Sexual Assault

Victimization Across the Life Span
A Color Atlas

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

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Barbara W. Girardin, RN, PhD
Forensic Health Care
Palomar Pomerado Health
Escondido, California

Diana K. Faugno, RN, BSN, CPN, FAAFS, SANE-A
District Director
Pediatrics/Nicu
Forensic Health Service
Palomar Pomerado Health
Escondido, California

Mary J. Spencer, MD
Clinical Professor of Pediatrics
University of California San Diego
School of Medicine
Medical Director
Child Abuse Prevention and Sexual Assault Response Team
Palomar Pomerado Health
Escondido, California

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

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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.

Lawrence R. Ricci, MD
Director, The Spurwink Child Abuse Program
Portland, Maine
Clinical Assistant Professor of Pediatrics
University of Vermont College of Medicine
Clinical Assistant Professor of Pediatrics
University of New England College of Osteopathic Medicine

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.

Kathy Bell, RN, BLS, SANE-A
Forensic Nurse Examiner
Tulsa Police Department
Tulsa, Oklahoma

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.

Barbara W. Girardin, RN, PhD
Diana K. Faugno, RN, BSN, CPN, FAAFS, SANE-A
Mary J. Spencer, MD
Angelo P. Giardino, MD, PhD

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Chapter 1

Infant Sexual Abuse: 0–3 years old

Barbara W. Girardin, RN, PhD
Diana K. Faugno, RN, BSN, CPN, FAAFS, SANE-A
Carolyn J. Levitt, MD
Malinda Waddell, RN, MN, FNP
Mary J. Spencer, MD

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.

