delay was principally due to the recantation by Sigmund Freud of his original theory that serious psychological disturbances were caused by sexual abuse of children. Having originally stated this case, he soon changed the theory to one that held that the histories of sexual abuse provided by his patients were, in fact, fantasies. As a result, the recognition of the importance of child abuse as a cause of adult problems was delayed until the middle of the 20th century.

Child sexual abuse is any form of sexual activity with a child by an adult, or by another child where there is no consent or consent is not possible. By this definition, it is possible for a child to be sexually abused by another child who is younger than they are.

Sexual abuse includes, but is not limited to, showing a child pornographic materials, placing the child’s hand on another person’s genitals, touching a child’s genitals, and/or penetration of any orifice of a child’s body (mouth, vagina, anus) with a penis, finger, or an object of any sort. Penetration does not have to occur for it to be sexual abuse.

The health harms of sexual abuse are mostly emotional, although genital injury may occur and can be diagnostic when a qualified physician examines the child. A surprising amount of sexual abuse occurs without genital injury. On the other hand, the emotional damage is often substantial and may require considerable attention.

The prevalence of sexual abuse was massively underestimated until the middle of the 20th century. Around 1950, Alfred Kinsey surveyed about 1400 women and discovered that 25% of them recalled a prepubertal sexual experience. Russell and Finkelhor confirmed this high prevalence with surveys in the 1970s.

Psychological maltreatment includes acts of commission or omission by the parents and other caregivers that could cause the child to have serious behavioral, emotional, or mental disorders. In some instances of psychological maltreatment, the acts of parents or other caregivers alone, without any harm yet evident in the child’s behavior or condition, are sufficient to warrant the intervention of child protective services. For example, the parents or caregivers may use terrorizing forms of punishment, such as confinement of a child in a dark closet.

The idea that human beings might have “rights,” defined as permissions that were absolutely guaranteed was first expressed by a set of English barons around 1225 when they forced a king to abide by a law. The idea was further developed in the 17th and 18th centuries by philosophers and was included in United States Declaration of Independence in 1776. Rights were stated to be granted by the deity as expressed in the Declaration or by a social contract that formed a government. In either case they were guaranteed by the local society, many members of which pledged their lives and fortunes in support of the defined rights. Rights are very powerful things, but in these early efforts they were only conferred on adult male persons with property. Later they have been extended to all humans.

Throughout most of history children were simply regarded as the property of their parents. The idea that they might be entitled to anything may have been introduced by John Stuart Mill around 1869. In his long essay, ‘On Liberty,’ Mill offers the statement that parents must provide their children with “an ordinary chance of a desirable existence.” In 1913, the poet-philosopher, Gibran wrote that children are not the property of their parents.

“And a woman who held a babe against her breast said ‘Speak to us of Children’ and he said:
Your children are not your children
They are the sons and daughters of Life's longing for itself
They come through you but not from you
And though they are with you yet they belong not to you
You may give them your love but not your thoughts
For they have their own thoughts
You may house their bodies but not their souls
For their souls dwell in the house of tomorrow, which you cannot visit even in your dreams
You may strive to be like them, but seek not to make them like you
For life goes not backward nor tarries with yesterday.”

The first published attempt to codify children’s rights was written in 1923 by Eglantyne Jebb, an English reformer and child advocate. Her manifesto consisted of the following stipulations:

1. The child must be given the means requisite for its normal development, both materially and spiritually.
2. The child that is hungry must be fed, the child that is sick must be nursed, the child that is backward must be helped, the delinquent child must be reclaimed, and the orphan and the waif must be sheltered and succored.
3. The child must be the first to receive relief in times of distress.
4. The child must be put in a position to earn a livelihood, and must be protected against every form of exploitation.
5. The child must be brought up in the consciousness that its talents must be devoted to the service of its fellow men.

Her statement was adopted by the League of Nations in 1924.

Another important statement was made by the Polish pediatrician, Janusz Korczak. His writing and his life were interrupted in 1942 when he insisted on accompanying 150 Jewish orphans who were being transported from Warsaw to Treblinka for gassing. Neither he nor any of the orphans were ever heard from again. He did not publish his list of children’s rights himself and it was later published by his biographer, Betty Jean Lifton. The list is long and both whimsical and profound. It includes the “right to be loved” and such concepts as a right to due process in delinquency situations, but Korczak extends this to require a court staffed by children. It includes optimal conditions for growth and development which poses a serious challenge to society. It includes a right to die. The lists written by Jebb and Korczak form the basis of contemporary policy statements about children’s rights.

Shortly after World War II the new United Nations General Assembly created an organization to assist children whose lives have been disrupted by war, called the United Nations Children’s Fund (UNICEF). The initial mission was relief of starvation and dislocation but it soon broadened to the general protection of children.

In 1989 The United Nations adopted the Convention on the Rights of the Child, a human rights treaty setting out the civil, political, economic, social, health, and cultural rights of children. The Convention generally defines a child as any human being under the age of eighteen, unless a country’s law recognizes an earlier age of majority.

The Convention provides that all children be registered at birth and provided with an identity. It requires participating nations to enact laws that protect children against abuse and neglect. It provides children with rights that are similar to those of adults with modifications for age and developmental status. It forbids commercial exploitation and, specifically, sexual exploitation and the abduction and sale of
children. It provides for the rights of children in delinquency proceedings. It provides rules for international adoption. It is, altogether, a very admirable document.

Nations that ratify this convention are bound to it by international law. Compliance is monitored by the United Nations Committee on the Rights of the Child, which is composed of members from countries around the world. Once a year, the Committee submits a report to the Third Committee of the United Nations General Assembly, which also hears a statement from the CRC Chair, and the Assembly adopts a Resolution on the Rights of the Child.

All of the member nations of the UN General Assembly have ratified the Convention except for the United States and Somalia. In fairness it should be stated that many of the signers offer fewer real protections for children in their countries compared to the United States. Still, the refusal of the US to endorse the UN Convention is disgraceful. Despite this, as recently as 2011 the federal government enacted the Child and Family Services Improvement and Innovation Act, a program focused on preventing child abuse and neglect. In addition, it stipulates that necessary services will be provided to families once a finding of child abuse and neglect is substantiated.

The Adverse Childhood Experiences study, a collaborative effort of the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, is the largest study that assessed child maltreatment and its adverse effect on future physical and emotional health. Emotional neglect and abuse was prevalent in approximately 15% and 10% of the adult population studied, respectively. It is therefore not surprising that the American Academy of Pediatrics has recognized that psychological maltreatment may be the basis for adverse developmental outcomes to children. However, the AAP also recognizes that psychological maltreatment “may be the most challenging and prevalent form of child abuse and neglect.” Health professionals that care for children are in a unique position to educate those individuals in both the child welfare and judicial systems regarding the serious consequences of psychological maltreatment and advocate for appropriate intervention.

David L. Chadwick, MD
Angelo P. Giardino, MD, PhD, MPH, FAAP
Randell Alexander, MD, PhD, FAAP
Jonathan D. Thackeray, MD, FAAP
Debra Esbern-Jenssen, MD, FAAP
The Fourth Edition of Chadwick's Child Maltreatment once again provides a comprehensive resource regarding child abuse and neglect. It is beautifully illustrated, well-referenced, and very much up to date. Readers will be well served by this essential resource. In particular, the ophthalmology sections have been put together with expertise and offer excellent photographic examples of the findings in abusive head trauma.

Alex V. Levin, MD, MHSc, FRCSC
Chief, Pediatric Ophthalmology and Ocular Genetics
Wills Eye Institute
Philadelphia, Pennsylvania

This Chadwick’s Child Maltreatment Fourth Edition textbook offers a comprehensive and detailed accounting of the medical, social work, and legal assessment and investigation of the alleged childhood abuse victim. It serves as an excellent resource for the multidisciplinary team responsible for the evaluation of these complex cases. Anyone working in the field of child maltreatment should add this publication to their annals.

Barbara Knox, MD
Medical Director
Child Protection Program
University of Wisconsin
Family Children’s Hospital
Associate Professor, Department of Pediatric
University of Wisconsin School of Medicine and Public Health
Madison, Wisconsin

The fourth edition of Chadwick’s Child Maltreatment ensures physicians, nurses, social-workers, and law enforcement professionals have a comprehensive reference that describes the identification, evaluation, and management of all facets of child abuse and neglect. Of note, in an era when abusive head trauma (shaken baby syndrome) is often fiercely litigated in courtrooms and in lay media, Chadwick’s Child Maltreatment Fourth Edition is a reputable source of mainstream, scientific information about abusive head trauma and its ophthalmologic manifestations.

Tanya Hinds, MD, FAAP
Assistant Professor of Pediatrics
Department of Pediatrics
The George Washington University School of Medicine and Health Sciences
Child Abuse Pediatrician
Freddie Mac Foundation Child and Adolescent Protection Center
Children’s National Medical Center
Washington, DC

This work is excellent! At a time when child maltreatment science is growing exponentially, the release of the Chadwick’s Child Maltreatment Fourth Edition publication by Alexander, Giardino, Thackeray, and Esernio-Jenssen brings scholarship and practice expertise to those who deliver care to children who have been maltreated or abused. It should be in libraries worldwide.

Patricia M. Speck, DNSc, APN, FNP-BC, DF-IAFN, FAAFS, FAAN
Associate Professor and Forensic Nursing Concentration Coordinator
University of Tennessee Health Science Center
College of Nursing
Department of Advanced Practice and Doctoral Studies
Memphis, Tennessee

The new Chadwick’s Child Maltreatment book is a must for health care providers who are seeing children who have been abused. There are many useful tips that professionals can adopt in their practice and use as a reference. The chapters are easy to follow as well as providing pictures with great case examples. The most current and up to date references in the chapters make it easy to follow the research in each area. I will be recommending this 4th edition as an excellent resource book for all programs that deal with child maltreatment.

Diana Faugno, MSN, RN, CPN, SANE-A, SANE-P, FAAP, DF-IAFN
Forensic Nurse
Barbara Sinatra Children’s Center
Rancho Mirage, California

The 4th edition of Chadwick’s Child Maltreatment is a comprehensive, evidence-based text that is a critical reference for healthcare professionals who provide care for children and families. The array of expert contributors has crafted a publication that provides essential knowledge of the many facets of child maltreatment and includes contemporary references, images and case studies. I would recommend this edition of Child Maltreatment as a ‘must have’ resource for professionals committed to curbing the epidemic of child maltreatment.

