

OK Sent
6-16-88

Protocol for the Examination and Treatment of Sexual Assault Victims

Recommended Procedures

Fourth Edition

U.S. Department of Justice
National Institute of Justice

110217

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this copyrighted material has been granted by
Iowa Department of Public Health

to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the copyright owner.

110217



TERRY E. BRANSTAD, Governor
Mary L. Ellis
Director of Public Health
Gene W. Shepard
Commissioner of Public Safety

110217

**Protocol for the Examination
and Treatment of
Sexual Assault Victims**

Recommended Procedures

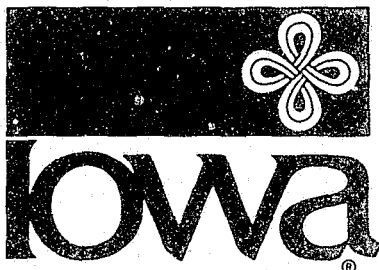
Fourth Edition

July 1987

NCJRS

MAR 29 1988

ACQUISITIONS



**Prepared By:
Iowa Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319-0075**

PREFACE

Sexual assaults are violent crimes directed against women, men, and children. Research on sexual assaults is a recent effort. Available studies yield important information for debunking myths about these crimes of violence.

- * 60% of adult rapes occur between people who know each other.
- * 85% of children sexually molested know the perpetrator: family members, neighbors, or other persons of authority.
- * 10% of adult sex crime victims are men.
- * A male child has a 1-in-6 chance of being sexually molested.
- * A female child has a 1-in-4 chance of being sexually molested.
- * 80-90% of sexually assaulted people do not seek help.
- * 50% of sexual assault victims who do report the crime delay reporting for 24 hours or more.

We need to educate ourselves about sexual assault and its consequences for the victim and society. Unless we all take responsibility for eliminating this horrendous crime, sexual assault will continue to be the fastest rising violent crime in our country. Sexual assault and abuse is a significant part of the growing interpersonal violent victimization syndrome in America today. Violence

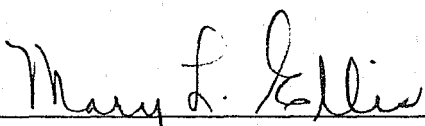
is a major public health problem requiring a multi-discipline intervention approach. Physicians, the public, and public health agencies need to view sexual assault/abuse management as a partnership between health and justice.

This document was prepared by consensus to assist the Iowa Department of Public Health, Iowa Department of Public Safety, physicians, and hospitals in complying with the Iowa Criminal Code. The Protocol contains a clear explanation of the legal aspects of sexual abuse as well as guidance for the appropriate examination and treatment of the individual.

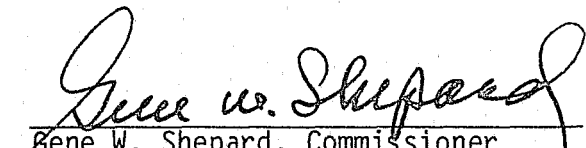
The collection and preservation of physical evidence is necessary for successful prosecution: Included are the procedures for collection of specimens and the preservation of the chain of custody.

Also, there is a complete description of the statutes which deal with this problem. Additionally, there is a section dealing with the development of a community team-management approach to intervention.

We express our appreciation to the members of the committee who spent many hours in the development of this material.



Mary L. Ellis
Director of Public Health
July 1, 1987



Gene W. Shepard, Commissioner
Department of Public Safety
July 1, 1987

PROTOCOL FOR THE EXAMINATION AND TREATMENT OF SEXUAL ASSAULT VICTIMS

The purpose of this protocol is to assist hospitals and other medical facilities in complying with the special needs of sexual assault victims, their families and friends, and to comply properly with the requirements of law enforcement authorities who consider the immediate medical care provider a necessary witness in the prosecution of the crime.

Victims of sexual abuse are generally regarded by medical staff and hospital administration as emergency patients, and have consequently been treated in emergency services. Although the situation of this type of patient is rarely a matter of life and death, she/he does have special and serious needs which must be met by the attending medical and nursing staff. This protocol will offer suggested medicolegal procedures to address these needs.

The Protocol identifies the special needs of sexual abuse patients, and makes suggestions for comprehensive emergency and followup care of these patients. As the recommendations are implemented, health care professionals who testify in court will have more complete recall of the patient, the event, and the examination findings, leaving less opportunity for her/his testimony to be discredited.

The protocol was prepared by the Iowa Department of Public Health with the assistance of the following committee members who gave of their time and expertise:

Theodore D. Scurletis, MD, Chairperson	Iowa Department of Public Health
Michael Abrams, MD	Broadlawns Medical Center
Charles A. de Prosse, MD	University of Iowa Hospitals & Clinics
Timothy Barber-Lindstrom	Department of Human Services
Carole Meade	Iowa Coalition Against Sexual Abuse
Michael Rehberg	Iowa Department of Public Safety
Earl F. Rose, MD	University of Iowa Hospitals & Clinics
Randell Alexander, MD	University of Iowa Hospitals & Clinics
Harold A. Young	Attorney General's Office
Judy Jesina, RN	Iowa Department of Public Health
Thomas L. Bennett, MD	Iowa State Medical Examiner's Office

CONSULTATION

Each member will provide consultation upon request as follows:

1. For assistance in matters relating to the examination of the patient:

Dr. Michael Abrams (515) 282-2200
Dr. Charles de Prosse (319) 356-3464

2. For assistance in matters relating to mandatory reporting of child sexual assault:

Timothy Barber-Lindstrom (515) 281-5583
1-800-362-2168

3. For assistance in matters relating to counseling of victims and development of community management teams:

Carole Meade¹ (515) 271-2918

4. For assistance in using the Iowa Department of Public Safety, Division of Criminal Investigation Sexual Abuse Evidence Collection Kits:

Michael Rehberg (515) 281-3666

5. For assistance in the examination of children:

Dr. Randell Alexander (319) 353-6136

6. For assistance relating to interpretation of law of trial procedures:

Harold Young (515) 281-3648
Dr. Earl Rose (319) 356-2139
Dr. Thomas Bennett (515) 281-6726

7. For assistance relating to the over-all program and reimbursement:

Dr. Theodore Scurletis (515) 281-4914
1-800-532-1579

8. For assistance relating to the Iowa Crime Victim Reparation Program:

Marda Howard (515)281-5044

¹ For information/assistance concerning sexual assault crisis counseling, please refer to the agency list located in Addendum A.

TABLE OF CONTENTS

PROTOCOL FOR THE EXAMINATION AND TREATMENT OF SEXUAL ABUSE VICTIMS

	Page
Part I	
A. Purpose	1
B. Definitions	1
C. Community Team Management of the Sexual Assault Victim	2
D. Consent	3
E. Medical/Legal Procedures	4
F. History	5
G. Examination	5
H. Laboratory Specimens	6
I. Clothing and Photographs	7
J. Child & Adolescent Sexual Abuse Management.	7
K. Management of Sexually Transmitted Diseases	9
L. Management of Possible Pregnancy	9
M. Counseling	10

STATE PROGRAMS WHICH PROVIDE ASSISTANCE FOR THE SEXUAL ASSAULT VICTIM

Part II

A. Sexual Assault Examination Reimbursement	14
B. Iowa Crime Victim Reparation Program	15

THE IOWA LAW OF SEXUAL ABUSE

Part III

INTRODUCTION	17
A. <u>Criminal Sexual Abuse Statutes</u> (rape and sodomy)	18
1. Definition of "sex act"	
2. Definition of "sexual abuse"	
3. Definition of "child"	
4. Factors related to degree of crime	
5. Distinction between "sexual abuse" and other sex offenses	
B. <u>Other Sex Offenses</u>	19
1. Assault with intent to commit sexual abuse	
2. Lascivious acts with a child	
3. Indecent contact with a child	
4. Incest	
C. <u>Child Abuse Statutes Based Upon Sexual Offenses</u>	21
1. Dual reporting requirements for child abuse cases	
2. Definition of child abuse by sexual offense	
3. Mandatory Reporting of Child Abuse	
4. Immunity for reporting	
5. Emergency treatment of children	
6. Doctor-patient privilege abrogated	
D. <u>Dependent Adult Abuse Statutes Based Upon Sexual Offenses</u>	23
1. Definition of "dependent adult"	
2. Definition of dependent adult abuse by sexual offense	
3. Permissive reporting of dependent adult abuse	
4. Immunity from liability for reporting	
E. <u>Documentation and Preservation of Evidence - The "Chain of Evidence"</u>	24
1. Definition of physical evidence - an exhibit	
2. Requirements for identification of an exhibit	
3. Requirements for establishing the chain of possession	
F. <u>Informed Consent of Minors</u>	25
1. Definition and foundation for the law of consent	
2. Conflict in the law of consent of minors	
3. Minors' consent in venereal disease cases	
4. The concept of the mature minor	
5. Recommended - and other - procedures for consent	

ADDENDA28
A. Iowa Sexual Assault Intervention, Domestic Violence Intervention, and Victim Assistance Centers.29
B. Sample Consent Form for Examination and Treatment.30
C. Sample Checklist for Medical Protocol for Examining and Managing Patients of Sexual Assault (Child-Adult).31
D. DCI Crime Laboratory - State of Iowa Sexual Assault Evidence Collection Kit Instructions38
E. Child Sexual Abuse Introitus and Forensic Genitalia Exam41
F. Iowa Crime Victim Reparation Program44
BIBLIOGRAPHY46
MEDICAL-LEGAL WITNESS BIBLIOGRAPHY54

**PROTOCOL FOR THE EXAMINATION
AND TREATMENT OF SEXUAL ASSAULT VICTIMS
PART I**

A. PURPOSE

The purpose of this protocol is to provide proper procedures for protection of patient and doctor as well as to comply with the Iowa Criminal Code, Section 709.10:

"Cost of Medical Examination in Crimes of Sexual Abuse. The cost of medical examination for the purpose of gathering evidence and the cost of treatment for the purpose of preventing venereal disease shall be borne by the Iowa State Department of Health (Ch 1245, 66 GA, ch 1, s 910)."

B. DEFINITIONS - See Also Part III

1. "Sexual Abuse" is defined as any "sex act" between persons when the act is performed in one of the following circumstances:
 - a. Such act is done by force or against the will of the other. In any case, where the consent or acquiescence of the other is procured by threats of violence toward any person, the act is done against the will of the other participant. Section 709.1(1).
 - b. Such other participant is suffering from a mental defect or incapacity which precludes giving consent. Section 709.1(1).
 - c. Such other participant is a child. Section 709.1(3). Section 702.5 defines "child" as follows: For purposes of this act, unless another age is specified, a "child" is any person under the age of fourteen years.
 - d. The other participant is fourteen or fifteen years of age and the person is a member of the same household as the other participant, the person is related to the other participant by blood or affinity to the fourth degree, or the person is in a position of authority over the other participant and used this authority to coerce the other participant to submit. Section 709.4(4).
 - e. The person is six or more years older than the other participant, and that other participant is fourteen or fifteen years of age. Section 709.4(5).
 - f. Any sex act between persons who are not at the time cohabitating as husband and wife is sexual abuse in the third degree by either of the participants when the act is performed by force or against the will of the other participant. Section 709.4(1).

2. The term "sex act" or "sexual activity" means any sexual contact between two or more persons by penetration of the penis into the vagina or anus, by contact between the mouth and genitalia, or by contact between the genitalia of one person and the genitalia or anus of another person or by use of artificial sexual organs or substitutes therefore in contact with genitalia or anus. Section 702.17.
3. Incest. A person except a child as defined in section 702.5, who performs a sex act with any person whom he or she knows to be related to him or her, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, commits incest. Incest is a class "D" felony.
4. Other Sex Offenses (see pages 19-20 of this document)
 1. Assault with intent to commit sexual abuse
 2. Lascivious acts with a child
 3. Indecent contact with a child
5. Mandatory Reporters of Child Abuse. Every health practitioner, practicing social worker, psychologist, school employee, licensed child care center employee, registered group day-care home employee, mental health center employee, and police officer is required by law to report suspected physical abuse, sexual abuse, other sex offenses, and neglect of children who come under their care.

C. COMMUNITY TEAM MANAGEMENT OF THE SEXUAL ASSAULT VICTIM

During the first few hours or days after a sexual assault, the victim may have contact with many professionals - hospital staff, law enforcement officers, prosecuting attorneys, and counselor/advocates. Each of these professionals is requesting something from the victim.

The needs of all these professionals can best be served by adopting a community team-management approach to sex crime intervention. One of the key elements to this approach is education: Each of these groups should receive training from others in the system. Another key element is communication: The team should schedule regular meetings to discuss case management and problems that have occurred. The community team can function in an integrated manner to care for the victims' legal, medical, and social needs from the sexual assault incident to the closure of all legal encumbrances and individual/family counseling.

This community management team should consist of a minimum of (but not be limited to) four cooperating agencies: Law enforcement, sexual assault counselor, medical personnel, and prosecuting attorney.

Responsibility and roles of the community management team:

Law Enforcement

Provides protection of victim, gathers evidence for possible prosecution, brings victim to medical facility, and notifies sexual assault counselor as per local protocol.

Sexual Assault Counselor/Psychologist (especially for children)

Provides "on-site" acute crises intervention and ongoing recovery counseling; is a victim advocate, interpreter, and direct liaison to the medical staff; and plays an essential coordinating role between the victim, law enforcement, medical facility/staff, judicial system, and family.

Receiving Medical Facility/Emergency Department

Provides acute and chronic medical care, collects laboratory and biological specimens for evidence and identifies with the victim's emergency medical needs, and eventually does followup exam and treatment.

Nursing staff role - is a patient advocate, coordinator, and educator about the medical examination; helps prepare the patient for optimum exam; helps collect evidence; and helps with medical treatment and followup.

Medical staff role - the physician has four main responsibilities: 1) to provide acute medical assessment and treatment; 2) to collect biological specimens for legal evidence; 3) to arrange for further follow-up and treatment; and 4) to serve as a patient advocate.

Prosecuting Attorney

Assembles evidence and organizes witnesses to prosecute the offender, and is a victim advocate.

