THE ROLE OF THE SEXUAL ASSAULT NURSE EXAMINER (SANE)

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OBJECTIVES: TO UNDERSTAND

• Medical exam as part of the healing process for children and families
• Triage of the medical evaluation
• Essential elements of a proper medical examination
• Medical examinations role within the overall investigative process
THINGS WE ARE NOT MEANT TO SEE AND HEAR
WHAT IS CHILD SEXUAL ABUSE?

Involvement of children in sexual activities …

• they cannot understand
• they are not developmentally prepared for (asymmetry)
• they cannot give informed consent
• in which they are exploited
• Can be violent or nonviolent
• Can be isolated or ongoing
• Can involve non-contact activities as well as physical contact
HISTORY OF MEDICAL SEXUAL ABUSE

- 1960s Mandated reporter laws in all 50 states
- 1980s Recognition of gonorrhea as a sexually transmitted infection in children
- 1983 Research on hymenal diameter
- 1985 First child advocacy center opened
- 1986 Use of colposcope in sexual abuse exams
- 1990s Expansion of research on normal anatomy and expected exam findings
WHY “IT’S NORMAL TO BE NORMAL”

- Perpetrator intent to avoid injury
- Prepubertal hymen is very sensitive
- Legal definition of penetration is through the labia, not the hymen (“vulvar coitus”)
- Genital and anal structures heal rapidly and completely
- Genital and anal structures are elastic, allowing penetration without injury
- Delayed disclosure by child
- Semen/sperm unlikely after washing or if > 24 hours
- Much of sexually abusive acts do not involve injury, i.e. fondling, pornography
WHO SHOULD HAVE A MEDICAL EVALUATION?

- The medical evaluation should be therapeutic for child sexual abuse victims. This is the primary reason for obtaining a medical examination.
- If sexual abuse is thought to be a possibility, a medical evaluation should be performed.
SEXUAL BEHAVIOR: WHAT’S NORMAL? WHAT’S ABNORMAL?

- 7 yo male & 7 yo female cousins are caught in parent’s bedrooms showing their private parts to each other

- 6 yo female is caught performing oral sex on her 3 yo brother
SEXUALIZED BEHAVIOR

- Children have normal sexual behaviors
- “Normal” sexual play is non-intimidating between developmentally similar children
- Non-abused children infrequently ask others to do sex acts, put mouth on sex parts, simulate intercourse
- Sexual behavior problems occur more frequently in children who have been abused or neglected

- Friedrich, et al., (1998) determined certain sexual behaviors in children were unusual, but there is no specific behavior or group of behaviors that can say definitively whether or not a child has been sexually abused. Sexually acting-out behaviors are suggestive of abuse, but not proof of abuse. Normal preteen children do not ask others to perform or themselves perform oral sexual acts or penile vaginal intercourse.
TOP TEN NORMAL BEHAVIORS

- (10) Dresses like opposite sex
- Hugs adults not known well
- Shows sex parts to adults
- Masturbates with hand
- Very interested in opposite sex
- Touches sex parts in public
- Tries to look at people when they are nude
- Stands too close
- Touches breasts
- (1) Touches sex parts at home

Friedrich: Normative Sexual Behavior In Children
LEAST COMMON BEHAVIORS

- Makes sexual sounds
- Asks others to do sex acts
- Inserts or masturbates with objects
- Pretends toys are having sex
- Undresses other children
- Tries to have intercourse
- Puts mouth on sex parts
- Touches animal’s sex parts
  - Draws sex parts
Behaviors do not “prove” sexual abuse
PERPETRATOR

• Typically well-known to or related to child with “authority” over child
• Most were not sex abuse victims (1/3)
• Strive to maintain secrecy with threats
• May engage in “grooming” behavior
• Male perps more common with sex abuse
• Likely to reoffend with other children
• Sexual orientation NOT a risk factor
• Mental health disorders are common
RELATIONSHIP OF PERPETRATOR TO VICTIM

- Father: 16%
- Stepfather: 10%
- Male cousin: 8%
- Male relative: 11%
- Female relative: 4%
- Uncle: 6%
- Male: 27%
- Unknown: 11%
- Other male relative: 11%
- Mother's boyfriend: 7%
- Unrelated Male: 27%
CAN I TELL YOU SOMETHING PERSONAL?
DISCLOSURE

• Many do not disclose
  • May be purposeful, accidental, or elicited
  • Most children with STDs do not disclose
  • Only 25% who disclose do so in the first year
  • 2/3 of adults surveyed who reported sexual abuse never disclosed to anyone as a child
  • Disclosure often incomplete and gradual

• Do not expect children to be forthcoming regarding details of sexual abuse
DISCLOSURE

• Recant
  • Many negative consequences for child after disclosure
  • Recantation rates reported from 4-27%, most are later reaffirmed

• Fabrication
  • Rates range from 0-10%
  • More common in older children
WHY DON’T ALL KIDS TALK?