Valerie Sievers, MSN, RN, CNS, CEN, SANE-A, SANE-P
Forensic Clinical Nurse Specialist Coordinator, Forensic Nursing & Correctional Healthcare
University of Colorado-Colorado Springs
Beth-El College of Nursing and Health Sciences
Colorado Springs, Colorado
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.
# Contents in Brief

| Chapter 1: | Sexual Abuse: Overview | 1 |
| Chapter 2: | Sexual Abuse: Issues Related to Interviewing Children | 19 |
| Chapter 3: | Sexual Abuse: The Medical Examination | 39 |
| Chapter 4: | Sexually Transmitted Infections | 79 |
| Chapter 5: | Sexual Behaviors in Children | 105 |
| Chapter 6: | Therapy Approaches for Sexually Abused Children | 115 |
| Chapter 7: | Positive and Negative Findings and What They Mean | 133 |
| Chapter 8: | Developmental Aspects of the Young Child | 161 |
| Chapter 9: | Understanding Resilience | 191 |
| Chapter 10: | The Lifelong Effects of Adverse Childhood Experiences | 203 |
| Chapter 11: | Psychological Maltreatment | 217 |
| Chapter 12: | Psychopathology and Child Maltreatment | 251 |
| Chapter 13: | Fabricated or Induced Illness by Carers | 269 |
| Chapter 14: | Psychological Assessment and Treatment Approaches | 287 |
| Chapter 15: | Role of the School | 309 |
| Chapter 16: | Sexual Abuse Atlas | 349 |
| Chapter 17: | Equipment for the Documentation of Sexual Abuse Atlas | 411 |
## CONTENTS IN DETAIL

### CHAPTER 1: SEXUAL ABUSE: OVERVIEW
- The Epidemiology of Child Sexual Abuse .................................................. 1
- Victim Risk Factors and Perpetrator Profiles ............................................. 2
- The Disclosure Process ............................................................................. 3
- Symptoms of Child Sexual Abuse .............................................................. 3
- Role of the Mental Health Provider ............................................................ 4
- Role of the Medical Provider .................................................................. 5
- Sexual Abuse Allegations and Custody Disputes ......................................... 7
- The Impact of Sexual Abuse and Treatment ............................................... 8
- Child Sexual Behavior ............................................................................. 10
- Legal Issues and Reporting ..................................................................... 10

### CHAPTER 2: SEXUAL ABUSE: ISSUES RELATED TO INTERVIEWING CHILDREN
- Training .................................................................................................... 21
- Number of Interviews ............................................................................... 21
- Medical History ........................................................................................ 22
- Sequence of Interviews and Interviewer Types ........................................... 22
- Preparing For the Forensic Interview ......................................................... 23
- Multiple Hypotheses ................................................................................ 25
- Forensic Interview Process ...................................................................... 25
- Engagement and Orienting the Child .......................................................... 26
- Transitioning To a Topic of Concern .......................................................... 28
- Minimizing Miscommunication ................................................................ 30
- Corroboration ........................................................................................... 31
- Multiple Events ........................................................................................ 31
- Closing the Interview ................................................................................ 32
- Blocks and Barriers to Disclosure .............................................................. 32
- Use of Media ............................................................................................. 34
- Forensic Interviews versus Medical Histories ............................................ 35
- Conclusions .............................................................................................. 35

### CHAPTER 3: SEXUAL ABUSE: THE MEDICAL EXAMINATION
- Purpose of the Medical Examination in Alleged Child Sexual Abuse .......... 39
- Preliminaries to Conducting an Examination .............................................. 40
  - Preliminary Evaluation: Step One ............................................................ 41
  - Preliminary Evaluation: Step Two ........................................................... 41
- Indications for a Physical Examination ...................................................... 43
  - Determining Need for an Immediate Examination ................................ 44
  - Deferring the Examination .................................................................. 44
- Preparing the Child for a Physical Examination ......................................... 45
- Examination Positions and Techniques ..................................................... 46
- Review of Genital and Anal Anatomy ......................................................... 46
  - Vagina ................................................................................................... 48
  - Vaginal Vestibule .................................................................................. 48
  - Hymenal Membrane .............................................................................. 49
<table>
<thead>
<tr>
<th>Contents in Detail</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Principles Regarding Sexually Transmitted Infections in Abused Children</td>
<td>79</td>
</tr>
<tr>
<td>Putting It All Together: Formulating a Diagnosis</td>
<td>53</td>
</tr>
<tr>
<td>Retinal Hemorrhages</td>
<td>56</td>
</tr>
<tr>
<td>Anus</td>
<td>56</td>
</tr>
<tr>
<td>Anal Anatomy</td>
<td>56</td>
</tr>
<tr>
<td>Interpreting Residual Effects from Sexual Contact</td>
<td>58</td>
</tr>
<tr>
<td>Examining and Interpreting Anal Findings</td>
<td>59</td>
</tr>
<tr>
<td>Male Genitalia</td>
<td>59</td>
</tr>
<tr>
<td>Residual Effects from Sexual Contact: Patterns of Trauma</td>
<td>60</td>
</tr>
<tr>
<td>Genital Fondling</td>
<td>60</td>
</tr>
<tr>
<td>Vulvar Coitus</td>
<td>61</td>
</tr>
<tr>
<td>Vaginal Penetration</td>
<td>61</td>
</tr>
<tr>
<td>Accidental Injuries</td>
<td>62</td>
</tr>
<tr>
<td>Labial Agglutination</td>
<td>63</td>
</tr>
<tr>
<td>Extragenital Trauma</td>
<td>63</td>
</tr>
<tr>
<td>Sodomy and Genital-to-Anal Contact Without Penetration</td>
<td>63</td>
</tr>
<tr>
<td>Interpretation of Healed and Healing Injuries</td>
<td>64</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>66</td>
</tr>
<tr>
<td>Forensic Evidence</td>
<td>66</td>
</tr>
<tr>
<td>Medical Conditions that Mimic Child Sexual Abuse</td>
<td>67</td>
</tr>
<tr>
<td>The Medical Record and Diagnostic Conclusions</td>
<td>67</td>
</tr>
<tr>
<td>Documenting the Clinical Evaluation</td>
<td>68</td>
</tr>
<tr>
<td>The Medical Record: Overview</td>
<td>69</td>
</tr>
<tr>
<td>Medical History Documentation</td>
<td>69</td>
</tr>
<tr>
<td>Putting It All Together: Formulating a Diagnosis</td>
<td>70</td>
</tr>
<tr>
<td>History of Sexual Abuse without Diagnostic Evidence</td>
<td>70</td>
</tr>
<tr>
<td>Diagnostic Findings Supported By History</td>
<td>71</td>
</tr>
<tr>
<td>Diagnostic Findings without Support of History</td>
<td>71</td>
</tr>
<tr>
<td>Confirmed Abuse without Residual Signs</td>
<td>71</td>
</tr>
<tr>
<td>Insufficient History and Diagnostic Findings</td>
<td>72</td>
</tr>
<tr>
<td>Other Possible Scenarios</td>
<td>72</td>
</tr>
<tr>
<td>Summary of Cases</td>
<td>72</td>
</tr>
<tr>
<td>Conclusion</td>
<td>73</td>
</tr>
</tbody>
</table>

### Chapter 4: Sexually Transmitted Infections

General Principles Regarding Sexually Transmitted Infections in Abused Children 79

Bacterial Sexually Transmitted Diseases 82

- Gonorrhea 82
  - Clinical Presentation 83
  - Laboratory Diagnosis 84
  - Treatment 84
- Chlamydia 84
  - Clinical Presentation 85
  - Laboratory Diagnosis 85
  - Treatment 85
- Syphilis 85
  - Clinical Presentation 86
  - Laboratory Diagnosis 86
  - Treatment 87
- Bacterial Vaginosis 87
  - Clinical Presentation and Laboratory Diagnosis 87
  - Treatment 88
- Trichomoniasis 88
  - Clinical Presentation 88
  - Laboratory Diagnosis 88
  - Treatment 88
### Chapter 5: Sexual Behaviors in Children

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical Background</td>
<td>105</td>
</tr>
<tr>
<td>Screening Measures</td>
<td>105</td>
</tr>
<tr>
<td>Establishing “Normal”</td>
<td>106</td>
</tr>
<tr>
<td>Contributing Factors to Sexual Behaviors</td>
<td>107</td>
</tr>
<tr>
<td>Age</td>
<td>107</td>
</tr>
<tr>
<td>Parents and Family</td>
<td>108</td>
</tr>
<tr>
<td>Adverse Life Experiences</td>
<td>108</td>
</tr>
<tr>
<td>Cultural Comparisons</td>
<td>109</td>
</tr>
<tr>
<td>Ethnic Minority Groups</td>
<td>109</td>
</tr>
<tr>
<td>Comfort with Verbalizations of Sexual Topics</td>
<td>109</td>
</tr>
<tr>
<td>Career-Related Responses to Sexual Behaviors in Children</td>
<td>110</td>
</tr>
<tr>
<td>Clinical Approach</td>
<td>110</td>
</tr>
<tr>
<td>Conclusions</td>
<td>111</td>
</tr>
</tbody>
</table>

### Chapter 6: Therapy Approaches for Sexually Abused Children

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequelae of CSA</td>
<td>115</td>
</tr>
<tr>
<td>Cognitive Symptoms</td>
<td>116</td>
</tr>
<tr>
<td>Emotional Symptoms</td>
<td>116</td>
</tr>
<tr>
<td>Behavioral Symptoms.</td>
<td>116</td>
</tr>
<tr>
<td>Engagement of Families in Therapy</td>
<td>117</td>
</tr>
<tr>
<td>Responsibilities of Referring Practitioners and Families</td>
<td>117</td>
</tr>
<tr>
<td>Responsibilities of Mental Health Practitioners</td>
<td>117</td>
</tr>
<tr>
<td>Clinical and Empirical Literature on the Treatment of CSA</td>
<td>118</td>
</tr>
<tr>
<td>Empirical Reviews of Efficacious Treatments for Sexual Abuse</td>
<td>118</td>
</tr>
<tr>
<td>Treatment Description of TF-CBT and its Eight Components</td>
<td>119</td>
</tr>
<tr>
<td>Psychoeducation and Parenting Skills</td>
<td>120</td>
</tr>
<tr>
<td>Goals of Psychoeducation</td>
<td>120</td>
</tr>
<tr>
<td>Application of Psychoeducation</td>
<td>120</td>
</tr>
<tr>
<td>Goals of Parenting Skills</td>
<td>121</td>
</tr>
<tr>
<td>Application of Parenting Skills</td>
<td>121</td>
</tr>
<tr>
<td>Relaxation, or Stress Management</td>
<td>121</td>
</tr>
<tr>
<td>Goals</td>
<td>121</td>
</tr>
<tr>
<td>Application</td>
<td>121</td>
</tr>
<tr>
<td>Affective Modulation</td>
<td>121</td>
</tr>
<tr>
<td>Goals</td>
<td>121</td>
</tr>
<tr>
<td>Application</td>
<td>122</td>
</tr>
</tbody>
</table>
## Contents in Detail