D. CONSENT²

To protect the physician, health facility, Iowa Department of Public Health, and patient's confidentiality, written and witnessed consent for the following procedures shall be obtained (not required if the victim is a child):

1. History and physical examination
2. Collection of specimens

² Consent Form, Examination and Treatment (See Addendum B)

3. Photographs
4. Release of information to proper authorities

MEDICAL/LEGAL PROCEDURES

The physician examining the victim of sexual abuse may be called at a later time to provide expert testimony at a trial. This testimony will describe for the jury the physician's assessment of the patient's condition at the time of the examination (testimony of the patient or child's direct words and description of the events) including documentation with diagrams and photographs to show the extent of physical injury. Testimony may also be required to establish the "chain of custody" of the physical evidence obtained at the examination. This might include smears and swabs, stained clothing, and other potential evidence retained by the physician and personally turned over to the proper law enforcement authorities in return for a detailed receipt. The physician, as an expert, should also be prepared to explain all examinations and test results; e.g., the meaning of the presence of sperm and prostatic acid phosphatase.

If physical evidence such as stained clothing, swabs, or smears are to be used in a court proceeding, it must be established that this evidence is, indeed, that collected from the patient. Therefore, it is important to know and to document all people who have had possession of this evidence. This is known as maintaining the "chain of custody", for it allows verification of who had possession of the object at all times, and is proof that the evidence submitted to the court is that collected from the patient. The physician's testimony may be required to establish this fact.

To maintain the chain of custody, the specimens of physical evidence must first be identified. Identification of the specimens is impossible without accurate labeling and careful packing. The specimen should be labeled with the patient's name, the source of the specimen, the time and date, the nature of the specimen, and, if possible, an identification number such as the hospital number. The person labeling an object should always sign his/her name for a personal signature is distinctive and will permit the person to testify with certainty that the identifying label and transmittal form was signed by that person. This creates the first link in the "chain" of custody.

Limiting the number of people handling a specimen is important for this decreases the chances of breaking the chain of custody. Ideally, the examining physician should personally transfer the specimen to an investigating officer or to the laboratory personnel preparing the specimen for examination or testing. If this is not possible, the specimen should be locked in a container or area with limited access. If handled by intermediaries or delivered to police officers, that person should sign a receipt or evidence-release form. This documents that the specimen was handled correctly, and there was no break in the chain of custody.

OBJECTIVE STATEMENTS

1. The record should contain the patient's statements. It should give descriptions of the physician's findings and what was done. It should state to WHOM specimens, clothing, or photographs were delivered.
2. NEVER say or write in the record an opinion concerning whether or not the patient was sexually assaulted. You should document the results of your assessment such as:
 - a. Evidence of sexual intercourse
 - b. Sexual assault or abuse examination results
 - c. Evidence of genital and/or physical trauma
3. Physicians should remember that both they and the record may be subpoenaed and that they may be required to testify. All information should be exact and detailed to avoid any misinterpretation. Negative findings are as important as positive ones, and may assist in the protection of an alleged assailant who has been falsely accused.

F. HISTORY

1. Chief complaint (record all histories offered, interview the patient and others separately), physical injury
2. Time and date of assault
Time of admission to examining facility
Time of exam
Time of patient's departure
3. Record if patient has bathed, gargled, douched, or had a bowel movement since sexual assault
4. Last menstrual period and current contraceptive usage
5. Date of last vaginal, anal, and/or oral intercourse
6. Medical history, allergies
7. Present illness, medication
8. If patient is a child, inquire as to history of any previous abuse

G. EXAMINATION³

1. Examination of patient in clothing. Describe disorder, disarray.

³ Sample Checklist, Medical Protocol for Examining and Managing Patients of Sexual Assault, Sample Record, Child-Adult Sexual Assault Exam (See Addendum C)

2. Assessment of emotional condition
3. Adult: Vitals (temperature, blood pressure, pulse)
Child: Vitals plus height, weight, head circumference
4. Entire skin surfaces
 - a. Note bruises, contusions, lacerations, and abrasions
 - b. Ultraviolet light fluorescence of semen on genitalia, thighs, and other appropriate areas
5. Head, neck, mouth, hair
6. Thorax, back, abdomen
7. Pelvis
8. Genitalia--note Tanner stage of sexual development
 - a. Female
 - b. Male
9. Rectum

H. LABORATORY SPECIMENS⁴

Recommended collection of evidence by use of a lab sexual abuse kit⁵; e.g., D.C.I. Sexual Assault Kit. Patient's last name should be etched on glass slide with diamond-tipped etcher or written with lead pencil. Specimens (blood, clothing) should be placed under lock and key for safe keeping.

- 1 Exam for sperm - presence and motility (hanging drop or wet mount)
2. Exam for dried sperm (air dried and/or Papanicolaou fixative)
3. Acid phosphatase - Use either:
 - a. Air dried swab (preferrable)
 - b. Saline suspension (satisfactory only for immediate testing)

⁴ E.R. Staff Information Form, D.C.I. Crime Laboratory, Sexual Assault Kit. (See Addendum D)

⁵ The Iowa D.C.I. Sexual Assault Kit can be obtained by contacting the Iowa Department of Public Safety, Division of Criminal Investigation Laboratory, Wallace State Office Building, Des Moines, Iowa 50319, (515)281-3666 (8:00 a.m. - 4:30 p.m.).

4. Culture for Neisseria gonorrhoea (i.e. Thayer-Martin)
5. Baseline serology, VDRL, or other
6. ABH antigen specimens

I. CLOTHING AND PHOTOGRAPHS

Patient's clothing, photographs, and any other potential evidence should be retained by the physician and personally turned over to the proper law enforcement authorities in return for a detailed receipt.

J. CHILD AND ADOLESCENT SEXUAL ABUSE MANAGEMENT

1. The following suggestions are offered to physicians who are asked to assist child sexual abuse victims or potential victims and their families.⁶ They are meant to complement other sections of this protocol. The physician should, prior to beginning his/her involvement in the case, remember to remain calm in the presence of the child and family while recognizing the potential for energetic reactions from other participants.

A medical examination should be performed in all cases,⁷ regardless of the date or type of sexual abuse complaint. Optimally, the examining physician already has or can rapidly establish a warm, trusting relationship with the child and can encourage a nonabusing caregiver to provide support to the child. Factors specific to each case will influence the child's reaction to the abuse as well as to the medical examination, the remainder of the investigation, and subsequent events; no one reaction pattern is universal. However, nearly all children will benefit from the presence of someone who can offer emotional support during the examination, the systematic, and efficient performance of an examination which includes an explanation of unfamiliar procedures, and at the conclusion of the examination the presentation of findings and recommendations for further medical services.

A thorough history and physical performed initially may reveal signs of physical abuse or neglect or stress. In addition, this aspect of the examination may serve to reduce the psychologic stress at times associated with genital examinations. However, prior to performing this general evaluation, the physician should consider the possibility of a life-threatening process such as penetration into peritoneal cavity, internal bleeding, or other significant injury.

⁶ Training film by Ross Laboratories, "Suffer the Children...Silence No More", is available from the Iowa Chapter of the American Academy of Pediatrics.

⁷ Child Sexual Abuse Introitus Exam Technique (See Addendum E)

The examination should document (in the written record and through diagrams or photographs) evidence of trauma, especially oral, anal, and vaginal. Even in the absence of trauma, the physician should check for genital or rectal foreign bodies and describe the anatomy including the size of the vaginal opening, condition of the hymenal ring, and tone of the anal sphincter.

The extent of the genital examination may be decided based on the history and the visual evaluation of the perineum. A speculum exam may be omitted in a girl with an intact hymen who is without evidence of genital trauma; however, a cotton-tipped swab may be passed through the hymenal ring to obtain specimens (to test for sperm, gonorrhea). Similarly, if there is no evidence of trauma, the digital exam is normal, and the stool is guaiac negative, anoscopy evaluation is not required and specimens may be obtained with a cotton swab. If the child may have performed fellatio on the assailant, obtain specimens from behind the upper- and lower-second molars and under the tongue as well as from the pharynx.

The evaluation should include an appropriate blood test for syphilis. If preventive treatment for gonorrhea and syphilis is not given, the child should be recultured for gonorrhea in one week and a blood sample obtained for syphilis in three weeks.

Interviewing usually occurs before or after the medical examination. Obtaining information from the child can be done by the physician or by other professional. In circumstances of evident emotional distress, the interview should be deferred. Most children, even the very young, should be seen alone to obtain their information independently. (The adults involved in the case should be interviewed separately without the child present.) The interviewer can establish a relationship with the child by discussing other topics before focusing on sexual abuse issues. Diagrams, pictures, or anatomically-correct dolls can help establish the child's terminology as well as help him/her demonstrate what happened. The interviewer should project a calm, unhurried, supportive attitude, keeping in mind that incest and other forms of child sexual abuse may occur without physical trauma and without manifestations of guilt or anger in the child.

Other children who have contact with the suspected perpetrator should be evaluated. Physicians and other professionals involved in child sexual abuse investigations should also recognize that children and families involved in cases of child sexual abuse, even cases which are unresolved or unproven, are often in great need of community services and support.

2. The protection of a child is an important duty of the physician. Psychosexual trauma must be recognized and minimized. Emotional support and gentle sympathetic understanding of both child and family are very important. The physician must be tactful and kind. The parents should be given reassurance and guidance. They should be encouraged to recognize that their own responses to the exam will, in large measure, influence their child's reactions to the situation and events to follow.
3. The possibility of other forms of abuse should be entertained, and young children should be considered for a bone survey.

K. MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES

1. Prevention (prophylaxis)

- a. At initial examination, take samples for gonococcal culture and chlamydia culture or smear. (VDRL is optional).
- b. If patient requests prophylactic treatment for venereal disease, refer to recommended treatment schedule of the Iowa Department of Public Health.

2. Treatment

- a. If initial tests are positive, assess and treat as recommended by the Iowa Department of Public Health.
- b. Assess all patients one week after treatment, performing the same tests as at the initial visit. Treat as recommended per the current treatment schedule of the Iowa Department of Public Health.

L. MANAGEMENT OF POSSIBLE PREGNANCY

Pregnancy considerations:

1. Pregnancy is rare with sexual assault. There is a calculated four percent chance of pregnancy with one intravaginal penetration with viable sperm if it happens during the time a woman ovulates.
2. The patient has several alternatives. It need not be an issue at time of initial examination. The patient is under extreme pressure and questions of pregnancy, abortion, and potential cancer may only increase anxiety.
3. Alternative of management:
 - a. Diethylstilbestrol (DES), 50 mg. per day times five days and starting within 72 hours of intercourse. This is FDA approved. If a patient taking DES becomes pregnant, abortion is recommended because offspring may develop vaginal cancer if a female, or bladder cancer if a male.
 - b. Ovrall, 2 tablets within 72 hours of exposure to coitus; and then 2 more tablets 12 hours later for a total of 4 tablets. Not FDA approved.
 - c. Ethinyl Estradiol, 5 mg. per day times five days. Not FDA approved.
 - d. Premarin, 12 mg. p.o. per day times five days. Not FDA approved.
 - e. Premarin intravenous push up to 24-48 hours after intercourse. Not FDA approved.

- f. Endometrial aspiration, menstrual extraction (suction)
- g. Elective termination of pregnancy
- h. Progesterone, 200 mg. intramuscular injection within 48 hours of intercourse. Not FDA approved.
- i. Patient should be counseled and advised, and be given time to determine which alternative she desires.

M. COUNSELING

Rape Trauma Syndrome:

Ann Wolbert Burgess, RN, Professor of Nursing at Boston College, identified a cluster of symptoms experienced by victims of a sexual assault as the "rape trauma syndrome". This syndrome has two phases of stress reaction: The immediate or acute phase, in which the victim's lifestyle is disrupted by the crisis; and the long-term process, in which the victim must reorganize this disrupted lifestyle. This syndrome includes physical, emotional, and behavioral stress reactions which result from a person being faced with a life-threatening event. Similarly, children experience such symptoms especially where there is a long denial period with incest.

1. Acute phase: Disorganization

A prevailing myth about sexual assault victims is that they are hysterical and tearful following a sexual assault. To the contrary, victims show two main styles of emotion: Expressed and controlled.

Expressed style: The victim demonstrates feelings such as anger, fear, and anxiety. The victim expresses these feelings by being restless during the interview, becoming tense when certain questions are asked, crying or sobbing, or smiling in an anxious manner.

Controlled style: The feelings of the victim are masked or hidden and a calm, composed, or subdued affect are noted.

Physical symptoms are common during this phase and may include:

Sleep pattern disturbances

Eating pattern disturbances

General soreness

Physical symptoms specific to the assault, such as irritation of the mouth by a person who was forced to have oral sex.

Flashbacks are common reactions, also. They may be triggered by sounds, sights, or smells.

The most common emotional reaction to sexual assault is fear -- fear of physical injury, mutilation or death, even after the danger apparently has ended. Other feelings commonly experienced include humiliation, degradation, guilt, shame, embarrassment, mistrust of people, anger and a desire for revenge. Because of the wide range of emotions, survivors often are prone to mood swings. Many suffer mild to severe depression which may last from a few weeks to several months, and may be recurring.

2. Long-term process: Reorganization

Various factors seem to influence how the victim copes with the crisis, such as the victim's personality type, the people available to her/him who respond to her/his distress in a serious and concerned manner, and the way in which they are treated by the people with whom they come in contact after the assault. The healing process is not an easy one. No amount of cognitive understanding will make the feelings dissipate. The journey of recovery and healing may take months or years.

Four lifestyle areas are effected during this phase: Physical, psychological, social, and sexual.

Physical lifestyle: Immediately following sexual assault, the victim may report many physical symptoms related to musculoskeletal pain, genitourinary difficulties, gastrointestinal upset, general malaise, as well as eating and sleeping pattern disruption. The health area that the victim has most difficulty with over extended time period is gynecological and menstrual.

