Child Sexual Abuse: The Basics

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Objectives

- **Who** should receive a medical evaluation in cases of suspected child sexual abuse and **who** should complete the evaluation?
- **What** is included in this medical evaluation?
- **When** should the medical evaluation should occur?
- **Where** should these medical evaluations occur?
- **Why** have a medical evaluation?
- **How** do you complete the medical evaluation and make evidenced based conclusions?

Definition

- Sexual abuse can be defined as the engaging of a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and/or that violate the social and legal taboos of society.
  - American Academy of Pediatrics

Legal Definition of Sexual Abuse

- Sexual abuse includes sexual intercourse, sexual contact, sexual exploitation, forced viewing of or listening to sexual activity, and permitting, allowing or encouraging a child to engage in commercial sex trafficking; any sex crime involving a child (< 18 years of age)

Who should receive a medical evaluation?

- **All** children and adolescents who are suspected victims of sexual abuse should be provided a medical evaluation
- Any child making a disclosure of sexual abuse

Indicators of Sexual Abuse

- **The single most important indicator is disclosure by the child** to a friend, classmate, teacher, friend's mother or other trusted adult
  - In most cases, it is a clear disclosure from a child that is the strongest evidence that sexual abuse has occurred
  - Children's disclosures of sexual abuse are rarely fabricated (Sorensen, 1991)
- Indicators of sexual abuse can surface through a child's history, physical symptoms and/or behavior

Who should complete the medical evaluation in cases of suspected Child Sexual Abuse?

- Child sexual abuse medical evaluations are best performed by health care professionals who are competent in these medical evaluations (Adams, 2015)
  - The provider should understand developmental anatomy as well as findings that could be mistaken for abuse
- A system of consultation and peer review with an expert should be in place to confirm physical or laboratory findings believed to be abnormal (Adams, 2015)

What is involved in the Medical Evaluation in Cases of Suspected Child Sexual Abuse?

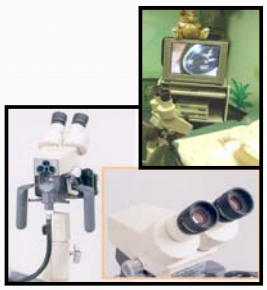
History

- History of current abuse concerns
  - type of contact and when this occurred
  - may be provided by a parent, law enforcement officer, social worker, child, adolescent and/or forensic interviewer
- Medical history includes:
  - medical conditions, surgeries, diagnostic procedures, prior abuse concerns, other intercourse (adolescents), medications, recent or current symptoms including anogenital pain, bleeding, itching or discharge

What does a medical evaluation include?

- Complete head-to-toe physical exam
- Examination of the anogenital area with a colposcope including photo documentation
- May include sexual assault evidence collection kit
- May include prophylaxis/testing for sexually transmitted infections
- May include prophylaxis/testing for pregnancy

This is a colposcope.
It magnifies what is seen and captures photos and/or video



Will the exam be like an adult female pelvic exam?

- An instrument called a speculum may be inserted into the vagina during an adolescent exam
- This is **not** done to a prepubertal child or a pubertal child who does not tolerate the procedure

What type of physical evidence?

- When the event recently occurred a child might have **injuries** such as bruises or tears
- Debris and **bodily fluid specimens** can be collected when events happened within the past few hours or days
- Occasionally, a child might have acquired a **sexually transmitted infection**
- When event(s) happened a week, month, or years ago, sometimes **healed tears or scars** can be seen

Sexual Assault Evidence Collection Kit

- If the presence of biologic material may have occurred, a kit is collected for forensic analysis
- Crime scene investigations are essential as forensic evidence is more likely to be recovered from children's clothing, towels and bedding than their bodies (Christian, 2000)
- Generally collected up to 72 hours in prepubertal children and up to 120 hours in pubertal children
- Kits are often referred to as "SANE exam", "rape kits" and "acute exams"

Wisconsin Crime Laboratory
Sexual Assault Evidence Collection

- **Step 1: Sexual Assault Report Form** – consent, assault information, post-assault hygiene, articles of clothing collected
- **Step 2: Clothing –** have patient undress on clean piece of exam paper and make bindle out of paper. Separate paper bag for each article of clothing.