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Processing, or the Cognitive Triad</td>
<td>122</td>
</tr>
<tr>
<td>Goals</td>
<td>122</td>
</tr>
<tr>
<td>Application</td>
<td>122</td>
</tr>
<tr>
<td>Trauma Narrative or Exposure</td>
<td>122</td>
</tr>
<tr>
<td>Goals</td>
<td>122</td>
</tr>
<tr>
<td>Application</td>
<td>123</td>
</tr>
<tr>
<td>Sharing the Trauma Narrative with the Parent</td>
<td>123</td>
</tr>
<tr>
<td>In Vivo Desensitization</td>
<td>123</td>
</tr>
<tr>
<td>Goals</td>
<td>123</td>
</tr>
<tr>
<td>Application</td>
<td>123</td>
</tr>
<tr>
<td>Conjoint Parent-Child Sessions</td>
<td>123</td>
</tr>
<tr>
<td>Goals</td>
<td>123</td>
</tr>
<tr>
<td>Application</td>
<td>124</td>
</tr>
<tr>
<td>Enhancing Safety Skills</td>
<td>124</td>
</tr>
<tr>
<td>Goal</td>
<td>124</td>
</tr>
<tr>
<td>Application</td>
<td>124</td>
</tr>
<tr>
<td>Conclusion</td>
<td>124</td>
</tr>
</tbody>
</table>

### CHAPTER 7: POSITIVE AND NEGATIVE FINDINGS AND WHAT THEY MEAN

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>133</td>
</tr>
<tr>
<td>Studies in Genital and Anal Findings in Children and Adolescents with</td>
<td></td>
</tr>
<tr>
<td>Suspected Abuse</td>
<td>133</td>
</tr>
<tr>
<td>Research</td>
<td>137</td>
</tr>
<tr>
<td>Hymenal Data</td>
<td>137</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td>138</td>
</tr>
<tr>
<td>Mimics</td>
<td>139</td>
</tr>
<tr>
<td>Anal Dilation</td>
<td>139</td>
</tr>
<tr>
<td>Injuries</td>
<td>139</td>
</tr>
<tr>
<td>Conclusions</td>
<td>140</td>
</tr>
<tr>
<td>Appendix 7-1</td>
<td>140</td>
</tr>
</tbody>
</table>

### CHAPTER 8: DEVELOPMENTAL ASPECTS OF THE YOUNG CHILD

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normative Development</td>
<td>161</td>
</tr>
<tr>
<td>The Nature of Development</td>
<td>161</td>
</tr>
<tr>
<td>Development is Jointly Influenced By Heredity and Environment</td>
<td>161</td>
</tr>
<tr>
<td>The Course of Development is Flexible</td>
<td>162</td>
</tr>
<tr>
<td>Development is Largely Continuous</td>
<td>162</td>
</tr>
<tr>
<td>Development in Different Domains is Connected</td>
<td>162</td>
</tr>
<tr>
<td>Bidirectional Relationships are Present in Development</td>
<td>162</td>
</tr>
<tr>
<td>Theories of Development</td>
<td>163</td>
</tr>
<tr>
<td>Psychoanalytic Theories</td>
<td>163</td>
</tr>
<tr>
<td>Behavioral Learning Theories</td>
<td>163</td>
</tr>
<tr>
<td>Cognitive Development Theory</td>
<td>163</td>
</tr>
<tr>
<td>Social Theories</td>
<td>164</td>
</tr>
<tr>
<td>Ethological Theories</td>
<td>164</td>
</tr>
<tr>
<td>Ecological Theory</td>
<td>164</td>
</tr>
<tr>
<td>Developmental Milestones</td>
<td>165</td>
</tr>
<tr>
<td>General Development</td>
<td>165</td>
</tr>
<tr>
<td>Infancy to Toddlerhood (Age 0 to 2½ Years)</td>
<td>165</td>
</tr>
<tr>
<td>The Preschool Period (Age 3 to 6 Years)</td>
<td>167</td>
</tr>
<tr>
<td>Middle Childhood (Age 6 to 12 Years)</td>
<td>167</td>
</tr>
<tr>
<td>Developmental Milestones and Maltreatment</td>
<td>167</td>
</tr>
<tr>
<td>Maltreatment and Development: Areas for Consideration</td>
<td>168</td>
</tr>
<tr>
<td>Development Issues in the Investigation and Prosecution of Maltreatment</td>
<td>168</td>
</tr>
</tbody>
</table>

xxii
Prevention and Intervention .................................................. 237
Universal Prevention Programs ............................................. 237
Selective Intervention Programs ........................................... 238
Indicated Intervention Programs .......................................... 239
Multi-Faceted Intervention Programs .................................... 239
Policy Approaches .............................................................. 240
Conclusion ........................................................................ 240

**CHAPTER 12: PSYCHOPATHOLOGY AND CHILD MALTREATMENT**
Definitions of Maltreatment .................................................. 251
Assessment .......................................................................... 252
Links Between Child Maltreatment and Mental Health .................. 253
Mechanisms Explaining the Links Between Maltreatment and Mental Health 253
Internalizing Problems ......................................................... 254
  Depression and Anxiety ...................................................... 254
  Posttraumatic Stress Disorder (PTSD) ................................ 254
Externalizing Problems ......................................................... 255
  Conduct Disorder .............................................................. 255
  Antisocial Behavior .......................................................... 255
Other Problems .................................................................... 255
  Attention-Deficit Hyperactivity Disorder (ADHD) .................. 255
  Substance Use ................................................................. 256
  Suicidal Behavior .............................................................. 256
Neurobiology ....................................................................... 256
Consideration of Treatment Approaches for Child Maltreatment ..... 258
Innovative Collaborative Approaches to Addressing Child Maltreatment 259
Conclusion ........................................................................ 260
Appendix 12-1 .................................................................... 260
Appendix 12-2 .................................................................... 261

**CHAPTER 13: FABRICATED OR INDUCED ILLNESS BY CARERS**
Overview ........................................................................... 269
Presentation and Epidemiology ............................................... 271
  Victims ............................................................................ 272
  Perpetrators ..................................................................... 272
  Conditions Created By FII Perpetrators ................................. 274
  Warning Signs .................................................................. 275
Investigation of Suspected Cases .............................................. 277
  The Role of Health Care Providers ........................................ 280
    Lack of Knowledge ........................................................ 281
    “Seduction” By a Perpetrator ............................................ 281
    Denial ........................................................................... 281
    System Issues .................................................................. 281
    Future Directions .......................................................... 282

**CHAPTER 14: PSYCHOLOGICAL ASSESSMENT AND TREATMENT APPROACHES**
Assessment .......................................................................... 287
  Assessment of Trauma Exposure and Posttraumatic Stress Symptoms 288
  Standardized Assessment of Overall Mental Health Functioning ... 289
  Standardized Assessment is a Clinical Encounter ................... 289
Effective Treatment Approaches for Trauma-Affected Youth ........... 290
  Trauma-Focused Cognitive Behavioral Therapy .................... 292
  Cognitive Behavioral Interventions for Trauma in Schools .......... 294
  Child-Parent Psychotherapy .............................................. 295
  Eye Movement Desensitization and Reprocessing ................... 295
Contents in Detail

Alternatives for Families Cognitive Behavioral Therapy .................................. 296
Parent-Child Interaction Therapy ......................................................................... 296
Treatments Designed For Child in Out-of-Home Care .......................................... 297
  Multidimensional Treatment Foster Care for Adolescents ................................. 297
  Multidimensional Treatment Foster Care for Preschooler ................................ 298
Promising Psychological Interventions ................................................................. 298
Conclusion ............................................................................................................. 299

**CHAPTER 15: ROLE OF THE SCHOOL**

Who Reports ........................................................................................................ 309
  Contents of the Reports ...................................................................................... 310
  Level of Proof Required to Report ................................................................... 310
  Penalty for Not Reporting .................................................................................. 311
  Immunity from Criminal Prosecution and Civil Liability ................................. 311
School Policies on Reporting ................................................................................ 311
  Purpose of the Policy .......................................................................................... 311
  Contents of the Policy ........................................................................................ 312
  Reporting Institutional Abuse ............................................................................ 313
Once a Report is Made .......................................................................................... 314
Discipline in Schools .............................................................................................. 315
False Allegations .................................................................................................... 316
Defense Against Abuse in School ......................................................................... 316
Selection of Personnel ........................................................................................... 317
  Background Record Checks .............................................................................. 317
  Interviewing ......................................................................................................... 317
  Reference Checks ............................................................................................... 318
Other Policy Considerations .................................................................................. 319
In-Service Training of Staff and Volunteers ......................................................... 319
  Screening Volunteers .......................................................................................... 319
  Supervision of Volunteers .................................................................................. 319
Beyond the Legal Minimums .................................................................................. 320
Characteristics of Children with a History of Maltreatment ................................. 322
  Trauma and Its Effects on Children and Adolescents ...................................... 324
  Effects on Development ..................................................................................... 326
  Sexual Abuse ...................................................................................................... 326
  Conclusions ......................................................................................................... 326
Characteristics of the Teacher ............................................................................... 327
Strategies for Teachers ........................................................................................... 327
  Build a Sense of Trust ......................................................................................... 328
  Expect Success ..................................................................................................... 328
  Teach Social Skills .............................................................................................. 329
  Teach Life Skills .................................................................................................. 330
  Teach Communications Skills .......................................................................... 330
  Allow Students to be Students ......................................................................... 331
  Teach Positive Coping Skills ............................................................................ 332
  Provide Pleasant Experiences .......................................................................... 333
  Build Self-Esteem ............................................................................................... 334
  Improve Academic Skills .................................................................................. 334
  Provide Avenues to Gain Insight ....................................................................... 335
Resiliency of Children ............................................................................................ 336
Training and Support for All Educational Staff Members ................................. 337
Educational Neglect ............................................................................................... 337
  Causes of Educational Neglect ......................................................................... 339
  Neglecting the Child with Special Needs .......................................................... 341
  Consequences of Educational Neglect .............................................................. 342
Contents in Detail

Summary ......................................................... 342
Conclusion ....................................................... 343

 CHAPTER 16: SEXUAL ABUSE ATLAS

Techniques and Basic Skills .................................. 350
Hymenal Configurations ....................................... 354
Findings Confused with Abuse ................................ 357
  Imperforate Hymen ........................................... 357
  Prolapsed Uterus .............................................. 357
  Lichen Sclerosis .............................................. 358
  Urethral Prolapse ............................................ 359
  Failure of Midline Fusion ................................... 360
  Labial Fusion ................................................. 360
  Straddle Injury .............................................. 360
  Vaginal Duplication ........................................ 361
  Vitiligo ....................................................... 361
  Foreign Body ................................................ 362
  Toxic Shock ................................................. 363
  Hymenal Projection ........................................ 364
  External Hymenal Midline .................................. 364
  Extensive Labial Fusion ..................................... 365
  Failed Midline Fusion ...................................... 365
  Possible Foreign Body ...................................... 366
  Lichen Sclerosis Causing Bleeding ......................... 367
  Labial Bruising ............................................. 367
  Duplication of Reproductive Structures ................. 367
  Pinworm ..................................................... 368
  Hemangioma .................................................. 368
  Perianal Vitiligo ............................................ 368
  Vaginal Discharge .......................................... 369