• Not developmentally ready, acts weren’t “bad”
• Sworn to secrecy
• Trapped and helpless
• Afraid to upset family
• Fears no one will believe
  • May have disclosed and been disbelieved
• Threats / does not feel safe
• Feels responsible, overwhelming guilt/shame
• Hard to talk about first sexual experience!
FORENSIC INTERVIEW

- Performed at advocacy centers
- Minimize number of interviews of child
- May serves as the “evidence” of child abuse in criminal proceedings
- Formally trained interviewers
  - Establish rapport and trust
  - Establish credibility
  - Open ended and non-leading questions
  - Age and developmentally appropriate questions
- Videotaped / observed by investigator
- Introduced in court until 12 years of age
FORENSIC EXTENDED ASSESSMENT

• Series of 6-8 sessions
• Appropriate for children with strong suspicion for abuse but with no disclosure
• Not necessary if positive forensic interview obtained
• Forensic interviewing coordinated by investigatory team
TRIAGE

- **Acute (< than 72 hours-forensic window)**
  - Emergency examination by trained provider
  - Evaluation for forensic evidence collection
  - Photo documentation with peer review
- **Non-acute (> than 72 hours)**
  - Non-emergent examination by trained provider
  - Photo documentation with peer review
- **ED must exclude EMC-medical screening exam**
- **SANE (< 1 week)**
  - SANEs perform medical screening exam by protocol
  - Families in crisis
  - Balancing resources with CHIPS
GOALS OF MEDICAL EVALUATION

• Reassure patient and family that the child’s body is healthy
  • 95% with normal examinations
  • altered body image after sexual abuse
• Identify medical complications of abuse or medical conditions mistaken for abuse
  • psychological / behavioral changes
  • genital and nongenital injuries
• STDs
• Pregnancy
• Identify findings of forensic significance
• Begin the healing process by reassuring physical and mental health and addressing fears and concerns
• Initiate treatment for physical or psychological complications with appropriate referral for follow-up care
• Initiate investigation
• Reviewing safety plan
• Communicating medical “truth” to investigative authorities
WHY PHOTODOCUMENTATION IN ALL CASES

• Peer review
• Quality assurance for program
• Education of new providers
• Prevent multiple examinations
• Comparison for repeat assaults
• Outside expert review
• It is NOT for the purpose of showing photos in court
• Photodocumentation is why we know what we know today
REQUIRED RESOURCES

• “Trained Medical Examiners”
• Nurse Practitioners, Sexual Assault Nurse Examiners (SANE), Physicians with training!
• Child friendly facilities with necessary equipment
• Existing regional resources
  • Children’s ED SANE Program (acute)
  • CHIPS (non-acute)
  • Crisis Center Birmingham Rape Response (acute, age 14 and over)
MEDICAL HISTORY

• Separate process from forensic interview
• Event history obtained from the caregiver(s) separate from patient
• Details of child’s disclosure, timeline, qualifiers (bath, clothes change)
• Child may be asked about medical symptoms
• Open ended questions
• Hearsay exception
• Carefully document, include quotations
MEDICAL EXAM TECHNIQUES

- Empower child---**consensual exam**
  - choice of parental presence
  - explain exam to
  - discuss photographs (abuse may have involved pornography)
  - respect pt’s modesty
- Position of comfort (caregiver lap)
- Complete exam with attention to oral and skin findings (neglect, physical abuse)
- Avoid position of abuse
EXAMINATION PRINCIPALS IN PREPUBERTAL CHILD

- Speculum exam is not performed
- Hymen not touched with swabs
- Saline drops may assist in visualization
- Digital rectal examination is not performed
- Exam not forced on uncooperative child (*)
- Abnormalities confirmed in alternate position
- Followup examination sometimes needed
WHO SHOULD PERFORM THESE EVALUATIONS?

- If not specifically trained
  - feel uncomfortable
  - call normal findings abnormal (“hymen not intact”)
  - call abnormal findings normal
  - not recognize medical conditions which might be mistaken for abuse
- Examination techniques, evidence collection, and photodocumentation not taught in general medical training
46 patients examined by PEMs with nonacute findings consistent with sexual abuse

Follow-up exam with trained child abuse physician in 2 days to 16 weeks (mean 2.1):

