# Sexual Assault

## Victimization Across the Life Span
## A Clinical Guide

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## A Clinical Guide

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# FOREWORD

Sexual assault is broadly defined as unwanted sexual contact of any kind. Among the acts included are rape, incest, molestation, fondling or grabbing, and forced viewing of or involvement in pornography. Drug-facilitated behavior was recently added in response to the recognition that pharmacologic agents can be used to make the victim more malleable. When sexual activity occurs between a significantly older person and a child, it is referred to as molestation or child sexual abuse rather than sexual assault. In children, there is often a "grooming" period where the perpetrator gradually escalates the type of sexual contact with the child and often does not use the force implied in the term sexual assault. But it is assault, both physically and emotionally, whether the victim is a child, an adolescent, or an adult.

The reported statistics are only an estimate of the problem's scope, with the actual reporting rate a mere fraction of the true incidence. Surveys of adults show as many as 18% of all women in the United States have been the victim of an attempted or completed rape over the course of their lives. The incidence of male victims is lower because of the reluctance of boys and men to report their victimization.

The financial costs of sexual assault are enormous; intangible costs, such as emotional suffering and risk of death from being victimized, are beyond measurement. Short term, there are healthcare consequences, such as unwanted pregnancy, sexually transmitted diseases, serious emotional upheavals, inability to carry out normal daily activities, decreased productivity, and, in some cases, loss of life. Longer-term disabilities can be both emotional and physical. It is well documented that survivors of sexual abuse have a much higher incidence of serious and chronic mental health problems than control populations of nonabused patients. Posttraumatic stress disorder, depression, suicidal ideation, and substance abuse are all over-represented among abused groups in case-control studies. Chronic physical symptoms, such as pain syndromes (pelvic, abdominal, chest, myalgias, headaches) and various somatization disorders, are reported in a wide variety of peer-reviewed medical specialty journals.

This book is the first to bring together the best information available concerning sexual victimization across the entire lifespan. Recognizing the radical differences required in approaching child, adolescent, and adult victims, the chapters are organized to present information from the medical and mental health literature specific to the various age groups. Victim and perpetrator characteristics are described. Most importantly, those who provide care for these victims and who handle the disposition of the perpetrators are given specific information to help them carry out their roles most effectively. This book offers information for all who care for the victims—the crisis hotline staff, law enforcement personnel, prehospital providers, specialized detectives, medical and mental health staff, specialized sexual assault examiners, and counselors. The information is as current, accurate, and specific as it can be in a rapidly evolving field. It will fill a need in many venues where sexual victimization is seen and care is given to victims.

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# FOREWORD

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

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

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

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

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

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

What can be done about this? One option would be to ignore the abuse. Yet this historically has not been done if the act becomes known, and it fails to meet the

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

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

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# PREFACE

What is sexual assault? It is a crime of violence, where the assailant uses sexual contact as a weapon, seeking to gain power and control. Often youths and adolescents are disproportionately targeted, although sexual assault can occur at any age. Sexual assault is also an act of opportunity. Particularly vulnerable populations include children, especially young females, and individuals who are less able to care for themselves, such as the homeless or physically or mentally handicapped persons. Their vulnerability and ease of manipulation makes them prey.

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

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

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

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# Overview of Child Sexual Abuse

John Loiselle, MD
Marla J. Friedman, DO

## Historical Perspective

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

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

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

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

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

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

## DEFINITION

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

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

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

Chapter 2

# Anogenital Anatomy: Developmental, Normal, Variant, and Healing

William J. Reed, MD, FAAP

## Medical Embryology of the External Genitalia

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

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

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

## Development of the External Genitalia in Boys

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

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

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

## Anatomic Variations in Boys

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

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

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

Chapter 3

# Evaluation of Child Sexual Abuse

Jacqueline M. Sugarman, MD

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

## History

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

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

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

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

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

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

**Physical Signs and Symptoms**

- Genital discharge, bleeding
- Genital pruritis (itching)
- Pregnancy, including pregnancy with genetic disorders
- Other genital infections
- Muscle weakness
- Migraine headache
- Genital skin lesions
- Genital or urethral trauma
- STDs: typical, atypical, or disseminated
- Recurrent urinary tract infections
- Drug overdose
- Abdominal pain
- Numbing of body parts
- Seizures
- Short stature
- Appetite disturbance
- Sleep disturbance
- Fatigue or exhaustion
- Enuresis and/or encopresis