Normal Findings ............................................. 370
  Crescentic Hymen .......................................... 370
  Annular Hymen .............................................. 370
  Large Urethral Opening Above Normal Hymen .............. 370
  Normal Intact Hymen ........................................ 371
  Anal Tag ..................................................... 371
  Normal Intact Annular Hymen .............................. 371
  Intravaginal Ridge ......................................... 372
  Normal Examination ........................................ 372
  Normal Anal Findings ...................................... 372
  Thickened Crescentic Hymen ............................... 372
  Circumferential or Annular Hymen ......................... 373
  Anterior Anal Venous Pooling .............................. 373
  Extensive Anal Pooling .................................... 373
  Midline White Line ........................................ 374
  Normal Examination After Sexual Assault ................. 374
  Smooth Avascular Posterior Area .......................... 374
  Hymenal Projection ......................................... 374
  Integrity of Hymen ......................................... 375
  Hymenal Mound ............................................. 375
  Anterior Intravaginal Ridge ............................... 375
  Knee-Chest Position ....................................... 375
  Intact Posterior Rim ...................................... 376
  Prominent Urethral Support Structures ................... 376
  Hymenal Tag ................................................ 377
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cylindrical Perianal Condylomata</td>
<td>404</td>
</tr>
<tr>
<td>Perianal Streptococcal Infection</td>
<td>405</td>
</tr>
<tr>
<td>Penile Lichen Planus</td>
<td>405</td>
</tr>
<tr>
<td>Flatwarts</td>
<td>405</td>
</tr>
<tr>
<td>Molluscum Contagiosum</td>
<td>406</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>406</td>
</tr>
<tr>
<td>Old Injuries</td>
<td>407</td>
</tr>
<tr>
<td>History of Penile Penetration</td>
<td>407</td>
</tr>
<tr>
<td>Previous Vaginal Penetration</td>
<td>407</td>
</tr>
<tr>
<td>Digital Penetration</td>
<td>408</td>
</tr>
<tr>
<td>Healed Transection</td>
<td>408</td>
</tr>
<tr>
<td><strong>Chapter 17: Equipment for the Documentation of Sexual Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Photodocumentation</td>
<td>411</td>
</tr>
<tr>
<td>Laboratory Specimens</td>
<td>413</td>
</tr>
<tr>
<td>Forensic Evidence Collection</td>
<td>414</td>
</tr>
<tr>
<td>Medication</td>
<td>416</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>416</td>
</tr>
</tbody>
</table>
Sexual Abuse: Overview

Lawrence R. Ricci, MD
Joyce Wientzen, LCSW

The Epidemiology of Child Sexual Abuse

In a 1977 lecture before the membership of the American Academy of Pediatrics, Henry Kempe, who in 1961 first identified and named the battered child syndrome defined child 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. The sexual activities he referred to range from nontouching abuses such as exhibitionism and voyeurism to physically intrusive acts such as oral-genital, genital-genital, or genital-anal contact to or by the child. His definition, virtually at the dawn of our understanding of child sexual abuse, remains useful today in emphasizing both the nature of the sexual acts and the lack of consent. The National Center for Child Abuse and Neglect, emphasizing the perpetrator's purpose rather than the act itself, defined child sexual abuse as contacts or interactions between a child and an adult when a child is being used for the sexual stimulation of the perpetrator or another person. Finkelhor, combining both definitions, described sexual abuse as the exposure of a child to sexual experiences that are inappropriate for his or her level of physical and emotional development, coercive in nature, and usually initiated for the purpose of adult sexual gratification.

In recent years attention has focused on sexual abuse by same- or similar-age peers or siblings. Yates has noted that sexual abuse can be differentiated from sexual play by determining whether there is a developmental asymmetry among the participants and by assessing the nature of the behavior. Paradise adds that the important point is not the age of the perpetrator in relation to the child but whether the perpetrator is in a position of power and control over the victim.

According to child protective services (CPS) data, more than 3 million children were reported as abused in the United States in 1996. A third of these children were confirmed or substantiated by state agencies to be victims of child abuse; 9% of the substantiated cases were for sexual abuse. If the annual incidence or number of new cases of child sexual abuse is 1% of the pediatric population, as is commonly believed, the prevalence would likely be 12% to 25% for girls and 8% to 10% for boys by age 18 years. Although the percentage of adults disclosing a history of sexual abuse in a number of studies ranges from 2% to 62% for females and from 3% to 16% for males, depending on the population studied and the definitions of abuse used, prevalence studies overall report that 1 in 4 women and 1 in 7 men are victims of sexual abuse at some time in their childhood. In support of these figures, a respected 1985 national survey found that 27% of women and 16% of men reported having been sexually abused before age 18 years.

Jones and Finkelhor recently identified a profound shift in the reporting and substantiation of child sexual abuse. The increases in CPS-substantiated cases seen in the
1980s to a peak of 149,800 cases in 1992 has been followed by a significant decline in the 1990s to 103,600 cases in 1998, a decrease of 31%. This decline in number of substantiated cases was associated with a similar decrease in the number of reports to CPS from 429,000 in 1991 to 315,400 in 1998, a 26% reduction. Although cases of other types of child maltreatment have also declined—for example, substantiated cases of physical abuse declined 16%—the decrease in child sexual abuse cases has been more marked.

This decline, according to Jones and Finkelhor, could represent a decline in the incidence of sexual abuse or a reduction in reporting and substantiation. Factors potentially accounting for a decrease in the incidence of child sexual abuse are prevention, incarceration, treatment of offenders, reduction in causal variables, and depletion of the reservoir of older cases. Factors potentially causing decreased reporting and substantiation include reduced vigilance, fear of retribution, changes in the definition of what is accepted by agencies for investigation, changes in policy regarding criteria to substantiate, and fear of lawsuits. Optimistically, if the decline represents a decrease in the incidence of sexual abuse, then the primary, secondary, and tertiary prevention efforts of the past 20 years would seem to have been in vain. However, if the decline represents fewer reports and fewer substantiations in the face of unchanging incidence, then we have simply returned to the era when child sexual abuse was the hidden problem that Kempe described in 1977. However, Jones and Finkelhor offer the argument that the decline is real and represents the result of prevention efforts.

**Victim Risk Factors and Perpetrator Profiles**

Risk factors for abuse have been difficult to identify. Race and socioeconomic status appear to have no influence on abuse risk, whereas gender and age likely do. Girls are more likely to be sexually abused than boys; however, boys are less likely to report the abuse. In a review of studies, Finkelhor and Barent found vulnerability for both boys and girls peaks between ages 7 and 13 years. However, these numbers may reflect an overrepresentation of older children because these children are more likely to disclose. Adolescents are at particular risk for sexual abuse. In one survey of adolescent students, 12% of males and 18% of females reported unwanted sexual activity between ages 13 and 16 years.

The risk factors for sexual abuse that appear most commonly in studies are factors in the child’s environment that diminish supervision and support, such as parental inadequacy, parental unavailability, and poor parent-child relationship. Children in substance abusing or violent homes are also at risk. It should be no surprise that these risk factors are also reflected in studies of physically abused and neglected children.

Abusers can be classified according to their relationship to the child as family, acquaintance, or stranger. Children, as opposed to adults, are infrequently victimized by strangers. Intrafamilial perpetrators constitute as many as 50% of all perpetrators against girls and 10% to 20% of perpetrators against boys. Even in adolescence as many as half of all sexual assaults are committed by acquaintances. In one survey, 84% of college women who reported unwanted sexual intercourse knew their assailants.

The perpetrators of sexual abuse of boys are most often acquaintances outside the home, for example, neighbors, teachers, coaches, religious leaders, and peers. Females may constitute as many as 10% of perpetrators of sexual abuse.

Becker reported that one quarter to one third of male offenders are juveniles, many have been sexually abused as children, and many abuse more than one child. Russell reported that when abused by family members, 23% of children experienced very serious abuse, such as vaginal intercourse or oral sex; 41%, serious abuse, such as digital penetration or touching; and 36%, least serious abuse, such as touching over the clothes. In the case of out-of-home offenders, there were more children abused in the very serious category and fewer in the serious and least serious categories.
Sexual Abuse: Issues Related to Interviewing Children

Julie Kenniston, MSW, LSW
Michelle Ditton, RN, SANE-A, SANE-P

The interviewing of children in child maltreatment cases has evolved significantly in the course of the last 25 years. These cases are often seen as “he said/she said” dilemmas that generate much scrutiny over the information-gathering process. Because child sexual abuse cases have medical evidence only 5% to 10% of the time, in the other 90% to 95% of cases it can be difficult to take the word of a child over the word of an adult. Even when evidence is present there are many hurdles to overcome in court. The dilemma extends to jurors who feel as if they are making a choice between an adult’s freedom and a child’s safety. Consequently, triers of fact (judges and jurors) need information that not only seems credible but also gives them confidence in their decisions.

One set of data provided to judges and jurors can be found in the interviews of child victims. Initially called investigative interviews, information-gathering sessions with children were conducted by child protection social workers and/or law enforcement. Other professionals, such as therapists or psychologists, were occasionally contracted by these entities to interview children. These interactions have been called, among other things, psychosocial evaluations in suspected child sexual abuse cases. Psychiatrists conducting evaluations had practice parameters for cases in which they were conducting forensic assessments for children or adolescents who may have been sexually abused. Although the names were different, the concepts were similar. These interactions with children were intended to gather data.

The process of these different interactions depended somewhat on the role of the interviewer. Ultimately, the goal was to gather information from the child that would assist in making a case decision. The tools used in interviews varied. Guidelines were not offered at a national level until the 1990s. Although analogue research offered guidance to child interviewers in the early years, techniques varied based on jurisdictional practice and individual interviewer preference. The growth and accountability of the field occurred in a court of law where interviewers had to defend their practices. Major sexual abuse cases of the 1980s and 1990s spurred interviewers to determine best practices not only by looking to research but also by learning from past cases what techniques were successfully defended in court. Several national training models gained momentum at the same time these cases were being fought in the national news. These trainings offered a forum for interviewers from around the country to receive continuing education focused on child interviewing and discuss commonalities and differences among jurisdictions.

The court system began moving away from scrutinizing the child and moved toward scrutinizing the interviewer, a more palatable situation in the eyes of jurors. This process initiated an evolution in interviewing. Even the name of the skill changed. What was once investigative interviewing became known as forensic interviewing. What was first identified primarily for child sexual abuse cases is now applied in allegations
of child sexual exploitation, human trafficking, physical abuse, witnessing violence, emotional maltreatment, and extreme neglect. The use of forensic interviews has been expanded beyond child maltreatment. In some jurisdictions, forensic interviewers are being asked to assist school systems in gathering information in cases of bullying.