Document Post-assault hygiene

- Urinated/defecated
- Wipe/wash genital area
- Bath/Shower
- Tampon use
- Brushed teeth/rinse mouth
- Ate or drank
- Changed clothing

Clothing Collection

Alternative Light Source

•Light sources may help identify foreign material on a victim's skin

• An alternative light source is often used and may illuminate semen as well as other substances such as milk, lubricating jelly, lotions and other material

• Illumination of a substance with an alternative light source is **not** specific for semen or biological evidence but can assist the examiner in swabbing potential evidence

Wisconsin Crime Laboratory Sexual Assault Evidence Collection

- **Step 3: Pubic Hair Combings**
  - not applicable prepubescent children
- **Step 4: Vaginal Swabs (4) and Smear (1)**
  - For prepubertal children: Vulvar or external genitalia (2) and Vestibular/vaginal or internal genitalia (2)
- **Step 5: Cervical Swabs (2) and Smear (1)**
  - For prepubertal children: Defer

Wisconsin Crime Laboratory Sexual Assault Evidence Collection

- **Step 6: Rectal Swabs (2) and Smear (1)**
- **Step 7: Oral Swabs (2), Smear (1) and Floss**
- **Step 8: Pubic Hair Standards -** (not applicable for prepubescent children)

Wisconsin Crime Laboratory
Sexual Assault Evidence Collection

- **Step 9: Miscellaneous and Foreign Material Collection**
  - **Step 9A: Debris -** Any foreign debris such as hairs, vegetation or fibers
  - **Step 9B: Dried Secretions -** Examples include saliva on a bite mark or suction injury
  - **Step 9C: Fingernail Evidence** - (use one moistened for each set of nails)

Wisconsin Crime Laboratory
Sexual Assault Evidence Collection

- **Step 10: Buccal Cell Standard (DNA) –**Using one swab, place the swab in solid contact with the inner cheek and gum surface during sampling.

Wisconsin Crime Laboratory
Sexual Assault Evidence Collection

- **Step 11: Optional Toxicology -** Collect samples if date rape drugs are suspected
  - Step 11A: Blood Sample – Fill a 10mL gray-top tube with blood. Toxicology blood samples should be collected within 24 hours
  - Step 11B: Urine Sample – Fill a 10mL gray-top tube with urine. Urine samples should be collected within four days

DO NOT PLACE THESE SAMPLES IN THE KIT BOX

Wisconsin Crime Laboratory Sexual Assault Evidence Collection

- The Sexual Assault Evidence Kit can be stored at **room temperature.** The Optional Toxicology Samples should be **refrigerated.**

What about Sexually Transmitted Infections (STI)

- Adolescents victims of sexual assault are typically offered prophylaxis for STIs (Gonorrhea, Chlamydia, Trichomoniasis)
- Prepubertal children should **not** be treated prior to confirming STIs in most cases
- The presence of a sexually transmitted infection in a prepubertal child is powerful evidence of sexual abuse
- HIV post exposure prophylaxis (PEP) and/or Hepatitis B immunization is sometimes indicated after an acute sexual assault

What about STIs in an Acute Examination <120 hours

Pubertal Children

- Acute Sexual Assault (<120 hours)
  - Offer prophylaxis for Gonorrhea, Chlamydia, Trichomonas, Bacterial Vaginosis and sometimes HIV (<72 hours) and Hepatitis
  - Base line testing for HIV, RPR, Hepatitis B/C if indicated
  - Follow-up testing for HIV, RPR and Hepatitis

Prepubertal Children

- Acute Sexual Assault (<72 hours)
  - Follow-up testing indicated in 2 weeks for Gonorrhea and Chlamydia (Do not give prophylaxis medications for these infections)
  - HIV prophylaxis if indicated
  - Base line testing for HIV, RPR, Hepatitis B/C if indicated
  - Follow-up testing for HIV, RPR and Hepatitis