Psychological lifestyle: Dreams and nightmares are a major problem for the sexual assault victim and occur during both the acute phase and long-term process. Two types of nightmares are common. One type is a situation in which the victim dreams of being in a similar situation and is attempting to try and get out of the situation but fails. The second type of dream occurs as time progresses. The dream material changes and often the victim will report mastery in the dream. However, the dream content still is of violence, and this is disturbing to the victim. Often she will see herself committing acts of violence such as killing and stabbing people.

Phobias: A common psychological defense that is seen in the sexual assault victim is the development of fears and phobias specific to the circumstances of the sexual assault. Victims will develop phobic reactions to a wide variety of circumstances such as being in crowds, being alone, or specific fears related to characteristics noted in the assailant such as the odor of gasoline or alcohol which the women could smell on the man.

Social Lifestyle: The sexual assault very often upsets the victim's normal social routine. Many victims are able to resume only a minimal level of functioning even after the acute phase ends. A common response is to turn for support to family members not normally seen on a daily basis. Many victims change residence specifically because of the sexual assault.

Sexual Lifestyle: Many women report a fear of sex after the sexual assault. The normal sexual style of the victim becomes disrupted following a sexual assault. The sexual assault is especially upsetting if the victim has never had any sexual experience before the sexual assault in that they have no other experience with which to compare. For the victim who has been sexually active, the fear often increases when their partner confronts them with resuming their sexual pattern.

A good first-person account of a survivor's healing process is the book, No Fairy Godmothers, No Magic Wands, by Judy H. Katz (see bibliography).

3. Counseling Implications

Counseling based on the following assumptions has been effective in working with the sexual assault victim manifesting the rape trauma syndrome.

Short-term Issue-oriented Model: Victim counseling is an issue-oriented crisis treatment model. The focus of the initial interview and followup is on the sexual assault incident, and the goal is to help the victim return to her previous lifestyle as quickly as possible.

Crisis Requests of the Victim: The victim is considered normal, that is, an individual who was managing adequately in their lifestyle prior to the crisis situation. In this context, the victim is viewed as a customer of emergency services who has specific requests; one who seeks particular services from the professional.

Crisis Intervention: The sexual assault is viewed as a crisis situation and previous problems that are not associated with the sexual assault are not considered priority issues for discussion in the counseling. Victim counseling is not considered psychotherapy. When other issues of concern are identified by the victim that indicate another treatment model, referrals are generally offered to the victim if so requested.

Counselor-initiated Model: The counselor takes the active role in initiating the followup contact. This approach is different from the traditional methods where the patient is expected to be the initiator. The counselor goes to see the victim and also makes the first telephone contact as opposed to having the victim make an office appointment for followup.

Sexual Assault Against Men:

In 1980, a study of male rapes published in the American Journal of Psychiatry estimated that 10 percent of identified sex crime victims are men.

Cultural expectations and masculine stereotyping make sexual assault of males difficult to identify and still more difficult to report. The report rate for male victims is almost certainly lower than the already low report rate for female victims. Professionals may have contact with nonreporting victims and overlook signs which would help them recognize the symptoms of same-sex assaults:

"Symptom recognition involves sensitivity to subtle, ambiguous behavioral cues and sometime misleading information. If a victim reports outright that he has been assaulted, believe him. This may sound obvious, but in your anxiety you may give verbal or nonverbal messages that say to the victim, 'I don't believe this happened.' Male victims are very sensitive to such messages and are likely to respond by creating a cover story or terminating the contact.

Most often, a victim will respond to his situation by denying what really happened -- to you and perhaps to himself. A male victim that asks for help but seems hesitant to tell you what happened or seems to be having difficulty telling you what happened may be a sexual assault victim. Ask him directly. As you talk with him, you may sense that 'something is missing' from his story. Ask concrete questions to locate that missing piece.

After a sexual assault, a victim may report physical injuries or mild distress with little indication from his tone or voice or facial expression that he is in crisis. He may show little or no emotion in speech or expression. This apparent inconsistency between the message and its delivery should clue you that he may be in a state of shock or extreme denial, and needs immediate attention.

A male victim typically sounds passive, self-denigrating and ashamed. He may feel that, in some way, the assault was his fault, that he got what he deserved, and that he should keep quiet about it. His tone of voice, inflection, faltering expressions and lack of eye contact are indicators of this response. He may try to protect you (and himself) by withholding information that he feels you may disapprove of or may find uncomfortable. It is essential to understand that homophobia and 'masculine' stereotype expectations are powerful reasons for any male victim's shame reaction.

The general rule of thumb is this: When responding to a male who reports or exhibits indications that he has been physically assaulted, but who seems passive and distracted, rather than angry and agitated, ask directly, clearly and concretely whether he has been sexually assaulted."

STATE PROGRAMS WHICH PROVIDE ASSISTANCE
FOR SEXUAL ASSAULT VICTIMS
PART II

A. SEXUAL ASSAULT EXAMINATION REIMBURSEMENT

470-8.1(135) Reimbursable services. The following services will be reimbursed as items essential to a sexual assault claim examination:

8.1(1) Physician's fee

- a. History,
- b. Physician,
- c. Collection of specimens,
- d. One return-visit for completion of service when necessary,
- e. Treatment for the purpose of preventing venereal disease.

8.1(2) Emergency Department

- a. Emergency room fee,
- b. Supplies (State of Iowa Sexual Abuse Evidence Kit),
- c. Pelvic exam tray.

8.1(3) Laboratory

- a. Wet mount for sperm,
- b. Fixed smear for sperm (Papanicolaou fixative)
- c. Swabs for:
 1. Acid phosphatase,
 2. ABH antigen
- d. Blood typing,
- e. Serology,
- f. Gonorrhea cultures,
- g. Pregnancy testing,
- h. Urinalysis.

470-8.2(135) Claim for reimbursement. A claim for reimbursement, which identifies the individual either by name or hospital number, must be submitted indicating that the claim is for the collection of evidence in a suspected sexual abuse, and must itemize all services rendered and the fee for each service. Claims must be submitted within forty-five days from date of service to:

Iowa Department of Public Health, Family & Community Health Division, Lucas State Office Building, Des Moines, Iowa 50319-0075. The telephone is: (515) 281-3732, or 1-800-532-1579 (ask for Annette Vanderburgh).

B. IOWA CRIME VICTIM REPARATION PROGRAM⁸

The Iowa Crime Victim Reparation Program had its beginning January 1, 1983. In the past, an innocent victim could only hope that her/his offender be found guilty and serve the punishment which they deserved. But at least an innocent victim can now receive some type of financial support, if eligible, under this relatively new program. Compensation may be awarded as follows:

1. For reasonable expenses for medical care needed as a direct result of injuries suffered in a criminal attack. (Up to \$10,000)
2. For reasonable charges for counseling by a licensed psychologist of child abuse and domestic abuse victims. (Up to \$500)
3. For reasonable charges for victim counseling by a victim counselor of a child abuse and domestic abuse victims. (Up to \$500)
4. For loss of income from your job because of bodily injuries suffered as the result of a crime. (Up to \$2,000)
5. Loss of support for dependents of the victim. (Up to \$2,000 per dependent or a total of \$6,000)
6. For reasonable replacement value of your clothing that is held by the police in evidence. (Up to \$100)
7. For reasonable funeral and burial expenses. (Up to \$2,500)

In short, a person may be eligible if:

1. She/he is an innocent victim who suffers bodily injury from a violent crime.
2. She/he is an innocent victim of a crime committed by an individual found guilty of driving while under the influence of alcohol or drugs.
3. She/he is a victim of child abuse.
4. She/he is a victim of domestic abuse.

⁸ Application for Reparation By a Victim of a Crime (See Addendum F)
Iowa Crime Victim Reparation Program Eligibility Guidelines

5. She/he is the dependent(s) of an innocent victim of a violent crime.
6. She/he is the parent or legal guardian of a victim who is under 18 years and has assumed the responsibility for expenses incurred by the victim's injury.
7. She/he is a person responsible for the maintenance of the victim who has suffered a loss or incurred expenses as a result of personal injury to the victim.

It is felt innocent victims should be helped to overcome the effects of their victimization. This program is designed to provide that help.

Innocent victims should contact:

Iowa Crime Victim Reparation Program, Iowa Department of Public Safety, Wallace State Office Building, Des Moines, IA 50319-0075. The telephone number is: (515)281-5044.

THE IOWA LAW OF "SEXUAL ABUSE" PART III

INTRODUCTION

All of the laws passed by the Iowa Legislature and currently in effect are found in the Code of Iowa, a three-volume set updated and published once every two years and available in most hospitals.

The law of "Sexual Abuse" in this state is actually a complex and interwoven series of both criminal and civil laws, or "statutes" as they are identified in legal terms, found in widely separated parts of this Code. The operation of these statutes, how they are applied, and how they work is often misunderstood. Much of the confusion is due to the use of terms which have commonly understood meanings in general usage, but take different meanings in legal application.

The best example of this confusion is the term "sexual abuse" itself. In common usage, this term has varied interpretations. Many believe it is generic and refers to all crimes of a sexual nature. Others believe it refers only to sex acts committed with children. Neither of these beliefs is technically accurate. The confusion is compounded by the Legislature's use of similar terms to define dissimilar subjects. An example is the legal distinction between "sexual abuse" and a "sexual offense."

The Legislature completely revised the criminal law of Iowa in 1978. At that time, the crimes of rape and sodomy were merged into a new crime category, "sexual abuse," and the terms "rape" and "sodomy" were legally discarded. As a result, the term "sexual abuse" now refers specifically to the rape or sodomization of an adult or a child. See Section A for a definitive outline of the present law of "Sexual Abuse" and for further definitions of terms in that specific crime category.

Alternatively, the term "sexual offense" as it is now used in the law is generic in nature and refers not only to the specific crimes defined as "sexual abuse", but also to all other sex crimes. See Section B, "Other Sex Offenses," for legal definition of these additional crimes.

To fully understand the legal area under review, it is necessary to understand that, in addition to the criminal justice system built around the criminal statutes there is an entirely separate system which responds to a sexual offense in certain circumstances where children or dependent adults are involved. A social service response system has been developed as a result of laws enacted for the protection of victims of sexual offenses unable to care for themselves. The Department of Human Services (formerly Social Services) is empowered to initiate action on behalf of the victim.

Where the justice system is concerned with punishing the perpetrator, the social service system is directed toward aiding and caring for the victim. It should be noted that when any adult or child is raped, the laws of sexual abuse operate to punish the perpetrator. When the victim is a child, a "child sexual abuse" report is made which activates the protective system, but this has no bearing or effect on the criminal prosecution function. Although these two systems may operate in parallel in a given case, they are totally separate in purpose and result.

Of the social service systems, the best known is that which responds to child abuse. Contained within this law are provisions for identifying the abused child through required reports to the Department of Human Services by health practitioners and other specified professionals who have significant contact with children. There are also provisions for the Courts to determine the child's needs and the appropriate services to ensure proper care. The child abuse laws are described in Section C, "Child Abuse Statutes Based Upon Sexual Offenses."

The final sections outline areas of the law which often prompt questions. Section E describes guidelines for documenting and preserving evidence in a sexual abuse case and defines the "chain of evidence." The role of the health practitioner in testifying about evidence is also described.

Section F contains a general consideration of informed consent of minors. The history and present state of the laws are presented along with procedures for obtaining consent or court-ordered approval, for treatment.

A. CRIMINAL SEXUAL ABUSE STATUTES (rape and sodomy)

As noted in the Introduction, the revision of Iowa criminal law in 1978 caused the commonly understood terms of "rape" and "sodomy" be merged into a crime category which is now known as "criminal sexual abuse." For a crime of sexual abuse to have occurred, a "sex act" must have been performed.

1. Definition of "sex act" (Chap. 702.17, Code of Iowa)⁹

- a. Contact between the genitalia of one person and the genitalia or anus of another, or
- b. Penetration of the penis into the vagina or anus, or
- c. Contact between the mouth and genitalia, or
- d. Use of artificial sexual organs or substitutes therefore in contact with the genitalia or anus.

Using the above definition as a foundation, Iowa presently defines criminal sexual abuse as follows:

2. Definition of "sexual abuse" (Chap. 709.1)

- a. Any sex act committed by force or against the will of the victim, or
- b. Any sex act performed where the victim is suffering from a mental defect or incapacity which precludes given consent, or
- c. Any sex act where the victim is a "child" the word "child" must also be separately defined, as shown in the following section.

⁹ All references are to the 1987 Code of Iowa unless otherwise noted.

3. Definition of "child" (Chap. 709.1-709.4)

- a. "Child" means a person up to (but not including) sixteen (16) years of age if the perpetrator of the sex act is a relative, member of the same household, or in a position of authority over the child and such authority was used to coerce submission.
- b. "Child" means a person up to (but not including) fourteen (14) years of age if the perpetrator is someone other than as described in the previous section.

Criminal sexual abuse is divided into first-, second-, and third-degree crimes. The fine points of law which distinguish the various degrees of the crime are beyond the scope of this manual as the degree of guilt is ultimately determined in the courts. However, the medical practitioner can supply valuable information by charting the following observations during the examination and treatment of the victim.

4. Factors related to the degree of crime (Chap. 709.2-709.4)

- a. Nature and extent of injuries
- b. The victim's statements concerning:
 1. Identity of the perpetrator
 2. Whether a weapon was used
 3. What threats were made
 4. Whether the perpetrator acted alone
- c. Any indication of preexisting mental defect or incapacity noted during examination of the victim

5. Distinction between "sexual abuse" and other sex offenses

As detailed above, the term "sexual abuse," as it is presently defined in the Iowa law, pertains only to those acts which are commonly known as rape and sodomy. There are several other sex crimes which do not fall within the definition of "sexual abuse" but which are particularly relevant to Section C, Child Sexual Abuse Statutes; and Section D, Dependent Adult Sexual Abuse Statutes, below. These "other sex offenses" are discussed in the following section.

B. OTHER SEX OFFENSES

The Iowa Legislature has adopted a consistent pattern of defining sexual abuse of children and of dependent adults for reporting and for protective services purposes by referencing the reporting laws to the commission of a "sexual offense as defined in chapter 709 or in section 726.2 of the Iowa Code." In addition to the crime of sexual abuse described in the preceding section, there are three other sex offenses in chapter 709 and the crime of

Incest in section 726.2 which bear upon the reporting requirement. A working knowledge of the definition of these offenses serves as a basis for understanding the reporting laws in the next two sections.