**Psychosomatic Disorders**

- Diffuse somatic complaints
- Hysterical or conversion reactions
- Abdominal pain
- Anorexia

**Sexual Problems**

- Sexualized play
- Sexual self-abuse
- Excessive masturbation
- Sexual perpetration to others
- Promiscuity or prostitution
- Sexual dysfunction
- Sexual revictimization
- Fear of intimacy

**Social and Behavioral Problems**

- School adjustment problems
- Taking on parental roles
- Phobias, avoidance behavior
- Temper tantrums
- Substance abuse
- Suicidal ideation, gestures, or attempts
- Neurotic or conduct disorders
- Social withdrawal
- Aggressive behavior
- Family conflicts
- Impulsive behavior
- Self-mutilating behavior
- Truancy or runaway behavior

**Other Psychologic Problems**

- Excessive guilt
- Irritability
- Feelings of helplessness
- Low self-esteem
- Amnesia
- Fear of criticism or praise
- Rage
- Altered states of consciousness
- Depression
- Self-hate, self-blame
- Mistrust
- Hyperalertness
- Terrified of rejection
- Anxiety
- Multiple personalities
- Identity diffusion
- Dissociation
- Obsessive ideas
- Flashbacks

**Other**

- Asymptomatic sibling of a victim
- Association with a known offender (Schmitt, 1982a)

*Data from Hunter et al. (1983), Krugman (1986), and Massie & Johnson (1989).*
*Reprinted with permission from Jenny C. Medical issues in sexual abuse. In: Briere J, Berliner L, Buckley JA, Jenny C, Reid T, eds.* The APSAC Handbook on Child Maltreatment. *Thousand Oaks, Calif: Sage Publications; 1996:197-199.*

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# FOREWORD

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

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

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

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

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

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

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# Foreword

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

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

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

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

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# PREFACE

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

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

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

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**Mary J. Spencer**, MD
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**CHAPTER 4:** ADOLESCENT SEXUAL ABUSE AND ASSAULT (13–17 YEARS)