What about STIs in a Non-Acute Examination >120 hours

Pubertal Children

- Sexual Assault (>120 hours)
  - Test for Gonorrhea, Chlamydia, Trichomonas, Bacterial Vaginosis and, HIV, RPR and Hepatitis B/C if indicated
  - Follow-up testing for HIV, RPR and Hepatitis

Prepubertal Children

- Sexual Assault (>72 hours)
  - Test for Gonorrhea and Chlamydia
  - Follow-up testing for HIV, RPR and Hepatitis

Document Medical Findings and Acute Injuries

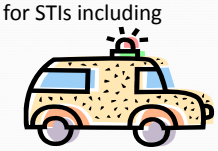
- Photo documentation is recommended as a standard of care but does not replace careful detailed description of examination findings and body diagram should be provided
- Be specific, for example contusions and swelling to the posterior rim of hymen with a transection at 6 o'clock
- **Positive findings are PEER REVIEWED by a child abuse expert**

When and **Where** should a child receive a medical evaluation in cases of suspected child sexual abuse?

When Should A Child Be Evaluated?

1) Immediate Evaluation

- Medical, psychological or safety concerns such as pain, bleeding, suicidal ideation or suspected human sex trafficking
- Sexual assault within the past 72 hours to 120 hours necessitating collection of potential trace evidence for forensic analysis
- Need for emergency contraception
- Need for post exposure prophylaxis (PEP) for STIs including HIV



When Should A Child Be Evaluated?

2) Urgent evaluation within 24 hours

- Sexual contact occurred within the last 2 weeks and there are no medical, psychological or safety needs identified

3) Earliest Convenience

- Last episode of abuse > 2 weeks ago
- Asymptomatic (no medical symptoms)
- Safety plan in place

Where should Children Be Evaluated

- Child Advocacy Centers are ideal locations
- Often these children are evaluated in Emergency Departments
- Important to have medical evaluations performed by health care professionals competent in these evaluations
- Follow-up medical evaluations may be indicated

Child Advocacy Centers

- "One Stop Shop" for child maltreatment
- Child-focused, child friendly
- Allows professionals to work together
- Designed to meet the needs of the specific community they serve
- All CACs strive to decrease the trauma children experience during child abuse investigations

Indications for a follow-up Medical Evaluation

- Findings on the initial examination are unclear
- Further testing for sexually transmitted infections needed
- Documentation of healing/resolution of acute findings
- Confirmation of initial findings by a more experienced medical provider

Why are Medical Evaluations important in cases of Child Sexual Abuse

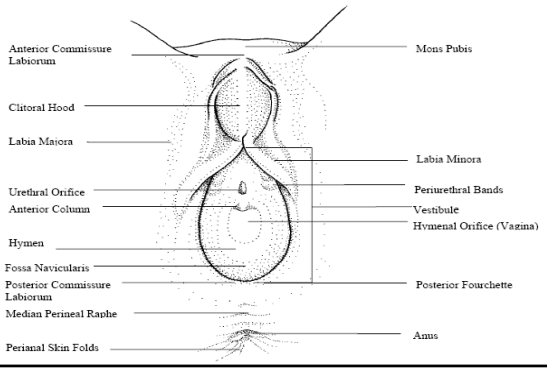
Why have a Medical Evaluation

- To obtain the history
- To assess for alternative explanations for medical findings
  - the evaluation may establish that a worrisome physical signs or symptoms were caused by something other than abuse
- For diagnosis and treatment of medical conditions
- To identify and document evidence of abuse: sexual abuse and physical abuse may both be present
- To assess the child's safety and well being

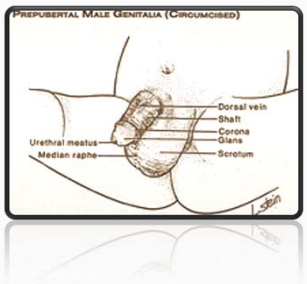
Why have a Medical Evaluation

- To reassure the child and family as appropriate
- To assess the child for developmental, emotional or behavioral issues and make referrals as indicated
- To provide expert witness testimony

Why are you talking about Anatomy?