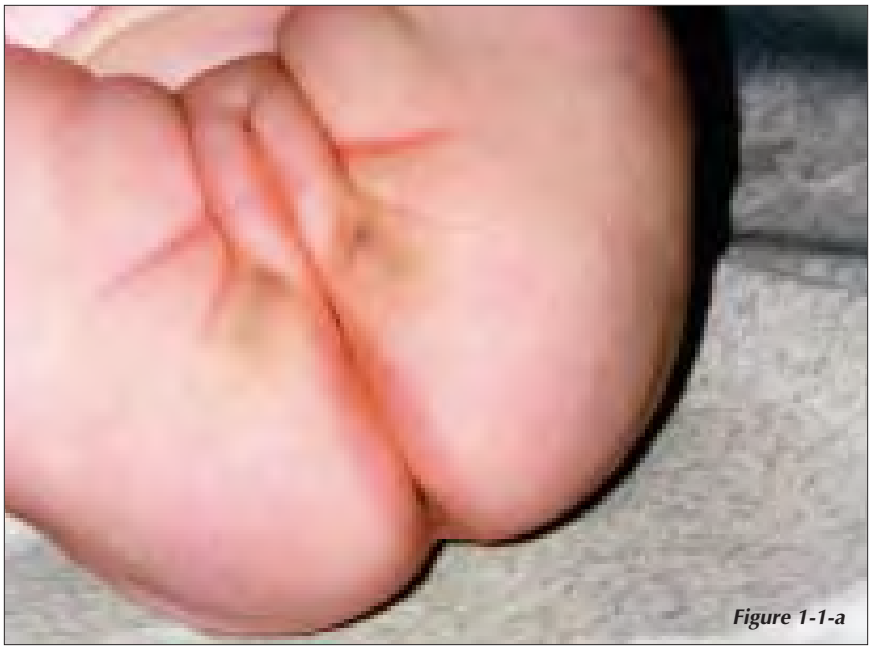

Figure 1-1-a

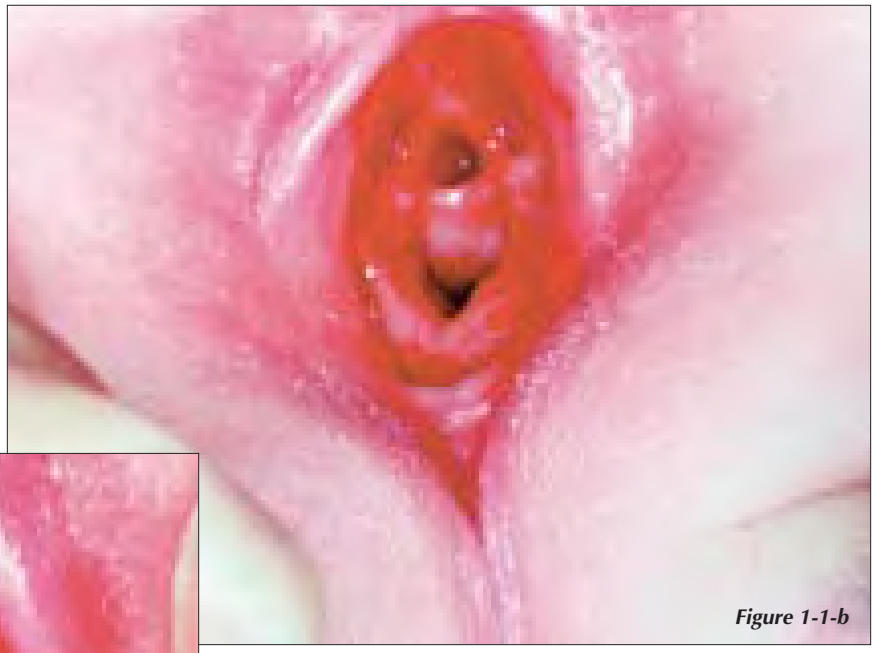

Figure 1-1-b

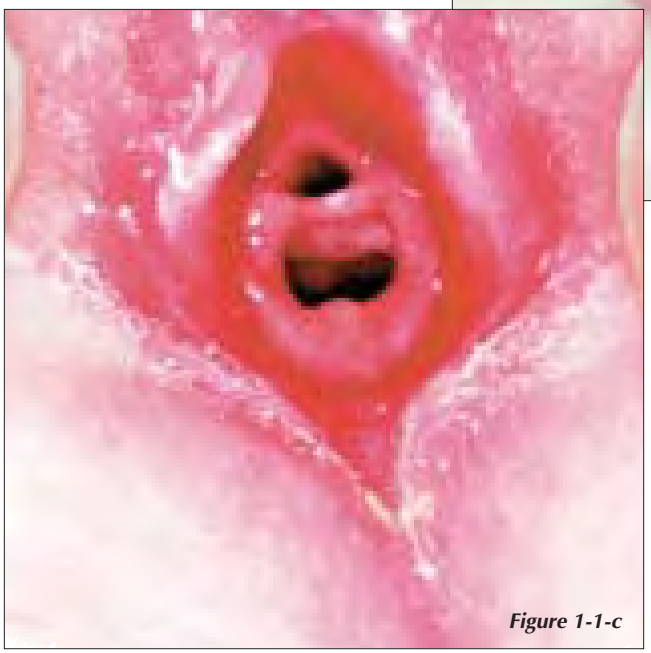

Figure 1-1-c

Chapter 2

Young Child Sexual Abuse: 4–8 years old

Barbara W. Girardin, RN, PhD
Diana K. Faugno, RN, BSN, CPN, FAAFS, SANE-A
Carolyn J. Levitt, MD
Malinda Waddell, RN, MN, FNP
Patricia M. Speck, APRN, MSN, BC
Mary J. Spencer, MD

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.