The term *forensic* indicates that the interview is “for court purposes,” although most cases of child abuse and witnessing violence do not go to trial. Every case does have the potential for civil or criminal action at the outset, so interviewers should use forensically sound practices in every interview. However, the comprehensive forensic interview might establish that legal action is unnecessary or identify a need for other services or interventions. This is a constant balancing act: sensitively gathering the most accurate information from a child and doing so in a legally defensible way. Ultimately, the child’s safety and well-being are the primary focus. Sometimes court action is a means to this end. Forensic interviews are conducted not only for prosecution but also to establish a need for protection of the child. Often protection and prosecution issues are clearer in physical abuse and extreme neglect cases because physical evidence is present. As stated previously, medical examinations in most child sexual abuse cases are normal, which has moved the field to put greater emphasis on the verbal history taken from the child. This chapter focuses on the unique aspects of interviewing children in child sexual abuse cases. However, many of the concepts presented apply to all types of child maltreatment and witnessing violence.

As a field, forensic interviewing is young. As most development progresses quickly in the early phases and levels out in the later years, interviewing is beginning to reach a leveling-out period. The body of research has grown substantially, and recent research has emerged to help build consensus among guidelines. There is notable consensus of the national models, and trainers of forensic interviewing often confer. Trainers agree that for the field to continually evolve, research-informed practice and practice-informed research are required. Some trainings have changed their verbiage from “protocols” to “guidelines” with the understanding that flexibility is required in the interview as each child brings his or her unique needs into the interview process.

The forensic interview is not the only information-gathering process with children in child sexual abuse cases. Medical providers, social workers, law enforcement, advocates, prosecutors, and mental health professionals all gather data from children to obtain the information they need. These roles will be described later in this chapter.

Interviewing children is a skill that varies depending on the professional seeking the information. Although subtle differences can be found in the manifestation of the skill, the basic tenets of interviewing children remain the same. In child sexual abuse cases, several components are important in gathering data to make decisions. Each professional has a different role but works as a member of a multidisciplinary team. In over 750 communities across the United States and abroad, this type of team operates in a child advocacy center (CAC). Whether this team of professionals uses a CAC or not, each profession represented on the team is responsible for a unique component of the child abuse investigation. In some CACs there is a team member whose primary role is to conduct forensic interviews and whose title is forensic interviewer or forensic interview specialist. In other CACs or multidisciplinary teams, the child protection worker, law enforcement, or other member of the team is responsible for conducting the forensic interview.

The forensic interview is typically the introduction of the child to the system after a suspicion of child maltreatment has resulted in a report. However, first responders might carry the responsibility for establishing the child’s safety and thus be the first to make contact with the family after the report is made. From the point of first contact, it is crucial that every professional working with the child understands the impact of the types of questions used as well as the style in which the questions are asked. If at all possible, those having contact with children should be trained on proper
Chapter 3

SEXUAL ABUSE: THE MEDICAL EXAMINATION
Martin A. Finkel, DO, FAAP

PURPOSE OF THE MEDICAL EXAMINATION IN ALLEGED CHILD SEXUAL ABUSE
Children alleged to have experienced sexually inappropriate activities are at risk for significant medical and psychological sequelae. The health care professional can play an important role in addressing the physical and psychological impact of sexual abuse. All professionals who interact with children suspected of experiencing sexual abuse need to understand the importance of the medical examination as well as what to expect from medical professionals who conduct these examinations and how to interpret medical reports. The physical examination can be therapeutic for the child and caregiver if conducted with sensitivity and skill. The physical examination of a child alleged to have been sexually abused is much more than simply checking for anogenital or extragenital findings. The examination serves several critically important purposes, as follows:

1. The diagnosis and treatment of medical and psychological residual to the alleged sexual contact. Residual signs can be found in the form of genital and anal trauma, extragenital trauma, sexually transmitted infections (STIs), and the presence of forensic evidence.

2. Addressing both anticipated and unanticipated worries and concerns that children have as a result of their experiences. This second purpose can be characterized as diagnosing “normality” to address concerns about alterations of body image and well-being.

Children should be given an opportunity to provide their medical history independent of their caregiver to the doctor prior to the physical examination. Most children will be able to separate from their caregiver. When the child is able to separate, he or she is provided an opportunity to potentially share historical details not shared with the caregiver, law enforcement (LE), or child protective service (CPS) workers in the context of being interviewed. Reluctance on the part of the child to share details with the caregiver might be attributed to (1) fear of upsetting the caregiver, (2) fear of culpability, (3) belief that the caregiver will be upset that the child did not tell sooner, (4) embarrassment or shame, and (5) free-floating anxiety regarding perceived consequences of “allowing” the sexual interaction. Reluctance to share details with law enforcement and/or CPS may occur because of preconceived attitudes toward these professionals and no frame of reference that they are helping professionals. Doctors traditionally are viewed by society as confidants, healers, and individuals who can safely be told the most personal worries or concerns.

The medical history obtained independently allows children to share in their own words what they experienced, address any worries or concerns they may have about their body as a result of their experience, and ultimately provides a contextually richer understanding of what occurred. The idiosyncratic details that the child provides to the doctor afford insight regarding whether he or she experienced physical injury and
Figure 3-6. Intravaginal longitudinal septum intersects hymenal orifice and vagina. This congenital defect may be associated with upper genital urinary tract anomalies which should be investigated in early adolescence.

Figure 3-7. Septate hymen bisecting hymenal orifice in the plane of the hymen without extension intravaginally.

Figure 3-8. Redundant tissue surrounding the hymenal orifice restricts visualization of orifice with traction and separation alone. Companion image demonstrates appearance with the use of the knee-chest position.

Figure 3-9. Knee-chest position allows redundant tissue to fall forward covering the urethra and allowing visualization of the crescentic shaped hymenal orifice.

Figure 3-10. Hymenal orifice not visualized with labial separation alone.
Figure 3-11. Labial traction affords unfolding of redundant tissue and visualization of annular orifice and intravaginal content as well as the urethra.

Figure 3-12. Anterior tag present below urethra representing a normal anatomic variation.

Figure 3-13. Prominent projection of hymenal tissue at the 6 o’clock position representing an external reflection of a posterior longitudinal intravaginal column.

Figure 3-14. Estrogenized annular hymen with slight redundancy and elasticity. Prominent anterior column.

Figure 3-15. Redundant estrogenized hymen with labial separation does not allow visualization of hymenal orifice.
Figure 3-16. With additional traction the cohesive forces of the moist tissues are overcome and the crescentic appearance is visualized.

Figure 3-17. Septate hymen in pubertal child. Tampons should not be used until septum is interrupted surgically.

Figure 3-18. Sleeve-like configuration of hymenal membrane in prepubertal child. Hymen demonstrates estrogen effect.

Figure 3-19. Annular configuration of estrogenized hymen in Tanner Stage II child.

Figure 3-20. Fimbriated appearance to hymenal edge with labial traction. Fimbriation or scalloping of edge circumferentially provides greater distensability to orifice. Scalloped appearance does not represent multiple small partial transections.
The Lifelong Effects of Adverse Childhood Experiences

Vincent J. Felitti, MD
Robert F. Anda, MD, MS

“They do not want to hear what their children suffer. They’ve made the telling of the suffering itself taboo.”

Alice Walker, Possessing the Secret of Joy.

This chapter will document how adverse childhood experiences play a major and lifelong role in the difficulty, effectiveness, and cost of adult medical practice, and are the major origin of numerous important public health, medical, and social problems. In all of these areas, the relationship between adverse childhood experiences and adult well being ordinarily goes unrecognized. Our evidence comes from the Adverse Childhood Experiences (ACE) study, a collaborative effort between Kaiser Permanente and the Centers for Disease Control (CDC) involving over 17,000 adults in a major retrospective and prospective epidemiologic analysis. The ACE study reveals how 10 categories of adverse life experience in childhood have a demonstrable impact, decades later, on health risks, disease burden, social malfunction, medical care costs, and life expectancy. This chapter will show that events that are lost in time, and then further protected by shame, secrecy, and social taboos against exploring certain areas of human experience, cost us heavily in health, humanity, and dollars. Routinely integrating the inquiry about, acknowledgement, and discussion of traumatic life experiences into the medical history has major benefits to patients, and is generally welcomed by them, though it is often uncomfortable for physicians. This professional discomfort has secondary ramifications in limiting the availability of such information in medicine, social work, and in the law enforcement, legislative, and judicial systems.

Origins of the ACE Study

The ACE study had its origins in our repeated counterintuitive experiences while operating a major obesity-reduction program using the technique of supplemented absolute fasting, which allows weight to be reduced non-surgically at approximately the rate of 300 lbs per year. We repeatedly found many patients fleeing their own success when major weight loss occurred. We were forced to recognize that eating has major psychoactive benefits that are obvious enough to be built into the language: “Sit down and have something to eat; you’ll feel better.” Many of our patients had a significant need to feel better, though these rarely surfaced spontaneously and hence were not known. Further exploration led to discovering the protective benefits of obesity. We slowly discovered that many of these patients had life experiences for which being obese was protective. If one has a need to de-sexualize oneself, as in a reaction to rape or childhood sexual molestation, then gaining a hundred pounds is an effective approach. A former rape victim who gained 105 pounds in the year subsequent to her rape commented: “Overweight is overlooked, and that’s the way I need to be.”
Similarly, being larger than others can project a sense of power, as illustrated in the common expression, “Throwing your weight around.”

Interviews with our obese patients unexpectedly led to discovering myriad long-term medical effects of seriously troubled childhoods. Such histories were almost never documented in their medical records. The high prevalence of abusive life experiences in the childhoods of our obese patients ultimately led us to consider to what degree this might also be the case in a general population. The ACE study was devised to determine in a general, middle-class, adult population the prevalence of 10 categories of stressful, traumatic childhood experiences that we had found so common in our obese population. And further, to determine what, if any, the additional long-term effects of these experiences might be.

These clinical observations at Kaiser Permanente’s Department of Preventive Medicine in San Diego dovetailed with new approaches to understanding the emotional underpinnings of behavior and disease that had recently emerged at the CDC among studies of nationally representative samples of US adults. Among these studies were: linking self-reported stress to the incidence of peptic ulcer disease, discovering the higher prevalence of smoking and lower incidence of quitting among persons who are depressed, and finding an increased incidence of coronary heart disease among persons experiencing hopelessness. The combination of clinical observations at Kaiser Permanente (KP) and the public health approach using the tools of medical epidemiology at the CDC proved to be a powerful combination in designing the ACE study and quantifying and interpreting the observed long-term effects of ACEs.