# Sexual Assault

## Victimization Across the Life Span
## A Color Atlas

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

Chapter 1

# Infant Sexual Abuse: 0–3 years old

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

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

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

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

# History of Sexual Abuse

## Acute Findings

**Case Study 1-1**

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

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

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

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

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

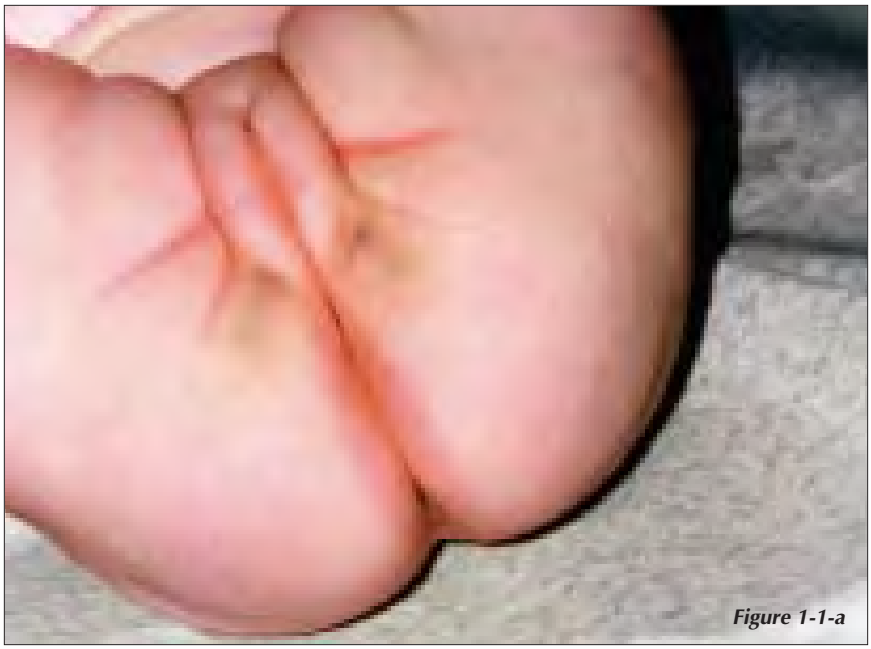

***Figure 1-1-a***

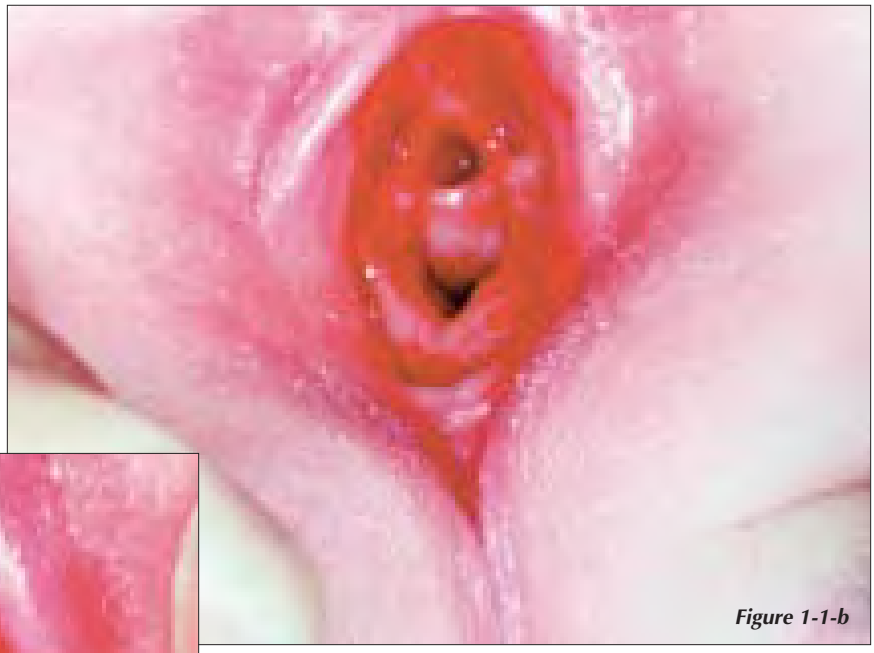