1. Assault with intent to commit sexual abuse (Chap.709.11)

Iowa law defines this crime in the terms used for its title; that is, any unwarranted touching of another person with the intent to commit a sex act in a manner which would constitute sexual abuse, if accomplished, is sufficient to create the offense.

This statute was enacted in 1981 and designed to fill a gap in the law by providing an increased penalty for an attempted rape in circumstances where the sex act was not actually performed. For example, this law would apply when the victim escaped from the attack. Prior to 1981, an attempted sexual abuse was only considered to be a lesser assault crime.

2. Lascivious acts with a child (Chap. 709.8)

Lascivious Acts with a Child is defined as a crime when any person eighteen (18) years of age or older performs any one of the following acts with a child under the age of fourteen (14):

- a. Fondle or touch the pubes or genitals of a child
- b. Permit or cause a child to fondle or touch his/her genitals or pubes
- c. Solicit a child to engage in a sex act
- d. Inflict pain or discomfort upon a child or permit a child to inflict pain or discomfort upon him/her. To constitute the offense, the act must have been done for the purpose of arousing or satisfying sexual desire; i.e., an accidental touching is not considered an offense. Further, this law does not apply if the parties to the act are married to each other.

3. Indecent contact with a child (Chap. 709.12)

This statute was also enacted in 1981, and was designed to protect children from additional forms of sexual contact not defined in the Lascivious Act law which was originally adopted in 1913.

Indecent Contact With A Child is defined as a crime when a person eighteen (18) years of age or older performs anyone of the following acts with a child under the age of fourteen (14):

- a. Fondle or touch the inner thigh, groin, buttock, anus, or breast of the child
- b. Touch the clothing covering the immediate area of the inner thigh, groin, buttock, anus, or breast of the child

- c. Solicit or permit a child to fondle or touch the inner thigh, groin, buttock, anus, or breast of the person.
- d. Solicit a child to engage in any act prohibited under section 2, lascivious acts with a child, subsections a, b, or d above.

As in the Lascivious Acts statute, the acts prohibited above must have been done for the purpose of arousing or satisfying sexual desire, and this law is also not applicable if the parties to the act are married to each other.

4. Incest (Chap. 726.2)

"Incest" is defined as any sex act between two persons except when both are legally defined as a child who are related as follows, legitimately or illegitimately:

ancestor	half-sister
descendent	aunt
brother	uncle
sister	nephew
half-brother	niece

The foregoing offenses, along with the crime of sexual abuse described in Section A, represent the "sexual offenses" which are the foundation of the child abuse and dependent adult abuse reporting laws outlined in the next two sections of this protocol.

C. CHILD ABUSE STATUTES BASED UPON SEXUAL OFFENSES

1. Dual reporting requirements for child abuse cases

When a child is presented for examination and there is reason on the part of the health practitioner to believe the child has been subjected to a sexual offense and that a parent, guardian or other person responsible for the child is accountable for the abuse, both a report to the appropriate law enforcement agency and to the local department of human services office is to be made. The latter report is mandated by Iowa's child abuse law and liability can result for a doctor and staff if a report is not made under circumstances where child abuse is suggested.

There are several categories of child abuse defined in Chapter 232 of the Code. Only the definition of child abuse by the commission of a sexual offense is relevant to this manual. If in doubt as to whether a category applies, report the incident.

2. Definition of child abuse by sexual offense [Chap. 232.68(2)(b)]

"Child abuse" means the commission of any sexual offense with or to a child pursuant to Chapter 709 or Section 726.2, as a result of the acts or omissions of the person responsible for the child.

For purposes of this law, "child" means a person under the age of sixteen (16) years.

3. Mandatory reporting of child abuse

Section 232.69 of the Code provides that every health practitioner who examines, attends, or treats a child and who reasonably believes the child has been abused must make a child abuse report to the county department of human services.

4. Immunity for Reporting

The child abuse law is designed to encourage the reporting of suspected abuse. The law recognizes the person making such a report may have a concern about angered parents attempting to retaliate by filing a suit for slander or by other means. Therefore, the Legislature adopted an all encompassing immunity for the protection of persons making child abuse reports.

Section 232.73 of the Code provides that anyone participating in good faith in making a child abuse report or taking photographs or x-rays for a child abuse report shall have immunity from any civil or criminal liability. Such persons have the same immunity with respect to participation in good faith in any judicial proceeding resulting from a report or relating to the subject matter of a report.

5. Emergency Treatment of Children

Infrequently a child will require emergency treatment and the parent or parents will be unavailable or unwilling to consent. In emergency situations there are three methods for providing treatment. The first is under an order of the juvenile court and is the proper procedure when time will permit. Section 232.78(3) of the Code provides that the juvenile court may enter an order authorizing a physician or hospital to perform emergency medical or surgical procedures, provided such procedures are necessary, to safeguard the life and health of the child, and there is not enough time to file a petition and hold a hearing as is ordinarily required.

The second is an emergency provision for treatment without a court order. A physician treating a child may keep the child in custody without a court order as required under section 232.78 and without the consent of a parent, guardian, or custodian. This method should be followed only when the child is in such circumstances or condition that his/her continued presence in the residence or in the care or custody of the parent, guardian, or custodian presents an imminent danger to the child's life or health, and there is not enough time to apply for a court order.

The third method is authorized under Section 910.A16(2). This provision allows licensed professionals to provide short-term medical and mental health services to victims without the prior consent or knowledge of the victim's parent(s) or guardian(s).

Whenever an emergency of this nature exists, the attending physician should immediately contact the county department of human services and

the probation office of the county juvenile court. Medical personnel need only to provide their opinion concerning the necessity of immediate treatment as these staffs are trained to facilitate the procedures for treatment on behalf of the child.

6. Doctor-Patient Privilege Revoked

Under ordinary circumstances, a health practitioner is bound by the doctrine of confidential communications. This doctrine is known as the doctor-patient privilege and requires a patients consent for the release of any medical information or communications from the patient to third parties.

The child abuse law revokes this privileged communication doctrine with the obvious understanding that parents might often be reluctant to consent to the release of information damaging to their interests in a child abuse case.

Section 232.74 of the Code provides that any other statute or rule of evidence which excludes or makes privileged the testimony of a health practitioner concerning confidential communications, shall not apply to evidence regarding a child's injuries or the causes in any civil or criminal case resulting from a child abuse report.

D. DEPENDENT ADULT ABUSE STATUTES BASED UPON SEXUAL OFFENSES

The 1983 Iowa Legislature enacted a law for the protection of adults unable to care for themselves. This legislation, generally referred to as "Adult Abuse," became effective July 1, 1983. The provisions of this new law closely parallel the protective features of the Iowa child abuse law.

1. Definition of "Dependent Adult" Iowa Administrative Code [Chap. 176.1(4)]

"Dependent Adult" means a person eighteen (18) years of age or older who is unable to protect his/her own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another.

2. Defintion of Dependent Adult Abuse by Sexual Offense [Chap.235B.1(a)(2)]

Dependent Adult Abuse means the commission of a sexual offense under chapter 709 (Sexual Abuse or other sex crimes) or section 726.2 (Incest) with or against a dependent adult. This legislation creates dual reporting considerations which are similar to those presented with a child sexual abuse case. There is, however, one distinction. When a suspected case of dependent adult sexual abuse is confronted, it should be reported to the appropriate law enforcement agency in the same manner as a child sexual abuse case. The distinction is found in the provisions for reporting to the Iowa Department of Human Services. Note the use of the term "may" in the following definition.

3. Permissive Reporting of Dependent Adult Abuse [Chap. 235B.4(a)]

A person who believes that a dependent adult has suffered abuse may report the suspected abuse to the department of human services.

In the foregoing definition, the use of the term "may" makes such a report optional. In child abuse cases, the health practitioner is a mandatory reporter of suspected child abuse activity. In a dependent adult sexual abuse case, a report to the department of human services is made by any person on an optional basis who believes a dependent adult has been sexually abused. The same protections are afforded to the person making the report as are found in the child abuse statute. Such reporting is encouraged in this protocol for the protection of the dependent adult.

4. Immunity From Liability for Reporting (Chap. 235B.7)

A person participating in good faith in reporting, cooperating or assisting in a case of dependent adult abuse has immunity from liability, civil or criminal. The person has the same immunity with respect to participation in good faith in a judicial proceeding resulting from the report.

The effect of the immunity provision is identical to that found in the child abuse law. Any person who makes a report to the human services department concerning the abuse of a dependent adult will be held harmless from any liability so long as the report or later testimony in court, if required, was given in good faith.

The immunity from liability granted in this law, just as in the child abuse law, is upheld regardless of any subsequent findings regarding the circumstances of the alleged abuse. In other words, even if an investigation reveals that the dependent adult was not sexually abused, a person making a report will not be held liable if there was a good faith belief that abuse may have occurred at the time the report was made.

E. DOCUMENTATION AND PRESERVATION OF EVIDENCE - THE "CHAIN OF EVIDENCE"

1. Definition of Physical Evidence - An Exhibit

"Chain of evidence" is a term used by the courts to identify the requirements for establishing the authenticity of an exhibit (a specific item of physical evidence) so that it can be "admitted" into the trial record in a court case. To be "admitted" means that the judge has determined the exhibit is in fact what it is claimed to be, that it was derived from the source claimed, and that it has been properly cared for so as to not alter its value as evidence. As examples, an exhibit can be a piece of clothing, a sample specimen from a patient, or any other tangible or physical material. An exhibit cannot be considered by the jury as evidence until it has been "admitted" into the trial record by the judge.

2. Requirements for Identification of an Exhibit

The requirements for identifying physical evidence are stringent. When

testifying in support of an exhibit, the person who obtained it must be able to identify the exhibit at the time of trial. To identify means to be able to distinguish the object as being unique from all other objects which might appear similar. In the instance of clothing or specimens, for example, identification would be impossible without accurate labeling and careful packaging. A person labeling an object should always sign his/her name. A personal signature is distinctive and will permit the person to testify with certainty that the identifying label, transmittal form, chain of evidence tag, or other record format was signed by that person. A signed label also identifies with equal certainty the evidence which it describes and to which it is attached.

In addition, the person who originally obtained the exhibit must be able to identify its source. Sourcing information should be included both on the identifying record of the evidence and in the regular patient charting. The witness must be able to state in court, for example: "I obtained this particular undergarment from (patient) during the initial examination at (place) (date) (time)," or "In examining (patient) at (place) (date) (time), I swabbed the vaginal vault and created these two smear slides which I then labelled as shown."

3. Requirements for establishing the chain of possession

Finally this same witness must create the first link in the "chain of evidence." This term refers to a further requirement that a continuous chain of possession must be shown for an exhibit from the point of its initial taking until its presentation in court. The party attempting to have the exhibit admitted into the record, usually the state prosecutor, must show through whose hands the exhibit has passed. The first witness must be able to identify the person to whom the exhibit was given and that it was in the same condition when given as when obtained, unless a legally valid purpose can be demonstrated for a change in condition such as laboratory testing. The next person to whom the exhibit was given must be called as a witness and be able to identify the exhibit, the person to whom he/she delivered it, and that it was not altered in any manner except as noted above while in this person's possession. The "chain of possession" continues until completed.

It is obvious that every person who handles the evidence becomes a link in the chain and is, therefore, required to be called to court as a witness. It is just as obvious that every effort should be made to eliminate unnecessary middle persons in the chain and to create the shortest chain of possession possible. This is best achieved when the person obtaining the evidence transfers it directly to a law enforcement officer, if one is present. Police and sheriff's departments are generally well trained in the handling, documentation, and preservation of evidence.

Procedures and forms for the packaging and labeling of evidence are more fully detailed in the examination protocol in Part I. It must be remembered that every examination under circumstances where sexual abuse may have occurred is a potential court case. Physical evidence in the form of exhibits can be critical to such a case and the inability to use

an exhibit in court due to a failure in the "chain of evidence" can result in the case being lost.

F. INFORMED CONSENT OF MINORS

1. Definition of Informed Consent

The requirement of a valid consent for treatment has been defined in Sard v. Hary, a 1977 Maryland case:

It is the duty of a physician, before treating a patient, to explain the procedure and to warn the patient of any material risks in the therapy, so as to enable the patient to make an intelligent and informed choice as to whether to undergo such treatment.

The foundation for consent issues in the law can be traced to a decision by Justice Cardozo in a 1914 New York case, Schloendorff v. Society of New York Hospital where it was determined:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

2. Conflict in the Law of Consent of Minors

The obvious omission of minors in Cardozo's statement has not been substantially clarified in the more than seventy years since it was issued. The matter of a minor's consent is a changing and evolving field where the continuing conflict is between the basic rights and responsibilities of parents to determine what is best for their children and the emergence of a concept that youths have the right to make decisions about their bodies and their care. The latter concept is reflected by almost every state, including Iowa, in the lowering of the age of majority from twenty-one (21) to eighteen (18) years of age and the further provision that a minor is emancipated by marriage.

3. Minors' Consent in Venereal Disease Cases

Many states have attempted to enact statutes concerning minors' consent. There is little uniformity except in one area. A majority of states has passed legislation allowing minors to obtain treatment for venereal disease without parental knowledge or consent. Iowa's law, found in section 140.9 of the Code, is as follows:

A minor who seeks diagnosis or treatment for venereal disease shall have the legal capacity to act and give consent to medical care and service for venereal disease by public and private hospitals or public and private clinics or physicians. Such medical diagnosis and treatment is to be provided by a physician licensed to practice medicine and surgery, osteopathy, or osteopathic medicine and surgery. Such consent shall not be subject to later disaffirmance by reason of such minority. The

consent of no other person or persons, including but not limited to spouse, parent, custodian, or guardian, shall be necessary.