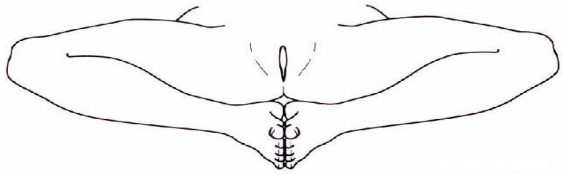
Prepubertal Male Genitalia



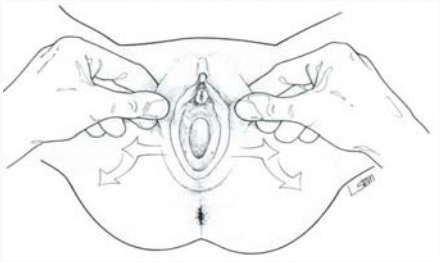
How to use Positions and Techniques for Visualization

Supine Frog-Leg

- For most pre-pubertal girls

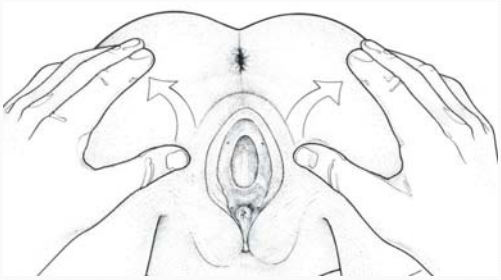


Traction



Prone Knee Chest

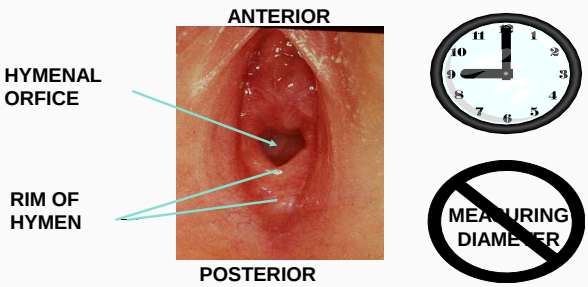
Holding in Prone Knee Chest



How to conclude?

- Explain evidenced based guidelines for forensic medical conclusions in cases of child sexual abuse

Viewing the Hymen



Normal Genital Anal Exams

- A normal exam is consistent with most forms of sexual abuse
- Most victims of sexual abuse, approximately 95%, have normal exams or non-specific findings which may be due to lack of injury associated with many forms of sexual abuse and/or rapid and complete healing of genital anal structures (Heger, 2002)

Interpretation of Findings from - **"2015 Updated Guidelines for Medical Care of Children Who May Have Been Sexually Abused"**

- Medical Evaluation of Suspected Child Sexual Abuse: 2009: Update
  - Joyce A. Adams
- Journal of Pediatric and Adolescent Gynecology (2007) 20:163-172
  - Joyce A. Adams, MD, Rich A. Kaplan, MD, Suzanne P. Starling, MD, Neha H. Mehta, MD, Martin A. Finkel, DO, Ann S. Botash, MD, Nancy D. Kellogg, MD, and Robert A. Shapiro, MD

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Normal variants

- Normal variations in appearance of the hymen
  - Annular, crescentic, imperforate, microperforate, septate, redundant
  - Hymen tags, bumps and mounds
  - Hymen notches or clefts (regardless of depth) above the 3 and 9 o'clock locations
  - Superficial notches at or below the 3 and 9 o'clock location
  - Narrow posterior rim

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Normal variants

- Periurethral or vestibular bands
- Intravaginal ridges or columns
- Hymenal bumps or mounds
- Linea vestibularis
- External hymenal ridge

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Normal variants

- Diastasis ani (smooth area)
- Perianal skin tag
- Hyperpigmentation of the skin of anogenital area
- Dilation of the urethral opening with application of labial traction