***Figure 1-1-b***

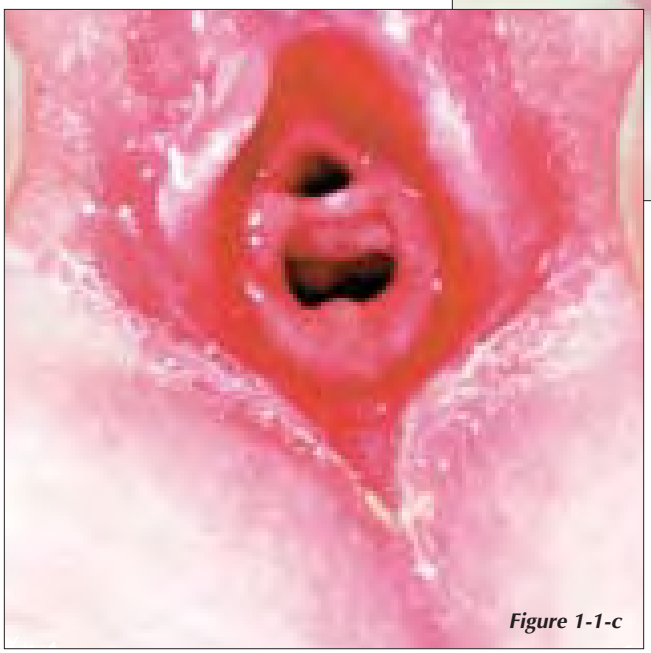

***Figure 1-1-c***

Chapter 2

# Young Child Sexual Abuse: 4–8 years old

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

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

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

# History of Sexual Abuse

## Acute Findings

### Digital Penetration of the Vagina

**Case Study 2-2**

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

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

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

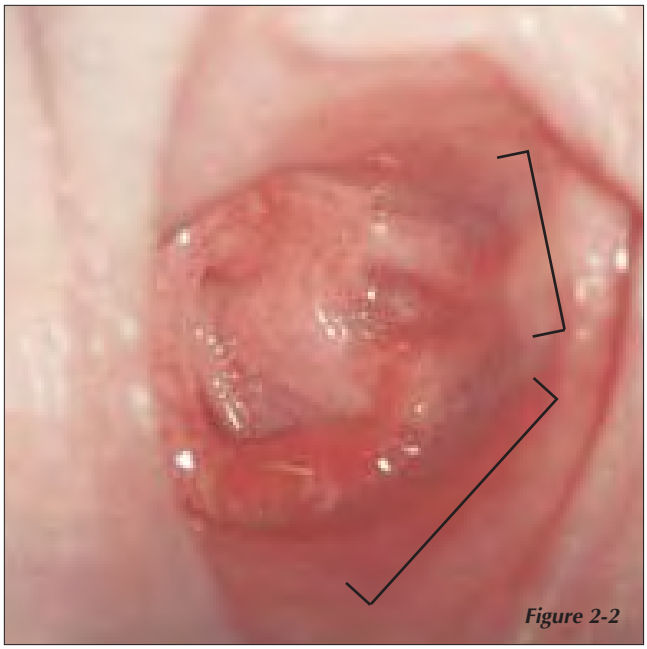

***Figure 2-2***

**Case Study 2-3**

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

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

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