4. The Concept of a Mature Minor

The concept of a "mature minor"; that is, a youth with the ability to make valid decisions about his/her own care and to give informed consent, has been finding its way into "case law," as opposed to statutory law, in many malpractice lawsuits. A survey of recent litigation reveals no court has found against a physician for treatment of a minor over the age of fifteen years (15) years on the minor's consent; and only rarely for those under the age of sixteen (16), except in procedures involving surgery, experimentation, or radical drug reactions.

There is no question that all states, including Iowa, should review this issue with regard to new legislation; yet no law nor court decision will answer all of the questions which can arise. Physicians must take some calculated risks, just as is done in any diagnosis or treatment decision, when a consent issue is raised and must be determined to the best benefit of the patient.

5. Recommended - and Other - Procedures for Consent

Under the present Iowa law, the physician can minimize the risk. When presented with a minor, who has allegedly been the subject of a sexual offense and who is in need of treatment, the physician in charge of the patient and of the treatment should first attempt to obtain parental consent in the normal manner. If such consent is refused or unavailable and the minor is "mature" - sixteen (16) or older - a balancing of the immediacy of need for treatment, the nature of the treatment and the maturity of the minor can ordinarily produce a valid and informed consent when treatment is needed, but not radical. This practice is not recommended, but is noted as available in the appropriate circumstance with a probable minimum risk. However, if the judgment is made that a minor is sufficiently mature to consent, the physician is unwise if he/she fails to note in the patient's chart the indications of maturity, the reasons for the judgment, and the discussion with the minor leading to the consent.

In all other circumstances where the child is less than sixteen (16) years of age, the physician is well advised to employ the emergency treatment procedures contained in the child abuse law and outlined in Section C, Part 5, above, if parental consent is not obtainable and treatment is deemed to be required. In following these procedures, with the assistance of social service workers and juvenile court officers, the treatment of the child can progress under a court order which makes the physician and medical facility virtually immune from a malpractice claim.

ADDENDA

- A. Iowa Sexual Assault Intervention, Domestic Violence Intervention and Victim-Assistance Centers
- B. Sample Consent Form for Examination and Treatment of Sexual Assault Victims
- C. Sample Checklist for Medical Protocol for Examining and Managing Patients of Sexual Assault -- Child/Adult
- D. Division of Criminal Investigation Crime Laboratory -- State of Iowa Sexual Assault Evidence Collection Kit Instructions
- E. Child Sexual Abuse Introitus Exam Technique
- F. Iowa Crime Victim Reparation Program

IOWA SEXUAL ASSAULT AND DOMESTIC VIOLENCE CENTERS

1. Story County Sexual Assault Care Center
P.O. Box 1150 — ISU Station
Ames, Iowa 50010
2. YWCA Shelter and Sexual Assault Center
2410 Mt. Pleasant Street
Burlington, Iowa 52644
3. YWCA Sexual Assault
Crisis Intervention Program
318 5th Street, S.E.
Cedar Rapids, Iowa 52401
4. Family Violence Services
Waubonsie Mental Health Center
Clarinda, Iowa 51632
5. Women's Resource Center —
Gateway YWCA — 317 7th Avenue, S.
Clinton, Iowa 52732
6. Domestic Violence Program
315 W. Pierce
Council Bluffs, Iowa 51501
7. Quad City Rape/Sexual Assault
Counseling Program
P.O. Box 190
Davenport, Iowa 52805
8. Helping Services for NE Iowa:
Services for Abused Women
Box 372
Decorah, Iowa 52101
9. Family Violence Center
1101 Walnut
Des Moines, Iowa 50309
10. Polk County Victim Services
1915 Hickman Road
Des Moines, Iowa 50314
11. Dubuque/Jackson County Mental
Health Center
Mercy Drive
Dubuque, Iowa 52001
12. YWCA Battered Women Program
35 N. Booth
Dubuque, Iowa 52001
13. Council for the Prevention of
Domestic Violence
Box 151
Estherville, Iowa 51334
14. Family Violence Center of
North Central Iowa
P.O. Box 173
Fort Dodge, Iowa 50501
15. Rape/Sexual Assault Victim Advocates
c/o Trinity Regional Hospital
Kenyon Road
Fort Dodge, Iowa 50501
16. Domestic Violence Project
P.O. Box 733
Iowa City, Iowa 52244
17. Rape Victim Advocacy Program
130 North Madison
Iowa City, Iowa 52242
18. Tri-State Coalition Against
Family Violence
Box 494
Keokuk, Iowa 52636
19. Dubuque/Jackson County
Mental Health Center
700 West Quarry
Jackson Co. Public Hospital
Maquoketa, Iowa 52060
20. Domestic Violence Alternatives
1500 E. Linn Street
Marshalltown, Iowa 50158
21. Crisis Intervention Services
22 North Georgia
Room 207 — 3rd Floor
Mason City, Iowa 50401
22. Sexual Assault Center
P.O. Box 872
Mason City, Iowa 50401
23. Muscatine Co. Rape/Assault
Care Services
c/o Family & Children Services
Medical Arts Building
Muscatine, Iowa 52761
24. Crisis Center
Box 446
Ottumwa, Iowa 52501
25. Domestic Violence Aid Center, Inc.
128 3rd Street, N.W.
Sioux Center, Iowa 51250
26. Council on Sexual Assault and
Domestic Violence
P.O. Box 1565
Sioux City, Iowa 51102
27. Rape/Sexual Assault &
Abuse Intervention
for Blackhawk County
2530 University Avenue
Waterloo, Iowa 50701

Carole Meade: Iowa Coalition Against Sexual Abuse
Illinois Hall
Twenty-fifth & Carpenter
Des Moines, IA 50311
(515)271-2918

SAMPLE CONSENT FORM
FOR
EXAMINATION & TREATMENT
OF
SEXUAL ASSAULT VICTIMS

I _____ consent and authorize
(print full name of patient)

Dr. _____ and/or the Medical Staff of
(print full name of physician)

_____ Hospital to obtain history, perform on me a physical examination, and collect and analyze laboratory material. This permission includes the taking of photographs if such is indicated in the judgment of the examining physician.

I consent and authorize _____ Hospital to disclose the information in my record to the staff of the Iowa Department of Public Health in Des Moines, Iowa, in order for them to verify services provided and to assure quality patient care. The confidentiality of such information will be maintained and guarded to prevent its release to unauthorized individuals.

_____, MD, DO
(Date) (Examiner's Signature)

I DO _____ DO NOT _____ authorize _____ Hospital to supply laboratory specimens, photographs, and copies of all medical reports pertinent to this visit to the appropriate law enforcement agency.

Patient's Signature _____ Date _____

Witness' Signature Title _____

Parent's/Guardian's Signature (if applicable) _____

Parent's/Guardian's Address (if applicable) _____

(Zip)

SAMPLE CHECKLIST FOR
MEDICAL PROTOCOL FOR EXAMINING AND MANAGING PATIENTS
OF SEXUAL ASSAULT
Child - Adult

To assist in documenting sexual assault records: (Please dictate the exam)

1. Sexual-assault counselor notified (If child abuse, Child Protective Services/
Social Worker notified)
2. Sexual-assault counselor present (CPS or Social Worker present)
3. Signed consent for examination of patient
4. Signed consent for release of medical information to appropriate law enforcement
agency
5. Time of assault
6. Date of assault
7. Time of examination
8. Examination of patient in clothes. (Please use anatomically-correct dolls)
9. Clothing saved
10. Date of last menstrual period
11. Current contraceptive useage
12. Any bathing, douching, and gargling if done since time of sexual assault?
13. Last time the patient had vaginal sexual intercourse

History, brief narrative of the assault including the following:

14. Did assaulter ejaculate or have orgasm?
15. Indicate what orifices entered by assaulter
16. Current symptoms (pain, bleeding, cuts, bruises, etc.)
17. Pertinent past medical history
18. Current illnesses
19. Emotional status of patient
20. Adult: Vitals (temperature, blood pressure, pulse)
Child: Vitals plus height, weight, head circumference
21. Current medications

- 22. Physical examination
- 23. Pelvic, genitalia examination
- 24. Rectal examination

Prepuberty Child

Findings in Acute Sexual Abuse:

Perineal contusions
 Perihymenal erythema, swelling, petechiae
 Abrasions, avulsions, lacerations
 Spasm of pubococcygeus muscle
 Seminal products
 Tense rectal sphincter
 Anal fissures
 Rectal-perianal contusions or ecchymoses
 Penile swelling, angio-edema reaction

Findings in Chronic Sexual Abuse:

Multiple hymenal transections, healed
 Rounded hymen remnants
 Spacious introitus >4 mm.
 Healed 1° laceration @ 6 o'clock
 Capacity to relax pubococcygeus muscle
 Leukorrhea
 Cervicitis
 Reflex relaxation of the anal sphincter
 Penile ecchymosis and scars

25. Ultra-violet lamp exam

Aging of Bruises

26. Laboratory studies

24 hours - Red, red/blue, crisp margins
 36-48 hours - Margins fading, violaceous to blue/black
 48-72 hours - Yellow margination with indistinct margins
 3-5 days - Central ecchymosis
 5-7 days - Fading yellow to green
 10-14 days - Brown to clear

LABORATORY SPECIMENS	CERVIX	VAGINA	MOUTH	*RECTUM	SKIN
Acid Phosphatase					
Permanent fix slides for sperm					
Gonorrhea Culture					
ABH Antigen					
Wet Mount					
P30 Antigen**					

Chain of Evidence Process

Physician to Nurse,
 Nurse to Lab Tech,
 Lab Tech to Lab in secure area,
 Lab Personnel,
 Pathologist,
 Results referred to Medical Record and examining physician.

VDRL DONE? YES _____ NO _____

*5-10cc. Saline may be instilled in vagina/rectum and aspirated after several minutes. Two to four swabs can be inserted through hymen opening for all specimens.

** Provided for in the D.C.I. Sexual Abuse Evidence Collection Kits

27. Exam wet slide immediately: Sperm present or absent on wet slide?
28. Sperm mobile or immobile?
29. Wet mount for Fungus, Trichomonas, other
30. ABH Antigen collected....(4 cotton-tipped swabs, air dried, and placed on labeled test tube) (Specimens retained in locked box or sent with law enforcement officer/s)
31. Combed pubic hair collected and placed in container
32. Debris from beneath fingernails collected and placed in container
33. Do pregnancy test, blood work, and drug screens as indicated
34. Designate source on all specimens sent to Laboratory
35. Impression/Assessment:

If adult:	If child/adolescent:
A. Physically assaulted	a. Sexual abuse exam
B. Sexually assaulted	b. Suspected child abuse - sexual abuse
C. Suspected physical or sexual assault	c. Evidence of sexual intercourse
D. Evidence of sexual intercourse	
36. Plan of treatment and aftercare
37. Return-appointment instructions given (to the ED, family physician, other) for follow-up counseling and continuity of care
38. Referral to other agency(ies)
39. Treatment for sexually transmitted diseases
40. Treatment to prevent pregnancy offered (please see alternatives in sexual assault treatment guide)
41. Repeat GC culture in 7 days and Herpes exam or culture. Also, consider Chlamydia culture if available.
42. VDRL in 6 weeks
43. It is recommended to give a statement about the physical and mental prognosis for the patient. Give patient and/or parents educational handouts.

MEDICAL NOTES	NURSING NOTES
<p>8. Current medications: YES _____ NO _____</p> <p>Under influence of drugs: YES _____ NO _____</p> <p>Specify: _____</p> <p>II. Past history of abuse or physical assault: YES _____ NO _____</p> <p>III. Physical exam (use anatomically-correct dolls)</p> <p>A. General appearance, emotional state, and behavior of patient: _____</p> <p>B. Description of clothing worn during assault: Torn _____ Blood-stained _____ Semen-stained _____ Normal _____</p> <p>C. Pubertal stage (Tanner): _____</p> <p>D. HEENT CHEST ABDOMEN BACK NEURO EXTREMITIES TRAUMA (Diagrams)</p> <p>Pictures completed: YES _____ NO _____</p> <p>Photographer: YES _____ NO _____</p> <p>E. Description of perineum: Normal _____ Laceration _____ Ecchymosis _____ Bleeding _____</p> <p>Describe hymen: _____</p> <p>Present: YES _____ NO _____</p>	<p>Dolls used for child exam: YES _____ NO _____ NA _____</p> <p>Pictures taken: YES _____ NO _____</p> <p>Photographer: YES _____ NO _____</p> <p>Number of pictures taken: _____</p> <p>Signed consent for exam: _____</p> <p>Release-of-Medical-Information form signed: YES _____ NO _____</p> <p>PHYSICAL OBSERVATIONS:</p> <p>_____</p> <p>_____</p> <p>EMOTIONAL OBSERVATIONS:</p> <p>_____</p> <p>_____</p> <p>Diagnostic studies done:</p> <p>GC culture _____ Acid Phosphatase _____ Hanging Drop _____ ABH (4) _____ Sperm Slides (2) _____ Pap Smear _____ Pubic Comb _____</p> <p>VDRL _____ ORTHO _____</p> <p>Treatment and medications:</p> <p>Instructions to patient/return appointment:</p> <p>_____</p>

MEDICAL NOTES	NURSING NOTES
---------------	---------------

F. Pelvic examination:

Vagina _____
 Cervix _____
 Uterus _____
 Adnex _____
 Rectum _____

Vaginal introitus measurement: _____

Penis _____
 Testicles _____
 Scrotum _____

G. Combing of pubic hair:
 YES _____ NO _____

H. Fingernail cleaning samples:
 YES _____ NO _____

I. Blood samples:
 YES _____ NO _____

J. Hair samples collected:
 YES _____ NO _____

K. Laboratory studies: Legal Chain of Evidence

Protocol - Physician
 Nurse
 Lab Personnel
 Locked container
 Lab Personnel
 Pathologist

OR: Sexual Assault Evidence Kit submitted to Law Enforcement Personnel

Signature Key:

May return to work/school:
 YES _____ NO _____ NA _____

Date of expected return: _____

List any restrictions: _____

Time patient left Emergency Dept: _____ a.m.
 _____ p.m.