The Department of Preventive Medicine at Kaiser Permanente in San Diego provided an unusual resource for carrying out such a study in its Health Appraisal division. At the time the ACE study began in 1995-1997, over 50,000 adults a year voluntarily chose to come for periodic comprehensive medical evaluation. This evaluation included detailed medical history, extensive laboratory testing, and complete physical examination. In any 4-year period, 81% of the adult members in San Diego chose to avail themselves of this service.

The ACE study consisted in our asking two groups of such adult Kaiser Health Plan members, each consisting of 13,000 consecutive individuals requesting such health appraisal, whether they would help us understand how childhood experiences might affect health later in life. We explained that we would also track their medical records prospectively to follow their clinical courses forward in time. The study was carried out in two separate waves to allow mid-point revision if necessary. Almost 70% of those asked agreed to participate in the ACE study. All persons had high-quality health insurance from Kaiser Health Plan. Average age was 57 years with a range from 26 into the nineties. Almost exactly half were men, half women. Approximately 80% were white including Hispanic, 10% black, 10% Asian; 74% had attended college. This was clearly a middle-class American population, and not one that could be dismissed as “not in my practice.” This may have a bearing on the deep intellectual interest the findings of this study have generated, as well as on the resistance to using them in practice.

Approval of the ACE study was slowed by institutional review board (IRB) concern that some patients might emotionally decompensate when faced with the intrusive questions that we proposed to ask by questionnaire about childhood experiences. Colleagues assured us that patients would be furious when faced with these types of questions and they believed that patients would be unlikely to respond truthfully. IRB agreement was ultimately obtained by arranging to have a responsible person carry a cell phone 24 hours a day for 3 years to accept emergency calls from those putative persons who might decompensate when asked about the reality of their lives. However, no phone calls were received. Instead, we had a number of patient compliments and a small collection of letters, one written on lined paper by an elderly woman: “Thank
Annular hymen, 370f, 373f
Anogenital examination, 45
APA. See American Psychological Association
APSAC. See American Professional Society on the Abuse of Children
Aptima universal NAAT culture use, 413f
Association for the Treatment of Sexual Abusers, 107
Attachment security, 179, 231–232
Attention-deficit/hyperactivity disorder, 255–256

B
Behavioral learning theories, 163
Behavioral Risk Factor Surveillance System, 213
Behavioral symptoms of child sexual abuse, 4, 7, 9–10, 108–109
Bibliotherapy, 335–336t
Bidirectional relationships, 162–163
Biohazard waste disposal, 414, 415f
Brain development, 178, 257–258

C
CAGs. See Child Advocacy Centers
CAPTA. See Federal Child Abuse Prevention and Treatment Act
Caregiver, 39, 41, 45–46, 257
See also Fabricated or induced illness by carers
CBCL. See Child Behavior Checklist
CBITS. See Cognitive Behavioral Interventions for Trauma in Schools
CBT. See Cognitive behavioral therapy
CECB. See California Evidence-Based Clearinghouse for Child Welfare
Centers for Disease Control, 252
Child. See Victim
Child abuse medical specialist subspecialty, 5
Child Advocacy Centers, 6, 20
Child Behavior Checklist, 106
Child development and maltreatment consequences, 177–180
considerations
cognitive development, 169–170
emotion/stress and memory, 170–171
intellectually disabled children, 177
investigation and prosecution of cases, 168–169

INDEX

A
AACAP. See American Academy of Child and Adolescent Psychology
Abrasions, linear, 390–391f
Abreactive play behavior, 324
Abusive injury findings, 151–155f, 157f, 382–383f, 385–391f, 407–408f
Accidental injury, 62, 399f, 401f
Accommodation syndrome, 3
Accumulation of risk model in psychological maltreatment, 230
ACEs. See Adverse childhood experiences
Acquaintances as perpetrators, 2
A-CSBI. See Adolescent Clinical Sexual Behavior Inventory
Acting out sexually, 4, 7, 10, 108–109
Acute injuries, 44, 139–140, 382–401f
ADHD. See Attention-deficit/hyperactivity disorder
Adolescent Clinical Sexual Behavior Inventory (A-CSBI), 108
Adolescents as perpetrators, 2–3
Adults, long-term outcomes of childhood abuse on, 9
Adverse childhood experiences, 4, 7, 9–10, 108–109, 191, 203–206, 205f, 205t, 257
Affect regulation, 179
Age and abuse vulnerability, 2
Age as sexual behavior contributing factor, 107–108, 107f
Aggressive play behavior, 324
Alternatives for Families Cognitive Behavioral Therapy, 296
American Academy of Child and Adolescent Psychiatry, 258
American Academy of Child and Adolescent Psychology, 23
American Academy of Pediatrics Committee on Adolescence, 5
American Academy of Pediatrics Committee on Child Abuse, 6, 58
American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, 168
American Medical Association Diagnostic and Treatment Guidelines, 3–4
American Professional Society on the Abuse of Children, 5, 23, 137
American Psychological Association, 23
Anal anatomy, 56–58, 57f
Anal fissures, 396f
Anal hematoma, 401f
Anal laceration, 385f
Anal penetration, 63–64, 381–382f, 385–386f, 390f, 394f, 396f, 400f, 407f
Anal polyps, 148f
Anal tag, 371f, 396f
Anal tears, 382f, 390f
Anal venous pooling, 373f

419
language development, 171
legal proceedings context understanding, 171–172
sexual behavior, 172–174
sexual behavior in abused children, 172–174
sexual behavior in non abused children, 172–173
social development, 171–172
special needs children, 174–177, 175t, 176t
See also Normative child development

Child-Parent Psychotherapy, 295
Child Protective Services, 1
Child PTSD Symptom Scale, 288

Child sexual abuse
defined, 1
epidemiology of, 1–12
impact of, 8–9
incidence of, 1–2
medical diagnosis, evolution of, 6
medical health provider role in, 5–7
mental health provider role in, 4–5
power, control, and, 1
substantiation of, 1–2
symptomology, 3–4
therapy-based investigation of, 5

Child sexual abuse accommodation syndrome, 3
Child Sexual Behavior Inventory, 105–106
Chocolate agar medium investigative use, 414f
Clinical encounter assessment, 289–290
Clinical evaluation findings documentation, 68–69
CNS function, diminished, 193

Cognitive Behavioral Interventions for Trauma in Schools, 294
Cognitive behavioral therapy, 9, 118
Cognitive development, 163–164, 169–170
Colposcope use, 412f
Complete disruptions, findings of, 398f
Condyloma acuminata, 95–96, 97t, 98, 403f, 404f
Condyloma lata, 86

Consensual sexual activity findings, 156f, 349
Corroboration, 31, 32–33b
Corrupting as psychological maltreatment, 219
CPP. See Child-Parent Psychotherapy
CPSS. See Child PTSD Symptom Scale
Crescentic hymen, 370f, 372f
Cribriform hymen, 379–380f
CSBI. See Child Sexual Behavior Inventory
Cultural issues and psychological maltreatment, 222–223

Custody disputes and sexual abuse allegations, 7–8
Cyndrical perianal condyloma acuminata, 404f

Differential effects of psychological maltreatment based on age and gender, 234
Digital camera use, 412f
Disclosure, block and barriers to, 33–35, 34b
Dissociate play behavior, 324
Divorce custody disputes and sexual abuse allegations, 7–8
DNA evidence, 7

Don’t Get So Upset (Jacobson), 319

E
The Early Assessment Risk Lists for Boys and Girls, 325
Ecological theories of child development, 164–165, 164f
Educational neglect, 337–343

EMDR. See Eye Movement Desensitization and Reprocessing
Emergency departments, hospital, 43
Emotional regulation, 178–179
Emotional responsiveness, denying, 219
Emotion/stress and memory, 170–171
Enlarged urethral opening, 370f

Equipment, investigative
evidence storage, 414, 416f
forensic evidence collection, 414, 416
laboratory specimens, 413–414f
medication, 416, 417f
photo documentation, 411–413, 412–413f
pregnancy test, 411f
telemedicine, 416–418, 417f

Estrogenized hymen, 378–379f
Ethnological theories of child development, 164
Evidence-based trauma screening, 287–290
Evidence storage, 414, 416f
Experience-dependant brain development, 257–258
Experience-expectant brain development, 257–258

External hymenal midline, 364f
Externalizing health problems, 233–234
Extragenital trauma, 60, 63
Eye Movement Desensitization and Reprocessing, 295–296

F
Fabricated or induced illness by carer
characteristics of, 270–271, 270t
future directions in, 282
healthcare provider role in, 280–282
history, 269–271, 270t
investigation of
diagnostic separation use in, 279
multidisciplinary approach to, 277–278
protection of the case, 277
reporting requirements, 278–279

safety plan use, 279–280
service plan use, 280
presentation and epidemiology
conditions created, 274–275, 274t
perpetrator characteristics, 272–274, 273t, 279–280
victim characteristics, 272t
warning signs, 275–277, 276t
reunification criteria, 282t
Factitious disorder by proxy. See Fabricated or induced illness by carer
Failed midline fusion, 365f
False allegations of abuse, 316
Familial abuse, 2, 9
Family Connections Program, 239–240
Family substance abuse issues, 341
Federal Child Abuse Prevention and Treatment Act, 251
Federal Indian Child Welfare Act of 1978, 313
Federal Rules of Evidence, 27
FII. See Fabricated or induced illness by carer
Findings
abusive injuries, 151–155f, 157f, 382–383f, 385–391f, 407–408f
accidental injuries, 399f, 401f
anal and hymenal dilation data, 139–140, 140–157f
consensual sexual activity, 156f, 349
examination techniques and basic skills, 350–353f
foreign body, 362f, 366f
genital and anal findings studies, 133–134, 134–137t, 137
injuries and acute trauma, 44, 139–140, 382–401f
lack of, 5, 6, 55–56, 349
medical mimics of sexual abuse, 139, 142–148f, 155f, 357–369f
normal variations, 140–142f, 149–150f, 351–356f, 370–381f
old abusive injuries, 64–66, 65f, 407–408f
research, 137–140
See also Sexually transmitted infections
First responders, 20–21
Flatwarts, 405f
Fluorescent treponemal antibody absorption testing, 87
Foreign body findings, 362f, 366f
Forensic assault kit use, 66–67
Forensic examination. See Physical examination
Forensic interview
blocks and barriers to disclosure in, 33–34b, 33–35
closing, 33
community resources for, 349
corroboration in, 26, 27b, 31, 32–33b
defined, 19–20, 22
disclosure, block and barriers to, 33–35, 34b
documentation, 24
engagement in, 26–28, 27b
equipment, 24
first responders and, 20–21
goals of, 35
interpretation use in, 24
interviewer, 19, 22–23
media use in, 34–35
medical history documentation, 35, 69–70
medical record questioning parameters, 68–69
miscommunication minimization in, 30–31
multiple event questioning, 31–32
multiple hypotheses consideration, 25b
number of, 21–22
open-ended questioning, 28–30, 29b
orientation of the child, 26–28, 27b
preparation for, 23–24
process of, 25–26
prosecution role of, 20
purpose of, 20–22
questioning parameters, 68–69
recording, 24
relevant questioning in, 29–30
risk of suggestion in, 22
sequence of, 22–23
standards of care in, 23
team communication plan, 24
topic of concern transitioning in, 28–30, 29b
training, 21–22
verbatim record keeping, 68–69
visual documentation, 69
“Freaking” (anal contact without penetration), 63–64
Frog-leg examination position, 350f
FTA-ABS. See Fluorescent treponemal antibody absorption testing
G
Gender, perpetrator, 2, 272–274, 273t
Genital anatomy review
hymenal membrane, 49–52f, 53t, 54f
hymenal orifice measurement, 53–56, 54–55t, 54–56
normal findings, 53t, 54f
post sexual contact mitigating factors, 55
vaginal vestibule, 48–49
vulvar penetration, 54
Genital fondling, 60–61
Genital lacerations, 383f
Genital-to-anal contact without penetration, 63–64
Genital touching and absence of findings, 54–55
Genital warts, 402f, 406f
Gingivostomatitis, 94f
Goose neck light source use, 412f