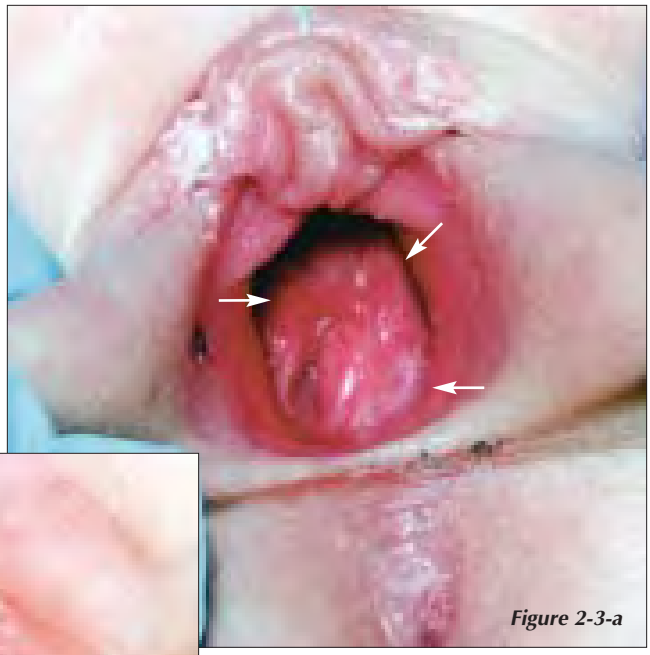

***Figure 2-3-a***

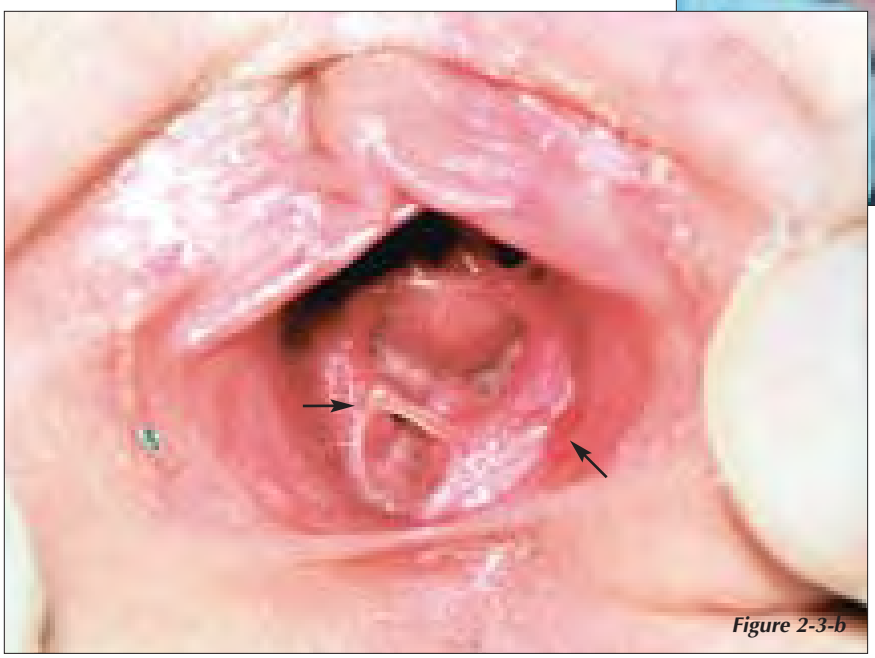

***Figure 2-3-b***

Chapter 3

# Pre-Adolescent Sexual Abuse: 9–12 years old

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

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

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

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

# History of Sexual Abuse

## Friend of the Family Perpetrator

**Case Study 3-1**

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

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

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

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

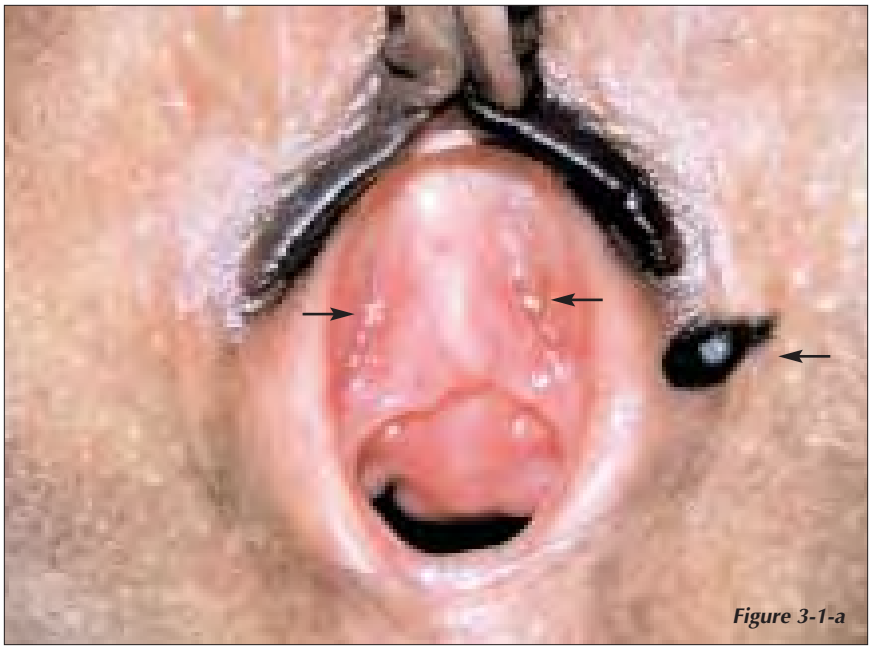

***Figure 3-1-a***

***Figure 3-1-b***

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