S M T W T F S

LABORATORY SPECIMENS	CERVIX	VAGINA	MOUTH	RECTUM	SKIN
Acid Phosphatase Permanent Fixed Slides for Sperm					
Gonorrhea Culture					
ABH Antigen					
Wet Mount					
P30 Antigen					

VDRL Done: YES _____ NO _____

MEDICAL NOTES	NURSING NOTES
<p>IV. Impression/Assessment:</p> <p>Sexual Abuse Examination Normal Examination Evidence of Sexual Intercourse Evidence of Trauma</p> <p>V. Treatment:</p> <p>DT Vaccination Sexually Transmitted Disease Prevention Pregnancy Prevention</p> <p>Follow-up Examinations for:</p> <p>GC/VDRL; Counseling; Prevention-Education; Continuity of Care; Long-Term Follow-up</p>	
<p>Signature _____ Date _____</p>	<p>Signature _____ Date _____</p>

STATE OF IOWA SEXUAL ASSAULT EVIDENCE COLLECTION KIT INSTRUCTIONS

THIS KIT IS DESIGNED TO ASSIST THE EXAMINING PHYSICIAN AND NURSE IN THE COLLECTION OF EVIDENTIARY SPECIMENS FOR ANALYSIS BY THE CRIME LABORATORY SERVING YOUR LOCAL POLICE AGENCY. THE HOSPITAL IS NOT REQUESTED OR ENCOURAGED TO ANALYZE ANY OF THE SPECIMENS/ EVIDENCE COLLECTED IN THIS KIT. ANY SPECIMENS REQUIRED BY THE HOSPITAL ARE TO BE COLLECTED WITH HOSPITAL SUPPLIES.

- STEP 1** **VICTIM INFORMATION AND SEXUAL ASSAULT HISTORY FORM**
Fill out all information requested on the form.
- STEP 2** **CLOTHING AND UNDERWEAR**
Collect victim's outer clothing and place each item in a separate hospital-provided paper bag (grocery-type). Staple shut and label as to contents. Collect victim's underwear and place in underwear bag which has been provided in this kit. Staple shut and fill out all information requested on underwear bag label.
1. Wet or damp clothing should be air dried before packaging.
 2. If victim is not wearing the clothing worn at the time of the alleged assault, collect only the items that are in direct contact with victim's genital area.
 3. If victim has changed clothing after assault, inform officer in charge so that the clothing worn at the time of the assault may be collected by the police.
 4. Do not cut through any existing holes, rips or stains in victim's clothing.
 5. Do not shake out victim's clothing or microscopic evidence will be lost.
- STEP 3** **DEBRIS COLLECTION**
Remove paper bindle from debris collection envelope. Unfold and place on flat surface. Collect any foreign material found on victim's body (leaves, fibers, hair, dried semen, etc.) and place in center of bindle. Refold in manner to retain debris, and return bindle to debris collection envelope. Note location sample was taken from on anatomical drawings on envelope. Seal and fill out all information requested on envelope.
- STEP 4** **PUBIC HAIR COMBINGS**
Remove paper towel and comb provided in pubic hair combings envelope. Place towel under victim's buttocks. Using comb provided, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall on paper towel. Fold towel in manner to retain both comb and any evidence present. Return to pubic hair combings envelope. Seal and fill out all information on envelope.
- STEP 5** **PULLED PUBIC HAIRS**
Remove paper bindle from pulled pubic hairs envelope, unfold and place on flat surface. Pull, do not cut, 10 to 15 full-length pubic hairs from various locations and place in center of bindle. Refold in manner to retain hairs and return bindle to pulled pubic hairs envelope. Seal and fill out all information requested on envelope.
- STEP 6** **VAGINAL SWABS AND SMEARS** (If within 5 days of assault)
Using both swabs simultaneously, carefully swab the vaginal walls and cervix. Using both swabs, prepare two smears. Allow both swabs(2) and smears(2) to air dry. Return smears to vaginal smears slide holder and place both swabs in swab box. Fill out information requested on containers, and return to envelope. Seal and fill out all information requested on envelope. **Do not stain or chemically fix smears. Do not moisten swabs prior to sample collection.**

STEP 7**ORAL/RECTAL SWABS** (only if oral/rectal assault has occurred)

Using two swabs carefully swab the rectal canal. Allow the swabs to air dry and return to the swab box. Label box in place provided and return to envelope.

Using two swabs, carefully swab the buccal area and gum line. Allow the swabs to air dry and return to the swab box. Label box in place provided and return to envelope.

 STEP 8**PULLED HEAD HAIRS**

Remove paper bundle from pulled head hairs envelope, unfold and place on flat surface. Pull, do not cut, a minimum of three full-length hairs from each of the following scalp locations: center, front, back, left side and right side. Place in center of the bundle and refold in manner to retain the hairs. Return to envelope, seal and fill out all information requested on envelope.

 STEP 9**KNOWN SALIVA SAMPLE**

Place both swabs in victim's mouth and have victim thoroughly saturate with saliva. Allow both swabs to air dry. Place swabs in swab box. Fill out all information requested on box. Return swab box to envelope, seal and fill out all information requested on envelope. **The victim should not have anything to drink, eat or smoke for a minimum of 15 minutes prior to saliva sample collection.**

 STEP 10**KNOWN BLOOD SAMPLE**

Using blood collection tube provided, draw to maximum volume from victim and write victim's name on blood tube label.

FINAL INSTRUCTIONS

- 1) Make sure all information requested on all sample envelopes has been filled out completely.
- 2) With the exception of sealed and labeled clothing and underwear bags, return all other evidence envelopes, used or unused, to kit box along with the sexual assault history form.
- 3) Initial and affix orange police evidence seals where indicated on box top.
- 4) Fill out all information requested on kit box top under "For Hospital Personnel".
- 5) Hand sealed kit and sealed sacks to investigating officer.

***NOTE: If officer is not present at this time, place sealed kit and sealed sacks in secure and refrigerated area, and hold for pick up by investigating officer.**

STEP 1

PATIENT INFORMATION FOR DCI LABORATORY

1. PATIENT'S NAME: _____
2. AGE: _____
3. RACE: _____
4. DATE AND TIME OF ALLEGED ASSAULT: __/__/19__ __: __AM/PM
5. DATE AND TIME OF HOSPITAL EXAMINATION: __/__/19__ __: __AM/PM
6. WAS THERE PENETRATION OF:

- | | | |
|--------|------------------------------------|-------------------------------------|
| VAGINA | ATTEMPTED <input type="checkbox"/> | SUCCESSFUL <input type="checkbox"/> |
| ANUS | ATTEMPTED <input type="checkbox"/> | SUCCESSFUL <input type="checkbox"/> |
| MOUTH | ATTEMPTED <input type="checkbox"/> | SUCCESSFUL <input type="checkbox"/> |

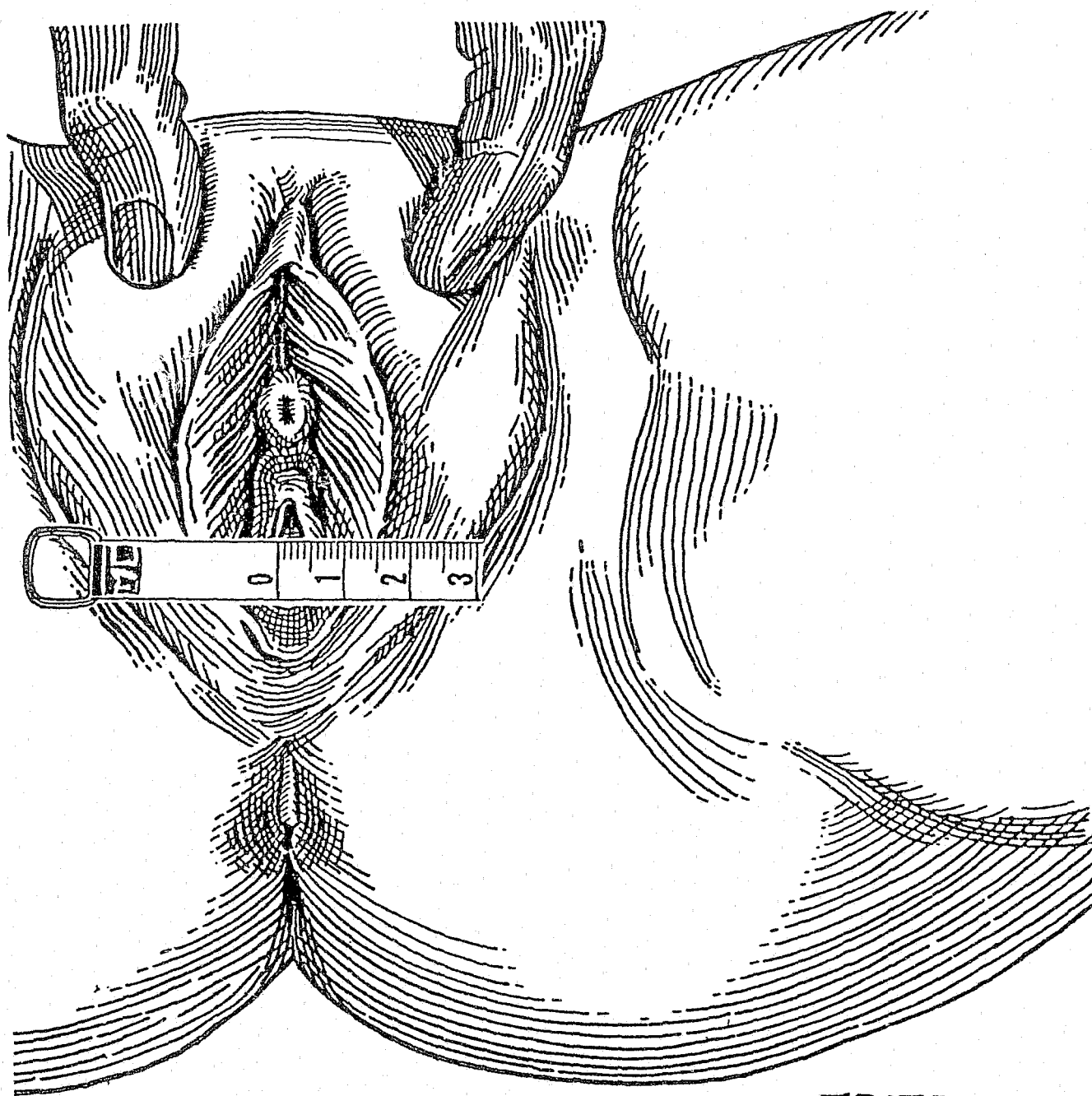
- | | | | |
|-------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | NOT SURE |
| EJACULATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EJACULATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EJACULATION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | YES | NO | NOT SURE |
| 7. DID ASSAILANT WEAR A CONDOM? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. WAS DOUCHE, SHOWER OR BATH TAKEN BETWEEN ASSAULT AND DOCTOR'S EXAMINATION? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. WERE CLOTHES CHANGED AFTER ASSAULT?
IF YES, ARE THEY AVAILABLE? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. ANY INJURIES RESULTING IN BLEEDING?
WAS VICTIM MENSTRUATING AT TIME OF ASSAULT? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. RACE OF SUSPECT(S) IF KNOWN: _____ | | | |
| 12. ANY CONSENSUAL COITUS IN THE PREVIOUS 72 HOURS? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

VICTIM'S DESCRIPTION OF ASSAULT: _____

CHILD SEXUAL ABUSE INTROITUS EXAM TECHNIQUE

1. All children with suspected or obvious sexual abuse require uro-genital examination.
2. The vaginal introitus and vulva should be described in appearance, size (gaping, relaxed - admits 1 or 2 fingers), and describe swelling, erythema, etc.
3. Pre-pubescent vaginal introitus varies 2-4 mm., and 4 mm. or more is indicative of vaginal penetration and, therefore, potential sexual abuse.
4. All pediatric patients with symptoms of vaginitis, dysuria, perineal itching/pain/swelling, and uro-genital discomfort need a uro-genital examination, and sexual abuse needs to be part of Differential Diagnosis.