H
Healed and healing injuries, 64–66, 65f, 72, 407–408f
Healthy sexual behavior, 10
Helfer Society, 5
Hemangioma, genital, 368f
Hemorrhagic herpes, 403f
Hepatitis A, C, D, G, 99t
Hepatitis B, 98–99t
Heredity and environment, influence on child development, 161–162
Herpes simplex virus, 93–94f, 93–95, 401f, 403f
History, sexual abuse, 70–72
HIV/AIDS, 89–93, 91–93t
Human papillomavirus, 95–96, 96f, 97t, 98
Hymen
crecentic, 370f, 372f
cribiform, 379–380f
estrogenized, 378–379f
external hymenal midline, 364f
imperforate, 357f
intact, normal, 371f
torn, 382f
transected, 382f, 392–393f, 408f
Hymenal discontinuity, 399f
Hymenal integrity, 375f
Hymenal membrane, 49–52f, 53t, 54f
Hymenal mound, 375f, 378f
Hymenal orifice measurement, 53–56, 54–55t, 54–56
Hymenal projection, 364f, 374f, 377f
Hymenal rim, 377f
Hymenal septum, 392–393f
Hymenal tag, 377f, 380f
Hymenal vascularization, 379f

I
Ignoring, as psychological maltreatment, 218–219
Imperforate hymen, 357f
Indicated intervention programs, 239
Insecure attachment style, 231–232
Interconnectivity of child development, 162
Internalizing health problems, 232–233
International Conference on Psychological Abuse of Children and Youth, 222
International Society for Traumatic Stress Studies, 258
Interpretators, language, 24
Intrafamilial abuse, 2, 9
Intravaginal ridge, 372f, 375f
Intravaginal rugae, 377
Invasiveness of abuse, 9
Investigation, therapy-based, 5
Investigation and prosecution of cases, 168–169
Investigative equipment. See Equipment, investigative
Investigative interview. See Forensic interview
Isolating, as psychological maltreatment, 218

J
Jacobson, Tamar, 319
Juvenile perpetrators, 2, 3

K
Knee-chest examination position, 350f, 376f

L
Labial agglutination, 63
Labial bruising, 367f
Labial fusion, 360f, 365f
Labial intercourse, 399f
Lacerations, anal, 385f
Lacerations, genital, 383f, 386f
Language development, 171
Latent syphilis, 86
Legal issues, 10–12, 11t, 171–172
Lice, pubic, 99f, 100t
Lichen planus, 405f
Lichen sclerosis, 145–146f, 358f, 367f
Lifelong effects of abuse
adult medical practice implications, 211–213
biomedical disease, 207–208
chronic disease development, 204
emotional disorders, 208–210f
obesity viewed as protection, 203–204
psychological disorder risk, 180
public health implications, 213
research, 203–206, 205f, 205t, 211–213
social function, 210–211, 210f
substance dependency, 204, 206–207f
Linear abrasions, 390–391f
Linen storage use, 416f
Longitudinal Studies of Child Abuse and Neglect, 223

M
Malingering by proxy. See Fabricated or induced illness by carer
MASC. See Multidimensional Anxiety Scale for Children
Maternal-child interactions, 179
Media, role of in sexual behavior, 108
Media, use in forensic interviewing, 34–35
Medical examination. See Physical examination
Medical history, 21, 22, 35, 39–40, 69–70
Medical mimics of child abuse
accidental injury, 62, 399f, 401f
categories of, 67
common findings, 139, 142–148f, 155f, 357–359f
normal variations, 140–142f, 149–150f, 351–356f, 370–381f
research, 139
Medical provider, 5–7, 11–12, 23, 27–28, 39
Medical record, 12, 67–70, 73
Medications, 81–82, 83t, 198
Memory and emotion/stress, 170–171
Mental health implications of child abuse, 253–256
Mental health provider, 4–5, 9
Microhemagglutination test, 87
Microscope use, 414f
Mini BLUEMAXX light source use, 413f
Miscommunication minimization, 30–31
Misdiagnosis of child sexual abuse, consequences of, 12
Molluscum contagiosum, 100f, 100t, 406f
Multidimensional Anxiety Scale for Children, 289
Multidimensional Treatment Foster Care for Adolescents, 297–298
Multidimensional Treatment Foster Care for Preschoolers, 297–298
Multidisciplinary teams, 23
Multifaceted intervention programs, 239–240
Multigenerational transmission, 227
Multiple events investigation, 31–32
Multiple hypotheses consideration, 25b
Munchausen syndrome, 269–270
See also Fabricated or induced illness by carer

N
NAATs. See Nucleic acid amplification tests
Narrative-inviting questions, 22
National Center on Child Abuse and Neglect, 1, 132, 175, 312
National Child Abuse and Neglect Data System, 224
National Child Traumatic Stress Network, 258–260
National Incidence Study of Child Abuse and Neglect, 175–176
National Longitudinal Study of Adolescent Health, 223
Nature of child development, 161–163
Neglect, as child abuse risk factor, 2
Neglect, educational, 337–343
Neonatal conjunctivitis, 85
Neonatal infection, 95
Neonatal transmission of sexually transmitted infections, 95
Neovascularization, 64–65
Neurobiology implications of child abuse, 256–258
Neurosyphilis, 87
NFP. See Nurse-Family Partnership
Nonabused females, genital findings in, 53t
Nondirective therapies, 9
Nonsexual transmission of sexually transmitted infections, 95
Nonverbal cues, 30–31
Normal intact hymen, 371f
Normal vaginal flora in children, 79
Normative child development
behavioral learning theories of, 163
bidirectional relationships and, 162–163
cognitive development theories of, 163–164
continuity of, 162
course of, 162
developmental milestones, 165–166t, 165–168
ecological theories of, 164–165, 164f
ethnological theories of, 164
heredity and environment, influence on, 161–162
interconnectivity of, 162
nature of, 161–163
psychoanalytic theories of, 163
social theories of, 164
Nucleic acid amplification tests, 79–80
Nurse-Family Partnership, 238
Nurturing play behavior, 324
O
Open-ended questioning, 28–30, 29b
Overpressuring, as psychological maltreatment, 219
P
Parental alienation syndrome, 7–8
Parental neglect factors, 2
Parent-Child Interaction Therapy, 296–297
Parent-family role in psychological maltreatment, 224–230
Parents, as sexual behavior contributing factor, 108
Parents as Teachers, 239
PARS. See Preschool Anxiety Revised Scale
Penetration, findings of, 60–64, 61–62f, 381–383f, 385–398f, 392–395f, 397–398f, 400f, 407f
Penile bruising, 400f
Penile burns, 400f
Penile lichen planus, 405f
PEP. See Postexposure antiretroviral prophylaxis
Perianal bruising, 400f
Perianal herpes, 403f
Perianal laceration, 400f
Perianal streptococcal infection, 405f
Perianal vitiligo, 361f
Perpetrators
acquaintances as, 2
age of, 2–3
characteristics of, 272–274, 273t, 279–280
childhood sexual abuse of, 2, 326
classification schemas, 3
degree of abuse and, 2
gender of, 2, 272–274, 273t
intrafamilial, 2
See also Fabricated or induced illness by carers
Perseverant play behavior, 324
Physical examination
best interests of the child in, 40
deferred examination need indicators, 44–45
DNA evidence and, 7
historical information and, 6
indicators for, 43–45
instruments, 7
positioning, 46, 47f
preliminaries to, 40–43
principal goals of, 6–7
privacy needs during, 45
purpose of, 39–40
timing of, 7, 44–45
total health status of victim and, 349
See also Equipment, investigative; Findings; Forensic interview
Physical findings. See Findings
Physical symptoms, as motivation to seek care, 22
Pinworms, 147f, 368f
Play therapy, 9
Postexposure antiretroviral prophylaxis, 92–93
Posttraumatic Stress Disorder
defined, 325
evidence-based trauma screening for, 288–289, 289t
as indication of sexual abuse, 4, 8–9, 116
loss of brain volume in, 257
as mental health implication of child abuse, 254–255
psychopathology of, 254–257
therapeutic intervention, 299
Precocious puberty, 378f
Preschool Anxiety Revised Scale, 289
Prevention and intervention in psychological maltreatment, 237–240
Primary syphilis, 86f
Privacy, during physical examination, 45
Problematic sexual behavior, 10
Proctitis, 100t
Proctocolitis, 100t
Prolapsed uterus, 357f
Prophylactic antibiotic treatment, 81–82, 83t
Prosecution, immunity from, 311
Prosecution of child sexual abuse, 6, 20
Protection of the child, need for, 20, 282t
Psychoanalytic theories of child development, 163

Psychological assessment
- evidence-based trauma screening, 287–290, 289t
- out-of-home care treatment approaches, 297–298
- promising psychological interventions, 298–299
- psychopathology, 252–253
- treatment approaches, 290–297, 291–292t
  - alternatives for families cognitive behavioral therapy, 296
  - child-parent psychotherapy, 295
  - cognitive behavioral interventions for trauma in schools, 294
  - eye movement desensitization and reprocessing, 295–296
  - parent-child interaction therapy, 296–197
  - trauma-focused cognitive behavioral therapy, 292–294, 293t