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Findings commonly caused by other medical conditions other than trauma or sexual contact

- Erythema (redness)
- Increased vascularity
- Labial adhesions
- Vaginal discharge

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Findings commonly caused by other medical conditions other than trauma or sexual contact

- Friability of the post fourchette or commisure
- Anal fissures
- Venous congestion or venous pooling in peri-anal area
- Molluscum contagiosum
- Anal dilatation in children with predisposing conditions

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Conditions Mistaken for Abuse

- Urethral Prolapse
- Lichen sclerosus et atrophicus
- Vulvar ulcers
- Redness, inflammation, and fissuring of the peri-anal or vulvar tissues due to infection that is not sexually transmitted

Findings Documented in Newborns or Commonly Seen in Non-abused children:

Conditions Mistaken for Abuse

- Failure of midline fusion
- Rectal prolapse
- Visualization of the pectinate/dentate line at the junction of the anoderm and rectal mucosa
- Partial dilation of the external anal sphincter causing the appearance of deep folds in the peri-anal skin
- Red/purple discoloration of genitals from lividity post-mortem, confirmed by histological analysis

Findings With No Expert Consensus on Interpretation With Respect to Sexual Contact or Trauma

- Complete anal dilation with relaxation of both the internal and external anal sphincters in the absence of other predisposing factors such as chronic constipation, sedation, anesthesia, and neuromuscular conditions
- Deep notches or clefts in the posterior/inferior rim of hymen (at or below 3 or 9 o'clock) that extend nearly to the base of the hymen
- Transections at 3 or 9 o'clock

Findings With No Expert Consensus on Interpretation With Respect to Sexual Contact or Trauma

- Genital or anal condyloma accuminatum in the absence of other indicators of abuse. Lesions appearing for the first time in a child older than 5-8 years may be more suspicious for sexual transmission
- Herpes Type 1 or 2 in the genital or anal area, confirmed by culture or PCR testing, in a child with no other indicators of sexual abuse

Findings Caused by Trauma and/or Sexual Contact

Acute trauma to external genital/anal tissues, which could be accidental or inflicted

- Acute lacerations or bruising of labia, penis, scrotum, peri-anal tissues, or perineum
- Fresh laceration of posterior fourchette or vestibule not involving hymen

Findings Caused by Trauma and/or Sexual Contact

Residual (healing) injuries to external genital/anal tissues (rare and difficult to diagnose unless an acute injury was previously documented at the same location)

- Perianal scar
- Scar of posterior fourchette or fossa

Findings Caused by Trauma and/or Sexual Contact

Injuries indicative of acute or healed trauma to the genital anal tissues

- Bruising, petechiae or abrasions on the hymen
- Acute lacerations/tears of the hymen
- Vaginal laceration
- Peri-anal lacerations with exposure of tissues below the dermis
- Healed hymenal transection/complete hymen cleft- a defect in the hymen between 4 o'clock and 8 o'clock that extends to the base of the hymen, with no hymenal tissue
- Missing segment of hymenal tissue

Findings Caused by Trauma and/or Sexual Contact

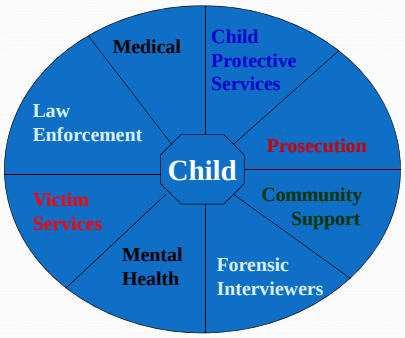
Infections transmitted by sexual contact, unless there is evidence of perinatal transmission

- Genital, rectal or pharyngeal Neisseria gonorrheae infection
- Syphilis
- Genital or rectal Chlamydia trachomatis infection
- Trichomonas vaginalis infection
- HIV, if transmission by blood transfusion has been ruled out

Diagnostic of sexual contact

- Pregnancy
- Semen identified in forensic specimens taken directly from a child's body

The Multidisciplinary Team



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