J. PETERS

FEMALE ANO-GENITAL FORENSIC FINDINGS

Numbers: 12°-3°-9°-6° Forensic Clock

- 1. Abrasions
- 2. Contusions
- 3. Deformity
- 4. Ecchymosis
- 5. Edema - swelling
- 6. Erythema
- 7. Fissures
- 8. Funneling
- 9. Fusion
- 10. Gaping orifice
- 11. Hymenal dilatation enlargement
- 12. Hypertrophy
- 13. Laceration
- 14. Leukorrhea - discharge
- 15. Microscarring
- 16. Neovascularization
- 17. Petechiae
- 18. Pigmentation change
- 19. Reflex Relaxation
- 20. Scarring
- 21. Synechiae
- 22. Transection
- 23. Venous pooling

CLITORIS

URETHRA

VULVA

LABIA MAJORA

LABIA MINOR

HYMENAL OPENING

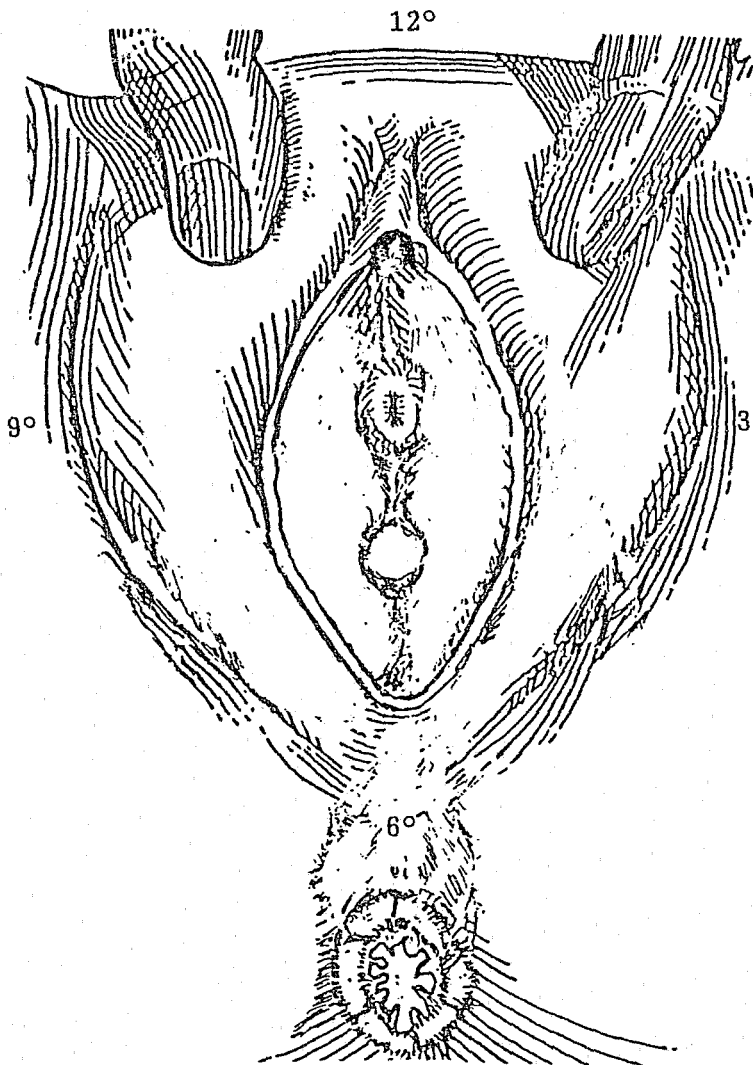
INTROITUS

HYMEN MEMBRANE

MEDIAN RAPHE

ANUS

ANAL OPENING



FOSSA NAVICULARIS

POSTERIOR FOURCHETTE

PERINEUM

CLITORIS _____

VULVA _____

URETHRA _____

HYMENAL OPENING _____

HYMENAL MEMBRANE _____

FOSSA NAVICULARIS _____

POSTERIOR FOURCHETTE _____

PERINEUM _____

ANUS _____

WET MOUNT (MICRO) _____

PICTURES TAKEN _____
(NUMBER)

CHILD SEXUAL ABUSE INTROITUS EXAM TECHNIQUE

1. All children with suspected or obvious sexual abuse require uro-genital examination.
2. The vaginal introitus and vulva should be described in appearance, size (gaping, relaxed - admits 1 or 2 fingers), and describe swelling, erythema, etc.
3. Pre-pubescent vaginal introitus varies 2-4 mm., and 4 mm. or more is indicative of vaginal penetration and, therefore, potential sexual abuse.
4. All pediatric patients with symptoms of vaginitis, dysuria, perineal itching/pain/swelling, and uro-genital discomfort need a uro-genital examination, and sexual abuse needs to be part of Differential Diagnosis.

WHO IS ELIGIBLE?

- * An innocent victim who suffers bodily injury from a violent crime.
- * An innocent victim of a crime committed by an individual found guilty of driving while under the influence of alcohol or drugs.
- * Victims of child abuse.
- * Victims of domestic abuse.
- * The dependent(s) of an innocent victim of a violent crime.
- * The parent or legal guardian of a victim who is under 18 years of age and has assumed responsibility for expenses incurred by the victim's injury.
- * A person responsible for the maintenance of the victim who has suffered a loss or incurred expenses as a result of personal injury to the victim.

WHAT MUST I DO TO BE ELIGIBLE?

- * You must report the crime to the local law enforcement agency within 24 hours of the occurrence of the crime. (If the crime cannot reasonably be reported within that time period, the crime shall be reported within 24 hours of the time a report can reasonably be made.)
- * You must file the claim application with the Department of Public Safety within 180 days after the date of the crime; or within 120 days after the date of death of the victim.
- * You must cooperate with the appropriate law enforcement agency in the investigation and prosecution of the crime relating to the claim.
- * You must cooperate with the Department of Public Safety in the claims process.

WHO IS NOT ELIGIBLE?

- * A victim in the same household with the criminal offender, unless a criminal conviction for the crime is obtained. However, a criminal conviction in a child abuse or domestic abuse case is not required.
- * A relative of the criminal offender, unless a criminal conviction for the crime is obtained.
- * Anyone injured or killed in a motor vehicle, on train, or aircraft crash, unless the injury or death was intentionally inflicted or resulted from a crime committed by an individual found guilty of driving while under the influence of alcohol or drugs.
- * Anyone contributing to the infliction of his/her own bodily injury or death.
- * A victim who was assisting, attempting, or committing a criminal act.

WHAT BENEFITS ARE AVAILABLE?

The State of Iowa has a program to help reimburse you if you are an innocent victim of a violent crime. Payments will be reduced by the amounts received or available from collateral sources such as insurance. Compensation may be awarded as follows:

- * For reasonable expenses for medical care needed as a direct result of injuries suffered in a criminal attack. (Up to \$10,000)
- * For reasonable charges for counseling by a licensed psychologist of child abuse and domestic abuse victims. (Up to \$500)
- * For reasonable charges for victim counseling by a victim counselor of child abuse and domestic abuse victims. (Up to \$500)
- * For loss of income from your job because of bodily injuries suffered as the result of a crime. (Up to \$2,000)
- * Loss of support for dependents of the victim. (Up to \$2,000 per dependent or a total of \$6,000)
- * For reasonable replacement value of your clothing that is held by the police for evidence. (Up to \$100)
- * For reasonable funeral and burial expenses. (Up to \$2,500)

COMPENSATIONS WILL NOT BE PAID

- * For stolen, damaged, or lost property.
- * For pain and suffering.
- * For losses paid or payable by other or collateral sources (health insurance, sick-leave pay, disability insurance, social security, workmen's compensation, unemployment compensation, funds from other governmental agencies) or the offender.

Iowa Crime Victim Reparation
Iowa Department of Public Safety
Wallace State Office Building
Des Moines, Iowa 50319-0075

(515)281-5044

BIBLIOGRAPHY

- American Family Physician, "Child Abuse, Accidents Rise With Unemployment". Vol. 27, No. 4, April 1983, pp. 269-270.
- Abrams, Michael E., MD, "Child Sexual Abuse Called Silent Epidemic". Iowa Medicine, Journal of the Iowa Medical Society. Vol. 74, November 1984, pp. 475-480.
- Adams, Christine, Tucker, MD. American Journal of Psychiatry. 139:10. "Proximate Effects of Sexual Abuse in Childhood: A Report on 28 Children". October 1982, pp. 1252-56.
- Albin, Richard J. "Immunohistological localization of prostatic acid phosphatase". Allergol Et. Immunopathol. Vol. 7, No. 361 (1979), pp. 361-364.
- "Alkaline and Acid Phosphatase". Standard Methods of Clinical Chemistry. pp. 81.
- Allard, Julie, and Davies, Anne, BSC, "Further Information on the Use of p-Nitrophenyl Phosphate to Quantitate Acid Phosphatase on Vaginal Swabs Examined in Cases of Sexual Assault". Med. Sci. Law. Vol. 19, No. 3 (1979), pp. 170-172.
- Amir, Menachim, "Patterns in Forcible Rape". University of Chicago Press, Chicago, IL; (1971) 390 pages.
- Anglin, MD, Trina, M. Physician Management of Sexually Abused Children and Adolescents. Current Problems in Pediatrics. July 1984: Vol. 14, No. 7: pp. 3-54.
- Balk, Sophie J., Dreyfus, Norma G., M.D., and Harris, Paul, MD, "Examination of Genitalia in Children: The Remaining Taboo". Pediatrics. Vol. 70, No. 5, November 1982.
- Barber-Lindstrom, Timothy, "Improving Coordination In the Child Protection System". Iowa Medicine, Journal of the Iowa Medical Society. Vol. 74, November 1984, pp. 484-486.
- Bard, Morton and Sangrey, Dawn, "The Crime Victim's Book". Basic Books, Inc., New York (1979) 223 pages.
- Brassard, M.R. School Programs to Prevent Intrafamily Child Sexual Abuse. Child Abuse and Neglect. Vol. 7: (1983), pp. 241-245.
- Breithaupt, David, M.D., "Family Violence, the Symptom...Alcoholism, the Disease". California Physician. July 1986.
- Broadlawns Medical Center Emergency Department.
- Brownmiller, Susan, "Against Our Will Men, Women & Rape". Simon and Schuster (1975) 476 pages.

- Burgess, Ann Wolbert and Holstrom, Lynda Lytle, "The Victim of Rape - Institutional Reactions". Wiley-Interscience, New York, (1978) 293 pages.
- Burgess, Ann W. with Nicholas Groth, Lynda L. Holstrom, Suzanne M. Sgroi, "Sexual Assault of Children and Adolescents". Lexington Books, D.C. Heath and Co., Lexington, Massachusetts (1978).
- Burgess, Ann W. and Holstrom, Lynda Lytle, "Rape: Crisis and Recovery". Robert J. Brady Co., Bowie, Maryland (1979).
- Cantwell, Hendrika B., MD. Denver Social Services. "Vaginal Inspection As It Relates to Child Sexual Abuse in Girls Under Thirteen". Child Abuse and Neglect. Vol. 7, (1983) pp. 171-176.
- Cantwell, Hendrika B., MD. "Sexual Abuse of Children in Denver, 1979". Child Abuse and Neglect. Vol. 5, (1981) pp. 75-85.
- Child Abuse and Neglect. Greater Des Moines Child Abuse and Neglect Council, Inc. "Intra-Family Sexual Abuse Program". Sands-Wing, Sidney L. August 1981.
- "Child In Need of Assistance Proceedings". Juvenile Justice. 232.67 Part 1 and 2.
- Cowell, Carol A. "Gynecological Assessment of Children and Young Adolescents". Pediatric Clinics of North America, Vol. 28, May 2, 1981.
- Dahlke, M.B., Cooke, C., et al. "Identification of Semen in 500 Patients Seen Because of Rape". American Journal of Clinical Pathology. Vol. 68, No. 6, December 1977, pp. 740-746.
- Daniel, William A., Jr., MD. and Paulshock, Bernadine Z. MD. "A Physician's Guide to Sexual Maturity". Patient Care. May 30, 1979.
- Davidson and Henry "Serum Enzyme Determinations as an Aid to Diagnosis". Clinical Diagnosis. pp. 719.
- Davies, A. Evaluation of Results From Tests Performed on Vaginal, Anal, and Oral Swabs Received in Casework. Journal of Forensic Science Society. Vol. 17, (1977) pp. 127-133.
- Davies, Anne and Wilson, Elizabeth, "The Persistence of Seminal Constituents in the Human Vagina". Forensic Science. Vol. 3, (1974) pp. 45-55.
- Davis, Linda J. and Brody, Elaine M., "Rape and Older Women - A Guide to Prevention and Protection". A publication of the National Center for Prevention and Control of Rape, 5600 Fishers Lane, Rockville, Maryland 20857 (1979).

- DeJong, A.R., MD, Gary A. Emmett, MD, Arturo A. Hervada, PhD. "Epidemiologic Factors in Sexual Abuse of Boys". American Journal of Disabled Children. Vol. 136, Nov. 1982, pp. 990-993.
- DeJong, A.R., MD, Department of Pediatrics. Thomas Jefferson University, Philadelphia, PA. "Sexual Abuse of Children". American Journal of Disabled Children. Vol. 136, February 1982, pp. 129-134, 142-146.
- Emergency Room Protocol IV-1 to IV-11.
- Emergency Room Protocol for Sexual Assault: Child and Adolescent Patients. Sexual Abuse Center, Harborview Medical Center, Seattle, Washington. December 1978, pp. 131-134.
- Enos, W.F., M.D. and Byer, J.C., M.D., "Prostatic Acid Phosphatase, Aspermia, and Alcoholism in Rape Cases". Journal of Forensic Sciences. Vol. 25, No. 2, April 1980, pp. 353-356.
- Enos, W.F., M.D., Conrath, T. B., B.A., and Byer, J.C., M.D. "Forensic Evaluation of the Sexually Abused Child". Pediatrics. Vol. 78, No. 3, September 86.
- Fiffield, Gary C., MD, MPH. "Psychiatry In Primary Care: How to Handle Child Abuse and Neglect Performing the Physical Assessment".
- Findley, Theodore P., M.D. "Quantitation of Vaginal Acid Phosphatase and Its Relationship to Time of Coitus". American Journal of Clinical Pathology. Vol. 68, No. 2, August 1977, pp. 238-242.
- Folland, David S., MD., Ralph E. Burke, BS, Alan R. Hinman, MD, Silliam, Schaffner, MD. "Gonorrhoea in Preadolescent Children: An Inquiry Into Source of Infection and Mode of Transmission". Pediatrics. Vol. 60, No. 2, August 1977, pp. 153-156.
- Godwin, Ira D., M.D. and Seitz, George K., "Vaginal Acid Phosphatase". March 1970, pp. 147-148.
- Gomez, Rolando R., M.D. et. al. "Qualitative and Quantitative Determinations of Acid Phosphatase Activity in Vaginal Washing". American Journal of Clinical Pathology. Vol. 64, October 1975, pp. 423-432.
- Green, Arthur H., MD. "Hospital Based Intervention in Child Abuse", Resident and Staff Physician. February 1983, pp. 76-92.
- Groth, A. Nicholas, Ph. D. and Burgess, Ann Wolbert, R.N. "Rape: A Sexual Deviation". American Journal of Orthopsychiatry. Vol. 47, No. 3, July 1977, pp. 400-406.
- Groth, A. Nicholas with Birnbaum, H. Jean, "Men Who Rape". Plenum Press, New York, N.Y. 1979.