Psychological maltreatment
- consequences, 230–234
  - accumulation of risk model, 230
  - differential effects based on age and gender, 234
  - externalizing health problems, 233–234
  - insecure attachment style, 231–232
  - internalizing health problems, 232–233
  - mental health problems, 232–243
  - opportunity factors, 230–231
  - social and cognitive impairments, 232
- definitional issues, 217–223
  - corrupting, 219
  - cultural issues, 222–223
  - degrading, 219
  - denying emotional responsiveness, 219
  - ignoring, 218–219
  - isolating, 218
  - overpressuring, 219
  - rejecting, 218
  - terrorizing, 219
- measures of assessment, 234, 235–236t, 236
- operational definitions, 219, 220–221t, 222
- prevalence of, 223–224
- prevention and intervention, 237–240
  - indicated intervention programs, 239
  - multifaceted intervention programs, 239–240
  - policy approaches, 240
  - selective prevention programs, 238–239
  - universal prevention programs, 237–238
- risk factors and correlates, 224–230
  - child and parent characteristics, 224–225
  - family and relationship dynamics, 227–228
  - gene-environment interaction, 230
  - mental health, 228
  - parental shame, violence and multigenerational transmission, 226–227
  - poor parenting skills and modeling, 225–226
  - socioeconomic stress and social support, 229–230
  - substance abuse, 229

Psychopathology
- assessment, 252–253
- definitions of, 251–252, 252t
- mental health implications of child abuse, 253–256
  - ADHD, 255–256
  - antisocial behavior, 255
- conduct disorders, 255
- depression and anxiety, 254
- externalizing problems, 255
- internalizing problems, 254
- mechanisms of, 253–254
- PTSD, 254–257
- substance abuse, 256
- suicidal behavior, 256
- neurobiology, 256–258
- PTSD. See Posttraumatic Stress Disorder
- Pubic lice, 99f, 100t

Q
- Questioning. See Forensic interview

R
- Rapid plasma reagin testing, 86–87
- Rapport building, 25–26
- Reactive attachment disorder, 231
- Regressive play behavior, 324
- Rejecting, as psychological maltreatment, 218
- Reporting
  - guidelines, 10–12, 11t, 278–279
  - immunity from prosecution for, 311
  - multiple abuse hypotheses, 25b
  - post report policies, 314–315
  - proof requirements, 310–311
  - report contents, 310
  - school policies, 309–314, 343
  - state reporting statutes, 349
- Residual effects of sexual contact
  - accidental injuries trauma patterns, 62
  - anal findings, 59
  - anorectal penetration, 63–64
  - extragenital trauma, 60, 63
  - female genitalia, 59
  - genital fondling, 60–61
  - labial agglutination, 63
  - male genitalia, 59–60, 59f
  - physical findings, 58–59, 59f
  - trauma patterns, 60–63
  - vaginal penetration, 61–62
  - vulvar coitus, 54, 61
- Resilience
  - characteristics of, 191, 198
  - defined, 191
  - outcomes of childhood trauma, 191
  - systems approach to, 192–198
    - genetic/epigenetic, 196–198
    - internal working models, 193
    - neuroendocrine, 193–196, 198
    - social/behavioral, 192–193, 198
    - toxic stress brain effects, 193–196
- Reunification criteria, 282t
- Risk factors and correlates in psychological maltreatment, 224–230
- RPR. See Rapid plasma reagin testing
Safety plan use, 279–280

SAMSHA. See Substance Abuse and Mental Health Services Administration

Scabies, 100t

SCARED. See Screen for Anxiety Related Emotional Disorders

Scar tissue formation, 64–66, 65f

School adaptation, 179–180

School role
  attendance issues, 309
  characteristics of children with a history of maltreatment, 322–323t, 322–326
  criminal and civil prosecution immunities, 311
  defense against abuse in schools, 316–317
  discipline policies, 315–316
  educational neglect
    consequences of, 342
    enrollment failure, 338, 339–340
    family substance abuse issues, 341
    indicators of, 339t
    parental choice and, 338–339
    permitted chronic truancy, 338, 340
    special education needs inattention, 338, 340–341
    special needs children, 174–177, 175–176t, 341–342
  effects of trauma on children and adolescents, 324–326
  false allegations of abuse, 316
  local minimums, 320–321t, 320–322
  non-reporting penalties, 311
  personnel selection, 317–319
    background record checks, 317
    interviewing, 317–318, 318t
    reference checks, 318–319
  post-report policies, 314–315
  proof requirements, 310–311
  report contents, 310
  reporting policies, 309–314, 343
  resiliency in children, 336–337
  supervision of volunteers, 319–320
  teacher characteristics, 327
  teacher strategies, 327–336
    academic skills improvement, 334–335
    bibliotherapy, 335–336t
    communication skills teaching, 330–331
    expecting success, 328–329
    life skills teaching, 330
    positive coping skills teaching, 332–333
    providing pleasant experiences, 333
    self-esteem building, 334
    social skills teaching, 329–330
    teaching the extremely helpful student, 331–332
    trust building, 328
  training of staff and volunteers, 319, 337

Screen for Anxiety Related Emotional Disorders, 289

Scrotal condyloma acuminata, 404f

Secondary syphilis, 86f

Selective prevention programs, 238–239

Service plan use, 280

Sexual abuse allegations and custody disputes, 7–8

Sexual behavior
  acting out, 4, 7, 10, 108–109
  clinical approach, 110–111
  contributing factors, 107–109
    adverse life experiences, 4, 7, 10, 108–109, 191, 203–206, 205f, 205t
    age, 107–108, 107t
    media, 108
    parents and family, 108
    psychiatric illness, 108
    defining, 106–107
    ethnic minorities view of, 109
    healthy, 10
    historical background, 105
    play behavior, 324
    problematic, 10
    professional biases in view of, 110
    screening measures, 105–106
  sexual topic verbalization comfort level variations, 109–110

Sexual behavior in abused children, 172–174

Sexual behavior in nonabused children, 172–173

Sexual Behavior Problems (SBP), defined, 107

Sexualized play behavior, 324

Sexually transmitted infections
  in anal abuse, 58
  bacterial transmission, 82–89
    bacterial vaginosis, 87–88, 87f
    calymmatobacterium, 89
    chancroid, 89f
    chlamydia, 84–85, 85f
    genital mycoplasmas, 88–89
    gonorrhea, 82–84, 82f, 83t, 84f
    granuloma inguinale, 89
    lymphogranuloma, 89
    syphilis, 85–87, 86f
    trichomoniasis, 88f
  enteritis, 100t
  findings, 138, 140, 401–406f
  general principles, in abused children, 79–80, 80–81t
  as indication of abuse, 6, 79, 83
  molluscum contagiosum, 100f, 100t
  NAATs use in, 79–80
  neonatal transmission of, 95
  nonsexual transmission of, 95
  normal vaginal flora in children and, 79
  physical examination issues, 80–81, 82t
  proctitis, 100t
  proctocolitis, 100t
  prophylactic antibiotic treatment, 81–82, 83t
  pubic lice, 99f, 100t
  recognizing potential for in interview, 42
  research data, 138, 140
  risk of, in abused children, 79
  scabies, 100t
  transmission modes, 66
  viral transmission
    hepatitis A, C, D, G, 99t
    hepatitis B, 98–99t
    herpes simplex, 93–94f, 93–95
    HIV/AIDS, 89–93
    human papillomavirus, 95–96, 96f, 97t, 98
perinatal transmission, 90
Short term effects, 8–9
Smooth avascular posterior area, 374f
Social and cognitive impairment consequences, 232
Social development, 171–172
Social theories of child development, 164
Sodomy without penetration, 63–64
SPARCS. See Structured Psychotherapy for Adolescents Responding to Chronic Stress
Special education needs inattention, 338, 340–341
Special needs children, 174–177, 175–176t, 341–342
Standards of care in forensic interview, 23
STI. See Sexually transmitted infections
Straddle injury, 360f, 399f
Strangers as perpetrators, 2
Streptoccal infection, 405f
Structured Psychotherapy for Adolescents Responding to Chronic Stress, 298–299
Substance Abuse and Mental Health Services Administration, 259
Substance abuse issues, family, 341
Substantiation of child sexual abuse, 1–2
Suggestion, risk of in interview, 22
Swabs, evidence collection, 414, 415–416f
Symptoms of child sexual abuse, 3–4
Syphilis, 86–87, 86f, 402f
T
TARGET. See Trauma Affect Regulation: Guidelines for Education and Therapy
Team communication plan, 24
Telemedicine, 416–418, 417f
Terrorizing, as psychological maltreatment, 219
Tertiary syphilis, 86
Therapeutic needs of the sexually abused child, 9
Therapy and treatment approaches
behavioral symptoms, 116–117
clinical and empirical literature on, 118–124
cognitive symptoms, 116
collaborative approaches, 259–260
efficacious treatments empirical review, 118–119
emotional symptoms, 116
evidence-based, 258–259
family engagement, 117–118
mental health practitioners responsibilities, 117–118
referring practitioners and family responsibilities, 117
non-trauma specific therapies, 258
sequelae of child sexual abuse, 115–117
symptom variety, 115–116
Therapy-based investigation, 5
Thickened crescentic hymen, 372f
Toxic shock, 363f
Trauma Affect Regulation: Guidelines for Education and Therapy, 299
Trauma-focused cognitive behavioral therapy
components of, 292–294, 293t
treatment description, 119–124, 122f
affective modulation, 121–122
cognitive processing or the cognitive trial, 122f
cojoint parent-child sessions, 123–124
enhancing safety skills, 124
psychoeducation and parenting skills, 120–121
relaxation, or stress management, 121
trauma narrative or exposure, 122–123
in vivo desensitization, 123
treatment description of, 119–124, 119t, 120t
Trauma Symptom Checklist for Young Children (TSCYC), 288
Trichomoniasis, 88f
U
UCLA Posttraumatic Stress DisorderReaction Index, 288
Unhealthy adult activities and childhood sexual abuse, 9
United Nations Children's Fund, 223
Universal prevention programs, 237–238
Urethral prolapse, 150f, 359f
Urethral support structures, 376f
Urethritis, 85
US Department of Health and Human Services (DHHS), 239
V
Vaginal bleeding, 387–389f
Vaginal discharge, 369f
Vaginal discharge findings, 394f
Vaginal duplication, 361f, 367f
Vaginal transection, 397f
Vaginal vestibule, 48–49
Venereal Disease Reference Laboratory testing, 86–87
Verbal cues, 30–31
Verbatim record keeping, 68–69
Victim
acute injury to, 44
characteristics, 272t
characteristics of, 322–323t, 322–326
discussions with, prior to physical examination, 41–43
emotional readiness for physical examination, 44–47
preparation for physical examination, 45–46
risk factors, 2–3
sexual behavior of, 4, 7, 10, 108–109
sexual behavior problems in, 4, 7, 10
Visual documentation, 69
Visual documentation, 69
Vitiligo, 361f
Vulvar coitus, 54, 61
Vulvar penetration, 54
Vulvovaginitis, 352f
W
Warning signs, 275–277, 276t
Woods lamp use, 413f
World Health Organization, 213
Y
Young Child PTSD Screen, 288