- 70% normal
- 9% nonspecific
- 4% concerning
- 17% clear evidence of abuse

<table>
<thead>
<tr>
<th>Year</th>
<th>Sample Size</th>
<th>Incorrect Identification</th>
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<tbody>
<tr>
<td>1987 Ladson</td>
<td>n=129</td>
<td>hymen 41%</td>
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<tr>
<td></td>
<td></td>
<td>labia majora 39%</td>
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<td></td>
<td></td>
<td>labia minora 24%</td>
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<tr>
<td></td>
<td></td>
<td>urethra 22%</td>
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<tr>
<td></td>
<td></td>
<td>clitoris 11%</td>
</tr>
<tr>
<td>2000 Lentsch</td>
<td>n=166</td>
<td>hymen 38%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>labia majora 21%</td>
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<tr>
<td></td>
<td></td>
<td>labia minora 17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>urethra 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clitoris 6%</td>
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COMMON MYTHS

- Girls can be born without a hymen
- Hymen is accidentally injured (horseback, sports, tampons, bicycle riding)
- Hymenal diameter relates to penetration
- Sexual contact always injures the hymen
- A doctor can administer a sex test
- Anal penetration leaves laxity or scars
- Injured genitalia never heals
CONFIRMATORY TECHNIQUES

• Pre-pubescent
  • Prone knee chest
  • Saline administration
  • Changing position / traction angle
  • Repeat examination

• Adolescents
  • Swab exploration
  • Foley catheter technique
  • Speculum examination
  • Repeat examination
SEXUAL MATURITY RATING

• Tanner Staging

• A standardized system of assessing the degree of sexual maturity of teens by examination

• There are two areas assessed for each gender:
  • Males: genitalia (G) & pubic hair (PH)
  • Females: breast (B) & pubic hair (PH)

• Each area is rated from 1 to 5

• 1 is for prepubertal & 5 is for fully mature
INTERPRETATION OF FINDINGS

• “Adams classification”
  • Evidence based categorization of findings initially published by Joyce Adams, MD
  • Expert consensus used when evidence not clear
  • Revised and updated frequently
  • Used as a guide for interpretation of findings

• Stratified into three distinct categories
  • Normal
  • No expert consensus
  • Diagnostic
FINDINGS DOCUMENTED IN NEWBORNS OR COMMONLY SEEN IN NON-ABUSED CHILDREN

- **Normal variants**
  - bumps, clefts, mounds, enlarged hymenal diameter, bands, hyperpigmentation

- **Findings commonly caused by medical conditions other than trauma or sexual contact**
  - erythema, labial adhesions, anal fissure, venous congestion, anal dilatation in predisposing conditions

- **Conditions mistaken for abuse**
  - urethral prolapse, ulcers, venous congestion
The following findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless a clear, timely, plausible description of accidental injury is provided by the child and/or caretaker.

Examples include:
- Missing hymenal tissue 4-8 (confirmed)
- Acute hymenal transection
- Deep perianal laceration
- Gonorrhea
“Pull out, Betty! Pull out! ... You've hit an artery!”

Gary Larson, The Far Side
AS OLD AS CREATION

SYPHILIS IS NOW CURABLE

CONSULT YOUR PHYSICIAN

TOWN OF HEMPSTEAD

WH. BUNCE, M.D., HEALTH OFFICER

FEDERAL DYAPROJECT
STD GUIDING PRINCIPLES

• Selective testing for STDs (pre-pubescent)
• Infection usually indicates sexual abuse in children (but not adolescents)
• Non-sexual transmission possible (perinatal)
• Post-pubescent victims should receive PEP
  • High prevalence and complications
• Pre-pubescent victims should not receive PEP in most cases
  • Low prevalence and unlikely to have complications
• Confirmatory / follow up testing often necessary
SELECTIVE TESTING

- Victim with symptoms of an STD
- Offender at high risk (drug use, previous jail stay, etc)
- Vaginal, rectal or oral penetration
- Multiple perpetrators or stranger
- Sibling or parent with an STD
- Parental request
- Already diagnosed with one STD
- Test all adolescents (controversial)
NUCLEIC ACID AMPLIFICATION - NAAT

1. Obtain human sample for testing.

2. Lyse bacterial cells to access ribosomal RNA (rRNA).

3. Wash lysate over beads coated with DNA that will hybridize to rRNA of interest.

4. Pull down beads, isolating rRNA of interest.

5. Make double-stranded DNA (dsDNA) copy of rRNA.

6. Transcription mediated amplification of dsDNA into millions of RNA molecules.


Labome: Laboratory Tests for Venereal Diseases
NAATS IN CHILDREN

- More sensitive than traditional culture test
- Lower prevalence population
- Possibility of false positives
- Confirmatory testing must be performed
- Treatment withheld until confirmatory testing obtained
- In the past we used urine based testing
- Current: vaginal, rectal, and oral NAAT swabs
### SEXUALLY TRANSMITTED DISEASES