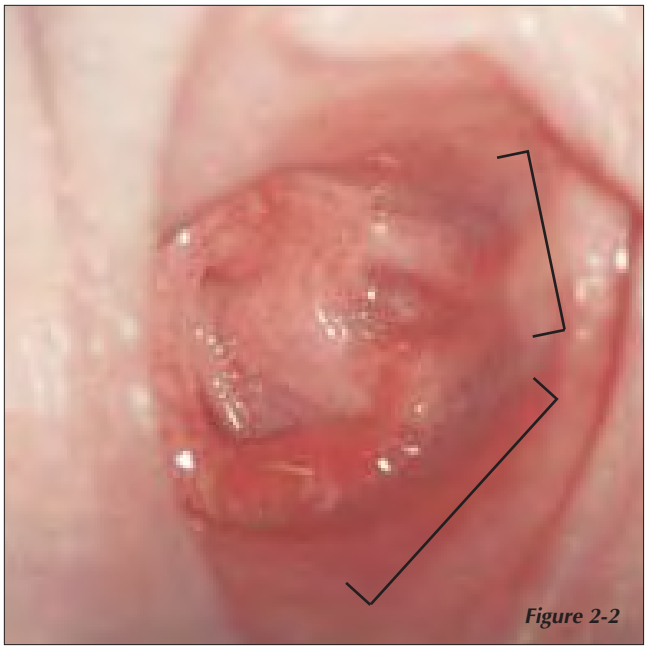

Figure 2-2

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.*

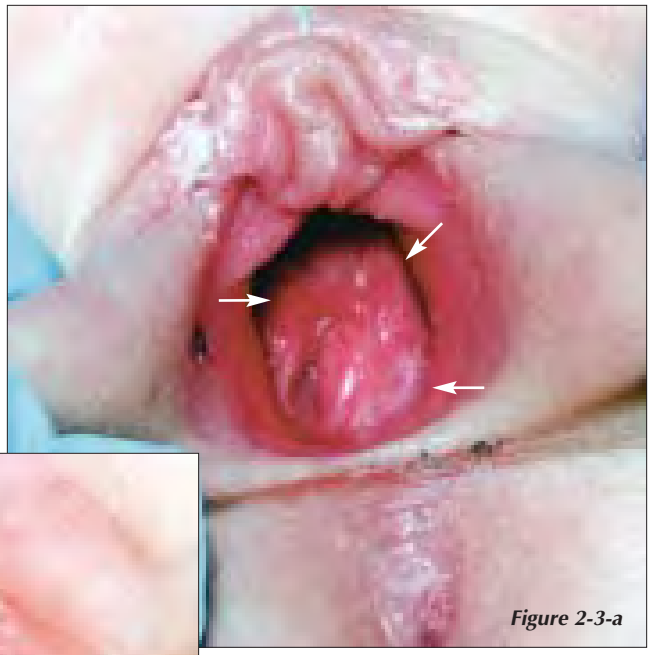

Figure 2-3-a

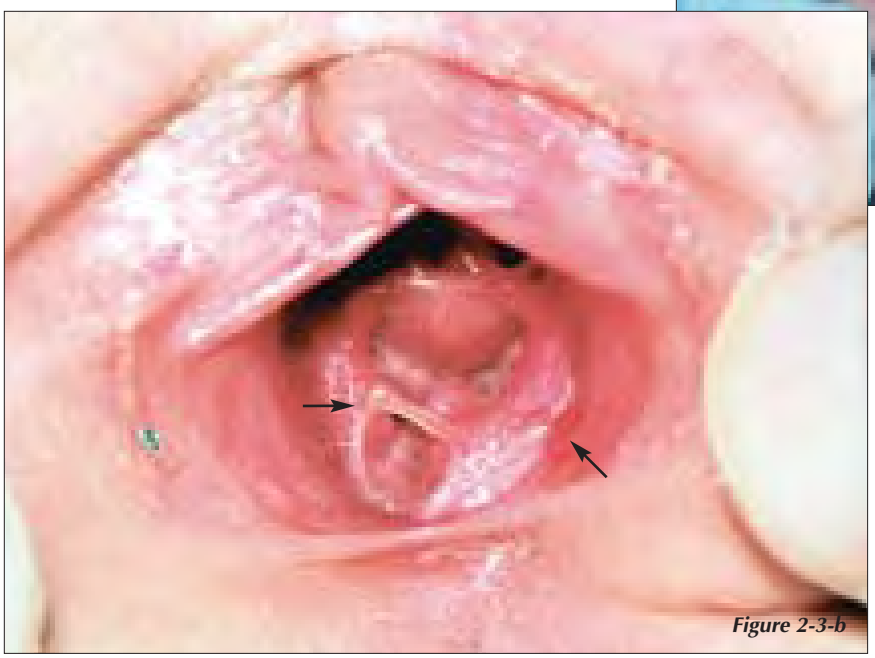

Figure 2-3-b

Chapter 3

Pre-Adolescent Sexual Abuse: 9–12 years old

Barbara W. Girardin, RN, PhD
Diana K. Faugno, RN, BSN, CPN, FAAFS, SANE-A
Mary J. Spencer, MD

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.

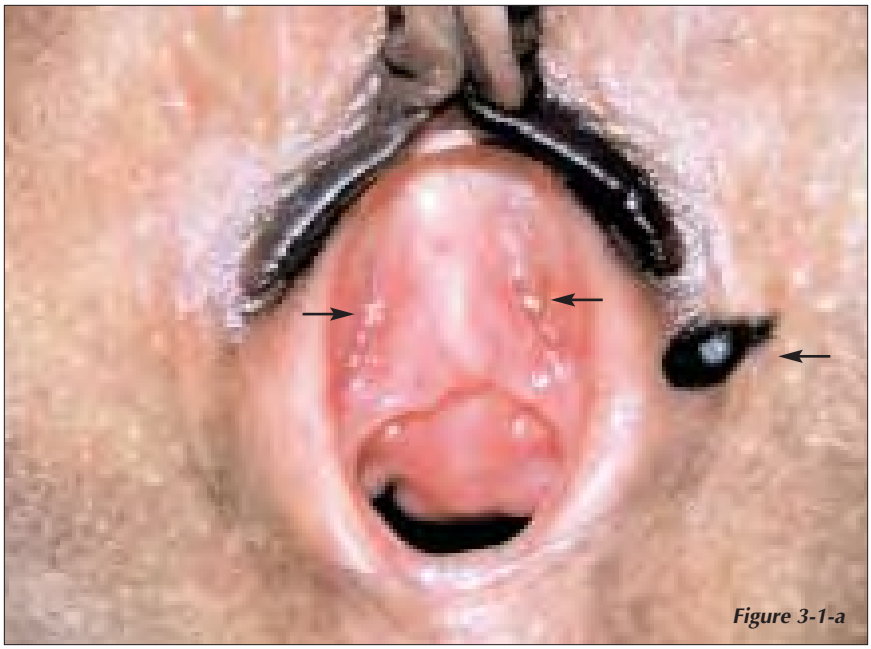

Figure 3-1-a

Figure 3-1-b

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