- Groth, A. Nicholas, PhD. "Sexual Dysfunction During Rape". The New England Journal of Medicine. Vol. 297, No. 14, October 1977, pp. 764-766.
- Halpern, Susan, "Rape: Helping the Victim". Medical Economics Co., New Jersey, (1978) 169 pages.
- Henry, R.J., M.D. "Enzymes". Clinical Chemistry Principles and Technics. pp. 485.
- Herjanic, Barbara, MD and Ronald P. Wilbois, MD. Department of Psychiatry, Obstetrics, Gynecology, and Pediatrics, Washington University, St. Louis. JAMA. Vol. 239, No. 4, January 23, 1978, pp. 331-333.
- Hilberman, Elaine, M.D., "The Rape Victim". American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009, (1976) 98 pages.
- "If evidence of an old injury or of a disease is found, this fact should be carefully noted on the record". The Journal of Legal Medicine. March 1975, pp. 37-38.
- Intra-Family Sexual Abuse Program. Broadlawn Medical Center.
- Josephson, Gordon W., M.D. "The Male Rape Victim: Evaluation and Treatment". JACEP. Vol. 8, No. 1, January 1979, pp. 19-20.
- Katz, Judy H., No Fairy Godmothers, No Magic Wands, E and R Publishing Company, P.O. Box 2008, Saratoga, CA 95070.
- Khan, Misbah, MD, MPH, Mary Sexton, PhD, MPH. "Sexual Abuse of Young Children". Clinical Pediatrics. May 1983, pp. 369-372. J. B. Lippincott Co. 009-9228/83/0500/0369, \$1.00.
- Kozol, Harry L. "Myths About Sex Offender". Medical Aspects of Human Sexuality. June 1971, pp. 51-61.
- Lam, William K.W., et. al. "Comparison of Acid Phosphatase Isonzymes of Human Seminal Fluid, Prostate, and Leukocytes". Clinical Chemistry. Vol. 25, No. 7, (1979) pp. 1285-1289.
- Leesburg, Virginia. Surgeon General's Workshop on Violence and Public Health Report. October 27-29, 1985.
- Levitt, Carolyn J., MD. "Sexual Abuse in Children". Childhood Sexual Abuse. Vol. 80, No. 2, August 1986.
- Lewin, W. Howard, M.D. "The Medicolegal Examination and Testimony - An Ophthalmologist's View". The Journal of Legal Medicine. March 1975, pp. 35-36.
- Linde, G.H., PhD. and Molnar, K.E., M.S. "The Simultaneous Identification of Seminal Acid Phosphatase and Phosphoglucomutase by Starch Gel Electrophoresis". Journal of Forensic Sciences. Vol. 25, No. 1, January 1980, pp. 113-117.
- MacNamara, Donal E. J. "Sexual Crimes and the Medical Examiner". Medical Aspects of Human Sexuality. April 1974, pp. 161-174.

- Masood, S., Bernhardt, H.E., et al. "Quantitative Determination of Endogenous Acid Phosphatase Activity in Vaginal Washings". Obstetrics and Gynecology. Vol. 51, No. 1, January 1978, pp. 33-36.
- McCartney, Cheryl F., M.D. "Counseling the Husband and Wife After the Woman Has Been Raped". Medical Aspects of Human Sexuality. May 1980, pp. 121-122.
- McCloskey, K.L., B.S. et. al. "Prostatic Acid Phosphatase Activity in the Post-coital Vagina". Journal of Forensic Sciences. April 1975, pp. 630-636.
- McCormack, Arlene, PhD., Janus, Mark-David, C.S.P., and Burgess, Ann Wolbert, RN., "Runaway Youths and Sexual Victimization: General Differences in an Adolescent Runaway Population". Child Abuse and Neglect. Vol. 10, (1986) pp. 387-395.
- McCubbin, Jack H., M.D. and Scott, Daniel, E., M.D. "Management of Alleged Sexual Assault". Vol. 69, September 1973, pp. 59-64.
- Moynihan, Barbara A., RN, BS, NP, Joan W. Duncan, PhD. "The Role of the Nurse in the Care of Sexual Assault Victims". Nursing Clinics of North America. pp. 95-188.
- "New Police Surgeon". Text (1978) Burges/Hilton/Hutchinson/Benham/London
- News Briefs, "Sexual Abuse of Children". AFA. June 1983, pp. 195.
- Nightingale, Richard, MD. "Adolescent Prostitution". Seminars in Adolescent Medicine. Vol. 3, September 1985.
- Orr, Donald P., MD. "Limitations of Emergency Room Evaluation of Sexually Abused Children". American Journal of Disabled Children. Vol. 132, September 1978, pp. 873-875.
- Owen, G.W. and Smalldon, K.W., M.Sc., "Blood and Semen Stains on Outer Clothing and Shoes Not Related to Crime: Report of Survey Using Presumptive Test". August 1974, pp. 391.
- Paired, Patricia, MD, FRCP, FCCMG., Barbara McGillvray. "Children of Incest". Journal of Pediatrics. Vol. 101, No. 5, pp. 854-857.
- Peters, Joseph J., MD. "Child Rape: Defusing a Psychological Time Bomb". Hospital Physician. February 1973, pp. 46.
- Pollack, Marilyn S., PhD. et. al. "Prenatal Identification of Paternity HLA Typing Helpful After Rape". JAMA. Vol. 244, No. 17, October 1980, pp. 1954-1956.

- Poznanski, Edna, MD., Peter Plos Jr., MD. "Incest". Medical Aspects of Human Sexuality.
- "Quantitative Analysis of Blood, Cerebrospinal Fluid, and Urine". Seiverd's Chemistry for Medical Technologists. pp. 251-253.
- "Rape and the Adolescent, Committee on Adolescence". Pediatrics. Vol. 172, No. 5, November 1983, pp. 738-40.
- "Rape and Sexual Assault (Topics in Emergency Medicine)". Aspen Publication; January 1982, pp. 55-63.
- Rimsza, Mary Ellen, MD, Elaine H. Niggemann, MS. Department of Pediatrics, Maricopa County General Hospital, Phoenix, Arizona. "Medical Evaluation of Sexually Abused Children: A Review of 311 Cases". Pediatrics. Vol. 69, No. 1, January 1982, pp. 8-14.
- Robinson, Henry A., Jr., LTC., MC, USA, Dale B. Sjerrod, Captain, MC, USA, Courtney H. Malcarney, Captain, MC, USA, Ft. Bragg, N.C. "Review of Child Molestation and Alleged Rape Cases". pp. 405-406.
- Romney, Martha Cohn, RN, MS, PNP. "Incest in Adolescence", Children's Hospital National Medical Center, 111 Michigan Ave. NW, Washington, D.C. 20009. pp. 813-817.
- Rosenfeld, Alvin A., MD. "The Clinical Management of Incest and Sexual Abuse of Children". JAMA, Vol. 242, No. 16, October 19, 1979, pp. 1761-1764.
- Rosenfeld, Alvin A. "Sexual Abuse of Children". JAMA. Vol. 240, No. 1, July 7, 1978, Special Communications. pp. 43-46.
- Roth, Richard A., Herner and Company. "Child Sexual Abuse: Incest, Assault, and Sexual Exploitation". U.S. Department of Health and Welfare Publication No. (OHDS) 79-30166. August 1978.
- Russell, Diana E. H., "The Politics of Rape". (1974) Stein and Day, New York.
- Russell, Diane E. H., "Rape in Marriage". (1982) Macmillan, New York.
- "RX after Rape". pp. 218.
- Sanford, Linda T. "Come Tell Me Right Away". Ed-U Press, Inc. P. O. Box 583, Fayetteville, NY 13066. pp. 1-24.
- Sarles, Richard M., MD. "Sexual Abuse and Rape". Pediatrics in Review. Vol. 4, No. 3, September 1982. pp. 93-98.

- Sarles, Ricahrd M. MD. "Incest". Pediatrics Review, Vol. 2, No. 2, August 1981, pp. 51-54.
- Schaefer, Joanne L., Lt. Col., NC, USAF et. al. "Counseling Sexual Abuse Victims". AFP. November 1978, pp. 85-91.
- Scheble, et. al. "Rape and Sexual Assault/Child Sexual Assault". Annals of Emergency Medicine. January 1982.
- Schor, David P., MD, "Child Abuse and Neglect: The Physician's Role". Iowa Medicine, Journal of the Iowa Medical Society. Vol. 74, November 1984. pp. 467-471.
- Schumann, G. Berry, M.D. et. al. "Prostatic Acid Phosphatase Current Assessment in Vaginal Fluid of Alleged Rape Victims". American Journal of Clinical Pathology. Vol. 66, December 1976, pp. 944-952.
- Seckinger, Daniel, M.D. and Gomez, Rolando, M.D. "Clinical Chemistry No. CC-95 Seminal Acid Phosphatase". Check Sample Program. (1975).
- Seidel, James, MD, PhD, Johathan Zonana, MD, Eva Totten, LC, SW. "Condylomata Acuminata As A Sign of Sexual Abuse in Children". Journal of Pediatrics. Vol. 95, No. 4, October 1979. pp. 553-554.
- Sensabaugh, G.F., D. Crim. "The Quantitative Acid Phosphatase Test. A Statistical Analysis of Endogenous and Postcoital Acid Phosphatase Levels in the Vagina". Journal of Forensic Sciences. Vol. 24, No. 2, April 1979, pp. 346-265.
- Shipman, Gordon, PhD. "Sex Education Between Parent and Child". Medical Aspects of Human Sexuality. May 1971, pp. 114-128.
- Silverman, Eugene M., M.D. and Silverman, Alida G., MSW, "Persistence of Spermatozoa in the Lower Genital Tracts of Women". JAMA. Vol. 240, No. 17, October 1978, pp. 1875-1877.
- Soules, Michael R., M.D. et. al. "The Forensic Laboratory Evaluation of Evidence in Alleged Rape". American Journal of Obstetrics and Gynecology. Vol. 130, No. 2, January 1978, pp. 142-146.
- Stark, E. "The Unspeakable Family Secret". Psychology Today. May 1984, pp. 42-46.
- Swanson, David W., MD. "Who Violates Children Sexually". Medical Aspects of Human Sexuality. February 1971, pp. 184-196.
- Teixeira, W. R. G., M.D., PhD., "Hymenal Colposcopic Examination in Sexual Offenses". The American Journal of Forensic Medicine and Pathology. Vol. 2, No. 3, September 1981.
- "The Medical Examinations of Cases of Rape". Medico - Legal Bulletin. Vol. 21, No. 77, July 1972.
- Thomas, J.N., Rogers, C.M. "Sexual Abuse of Children". Nursing Clinics of North American. Vol. 16, No. 1, March 1981, pp. 179-188.

- Toates, P. "The Forensic Identification of Semen by Isoelectric Focusing of Seminal Acid Phosphatase". Forensic Science International. Vol. 14, (1979) pp. 191-124.
- Usher, A. and Stapleton, R.R. "An Unusual Forensic Application of Blood Group Studies". Med. Sci. Law. Vol. 19, No. 3, (1979) pp. 165-169.
- Walker, Lenore E., "The Battered Woman". Harper & Row Publ., New York, N.Y. (1979) 240 pages.
- White, Susanne T., MD, MPH, Frank A. Lola, MD, David L. Ingram, MD, Anna Pearson, BS. "Sexual Transmitted Diseases in Sexually Abused Children". Pediatrics. Vol. 72, No. 1, July 1983.
- Widholm, Olof, MD. "Genital Bleeding During Childhood". Insight Publishing Co., Inc., (1981) pp. 16-28.
- Woodling, Bruce, MD., Heger, Astrid, MD., "The Use of the Colposcope in the Diagnosis of Sexual Abuse in the Pediatric Age Group". Child Abuse and Neglect. Vol. 10, (1986) pp. 111-114.
- Woodling, Bruce, MD., Peter D. Kossoris, J.D. "Sexual Misuse: Rape, Molestation, and Incest". Pediatrics Clinics of North America. Vol. 28, No. 2, May 1981, pp. 481-499.
- Wynne, J.M. "Injuries to the Genitalia in Female Children". South African Medical Journal. Vol. 57, No. 2, January 12, 1980, pp. 47-50.
- Young, Harold, JD, "The Iowa Child Abuse Law Revisited". Iowa Medicine, Journal of the Iowa Medical Society. Vol. 74, November 1984, pp. 481-483.

MEDICAL-LEGAL WITNESS BIBLIOGRAPHY

- Arign, D.C. "Expert Medical Testimony". JAMA. Vol. 236, No. 6, August 9, 1976.
- Arnold L.C. "The Responsibilities of the Medical Expert". Medical Trial Tech Q. Vol. 27, 1980 Winter-Spring, pp. 126-132.
- Caplan, L. "The Expert Witness". Medical Legal Journal. Vol. 47, No. 4: 1979, pp. 124-137.
- Curran, William J., McGarry, A. Louis, Petty, Charles S. Modern Legal Medicine Psychiatry and Forensic Science. (1980) E. A. Davis Corporation, pp. 491-572.
- a) Courtroom Testimony
 - b) The Rape Experience
 - c) The Psychology of the Rape Experience
 - d) Community Investigation of Rape and Sexual Assault.
- Drury, R.A.B. "Attend An Inquest". British Medical Journal. Vol. 1, (1979) pp. 176-177.
- Halleck, Seymour L., "Expert Witness Roles". Law in the Practice of Psychiatry. (1980) Chapter 10.
- a) 195-206
 - b) Insanity Defense, Chapter 11, pp. 207-226
 - c) Competency to Stand Trial, Chapter 12, pp. 225-246.
- Harper, P.P.D Symposium: Doctors and Civil Litigation. Journal of the Royal Society of Medicine. Vol. 73, April 1980.
- Harsley J-D, Jack E. "Testifying in Court". The Advanced Course (1975).
- Holder, A.R. "Leading Cases". JAMA. Vol. 231, No. 11, March 17, 1975.
- Knight, B. "Give Evidence". British Medical Journal. Vol. 2, (1978) pp. 1414-1415.
- Lane, F. "Cross-Examination of the Medical Witness". Medical Trial Tech Q. 1980 Winter-Spring, Vol. 27, pp. 467-504.
- Lane, F. "Trial Technique: Preparation and Presentation of Medical Evidence." Medical Trial Tech. Q. Vol. 25, No. 4, 1979 Spring, pp. 451-473.
- Lawton, J. "The Limitations of Expert Scientific Evidence", Forensic Science Society. Vol. 20, No. 4, October 1980, pp. 237-242.
- Leake, H.C., III, Smith D.J. "Preparing for and Testifying in a Child Abuse Hearing". Clinical Pediatrics. November 1977, pp. 1057-1063.