**Common**
- Trichomonas vaginalis  | Diagnostic
- Neisseria gonorrhoea  | Diagnostic
- Chlamydia trachomatis  | Diagnostic
- Human papilloma virus  | Suspicious
- Bacterial vaginosis***  | Inconclusive

**Less common**
- Herpes simplex virus  | Suspicious
- Molluscum contagiosum  | Unlikely
- Syphilis  | Diagnostic
- Hepatitis B  | Diagnostic
- HIV  | Diagnostic

***Not reported unless other concerns for abuse
FORENSIC EVIDENCE

- Semen/seminal products
- Blood
- Saliva
- Hair
- Bite marks
- STDs
- Pregnancy
- Date rape drugs
PRE-PUBESCENT FORENSICS

- Most pediatric exams do not yield forensic evidence
- Body swabs rarely positive after 24 hours
- Most forensic evidence found on clothing / linens
- Forensic evidence may be present even when only fondling disclosed
- Bathing / wiping may not eradicate DNA
- Medical history regarding clothing and bathing important
Fig 1. Identification of any forensic evidence versus time (odds ratio at ≤24 hours: 6.35; 95% confidence interval: 2.49, 17.14; P < .001).
• Most state laws use 72 hour window though evidence may occasionally be available after 72 hours
• State provides standard evidence collection kit
• Evidence collected at time of examination and sealed
• Forensics kits transferred to crime lab with chain of custody via law enforcement
• Processed at request of DA’s office
• Results not immediately available (this is not CSI)
FORENSIC EVIDENCE COLLECTION KIT

STATE OF ALABAMA
SEXUAL ASSAULT EVIDENCE COLLECTION KIT

MEDICAL PERSONNEL

Patient’s Name: 
Name: 
Sex: 
Age: 
Med. Pac. No.: 
Hospital: 
Date of Examination: 
Attending Physician: 
Signature: 
Attending Physician: 
Signature: 

POLICE PERSONNEL

Law Enforcement Agency: 
Investigating Officer: 
Case No.: 
Date/Time of Incident: 

CHAIN OF POSSESSION

Received from: 
Date: 
Time: 
Received by: 
Date: 
Time: 
Received from: 
Date: 
Time: 
Received by: 
Date: 
Time: 

Deliver to the Crime Laboratory Immediately
NO REFRIGERATION REQUIRED

FORENSIC LABORATORY PERSONNEL

Laboratory Number: 
Date Received: 
Investigator: 

NOSYMONTHNO

Provided free of charge by the Alabama Department of Forensic Sciences

VAGINAL SWABS AND SMEAR
PELVIC SWABS AND SMEAR
**ALABAMA’S CONSENT LAWS**

- 14 is the age of consent/refusal general health care
- 19 is the age of emancipation (parental request)
- 12 is age of consent for STI treatment
- 16 is age of consent for sexual activity
- 16 or older engages in sexual contact with a person less than 16 providing he is at least 24 months older
- Forcible coercion
- Capable of consent / physically incapacitated
Laceration  | Abrasions  | Bruises  | Edema
---|---|---|---
Consensual | Nonconsensual | Consensual | Nonconsensual
Jones et al, 2003
So now what?!?!

I am 100% certain that I am 0% sure of what I’m going to do.
"CROSSING YOUR FINGERS" WON'T PREVENT—VENereal DISEASE

BUT—A PROPHYLAXIS WILL
POST-EXPOSURE PROPHYLAXIS
(< 120 HOURS)

- Routine (> 5-10 % risk)
  - Ceftriaxone
  - Azithromycin
  - Flagyl (wait 24hrs for alcohol ingestion)
  - Ullipristal (Ella)
  - HPV vaccination in followup
- Infrequent (< 1% risk)
  - HIV PEP Protocol
  - Hepatitis B Immunization (if not immunized)
DRUG FACILITATED SEXUAL ASSAULT

- Victim with a period of memory loss for the events
- Victim thinks that she was drugged
- ETOH most common
- Designer drugs not detected on routine toxicology—rapidly cleared
- Specific testing for GHB / Rohypnol (sedative hypnotic panel) difficult to do and not sensitive
AFTER A REPORT IS FILED

• Prefer dual reporting to police
• DHR investigation (2-5 day initiation)
  • Safety plan (within 12 hours if perp has access)
  • Referral for forensic interview
  • Family assessment
  • Investigation of events and circumstances; including prior reports
• Children taken into custody must appear before a judge within 72 hours
• Disposition (30-90 days)
  • Indicated
  • Not indicated
• Services regardless of disposition
CONCLUSIONS

• A medical evaluation should be a part of the investigation of any child with a history of possible sexual abuse
• The child’s history is often the critical evidence in sexual abuse investigations
• Examinations should be performed by trained medical examiners
“Mr. Osborne, may I be excused? My brain is full.”